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# The COVID-19 Pandemic: Failing Forward in Public Health

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

## INTRODUCTION: THE TRANSFORMATION OF EUROPEAN UNION PUBLIC HEALTH

Although most governments were heavily scrutinized and looked bad early in the COVID-19 pandemic, the EU was most noticeable for its absence. As spring 2020 turned to summer it has become clear that most European citizens, and most European governments, expected their local, regional, and especially member state governments to protect them, not the EU. They are not wrong; the role of the EU in responding to a ramifying crisis such as COVID-19, with components ranging from public health to liquidity to trade to demand crises, is far from obvious. The law and politics are clear: the EU can only help save Europeans from a human public health crisis if member states instruct it to (Anderson et al. 2020).

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This chapter first presents the standard crisis narrative of EU public health policy. It then discusses the EU's COVID-19 response in terms of the three faces of European health policy—explicit health-focused policy such as public health protection, market-making and -regulating policies, and fiscal governance (Greer 2014). For decades, the second face of EU health policy, market regulation and integration, had dominated health policy, while explicit health policy was tightly constrained by member states and fiscal governance difficult to enforce on member states. With the crisis, however, European member states shifted the EU's emphasis considerably. They adopted a much more ambitious health policy agenda and a very different, if contradictory and contested, approach to fiscal governance that might lead it to look more like a federation. The conclusion returns to the European integration theories, arguing that the stylized debates of neofunctionalists and intergovernmentalists always obscured the extent to which member states have used the EU to rescue themselves before, and in the COVID-19 crisis are doing so again. The focus of the chapter is on the EU's own internal politics and policies. What is beyond the scope of this chapter is the course of its international engagement in COVID-19 response, including aid and vaccine politics, as it is politically and legally a different topic.

Initially, in March and April 2020, member states made minimal practical use of EU health law and policy, outside of sharing information and data through existing coordination mechanisms.<sup>1</sup> Instead, the first months of the crisis saw acute regulatory variation (Alemanno 2020). Member states showed little sense of solidarity in the face of a shared risk. Export bans on needed personal protective equipment (PPE), poorly coordinated border closures and widespread member state egotism all looked bad and fed into preexisting media narratives of EU crisis. Arguments about shared debt felt more like 2010 than 2020, with governments of self-styled “frugal” northern creditor states arguing for conditionality, and framing shared debt as bailouts for southern Europe.

This stage passed quickly as states reached an agreement about the goal of regulation, namely the reduction of transmission, and noted the need for some commonality in their pursuit of this goal (Alemanno 2020). Export bans were lifted, shared public procurements were organized and the funding for EU public procurement was increased. By late summer 2020, there was a huge new health budget, and a substantial enough program of shared debt to create an expert debate about whether there had been a transformation in the EU's basic political economy. European integration was once again being forged through crisis.

The constitutional place of public health, at least from the position of the EU institutions shifted almost overnight. European Union law had traditionally, and in line with world trade law, defined “public health” as a justification

<sup>1</sup>Decision No. 1082/2013/EU of the European Parliament and of the Council of 22 October 2013 on serious crossborder threats to health.

for member states to adopt measures in exception to the Art. 36 TFEU prohibition of infringement the freedom of movement of goods, services, or people. Although the determination as to the legality of the invocation of public health as an exception was made by European Union Judges, the substantive protection of public health was only ever intended to protect the health of national populations; never that of the population of the whole of the EU. It was a member state level concept that could justify member state level exceptions to EU policies (Weatherill and Beaumont 1999). The protection of public health of the whole of the EU was done through regulation of standards, for e.g. food, and pharmaceuticals, toys, medical devices, chemicals, blood, and blood products—never in opposition to other (EU) public policy objectives, but rather as its by-product.

European law accordingly looked on it with skepticism (the foundational *Cassis de Dijon* decision was actually about whether Germany was overusing the public health exception to discriminate against the French drink) (Greer and Jarman, forthcoming). Faced with member states' initial rush to close borders, including export bans, the Commission articulated a new logic: public health was a *European* concept and its invocation should be on behalf not of member states but EU citizens. Public health was an exception to EU law; now it is EU law (Purnhagen et al. 2020; de Ruijter et al. 2020).

A legal statement from the Commission is one thing, but money is something else. The European Union Health Programme had been losing its distinctive organizational identity for years while its small size (€446m 2014–2020) meant it had limited influence. The new “EU4Health” plan for 2021–2027, was €1.7 billion, reduced from an initial Commission proposal of €9.6 billion, and was accompanied by a huge increase in RescEU, the civil protection mechanism, and a separate vaccines strategy. EU4Health included crisis response, health systems strengthening (e.g. broader investment in the capacity and resilience of health systems so they can address unexpected consequences of COVID-19 as well as future problems), and continuing work on the preexisting priority areas of cancer, pharmaceuticals, and eHealth.<sup>2</sup>

It is worth noting that both crisis response and health systems strengthening open up space for direct and useful assistance to health systems, which has been a taboo topic for richer countries that are well aware of the scale of the Union's territorial inequalities. But it seems that member states have adopted an argument that neofunctionalists (see Niemann, this volume) and public health experts share: if the EU is to be an integrated area, that means every member state must have the public health capacity (surveillance, testing, tracing, and eventually vaccination) and health care capacity to keep the whole

<sup>2</sup>Brussels, 28.5.2020 COM(2020) 405 final. 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”).

Union safe from this highly infectious virus. There will undoubtedly be disappointments in store for both neofunctionalists and public health advocates, but it is a major alteration to the old equilibrium in which cohesion funds for capital projects, best understood as side payments, were the most health systems could really get from the EU.

Beyond the specific health budget, the EU responded relatively quickly to the unprecedentedly large and unusual economic crisis that the virus brought. Data on the scale of the catastrophe in Europe was staggering, with the EU economy contracting by 3.5% and the Eurozone economy shrinking by 3.8% in the first quarter of 2020, before the economic impact had really hit.<sup>3</sup> Most member states passed elaborate plans for income support and replacement in order to enable their firms and workers to survive the shutdowns and the contraction of overall trade that affected Europe's small and open economies. The initial, obvious, response from the EU level was to activate the "general escape clause" that suspended the operation of the fiscal compact and fiscal governance system in general.<sup>4</sup> This might take some pressure off, but it did nothing to address a Eurozone structure that been slowly asphyxiating economies such as Italy, Greece, and Spain for a decade. The innovation, possibly the one that will most impress historians, was the creation of an explicit and unconditional EU debt facility to support member states in managing the pandemic and its effects—a remarkably integrative step.

### A HEALTH POLICY FORGED IN CRISIS

More so than some other policy areas, the progress of EU public health policy has been written in terms of crisis and response. The eruption of a crisis opens a window of political opportunity (see also Ansell, this volume, Chapter 1 this volume). It increases the political will behind the search for a solution and makes it easier to achieve consensus on a common response, while the element of urgency reduces the time made available for debate and, potentially, obstruction. In health these factors are amplified by the presence of fear, which is readily present around issues such as communicable disease and is a powerful tool for shifting both public opinion and political commitment. Without a frightening crisis as a focusing event and problem, it has proven very difficult to get public health policy onto the EU agenda (Kingdon 2003). Member states guarded their autonomy, and many public health proposals encounter powerful resistance from big industries in areas such as tobacco, chemicals, and junk food (Greer and Kurzer 2013; Passarani 2019; Guigner 2018).

<sup>3</sup><https://ec.europa.eu/eurostat/documents/2995521/10294708/2-30042020-BP-EN.pdf/526405c5-289c-30f5-068a-d907b7d663c6>.

<sup>4</sup>European Council (ECFIN): 23 March 2020 Statement of EU ministers of finance on the Stability and Growth Pact in light of the COVID-19 crisis 23 March 2020. <https://www.consilium.europa.eu/en/press/press-releases/2020/03/23/statement-of-eu-ministers-of-finance-on-the-stability-and-growth-pact-in-light-of-the-covid-19-crisis/>.

While there had long been speculative proposals for European public health integration (Davesne and Guigner 2013), the first inklings of an EU health policy were partly in response to perceptions of a crisis in abuse of illegal drugs, and the first treaty language explicitly focused on that as a target of EU public health action. AIDS was also seen as a crisis where member states could productively work together through the EU (Steffen 2012). In retellings of the history of EU public health policy, though, the variant Creutzfeld-Jakobsen (vCJD) episode occupies a central role in the crisis story (Ansell and Vogel 2006; Ansell and Gingrich 2007; Farrell 2005).

Nicknamed “mad cow disease,” the story fit with broad neofunctionalist narratives as well as a Kingdonian multiple-streams approach. The problem was that integration of European food systems had radically outpaced the regulatory system, and an innovative agricultural sector had adopted practices few voters knew about or, it turns out, liked. Variant CJD was a relative of scrapie, a sheep disease, that spread into cattle through feed that included ground-up sheep and cattle. When this became public, it turned out that many Europeans were repelled by the idea of a food system that involved forcing herbivores to become not just carnivores but cannibals. Revulsion at the system that created the disease came with concern about the inability of any authorities to monitor what was happening in the food system, with the traffic in animals and animal products across borders essentially unregulated. As neofunctionalists would predict, increasing integration in one area (food production) led to problems that created a demand for European solutions to the new European problems (see Niemann, this volume).

The disease itself was a perfect focusing event and political problem, with garish images that everybody alive at the time is likely to remember—cows writhing in agony, a British agriculture minister trying to instill public confidence by feeding his young daughter a beef burger on television. While member states indeed resorted immediately to domestic actions—in 1996 France put an embargo on British beef—they also moved to creating a Europe-wide system of food safety and regulation including amendments to the Amsterdam treaty enabling broader EU powers. Their food systems were simply too integrated to do otherwise, and so the EU failed forward into a much broader set of standards and tightly integrated information systems. By now there is an entrenched EU regulatory framework laid out in the 2002 General Food Law Regulation. It is managed by DG SANTE (the Commission’s health directorate), an EU agency (the European Food Safety Authority) and an established and integrated network of food safety and agriculture regulators operating across the EU to police production and handling of food as well as keep records on what is going where in the integrated European market (Grant 2012). The system is still far from perfect, as we saw with “Horsegate” in 2013 (Brooks et al. 2017), and the 2011 scandal of e.coli in German vegetables. But then, its ambition is immense and its successes impressive. Measured purely in terms of the magnitude of the policy output, it was

a dramatic, expensive, and largely implemented commitment to Europeanize food production and safety.

Variant CJD might be a landmark in the broad relationship of the EU to public health, but it also was substantially limited to the food system. That is partly because vCJD was fundamentally a problem of food safety and veterinary health with only limited opportunities for human to human transmission (primarily via the blood supply). It is also because of the strong treaty bases, in agriculture and consumer protection, that exist in food policy. These were supplemented in the 1997 Amsterdam Treaty by new specific treaty powers for the EU to regulate blood and blood products, filling in that gap and also responding to issues about blood safety triggered by the scandal of HIV-infected blood supplies in France (Farrell 2005; Steffen 1992).

Reflecting the lowest-common denominator nature of EU policymaking and the sheer difficulty of Europeanizing a sector like food and agriculture, as well as health ministries' resistance to European action, the vCJD public health crisis produced an animal health response. It created a situation in which the EU has dramatic executive powers in animal health that vanish in questions of human health that do not involve blood. Had COVID-19 been a disease of pigs or sheep, the EU could have taken radical steps such as closing borders or ordering mass culls. But as it came in humans, there was little it could initially do; health ministers had done a good job of defending health systems and public health policies against EU imposition even as agriculture ministers, who were long comfortable in Brussels, had settled into a new, Europeanized, system.

The twenty-first century produced an increasing number and intensity of human health crises. They brought pressure on member state governments to act, and that sometimes meant acting through the EU. The 2001 terrorist attacks in the US and wars in Afghanistan and Iraq were the backdrop for a series of anthrax attacks that pushed public health up the global agenda while giving it a strong securitized tone (Greer 2017; also see Fidler and Gostin 2008). The 2003 SARS crisis had essentially no impact on European public health, but it changed the politics of public health in Europe as elsewhere (Fidler 2004). By showing the speed with which new communicable disease risks could emerge and travel the world, it inspired the first real efforts to build a European capacity in communicable disease control (Greer 2012).

The 2009 H1N1 influenza pandemic is widely remembered as a policy failure, in part because the pandemic strain of influenza was less harmful than seasonal influenza but also because it exposed a variety of dysfunctions in the European system, especially the hoarding and then wasting of vaccines and antiviral medication. Within the world of EU public health, though, there was considerable learning (de Ruijter 2019). H1N1 might turn out to have been the critical juncture at which the trajectory of EU health emergencies policy was set.

A 2013 decision set up a clearer framework and role for the EU in addressing health threats—a small role, but a bigger and more formal one

than before.<sup>5</sup> In a sector-specific replay of the kinds of socialization mechanisms that Europeanize politics more broadly (Van Middelaar 2013; also see Ansell, this volume; Cross, this volume), the Health Security Committee of member state representatives became an increasingly clear coordinating body with shared understandings among its members. Its role extended beyond its legal mandate into areas where member states wanted coordination. For example, radiologic emergencies and threats to health are governed under the EURATOM treaty. There is no desire to revise that treaty, so member states just agree to coordinate through the standard health threats system with the Health Security Committee at its core. It contributed to a sense among public health policymakers and advisors that the EU was indeed a community of fate in public health matters (Pacces and Weimer 2020).

The concrete problems of procuring medicines and vaccines during the H1N1 pandemic also led to the elaboration of the Joint Procurement mechanism which is effectively an EU buyers' club for medicines. It allows EU member states, most of which are not especially big pharmaceutical markets, to negotiate for better prices and terms. The West African Ebola outbreak in 2014 had similarly little impact on European morbidity and mortality but efforts to coordinate responses further developed mechanisms that member states could use when they chose (even if they frequently chose not to coordinate).

The EU's civil protection system after Lisbon changed focus as well. EU civil protection evolved largely in response to natural disasters and the obvious fact that global heating would expose more and more of the continent to more and severe kinds of disasters, from floods to wildfires to heat waves. Initially EU disaster response action had been largely targeted abroad, operating under external relations DGs and coordinating member state resources (e.g. search and rescue teams) with EU foreign aid. Gradually, it began to work inwards, supported by TFEU Articles 196 (on mutual aid among states) and 214 (authorizing the EU to aid victims of disasters worldwide), which provide a solid legal base for the development of EU civil protection capacity. It was primarily a matchmaking service, smoothing the process by which member states with spare resources (e.g. firefighting equipment) could loan them to member states with unexpected needs (e.g. fires). The scheme, called RescEU from March 2019, did not really have its own resources (equipment, people, or money) or foresight capacities. It did preparatory coordinating work, such as identifying and classifying medical and health resources that member states could volunteer in order to speed requests and avoid mismatches while making some efforts to harmonize or at least familiarize teams with each other.

By 2020 the cumulation of these different disaster responses meant that the EU had an agency responsible for coordinating communicable disease

<sup>5</sup>Decision No. 1082/2013/EU of the European Parliament and of the Council of 22 October 2013 on serious crossborder threats to health.



response (ECDC), a thin but institutionalized public health and health emergencies capacity in the Commission, and a useful-looking bridge between its civil protection system and health. The informal dimensions of this structure were bigger than they looked on paper and rooted it more deeply in member state politics than an outside observer might have thought, with groups like the Health Security Committee coordinating formally and informally.

No simple linear relationship between crisis and response exists, of course. As this book shows, crises are socially constructed (see Chapter 1 this volume; Ansell, this volume; Cross, this volume), as with the illegal drug crisis of the 1980s and 1990s, not all crises lead to actions, not all are stimuli to political action are actual crises, and there is no reason to expect that a crisis leads to a logical solution.

### COVID-19 AND EUROPEAN INTEGRATION

At the start of 2020 European Union public health policymakers and researchers, a small group, were cautiously optimistic about the future (Brooks and Guy 2020, forthcoming). The Juncker Commission had once considered abandoning health policy entirely (European Commission 2017) and had systematically sidelined the small Directorate-General for Health and Food Safety (SANTE). After that experience, the survival of the DG and a comparatively expansive mandate letter for the new Commissioner was cause for optimism (Greer et al. 2019). In the specific area of communicable disease control and health emergencies, the decade since the H1N1 influenza pandemic had been put to good use, developing and testing networks and legal forms to enable useful coordination in future health emergencies. But there was still no designated health emergencies budget line, the public health treaty base (Art. 168 TFEU) was very limiting, and the EU's civil protection mechanism was still being built.

By June, the situation looked quite different. Europe had been a global epicenter of the pandemic and the pandemic had reshaped EU health politics. The COVID-19 crisis hit Europe hard, starting with an outbreak in Italy in February, and the continent was clearly the global epicenter of the disease by late March and April. European governments, member state, and regional, acted, and Europeans turned to their governments to protect them. Much as it might frustrate us, it is hard to say how well any of them did. Despite citizens' desire to find heroes and villains among governments, and political scientists' desire to have mortality figures prove pet theories, the data is just not good enough and the causality too complex. Epidemiological factors such as transmission routes, social factors such as intergenerational living, and population health factors such as age profile and comorbidities (such as diabetes) all feed into the eventual outcome, and even that is hard to measure due to sampling problems with tests (Karanikolos and McKee 2020). But while it is not clear whether most governments did especially well or poorly, what is clear is that European member states initially moved on their own, revealing strengths that

had been easy to forget earlier. Only as the crisis evolved and governments realized their shared fates did they begin to work together.

This section frames the EU's change of course in terms of the three faces of EU health policy. Conversations about EU health policy were long bedeviled by the fact that most of EU health policy was not named as such, making EU health policies a constant "treaty base game" (Rhodes 1995) and leading to legal-epistemological debates about whether things like the General Food Law Regulation, which promoted human health primarily on agricultural, internal market, and consumer protection treaty bases, was "health" (Hervey and McHale 2015; Hervey 2017).

The three faces framework identifies three major and quite different ways in which the EU shapes health. The first face, health policy, is the face that resembles health policy elsewhere: built on Article 168, run by DG SANTE or agencies such as the ECDC or the EMCDDA (European Monitoring Centre for Drugs and Drug Addiction), and with the stated intent of promoting health. This has been by far the least consequential dimension of EU health policy to date; member states worked, in treaties, legislation, and daily politics, to restrain EU powers over human health and health systems, and succeeded. The second face is where the EU has had its most significant impact on health to date. It is the law of the internal market and its regulation. This includes the other policy areas that have human health named as an explicit policy goal, including labor law (social policy), environmental protection, and consumer protection. It also includes ones that have no legal, political, or historical commitment to human health, including law on the regulation of services, state aids, competition, cross-border mobility, and insurance. The irruption of these policy logics into health care systems was perhaps the biggest story in EU health policy for two decades; while member states had barred the door against EU action in health systems regulation and development, they were vulnerable to a simple reclassification of health systems as "services" and regulation of them on that basis. Efforts to establish the "specificity" of health care in the eyes of courts, and turn back challenges to see it as a service, or as a case of public procurement, state aids, competition law, or one of the other kinds of EU law, led to a directive and shaped EU health politics.

The third face of EU health policy is fiscal governance. Fiscal governance refers to the set of rules that were instituted to preserve the Eurozone by requiring member state adherence to budgetary limits, notably a deficit ceiling of 3% and a debt ceiling of 60% of GDP. The logic is that since the EU does not have internal redistribution on a large scale, and the ECB's defense of the Euro creates a soft budget constraint, member states will be tempted to issue too much debt, avoid making necessary structural changes, and eventually create debt crises (see Hjertaker and Tranøy, this volume for further discussion). EU fiscal governance is largely a history of failure. No matter how elaborate and legalized the system, it was hard to compel member states to make the kinds of austere policies that the system demanded. Furthermore, it is not clear that EU fiscal governance could be expected to work. All stick

and no carrot, it asked member states to pursue often brutal policies of internal devaluation right when the good policy would ask for countercyclical spending or social investment. Failing to address the alarming and growing scale of internal divergence between EU economies, it coded deficits and debt simply as failings of individual governments. Its crude moralism poisoned European political debate while blocking policies, such as the issuance of European debt, that might have addressed the internal divergence within the EU. A rigidly liberal framework in a rapidly diverging economy could point to a terminal crisis of some sort, but also pointed to a future in which much of southern and central Europe would become a permanent periphery—a giant *mezzogiorno* (Greer 2020).

Such a policy attracted not just principled and political opposition, but also led to numerous efforts to undermine it by those whom it would make suffer. Just as with previous efforts to impose fiscal governance rules in Europe, it began to decay quickly as opponents worked to undermine it (Zeitlin and Vanhercke 2018). The fiscal governance scheme set up in 2012 was, predictably, becoming rotten by 2020. Threats to act against member states with deficits were not credible while the vast and elaborate surveillance system that advocates of austerity had built was being undermined as opponents of austerity expanded goals, added and queried indicators, and increased the scope of conflict until the old, crude, rules were hard to apply at all (Greer and Brooks 2020).

By January of 2020, then, advocates of more ambitious EU health policies were relieved that DG SANTE had not been abolished and the new Commissioner actually had a more expansive mandate than under the Juncker Commission (see also Kassim and Tholoniati, this volume). They were nonetheless still struck in a structural trap: the only kinds of consequential policy affecting health that could plausibly be proposed could not be made in the name of health. There was only one open legislative file in health (on health technology assessment). Insinuating health objectives and engagement with health sector actors into the second and third faces seemed the rational strategy, whether it meant trying to promote health objectives in EU research policy or turn the European Semester from a crude tool of austerity into something less dangerous to health and social policy, or even a way to push up the salience of health objectives (Zeitlin and Vanhercke 2018). The fact that the UN Sustainable Development Goals were integrated into the Semester gave hope that the Semester would be more socially oriented, or at least less effective as a tool of austerity. Undermining the institutionalized austerity of EU fiscal governance, and the neoliberalism of internal markets policy under Juncker and Barroso, was hard, slow, and essentially defensive work.

### *Health Policy: From Exception to Policy*

The EU's immediate health policy responses to COVID-19 used the two key resources that were already available at the start of 2020: the ECDC, the

health emergencies system, and the RescEU civil protection mechanism. The ECDC fulfilled its function without visible hitches. It gathered and circulated data, its systems for transmitting information worked well, and its expertise was used. No member state government chose to rely on the EU (or WHO) directly for advice, and the ECDC, knowing its role, did not produce the kinds of detailed guidance that was being published by state-level institutions or WHO. Governments filtered EU and other information and advice through their own committees of experts, whose composition and transparency varied greatly. ECDC's role was always limited. It had fewer than 300 staff and was manifestly not designed to be the front line of European health emergency response (in the language of the field, its role is risk assessment). Rather, it was designed to be a hub for member state level experts and information, and it fulfilled that role (Greer 2012; Guigner 2004, 2006; Deruelle 2016). The Commission and member states in the Health Security Committee are in charge of risk management, where decisions are made, and actions are taken. Again, the system worked as one might have predicted; the Committee coordinated as intended. It was a vehicle through which EU member states coordinated more and more issues, as the first wave of panic and national egotism subsided, and they realized the benefits of coordination as well as safety in numbers (see Trondal, this volume).

The system worked, but it was a small and historically unambitious system made up of a committee whose informal role exceeded its formal powers, a supranational agency that was dwarfed by many of the national agencies it coordinated, and a small Luxembourg-based unit of a small DG that lacked its own budget line, supported by an administrative agency (CHAFEA) with no independent legal basis. Already tested by the crisis, it was then given a new challenge. The Commission rapidly prepared a new work plan and the EU budget was amended, increasing money for health work in the EU4Health program as well as RescEU's dramatic expansion. Whether this substantial increment will stay remains to be seen (historically, public health emergency response has a way of declining as memory of the last crisis diminishes). It is also unclear whether the funding and priority-setting mechanisms will be politically sustainable now that their policy role is central and the amounts of money far greater. However, the guidance and initiatives issued by the Commission may well raise the expectations of citizens, market actors, and member states (Alemanno 2020: 316) and, as neofunctional theory anticipates, underpin relocation of the political debate to the European level.

Civil protection (RescEU), like the EU, initially disappointed. A match-making service is of no great value in a moment of autarchy and egotism, and was not designed for a situation in which all states face the same needs. Member states were either in deep crisis or feared that they were about to descend into crisis. That made them reluctant to offer up any current surpluses to states in need, lest they should soon need these themselves. But as the unevenness of the pandemic became clear as well as the long-term nature of its threat, member states came to the view enlightened self-interest meant a

policy that stockpiled EU resources, even ones that were immediately relevant to COVID-19 and scarce. Accordingly, by April RescEU was stockpiling equipment of immediate usefulness and by late summer its budget was much larger.

### *Markets: Preserving the Internal Market*

Legal scholars often write that the “four freedoms” of movement of capital, goods, people, and services are constitutional principles of the EU. When member states initially started closing borders to each other’s citizens and imposing export bans on important equipment such as personal protective equipment (PPE), it could be regarded as necessary emergency measures but also as a blow to the heart of the EU. As noted above, member states either were in crisis or feared crisis. They accordingly hoarded supplies and applied export bans, creating a new and unexpected landscape of inequality based on who happened to have a given kind of factory within their borders. There was a barely plausible public health case for closing borders to people in some states, especially if combined with domestic restrictions on movement. Export bans, on the other hand, were a direct assault on the internal market and solidarity. Member states turned a public health crisis into what could have been an EU constitutional crisis.

The Commission reacted forcefully to the export bans (de Ruijter et al. 2020). They fought back with infringement proceedings against illegal restraint of trade in goods. There would be little reason to expect courts applying EU law to support member state actions that reverse principles dating to 1956. But courts, of course, live in political worlds; so why did the EU so quickly manage to reestablish its market? The Commission’s success might be partly due to revulsion at some cases of apparent national egotism (Italy receiving masks from China before Germany, Czechia seizing a shipment of masks Italy had bought) several of which later turned out to be less clear-cut than they looked, but which looked very bad at the time. Furthermore, member states quickly started to recognize that the pandemic would hit them unevenly. A functioning European market would serve them all better than a weird landscape of plenty and want based on what kinds of factories were located where.

Restrictions on personal mobility took longer to undo and at the time of writing are still widespread. The EU, with energetic input from the Commission, began to try to coordinate and slowly reduce personal movement restrictions, even developing an app to make it easier to work out who could travel where and what would be permitted when they arrived. Schengen states developed common external border policies, setting standards that tightly restricted arrivals from countries which did not have their epidemics under control such as Brazil, Russia, and the United States. In this area, the Home Affairs Council formation led. Its increasingly tight coordination led, by July 2020, to integrated European decision-making on entrances. Given that its first decisions in 2020 were to effectively close Europe to some of the world’s

most powerful countries and Europe's biggest trading partners, the European decision to act together and formulate transparent rules was a test passed for integration. At the time of writing in autumn 2020, the key question was how the UK would be handled. Schengen might be European, but member states control border guards, and Southern European countries which had never really recovered from 2010 and faced bleak economic prospects opted to admit British tourists despite the manifest failure of the government to control the virus in England.

### *Fiscal Governance: A Hamiltonian Moment?*

The first line of defense for the Euro and Eurozone economies is always the European Central Bank (Dyson 2001, also see Hjertaker and Tranøy, this volume). The ECB wobbled early in the crisis, with a wayward statement by its head Christine Lagarde that disrupted Italian bond markets. But it quickly reverted to its de facto role as guarantor of the Eurozone's financial stability, a role that sophisticated political observers had identified soon after its birth. Its clear and continued commitment to ensuring the smooth functioning of the Eurozone monetary system meant that potential liquidity crises in the early period were averted. However, the problem with relying on central banks to compensate for fiscal policy failure, as the EU, US, and other countries show, is that all of their tools increase inequality and finance-sector rentierism.

The elaborate structure of EU fiscal governance collapsed almost immediately. The Commission quickly invoked the "general escape clause," which lifted the Stability and Growth Pact's restrictions on member state spending. The Semester's surveillance continues, but it had become an increasingly diffuse process with health goals included, and it is unclear how much it will matter. In mid-2020, it was a sideshow and by late 2020 it was being integrated into a new Recovery and Resilience Facility. There will inevitably be a pro-austerity backlash from the right in European and world politics, but it is not at all clear that proponents of austerity will find the existing fiscal governance structures a promising tool when they renew their push. Others float the idea that the Semester might be used to strengthen the EU's resilience in the face of pandemics (Renda and Castro 2020), linking this to integration of the Sustainable Development Goals (SDGs) in a further dilution of the framework's original purpose. The integration of the Recovery and Resilience Facility, below, with the Semester might suggest just such an outcome.

The real excitement was the unprecedented issuance of common European debt as a response to the crisis. This might turn out to be the biggest single change that the crisis precipitates, and seems to constitute an early, significant evidence of *heading forward*. Students of political economy debated whether this was the EU's "Hamiltonian moment," referring to the critical juncture in American political economy when the federal government assumed states' war debts and created its own debt in 1790. In an object lesson in the difficulties of historical analogy, the discussion of whether the EU had a Hamiltonian

moment in 2020 fell immediately into conceptual confusion. The question was not whether the EU had suddenly turned into the US. It was whether the EU would start to develop the fiscal capacity that every other viable federal government has and uses to stabilize its internal divergence (Greer 2020; Greer and Elliott 2019). The original Hamiltonian moment in eighteenth-century North America was a very limited federal decision (assuming debts plausibly related to the revolutionary war against the UK) that turned out to have enormous path-dependent consequences for the country's fiscal structure. It put the US on a road to convergence with most other federations with a big role for the central government and its debt. 2020 produced nothing like a Europeanization of the crushing debt burdens of Greece or Italy, but on the other hand it created a mechanism to issue very solid debt for member states without any conditionality.

The impact of this could be far-reaching. As is well known, the EU grew up as a regulatory polity, a law-state (Kelemen 2019; Majone 1994; Page 2001). Compared to other federations it has combined an unusually deep regulatory reach into the affairs of its member states with nugatory fiscal capacity and essentially no implementation capacity. But now, it will issue European debt to sustain its member states through at least one big crisis, without conditionality and with a role for the European institutions in allocating the money. The debt is for response to the specific and unprecedented crisis of COVID-19, but since the crisis will last a long time, the virtues of shared debt as a way to maintain the EU's internal economic and political coherence might start to appeal to policymakers. Even if it is wound down, which is clearly the preference of "creditor" member states, the experience of having issued and distributed shared debt is a precedent for European action that will be hard to forget.

### CONCLUSION: ANOTHER EUROPEAN RESCUE OF THE NATION-STATE?

European integration, and on bad days EU studies in general, has long been understood through a literature that focused on stylized duels of neofunctionalists and intergovernmentalists. While interesting and theoretically productive, the debate distracted us from the fact that the empirical stories of European advance were often very similar. Member states confront a problem that they share; they identify a shared approach, typically after initial attempts to address it individually or through intergovernmental mechanisms; they formalize a least-common-denominator response through the EU institutions, reining in ambitious EU actors (Kleine 2013); the result is integration, but rarely integration at the scale that advocates of European Union or comprehensive policy solutions would like to see. In other words, they fail forward (Jones et al. 2015, also see Stenstad and Tranøy, this volume). Faced with what the introduction refers to as disintegration (scenario 1), member states will try *muddling through* and might find themselves taking major steps. To the extent

that they muddle, they might create the conditions for another crisis that will require another European rescue of the nation-state (Milward 1999).

This chapter is being written early in the COVID-19 crisis. Epidemiologically, the virus is likely to stay endemic in our species for a long time to come; the opportunity to stamp it out worldwide was lost in January or February 2020 at the latest. Even suppressing it consistently in an age of interconnected economies and personal mobility is likely to be impossible. If some EU countries, formally or informally, adopt a “herd immunity” strategy of letting the disease circulate more or less unconstrained, they will eventually export the disease to the rest of the Union, just like a few major disease-exporting trading partners are a threat so long as there is no vaccine. At some point, either there will be a widely distributed vaccine that is safe and effective, or countries will, at enormous cost, start to overshoot and then stabilize around the “herd immunity” threshold of 60–70% infection. Until then, economic disruption is the best-case scenario, and many more deaths the worst. The vaccine itself will pose serious policy problems, from trials of a vaccine on a very short timescale, to distributional decisions about who gets what vaccine when. These problems will test EU solidarity and clout in the global marketplace. The upshot is that this chapter, written in September 2020, is at most a half-time discussion. More likely is that we are early in a reckoning with a pandemic that could easily last four or five years.

The likely long duration of the crisis matters in understanding the EU’s behavior because European integration can be slow, or at least slower than politics in most member states. The vCJD crisis was in 1996, but the General Food Law Regulation passed in 2002. A financial crisis that started in 2008 and morphed into a debt crisis in Europe in 2010 led to frantic improvisation at first (the Troika). The fiscal governance system that was intended to prevent another such crisis was only really built in 2012. The EU is not a quick-moving machine, and the ordinary legislative process in particular was not designed to be fast or decisive. Treaty changes are still less so. The existing mechanisms which embody genuine solidarity—collective purchase of vaccines via the Joint Procurement Agreement and emergency response mechanisms like RescEU—are voluntary, intergovernmental and do not move quickly enough to accommodate urgent needs (de Ruijter et al. 2020: 18). But the length of the crisis and the disruptions it entails give more than enough time for member states to learn and conclude that they want still more, or different, Europe. A crisis that lingers for years—and whose economic and social consequences are visible for longer—creates plenty of time for evolution in areas such as the management of the expanded health budget or shared debt. There will be time and pressure to build capacity and harder law, and to develop bigger ambitions for EU health.

What we can say, from the perspective of June 2020, is that the EU has actually had a good crisis. The predictable, if demoralizing, phase of disorganization and national egotism lasted only about a month (March–April). In May and June 2020 it created a substantial new first-face health policy agenda, reasserted its second-face market-preserving powers, and shifted its fiscal stance



in a much more supportive direction. “To the uninitiated, there is something quite logical in assuming that the EU is competent where its Member States are mutually dependent. Yet, public health is far from integrated” wrote Deruelle (Deruelle 2020), highlighting the tension that neofunctionalist theory would have us expect to produce integration. The COVID-19 crisis exposed European Union member states’ interdependence. It has, so far, also led to integration.

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