Testing the Limits of EU Health Emergency Power

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Due to its borderless nature, COVID-19 is a matter of common European interest since its first detection on the continent. Yet this pandemic outbreak has largely been handled as an essentially national matter. Each country adopted its own different health response, according to its own risk analysis framework, with little regard for the scientific and management risk advice provided by the EU, notably the European Centre for Disease Prevention and Control (ECDC).

After some initial country-by-country variation, member states have progressively converged on 'social distancing' as the preferred non-pharmaceutical approach (NPA) to counter the disease. Virtually, all countries – with the notable exception of Sweden – required social distancing of the entire population, through the prohibition of public gatherings, schools closures (total or partial), and introduced border/travel restrictions, both for intra-state and intra-EU mobility. More than half of the Member States had proclaimed the state of emergency as examined in the Verfassungsblog's Fighting COVID 19 debate.

Due to their inherent cross-border spillovers, many of these national responses to COVID-19 raise major concerns under EU law. Yet only a few of them have been timidly denounced by the EU Commission as the Guardian of the Treaty. How long will this last?

Such a decentralized and uncoordinated COVID-19 crisis management has been and remains not only a source of confusion for citizens in a highly interdependent Union, but also a cause of constitutional concern for the Union's own integrity. To justify such an outcome as the inevitable consequence of EU's limited competence in public health is a well-rehearsed yet largely inaccurate argument.

True, while the Treaty mandates that a high level of human health protection be guaranteed in all Union policies, it explicitly excludes (Article 168.5 TFEU) the possibility for the EU to adopt public health harmonizing measures or to organise and deliver of health services and medical care on its basis. However, the very same provision entrusts the EU to play inter alia a complementing, supporting role by coordinating Member States – which maintain the main responsibility for public health – in the "fight against [...] serious cross-border threats to health" and "also adopt incentive measures designed to [...] combat the major cross-border health scourges".

Believe it or not, protecting citizens from such threats – notably "to improve surveillance and preparedness for epidemics"– is one of the three strategic objectives of the current EU health policy and can (and must) be read in conjunction with other health-related legal basis, such as disaster protection (Article 196 TFEU).

Since the early 1990s, the EU set up a network to ensure the epidemiological surveillance of communicable diseases, and an Early Warning Response System for the prevention and control of these diseases. Following the SARS and H1N1 outbreaks, this network was upgraded into a fully-fledged legal framework for European Union action on health emergencies – the Cross-border Health Threats Decision. This is coordinated by the Health Security Committee (HSC), which is in existence since 2001, and builds upon the scientific input of the European Centre for Disease Prevention and Control. In the case of COVID-19, an ad hoc advisory expert panel – composed of epidemiologists and virologists from different Member States and chaired by the EU Commission President – has been set up to formulate 'EU guidelines on science-based and coordinated risk management measures'.

The Cross-border Health Threats Decision expressly requires Member States and the Commission to consult each other in the Health Security Committee (HSC) – which is made up of representatives from the ministries of health – with a view to coordinate

Member States' public health responses and crisis communication.

It is manifest that neither occurred until approximately mid-March 2020, after the Italian government activated the EU civil protection mechanism established under the "solidarity clause" (Article 222 TFEU).

Yet, on 25 January 2020, the ECDC alerted all Member States that:

> *"In light of the currently available information [...] the potential impact of 2019-nCoV outbreaks is high and further global spread is likely".*

Member States failed to come together and react jointly by enacting instead national responses. While several factors explain the ineffectiveness of the EU Cross-border Health Threats mechanism as currently designed and operationalized, they essentially all point to a major, structural cause. Health care being in Member States' hand, the pre-conditions to make a sustained EU-wide public health coordination happen are far from being met. Those range from the existence of common methods for data collection on the spread of the virus, the characteristics of infected and recovered persons and their potential direct contacts, a EU-wide common testing strategy to cross-border cooperation in healthcare emergency assistance; all areas clearly falling under the healthcare exclusive competence of each member state. Not only the EU does not have any of these frameworks in place, but also lacks a mapping of its member states emergency preparedness plans as of today.

As Member states are moving to phase 2 of the COVID-19 crisis by relaxing some of their restrictions, the EU is expected to play a greater role than the one exercised in the first stage of the outbreak. This is not only required to eventually discharge its Treaty mandate, but also to ultimately saving lives. This new role for the EU in responding to the next phase of the pandemic management consists of the design and enforcement of a EU-wide coordinated approach to the lifting of restrictive measures (and potentially their reintroduction) in the coming weeks and months. That's what the EU Commission proposed, together with European Council, by taking into account how the specific epidemiological situation, territorial organisation, healthcare service arrangements, population distribution or economic dynamics might affect Member States' decisions on where, when and how measures are lifted.

The Joint European Roadmap towards Lifting COVID-19 Containment Measures (EU Exit Roadmap) offers three main criteria to assess whether time has come to begin to relax the confinement for each and every member state:

- **An epidemiological criterion** showing that the spread of the disease has significantly decreased for a sustained period of time;
- **Sufficient health system capacity**, i.e. the extent to which the different health care systems can cope with future increase in infection rates after lifting of the measures;
- **Appropriate monitoring capacity**,including large-scale testing capacity to detect and monitor the spread of the virus combined with contact tracing and quarantine capacity in case of reappearance and further spread of infections.

This rather unusual guidance document strikes a fine balance between the need for EU-wide coordination and Member States' different country-specific needs and cost-benefit calculus. It essentially introduces a set of meta-criteria or benchmarks framing the exercise of member states' health prerogatives. In so doing, it also leaves each member state the choice, depending on their size and organization, "at what level compliance with the criteria above should be assessed" (e.g. regional or macro-regional level rather than at national level).

This roadmap, together with a flurry of new documents freshly produced under time pressure by the EU Commission through its above-described public health emergencies bodies, call for a close legal analysis. These guidance documents include the 'COVID-19 Guidelines for Border Management Measures to Protect Health and Ensure the Availability of Goods and Essential Services', the 'Guidelines on EU *Emergency Assistance*in*Cross–Border Cooperation* in *Health*-

*care*related to the *COVID-19* crisis', the 'App Toolbox on the use of digital means to empower citizens to take effective and targeted social distancing measures', and the proposed 'Guidance for common testing strategies'. While adopted in a situation of emergency, these guidance documents show a timid yet auspicious attempt by the Union to operationalize untested competences contained in the Treaties and to do so in a situation of emergency.

The question is then if and to what extent the Commission will be enforcing those guidelines, notably the EU Exit Roadmap, while called upon to discharge its duty to balance public health benefits against other social and economic impacts.

What if a given Member State lifts its COVID-19 restrictions too early, i.e. in the absence of a "significantly decreased of the spread of the disease for a sustained period of time"? What if it does so despite not having 'sufficient health capacity' in case of reappearance? Or what if a country fails to reintroduce a restrictive when the spread of the virus has significantly increased?

Far from constituting EU legal acts, and produce legally effects invocable by third parties, these guidelines are set to raise legitimate expectations vis-à-vis EU citizens, companies and also member states. While they may certainly be used to contextualize the examination of the legality of these national measures under EU law, in particular their proportionality, it remains unclear what their most immediate and long-term legal implications may be. Theoretically, should they go through the legislative process and be transformed into legislative acts, the EU COVID-19-related guidelines could qualify as "incentive measures" under the new and untested Article 168(5). Incentives measures would emerge as a novel tertium genus falling in between existing coordination public health measures and prohibited harmonization public health measures.

Be as it may, by testing the outer limits of the EU public health competence, COVID-19 is set to go down in history as a major catalyst in the advancement of EU health emergency action. Never before, legally defining – or re-defining – who does what, how and when under EU law meant saving lives or causing deaths.

On this note, you may wonder how possible it is that EU leaders could miss a one-in-a-generation opportunity to translate into action the "A-Europe-that-protects" mantra that was so well-rehearsed ahead of the latest EU parliament elections. French President Emmanuel Macron famously crafted this strategic narrative to address the EU's failure "to respond to its peoples' need for protection from the major shocks of the modern world" (*sic*).

As suggested in this brief legal account of the EU response to COVID-19, it would have been and remains possible for the EU to make a difference in the sanitary (not only financial) crisis induced by this pandemic. While this won't make it up for the lives lost, its symbolic value shouldn't be underestimated.

To learn more about the world's and European's regulatory response to COVID-19, you can read the Special Issue of the European Journal of Risk Regulation: Taming COVID-19 by Regulation.

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