

spots. Even after COVID-19 has passed, global heating, antimicrobial resistance and globalization ensure that there will be more such needs for public health action.

It is a truism that European public health, and European integration, grow through crises.<sup>9</sup> EU public health, like the EU, has 'failed forward' several times.<sup>10</sup> COVID-19, by far the biggest public health crisis of the EU's history, could prompt the biggest and most valuable steps yet.

*Conflicts of interest:* S.L.G. is Senior Expert Advisor to the European Observatory on Health Systems and Policies.

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doi:10.1093/eurpub/ckaa088

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*The European Journal of Public Health*, Vol. 30, No. 4, 624–625

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## Will COVID-19 lead to a major change of the EU Public Health mandate? A renewed approach to EU's role is needed

These days we see the first assessments on the EU's role as crisis manager. Commentators differ in their view whether the EU has failed, been late or has finally come to a substantial response.<sup>1,2</sup>

We should bear in mind that there is a limited EU role in crisis response specifically and for Public Health in general. With regard to the first, Member States (MS) and even sub-national levels are the first and key crisis managers addressing the responses to the pandemic. Moreover, despite some responsibilities and institutions for supporting the immediate crisis response (e.g. ECDC, Early Warning & Response System, Health Security Committee, Decision on serious cross-border threats), the EU role is with coordination, sharing information and building supporting structures for MS to be prepared better for an emergency response. With regard to Public Health in general, the EU has a narrow mandate<sup>3</sup> with limited law-making powers. There is a strong reluctance by MS to hand over responsibilities, because health(care) is close to their citizens.

It is tempting to assume that the COVID-19 crisis could lead to major shifts of authority to the EU to address deficiencies in the national responses. This could only be realistically envisaged if there is an added value and greater efficiency to organize responses jointly.<sup>3</sup> Part of the COVID-19 crisis and its characteristics and responses might call for better coordinated European responses with the virus crossing borders, need for highly specialized treatment facilities in intensive care units (ICU) or harmonized surveillance and social distancing guidelines. Moreover, Public Health crises such as infectious disease outbreaks have in the past triggered the expansion of the EU powers and institutions. Responses to BSE/CJD, SARS and H1N1 have created some of the

EU institutions and mechanisms in Public Health<sup>4</sup> that are currently used and tested by the COVID-19 outbreak.

However, there are good reasons why we may not expect major transfers of health responsibilities to the EU but rather institutional innovations in the form of layering or other mechanisms of incremental institutional change.<sup>5</sup> First, one can argue that the best role for Europe is to provide what it already does. Many institutions and procedures at EU level are in principle established to support the crisis management of MS. A prime example is the ECDC Fellowship Program (previously EPIET training) which after 25 years has the effect that in all MS highly trained communicable disease staff is available.<sup>6</sup> Hence, it rather calls for adding certain tasks to existing work, serving new goals with existing structures or change of impact due to the new COVID-19 environment.<sup>5</sup> Second, the red lines for national governments have become clear in the past with no infectious disease 'management' for ECDC and have become apparent in some of the crisis measures taken unilateral by national governments. However, this does not need to be problematic, because a more decentralized approach can take care of regional variances much better than a one size fits all approach. Furthermore, a European Intervention Task Force coordinated by Brussels would just not work due to language and cultural differences, nor would it help to build up capacities in affected countries. Finally, in the current political mood with major Euro scepticism and reservations towards what the EU is doing, a major reformulations of the EU mandate seem not plausible in the near future.

In the following, a few preliminary suggestions are made for incremental innovations that could be initiated at EU level to

support MS. These suggestions are not exhaustive but to our knowledge can be instigated within the current EU mandate for health<sup>3</sup> and using existing (legal) institutions. Of course, the next crises might look different but there are generic measures that can be taken.

- (1) The COVID-19 pandemic has highlighted the importance of national Public Health structures for surveillance. So far, EU-wide comparative analysis in Public Health is scarce. The EU can support crisis coordination and emergency preparedness by case-definitions and IT-based reporting, compiling data on critical infrastructures for Public Health crisis and by requesting MS to report to the EU. Comparative statistics are important to monitor and understand outbreaks. They obviously do not per se lead to better preparedness but raise awareness also show how a country performs vice versa their peers and may trigger reconsidering current plans and levels hold for critical infrastructure. As a next additional layer, the EU could provide a system for how available infrastructure could be requested by another MS. Currently, patients are treated outside their home country due to shortage in ICU/ventilation places. Another examples involves the reporting of available beds for burn patients and cross-border transfers in case of disasters.<sup>7</sup>
- (2) Better attention to Public Health structures could be integrated to the European Semester—the EU surveillance process for reviewing and coordinating public policies and national budgets in its MS.<sup>8</sup> It would require a double redirection. The current health focus should move beyond ‘healthcare’ structures and their preparedness to address the consequences of the demographic transition to include the fitness of Public Health structures to deal with crises. And the European Semester also needs to incorporate more health and social aspects in general as those two factors will influence in future financial sustainability of the MS more and more.<sup>9</sup>
- (3) The joint procurement of medical counter measures should be foreseen within the Decision of cross-border threats. So far, the procedure has not been used—there has been no need and emergency obviously. Only in March 2020, the first call for joint procurement for personal protective materials was launched. Adding a next layer involves joint stock taking that the EC has announced recently,<sup>10</sup> because COVID-19 has elicited our dependency on global production processes and shipping chains and disruptions to it. However, joint stock taking will require a decision on what is essential to be stocked, the level of stocks, how in case of emergency stocks will be divided and how the additional costs will be borne.
- (4) The cooperation with WHO should be assessed. The International Health Regulations is one of the few arrangements all UN MS could agree on—including all EU MS. They have to be updated to un-politicize the management of a crisis. The reporting structure of pandemic preparedness of the UN MS to WHO have to be in

line with European ones, and non-UN countries have to be included too.

None of those innovations would require major changes to the EU mandate, nor major new legislative initiatives but could be covered by existing secondary legislation by adding other layers of work or focus in the current remit. These suggestions outlined above and potential other measures may allow the EU to facilitate the (joint) emergency preparedness of MS in the future.

*Conflicts of interest:* None declared.

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doi:10.1093/eurpub/ckaa103

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 The European Journal of Public Health, Vol. 30, No. 4, 625–626

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## The EU and the social determinants of health in a post-COVID world

The EU has not played a central role in responses to COVID-19 and Greer and de Ruijter’s article provides some clues regarding why.<sup>1</sup> Put simply, member states have been resistant to building the institutional mechanisms needed to address a cross-national health threat, such as a pandemic, and so the EU’s role has by virtue of these constraints been relatively minor. This was not inevitable and there are, as Greer and de Ruijter describe, a number of options open to the EU both now and in the future.

Alongside their insightful suggestions, another strand to an ‘EU public health policy’ that responds to this crisis would be to minimize the social disruption created by the pandemic. Reducing transmission rates through physical distancing will exacerbate inequalities in the social determinants of health and there is every indication that exposure to these social risks will not be short-lived.<sup>2</sup> Many households have faced significant income shocks because of reduced hours, cuts in wages, or simply job loss. Millions across