Health and European solidarity after the pandemic

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The Covid-19 pandemic has clearly exposed the Achilles heel of the European project: the gap between the European Union's powers and competencies on the one hand, and, on the other, the issues that are closest to European citizens' concerns – health, employment, social protection and education. At the same time, the pandemic has made an excellent case for the benefits of solidarity, at European as well as international level. The proposals that the European Commission has presented in response to the health and social crisis are bolder and more ambitious than any previous initiatives. Yet there is still a long way to go to further transfer responsibilities in the social field from the member states to the EU, and to make solidarity a strong feature of European social policies, as these, more than other policies, are inevitably linked to cultural values and political beliefs. In spite of this, a more solidary future for Europe is possible, if the EU can find the political will to enforce a narrative for sustainable development that addresses inequalities and the well-being of EU citizens.

The social contract, a European idea

No scholarly article could make the case for strong European solidarity, or for better global multilateral governance, more eloquently than the coronavirus pandemic of 2019. Do we still need to demonstrate the merits of cross-border cooperation after watching the virus spread across countries like wildfire, or after witnessing the astounding success of international scientific cooperation in creating several vaccines in record time?

Yet, at the same time, nothing like Covid-19 could expose so bluntly the Achilles heel of the European project. While the EU has acquired powers that can transform people's lives – trade, competition, macroeconomic stability – the issues that interest European citizens most are still those where the EU has the least direct competence: health, employment, social protection, education.

Healthcare is perhaps the most obvious example of this gap between people's concerns and EU powers. Public health is an exclusively national competence, and with the exception of self-selected success stories, member states have been traditionally reluctant to share

knowledge or engage in transparency and information-sharing about their national systems and policies.

Up to a point this is inevitable. A common European demos is not strong enough to give EU institutions the legitimacy to make hard choices on (the distribution of) limited resources involving the lives of people. But the advantages of solidarity against health threats between countries united by a common border and common values should be obvious – and how can you convince citizens that the EU matters for them, if it cannot keep them in good health?

When the pandemic struck, even for health emergencies – where the importance of cooperation within the single market was obvious even without the Covid-19 pandemic – the one and only legal instrument at the disposal of the EU was a Decision of 2013 on serious cross-border threats to health. That Decision, adopted in the aftermath of the H1N1 flu outbreak, a good decade after the first SARS coronavirus outbreak, established "the rules for epidemiological surveillance, surveillance of serious cross-border threats to health, early warning of and response to such threats, including with regard to planning preparation and reaction linked to these activities, in order to coordinate and complement national policies".

Those 'rules' failed the reality check of the Covid-19 pandemic. Predictably, an administrative decision agreed between health ministries in 2013 was not enough to ensure the transparent flow of information between member states, the coordination of restrictions to mobility and trade, or even less the distribution of protective equipment to fight the worst pandemic since the Spanish flu of 1918.

With this kind of inaction and solidarity gap, it is difficult to convince the average European citizen of the added value of the EU or the merits of a European social contract. Yet the social contract is a very European idea: a heritage of Stoic philosophy and Roman Canon Law, rediscovered in the age of Enlightenment and, for the last three centuries, the main doctrine of political legitimacy.

There are many views of what a 'European social contract' might entail, but the essence of the concept is simple: legitimacy rests on consent – and ever since the financial crisis of 2007, European institutions have been at pains to explain why citizens should adhere to a project that ostensibly does so little for the issues they care about most.

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Surveys over the years consistently show that Europeans are strongly attached to their national welfare regime. As the late Tony Judt put it 25 years ago in his extraordinarily prescient A Grand Illusion: Essay on Europe: European citizens have

consistently felt that protection from the forces of globalisation or natural disasters will come from national institutions rather than from European or multilateral organisations.

Since its inception, the European project has rested on the reductivist assumption that economic integration necessarily creates social and political affinities. Time has shown that production and finance can become globally integrated, that European economies can become interdependent, more so today than at any other time in history – while other aspects of human existence do not necessarily follow suit, at least not at comparable speed. I can think of no better argument than Covid-19 to disprove this assumption.

The limits of European solidarity

If inclusion and solidarity are not the EU's strongest suit, it is not for lack of words. For half a century, the European institutions have been remarkably productive on the declamatory aspects of EU solidarity. Particularly since the Maastricht Treaty of 1992, there has been much repetition of a 'Social Europe' or 'European Social Model' that combines economic growth, high living standards and universal social protection. The Charter of Fundamental Rights of the EU, proclaimed in December 2000, states that "Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all the Union's policies and activities" (Article 35).

This emphasis on welfare and inclusion is what sets the EU apart from other less ambitious multilateral organisations and regional economic integration projects, and it is what supposedly binds Europeans together in contrast to the 'American way of life' or the objectivism of Ayn Rand.

But solidarity and a shared sense of identity are difficult to translate from paper into practice. Social Europe has never been a homogeneous set of objectives or instruments. Some elements were born in 1957 with the original EC Treaty, and evolved through qualified majority voting, the European Single Act, free movement, health and safety, and the European Social Fund. Other policies acquired a Treaty basis in the 1990s.

The cumulative result is a panoply of legal, financial and policy instruments that are not entirely coherent, but certainly not negligible either. As the EU begins to address the social, political and economic impact of the Covid-19 pandemic, the debate on European solidarity remains handicapped by confusion and contradictory views about the role the European Union should play in employment, social protection, public health and health threats, education and skills development and, more broadly, in the reduction of inequalities.

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and underdelivering on the social dimension of the EU. And in more recent years, populist governments and nationalist parties across Europe have rekindled a divisive narrative of identity politics that would shock earlier generations of Europhiles.

Then came Covid-19.

The harsh lessons of a pandemic

The pandemic has revealed the shortcomings and limited resilience of EU welfare regimes, be it with regard to healthcare systems, social protection or education. In human resources and human capital, strategy planning, infrastructure or technology, very few countries, systems or institutions were prepared.

Covid-19 has reminded us of an obvious but often forgotten fact: strong, resilient health systems are not a cost for society, but an investment. Hundreds of years of wildfires have taught us that emergency preparedness is not a waste of time or money: every single urban centre in Europe has a permanent fire department and a reserve of fire engines. Now we will remember – hopefully – that we also need better preparedness against pathogens, which spread like wildfire across our borders and societies. And we will remember that the social determinants of health – in other words, not just healthcare coverage but also the factors that make people more vulnerable such as poverty, joblessness and exclusion — deserve far greater policy priority, at European level as well as nationally.

Several factors, such as the age and density of the population, imply different policies and country performances. But we can already draw a few common lessons on what the EU and its member states need to do as a matter of urgency. None of these lessons is new.[1]

First, invest in the recruitment and training of the health workforce (to address skills needs, ageing and structural shortages), and in the capacity of health systems (the number of ICU units relative to the population, for example, is six times higher in some countries than in others).

Second, increase the response capacities (testing, tracking, isolating) and the efficient use of data. Most Member States implemented similar containment measures, but with dramatically varying speeds and effectiveness; many of them have been unable to use simple health data for effective decision-making and surveillance. Most governments' ministries had no mechanism for, or practice of, coordinating between them. The lack of communication between regional and national authorities, or between public health and social policy has been extremely damaging.

Third, strengthen primary healthcare and prevention, as a key instrument of public health resilience and to maintain the continuity of care. The pandemic should be an incentive for Member States to address an old problem that takes new relevance today: the insufficient levels of (absolute and relative) investment in health promotion and disease prevention. This is only 3 per cent of total health spending on average.

1 Colombo, F. (2020), 'Resilience of Health Systems to the COVID-19 Pandemic in Europe: Learning from the first wave', OECD.

Lastly, deepen EU and international cooperation, in a wide range of areas with clear European added value: to tackle the cross-border nature of health threats, to obtain more effective synergies in research cooperation as well as in public procurement for medicines including vaccines and medical devices, to improve the mobility of healthcare professionals, to make medicine supply chains more resilient. In the years before Covid.

The EU has always seen itself as a paladin of multilateralism and global governance. In recent years, the rise of populist ideologies has made this ideal seem unrealistic, quaint even. In 2021, Europe may well feel vindicated, even if the task remains daunting.

The Commission rises to the occasion

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Leadership matters, and different political leaders have different priorities. Consider the radical contrast between the mission letters given by Jean-Claude Juncker and Ursula von der Leyen to their respective commissioners for health; both were issued before anyone had heard of a new strain of coronavirus.

Juncker's mandate to Vytenis Andriukaitis in 2014 was a blunt admonishment not to meddle with Member States In the area of human health, the tasks given to the Commission under the Treaty are more limited. The specific exclusion of national health policy and of the management of health services illustrate the importance of respecting the rules on subsidiarity and proportionality").

Von der Leyen's letter to Stella Kyriakides, issued in September 2019 before the pandemic, was already a constructive set of initiatives aiming to build a 'European Health Union', with no reminder of subsidiarity: a European cancer plan; affordable medicine supply; using e-health to reduce inequalities, promote better health data exchange, and support research on medical devices; tackling antimicrobial resistance.

Then the Commission proposed an increase of the seven-year EU Health programme from €450 million to €9.4 billion (lawmakers finally agreed on €5.1 billion). And in June, the Commission presented the enhancement of the EU Civil Protection Mechanism, and a European strategy to accelerate the development, manufacturing and deployment of vaccines against Covid-19, including an advance purchase agreement with manufacturers in return for the right to buy a specified number of vaccine doses in a given timeframe.

In November, the Commission presented a set of proposals in response to the pandemic. Their ambition and breadth would have been unthinkable without the wake-up call of Covid-19. A communication on Building a European Health Union: Reinforcing the EU's resilience

for cross-border health threats[2] was presented together with three legislative proposals – an upgrading of the Decision of 2013 on serious cross-border health threats; a strengthening of the mandate of the European Centre for Disease Prevention and Control (ECDC); and an extension of the mandate of the European Medicines Agency (EMA). A 'Pharmaceutical Strategy' further aims to create a future-proof regulatory framework to promote research and technologies, improve access to innovative medicines and reduce Europe's dependency.

The Commission argues that these initiatives would "put in place a robust and cost-effective framework to enable EU member states to respond to future health crises as a Union". And indeed, the new framework, if approved by member states and the European Parliament – a very big if – would significantly strengthen preparedness. An EU health crisis and pandemic preparedness plan and recommendations would be developed for the adoption of plans at national levels, with reporting and auditing obligations, supported by the ECDC. An integrated surveillance system would be created at EU level, together with stronger reporting obligations by Member States on their health system indicators.

There is more. A declaration of an EU emergency situation would trigger the development, stockpiling and procurement of crisis relevant products. The ECDC's mandate – a shy imitation of the US Atlanta-based CDC (Centers for Disease Control and Prevention) – would be reinforced to strengthen epidemiological surveillance, preparedness and response planning, with the capacity to deploy an EU Health Task Force to assist countries. The EMA's mandate would strengthen its response capacity to health crises – for example, by monitoring the risk of shortages of critical medicines.

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Lastly, the pandemic has also exposed the vulnerability of Europe's supply chains of medical countermeasure stockpiles in case of a serious pathogen threat, and its lack of a coordinated approach for the development, production and procurement of medical countermeasures. Just as the creation of the ECDC was inspired by the CDC, the Commission has proposed to create a European BARDA (the US Biomedical Advanced Research and Development Authority), to support the EU capacity and readiness to respond to cross-border emergencies.

The uphill road ahead

Will Member States follow the Commission's lead? Will the 2019 pandemic mark a turning point in the European project? It is hard to say. Beyond exhortation and declamatory statements, European solidarity has shown its limits, particularly in the field of healthcare.

National governments have greater political legitimacy and wider breadth and depth than EU institutions. And while the views of member states differ significantly, the long debate over

2 COM(2020)724 final of 11 November 2020.

the Lisbon Treaty showed that there was little scope for a consensus on further transfer of legal and constitutional powers to the EU in the social field.

But policies, not treaties, can address Europe's transformations. Beyond any constitutional limits, three obstacles stand in the way of a stronger health and social dimension for the EU and, ultimately, of a new European social contract.

The first obstacle stems from the very nature of welfare policies. Forging a European approach on, say, energy security requires an analysis of complex economic realities and technical issues, a debate about common goals and a difficult compromise between national interests. Healthcare, education, and social protection require all of that – and must still make room for the expression of strong personal and cultural values, for income redistribution and its vested interests, for ideology and political belief. A social contract, national or European, is about politics and well-being: their inherent subjectivity and political nature should not be underestimated, particularly since populist forces are stoking nationalist sentiments across Western democracies.

The second obstacle is that, while globalisation increases the demand for meaningful EU and international cooperation, social transformations are mostly internally driven and follow different national patterns. For example, Europe's healthcare systems are gradually converging into a hybrid model, but they are still national regimes that respond to different incentives and produce distinct outcomes: the Bismarck model of Germany and Belgium, the Beveridge tradition of the UK and Spain, and the Semashko legacy from Soviet times still present in Poland and Hungary. For all the importance of globalisation, the main long-term challenges of Europe's health and welfare regimes are only indirectly related to globalisation: maturing welfare provisions, low fertility, and ageing, changing family structures, new technologies. And if the response of EU institutions falls short of expectations, it is because nation states remain the dominant players even as governments steadily lose control over information flows, technology, migratory patterns, and financial transactions. At the same time, national social protection and healthcare policies are still often organised around a stable nuclear family model, ignoring the impact of immigration, new family types, female unpaid work, or lifelong learning needs.

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The third obstacle is Europe's transformation from a small club of privileged nations to a community of 27 member states, and the diversity of situations this entails. From maternal mortality rates (3 per 100,000 live births in one member states, 30 in another), to the employment rate of women and older workers, to school dropouts, one would struggle to find a relevant social indicator that does not vary radically from country to country. If today's 27 member states had to start from scratch, they would be unlikely to reach the level of consensus and policy development reflected in 50 years of social acquis.

The aftermath of the financial crisis of 2007 was a reminder of the striking resilience of European integration and welfare regimes. The doomsayers were proven wrong on the eurozone

sovereign debt. But the crisis also revealed the deep cleavage in political views, the radically different starting points and performance of EU economies, and the limitations of the EU when it comes to ensuring equality, social protection and, in one word, solidarity.

Ten years ago, as the eurozone started its slow recovery from the crisis, some EU countries were thrilled by an earlier-than-expected return to growth, while others still suffered a crippling 20 per cent contraction of their GDP; some countries struggled to keep their unemployment rates below 5 per cent, others would have been very happy to have had rates of only three times this figure.

For years policymakers and academics have argued that, over the next decade, the EU should define its role as a political entity, and reform itself to respond to the challenges of the global age we now live in.[3] The staggering healthcare, economic and social impact of the Covid-19 pandemic gives a new sense of urgency to the task, as inequality again comes to the forefront of the EU agenda, with the spectre of rising public debt, higher economic and health inequalities, lower labour participation, and increased labour segmentation and structural unemployment. The pandemic of 2019 is a second chance to develop a stronger social dimension of the European project.

A stronger Europe is possible

So, what kind of role should the EU play? There is broad agreement that the worst way to meet Europe's challenges, from climate change to pandemic threats, is uncoordinated action by individual member states within the EU as well as globally. But there is little consensus on the specifics of a (national or European) strategy.

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The European Social Model of the 1990s, synonymous with continental Europe's welfare states and social protection regimes, appears an unsatisfactory answer to the challenges of the EU27. But even the widespread critiques of financial capitalism that engendered the crisis of 2007 failed to produce a common view on national social policies, or a consensus on the solidarity role of the EU.

So, one could be forgiven for seeking refuge in the safety of proclamations on solidarity and a European social contract, long on good intentions and short on operational content.

And yet the need for a European voice and stronger global governance is too strong to abandon hope. EU integration tends to blossom in times of growth and hibernate during economic downturns. It should do the opposite now.

Each of the challenges for the EU in the next decade has a strong social dimension: exploiting the job potential of a greener economy; increasing productivity and competing for

3 See for example, Tsoukalis, L. (2009), *The EU in a world in transition: fit for what purpose*?, London: Policy Network.

talent in a knowledge-based society; adapting Europe's employment and social structures to demographic ageing and migration; tackling emerging threats.

EU institutions and policies will not be the main actors in addressing these issues. The core responsibility for healthcare, education, employment and social policies – not for tackling income inequalities and preventive welfare – will continue to rest with the member states. And the diversity of situations between and within countries will require if anything a more differentiated approach. But there is scope for a stronger European dimension to national reform policies.

EU institutions can help define the path to sustainable development and the implications of Europe's transformations for public policies. They can make the social justice case for economic reform. They can steer policy development and innovation, particularly as concerns the emerging social risks and cross-border threats – there will be other pandemics, no doubt – that are outside the traditional scope of most national welfare regimes and require a high degree of social innovation: managing economic migration and integrating multicultural communities; maximising the employment and social impact of climate change; and addressing urban/rural cleavages and labour mobility.

In turn, the most effective way to promote these key strategic goals is to strengthen the links and conditionality between EU policy priorities and financial instruments, and to shift the role of EU funds from mere redistribution tools to incentives towards the achievement of agreed objectives.

Time will tell, as the social and economic impact of the Covid-19 pandemic unfolds, whether member states and EU institutions have the strength and leadership capacity to establish and enforce effective common policies in areas of limited EU competence such as healthcare. The first reactions of member states to the Commission's bold proposals on a European Health Union already suggest a difficult, uphill road.

But what matters is not competence but relevance: not who has the right to act but who brings added value. And what is required is not a new proclamation or a reshuffle of old ones, but clarity and simplicity – because past failures occurred not in the proclamation of the right priorities but in focus, ownership, and implementation.

The credibility of the EU will rest on its political will to forge and implement a narrative for sustainable development that addresses inequality and the well-being of its citizens. This is difficult but not impossible, and even more necessary in the wake of Covid-19. What is needed is a social contract where quality of life and distributive aims have a more prominent role in the European project and in its global impact.

Our societies will have to address complex challenges that do not lend themselves to simplistic solutions. As Yuval Noah Harari put it, for the last two thousand years philosophy, religion and science have been telling us that the most important thing in life is to know oneself; yet very soon an algorithm will know us better than we know ourselves, and biotechnology will give us the capacity to reshape life. Whether we like it or not, we are now being forced to rethink what it means to be human.

The only way we will meet these challenges is through institutional reform for deeper levels of interdisciplinary and cross-border cooperation, towards a far stronger role for knowledge,

science, and the humanities. Think about this paradox: just as healthcare, science, and technology advance with giant steps, so does scepticism about health and science. We know that vaccination is the most effective public health instrument in human history; we know that homeopathy is to medicine what astrology is to astronomy. And yet, trust in vaccines has been steadily decreasing in Europe – just as the Covid-19 pandemic has reminded us of the merits of immunity, and homeopathic products pushed by a few unscrupulous multinationals are trusted by many as a natural alternative to clinical trials and scientifically sound medicine.

We need more decisions informed by reasoned debate, based on evidence. All opinions are legitimate, but not all opinions are equal. People should be free to think and say that the Earth is flat – but if they do, they must be told in no uncertain terms that they are wrong.

Europe needs financial incentives for innovation, institutional support, and economies of scale. This can be, I think, the ambition of a European Union that is confident about its future and proud of its achievements without being encumbered by the weight of tradition. What EU institutions can contribute to the transformation of national healthcare or education systems will always be a drop in the ocean – but it can be the right drop.

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Overcoming Europe's pessimism

To be confident that a better, more solidary future for Europe is possible, we just need to bear in mind that Western Europe's economic reconstruction of the post-war period was based not on natural resources but on immaterial wealth: people, their talent, and their attitude to personal development.

These are uncertain times. It is understandable that many European citizens feel apprehensive about the present, pessimistic about the future, and distrustful of public institutions. We see this anxiety every day – in the media, in surveys and in cultural expression.

Europe's pessimism can be explained in part by the lasting impact of the economic crisis, the rise of inequality, and the realisation that the world is drifting in ways we do not understand or control. But the sense of anxiety and apprehension about our own future are not inevitable. Most countries are more deeply unequal than those of Europe, and most people have weaker social protection, and yet their civil societies and institutions can sometimes be more confident about their personal and collective future than we are.

Amin Maalouf once said that the success or the failure of the European project will determine whether human adventure will find the path of progress, and that with our words and actions, as fellow Europeans, we can all make a difference.