The EU's Global Health Crisis Management: Past and Present

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SUSAN BERGNER, APR 17 2020

Covid-19 is bending and at times nearly breaking the EU's capabilities to act as global health crisis manager. The far-reaching multi-sectoral impact and the internationally entangled nature of the health crisis are challenging not only Europe but the whole international community. Transnational health crises demand an international response and can offer windows of opportunities to introduce change. The EU might be able to emerge stronger out of the crises if it learns from the past and further elaborates sustainable health crisis management structures. However, the best prevention against health crises remains a solid investment in health systems. This article will show that a successful EU's crisis response depends on four key aspects. Firstly, the creation of sustainable and rapidly available medical and human resources on EU level. Secondly, the willingness and ability to proactively contribute to an international response. Thirdly, the delegation of responsibilities to the European Commission in health crises. Lastly, the involvement of civil society actors to include social impact assessments in policy planning and implementation.

To provide an understanding of global health crises, the article will begin by revisiting characteristics of transnational health crises and their framing as risks or opportunities. After teasing out challenges and untapped potential of crises, barriers and drivers for a successful health crisis response will be deducted from the past. The analysis of EU's global health crisis management in previous settings will allow to draw lessons for the current Covid-19 outbreak.

Transnational health crises need transnational responses

Health crises severely affect the well-being of people and the functioning of health systems, their emergence can have multiple reasons which may be located in the biological realm such as diseases but can go well beyond (e.g. climate change). As witnessed within the Covid-19 outbreak, other sectors like the economy or foreign policy can be heavily impacted. Not only do health crises often traverse multiple sectors but they also can cross national boundaries making state-level responses insufficient and at times ineffective. Transnational crises surpass the organizational, policy and legal tools of governments (Boin and Rhinard 2008), thus, a coordinated response from local to global levels is needed. Moreover, non-state actors like NGOs or the private sector are often playing an active role in health crises (e.g. providing access to health care services) and must be considered in policy responses.

The EU in turn has two major advantages in responding to transnational crises in comparison to state actors. Firstly, the regional scale of the health crisis can be better assessed due to the European Center for Disease Control's (ECDC) early warning mechanisms for communicable diseases. Secondly, the EU can play a unique role in coordinating efforts if member states accept the Union's authority. The EU might even have the potential to enhance a global response by sharing its regional experience on the international scene.

The finding that transnational health crises are in need of transnational responses hasn't really sunk in yet on member states' level. This is reflected in the bizarre orchestra of national measures particularly at the beginning of the Covid-19 outbreak in Europe. The EU for its part has been too involved in coordinating member states' policies to view its scope of action on global scale and has only recently lifted its gaze towards the international sphere.

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Crises as windows of opportunities

Crises may exacerbate existing societal tensions, inequalities and shared vulnerabilities. Experiences from the refugee crisis show that there is a risk of radicalisation in European societies expressed in Euroscepticism, outward nationalism and populism (see e.g. Modebadze 2019). This may also pose challenges for the current Covid-19 outbreak. In many cases, crises in Europe are painfully disclosing the Union's weakness in providing a coordinated and coherent response as member states are acting within national logics barely recognizing the EU as the leading coordinator.

However, crises may also be described as drivers of change. Research on the political aftermaths of disasters has shown that formal change like the creation of institutions as well as informal change such as the mobilisation of civil society actors are likely to emerge after major crises. In the wake of the Tsunami in 2004, Indonesia has for example developed an early warning system, new institutions, and engaged in the peace process in Aceh (Birkmann et al. 2010).

EU health governance and crises management for its part has largely evolved in response to transnational health crises. We could even call this a learning through crises. Many voices in the Covid-19 debate refer to the possibility for the EU to come out stronger. Clearly, health crises pose challenges and risks to the EU, national governments and the people, but at the same time, they also can be seen as windows of opportunities to introduce change. To use this window wisely, we might have to take a look at EU's global health crisis management in the past.

A look in the rear-view: EU Lessons from past global health crises

The emergence of EU health governance induced by health crises can be traced back several decades; the shift to EU policy-making in blood quality and safety for example has emerged in response to the HIV/AIDS blood contamination scandals in several member states in the 1980s (see Farrell 2005). Similarly, the SARS pandemic has sparked the establishment of the ECDC (Ammon 2015). The analysis will draw from more recent accounts of EU's global health crises management with view to insights from the avian flu (H5N1) 2005, swine flu (H1N1) 2009 and the Ebola outbreak in West Africa 2014.

It is important to pause at this point for a short distinction between the internal and the external gaze. The internal health crises management perspective is concerned with EU's actions within Europe, whereas external measures target the international community. The line between these two spheres is porous and it its is clear that the ability to act internationally might heavily depend on an effective crisis management within Europe. Thus, lessons from the EU's regional health crisis management as well as the global scale are considered.

EU's global health crisis management might face barriers but also drivers which can influence the EU's performance. Looking at the European reaction to past health crises, four key factors can be teased out; available resources, degree of affectedness, centralisation of coordination efforts, and the role of emotions notably fear. These factors might constrain or enable a successful management of health crises depending on their consideration in EU policies.

The Ebola outbreak in West Africa has put the question of capacities to the front. The Union's capability to act beyond European borders was severely hampered by the failure to swiftly mobilise crucial resources. The inability to rapidly deploy medical and public health experts and to mobilise medical resources as well as the ECDC being insufficiently equipped to work abroad disclosed the need to activate resources internationally (see Haussig et al. 2017; Jordana and Triviño Salazar 2020). This seems to hold true for other regional experiences; South East Asian states turned outward and relied heaviliy on their bilateral channels during the avian flu outbreak because there was a lack of resource mobilisation on the regional level (Maier-Knapp 2011). With view to the West African Ebola experience, the EU has created the European Medical Corps under the EU Civil Protection Mechanism to be able to quickly deploy expert teams if necessary. Resources can be a severe constraining factor, but they might turn into a facilitator of crisis management measures if properly installed.

The degree of affectedness can have a great effect on the willingness of the EU to act on the international stage

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within a global health crisis. Here it seems that it is sufficient for the EU to *perceive* a high level of European affectedness to delay an international response. In the case of Ebola, the initial response was to protect the EU, facilitating entry screening of travellers from Ebola-affected countries, and only later a change of behaviour has taken place introducing measures to assist the West African region. This pattern was not new as the interregional cooperation during the avian flu has equally been neglected. The EU has channelled most of its technical and financial assistance to South East Asia through the World Bank but didn't fully use the interregional formats like the ASEAN-EU ministerial meetings to address the health crisis resulting in a short of direct commitments (Maier-Knapp 2011). If the EU wants to be a global health actor as stated in its Council conclusions it has to be present on the international scene during global health crises right from the beginning. A late reactive response will negatively impact the EU's external perception, likewise, negative effects on other policy sectors will be felt as the world is more interconnected than ever, bringing international impacts of health crises right back home.

Across different health crises a need for a coordination node becomes visible; the EU by its nature is well placed for this unpopular task. During the Swine flu the Commission feared a duplication of member states efforts, same goes for the coordination of national responses with regards to the Ebola crisis in West Africa (Brazova and Matczak 2015; European Commission 2015). In this light the adoption of the Decision on serious cross-border threats to health in the wake of the swine flu, can be read as a step towards more authority of the EU institutions in health crises. Throughout the H1N1 crises the assistance of the ECDC became crucial (Dorussen, Fanoulis and Kirchner, 2015), demonstrating the advantage of centralised knowledge when coping with a regional disease outbreak. On the other hand, the minimal authority of the ECDC during the Ebola outbreak showed that a further delegation of responsibilities might be useful as supranational organisations are better equipped to deliver a multi-levelled and multi-sectoral response (Jordana and Triviño Salazar 2020; Maier-Knapp 2011). To provide a truly multi-levelled and multi-sectoral approach, a closer collaboration of the different EU institutions is needed, otherwise it will be difficult for the EU to develop a comprehensive response in health crises.

Crises might generally be perceived as very emotional episodes, for health crises this is an almost intrinsic aspect. Being aware of the fact that emotions are an omnipresent part of international relations (see e.g. Clément and Sangar 2018; Koschut 2018), we however must admit that health crises spark great fear across societies as they pose direct often unknown risks to physical integrity. The involvement of stakeholders such as experts, NGOs or health workforce together with a broad communication with the public has proven to be a driver for successfully coping with the Swine flu crisis at member states' level (Brazova and Matczak, 2015). This is equally important when looking at the EU's crisis management during the Ebola outbreak, where the Union has been criticised for not sufficiently involving humanitarian actors (Quaglio et al., 2016). The engagement with civil society actors can be beneficial for the effectiveness of context specific measures and it might increase social acceptance within the society.

Takeaways for the current Covid-19 outbreak

The Covid-19 outbreak has been utterly underestimated in Europe and a coordinated response internally in the EU and externally with view to the international community has taken some time and is still not fully visible. Amidst the global health crisis, there is still a lot of room for manoeuvre and lessons taken from the past might come out useful.

Covid-19 showed once again the deficit of medical and human resources on member states' level within their national health systems and a slow mobilisation of resources on EU level. The dependency of the willingness of governments to provide equipment and health workforce has proven to be a setback on the EU's capacities to quickly deploy materials wherever they are needed. Thus, a sustainable allocation of resources on EU level is needed, and the creation of a rescEU stockpile of medical equipment is a first step. However, the EU might also think about the creation of a genuinely European health workforce that can be called on in cases of emergency without the consent of member states.

History is also repeating itself with regard to the EU's presence on the international stage right from the beginning of the crisis. Admittedly, the EU has never faced such a large-scale health crisis in Europe with severe consequences on almost every policy sector, however, there are not only different directorates and agencies responsible for the regional European perspective but there are also several actors in charge of the outward dimension. Thus, action on

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the international stage has to go in parallel to measures taken within the EU. This would accelerate the Union's pace and can equally provide a more strategic view as measures taken within the EU might have unintended consequences for the international community. It would be useful to create a global health coordination unit within the European External Action Service (EEAS) to properly acknowledge the international dimension of the crisis from the start. This would bring different external aspects of the health crises together that might be affected such as development policy, trade, environmental and climate policy, neighbourhood policy, migration policy and border management among others. Such a strategic international foresight could have prevented the anger of neighbouring states suddenly facing closed EU borders and might have directly alluded to possible derogations.

The Covid-19 crisis has depicted Europe as an interplay of distinct national measures without concerted action. Even now the EU is having a hard time to coordinate and harmonize member states' efforts which have proven to be quite contradictory in times. The EU clearly needs enforcement mechanisms during health crises to ensure a coherent response on regional level. The Decision on serious cross-border threats to health might have to be updated in this regard specifically naming the EU's responsibilities in global health emergencies and back it up with the necessary resources. A formal delegation of authority can just untap its full potential if it is accompanied by the respective instruments and tools.

As Covid-19 is reaching far beyond the scope of disease control, it would be wise to involve civil society actors in assessing the social impact of public health policies in particular and the societal impact of the Covid-19 outbreak more broadly speaking. In times where the public and democratic system is put under strain, it is important to (virtually) engage with civil society actors to grasp the social climate and ensure basic and regular care. If the EU wants to act as a successful global health crises manager, it has to overcome the 'first Europe then the rest logic' and act at all levels – regional and international – simultaneously. To act swiftly, European resources are needed at European level without the need to exclusively rely on member states willingness to provide them. Concerted action on nation states' level will need to be guided by a strengthened European Commission. Putting the people at the centre of action is key in ensuring a healthy social climate in Europe and beyond.

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