

The Fatal Flaw in EU Policy on Public Health

– could the EU deliver better next time to protect EU citizens against a cross-border health threat?

(work in progress – not to be cited)

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Abstract

The outbreak of the pandemic declared by the World Health Organisation (WHO) on 11 March was marked by purely national reactions, even from governments most supportive of the EU, with no mention of European interdependence.¹ Opinion polls suggest that 70% of European citizens expect the European Union (EU) to do more on health matters², so the absence of the EU institutions at the outbreak of the epidemic was damaging. Addresses to the nation and declarations of states of emergency were accompanied by the overnight closing of borders and an end to freedom of movement. The EU has come in for criticism for its slow response even though it has since stepped up its initiatives across all its policies, from opening up medical supplies across borders to fundraising and research for a vaccine against COVID-19 and introducing a measure of coordination in the gradual restoration of freedom of movement.³ Early criticism of the absence of a European response⁴ has overshadowed initiatives taken

¹ There has been a lack of foresight by national leaders, who have pretended not to know that interdependence requires “a single European answer with strict containment measures” and “an EU-wide plan to re-start the European economy afterwards”. The current EU has been dubbed an “incomplete *Res Publica*” by the CesUE, a media network for Europe that provides research, education and communication services related to European integration and global governance issues. See CesUE’s petition, ‘A European Answer to the Coronavirus Threat to Prove that the EU is a True Community with a Shared Future’, (Euractiv Italia) < <https://www.cesue.eu/en/appeal> >

² This expectation was present even before the COVID-19 pandemic. In 2017 a Eurobarometer survey expressed that when it comes to health and social security, 70% of people would like the EU to intervene more, while 49% feel current EU action is insufficient. Eurobarometer 2017 Survey, ‘Delivering on Europe – citizens’ views on current and future EU action’, QA-01-18-917-EN-C.

Despite this, European Parliamentary party manifestos 2019 did not prioritise health as a major issue overall. The European Public Health Association (EUPHA) had previously even made a call for placing health higher on the EU agenda in order to reach the Sustainable Development Goals (SDGs). EUPHA, ‘What are the European Union political parties planning for your health? A response to the European Union parties’ manifestos’, (2 May 2019).

<https://eupha.org/repository/advocacy/EUPHA_statement_What_are_the_European_Union_political_parties_planning_for_your_health.pdf>

³ Some have expressed that the social perception of the EU will be shaped for years by its response to the crisis. Thus it is vital that the EU’s delayed response proves the EU to be a community of values that can provide a life-line for its’ citizens and member states in the face of political, economic and health threats.

⁴ The European Commission did issue some information and guidelines for border management measures in the Official Journal of the EU on 16 March 2020, however these were not binding, and in general did not lead to much coordination. (2020/C 86 I/01).

since, especially with the presentation of the ambitious proposal EU4Health as part of the recovery package with a self-standing programme which represented a 2000% increase in the budget, but was then cut back.

I. Was the slow response to COVID-19 a systemic failure of the EU?

If one believes that the absence of the immediate response was due to a failure in political leadership, then probably the EU already has, and is belatedly stepping up to have the necessary instruments to act immediately next time. But will even its ambitious package of proposals really be enough to provide such a guarantee? If one believes that the initial failure of the EU was more systemic than one of absence of political leadership, then no amount of funding without changing the system can be enough. According to this argument, the EU is primarily a legal entity dependent on what competences are given to its Institutions by the Member States. If the failure is systemic could this be put right by changing the Treaties and giving the EU real responsibilities for public health? Treaty reform is a slow process and solutions are more urgently needed, especially since there could be a second wave of the same pandemic this year or next. Could introducing a European right to health protection be sufficient and quicker to achieve?

In the debate about the EU response, opinion is in reality divided as to the reasons for the initial failure.⁵ If one looks back to the early 1990's and the debate surrounding the introduction of public health as an article (now Article 168) in the Maastricht Treaty, it is difficult to avoid the conclusion that the recent EU failings have been more systematic than simply political. First, Maastricht classified public health with a group of new policies for a citizens' Europe including many such as culture where EU legislation and approximation of national laws and practices would be clearly inappropriate. An old communication of the European Commission "From the Single Act to Maastricht and Beyond"⁶ subtitled "the means to match our ambitions" which with hindsight appears singularly inappropriate in the case of public health. The European Commission had emphasised that: "In areas so vital to society as the environment, social policy, health, education, culture and consumer protection, the new Treaty provisions include ones that are fully consonant with the principle of subsidiarity. These are the most obvious areas where national diversity has to be respected". Later on, the Commission made it clear that the new health Treaty article met the limited objective of providing a legal basis for Europe against Cancer, an awareness raising campaign and research initiative. At the time, Treaty

⁵ A good example of divided opinion can be seen in G. Verhofstadt, 'The Union and Covid-19: Is there a future after failure?', European Policy Centre, 25 March 2020.

⁶ Commission of the European Communities, 'From the Single Act to Maastricht and Beyond. The Means to Match our Ambitions', (COM 92) 2000 final, p. 1-41, available at < <http://aei.pitt.edu/2938/>> last visited: 25.11.2020.

reforms in the Intergovernmental Conference were secretive, but apparently between the Luxembourg and Netherlands presidencies the new policy areas were watered down.

The prospect though simply of new areas coming into the Treaty, and being added to the list of EU activities, did attract health promotion and patient rights groups to become more involved with the EU. To respond to the demands of expanding activity under the Maastricht Treaty, Tony Venables (co-author of this paper) was involved at the time with setting up ECAS (European citizen action service). One of our first actions was to set up a coalition to lobby for Treaty reform called VOICE (voluntary organisations in a citizens' Europe) which analysed proposals and had meetings with the Council Presidency. Subsequently ECAS helped set up the European Public Health Alliance (EPHA) which has become an effective campaign group and valid interlocutor of the EU Institutions. Maastricht allowed stakeholders to create such non-governmental networks, but could they obtain significant benefits for EU citizens beyond those directly involved? That is more doubtful. Venables remembers receiving a cold shower from Piet Dankert when meeting him in Strasbourg in January 1993 and explained how promising he and his colleagues found the new Treaty articles to expand Community competence. Dankert simply said "No. They were put in to set limits on European competence." He was in the know since at the time he was a lead negotiator for the Maastricht Treaty as Secretary of State for European affairs in the Netherlands, 1989-1994.

II. From Maastricht to Lisbon Treaty

It is worth comparing how EU public health is being regarded now versus the view taken back in 1992 under the old Treaties. Under the Maastricht Treaty, emphasis was not on common policies between the EU Member States, but on "encouraging co-operation between the Member States and, if necessary, lending support to their action." Article 129 (which has since become Article 168 TFEU) set limits on the then Community (now, Union) activity in public health. It was to concentrate on the traditional area of cross-border cooperation during "major health scourges". This gave a firm legal basis to campaigns such as "Europe Against Cancer", and those decided against AIDS or drug abuse. However, what means and entails a major health scourge remained to be defined. The emphasis was to be on preventative measures, which meant that there would be no question of the Community attempting to set standards for treatment or the performance of the health services.⁷

⁷ T. Venables (ECAS), D. Martin (MEP and rapporteur on the Treaty on the European Union), *Current EC Legal Developments - The Amendment of the Treaties*, (Butterworths 1992) 59

Prevention was to be pursued by promoting research and through health information and education.⁸ At a late stage in the negotiations “drug dependence” was added – a sign of will treat this as a priority and more in the then Community than in the intergovernmental area. In its observations, the EC Commission indicated that it wanted a more coherent approach to public health, rather than an approach where disease specific measures were taken in isolation from each other. There was also a provision similar to that for culture, that “health protection requirements should form a constituent part of the Community’s other policies”. This was meant to allow health considerations to be given added weight in Community legislation on pharmaceuticals, food and environmental protection, as well as introducing them to other policies such as the Common Agricultural Policy.⁹

In the Maastricht Treaty there was a requirement that the EU Member States shall, in liaison with the EC Commission, co-ordinate their policies and programmes. However, when it came to taking specific measures, whilst providing for majority voting and co-decision with the European Parliament, these were again restricted to “incentive measures, excluding any harmonisation of the laws and regulations of the Member States”. In other cases, the European Parliament could be by-passed when the Council adopted recommendations on the basis of an EC Commission proposal. It should be noted that Article 129, para 3, of Maastricht Treaty seemed to appear to give the then Community rather broader competence for public health in its external policies than for its domestic ones. The intention, though, clearly was that the new policy should be open-looking and that in this case, like culture, there should be close cooperation with other organisations (i.e. WHO).¹⁰

III. How has the situation evolved until Lisbon?

This passage now reads as dated, but it is worth recalling the origins of the inclusion of public health in the Treaty at Maastricht as outlined above, since many experts argue that the situation has evolved. In our opinion, there is an element of wishful thinking involved. Is it not more a case of stakeholders and researchers who would like to see more EU action on public health, realising that Treaty reform in this area is unlikely to get on the agenda and so accommodating themselves to the current wording? They point out the potential, rather than the limitations of the public health article. According to this argument, the Health in All Policies (HiAP)

⁸ Prevention is still a major aspect of health policy considerations. The EUPHA’s 2019 response to parliamentary manifestos called for “EU parties and groups to put more focus on health promotion and disease prevention” among other things. See EUPHA (n. 2)

⁹ T. Venables, D. Martin (n. 6)

¹⁰ *ibid*

approach, which is indeed one of the mantras of the EU Treaties and policies creates a bridge from an article where legal competence is limited towards ones such as Article 114 TFEU on the internal market where there are fewer limitations.¹¹ It is important to note at this stage that recourse to Article 114 TFEU is a contested approach, and it is therefore not appropriate for emergency action which needs an unambiguous mandate and guarantee of a quick response. The drawback in relation to competence is that the cross-cutting role of public health is more aspirational than clearly defined, even though it can be argued that it has its basis in a human rights perspective and that the enjoyment of the highest attainable standard of health is protected by international conventions and the EU Charter on Fundamental Rights. Public health is still marked by the ambiguous legacy of the Maastricht Treaty setting ambitious objectives¹² and failing to provide the means to achieve them. The changes introduced by the Lisbon Treaty in 2009 merely repeated this pattern by emphasising at the same time that cross-border health scourges are a European issue, whilst re-emphasising the national competence for the delivery of health services. Thus, all the instruments are in place for the EU to play a more immediate and effective role if there is a new wave of COVID-19 or a new pandemic. Emergency alert systems have been agreed and a European centre for disease control is fully operational – it is only a decision-making authority that is lacking!

How can one really expect the EU to take the lead when its mandate is to play a supportive role and not interfere with Member States' primary responsibilities for health care?¹³ One can argue that the health care systems do not in reality exist in watertight compartments and that the new European health programme will make the EU a bigger player in their operations. One could point to examples of cross-border cooperation in the operation of health care systems, the free movement of health professionals, millions of tourists using the European health insurance card for emergency treatment, European patients' rights, and the fact that new drugs are approved by the European Medicines Agency in Amsterdam. When EU4Health was published and first discussed by EU Health Ministers they were quick to welcome the initiative in broad terms and

¹¹ Article 114 is the most frequently invoked legal basis. When proposing and adopting internal market measures on the basis of Article 114 TFEU, the Commission, the Parliament and the Council must take as a base a high level of health, safety, environmental protection and consumer protection.

¹² Case law developed by the CJEU has also led to the pursuance of ambitious public health objectives through the issue of internal market integration. See Joined Cases C-154 and 155/04 Alliance for Natural Health [2005] ECR I-6451.

¹³ Regulation (EU) No 282/2014 of the European Parliament and of the Council on the establishment of a third Programme for the Union's action in the field of health (2014-2020) and repealing decision No 1350/2007/EC

especially the budget proposed of €9.4 billion euros whilst warning that the Commission should not trespass on their responsibility for the organisation of the health care system.¹⁴

In the final stages of the negotiation on the overall budget and recovery package agreed on 21 July 2020¹⁵, the new health programme was cut back to 1.67 billion euros with 3 billion euros in a separate fund – RescEU – to stockpile medical and other emergency equipment in which Europe should become more self-sufficient. On 22 July, EPHA described this “a lost opportunity for the health of Europe” and concluded its statement by saying “It is true that health funding has been increased compared to the previous budget settlement, but there are now questions on how the resources available will be allocated and which European Commission priorities might no longer be supported. In the quest for European unity, a high price has been paid, and a unique opportunity to comprehensively tackle the current and future challenges affecting the health and well-being of millions of people living in Europe, has been lost”. On 23 July the European Parliament adopted a resolution deploring this and other cuts which will “undermine the foundations of a sustainable and resilient recovery”.¹⁶ How did it come about that in the midst of a pandemic, EU governments should decide to axe a new self-standing and comprehensive European health programme, seen as game changing and widely supported by stakeholders in the sector? Was this simply the unintended consequence of a last-minute deal on the massive recovery package, or were there reservations of the kind shown by governments, when it comes to EU treaty reforms and public health policy. The European Parliament will undoubtedly seek explanations and attempt to restore the cuts.

Certainly this setback reflects lack of public awareness and therefore active support for giving public health a more European dimension, however optimistic one might be from reading Eurobarometer opinion polls. When people are asked, the results suggest that there is at least latent support for more Europe, especially in areas which have such an immediate impact on daily life and well-being. However, people and voters are not often asked. In his article, Vincent

¹⁴ EU4Health discussions began in February, with the Programme being released on 28 May 2020. It concluded with the proposal to boost EU’s preparedness for major cross border health threats; strengthen health systems so that they can face epidemics as well as long-term challenges; and, make medicines and medical devices available and affordable. It is clear that this Programme has been fairly ineffective as the EU Summit cut it to €1.67 billion.

¹⁵ See European Council, ‘Special European Council’, 17-21 July 2020.

<<https://www.consilium.europa.eu/en/meetings/european-council/2020/07/17-21/>>

¹⁶ See European Parliament, ‘Motion for a Resolution’, 23 July 2020.

<https://www.europarl.europa.eu/doceo/document/B-9-2020-0229_EN.html>

Delhomme¹⁷ puts his finger on the problem in the opening sentence: “It is a striking feature of EU health law and policy that it has developed in a lack of general awareness from the general public”. If there had been more awareness, backed up by calls to support EU4Health by patient rights groups and the health professionals in the front-line fighting Covid-19, would such a relatively small budget in the overall scheme really have been reduced so drastically? That would have been almost politically impossible. Lack of public awareness let alone involvement is as much a fatal flaw in EU public health policy as the lack of legal competence. It is but a weakness that could be more easily addressed than Treaty reform, especially in a crisis which has shown how linked we are in Europe across national borders.

More recently, during October and November of 2020 there has been progress. On the 15th of October, the European Commission published its new strategy on the deployment of Covid-19 in the EU.¹⁸ Unlike in the past, the EU will have not only to approve but also to purchase the vaccines should they become available and ensure their actual distribution across the Member States. This shows that the EU is stretching its powers to have a stronger role regarding the way vaccines will be made accessible to EU citizens at national level. From an institutional point of view, this is a remarkable development which paves the way to more European integration and wider cooperation amongst the EU Member States. It also means that this newly proposed policy requires sufficient cooperation between the supranational EU institutions and the Member States to ensure that the new strategy on vaccines is being materialised and coordinated on a harmonised manner across the Member States to safeguard solidarity on public health matters. It is yet to be seen how the EU governments will respond to this proposal of the European Commission keeping in mind the differences in Member State health systems. On the 11th of November, the European Commission issued a communication proposing a broader remit for tasks and decision-making in relation to cross-border health to the European Centre for Disease Prevention and Control (ECDC) and the European Medicines Agency (EMA). This, along with opinion polls, show a big case for citizens wanting the EU to do more. However, this communication from the European Commission had no mention of citizens’ action – it is a purely top-down approach.

¹⁷ V. Delhomme, ‘Health as a shared competence of the EU: for a general and direct legislative competence of the EU in health’, [2020] EJRR Special Issue “Towards a European Health Union”.

¹⁸ European Commission, ‘Communication from the Commission to the European Parliament and the Council. Preparedness for COVID-19 vaccination strategies and vaccine deployment, Brussels, 15.10.2020 COM(2020) 680 final, p. 1-16.

IV. Obstacles to Treaty reform

Although the revision of the relevant Treaty provisions is needed, this would not be a speedy solution and offers no guarantee of succeeding. The lack of agility and guarantee of results is due to three main obstacles. The first being that national governments in reality do not have strong political will to reform the Treaties. To its detriment, Treaty reform is an institutional discussion that would only come at a time when there is economic fallout and as a result citizens are demanding tangible results. When there is a crisis the EU tends to deliver to the people in an outward-looking way; there is a sense that they cannot afford to get into an internal naval-gazing exercise. The upcoming Conference on the Future of Europe, the start of which has been delayed, will examine the EU's response to this crisis.¹⁹ European Council Ministers have taken the view that the Conference should be launched as soon as epidemiological conditions allow for it. In their position paper, they stated that the focus should be on “how to develop EU policies over the medium and long term in order to tackle more effectively the challenges facing Europe, including the economic repercussions of the COVID-19 pandemic and lessons learned from the crisis”.²⁰ If Treaty reform has a chance of being raised, it will be at this Conference. The Conference lasts for two years and is unlikely to receive clear dicta in favour of reform. Thus, presents the second obstacle. Even if the EU-27 governments did agree to embark on this process, reform would have to be decided by an Intergovernmental Conference Decision and then ratified unanimously by EU Member states.

The lack of guarantee that Treaty reform will actually succeed can be explained not just in terms of political and nationalistic resistance, but also by the relationship between healthcare and citizenship. One of the fundamentals of the social contract underpinning European citizenship is access to healthcare. It provides solidarity and mutual support via taxes and the equal availability of services. A share of the national budget goes towards supporting those in need of care in the knowledge that the taxpayer is also likely to be a beneficiary at some point in his or her life. Marshall's seminal post war work²¹ links citizenship – the idea that we of sovereignty are all in the same boat – and social rights to the welfare state. His work was written in the period after World War 2 when ex-soldiers thought that now a welfare state would be

¹⁹ CesUE has suggested turning this Conference into a fully-fledged European Convention to draft a new Constitutional Pact among the EU citizens and Member States. See CesUE Petition (n. 1)

²⁰ Council of the EU, ‘Conference on the Future of Europe – Council agrees its position’, Press Release, 24 June 2020

< <https://www.consilium.europa.eu/en/press/press-releases/2020/06/24/conference-on-the-future-of-europe-council-agrees-its-position/> >

²¹ T.H. Marshall, *Citizenship and Social Class*, (Cambridge University Press 1950)

established, and so offering the idea that healthcare is essential to the social contract. So presents the third obstacle to Treaty reform. Healthcare is organised nationally and EU policymakers see resistance to the EU developing a stronger health policy. It may be argued that the understanding of this being purely a national issue is superficial, however this argument underestimates the concept of the state social contract and the reluctance to see any EU structure on top of such a large and fundamental public policy area.

The reflections from the long-awaited Conference ‘on the Future of Europe’ could form the basis of an Interinstitutional Agreement among the Commission, Parliament and Council. The added value of the latter would be to respond sooner to the need for changes related to access to healthcare in the EU rather than waiting for a fully-fledged revision of the EU Treaties which will need some years to materialise.

V. A demand to add a European citizenship right to health protection

This is why at the ECIT Foundation, in partnership with The Good Lobby, we are thinking of a way other than Treaty reform – a demand to add a European citizenship right to health protection to Article 21 of the Treaty on the Functioning of the EU (TFEU). This article reinforces rights to freedom of movement and introduces the limited political rights attached to this status. Adding health would make this first transnational citizenship of the modern era as relevant to the majority living and working in their country of origin as to the 13 million or so on the move. Is this possible without falling back on Treaty reform? Under Part Two of the Treaty, “non-discrimination and citizenship of the Union” citizenship of the Union is established, free standing, not attached to any particular policy and “shall be additional to and not replace national citizenship” (Article 20). This particular safeguard is fitting when health rights are considered. Health rights are usually associated with the delivery of health care, which is a national competence, but are also linked to health determinants which cross borders and so do have a European dimension. The legal basis for this reform could be Article 25 TFEU which is hard to implement since it requires unanimity among the Member States and a special legislative procedure. This seems surprising in such a sensitive area like European citizenship. There is an opportunity right now to make the attempt since the Commission has just launched a consultative process to prepare for the report it has to prepare every three years under the Treaty article thereof. It is also being considered to launch a European citizens’

initiative²² demanding a European right to health protection. This would require a vast effort fundraising, setting up a citizens' committee of seven, formulating the demand in a way that could be accepted by the Commission as within its competence and lobby at both European and national level so that over 1 million signatures are collected.

VI. Concluding Remarks

There is not enough citizens awareness of the EU's role in relation to public health. This lack of awareness has led the EU to be resistant in relation to health policy. The ambitious but vital EU4Health Programme would not have been so detrimentally cut if citizens were more conscious of Europe and its role, or potential role, in healthcare. There is insufficient engagement with EU public health policy which has led the EU to overestimate its lack of legal competence. This hamartia needs a grass-roots approach in order to bring about systemic change. Treaty reform poses too many obstacles in relation to speed and sufficiency for the current crisis. Our proposal of a health ECI would bring citizens across European national borders together to deal with an issue that is common to them all, health. This pandemic knows no borders, so we as EU citizens need to unite from the bottom in order to bring about real change and impact in the way public health is dealt with by the EU across its Member States.

²² A European Citizenship Initiative (ECI) is an instrument of participatory democracy, allowing one million citizens residing in one quarter of the Member States to invite the Commission to submit a proposal for a legal act to implement the EU Treaties. See European Parliament Website, 'Fact Sheets on the EU'.
<<https://www.europarl.europa.eu/factsheets/en/sheet/149/european-citizens-initiative>>

Proposal for an ECI Demanding a European Right to Health Protection

Title: Citizens' initiative for a European right to health protection.

Aims. A right to protection against major cross-border epidemics and other threats to health should be added to EU citizenship. To enforce this new European right, a European law should require:

- coordination among Member States in emergency situations, whilst maintaining freedom of movement, the preservation of the internal market and a high level of health protection across all EU policies and budgets ;
- anchoring this new EU health citizenship in the Charter of fundamental rights to guarantee health rights and other rights and democratic freedoms affected by emergency measures , such as protection of privacy , safety at work and the fight against all forms of discrimination;
- a European health right should include a right to be informed, heard and participate in decisions for mutual support among health services. The European Health Union proposed by the President of the European Commission should be a Union not just of States, but also of citizens

Legal bases: Articles 20, 25,114,168 TFEU (Treaty on the functioning of the EU) and Article 35 of the Charter of fundamental rights; Regulation (EU)2016/399 on the Schengen Borders Code

Explanatory text.

The Corona virus which has swept over Europe and the rest of the world knows no boundaries and yet the immediate response even within EU-27 was nationalistic. Where was Europe at the outset, even if the EU has come back more strongly since? In an emergency, people naturally turn to their own State for protection, but they also have high expectations of the EU. “When it comes to health and social security, 70% of people would like the EU to intervene more, while 49% feel current EU action is insufficient” (European Parliament survey on social Europe, 9/06/2017). National health measures have been accompanied by the uncoordinated imposition of a chaotic mosaic of border controls in the Schengen area varying from keeping the borders open to imposing health checks, requiring a period of quarantine, to closing them all together. And yet, whilst respecting regional differences and in the organisation of the health care system, most countries have converged on a similar set of precautions to slow the spread and resurgence of the virus. Earlier coordination could have saved more lives, encouraged more cross-border solidarity and mitigated economic damage.

Many were asking: “What is the point of the EU when it can't take the lead to fight Covid-19?” If you support this ECI it will give you if followed up ,a guarantee that in future the EU will be able to take such a lead and that it will be answerable to the European citizen. The initiative follows letters from leading European citizens demanding an increase in the powers of the EU in the health sector and several petitions which have been echoed in resolutions of the European Parliament. To bring about change more grass-roots support from EU citizens joining forces across the EU is needed. Even though during the crisis freedom of movement

was swept aside, EU citizens kept in touch, organised cross-border solidarity and were well informed of what was happening in neighbouring countries. They now want more rights to hold their own government and the EU to account.

This ECI first has to be registered with the Commission. If accepted it would then require support from over 1 million EU citizens from a minimum of 7 Member States. This is a powerful agenda -setting instrument and a means of building on solidarity in a set of demands for new European rights and EU legislation.

This year the European Commission is due to publish its triannual report on Union citizenship required under Article 25 TFEU. This report can lead to “provisions to strengthen or to add to the rights listed in Article 20(2) “. EU citizenship has more history, legal substance and popularity than generally assumed, but its remit is too narrow. The advantage of adding a right to protection of health against cross-border epidemics would be to make EU citizenship broader more relevant to all citizens and not just to those able to take advantage of the right to freedom of movement. Health rights are associated with rights to health care which is the responsibility of Member States, but should involve prevention as well against the threats which often know no borders. Would this be such a big step? EU citizens have European health insurance cards, benefit from a patients’ rights directive, whilst EU legislation allows nurses, doctors and other health professionals to work in another Member State. Health care systems do not exist in watertight compartments. At the same time the right to health is a sensitive issue of national sovereignty and there should be widespread debate about how it is best protected at national, at European and at global level in different ways.

A European citizens’ right on its own may remain a dead letter. The ECI therefore calls for three additional measures:

-A European law placing an obligation on the EU Institutions and Member States to coordinate their action to fight cross border epidemics and other health scourges. Such a law would provide a framework for EU action and emergency coordination among Member states to guarantee defence of a European health citizenship and limit the impact of a pandemic. It should provide for sharing of resources in hospitals and care homes, mobility of health care professionals and inter-regional solidarity in treatment. EU activities are currently at the limits of what is legally possible for the Commission, scattered and difficult for EU citizens to grasp. Such a framework should bring them together to make sure public health becomes a priority across the board in the internal market, social policy and research. This requirement should include revision of the Schengen border code. Immediate EU-wide coordination of emergency measures affecting freedom of movement should occur. This would replace unilateral and uncoordinated national actions to temporarily close borders and is particularly called for when the threat is not isolated but pan-European. This would involve making sure that any restrictions are based on scientific evidence, consistent across borders and limited to what is strictly necessary. The Commission proposal for “green channels” should become part of the Schengen Code allowing for more not less cross-border movement of nurses, doctors, carers and other front-line staff, as well as the passage of medical supplies and other necessary goods and services

- EU citizenship was created by the Maastricht Treaty in 1993 whilst the Lisbon Treaty in 2009 placed this first transnational citizenship of the modern era in the broader framework of the Charter of Fundamental rights. This link needs to become legally binding. Moreover,

negotiations have begun for the EU to become a party to the Council of Europe Convention on human rights. It should be possible for citizens to invoke the Charter to protect EU citizenship. Health rights which are inextricably linked to others. This should lead to an action plan to protect both health and other rights and fundamental freedoms. In addition to a health and economic crisis, there will be a human rights crisis. An epidemic brings its own challenges. For example, tracing the virus is a priority to protect health but poses challenges for data protection, which many see as insurmountable. As a result of COVID 19, EU legislation on safety at work should set minimum standards. Whilst apparently putting everyone in the same boat, a pandemic can lead to discrimination against foreigners, minorities, migrants and others already in a weak position. The EU must act now against any national measures to make the emergency measures a pretext for lasting restrictions on European values and democracy.

-A European right to health is not the same as a right to individual health treatment and care under social security and assistance budgets which is the responsibility of Member States. As already stressed, the systems of health care do not exist in watertight compartments. The pandemic has brought them closer together with joint decisions in the search for vaccines, public procurement and stockpiling of medical equipment. A massive 750 billion recovery fund "Next Generation EU" on top of the EU's normal budget and emergency loan schemes by the European Central bank is being implemented, involving for the first time a degree of debt sharing among European taxpayers. There is nothing wrong with health services coming closer together and sharing resources in the face of a common threat, but only provided the citizen is not left behind. The process is insufficiently transparent. Even with the best of intentions EU policymakers can add to the EU democratic deficit, especially when the decision making is primarily intergovernmental leading to a diminished power of control by the European Parliament. We warn against a top down European Health Union and plead for a bottom-up approach demanding no such Union without citizens and no pooling of resources without more transparent and participatory decision-making. European citizen's rights to be informed, heard, participate in decision-making and have access to justice should therefore be included in the new European law we demand.

To implement these demands we propose:

-an interinstitutional agreement to be put in place immediately so that Commission, European Parliament act together to give citizens an enforceable European health right;

-a proposal for a European law based on Article 25 TFEU making this right legally binding, linked to the Charter of Fundamental Rights;

-deliberations with citizens in the Convention on the Future of Europe to examine whether these steps are sufficient and whether a revision of the Treaties and in particular Article 168 TFEU on public health which restricts EU powers, is necessary.

