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The emergence of post-Westphalian health governance during the COVID-19 pandemic: the European Health Union

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Abstract: The global response to the COVID-19 pandemic in 2020/21 was dominated by the Westphalian primacy of national territory and sovereignty, significantly worsening and prolonging this global health crisis. Global platforms for cross-border coordination and cooperation, set up by the WHO and other global health partnerships, were constrained by national self-interest. Arguably, the lack of a global supranational (or post-Westphalian) authority in global health governance is one important structural reason for the fragmented, chaotic and ineffective global health response to a post-Westphalian challenge like COVID-19. We argue that the failure of Westphalian governance responses to the pandemic provides a unique window of opportunity for post-Westphalian governance structures to be established and play a vital role in reforming international pandemic preparedness. While we realise that this is unlikely to happen anytime soon at the global level, we show that a comprehensive post-Westphalian health governance framework is indeed emerging at EU level in the form of a European Health Union. Through a combined conceptualisation of supranational governance and the securitisation process of international health crises, we demonstrate how COVID-19 has pushed the door wide open for the emergence of post-Westphalian health governance at EU level coordinated by the European Commission.

1. Introduction

The global response to COVID-19 in 2020/2021 can be largely summarised as fragmented, chaotic and ineffective, dominated by national interests of territorial sovereignty, the so-called Westphalian primacy of the global political system.

Initially, the Chinese government tried to cover up the outbreak. The Chinese government only started collaborating with the WHO when rapidly rising infections in Wuhan and neighbouring cities made any cover-ups difficult to sustain (WHO, 2020a). This strategy resembled a typically state-centric perspective with a long tradition in international health governance. Unfortunately, other governments did not cover themselves in glory either. Many governments ignored and undermined the WHO's legally binding International Health Regulations (IHRs), the most crucial international pandemic preparedness mechanism (Habibi et al., 2020). Other governments, most notably the US government under then-President Donald Trump and the Brazilian government under President Jair Bolsonaro, denied the threat originating from SARS-CoV-2 (the virus responsible for causing COVID-19), even when infection and mortality rates were skyrocketing in both countries. The UK government considerably downplayed the threat at the beginning of 2020. And due to geopolitical tensions, the G7 and G20 failed to agree on a collective approach to COVID-19 (Global Preparedness Monitoring Board, 2020, 25).

The global coordination platforms mounted by the WHO to promote cooperation on international clinical trials, global information-sharing on relevant tools and technologies, such as ventilators and personal protective equipment, or the equitable distribution of COVID-19 vaccines worldwide, were contested, undermined and ignored by governments across the world (WHO, 2020b, c, d; BBC, 2020; Londoño, 2020; Vogel, 2020; Patnaik, 2021; Callaway, 2020, Phelan et al., 2020).

Not only has this Westphalian approach to an essentially post-Westphalian challenge made it more difficult to contain the pandemic. Through widespread (vaccine) nationalism, Westphalian mindsets have also exacerbated the pandemic, accelerating the emergence of new, aggressive variants of the virus, facilitating the uncontrolled rise of infection and mortality rates globally and undermining an effective global vaccine rollout. The COVID-19 pandemic is only the most recent example of a global challenge that simultaneously affects all countries and world regions, ignoring

the Westphalian principles of state borders, territory, sovereignty and national interest. No state is capable of solving these cross-border problems alone.

In this context, there has been renewed talk about reforming international pandemic preparedness mechanisms (Gostin et al., 2020; Paul et al., 2020; Global Preparedness Monitoring Board, 2020), which are firmly embedded in Westphalian governance principles. And in the aftermath of COVID-19 and the disastrous failure of a global health response dominated by Westphalian mindsets, it is necessary to rethink the potential of post-Westphalian governance in global health and pandemic preparedness. In other words, can post-Westphalian governance be an answer to the manifold limitations of the current Westphalian global health governance architecture? And how can post-Westphalian governance structures emerge in the first place?

In the global response to COVID-19, the European Commission stood out as the only actor approaching the pandemic through a post-Westphalian mindset. This article examines how an EU-wide post-Westphalian response to COVID-19 has unfolded in 2020 and 2021 and what we can learn from this development for future discussions on post-Westphalian governance in global health and pandemic preparedness.

For the theoretical underpinning, the article discusses the potential role of securitisation processes in expanding supranational authority in global health governance, focusing on the WHO and the European Commission. Then, the article traces the EU-wide response to COVID-19 in 2020 and 2021 and contrasts the EU-wide Westphalian approach in 2020 with an emerging post-Westphalian approach in late 2020 and throughout 2021, led by the European Commission through the proposal of a European Health Union and EU-wide vaccines procurement. Finally, we conclude with some reflections on the relevant role of supranational authority as an essential element in global pandemic preparedness and responses to future pandemics.

2. The expansion of supranational authority through the securitisation of international health crises

Supranational decision-making as pooled sovereignty

Despite ever more frequent infectious disease outbreaks and global health challenges, spreading across the globe within weeks and affecting many countries and world regions simultaneously, an overarching organisation above states with supranational authority is non-existent in global health governance. Instead, the global health governance architecture continues to be highly fragmented and pervaded by state-centric ideas prioritising the primacy of state territory, state sovereignty and national interest. A reality that seriously undermined a coordinated global response to the COVID-19 pandemic.

The World Health Organisation (WHO), as the leading international organisation in global health governance, lacks formalised supranational decision-making structures, and its authority is severely circumscribed by its member states (Cueto et al., 2019). Apart from the WHO, transnational networks and global public-private partnerships have significantly shaped global health governance and global responses to major infectious diseases over the last thirty years, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, the international drug purchase facility UNITAID, the global vaccine alliance GAVI, the Coalition for Epidemic Preparedness Innovations (CEPI), the Drugs for Neglected Diseases *initiative* (DND*i*), the TB Alliance or the Roll Back Malaria Partnership (Cueto et al., 2019, 286). But these initiatives are not supranational organisations either and have contributed to the fragmented nature of global health governance. As a consequence, the global response to COVID-19, coordinated by the WHO and global public-private partnerships, has lacked relevant supranational elements and could easily be undermined by governments.

By contrast, the EU is widely regarded as the leading supranational organisation in global governance, where member states agree to cede sovereignty on some issues to a higher authority so that national authority structures and the influence of member states are superseded by a higher authority above the nation-state, such as the European Commission (Webb, 2021). This process is also called pooled sovereignty.

Pooled sovereignty is a system of shared decision-making with either unanimous veto powers by states in differing forms of international cooperation or a system of the sharing of competencies between states and a higher authority of some kind, normally where the veto is removed from decision-making (Le Cacheux and Eloi, 2018). The latter is an example of governance pursued by the EU within Europe and in external action. Cooperation, and deeper integration, is greatest in

areas where states can see the benefits of doing so and where domestic public opinion will not be offended. The best example in an EU context is the Single European Market. Conversely, there will be less cooperation in domestically sensitive areas such as foreign and security policy. As a form of pooled sovereignty, the EU challenges the notion of Westphalian sovereignty; it is also a form of regionalised cooperation predicated on pooled sovereignties (Le Cacheux and Eloi, 2018).

Supranational organisations also reify their member states' interests on the global stage in external policy by acting collectively (Mamudu and Studlar, 2009) but can also be a source of division where issues are contested. The European Commission represents the ultimate symbol of EU supranational governance that is at the centre of the European integration process (Nugent and Rhinard, 2019). As Egeberg states:

> Classical international organizations are formally governed by ministers who have their primary institutional affiliation at the *national* level. The European Commission […] represents a notable organizational innovation in the way that executive politicians at the top, i.e., the commissioners, have their primary institutional affiliation at the *international* level. Thus, the Commission constitutes a 'laboratory' for experiments in supranational institution-building. (Egeberg, 2012, 939; emphasis in the original)

Historically, the evolution of supranational authority within the EU has been the result of intense conflicts between intergovernmentalism (that is, state-centric governance prioritising EU member states' national interests and Westphalian mindsets) and supranationalism (that is, post-Westphalian ideas transcending Westphalian mindsets). The European Council, composed of EU member states' heads of state or government, and the Council of Ministers usually stand for a state-centric approach to EU governance, whereas the European Commission embraces a supranational approach. Since the creation of the EU in 1992, supranational governance has usually evolved in moments of crisis, with the European Commission and the Court of Justice of the European Union (CJEU) at the centre of this communitarising process (Schimmelfennig, 2015).

Even though the Commission has acquired far-reaching supranational competencies in several policy areas, such as agriculture, fisheries, and trade, its competencies in EU-wide health governance and pandemic preparedness are extremely limited. Instead, health policy remains in

the hands of EU member states. As the article will show, however, this situation seems to be changing in the context of the COVID-19 health crisis.

The securitisation of infectious disease outbreaks through surveillance mechanisms and medical countermeasures

In global health governance, supranational authority is almost completely absent. And states rarely grant international organisations additional supranational competencies. But the securitisation process of international health crises represents one of the few instances that may put states into a position to grant international organisations supranational competencies.

Today, infectious disease outbreaks and other international health crises like bioterrorism are commonly understood as foreign policy issues posing a threat to states' national security. Some of the most serious health crises of the past two decades, such as the 2001 anthrax attacks in the US, the 2002/03 SARS pandemic, the 2009 swine flu (H1N1) pandemic, the 2014-2016 Ebola outbreak in West Africa and the 2015/2016 Zika pandemic in Latin America, were highly securitised, with governments and other global health actors turning into securitising actors to contain the health crisis and defend the national health security of (primarily Western) governments (McInnes and Lee, 2006; Davies, 2008; Rushton, 2011; Flahault et al., 2016; Nunes, 2016). In these health crises, the securitisation of infectious diseases usually has privileged traditional, state-centric concerns of (Western) state security and international security over globalist ideas such as human security and global solidarity (Rushton, 2011, 780; Flahault et al., 2016).

Some of the key tools envisioned by governments, the WHO and other international organisations to defend national health security are (1) surveillance, monitoring and emergency response mechanisms to enable the early detection of a health crisis and facilitate national and international pandemic preparedness activities, as well as (2) medical countermeasures, such as vaccines, antibiotics, antivirals and other treatment to contain the health crisis (Rushton, 2011, 784-785; Elbe, 2012, 1; Kamradt-Scott, 2015).

Through the stockpiling of medicines, the employment of medical countermeasures keeps the disruption of financial, commercial and trade flows and the movement of goods, services and people to a minimum (Elbe, 2012, 9). In the 2000s, this happened in the wake of the 2005 avian

flu (H5N1) and 2009 swine flu (H1N1) outbreaks, when on the WHO's advice, governments across the world started stockpiling the antiviral drug Tamiflu (Elbe, 2012, 21-22). During the 2014-2016 Ebola outbreak in West Africa, the use of medical countermeasures in the securitisation of Ebola saw an unprecedented acceleration of research and development on Ebola vaccine candidates supported by billions of US dollars from global health actors, the use of experimental drugs in humans and the harmonisation of standards and protocols (Roemer-Maler and Elbe, 2016). Without the portrayal of the crisis as a major security threat to Western countries, these measures would probably not have been employed.

In the same vein, the securitisation of COVID-19 as a major national and global security threat, disrupting international trade, shutting down economies across the world and bringing to a halt the free movement of goods, services and people within the EU, drew global health actors' almost exclusive attention to the development of medical countermeasures to contain the pandemic. Due to this sense of urgency propped up by billions of euros and US dollars, only one year after the start of the outbreak, several COVID-19 vaccines were approved for rollout in individual countries.

The securitisation of infectious disease and the expansion of supranational governance

Under specific circumstances, the securitisation of international health crises through surveillance and monitoring mechanisms as well as the distribution of medical countermeasures can lead to an expansion of supranational authority in global health governance. This happened to the WHO during the 2002/03 SARS pandemic, the first major pandemic of the 21st century. And it gradually happened in the EU throughout the last two decades.

The WHO detected the SARS outbreak in its early stages by relying on its web-based monitoring and surveillance mechanisms, the Global Outbreak Alert and Response Network and the ProMED reporting system, that relied on local media messages and social media, NGOs and other non-state actors. These transnational monitoring networks allowed the WHO to circumvent state governments and collect information about the infectious disease outbreak in China even though the Chinese government initially refused to share data with the WHO (Fidler, 2004, 73-74; Zhou and Coleman, 2016, 292). China's cover-up reflected a long tradition of underreporting and censoring epidemiological information on disease outbreaks within state territories, given

governments' concerns about trade disruptions and economic harm (Cueto et al., 2019). But transnational monitoring and surveillance networks allowed the WHO to free itself from its reliance on governments' lacking willingness to share epidemiological data. At the same time, the role of the central actor in providing knowledge and information about the health crisis put the WHO into an authoritative position, supported particularly by Western states (Davies, 2008).

Encouraged by the unprecedented support of Western states and invigorated by the novelty of the disease and its unpredictable consequences, the WHO stepped up its activity, challenging the Chinese government and putting itself into the role of a supranational authority acting above governments. According to its constitution, the WHO is to serve its member states by providing a platform to share epidemiological information and coordinate international responses to infectious disease outbreaks (Fidler, 2004, 137, 143). During the SARS crisis, the WHO went much beyond its originally defined authority by issuing a set of travel advisories and recommendations without seeking approval from its member states (Fidler, 2003, 491; WHO, 2003). Before the SARS crisis, travel advisories restricting travel and trade were usually left to WHO member states' discretion (Fidler, 2004, 137-140).

But this fleeting supranational moment did not translate into more formal and permanent supranational decision-making structures. And once the health crisis had died down, member states were careful to maintain tight control over the WHO. And international pandemic preparedness continues to be dominated by intergovernmental and state-centric approaches, with Westphalian mindsets applied to post-Westphalian challenges. This became tragically clear during the COVID-19 pandemic.

In the EU, however, the "collective securitisation" (Bengtsson and Rhinard, 2019, 351) of international health crises and infectious disease outbreaks over the last two decades has prompted the gradual development of some limited EU-wide coordination policies in the area of health policy. And EU member states have gradually ceded powers to the European Commission to make pandemic health policy on their behalf.

As a consequence of the 2001 anthrax attacks in the US, the EU set up an intergovernmental Health Security Committee, chaired by the European Commission, to coordinate EU-wide responses to infectious disease outbreaks, assisting member states in national preparedness activities and sharing best practices (Bengtsson and Rhinard, 2019, 361; European Commission, n.d.). Following

the 2002/03 SARS pandemic, EU member states set up the European Centre for Disease Prevention and Control (ECDC) as the first EU-wide health agency to assist in the coordination of European-wide responses to infectious disease outbreaks through risk assessment and the analysis and interpretation of epidemiological data (Burki, 2019).

In the wake of the 2009 swine flu pandemic, both the Health Security Committee and the ECDC were further strengthened. The ECDC became the principal operating agency of the Early Warning Response System, the EU's leading web-based monitoring and surveillance mechanism in place since 1998 and similar to the WHO's monitoring and surveillance mechanisms (Guglielmetti et al., 2006), allowing the Commission to create an EU-wide communication network with EU member states on international health crises, such as the 2014-2016 Ebola outbreak, the 2015/16 Zika outbreak and the COVID-19 crisis (European Commission, n.d.b; European Union, 2013, (16)).

In the same vein, the Commission was granted the authority to proclaim a public health emergency in communication with the WHO director-general as far as any international health crisis is concerned that poses a threat to the EU or when "medical needs are unmet in relation to that threat" (European Union, 2013, article 12). In this context, the European Union also set up a joint procurement process for medical countermeasures, such as pandemic vaccines, after the European Parliament and the Council had emphasised that such a process would benefit member states and their citizens and guarantee equitable access to medicines (European Union, 2013, (13) and article 5).

All these measures taken in the context of a collective securitisation process of major pandemics and international health crises over the last two decades gradually put the Commission into the role of the central securitising actor to coordinate communication and national preparedness activities with EU member states. The securistisation of international health crises has transformed traditional, state-centric control of health policy at the EU member state level into more innovative policy formulations driven by the European Commission (Backman and Rhinard, 2018). Indeed, Backman and Rhinard found 'strong indications of Commission entrepreneurship, using crises as windows of opportunity to advance previously stalled initiatives, assembling networks of national officials interested in crisis-related tasks, and promoting analysis of European vulnerability in the face of increasingly complex threats' (Backman and Rhinard, 2018, 270).

To summarise, securitisation processes of international health crises can provide international organisations like the WHO and the EU with a window of opportunity to increase their (supranational) authority. Given the fact that the WHO is an intergovernmental organisation tightly controlled by its member states, any supranational authority that the WHO may gain during an international health crisis is only temporary and vanishes once the crisis is contained. Hence, despite the strong securitisation of infectious disease outbreaks over the last two decades, international pandemic preparedness continues highly state-centric. Once the SARS outbreak was contained, the WHO could never repeat its supranational moment and has remained trapped by Westphalian mindsets. Within the EU, however, given its nature as an international organisation with intergovernmental and supranational elements, the situation has been very different. Following a process of collective securitisation of international health crises at EU level and the role of the Commission as a supranational actor, the securitisation process has gradually allowed the Commission to become the central coordinating actor on EU-wide pandemic preparedness. But until the COVID-19 pandemic, this role was highly circumscribed, with EU member states in tight control of pandemic preparedness activities.

3. The European health response to COVID-19

3.1 Supranational authority in the backseat

In the EU, the early pandemic response was dominated by EU member states. EU institutions, however, were also involved. The Commission's first main intervention was on 24 February 2020, with a new aid package to contain the disease in Europe and internationally. Further communications and meetings occurred between late February and early March within and between the Commission and the Council. On 10 March, the European Parliament held a plenary session on the emerging pandemic, and the Council met virtually on the same day to discuss the evolving situation of Covid-19 (European Council, 2020).

By late March 2020, most EU member states restricted movement within and between countries in Europe. The period between late February and late March revealed the limits of intra-EU cooperation in the pandemic; the intra-EU Covid-19 debate changed at this juncture, instead

highlighting measures that the Commission could bring to bear to support EU member states. In late March, the Commission relaxed state aid rules to alleviate the economic impacts of the pandemic on national economies in the EU (European Commission, 2020b). Northern EU member states baulked at the idea, as this goes against the principle of market competition. Subsequently, in early April, a series of economic measures were adopted by the Commission responding to the economic crisis as it emerged (European Commission, 2020c). This was followed up with a series of economic policy responses to coordinate EU responses to the pandemic, under pressure from industry.

The EU response to the early part of the pandemic was characterised by divisions within and between EU member states. In particular, the Commission did not have a pivotal position in coordinating national responses to Covid-19, due mainly to different national positions towards the pandemic. Here, it is appropriate to briefly present national responses to the pandemic in Germany, France and Italy as the EU's most populous member states.

Germany's early response to the Covid-19 crisis in 2020 was generally considered to be a success (Desson et al., 2020; Wieler et al., 2020). The federal government mapped local and regional approaches to pandemic response and prevention, and responses were coordinated between local, state and federal governance levels. Germany's federal system of government also places responsibility for health with the *Länder,* and they have resources and policy levers to implement policies. Finally, the national centre for epidemiological research, the Robert Koch Institute, guided the national response through research input and contacts with local and regional health system elites.

France's early response to the pandemic in 2020 was guided by two traditions in French health policy. First, the French commitment to global humanitarian health internationally. Second, the French commitment to universal health care in France itself (Atlani-Duault et al., 2020). In contrast to the German federalised response to health policy, the French approach to health stems from the Jacobin principle of centralisation in the state. Thus, France has been too centralised and inflexible in its response to Covid-19 in comparison to Germany, resulting in higher numbers of deaths and infections derived from Covid-19.

Italy's early response to the pandemic in 2020 highlighted the strengths and weaknesses of its regional health care system. Much of the response to the Covid-19 crisis has been by Italy's 20

regions, with a degree of coordination of policies between the regions' health departments and the Ministry of Health in Rome. This would seem to be positive to allow a flexible local and regional response to policy problems as they relate to health. However, this hides the degree to which there was huge variation in performance between Italy's regions towards the Covid-19 pandemic (Paterlini, 2020).

In the context of these differing national strategies informed by different historical traditions, there have been few instances of inter-EU cooperation between EU member states in responding to the pandemic. There are exceptions to this, such as German support for French patients in the Alsace region of France (but this collaboration was not coordinated by the Commission and due to the initiative of individual EU member states). Germany also helped Italy by taking Covid-19 patients from Italy as well in small numbers. Finally, Germany also assisted Portugal by flying in doctors and nurses to help alleviate the country's hospital crisis and growing Covid-19 infection rate (Roberts, 2020).

In May 2020, however, the Commission launched the European recovery fund, known as the Next Generation EU (NGEU). The final amounts agreed by the European Council in July 2020 amounted to €390bn in expenditures and €360bn in loans. The Commission-led NGEU is an attempt to provide supranational solutions to COVID-induced economic problems but is quasi-Westphalian at its core; the NGEU is significantly tempered by national politics and is circumscribed by several problems. First, the NGEU is not substantial enough for solving national economic problems, as fostering growth also requires national solutions to debt burdens in heavily indebted states such as Italy and Spain. Second, the NGEU will not address longstanding social disparities in EU member states on its own. Third, the NGEU has induced the EU to become the largest global issuer of supranational bonds. Still, this raising of EU funds needs to be combined with similar national bond issuing schemes to raise further revenues to aid the economic recovery. Finally, the NGEU will not lead to the fiscal integration of taxes in the EU due to the resistance of more fiscally conservative EU member states in the richer north (Darvas, 2021).

To summarise, throughout 2020 there was no coordinated and effective EU-wide response to Covid-19. Policy responses were mostly initiated by individual EU member states (this is similar to the global response in 2020 where the WHO's global coordination efforts were torpedoed by national strategies). As at the global level, health policymaking was informed by nationalism rather

than European solidarity (lack of coordination regarding travel restrictions, personal protective equipment (PPE) and lockdowns). Italy and Spain, which had to confront major outbreaks in 2020, were largely left on their own in the opening months of the COVID-19 crisis, and responses of EU member states largely continued to be national in focus. The Commission, however, played a crucial role in launching an economic recovery package. Although the Commission-led recovery package is largely Westphalian rather than supranational, its implementation will be vital for an EU-wide economic recovery to COVID once the pandemic has been contained.

3.2 New dimensions of supranational authority emerging (and contested)

The proposal of a European Health Union: monitoring and surveillance

As a reaction to these uncoordinated efforts, the Commission proposed creating a European Health Union in late 2020 (European Commission, 2020a). This proposal is in line with the Commission President Ursula von der Leyen's idea of a 'geopolitical European Commission' (Gstöhl, 2020). The reason going forwards for the geopolitical Commission is for the EU to transform itself from a solely functionalist human-security centric actor towards embracing its burgeoning weight in international affairs unified as a great power with strategic autonomy from the US, China and Russia (Stoatman, 2021; Cloos, 2021).

The European Health Union (EHU) builds on previous processes of health policy integration stimulated by the securitisation of the 2009 swine flu pandemic. But whilst the EHU is designed to increase the Commission's powers in EU member states' health systems and policies, health care will continue to be controlled by member states (Alemanno, 2020, 725). The European Health Union proposals are based on Article 168(5) of the Treaty of Lisbon (Council of the European Union, 2008), and cover key areas of health governance related to: (i) the management of health crises, (ii) aligning the ECDC [European Centre for Disease Prevention and Control] to Commission priorities in health, (iii) an extension of the mandate of the European Medicines Agency, and (iv) the enhancement of the European Civil Protection Mechanism. (Alemanno, 2020, 723-724).

The idea behind the European Health Union is to level up health care standards in EU member states, deal with pandemics and reduce inequalities of health outcomes. This might be a way for

the EU to gain further traction in health policy, starting with pandemic preparedness during the COVID-19 crisis. While EU member states remain in control of health policy overall, there are possibilities for differentiated integration with member states taking different integration routes according to their needs and preferences (Guy, 2020).

The European Health Union initiative is a form of pooled sovereignty (Kickbusch and de Ruijter, 2021). The Covid-19 pandemic might lead to greater integration of national health systems/policies due to EU crisis planning in health (Bazzan, 2020), in the same kind of how major European crises in the past have frequently led to intensified integration processes as a consequence. The idea of the European Health Union aims to coordinate health crises, accrue medicines/vaccines for health crises and encourage the prevention, treatment, and aftercare of diseases multilaterally in the EU. To improve cross-border coordination of crisis preparedness and management of health crises, the Commission has suggested a range of policy responses:

- declare emergency situations at EU level to ensure EU measures
- take risk management decisions at EU level
- harmonise EU, national and regional preparedness plans
- regularly audit and stress-test preparedness plans
- monitor the supply of medicines and medical devices and mitigate shortages (European Commission, 2020a)

The Commission also places greater prominence on strong common preparedness and response led by EU Agencies, especially the European Centre for Disease Prevention and Control (ECDC). In particular, the EU places greater emphasis in terms of multilateral approaches to preparedness/control of diseases:

- monitor infectious disease outbreaks based on common standards and definitions
- do better risk analysis, modelling and assessment of health care capacities for specialised treatments
- issue recommendations for response
- mobilise and deploy an EU Health Task Force to help local response in the Member States (European Commission, 2020a)

Additionally, the European Medicines Agency (EMA), created in 1995, is projected to take a leading role in health crises, according to the Commission:

- monitor and mitigate shortages of medicines and medical devices
- coordinate and advise on medicines with potential to treat, prevent or diagnose diseases that cause crisis
- coordinate studies and clinical trials to monitor the effectiveness and safety of vaccines (European Commission, 2020a)

No less important, next to the ECDC and the EMA the Commission aims to set up a third European agency focused on health preparedness and emergency response, the European Health Emergency Preparedness and Response Authority (HERA). As a first step towards establishing this new agency, the Commission established the HERA incubator in order to boost the EU's capacity to develop COVID-19 vaccines adapted to new variants. This involves accelerating regulatory procedures and scaling up the EU-wide industrial production of vaccines (European Commission, 2021a).

COVID-19 vaccines procurement and vaccination: medical countermeasures

Often regulatory politics in health policy in the EU is as much determined by industries' interests as it is by public policy; the pharmaceutical industry is one such example (Permanand and Mossialos, 2005). Arguably, in the COVID-19 pandemic, big pharma in Europe and elsewhere have pursued markets for their COVID-19 vaccines, as highlighted by the arguments over supply between the European Commission and AstraZeneca in early 2021 (Deutsch and Wheaton, 2021). It is also clear that there is a vaccine nationalism in play amongst many countries that leaves the poor at a disadvantage globally (Nhamo et al., 2020). But this same nationalism impacts the ability of all actors in responding to the COVID-19 pandemic going forward, including the Commission. There is also evidence that EU member states see public health as part of the national domain (Steurs et al., 2018), and this also impacts the Commission's prospects for a European Health Union.

Nevertheless, within the EU, the Commission has a strategy of minimising vaccine nationalism among EU member states. Furthermore, the Commission has a coordinating role for EU members,

alleviating the divide between powerful member states/big pharmaceutical industries and smaller member states. The EU, therefore, internally avoids, to a greater extent, the damaging vaccine nationalism at the global level that the WHO and its global vaccine procurement and distribution mechanism COVAX have been helpless in controlling (Hafner et al., 2020; Patnaik 2021).

A first idea of what a European Health Union might look like in the future was given by the Commission's strategy in late 2020 to pursue an EU-wide approach to purchasing COVID-19 vaccines, with vaccines being approved by the European Medicines Agency rather than national medicines agencies.

But mistakes committed by the Commission in the procurement process with pharmaceutical companies (particularly with AstraZeneca) and initial difficulties in the ramping up of the vaccine production process led to an extremely slow vaccine rollout in the first few months of 2021. The sluggish vaccines rollout across the EU attracted considerable criticism from the WHO and EU member states. As a solution to this problem, some member states resorted to nationalist behaviour and thus challenged the EU-wide approach coordinated by the Commission. Hungary and Slovakia, for instance, also relied on Russia's Sputnik V vaccine, although the European Medicines Agency did not approve the Russian vaccine (Martuscelli, 2021). But it should be highlighted that many EU member states can also be blamed for the slow EU-wide vaccines rollout. Many EU member states administered significantly fewer vaccine doses than received by the Commission due to a lack of national preparation and planning and controversies revolving around the efficacy and safety of the AstraZeneca vaccine, along with the Pfizer/BioNTech vaccine one of the principal vaccines initially used in EU vaccination programmes (Hirsch and Deutsch, 2021).

But after these initial problems with AstraZeneca and a strategic switch from the AstraZeneca vaccine to the Pfizer/BioNTech vaccine, the EU fared much better as 2021 progressed (Economist, 202; De Maio, 2021, 1). The EU could considerably increase its levels of vaccinations and started to catch-up with the UK and the US by the middle of the year, countries which had been leading the vaccines rollout from early on (Economist, 2021). Already in April 2021, the EU exported more vaccines (113.5 million) to third countries than it administered to its own population, 15.2 million of which were shipped to the UK, one of the early national leaders in the global vaccination effort (Chrysoloras, 2021). By the end of July 2021, 70 per cent of the adult population of the EU

had at least received one vaccine dose, thus achieving the Commission's vaccination target (European Commission, 2021b). And by the end of August 2021, the Commission also hit its target of fully vaccinating (two doses) 70 per cent of all adults across the EU (European Commission, 2021c). As a consequence, the EU has become the most successful regional integration project and world region in COVID-19 vaccination efforts.

A post-Westphalian health governance framework emerging

The initial response of EU member states to the pandemic was no less fragmented and piece-meal than at the global level, pervaded by the (Westphalian) primacy of national interests and various forms of nationalism. But the pre-existence of a formalised and institutionalised post-Westphalian governance architecture in the EU, embodied by the Commission as a supranational authority and other well-established supranational decision-making structures, has provided a window of opportunity for a transformative reform of EU-wide governance structures on pandemic preparedness.

As a reaction to the fragmented Westphalian response to COVID-19 in 2020, the European Commission has carved out a much more assertive role in health governance through the collective securitisation of COVID-19, which includes various pandemic preparedness measures, most importantly the expansion of surveillance and monitoring mechanisms and the EU-wide provision of medical countermeasures. The collective security threat of COVID-19 to the national (health) security of EU member states and the security of the union as a whole (the shutdown of EU economies, the disruption of the European single market, the suspension of the free movement of people) incentivised EU member states to concede some of their sovereignty to the Commission, putting the Commission into the driving seat for the EU-wide coordination of pandemic preparedness measures and collectively reifying EU member states' national interests of disease containment.

The principal goal of the Commission's proposal for a European Health Union relates to strengthening the EU's pandemic preparedness for future international health crises. This involves the upgrade and expansion of already existing pandemic preparedness measures which were created throughout the last two decades as a consequence of previous international health crises,

most importantly the 2001 anthrax attacks, the 2002/03 SARS crisis and the 2009 swine flu pandemic. In this context, the European Health Union envisages granting new competencies to the European Medicines Agency and the European Centre for Disease Prevention and Control and proposes the establishment of the European Health Emergency Preparedness and Response Authority as a third EU agency. This triangle of EU agencies focused on pandemic preparedness, monitoring, surveillance, and medical countermeasures will be coordinated by the Commission. By highlighting the urgency of strengthened pandemic preparedness measures in the form of monitoring and surveillance mechanisms and EU-wide medical countermeasures, the Commission pushed for expanding its supranational competencies in EU-wide pandemic preparedness measures vis-à-vis EU member states. This process builds on similar developments which occurred in the wake of other international health crises in the past.

The Commission's assertive role in providing EU-wide medical countermeasures throughout 2021 sketched the first vague contours of a European Health Union in action – and a comprehensive post-Westphalian health governance structure emerging. The Commission's EU-wide procurement of COVID-19 vaccines, their collective approval through the European Medicines Agency, the buildup of EU-wide capacities for the production of these vaccines and their adaption to new variants of the virus underscored that such an international health crisis could be successfully tackled through a post-Westphalian governance structure with the Commission in the lead. These medical countermeasures have helped keep vaccine nationalism among EU member states at a minimum, avoiding aggravating the health crisis even further, and has put the EU and EU member states into the lead in global vaccination efforts. At the global level, neither the WHO nor the WHO's global coordination mechanisms, such as the COVAX vaccine facility, have been able to ease vaccine nationalism among governments worldwide, thus exacerbating the crisis.

At the same time, it might be argued that different national health traditions, as briefly exemplified by the German, French and Italian approaches to COVID-19 in 2020, complicate EU-wide approaches to pandemic preparedness, undermining supranational governance at the EU level. Through the European Health Union, however, the Commission works as a galvaniser for integrating disparate health policies at the EU level (Brooks et al, 2020). This is important precisely because national histories/traditions in health policymaking form building blocks for higher-level pandemic preparedness cooperation at the EU level and form part of the EU's contribution to

building multilateral solutions to systemic policy problems at the European and global levels. In pandemic preparedness, the Commission is not in competition with the national level of governance; indeed, it works with the national level to improve policymaking by exercising agency in pandemic preparedness, moving towards more supranational forms of governance (Brooks et al., 2020; Dworkin, 2021).

The Commission's assertive role has placed European integration at the heart of health policy management in the EU and has potentially propelled the European Commission/European Union into a central position in global health governance. The EU's push to have purchase on health policy management internally in the EU is a prerequisite for the EU playing a greater role in health management globally (Kickbusch and de Ruijter, 2021). The EU can have an impact in Europe and globally by using its economic, environmental, development, legal and regulatory levers to affect policy change by raising standards (Bradford, 2020). The European Health Union is a prime example of the EU's attempts to level up health standards in EU member states and create more uniform standards (Kickbusch and de Ruijter, 2021). In the end, the EU is a regulation actor and seeks others to emulate its standards to be brought into its regulatory orbit (Bradford, 2020). This gives the EU powers in Europe and globally, and health governance is no exception.

4. Conclusion

The COVID-19 pandemic is the greatest international health crisis in decades. While the global response to this post-Westphalian crisis par excellence was marred by a Westphalian script, severely undermining the international authority of the WHO and its global coordination efforts, the EU-wide response witnessed a further shift towards a more post-Westphalian approach to international health crises.

At the EU level, the Westphalian script also dominated the response to the pandemic in 2020, particularly because health policy has traditionally been in the hands of member states. The ineffective Westphalian governance response, however, stimulated the development of a more assertive role on the part of the European Commission. The Commission's announcement of a European Health Union, its EU-wide procurement process of COVID-19 vaccines, their EU-wide approval through the European Medicines Agency and their EU-wide rollout can be cautiously

interpreted as the emergence of a post-Westphalian counterweight to Westphalian principles in governing health policies in the EU. These post-Westphalian governance responses may also give us a flavour of what supranational authorities like the Commission can achieve if fully supported by EU member states. The assertion of the European Commission in health policy has been accompanied by suspicion and, at times, harsh criticism on the part of EU member states, not least because of the sluggish EU-wide vaccine rollout in the first quarter of 2021. This shows that EU member states jealously guard their national sovereignty even in times of major crisis, as it happened with governments worldwide in the context of WHO coordination efforts. And yet, the Commission is still in a far better position than the WHO and other global health governance actors to uphold its authority and build on recent post-Westphalian governance approaches in the aftermath of COVID-19 due to a well-established EU architecture of supranational decision-making and the Commission's launch of an unprecedented post-COVID-19 economic stimulus package. Such formalised supranational structures of pooled sovereignty do not exist in the WHO or elsewhere in global health governance.

The Commission's actions have also increased EU autonomy and actorness in external policymaking, with the Commission emerging as a geopolitical actor on the world stage. And the COVID-19 crisis has allowed the EU to influence health policymaking as an actor in its own right at the international level. Not only has the Commission turned into a leading exporter of COVID-19 vaccines. It has also supported novel WHO initiatives, such as the Health Systems for Health Security (HSforHS) framework (The Lancet, 2021, 941). This framework, presented by the WHO a few months before the COVID-19 outbreak, aims to promote health security by complementing existing international monitoring and surveillance measures, such as the International Health Regulations, with strengthened national health systems to improve countries' emergency preparedness (Chungong et al., 2021). During the pandemic, the framework has gained considerable traction as a more comprehensive response to pandemic preparedness. And the European Health Union represents the EU's response to this framework.

We are not arguing that post-Westphalian governance in the form of supranational authority is a panacea for future pandemics. But it can reduce the limitations and pitfalls of Westphalian state-centric governance by lowering transaction costs, harmonising technical standards and procedures, breaking fragmentation, reining in nationalism and, as a consequence, contributing to crafting post-

Westphalian responses to post-Westphalian governance challenges. Even after COVID-19, post-Westphalian governance in global health will remain largely absent. And any efforts of the WHO to establish more formal supranational authority structures will be constantly dragged down by the long-lasting and resilient legacy of Westphalian principles. But the EU, embodied by the European Commission, has shown that post-Westphalian health governance is possible – and also desirable, as it played a major role in containing the outbreak within the EU. Indeed, as was the case over the past two decades, post-Westphalian health governance in the EU will remain incremental. And the European Health Union will continue to be challenged by the Westphalian mindset of EU member states. But the existence of a highly advanced post-Westphalian governance architecture in the EU combined with a much more assertive and geopolitical European Commission in health policy and pandemic preparedness provides a unique window of opportunity for a more transformative reform of EU-wide and, potentially, global pandemic preparedness.

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