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The European Union and the Coronavirus

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Europeans have lost the habit of dealing with deadly epidemics. Until the 18th century, the continent had three epidemics per century. Even if, with regard to emerging infections, 90% of the bacteria and viruses identified were not known thirty years ago (Ebola, SARS, H5N1, etc.), the omnipotence of medicine reassured us. The coronavirus has shown the fragility of our societies. We will have to wait a few months to draw conclusions about this health crisis with so many forgotten precedents.[1]

I – OFTEN UNFOUNDED CRITICISM REGARDING THE ACTION TAKEN BY THE UNION

1 – The Union only enjoys supporting competence in the area of health

1.1 The Union's competence in the area of health.

1.1.1 The definition of competence

"*The Union shall act only within the limits of the powers conferred on it by the Treaties*" [2]. In the field of health, the Union has only a supporting competence if we adhere to the what is set out in the Treaty of Lisbon[3]: it can only intervene to support, coordinate or complement the actions take by the States.

However, this competence has been gradually strengthened. The Treaty of Rome (1957) makes no mention of health. The aim of giving a more social content to European integration and the mad cow crisis[4] led to the gradual introduction of health issues into the Treaties. Health is mentioned in the Single European Act (1986)[5] but it was with the Maastricht Treaty (1992) that public health became a Community policy with the objective of achieving "*a high level of human health protection*". The Community encourages cooperation and coordination between States and the Commission "*may take any initiative to promote such coordination*"[6]. The Union's competence was strengthened with the Treaty of Amsterdam (1997)[7]. Health has become a transversal policy. The Treaty of Lisbon (2007) incorporated the previous provisions - the objective: transversality; the methods: research, cooperation between States - and complements them. The Union's competence also covers "*the monitoring of serious cross-border threats to health, warning in the event of threats and fighting against them*".

The Treaty on the Functioning of the European Union (TFEU) now allows the Union to adopt legislative acts in the field of health on the strength of two legal bases. An explicit basis, with Article 168, which specifies the Union's competence in the field of public health[8]. An indirect basis, with Article 114, which empowers it to harmonize national legislations with a view to the completion of the internal market, in particular in the field of health, specifically referred to in that Article[9].

This competence does not call into question the primary role of States in this area. The Union "*shall complement the action of the Member States (and) shall encourage cooperation between Member States*", but "*the Union's action shall be conducted with due regard for the responsibilities of the Member States*"[10]. "*Member States coordinate their policies and programmes (...). The Commission may take any useful initiative to promote such coordination*". Health care falls within the competence of the Member States. It is they who finance, manage and organise the provision of health services and care. Any action taken by the Union is intended to complement national policies, not to replace them.

1.1.2 Competence Management.

Supporting competence is a difficult exercise. The Union is always caught between doing too much and/or not

1. The present paper completes the presentation of measures adopted by the Union and the Member States drafted by the Foundation "COVID-19 : European responses, a complete picture" in The Letter by the Robert Schuman Foundation on 30th March 2020

2. Article 5 of the TEU

3. The treaty on the functioning of the European Union (TFEU) divides competences into three categories: exclusive competences, shared competences and supporting competences.

4. Bovine spongiform encephalopathy (ESB).

5. Health is one of the objectives in the European Environment Policy.

6. Title X Public Health, art.129 of the Treaty establishing the European Community (TEC)

7. Art. 152 of the TEC.

8. Title IV Public Health Art. 168 of the TFEU.

9. Art. 114 of the TFEU.

10. Art 168 of the TFEU §7

enough. Especially since these two opposing forces are exerted simultaneously:

- the integrational force. The European Court of Justice, making the link between health, the improvement of the internal market and the principle of free movement, has developed case law favourable to Community intervention and patients' rights[11].

- the regulating force. The principle of subsidiarity applies to areas of non-exclusive competence, shared between the Union and the Member States. The Union can only intervene if its actions are more effective than those carried out at national level. In theory, the Union's intervention is essentially limited to facilitating cooperation between Member States and coordinating their action. In practice, the Commission has a very broad view of its competence, often justifying its proposals by the deepening of the internal market or the cross-border dimension of a subject. However, the national parliaments ensure that the principles are respected[12].

1.2 The Union's involvement in the field of health

1.2.1 Ensuring the free movement of patients and carers in the Union.

- The patients. The Community's intrusions into the health field began as early as the 1970s, even before there was an indisputable legal basis. They were mainly inspired by the internal market and the free movement of workers, in this case patients. The aim was to ensure access to care and its reimbursement, regardless of the Member State in which it takes place. The first regulations concerned the coordination of social security systems[13]. In 2003 the creation of the European Health Insurance Card facilitated this mobility[14]. Patient mobility remains a marginal phenomenon. The care provided to European patients outside their country of affiliation represents 1% of public health expenditure, or around €10 billion per year[15].

- Health care professionals and services. Health services are subject to the principle of free movement of services and professionals enjoy freedom of establishment, two founding freedoms of the single market. Mutual recognition of diplomas required for access to the regulated professions facilitates this mobility. It is in the health sector that this mutual recognition was the earliest (as early as 1975 for doctors) since training and conditions of practice vary little from one country to another. This recognition was finalised in 2005[16]. The conditions for the establishment of health professionals in the Union are relatively straightforward. This mobility is extremely useful for the host countries but is often extremely detrimental for the countries of origin since it increases medical shortages.

1.2.2 Authorities devoted to health and a specific regulatory framework

DG Health proposes and implements EU health legislation. Since 1998, it has relied on an epidemiological surveillance network based on permanent communication between national health authorities.[17]. The case of "*serious cross-border threats*" has been under consideration since 2013. [18]. Within the Directorate, the Operational Centre for Health Crisis Management provides the Commission with an overview of epidemic phenomena and has the mission to "*build and share knowledge of health emergency management across Europe*".

Health agencies complement this commitment. This is the case of the European Medicines Agency[19] responsible for evaluating applications for marketing authorisations for medicinal products and the European Centre for Disease Prevention and Control[20]. Its regulations specify: "*The Community shall set as a priority the protection of human health by preventing human illness (and) countering threats to health. The mission of the Centre is (...) to assess current and emerging threats to health from transmissable diseases (...). An effective response to epidemics requires a coherent approach across Member States.*"

11. *According to the coordinating regulations, a person treated in the territory of another State may be reimbursed for treatment on the basis of the scheme of the State where the treatment is carried out, subject to prior authorisation. The Court of Justice, in numerous judgments - Kohll (1998), Smits (2001), Van Braeckel (2001), Watts (2006) - has given patients guarantees that their expenses will be covered under the same conditions as those in their country of affiliation. This interpretation, which is the opposite of that of the regulations, creates difficulties because, on the one hand, an insured person can request additional reimbursement in his or her country of affiliation and, on the other hand, patients can choose the State where the treatment will take place in view of the conditions of reimbursement.*

12. *European Resolution on the application of patients' rights in cross-border healthcare, Senate No. 77 (2008-2009). European Resolution on Health Technology Assessment. Senate, No. 87 (2017-2018). Political Opinion of 7 June 2018 on the Civil Protection Mechanism - RescUE-.*

13. *Cf. two regulations on the coordination of social security schemes applicable to workers and their families moving within the Community (Regulations 1408/71 and 574/72). Specific provisions concern cross-border workers (Directive 2011/24)*

14. *The European Health Insurance Card certifies the health insurance rights of its holder. It is a guarantee for the health care system of the country where the person is staying that the patient is insured in his or her home country and that the health insurance fund of the host country will be reimbursed by its counterpart in the home country.*

15. *(Patient mobility in the EU) La mobilité des patients dans l'UE, Pratiques et organisation des Soins, 2012/4.*

16. *Directive 2005/36/EC 7th September 2005 regarding the recognition of professional qualifications.*

17. *Decision 2119/98/EC 24th September 1998 establishing a network for the epidemiological surveillance and control of communicable diseases in the Community.*

18. *Decision 1082/2013/EU 22nd October 2013 regarding serious cross-border health threats*

19. *European Medicines Agency (EMA) created in 1995 whose HQ is in Amsterdam. (Regulation n° 726/2004 31st March 2004).*

20. *The European Centre for Disease Prevention and Control (ECDC) created in 2015 whose HQ is in Stockholm. (Regulation N° 851/2004 21 April 2004).*

In addition to health issues, the Union has a European civil protection mechanism to protect European citizens in the event of man-made or natural disasters and to organise international solidarity.[21]. The Emergency Response Coordination Centre is the heart of the mechanism. It coordinates the delivery of aid (relief items, specialised equipment, teams, etc.) and can activate a "*European medical corps*"[22].

Financing under a strategic framework.

Action on health at EU level is an integral part of the overall Europe 2020 strategy.[23]. Since 2003, "*health programmes*" have been defining priority objectives [24] and structure European intervention. 2020 is the final year of the EU's third health programme [25]. This health programme was completed in 2016 by a "*Strategic Plan 2016-2020*". Health emergencies are changing. The Union provides budgetary support for cooperation through co-financing. The health programme has mobilised €450 million over the period 2014-2020.[26]. The funding applicable in the event of a crisis is that of the European Agency ECDC and the Civil Protection Mechanism.

1.2.3 Raising awareness regarding emerging health threats

The health crisis, staggering for Europeans, is not unbelievable for all those, scientists or politicians, who have ever worked on these issues. It is always easy, after the fact, to find traces of gloomy forecasts. In 2006, Michel Barnier, following the 2004 tsunami in the Indian Ocean, called for the creation of a European civil protection force[27]. Pandemics are among the "*most serious transnational crises that could affect the Union, even though there are no scenarios or action protocols at European level to respond to them*"[28]. In 2012, for example, the French Senate's Delegation dedicated to forecasting published a premonitory report on emerging diseases [29].

For its part, the strategic plan presented by the Commission in 2016 refers for the first time to "*new global threats*". With the fluidity of trade and travel, diseases can spread rapidly and have catastrophic economic and health consequences. In all these areas, the EU must make a major contribution. Within this limited framework, the Union could only be a secondary player in the health crisis. However, this did not prevent it from taking initiatives.

2. The measures adopted by Europe

2.1 Undeniable European pro-activism

Time frame: China notified the WHO of the emergence of a pneumonia of unknown origin on 31 December 2019. The coronavirus was identified on 7 January 2020. The first death was recorded on 11 January. Human-to-human transmission was confirmed on the 20th. WHO classified the epidemic as a "*public health emergency of international concern*" on 30 January. The first EU decision was taken the following day with the launch of a call for proposals for research into a vaccine. The EU is "*working on all fronts*". The initiatives concern several areas[30]:

- Mobilization of services. The European Centre for Disease Prevention and Control is on the front line. All European documentation is gathered there. The Centre prepares day-to-day data on the disease and disseminates recommendations for good practice.[31] Likewise, the Commission, is being advised by a new expert group dedicated to Covid-19[32];
- Financial support for research and the pharmaceutical industry, either through the Horizon 2020 research programme or in the form of loan guarantees[33];
- Logistical support. The Union is financing the repatriation of European citizens via the civil protection mechanism. The flights are organised by the Member States and co-financed by the Union[34];
- Equipment. Creation of a Strategic Medical Equipment Reserve - SEMER - (19 March), joint call for tender launched by the Commission to purchase personal protective equipment (24 March)[35];
- International action. Medical assistance to China in the form of 30 tonnes of personal protective

21. *Based on art.196 TFEU, a European mechanism for civil protection was created in 2001 (decision n°1313/2013).*

22. *The European medical corps was created in 2014. It brings together medical teams from 11 countries, certified according to the standards established by the WHO. Spending. Seventy-five per cent of the expenditure is covered by the Union.*

23. *Commission, Strategy for smart, sustainable and inclusive growth, known as the "Europe 2020" strategy", COM (2010) 2020.*

24. *Prioritisation is essential as health is multifaceted (care/ research; communicable diseases/ drug abuse; infant mortality/ ageing; chronic/emerging diseases etc.). The "strategic objectives" are in fact broken down into 23 "thematic priorities"*

25. *Regulation (EU) No 282/2014 of 11 March 2014 establishing a third programme of Community action in the field of health (2014-2020).*

26. *Health is funded through the research programmes and cohesion policy.*

27. *Michel Barnier, report "for a European civil protection force, Europe Aid" May 2006.*

28. *The following risks are envisaged: earthquakes and tsunamis; fires; floods and landslides; industrial and nuclear accidents; terrorist attacks; maritime disasters; major pandemics.*

29. *Fabienne Keller, Background Report on Emerging Infectious Disease Threats, Sénat N° 638 (2011-2012).*

30. *See the full timeline drafted by the Robert Schuman Foundation on 30 March 2020.*

31. *Notably see a paper dated 18 March on "social distancing".*

32. *The COVID-19 Advisory Group, tasked with developing guidelines for coordinated risk management measures, has seven members.*

33. *€47.5 billion funded under the Horizon 2020 programme for vaccine research and diagnostics, on 31 January and 6 March; €45m for the Innovative Medicines Initiative, on 3 March, and €80m in support of the German pharmaceutical company Curevac, on 17 March.*

34. *By 30 March, the Union had made a financial contribution to the repatriation by air of 4383 European citizens. The cost to the Union is €1 million per plane.*

35. *"The call for tenders covers masks, gloves, goggles, face shields, surgical masks and coveralls. This procurement will help ensure that hospitals, health professionals, nursing homes and people in need have the necessary equipment to protect themselves from the virus and limit its spread". CP of the Commission, 24 March 2020.*

equipment[36], support for testing centres in Africa (€15 million, 24 February), financial support to WHO (€114 million, 24 February);

- an important economic aspect with support for national economies in the form of an investment plan - "an investment initiative in response to the coronavirus" - and the suspension of some of the rules on which European integration has been built: State aid, budgetary rules, etc. This economic aspect is the subject of the second part of the study.

2.2. European action nevertheless has left an impression of unease.

2.2.1- A certain amount of disappointment.

European public opinion is monitored on a regular basis. In these surveys everyone can find what they expect, as the results vary so much from one country to another [37]. But they converge on one point: the lack of public awareness of European issues is obvious. The challenge of informing people has not yet been won. This discrepancy is striking when Europeans are asked about the priorities they consider desirable for the Union. To the question "*what do you think the Union's main expenses are?*" Europeans answer: staff expenditure and defence. To the question "*what are the areas in which the Union should use its budget?*" the answer is 40% on public health.[38]. However, the Union's budget is an intervention budget where the share of staff expenditure is very low, that of military expenditure is symbolic and health is not a Union competence!

The Union can only give what it has, can only intervene within the limits of its competences. The desired profile for an ideal Europe disregards the Union's competences and reveals the social expectations of the moment. There will always be a gap between what the Union does and what citizens would like it to do.
This is all the more so since the Union's decision-making mechanisms are complex. The citizen does not know who does what. This is particularly true when competences are shared. Accusing the Union of shortcomings is a way of bypassing one's own inadequacies. Of course, the States are the first to be blamed for the health tragedy, but in the current context, the argument about the limits of the Union's powers is inaudible. Criticism wins everyone over.

2.2.3 Without absolving the Commission of its own responsibility

There are, first of all, flawed initiatives. Clearly, a threat to European food supply would add the plague to cholera. "*Ensuring security of supply' is one of the objectives of the common agricultural policy. We must guarantee harvests and picking, transport and accommodation for teams that could replace the usual seasonal workers, ensure transport and distribution. In view of this duty of the Union, the Commission proposes to postpone by one month the deadline for applications for direct payments*"(17 March)[39]. The Union must concern itself with the fisheries sector by organising distribution. Similarly, in the support plans, it is very difficult to identify the true support provided by the Union, since confusion is possible (maintained?) between direct aid and guarantees, additional or earmarked financing. The amending budget - the appropriations added to the initial European budget - presented by the Commission on 27 March illustrates this disappointment[40]. Only 20% are devoted to COVID-19.

Secondly, it appears that discourse is somewhat out of sync. The Commission has the immense merit of having dared to break with economic discourse, of daring to "*suspend*" some of the emblematic European rules, but as far as health measures are concerned, it remains a little out of step, and its credibility has been affected. The citizen does not expect the Commission to publish recommendations for good practice[41], hammered out by all the States (keeping social distance, washing one's hands, avoiding hugs), but rather a position commensurate with what is at stake; not a call to order, but a reminder of the elementary, founding rules of the Union, when it appears that, despite the Commission's repeated but undoubtedly too timid appeals, the individual temptation of the States prevails.

36. *The Commission coordinated the delivery of emergency medical supplies to China. Transport costs are co-financed by the EU's Civil Protection Mechanism. 30.5 tonnes of personal protective equipment have been delivered to China by France, Germany, Italy, Latvia and Estonia.*

37. *See in particular "Observatory of Economic Policies in Europe – Development of the EU's image in European public opinion" Summer 2019.*

38. *The Europeans and the EU budget, Eurobarometer November 2018*

39. *The Commission also increased the minima, i.e. aid that the States can give to farmers without prior authorisation by the Commission but this is a measure generally applicable to SMEs and not one specifically directed at agriculture.*

40. *COM (2020) 145 final. The amending budget covers EUR 567 billion in commitment appropriations (CA) and EUR 77 billion in payment appropriations (PA). The allocations go to the management of migrants in Greece (€350 billion), to the reconstruction of Albania after the earthquake (€100 billion) and to the Covid-19 crisis (€115 billion in CA and €40 billion in PA).*

41. Commission, Recommendations for good practice on Community public health measures and screening, 19 March 2020.

In its Covid-19 crisis communication, the Commission justifies its intervention by referring to European coordination and solidarity. Coordination? It is a recurrent call made by the President of the Commission. Admittedly, "*our measures to contain the coronavirus epidemic will only be effective if we coordinate our action at European level*", but the Member States have responded to the health crisis in a disorganised manner. Solidarity? It is even worse, undermining the very *raison d'être* of European integration. The Union and the Commission often emerge weakened from the crises they experience. During the bovine spongiform encephalopathy (BSE) crisis, the Commission was accused of giving priority to the interests of the market by maintaining the ban on cattle exports from the United Kingdom for only one year. During the financial crisis of 2008, the Commission stepped aside, leaving recovery to the States and the Central Bank. The current crisis shows a new weakness. The Commission is no longer in the provocative liberalism of the BSE crisis, nor in the silence it kept in 2008, now it is somewhat in denial. Coordination and solidarity, so often evoked by the Commission, are the tragic mark of European "*disunity*".

II - SERIOUSLY FRAGMENTED EUROPEAN INTEGRATION

The Union risks becoming a collateral victim of the Covid-19 crisis. The economic earthquake that could go with it will require adjustments and sometimes upheaval. The crisis is undermining the integration that Europeans have taken so long to build. Worse still, it is affecting the very meaning of European integration.

1 Heartrending adjustments

1.1 Some of the historical foundations of the Union are directly being affected

1.1.1 Free Movement.

- The legal framework. The free movement of people is the primary success of European integration. It is inseparable from an area of freedom, security and justice. It applies to everyone, and the creation of the Schengen area provides for the abolition of internal border controls and for the common rules applicable to external borders, as codified in the Schengen Borders Code[42]. In the present situation, two provisions apply. One concerns external border control. Health threats are expressly provided for [43]. The other concerns the temporary reintroduction of checks at internal borders, in particular in the event of a serious threat to public policy (Article 25). The duration is ten days, extendable up to two months in the event of an unforeseeable threat, and thirty days, extendable up to six months, in the event of a foreseeable threat.

- Implementation. The Commission first considered that border control was "*contrary to the need of the moment to demonstrate real European solidarity (...) Border authorities should continue to coordinate closely. At present, no Member State has announced its intention to introduce internal border controls*", the Commission announced on 27 February. Before the wave broke. The first Member State to re-establish internal border controls was Austria on 11 March. Since then, nine other Member States have re-established controls (from simple checks to the closure of borders). This temporary reintroduction of border controls has already been applied in the past, but this is the first time that Member States have decided to do so for health reasons. On 16 March the Commission presented "*guidelines on border measures to protect health and ensure the availability of essential goods and services*" which legitimise these controls. "*Member States may reintroduce checks at internal borders for reasons of public order which, in extremely serious situations, may include public health*". The criterion of Article 25 of the Borders Code is fulfilled. The Commission has also provided for the closure of external borders for a period of at least thirty days.
- In order to mitigate this revolution, the Commission has retained an opening statement. It insists on the need to maintain coordination - "*Our measures to contain the epidemic will only be effective if we coordinate our action at European level*" - and on the free movement of goods. "*Our single market is an essential instrument*

42. *The 1985 Schengen Agreement supplemented by the 1990 Implementing Convention and a "Schengen Borders Code" established in 2006, amended in 2013 and 2016 to provide for the temporary reintroduction of border controls, now codified by the EU Regulation of 9 March 2016 on a Union Code on the rules governing the movement of people across borders.*

43. *Schengen Border Code: see notably subparagraph 6, article 6 and article 2 § 21.*

of European solidarity (...) let us ensure that essential goods and services continue to circulate in our internal market. This is the only way to prevent shortages of medical equipment or food". Action concerns the free movement of workers in the transport sector, the priority "*green corridors*" for freight transport.

1.1.2 The practice of competition

- The legal framework. Free competition is a pillar of the internal market. Competition law is an exclusive competence of the Union and the Directorate-General for Competition has often been regarded as the Commission's powerful and feared "*flagship*". State aid law is a component of this law. The scheme is provided for in Articles 107 to 109 TFEU. The principle is the incompatibility of State aid with the internal market, but this is not absolute. Article 107(3)(b) provides for a derogation: "*Aid intended (...) to remedy a serious disturbance in the economy of a Member State may be considered to be compatible with the internal market*". The article was invoked in 1974 and in 2008.

- Implementation. The main budgetary response to the coronavirus will come from national State budgets. The impact of the epidemic is of a nature and magnitude that allows for the above-mentioned derogation. On 19 March, after the President announced "*maximum flexibility*", the Commission adopted a temporary framework for State aid to support the economy. States may devise broad support measures (compensation, liquidity support, recapitalisation).

1.1.3 Management of public finances

Public finances will support the economy "*no matter what the cost*" [44]. The rules of the Stability and Growth Pact that govern the States' public finances (essentially 3% deficit and 60% public debt) have been "*suspended*". The rules of the budgetary pact (Treaty on Stability, Coordination and Governance) are to be suspended. The longer the crisis lasts, the more dramatic the scissor effect on public finances will be: spending will explode, while at the same time, money will no longer be circulating or coming in. With the cessation of activity, practically reduced to food and pharmaceuticals, there will no longer be any VAT revenue (an important part of the States' tax revenues). In most Member States, the public deficit will explode.

The virus is suspending some of the European economic legislation that has been laboriously constructed over the last twenty years. But not all of it. On 25 March, the Commission President "*urged*" States to screen direct investment to "*protect critical companies from foreign takeovers or influence*" as allowed by recent regulations[45]. The Union could also be that of foreign envy.

1.1.4 Budgetary and financial support.

The economy could be affected as never before in the last century. The Union must expect an economic earthquake. Growth was uneven, depression will be for everyone. The Union's most positive action cannot be limited to lifting its regulations! Faced with the evidence of economic disaster, all support must be mobilised. The Union's support. The Solidarity Fund[46] is an emergency allocation with a budget of €800 million, including emergency health aid. The Union's financial support is mainly based on an investment plan, a "*Coronavirus Response Investment Initiative*" designed to support national healthcare systems, SMEs, labour markets and other vulnerable sectors. The Commission has announced an overall package of €65 billion, including €7.5 billion but including €7.5 billion from regional aid non-repayments and the remaining uncommitted structural funds.
This investment plan has gone relatively unnoticed, as the public has expected more from the European Central Bank (ECB) than from the Commission. But the ECB lived up to expectations. As the interest rate leverage was inoperative (rates are already low), the ECB announced on 18 March the implementation of a €750 billion plan to buy back the debt of eurozone governments and companies on the financial markets. As a last resort, the European Stability Mechanism (ESM), designed as a crisis tool, could be called upon. The ESM can grant loans and buy back bonds in order to cope with a possible default. The ESM has

44. *Formula used by the French President, Emmanuel Macron on 12 March 2020, taking up the formula pronounced by Mario Draghi on 26 July 2012, whatever it takes, to save the euro zone.*

a lending capacity of €500 billion on the basis of a capital of €700 billion (€80 billion paid-up capital and 620 callable). In the event of a euro-zone member State in difficulty, €80 billion can be paid out immediately. The question remains. The shake-up is such that even the question of eurobonds, "*coronabonds*", issued by the Union, is now starting to be raised. This possible shift by Germany, which has always opposed the pooling of public debt, reflects the extent of the crisis.

1.2 Solidarity

1.2.1 Flawed Solidarity

Solidarity between States is the bedrock of Europe. These few words are to be found in the first sentence of the Treaty of Rome and in the first article of the TEU: "*The States are engaged in a process of creating an ever-closer union among the peoples of Europe*". Solidarity is expressed through decision-making mechanisms, economic integration, budget transfers, financial aid, dedicated programmes, solidarity clauses added by the Treaty of Lisbon (disaster, terrorism). Solidarity is a political postulate, but it is also a construction based on the idea of European cooperation and mutual aid. This mutual aid is intended to be activated especially in times of crisis affecting one Member State, but which may affect all of them. All the conditions were in place for this solidarity to be expressed in the clearest possible way.

But in the Covid-19 crisis, however, public opinion expects no clauses, no funds and no speeches. They expect planes to bring back sick people or bring in doctors and masks...

Assistance from doctors? Italy has been assisted by a Chinese medical team (11 March), then by Cuban medical brigades and Russian military virologists (22 March). These were highly political and undoubtedly gestures of propaganda. But there has not been a single doctor from another Member State of the Union!

Patient transfers? Might the Commission, which, according to the terms of the Treaty, "*may take any useful initiative to promote coordination between States*", not have proposed, organised and financed this solidarity, while the States had not yet been overwhelmed by the wave of contamination?

1.2.2 Extremely serious political consequences

The mismatch between expectations and skills is an excuse, but it does not explain everything. This episode is crucial for the Union. Firstly, it highlights Europe's divisions. Italy, which had already suffered from insufficient solidarity in the face of the influx of migrants, believes it is alone in the face of the virus. This crisis could aggravate Euro-defiance and the temptation to retreat into nationalism. It is to be feared that the feeling of belonging to the same embryonic community, already bruised by Brexit, will be even worse and that mistrust of belonging to the Union will increase. There are still two possible ways forward. The twilight voice. "*The lack of solidarity is placing the Union in mortal danger*", commented Jacques Delors.[47] Or that of trust and resilience. For the Union was on the brink of an abyss during the financial crisis of 2008-2010 with the anxieties and failures (Greece, Portugal, Spain) and the same calls for solidarity. The European Union has always weathered storms. It is once again severely affected, but must nevertheless reflect on the post-crisis period.

2. Post-crisis scenarios

2.1 Immediate adjustments: the budgetary question.

The Covid-19 has come at the same time as the budget negotiations for the next Multiannual Financial Framework (MFF) are entering their final arbitration phase. The Covid-19 crisis is expected to have three implications. On the one hand, the allocation dedicated to civil protection and crisis management - the rescuEU mechanism - which has been little discussed so far, will obviously be mentioned. The Commission proposed "*to increase the resources available for crisis response to deal with unforeseen events or disasters*"[48]. The Commission's allocation for RescUe is modest. Clearly, no reduction would now be included, and the Commission's original proposal must be defended again.

Similarly, the MFF principle has shown its limitations. The MFF is based on seven-year programming and is not a short-term support tool to be mobilised in the event of a crisis. This is the very principle of programming! This principle can be maintained, but the MFF must be backed up by a much more substantial flexibility reserve than the existing special and flexibility instruments.

45. *Regulation (EU) 2019/452 of 19 March 2019 establishing a framework for the screening of foreign direct investment in the Union.*

46. *The EU Solidarity Fund (EUSF) is intended to provide financial assistance in the event of a major disaster occurring on the territory of a State or a candidate country in accordance with Article 10 of the Regulation on the multiannual financial framework. €598 million has been included in the 2020 budget.*

47. *Jacques Delors, 28 March 2020.*

48. Commission, draft multi-annual financial framework 2021-2027, COM (2018) 321 final

Finally, in this new context, budgetary squabbles seem derisory. Clearly, the European budget will be under severe strain in the coming years. The expected arbitration will have to take account of this episode. A few years ago, Alain Lamassoure noted that the European budget was lower than France's 2010 budget deficit alone! For the sake of the Union's credibility it would seem unreasonable to go down the same path.

2.2 The institutional debate

Every crisis raises the question of integration. The answer has always been one step further in regulation, in criteria, but basically without seeking efficiency. This health test highlights that the model is now losing impetus. There can be no qualitative leap in integration without identity and European identity does not yet exist. This time it will be difficult to convince people of federalism, since national reflexes have been so powerful. "*European disunity reminds us that the Union is still a collection of national realities. Even though integration has made great progress, the Union remains divided by structural discontinuities. These discontinuities are more revealed than produced by the current crisis*"[49]. These comments referred to the European "disunity" during the 2008 crisis. Nothing has changed. We must now have the humility to take note of these disparities. Some express the wish for health to become a shared competence of the Union and no longer just a supporting competence[50]. Apart from the fact that a Treaty amendment does not seem to be very feasible in the short term, the Commission often has an extensive interpretation of its competences and it is by no means certain that this shift will make much difference. A common-sense approach would be for the Union simply to carry out its mission. In this case, the task defined by the Treaty: to encourage cooperation and take any initiative to promote coordination between States. On these two points, the States have been seriously lacking. There is no need to change treaties or regulations. They have lacked a strong voice to remind them of this. It is time to do so and perhaps in an ostentatious way. States have individually tackled the problem but have never played as a group.

2.3 Future Challenges: Europe and Africa

Covid-19 is a global cataclysm. The epicentre of the virus, which passed from China to Europe, is now reaching the United States. Will China emerge weakened or strengthened? There is a geopolitical aspect to the coronavirus and the balance of power and influence will be shaken. All are/will be affected but the wager will favour the one who loses the least. This is why European unity is so crucial. The final battle against the virus will be fought in Africa. With its demography, urbanisation and embryonic health systems. With, no doubt, millions of deaths and resentment (at the very least) that only requires an occasion for it to flare up. Confining Europe was unthinkable, but confining Africa is impossible. The Union retains levers of influence, means and action. The Union, which will perhaps have a vaccine before the epidemic reaches the heart of the continent, can recover faith in itself and a mission by trying to save Africa from the collapse that is looming over it.

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French Senate Honorary Counselor

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49. *Yann Richard, « La crise européenne, un regard de géographe », Ecogéo 2012*

50. *Gérard Larc her, President of the French Senate, interview in Le Parisien 29th March 2020*

ANNEX:
THE COMPETENCE OF THE EUROPEAN UNION IN HEALTH MATTERS
Consolidated version of the Treaty on the Functioning of the European Union

PART THREE: UNION POLICIES AND INTERNAL ACTIONS
TITLE XIV: PUBLIC HEALTH

ARTICLE 168

1. A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities.

Union action, which shall complement national policies, shall be directed towards improving public health, preventing physical and mental illness and diseases, and obviating sources of danger to physical and mental health. Such action shall cover the fight against the major health scourges, by promoting research into their causes, their transmission and their prevention, as well as health information and education, and monitoring, early warning of and combating serious cross-border threats to health.

The Union shall complement the Member States' action in reducing drugs-related health damage, including information and prevention.

2. The Union shall encourage cooperation between the Member States in the areas referred to in this Article and, if necessary, lend support to their action. It shall in particular encourage cooperation between the Member States to improve the complementarity of their health services in cross-border areas.

Member States shall, in liaison with the Commission, coordinate among themselves their policies and programmes in the areas referred to in paragraph 1. The Commission may, in close contact with the Member States, take any useful initiative to promote such coordination, in particular initiatives aiming at the establishment of guidelines and indicators, the organisation of exchange of best practice, and the preparation of the necessary elements for periodic monitoring and evaluation. The European Parliament shall be kept fully informed.

3. The Union and the Member States shall foster cooperation with third countries and the competent international organisations in the sphere of public health.

4. By way of derogation from Article 2(5) and Article 6(a) and in accordance with Article 4(2)(k) the European Parliament and the Council, acting in accordance with the ordinary legislative procedure and after consulting the Economic and Social Committee and the Committee of the Regions, shall contribute to the achievement of the objectives referred to in this Article through adopting in order to meet common safety concerns:

(a) measures setting high standards of quality and safety of organs and substances of human origin, blood and blood derivatives; these measures shall not prevent any Member State from maintaining or introducing more stringent protective measures;

(b) measures in the veterinary and phytosanitary fields which have as their direct objective the protection of public health;

(c) measures setting high standards of quality and safety for medicinal products and devices for medical use.

5. The European Parliament and the Council, acting in accordance with the ordinary legislative procedure and after consulting the Economic and Social Committee and the Committee of the Regions, may also adopt incentive measures designed to protect and improve human health and in particular to combat the major cross-border health scourges, measures concerning monitoring, early warning of and combating serious cross-border threats to health, and measures which have as their direct objective the protection of

public health regarding tobacco and the abuse of alcohol, excluding any harmonisation of the laws and regulations of the Member States.

6. The Council, on a proposal from the Commission, may also adopt recommendations for the purposes set out in this Article.

7. Union action shall respect the responsibilities of the Member States for the definition of their health policy and for the organisation and delivery of health services and medical care. The responsibilities of the Member States shall include the management of health services and medical care and the allocation of the resources assigned to them. The measures referred to in paragraph 4(a) shall not affect national provisions on the donation or medical use of organs and blood.

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