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

Markus Fraundorfer Lecturer in Global Governance, University of Leeds, United Kingdom, and Neil Winn Senior Lecturer in European Studies, University of Leeds, United Kingdom

The 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 crisis. Global platforms for cross-border coordination and cooperation were constrained by national self-interest. Arguably, the lack of a worldwide supranational (or post-Westphalian) authority in health governance is one important structural reason for the fragmented, chaotic, and ineffective response to Covid-19. The failure of Westphalian governance responses to the pandemic provides a unique opportunity for post-Westphalian governance structures to be established and contribute to reforming international pandemic preparedness. While this is unlikely to happen soon at the global level, a comprehensive framework is emerging at the European Union level in the form of a European Health Union. Through a combined conceptualisation of supranational governance and the securitisation process of international health crises, Covid-19 has opened the door to post-Westphalian health governance coordinated by the European Commission.

Keywords: Covid-19, European Health Union, global health governance, pandemic preparedness, post-Westphalian governance, regional health governance, supranational authority

Introduction

The global response to Covid-19 in 2020–21 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. It only started collaborating with the World Health Organization (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 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 Government of the United States 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 Government of the United Kingdom considerably downplayed the threat at the beginning of 2020. And, owing to geopolitical tensions, the Group of Seven (G7) and the Group of Twenty (G20) failed to agree on a collective approach to Covid-19 (Global Preparedness Monitoring Board, 2020, p. 25).

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

This Westphalian approach to an essentially post-Westphalian challenge has not only made it more difficult to contain the pandemic, but, through widespread (vaccine) nationalism, Westphalian mindsets have also exacerbated it. This has accelerated the emergence of new, aggressive variants of the virus, facilitating the uncontrolled rise of infection and mortality rates globally and undermining an effective vaccine rollout across the globe. The Covid-19 pandemic is only the most recent example of a global challenge that simultaneously affects all countries and regions of the world, 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 (Global Preparedness Monitoring Board, 2020; Gostin, Moon, and Meier, 2020; Paul, Brown, and Ridde, 2020), which are firmly embedded in Westphalian governance principles. Furthermore, 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?

The European Commission stood out as the only actor approaching the global response to Covid-19 with a post-Westphalian mindset. This paper examines how a European Union (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.

To establish a theoretical underpinning, the paper discusses the potential role of securitisation processes in expanding supranational authority in global health governance, focusing on WHO and the European Commission. Next it traces the EU-wide response to Covid-19 in 2020–21 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 (EHU) and EU-wide vaccines procurement. The paper concludes with some reflections on the relevant role of supranational authority as an essential element of global pandemic preparedness and responses to pandemics in the future.
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 planet within weeks and affecting many countries and 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 and sovereignty and national interest. A reality that seriously undermined a coordinated global response to the Covid-19 pandemic.

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, Brown, and Fee, 2019). Apart from WHO, transnational networks and global public–private partnerships have significantly shaped global health governance and global responses to major infectious diseases over the past 30 years, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, the international drug purchase facility Unitaid, the Global Alliance for Vaccines and Immunisation (GAVI), the Coalition for Epidemic Preparedness Innovations (CEPI), the Drugs for Neglected Diseases initiative (DNDi), the TB Alliance, or the Roll Back Malaria Partnership (Cueto, Brown, and Fee, 2019, p. 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 global public–private partnerships, has lacked relevant supranational elements and could be easily undermined by governments.

By contrast, the EU is widely regarded as the leading supranational organisation in global governance, within which member states agree to cede sovereignty on some issues to a higher authority. Hence, 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 decision-making with either unanimous veto powers by states in differing forms of international cooperation or a system of sharing of competencies between states and a higher authority of some kind, normally with the veto 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, are 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 European Single 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 this
can be a source of division, too, when 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 (2012, p. 939; emphasis in the original) 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.*

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 1993, 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 heart 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 this paper shows, however, this situation seems to be changing in the context of the Covid-19 crisis.

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

Supranational authority is almost completely absent in global health governance, and states rarely grant international organisations additional supranational competencies. Yet, the securitisation process of international health crises represents one of the few instances that may put states in a position to confer international organisations supranational competencies.

Today, infectious disease outbreaks and other international health dangers, such as 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 2014–16 Ebola outbreak in West Africa, and the 2015–16 Zika pandemic in Latin America, were highly securitised, with governments and other global health actors turning into securitising actors to contain
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The event and defend the national health security of (primarily Western) governments (McInnes and Lee, 2006; Davies, 2008; Rushton, 2011; Flahaut et al., 2016; Nunes, 2016). The securitisation of infectious diseases during these health crises has usually privileged the traditional, state-centric concerns of (Western) state security and international security over globalist ideas such as human security and global solidarity (Rushton, 2011, p. 780; Flahaut et al., 2016).

Some of the key tools envisioned by governments, WHO, and other international organisations to defend national health security are: (i) surveillance, monitoring, and emergency response mechanisms to enable the early detection of a health crisis and facilitate national and international pandemic preparedness activities; and (ii) medical countermeasures such as vaccines, antibiotics, antivirals and other treatments to contain the health crisis (Rushton, 2011, pp. 784–785; Kamradt-Scott, 2015; Elbe, 2018, p. 1).

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, 2018 p. 9). In the twenty-first century, this happened in the wake of the 2005 avian flu (H5N1) and 2009 swine flu (H1N1) outbreaks, when on WHO’s advice, governments across the world started stockpiling the antiviral drug Tamiflu (Elbe, 2018, pp. 21–22). During the 2014–16 Ebola outbreak in West Africa, the use of medical countermeasures in the securitisation of the virus saw an unprecedented acceleration of research and development on 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 steps would probably not have been taken.

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, resulted in global health actors devoting almost exclusive attention to the development of medical countermeasures to contain the pandemic. Due to this sense of urgency and the channelling of billions of euros and US dollars, several Covid-19 vaccines were approved for rollout in individual countries only one year after the outbreak.

The securitisation of infectious disease and the expansion of supranational governance

In specific circumstances, the securitisation of international health crises through surveillance and monitoring mechanisms and the distribution of medical countermeasures can lead to an expansion of supranational authority in global health governance. This happened to WHO during the 2002–03 SARS pandemic, the first major pandemic of the twenty-first century. And it has gradually happened in the EU throughout the past two decades.
WHO detected the SARS outbreak in its early stages through its web-based monitoring and surveillance mechanisms, the Global Outbreak Alert and Response Network and the ProMED reporting system, which relied on local media messages and social media, non-governmental organisations (NGOs), and other non-state actors. These transnational monitoring networks allowed WHO to circumvent state governments and collect information on the infectious disease outbreak in China, even though the Chinese government initially refused to share data with WHO (Fidler, 2004, pp. 73–74; Zhou and Coleman, 2016, p. 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, Brown, and Fee, 2019). However, transnational monitoring and surveillance networks allowed WHO to free itself from its reliance on governments’ unwillingness to share epidemiological data. At the same time, the role of the central actor in distributing knowledge of and information on the health crisis put WHO in an authoritative position, supported particularly by Western states (Davies, 2008).

Encouraged by the unprecedented backing of Western states and invigorated by the novelty of the disease and its unpredictable consequences, WHO stepped up its activity, challenging the Chinese government and positioning itself as a supranational authority acting above governments. According to its Constitution, WHO is to serve its member states by providing a platform to share epidemiological information and to coordinate international responses to infectious disease outbreaks (Fidler, 2004, pp. 137, 143). During the SARS crisis, WHO went far beyond its originally defined authority by issuing a set of travel advisories and recommendations without seeking approval from its member states (Fidler, 2003, p. 491; WHO, 2003). Before the SARS crisis, advisories restricting travel and trade were usually at the discretion of WHO member states (Fidler, 2004, pp. 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 WHO. Furthermore, 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 of 2020–21.

In the EU, however, the ‘collective securitisation’ (Bengtsson and Rhinard, 2019, p. 351) of international health crises and infectious disease outbreaks over the past two decades has prompted the gradual development of some limited EU-wide coordination policies in the area of health policy. In addition, EU member states have steadily 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
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states with national preparedness activities and sharing best practices (Bengtsson and Rhinard, 2019, p. 361; European Commission, n.d.a). Following the 2002–03 SARS pandemic, EU member states set up the European Centre for Disease Prevention and Control (ECDC), the first EU-wide health agency to assist with 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, the Health Security Committee and the ECDC were strengthened further. The ECDC became the principal operating agency of the Early Warning and Response System, the EU’s leading web-based monitoring and surveillance mechanism in place since 1998 and similar to WHO’s monitoring and surveillance mechanisms (Guglielmetti et al., 2006). This allowed the Commission to create an EU-wide communication network with EU member states centred on international health crises, such as Ebola in 2014–16, Zika in 2015–16, and Covid-19 in 2020–21 (European Commission, n.d.b; European Union, 2013, para. 16).

In the same vein, the Commission was granted the authority to proclaim a public health emergency in communication with the Director-General of WHO 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, art. 12). In this context, the EU 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, para. 13 and art. 5).

All of these measures taken in the milieu of a collective securitisation process of major pandemics and international health crises over the past two decades gradually accorded the Commission the role of central securitising actor in coordinating communication and national preparedness activities with EU member states. The securitisation 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 (2018, p. 270) 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’.

To summarise, securitisation processes of international health crises can provide international organisations like the EU and WHO with a window of opportunity to increase their (supranational) authority. Given that WHO is an intergovernmental organisation tightly controlled by its member states, any supranational authority that it may gain during an international health crisis is only temporary, vanishing once the event is contained. Hence, despite the strong securitisation of infectious disease outbreaks over the past two decades, international pandemic preparedness continues
to be highly state-centric. Once the SARS outbreak was contained, 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 the Union level and given the role of the Commission as a supranational actor, the securitisation process has gradually allowed the Commission to become the central coordinating actor in EU-wide pandemic preparedness. Until the Covid-19 pandemic, though, this role was highly circumscribed, with EU member states in tight control of preparedness activities.

**The European health response to Covid-19**

**Supranational authority in the backseat**

In the EU, the early pandemic response was dominated by member states. EU institutions, however, were also involved. The Commission’s first main intervention was on 24 February 2020, involving 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 Covid-19 situation (European Council, 2020).

By late March 2020, most EU member states had restricted movement within and between countries in Europe. The period between late February and late March revealed the limits of intra-EU cooperation to address the pandemic; the intra-EU Covid-19 debate changed at this juncture, highlighting instead measures that the Commission could implement 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 in response to the economic crisis as it emerged (European Commission, 2020c). This was followed by a series of economic policy initiatives to coordinate EU responses to the pandemic, under pressure from industry.

The EU’s response to the early part of the pandemic was characterised by divisions within and between member states. In particular, the Commission did not have a pivotal role in coordinating national responses to Covid-19, due mainly to different national positions towards the pandemic. Here, it is appropriate to present briefly 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, Rexroth, and Gottschalk, 2020). The
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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 16 Länder (‘lands’), and they have the resources and 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 its national health policy: (i) the commitment to global humanitarian health internationally; and (ii) the commitment to universal healthcare 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 owing to Covid-19.

Italy’s early response to the pandemic in 2020 highlighted the strengths and weaknesses of its regional healthcare system. Much of the response to the crisis has been conducted by the 20 regions of the country, 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 the regions towards the Covid-19 pandemic (Paterlini, 2020).

Apropos of these differing national strategies informed by different historical traditions, there have been few instances of inter-EU cooperation between member states in responding to the pandemic, such as German support for French patients in the Alsace region of France (but this was not coordinated by the Commission and due to the initiative of individual EU member states). Germany also helped Italy by taking small numbers of Covid-19 patients from the country, and assisted Portugal by flying in doctors and nurses to help alleviate its hospital crisis and mounting infection rate (Roberts, 2021).

In May 2020, however, the Commission launched the European recovery fund, known as ‘NextGenerationEU’ (NGEU). The final amounts agreed by the European Council in July 2020 amounted to EUR 390 billion in expenditures and EUR 360 billion in loans. The Commission-led NGEU is an attempt to provide supranational solutions to Covid-induced economic problems, but it 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 to solve 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 procure further revenues to aid economic recovery. Lastly, the NGEU will not lead to the fiscal integration of taxes in the EU because of the resistance of more fiscally conservative EU member states in the richer north (Darvas, 2021).

To summarise, there was no coordinated and effective EU-wide response to Covid-19 throughout 2020. Policy responses were mostly initiated by individual EU member states—similar to the global response in 2020 when WHO’s worldwide coordination efforts were torpedoed by national strategies. As at the global level, health policymaking was informed by nationalism rather than European solidarity (a lack of coordination regarding travel restrictions, 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 crisis, and the 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 it is largely Westphalian, rather than supranational, its implementation will be vital for an EU-wide economic recovery to Covid-19 once the pandemic has been contained.

New dimensions of supranational authority emerging (and contested)

The proposed European Health Union: monitoring and surveillance

As a reaction to these uncoordinated efforts, the Commission proposed creating an EHU in late 2020 (European Commission, 2020a). This suggestion is in line with Commission President Ursula von der Leyen’s notion of a ‘geopolitical European Commission’ (Gstöhl, 2020). The driving idea is for the EU to move 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 China, Russia, and the US (Cloos, 2021; Stoatman, 2021).

The EHU builds on previous processes of health policy integration stimulated by the securitisation of the 2009 swine flu pandemic. However, while the EHU is designed to increase the Commission’s powers in relation to EU member states’ health systems and policies, healthcare will continue to be controlled by member states (Alemanno, 2020, p. 725). The objectives of the EHU are based on Article 168 of the Treaty of Lisbon (Council of the European Union, 2008, pp. 160–162), and cover key areas of health governance pertaining to: (i) managing health crises; (ii) aligning the ECDC with the Commission’s health priorities; (iii) extending the mandate of the European Medicines Agency (EMA); and (iv) enhancing the European Civil Protection Mechanism (Alemanno, 2020, pp. 723–724).

The thinking behind the EHU is to ‘level up’ healthcare standards in EU member states, deal with pandemics, and reduce inequalities in 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. Although EU member states remain in control of health policy overall, there are possibilities for differentiated integration with member states taking different routes depending on their needs and preferences (Guy, 2020).
The EHU 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 owing to EU crisis planning in the health sector (Bazzan, 2020), in the same kind of way that major European crises in the past have frequently led to intensified integration processes as a consequence. The EHU aims to coordinate health crises, accrue medicines/vaccines for them, and encourage the prevention, treatment, and aftercare of diseases multilaterally in the EU. To improve cross-border coordination of crisis preparedness and the management of health crises, the Commission has suggested a range of policy responses:

- declare emergency situations at the EU level to ensure EU measures;
- take risk management decisions at the EU level;
- harmonise EU, national, and regional preparedness plans;
- regularly audit and stress test preparedness plans; and
- 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 responses led by EU agencies, especially the ECDC. In particular, the EU puts more emphasis on multilateral approaches to preparedness/control of diseases:

- monitor infectious disease outbreaks based on common standards and definitions;
- conduct better risk analysis, modelling, and assessments of healthcare capacities for specialised treatments;
- issue response recommendations; and
- mobilise and deploy an EU Health Task Force to facilitate local response in member states (European Commission, 2020a).

Furthermore, according to the Commission, the EMA, created in 1995, is projected to assume a leading role in health crises, notably with respect to:

- monitoring and mitigating shortages of medicines and medical devices;
- coordinating and advising on medicines with the potential to treat, prevent, or diagnose diseases that cause a crisis; and
- coordinating studies and clinical trials to monitor the effectiveness and safety of vaccines (European Commission, 2020a).

No less important than 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 doing so, the Commission established the HERA incubator 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 EU health policy is determined as much by industries’ interests as it is by public policy; the pharmaceutical industry is one such example (Permanand and Mossialos, 2005). Arguably, during the Covid-19 pandemic, ‘Big Pharma’ in Europe and elsewhere have pursued markets for their vaccines, as highlighted by arguments over supply between the European Commission and AstraZeneca in early 2021 (Deutsch and Wheaton, 2021). It is also clear that vaccine nationalism is in play among many countries, which leaves the poor at a disadvantage globally (Nhamo et al., 2020). But this same nationalism affects the ability of all actors engaged 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 on the Commission’s proposal for an EHU.

Nevertheless, within the EU, the Commission has a strategy of minimising vaccine nationalism among member states. Furthermore, it envisages 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 WHO and its global vaccine procurement and distribution mechanism COVAX have been helpless in controlling (Hafner et al., 2020; Patnaik, 2021).

An initial idea of what a future EHU might look like was offered by the Commission’s strategy in late 2020 to pursue an EU-wide approach to purchasing Covid-19 vaccines, with approvals being granted by the EMA rather than national medicines agencies. But mistakes made by the Commission in the procurement process with pharmaceutical companies (particularly with AstraZeneca) and initial difficulties in ramping up the production process led to an extremely slow vaccine rollout across the EU in the first few months of 2021, attracting considerable criticism from EU member states and WHO. 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 EMA did not approve it (Martuscelli, 2021). One should note, however, that many EU member states can also be blamed for the slow EU-wide vaccines rollout. A number of them administered significantly fewer vaccine doses than received by the Commission due to a lack of national preparation and planning and controversies about the efficacy and safety of the AstraZeneca vaccine, one of the principal vaccines (along with the Pfizer–BioNTech vaccine) administered initially by EU vaccination programmes (Hirsch and Deutsch, 2021).

After these initial problems with AstraZeneca and a strategic switch from its vaccine to that of Pfizer–BioNTech, though, the EU fared much better as 2021 progressed (De Maio, 2021, p. 1; The Economist, 2021). The EU has considerably increased its vaccination levels and started to catch up with the UK and the US by the middle of the year, the countries that have been leading the rollout from early on (The Economist, 2021). Already in April 2021, the EU was exporting more vaccines (113.5 million)
to third countries than it was administering to its own population; 15.2 million of these were shipped to the UK (Chrysoloras, 2021). By the end of July 2021, 70 per cent of the adult population in the EU had received at least one vaccine dose, thus achieving the Commission’s vaccination target (European Commission, 2021b). And by the end of August 2021, the Commission had hit its target of fully vaccinating (two doses) 70 per cent of all adults across the EU (European Commission, 2021c). Hence, the EU has become the most successful regional integration project and world region in terms of Covid-19 vaccination.

A post-Westphalian health governance framework emerging

The initial response of EU member states to the pandemic was no less fragmented and piecemeal than at the global level, pervaded by the (Westphalian) primacy of national interests and various forms of nationalism. Yet, 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 transformative reform of EU-wide governance structures focused on pandemic preparedness.

In reaction to the fragmented Westphalian response to Covid-19 in 2020, the European Commission has carved out a much more assertive role for itself 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 Single European Market, and the suspension of the free movement of people) incentivised member states to concede some of their sovereignty to the Commission, putting it in the driving seat with regard to EU-wide coordination of pandemic preparedness measures and collectively reifying EU member states’ national interests concerning disease containment.

The principal goal of the Commission’s proposal for an EHU relates to strengthening the EU’s pandemic preparedness for international health crises in the future. This involves the upgrade and expansion of already existing pandemic preparedness measures, which were created over the past two decades following 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 EHU envisages granting new competencies to the EMA and the ECDC and proposes the establishment of HERA as a third EU agency. This triangle of EU agencies centred 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 has pushed for expanding its supranational competencies in EU-wide pandemic preparedness measures vis-à-vis
EU member states. This process builds on similar developments that 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 served as a sketch of the first vague contours of an EHU in action—and the emergence of a comprehensive post-Westphalian health governance structure. The Commission’s EU-wide procurement of Covid-19 vaccines, their collective approval through the EMA, the build-up 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 at the head. These medical countermeasures have helped to 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 with respect to global vaccination efforts. At the global level, neither WHO nor its 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, one might argue 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 EHU, however, the Commission works as a galvaniser of integration of disparate health policies at the EU level (Brooks, de Ruijter, and Greer, 2020). This is important precisely because national histories/traditions with respect to health policymaking form the building blocks of higher-level pandemic preparedness cooperation at the EU level and constitute part of the EU’s contribution to generating multilateral solutions to systemic policy problems at the European and global level. In terms of 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 types of governance (Brooks, de Ruijter, and Greer, 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 is a prerequisite for it 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 EHU is a prime example of the EU’s attempts to ‘level up’ health standards in EU member states and create more uniform benchmarks (Kickbusch and de Ruijter, 2021). In the end, the EU is a regulation actor that requires others to emulate its standards, in order to be brought into its regulatory orbit (Bradford, 2020). This gives the EU powers in Europe and around the world; health governance is no exception.
Introduction
The Covid-19 pandemic is the greatest international health crisis in decades. While the global response to this post-Westphalian emergency par excellence was marred by a Westphalian script, severely undermining the international authority of 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. Its announcement of an EHU, its EU-wide procurement of Covid-19 vaccines, their EU-wide approval through the EMA, 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 offer 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 happened with governments worldwide in the context of WHO coordination efforts. And yet, the Commission is still in a far better position than 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, owing 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 WHO or elsewhere in global health governance.

The Commission’s actions have also increased EU autonomy and actoriness in external policymaking, with the Commission emerging as a geopolitical actor on the world stage. In addition, 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, but also it has supported novel WHO initiatives, such as the Health Systems for Health Security (HSforHS) framework (The Lancet, 2021). This framework, presented by 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, HSforHS has gained considerable traction as a more comprehensive response to pandemic preparedness. The EHU 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, interrupting fragmentation, reining in nationalism, and, therefore, contributing to crafting post-Westphalian responses to post-Westphalian governance challenges. Even after the Covid-19 crisis, post-Westphalian governance in global health will remain largely absent. And any efforts by WHO to establish more formal supranational authority structures will be constantly undermined by the long-lasting and resilient legacy of Westphalian principles. However, the EU, embodied by the European Commission, has shown that post-Westphalian health governance is possible—and desirable—as it played a major role in containing the outbreak within the EU. Indeed, as over the past two decades, post-Westphalian health governance in the EU will remain incremental, and the EHU will continue to be challenged by the Westphalian mindset of EU member states. Yet, 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 opportunity for more transformative reform of EU-wide and, potentially, global pandemic preparedness.

Acknowledgements
We thank Garrett Wallace Brown and two anonymous peer reviewers for their thoughtful comments on earlier versions of this paper.

Data availability statement
Data sharing not applicable to this article as no datasets were generated or analysed during the current study.

Correspondence
Markus Fraundorfer, Faculty of Social Sciences, School of Politics and International Studies, University of Leeds, Leeds, LS2 9JT, United Kingdom.
E-mail: m.fraundorfer@leeds.ac.uk

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