



The importance of health security in post-Brexit EU–UK relations

European View
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journals.sagepub.com/home/euv**Andrew Glencross****Abstract**

This article examines the possibilities for negotiating the UK–EU health-security relationship after 2020. Health security, in the sense of measures to prevent and mitigate health emergencies, had played a marginal role in the UK–EU negotiations, but COVID-19 has greatly amplified this policy area's significance. At the beginning of the pandemic, Brussels introduced significant measures to promote public health sovereignty, notably joint procurement and stockpiling of personal protective equipment. The UK went against the grain by limiting its involvement in joint procurement at a time when other countries were rushing to participate. UK participation in some EU health measures is possible on existing terms, but not joint procurement. This leaves the UK facing an uncertain future because of the potential risks associated with not participating in EU programmes, notably in terms of access to personal protective equipment supplies and possible market distortion resulting from new EU policies promoting stockpiling and reshoring. The politicisation of health security thus adds another complication to the post-Brexit EU–UK relationship.

Keywords

Brexit, Health security, COVID-19, Health sovereignty, Stockpiling

Introduction

The EU has traditionally had very limited involvement in public health policy, with only supporting competences in what is a highly complex policy area where member states typically preferred maximum autonomy (Greer et al. 2019). Thus it is no surprise that health-related matters initially played a marginal role in the negotiations over the future

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UK–EU relationship. However, the COVID-19 pandemic has greatly amplified the significance of health security in a way that fundamentally intersects with policy priorities in the UK and the EU27. In particular, the EU response is defined by significant legislative and financial measures to promote what has been dubbed public health sovereignty or *souveraineté sanitaire* (Hackenborich et al. 2020). Hence this article explores the way health security—in the sense of measures to prevent and mitigate health emergencies such as pandemics—is destined to be an important and fraught dimension of the UK–EU relationship in the coming years. This is because the UK’s desire to regain control of policymaking is fundamentally at odds with the EU’s cooperative and increasingly solidaristic approach to health security.

The Political Declaration on the future UK–EU relationship agreed by the European Council in October 2019, which concluded the first phase of Brexit, specifically mentioned health security. It stated that ‘the Parties should cooperate in matters of health security in line with existing Union arrangements with third countries. The Parties will aim to cooperate in international fora on prevention, detection, preparation for and response to established and emerging threats to health security in a consistent manner’ (European Commission 2019, 21).

Yet the aspiration to cooperate in this area did not feature in the UK government’s Draft UK–EU Comprehensive Free Trade Agreement, or in drafts of separate agreements for specific sectors, published at the start of 2020. By contrast, a chapter of the EU’s *Draft Text of the Agreement on the New Partnership with the United Kingdom* was devoted to this topic under the broader rubric of ‘thematic cooperation’ (European Commission 2020a). UK and EU negotiators have discussed thematic cooperation since the beginning of the second phase of Brexit talks in March 2020, albeit with only one slot reserved for this topic in any given round of talks—an indication of its low-priority status. The notion of health security as an afterthought of Brexit, a loose end to be tied up after a hard-fought trade negotiation, is less and less plausible because of the lasting implications of the COVID-19 pandemic, not least when it comes to building resilience against a future epidemic. Nevertheless, the true effect of EU withdrawal on health security in the UK will only be revealed after 2020, at which point policymakers on both sides will need to be prepared for tough decisions.

Health security during and after the Brexit transition

Health security does not fit neatly in the classic delineation of EU decision-making in terms of supranationalism or intergovernmentalism. Impetus for policymaking in this area comes from the Commission, which has the independent authority to declare a ‘public health emergency’, and the European Centre for Prevention and Disease Control (ECDC) based in Stockholm, whose work and budget are overseen by the European Parliament (Bengtsson and Rhinard 2019). The ordinary legislative procedure can be used under Article 168 of the Treaty on the Functioning of the European Union to take direct measures to promote public health, as in the creation of the Health and Security Committee (HSC) in 2013 to prepare and coordinate national responses to serious

cross-border threats to health (Greer et al. 2019, 86). In practice, health security in the EU system revolves around networked coordination between EU and national authorities as well as experts, which has collectively shaped the securitisation of public health (Bengtsson and Rhinard 2019). The international aspect of health security is also a mixed bag because the Commission is responsible for negotiating trade deals that may have a health component, which member states need to ratify unanimously if a deal intersects with national health competences, while the ECDC has a variety of partnerships with third countries.

During the post-Brexit transition period, as per the 2019 Withdrawal Agreement, the UK has benefited from a special status meaning it could participate in EU health-security measures on the same terms as EU member states. This arrangement has allowed the UK to retain full access (overseen by Public Health England) to the Early Warning and Response System (EWRS), administered by the ECDC, for the prevention and control of communicable diseases. Moreover, UK representatives could attend meetings of the HSC. The UK also had the opportunity to participate in joint procurement programmes launched by the Commission in March 2020 for ventilators, protective personal equipment for medical staff (PPE) and COVID-19 testing kits. There was fairly extensive press coverage in the UK of Westminster's decision not to participate in these bulk-buying initiatives (House of Commons Library 2020). Less well known is the fact that, in May 2020, the UK received a delivery of PPE via the EU's Emergency Support Instrument, to which the EU allocated €2.7 billion to support member states' health care systems during the early months of the pandemic (British Medical Association 2020). According to the British Medical Association (2020, 1), 'the UK requested access to the scheme and had been selected based on a formula which considered "epidemiological data, needs of the countries and the access to equipment"'.

In the absence of a new UK–EU agreement covering health security, the UK stands to lose the ability to participate in the above institutions and programmes. Currently, full access to the EWRS and other information-sharing systems of the ECDC is reserved for EU and European Economic Area (EEA) member states. EEA countries (Iceland, Liechtenstein and Norway) provide approximately €1.5 million per annum to the ECDC budget, in sums calculated in proportion to their gross domestic product. Other countries may be allowed temporary, ad hoc access to manage a health emergency that poses a cross-border threat in Europe (as provided for in the EU's draft of the UK–EU partnership agreement), but third countries do not have routine access to the full range of ECDC health coordination systems (Greer et al. 2019). Switzerland, despite extensive bilateral treaties with the EU, is not a full member of the ECDC. EEA countries, plus Turkey and Serbia, have official observer status within the HSC. This status is available to EU candidate countries as well as other third countries 'where it is in the interest of the Union that such country is involved in the works of the HSC, in particular based on an international agreement, an administrative arrangement or EU legislation' (European Commission 2013, 1).

Hence there is legal scope after the transition period to find an agreement over UK partial participation in the ECDC and to obtain observer status at the HSC within the

existing rules. The same is not true of the EU's Joint Procurement Agreement (JPA), which currently covers 37 countries including the UK. The JPA is a voluntary scheme that has existed since 2014 and allows signatory states to pool resources when tendering for medical counter-measures (vaccines, antivirals, PPE and assorted equipment). In effect, it is a buyers' club that negotiates collectively to benefit from economies of scale and to avoid competition for scarce resources among purchasing states (Greer et al. 2019, 82–4). Each participating state has the option, on a case-by-case basis, of associating themselves with a particular joint procurement procedure until the publication of a call for tenders.

The need to respond to the COVID-19 pandemic breathed new life into this initiative, resulting in four calls for tenders by the end of March 2020. The pandemic brought about a flurry of new signatories, with 12 countries joining since February 2020. For instance, Norway, which did not sign the JPA when it launched in 2014, rushed to become a member of the scheme in March 2020 but was too late to participate in the first tender (Eliassen and Melchior 2020). For its part, the UK opted not to participate in the four initial tenders launched between April and May 2020 worth €3 billion, a decision justified by Cabinet Minister Michael Gove on the basis that 'there's nothing that participating in [the JPA] scheme would have allowed us to do that we have not been able to do ourselves' (House of Commons Library 2020, 18). Instead, the UK organised a separate initiative for procuring ventilator equipment that met with limited success. The JPA is only available to EU, EEA and candidate countries. Thus if the UK wanted to remain a participating state, it would need to negotiate a new arrangement without precedent. Switzerland, which does not fit existing categories for membership, is not able to participate in the JPA. Moreover, the JPA is subject to EU law, which means the UK would have to accept involvement of the Court of Justice of the EU in the event of disputes over procurement processes. In addition to the theoretical problem of the sovereignty implications of the JPA, the UK also faces more practical challenges resulting from the knock-on effects of EU moves to improve the health sovereignty of the EU27.

EU health sovereignty and the challenge for Brexit Britain

Traditionally, the EU's direct involvement in public health policy was legally and politically structured as a complement to national measures, notably via the work of two bodies: the ECDC and the European Medicines Agency (Greer et al. 2019). COVID-19 has changed all that by putting health at the centre of the ongoing conversation on the future of Europe, overlapping neatly with the idea that EU legitimacy can best be enhanced by policies that protect citizens in their everyday lives. This desire helps explain the new raft of legislative and financial measures to fight the pandemic and improve future EU preparedness. These include joint procurement for medical counter-measures, PPE stockpiling, a Pharmaceutical Strategy aimed at reducing direct dependence on raw materials sourced from non-EU countries and export controls on PPE. In May 2020 the European Commission prepared a programme called EU4Health with a proposed budget of €9.4 billion provisionally allocated for 2021–27 to respond to the effects of the COVID-19 pandemic. Yet the hard-fought negotiation over the EU's multiannual financial framework reduced the available funds for this programme to €1.7 billion.

Despite the pared-down financial ambitions, two features of the EU response to COVID-19 stand out for their potential implications for the UK after transition. The first concerns EU-wide export restrictions like those imposed by the European Commission on 14 March 2020. This regulation placed binding restrictions on exports of certain types of PPE outside the EU, the European Free-Trade Association countries and a host of micro-states/EU overseas territories. Under this regulation, exports of five types of PPE were subject to export authorisation by national authorities (spectacles and visors, face shields, mouth–nose protection equipment, protective garments and gloves). The worry was that without such measures the EU might not have sufficient stocks of PPE for its own needs; the restrictions, which were legally binding on the UK, were lifted by the end of May 2020. During this time, 95% of export licence requests were approved by national authorities within the EU (*Reuters* 2020).

The second emergency measure undertaken by the EU is the development of an emergency medical stockpile, including PPE, under the RescEU programme nested within the EU's Civil Protection Mechanism (CPM). Prior to 2020, RescEU reserve capacities only applied to forest-firefighting planes and helicopters. In March 2020, the European Commission announced it would fund up to 100% of the costs for the development and deployment of stockpiles designed to offer emergency supplies during the COVID-19 crisis and future health crises (European Commission 2020b). A sum of €380 million was earmarked from the Emergency Support Initiative to pay for these stockpiles, which started with Romania and Germany ordering masks that were subsequently distributed to Italy, Spain and Croatia. The CPM is not exclusive to EU member states: Iceland, Montenegro, North Macedonia, Norway, Serbia and Turkey all take part in it. The wording of the CPM's rules for participation specifies that, beyond EU and EEA countries, 'other European countries when agreements and procedures so provide' can participate in this arrangement (European Parliament and Council 2019, art. 28).

During the transition period, as explained above, the UK is shielded from any market distortions resulting from the two measures described above. Conversely, after transition, EU public health policies may affect the cost and availability of medical countermeasures, notably PPE, for the UK. Traditionally, the EU has been an important source of PPE for use in the UK, although the proportion of EU imports fell in March and April 2020 (Bevington 2020). Based on the March–May 2020 precedent, UK imports of PPE and medical products or equipment sourced from the EU could be subject to export controls in the event of a severe second wave of COVID-19 or another pandemic. Even if such measures do not result in quantitative restrictions, export licensing adds a bureaucratic impediment that could delay the importation of EU-sourced supplies in an emergency situation. Reduced access to EU-sourced PPE will inevitably make the UK more dependent on China for these supplies, as occurred during March and April 2020.

Equally significantly, EU-organised joint procurement and stockpiling could limit supplies to the UK—or at least increase the cost of bidding against the EU on the global market, which is dominated by Chinese producers that supply 40% of the global PPE market (Bevington 2020). As the world's biggest trader in pharmaceutical and

medicinal products, the EU's COVID-19-related policies to promote stockpiling and reshoring will undoubtedly impact global markets. The greater the scale of the EU's joint efforts in purchasing and stockpiling, the more market power it will have in comparison to the UK government. This fear of exclusion explains the rush of countries that joined the JPA in 2020 as the pandemic struck Europe and countries worldwide sought to block exports of essential medical supplies. The European Commission's intention to provide more funds for stockpiling and facilitate the development of EU-based PPE manufacturing, matched by similar ambitions for the pharmaceutical sector, only amplifies the risk the UK faces as a third country when trying to go it alone.

Conclusion

As demonstrated above, the UK faces an uncertain future after transition if it neglects to negotiate on the subject of health security with the EU. The negative consequences of a broken health-security relationship will also be felt in Europe. The loss of UK participation in the ECDC will impair the surveillance and tracking of cross-border disease threats amongst highly integrated and mobile populations. The EU has suggested accessing the EWRS on an ad hoc basis, which should be the minimum level of participation sought by the UK, alongside obtaining observer status in the HSC, which current rules permit. In addition, the EU27 will need to invest in developing expertise in areas where it traditionally depended on UK inputs, notably in medical research and pharmaceuticals. Nevertheless, the harm caused by disruption in the EU–UK health-security relationship is asymmetrical and politically potentially highly disruptive in the age of COVID-19.

As a country particularly dependent on PPE imports, the UK is at greater risk of supply disruption if it fails to negotiate a relationship that provides for some degree of participation in existing as well as newly launched EU public health policies. Privileging sovereignty over cooperation in the area of health security means the UK government could be punished if its unilateral approach does not pay off. Indeed, the scramble for PPE brought about by the COVID-19 pandemic turned into a geopolitical 'great game' as Russia and China sought to burnish their reputations in Europe by providing this form of medical assistance. This 'battle of narratives', as the EU's High Representative Josep Borrell (2020) has dubbed it, only underscores the value of the JPA and the importance of stockpiling to ensure resilience against a second wave of COVID-19 as well as future pandemics. However, based on existing EU arrangements with third countries, it would appear impossible for the UK to access the JPA without requiring the EU to change its rules of participation and the UK to accept an oversight role for the Court of Justice of the EU. By contrast, the rules governing the CPM suggest it would be possible for the UK to benefit from RescEU stockpiling as a participating state, albeit dependent upon it making an appropriate financial contribution.

In the aftermath of COVID-19, the EU's foreign policy chief notes that the EU must demonstrate that it 'is a Union that protects and that solidarity is not an empty phrase' (Borrell 2020). This focus on material solidarity is welcome, but it makes reconfiguring the UK–EU health-security relationship more difficult as Brexit has made the UK more

wary of making commitments to joint enterprises. The new reality the UK faces after the Brexit transition is one in which the EU's push for greater health sovereignty is liable to affect British policymakers regardless of whether London participates. The politicisation of health security as a result of COVID-19 thus adds another complication to the already fraught post-Brexit EU–UK relationship.

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