

Impact of COVID-19 measures on democracy and fundamental rights

Best practices and lessons learned in
the Member States and third
countries



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Abstract

This research study examines the impact of COVID-19 measures on democracy and fundamental rights in the EU. It considers what best practices have been evidenced, and the lessons that can be learned from comparative experience within EU Member States as well as relevant third countries.

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LIST OF ABBREVIATIONS

COE	Council of Europe
COREPER	Comité des représentants permanents / Committee of the Permanent Representatives of the Governments of the Member States to the European Union
COVID-19	Coronavirus disease 2019
EASA	European Union Aviation Safety Agency
ECDC	European Centre for Disease Control and Prevention
ECtHR	European Court of Human Rights
EMA	European Medicines Agency
EP	European Parliament
ESM	European Stability Mechanism
EU	European Union
EUCFR	EU Charter on Fundamental Rights
GDPR	General Data Protection Regulation
HERA	Health Emergency Response Authority
HIC	High Income Country
LMIC	Low and Middle Income Country
NPHE	National Public Health Emergency Team for COVID-19 (Ireland)
OECD	Organisation for Economic Co-operation and Development
OMT	Outbreak Management Team (Netherlands)
PHEIC	Public Health Emergency of International Concern
UN	United Nations
WHO	World Health Organisation

EXECUTIVE SUMMARY

Background

The World Health Organisation declared the novel coronavirus, SARS-CoV-2 which causes coronavirus disease (COVID-19), to be a Public Health Emergency of International Concern on 30 January 2020. Countries globally adopted some of the most restrictive measures in contemporary history, including the closure of schools and workplaces, isolation and quarantine strategies, and national lockdowns. The pandemic tested the capacity of administrative and legal systems to adapt to unpredictable and highly risk laden situations. The stressors of a global health emergency proved to be a litmus test for the resilience of democracies and safeguards for the rule of law and fundamental rights. This report examines pandemic governance in the EU and its Member States during the COVID-19 pandemic between 2020 and 2022. It describes how the COVID-19 pandemic was addressed by EU Member States, either in terms of declaring a state of emergency or similar regimes, or using emergency powers or emergency health legislation, or normal legislation. The report considers the role of the European Union in coordination, but also in scrutiny of Member State response from a fundamental rights and democracy perspective. It analyses the consequences of EU and Member State action for fundamental values, and, in particular, within the context of vaccination policies and COVID-19 passes.

Aim

The aim of this report is to analyse and provide recommendations on:

- pandemic decision-making, including the use of data and scientific research, comparing the various approaches of member states, and examining their efficacy in relation to slowing down the pandemic and ensuring democratic input, human rights protection, public trust and compliance;
- the legal bases for Member State action in response to the COVID-19 pandemic, and the impact of these approaches on democracy, the rule of law, fundamental rights, the separation of powers and national systems of checks and balances;
- the various restrictive measures adopted by Member States, and their respective impact on democracy, the rule of law and fundamental rights;
- the approaches, policies and laws related to vaccination and COVID-19 passes, and related issues of vaccine hesitancy; and
- the EU institutions' roles and actions in terms of policy coordination, scrutiny and protection of democracy, rule of law and fundamental rights from the negative effects of COVID-19 and the measures adopted to confront it.

Key Findings

The prevalence of restrictive policies, adopted by almost all states at the start of the pandemic and reintroduced by some in response to successive waves of COVID-19 in 2020 and 2021, declined over the course of 2021-2022. Many factors account for this, including the increasing levels of information available on more effective means of reducing transmission, and improvement of diagnostic tools and therapeutics, as well as concern for public support and compliance, and the influence of decisions made by neighbouring states. Blunt comparison of EU Member States would indicate that there is no direct correlation between states which have adopted (on average) highly restrictive or laissez-faire regimes, and cumulative COVID-19 related deaths, however, this approach masks a range of factors including each Member State's unique epidemiological, social and economic situation, as well as the range and timing of measures.

COVID-19 bred 'shadow' pandemics of educational deprivation, domestic violence, unemployment, poverty, social-isolation and mental health crises unaccounted for in national decision-making or advisory bodies. Further and broader expertise in both the sciences and social sciences is needed to inform not only immediate measures, but also in devising longer-term strategies for recovery.

Trust is multidirectional between governments, experts and the public, and high levels of trust are essential to effective pandemic management. The perception of the legitimacy of government action is strongly connected with public access to information and understanding the justification of pandemic measures. Trust in experts is strong predicated on the perception that they are independent, and transparent in their reasoning.

Member States relied on a range of legal bases in response to the pandemic, including the constitutional declaration of a state of emergency, statutory emergency regimes, and ordinary legislation. While concerns for the misuse or abuse of emergency powers are well founded, there is no clear or evidenced connection in EU Member States between the use of emergency powers and practices detrimental to fundamental rights and the rule of law. Member States continued pre-existing trends: those committed to high levels of political accountability tended to show this in decision-making processes; while states tending towards autocratic or anti-democratic practices continued that trajectory.

The COVID-19 pandemic caused significant challenges for parliaments and courts. Closure of buildings resulted in significant backlog to court proceedings, while parliamentary activity was limited. Democratic digital innovation allowing remote access to court proceedings, and parliaments, varies across Member States. Support for digital literacy is needed to ensure equitable access.

Restrictive measures are the first tool available to Member States to slow the spread of an infectious disease, however, they inevitably have significant negative social and economic costs, particularly for the most vulnerable groups in society, and by their nature have significant implications for fundamental rights. Non-pharmaceutical interventions such as washing hands, wearing masks, and socially distancing, can help to limit the spread of infectious disease. Public health awareness, and a shift in personal and organisational behaviour to adopt protective measures including regular testing, distancing, hand hygiene and improved ventilation reduced the need for strict bans and closures.

The rights to life, health and other freedoms are indivisible and interdependent, and should be balanced, especially in the heat of pandemic decision making, using the well-tested framework of legality, necessity and proportionality provided by international human rights treaties and national laws and constitutions. Studies of the efficacy of restrictive measures are still uncertain, but early findings suggest that precisely targeted and well-timed interventions can avoid the necessity of introducing more severe and restrictive measures if a pandemic situation escalates.

The European Union has limited competences relevant to the field of public health emergencies which likely hobbled an initial, coordinated response across EU Member States. Towards the end of 2020, the EU played a more significant role in the coordination of border policies, coordination of COVID-19 passes, and vaccine development and procurement. EU funding enabled research and development aiding pandemic response, while the European Centre for Disease Control played an important role in data aggregation and sharing.

EU institutions, notably the European Parliament, played an important role in the scrutiny of Member States' responses to pandemic from the perspective of fundamental rights. The EU Commission highlighted concerns in Member States practices in the annual Rule of Law Reports.

The EU has achieved a higher average rate of vaccination compared with global rates, however there is a wide divergence in vaccination rates across EU Member States correlating with levels of vaccine hesitancy. Vaccine mandates may be justified on fundamental rights terms when connected with certain circumstances or professions. However, they have not been conclusively proven to incentivise higher vaccination rates, particularly among groups or communities which are vaccine-hesitant.

A 'one-size-fits-all' approach to encouraging vaccine acceptance and tackling vaccine hesitancy is unlikely to be effective. Attention must be paid to the underlying reasons for vaccine hesitancy, as well as the unique dynamics of the target group or population.

COVID-19 passes (providing e.g. recognition for vaccination, recovery, or testing) supported the re-opening of public spaces, and businesses and there is some (early) evidence that they may encourage some groups to be vaccinated. However, a number of legal, ethical, scientific and technical concerns were raised over their use. Scientific concerns relate to uncertainty regarding the longevity of immunity, and the encouragement of risky behaviours, while technical concerns related to the security and data privacy of digital applications. Concerns relating to the COVID-19 passes being 'discriminatory by design' and leading to exclusion of unvaccinated populations, and underlining vaccine access inequities.

'The COVID-19 pandemic is a public health emergency— but it is far more. It is an economic crisis. A social crisis. And a human crisis that is fast becoming a human rights crisis.'¹

United Nations Secretary-General António Guterres

1. INTRODUCTION

The novel coronavirus, SARS-CoV-2, was first reported to the World Health Organisation Country Office in China on 31 December 2019. Following the rapid spread of the virus, the WHO declared the outbreak of the virus that causes coronavirus disease (COVID-19) to be a Public Health Emergency of International Concern [PHEIC] on 30 January 2020. The first death in Europe related to the SARS-CoV-2 was reported by French authorities on 15 February 2020. On 11 March 2020, the WHO began to describe the outbreak of the SARS-CoV-2 as a pandemic² Since then, EU Member States have been among those most negatively impacted by the virus, with Bulgaria, Hungary, Croatia, Czechia and Slovakia ranking in the top ten worst states for having the highest per capita mortality rates³

The pandemic tested the capacity of administrative and legal systems to adapt to unpredictable and highly risk laden situations. Laws and regulatory frameworks proved to be unprepared for the demands of a global health emergency, and the boundaries of the constitutional limitations on the use of power were stretched⁴. As a consequence, the stressors of a global health emergency proved to be a litmus test for the resilience of democracies and safeguards for the rule of law and fundamental rights. A majority of states both within the EU, and globally, adopted highly restrictive measures both limiting and, in some cases, derogating from fundamental rights protections. Almost all public policy sectors were impacted. Within two months of its declaration as a PHEIC, some of the most restrictive measures in contemporary history were imposed across Europe and the world, including the closure of schools and workplaces, and orders to stay at home under lockdown conditions. In addition to devastating loss of human life, this global health emergency has had profound and potentially enduring effects on political and legal systems, economies and societies. Simply, 'the depth of the economic crisis, the rise of systemic vulnerabilities but also of socio-economic inequalities and access to health across the EU are unprecedented'⁵.

The COVID-19 health emergency tested the limits of both constitutional and legislative frameworks governing the use of emergency powers and executive decision-making. Governing under extended de facto or de jure emergency regimes, many executives have operated relatively free of legislative or judicial oversight⁶. The closure of courts and parliamentary assemblies, in addition to self-imposed

¹ United Nations Secretary-General António Guterres, We are all in this Together: Human Rights and COVID-19 Response and Recovery, 23 April 2020.

² WHO statements establish they cannot declare a pandemic, as it is not within their available tools, and does not exist in WHO law.

³ 'COVID-19 Map' (Johns Hopkins Coronavirus Resource Center), <https://coronavirus.jhu.edu/map.html>, accessed 1 November 2022.

⁴ Grogan, J., 'States of Emergency: Analysing Global Use of Emergency Powers in Response to COVID-19', (2020) European Journal of Law Reform 338-354.

⁵ Wolff, S., and Ladi, S., 'European Union Responses to the Covid-19 Pandemic: Adaptability in Times of Permanent Emergency' (2020) 42 Journal of European Integration 1025, <http://dx.doi.org/10.1080/07036337.2020.1853120>.

⁶ Ginsburg, T. and Versteeg, M., 'Binding the Unbound Executive: Checks and Balances in Times of Pandemic' (2020) Virginia Public Law and Legal Theory Research Paper 2020-52 and (2020) University of Chicago Public Law Working Paper 747; Grogan (n 4) 338; Grogan, J. and Donald, A., (eds) *The Routledge Handbook on Law and the COVID-19 Pandemic* (Routledge 2022); Petrov J., 'The COVID-19 Emergency

restraint and deference to executive decision-making under emergency conditions, has in many cases weakened robust scrutiny and oversight and the system of checks and balances. Responses to the pandemic have exposed critical issues for the rule of law in EU Member States⁷. Many COVID-19 measures did not have a clear basis in law. Rules changed too quickly for individuals to adapt (or mount effective judicial challenges) and were often so vague as to leave implementing authorities unable to apply them consistently. Oversight over executive action was commonly insufficient. The forms of decision-making, the degree of accountability for decisions taken, and the measures adopted as a consequence have, in some cases, revealed systemic weaknesses in governance systems in terms of their capacity to respond to emergency. Such weaknesses have in some countries exposed and accelerated pre-existing trends towards the autocratisation of state governance and the decline of democracy⁸, particularly in EU states already steeply trending towards rule of law backsliding⁹.

At EU level, in the first phase of the pandemic, the nationalism and protectionism of Member States' responses, coupled with a limited response by EU institutions due to a lack of capacity, coordination and competence, exposed the frailties of the Union in health crisis conditions¹⁰. However, this shifted as the EU's led coordinating efforts to support free movement, though often limited to recommendations on travel. More concrete actions included the COVID-19 Digital Certificate, and the funding and procurement of vaccines. The European Parliament led efforts at scrutinising the impact of pandemic, and the measures Member States adopted in response to it, on fundamental rights and the rule of law. The robust fiscal response of the EU and its Member States in the Recovery and Resilience Facility, shows the interrelationship between fundamental values and economic recovery, as concerns over corruption and rule of law continue to exclude Hungary at the time of writing in November 2022.

While the pandemic was global, responses to it were primarily local. Response to the pandemic worldwide has been primarily undertaken by national governments, often disregarding international guidance or efforts at international coordination and solidarity. The 'profound weaknesses in the global governance of health; inadequate preparation, coordination, and accountability hampered the collective response of nations at each stage'¹¹. The WHO lamented the 'two-track pandemic' between richer and poorer nations, warning that the inequitable distribution of tools essential to the mitigation of transmission would lead to a prolonging of the pandemic, since '[i]f this virus is circulating anywhere, it's a threat everywhere'¹².

Pre-pandemic estimation of preparedness were proven to be unpredictable. In the 2019 Global Health Security Index, the United States and the United Kingdom were ranked first and second globally for

in the Age of Executive Aggrandizement: What Role for Legislative and Judicial Checks?' (2020) 8 The Theory and Practice of Legislation 71.

⁷ De Ruijter, A., and others, 'EU Solidarity and Policy in Fighting Infectious Diseases: State of Play, Obstacles, Citizen Preferences and Ways Forward' (Social Science Research Network 2020), <https://papers.ssrn.com/abstract=3570550>.

⁸ See e.g. V-Dem Institute, Democracy Report 2021: Autocratization Turns Viral (10 March 2021); and Foa, R., and Mounk, Y., 'The Signs of Deconsolidation' (2017) 28(1) Journal of Democracy 5.

⁹ See e.g. Pech, L., and Scheppele, K.-L., 'Illiberalism within: Rule of Law Backsliding in the EU' (2017) 19 Cambridge Yearbook of European Legal Studies 3, <http://dx.doi.org/10.1017/cel.2017.9>.

¹⁰ See e.g. Bastos, F., and de Ruijter, A., 'Break or Bend in Case of Emergency?: Rule of Law and State of Emergency in European Public Health Administration' (2019) 10(4) European Journal of Risk Regulation 610.

¹¹ Williamson, A., and others, 'Effective Post-Pandemic Governance Must Focus on Shared Challenges' (2022) 399 Lancet 1999, [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(22\)00891-1/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(22)00891-1/fulltext), accessed 1 November 2022.

¹² 38th WHO Regulatory Update, 12 September 2021, https://cdn.who.int/media/docs/default-source/medicines/regulatory-updates/covid-19/38th-who-regulatory-update-on-covid-19_12sep2021.pdf?sfvrsn=a17518a9_5&download=true.

their estimated pandemic preparedness¹³. However, these states were among the most negatively affected by the pandemic. By the same token, states such as Rwanda (117th¹⁴) outperformed their ranking. This indicates the unreliability of the use of technical metrics (e.g., the number of ventilators, or a states' gene sequencing ability) as a predictor of public health outcomes in pandemic¹⁵. A technocratic approach, which views pandemic only as a medical issue, disguises the political, legal and sociological reality. Rwanda, as well as states including Singapore and Taiwan, which had prior experience of confronting a pandemic, responded to the pandemic with an effective deployment of technology, speedy coordination across all levels of government, community mobilisation, and public health messaging that engendered trust.

As we look forward to future, we can immediately glean that assessment of pandemic preparedness should not only encompass health security indicators, but also indicators relating to good governance, public health education, and public trust in government, and scientific expertise. Beyond this, EU States can and should learn lessons from each other's and global experience. There is emerging evidence of good practices: those state policies based on legal certainty, transparency, clear communication, and early-reaction have strongly correlated with lower mortality rates, and more positive public perception of the handling of the pandemic. Democratic engagement, protection of fundamental rights, public participation, and a political willingness to learn from mistakes have improved the quality of COVID-19 measures and public compliance. As public compliance primarily rests on trust in the legitimacy and efficacy of government action, the core principles of legality, legal certainty, the separation of powers, and protection of fundamental rights are not only foundational values of the EU and its Member States but are also essential to the legitimate and effective management of a pandemic emergency.

1.1. Structure of the report

This report examines the impact of the COVID-19 pandemic on fundamental rights and democracy within the European Union. It seeks to identify best practices in law and governance, which ensure an effective response to a global health crisis without sacrificing the foundational values of democracy, the rule of law and human rights.

Chapter 2 examines pandemic governance: it compares various general approaches adopted by Member States, e.g., less restrictive 'laissez-faire' regimes, to intermediate and highly prescriptive policy mixes. It considers the efficacy of the regimes in relation to slowing down the pandemic, as well as their connection with issues of democratic input, rights concerns, public trust and compliance. It explores whether the type of measures adopted by Member States changed over time in relation to the various waves of the pandemic, and whether Member States learnt from their own and other countries' experience. The chapter provides some initial analysis on decision-making during the pandemic and examines the use of data and scientific research by Member States' governments.

Chapter 3 examines the legal basis for responses to the COVID-19 pandemic in Member States. It describes how the pandemic was addressed by EU Member States in terms of either declaring a constitutional state of emergency, or using emergency powers or emergency health legislation, or governing through normal legislation. It considers the pros and cons of such responses to a health crisis

¹³ NTI and John Hopkins Center for Health Security, 2019 Global Health Security Index (October 2019) 20, <https://www.ghsindex.org/wp-content/uploads/2020/04/2019-Global-Health-Security-Index.pdf>.

¹⁴ *ibid*.

¹⁵ Davies, S.E., and Wenham, C., 'Why the COVID-19 Response Needs International Relations' (2020) 96 International Affairs 1227, <http://dx.doi.org/10.1093/ia/iaa135>.

and their impact on democracy, the rule of law, fundamental rights, and the balance of powers. It draws on relevant jurisprudence and the views of international bodies and considers the efficacy of national oversight in parliaments and courts to ensure democratic scrutiny and compliance with human rights and the rule of law.

Chapter 4 analyses the various types of restrictive measures adopted by the Member States and examines their respective impact on democracy, the rule of law and fundamental rights. It discusses the decision-making processes that led to their introduction and removal, including evaluation of their scientific basis, as well as their legality, necessity and proportionality. It examines the impact of restrictive measures on the individual and fundamental rights of vulnerable groups and on equality in general.

Chapter 5 examines the EU institutions' roles and actions in terms of policy coordination, scrutiny and protection of democracy, rule of law and fundamental rights from the negative effects of COVID-19 and the measures adopted to confront it.

Chapter 6 examines Member States' approaches in relation to vaccination distribution and prioritisation policies and COVID-19 passes. It explores the differences between Member States in terms of vaccination hesitancy among the population and the measures taken by governments to overcome it. It considers the emerging evidence on the efficacy of vaccination policies and legislation, including in relation to COVID-19 passes, as related to vaccination rates and ultimately to slowing down the pandemic.

Chapter 7 concludes with recommendations for EU Institutions, Member States and stakeholders for the future, addressing and reflecting on the various areas explored in this report.

1.2. Efficacy, best practice, and lessons to be learned

As part of its analysis, this report provides emerging evidence on the efficacy of vaccination policies, COVID-19 passes, and restrictive measures in respect of minimising infections and deaths, based on scientific studies from 2020 onwards. Where relevant, it highlights the time of the findings (for example, experts' optimism in 2020 that the COVID-19 pandemic would be over within months), as well as the metric against which the findings are measured. However, the multifaceted nature of the impact of COVID-19, the variable timing and intensity of responses, differences between the pre-existing state of national health, political, economic, social and legal systems, and the inconsistent quality of data provided, make it difficult to discern with confidence the 'most effective' approach to pandemic management. Moreover, organisations and projects tracking government policies on COVID-19 (for example, the Oxford COVID-19 Government Response Tracker¹⁶, the Economist Intelligence Unit¹⁷, and the LexAtlas Project¹⁸) have used different criteria for analysis and evaluation. The strongest note of caution on the limitations of such a study must be emphasised.

Evaluating the efficacy of restrictive measures, particularly in relation to their stringency or degree of restrictiveness, is also challenging in other ways. The introduction of severely restrictive measures—including long periods of lockdown, and the closure of schools and businesses—were often precipitated by escalating infection rates and the perception of an uncontrolled pandemic which risked

¹⁶ Oxford COVID-19 Government Response Tracker, available at <https://www.bsg.ox.ac.uk/research/covid-19-government-response-tracker>, accessed 9 November 2022.

¹⁷ The Economist Intelligence Unit: Coronavirus Analysis, available at <https://www.eiu.com/n/global-themes/covid-19-hub/>, accessed 9 November 2022.

¹⁸ LexAtlas project, available at <https://lexatlas-c19.org/>, accessed 9 November 2022.

overwhelming national health systems. Counterfactual scenarios ('If Italy had ..., then....') are difficult to establish, and impossible to prove. Direct comparison is this very difficult.

The tools we use to evaluate efficacy in respect of minimising infections and deaths are equally blunt and can lose both context and nuance. For example, comparing mortality rates assumes that all states counted deaths caused by COVID-19 in the same way, at the same time, and accurately reported them. A focus on deaths can also discount a range of other consequences both quantifiable (e.g., GDP), and less easily quantifiable (e.g. long-term impacts on mental and physical health, as well as education). Similarly, such absolute focus on infection and mortality rates, or the number of deaths, in each country also loses sight of other metrics against which we should evaluate good (pandemic) governance: for example, the quality of democratic systems, the impact on individual and community welfare, as well as the wider socio-economic impact. Indeed, these two types of metrics are interconnected to the extent that there is evidence that respect for human rights, democracy and the rule of law when designing pandemic responses can increase public compliance with restrictive measures, and in turn lead to better health outcomes (section 4.3).

Accordingly, this report seeks to contextualise the impact of pandemic governance on fundamental rights, democracy and the rule of law. It discusses how states have sought to balance competing rights and interests, and identifies practices adopted by Member States and third countries which can support the protection of fundamental values without compromising the core aim of protecting public health. The report aims to offer universal lessons drawn from international experience. However, it cautions that it can be difficult to divorce provisions taken in response to the pandemic from the wider national social, economic, and political contexts in which they operate. For example, highlighting endorsement of executive decisions by courts or parliaments is meaningless in a state without a healthy separation of powers where there is no judicial independence and meaningful parliamentary scrutiny has been hobbled.

Ultimately, however, advocating best practices and lessons to be learned is only a beginning. Whether it is meaningful depends on whether reform of institutions, or changes to political culture, follow. This in turn relies on a political willingness to acknowledge faults and failures, what should have been done differently, and to make necessary changes for the future.

2. PANDEMIC GOVERNANCE

KEY FINDINGS

Globally and within the EU, countries initially adopted a wide range of restrictive measures in response to the COVID-19 pandemic; however, the prevalence of restrictive policies declined over the course of 2020-2022. Many factors account for this, including the increasing levels of information available on more effective means of reducing transmission, improvement of diagnostic tools and therapeutics, and the availability of vaccines, as well as concern about public support and compliance, and the influence of decisions made by neighbouring states.

Blunt comparison of EU Member States would indicate that there is no direct correlation between the restrictiveness of COVID-19 measures, and cumulative COVID-19 related deaths. The level of stringency as a single measure masks a range of factors including each Member State's unique epidemiological, social and economic situation, as well as the range and timing of measures.

Experts have raised concerns about the collection and quality of data, and the non-availability of disaggregated data, that relate to wider issues of decision-making during the pandemic. It is imperative for EU, national, regional, and local authorities to share accurate and relevant data in a timely and highly accessible manner.

COVID-19 bred 'shadow' pandemics of educational deprivation, domestic violence, unemployment, poverty, social-isolation and mental health crises, further and broader expertise in both the sciences and social sciences was needed to inform not only immediate measures, but also longer-term strategies for recovery.

Trust is multidirectional between governments, experts and the public, and evidence shows that high levels of trust are essential to effective pandemic management. The perception of the legitimacy of government action is strongly connected with public access to information and public understanding of the justification for pandemic measures. Trust in experts is strongly predicated on the perception that they are independent and transparent in their reasoning.

Pandemic governance refers to the public management of pandemic, including the policies, actions, decision-making processes, and their accountability. It encompasses not only the laws, rules, and regulations adopted by states, but also their implementation and enforcement.

Within the framework of analysing pandemic governance, this chapter provides a comparative overview of the various approaches adopted by Member States differentiated by their level of stringency, from highly restrictive regimes to low-level (or 'laissez faire') regimes (section 1.1). It identifies the divergence in response between the most and least restrictive EU Member States, and highlights—again with caveats on the limitations of the study—initial correlations with COVID-19 related deaths. Section 2.2 begins to contextualise the decision-making processes of governments, scientific expertise and advice underlying these policies, and it examines the use of data and scientific research by Member States. Section 2.3 explores the connection between pandemic governance and the issues of democratic input, human rights concerns, public trust, and compliance. The chapter ends with a short discussion of key recommendations on building trust during emergency response (section 2.4).

2.1. Approaches to pandemic management

During the pandemic, states were faced with the difficult challenge of finding a balance between, on the one hand, the positive obligations which arise from the right to life and the necessity to effectively manage the public health emergency and, on the other hand, the principles of democratic decision-making and the negative obligation not to disproportionately restrict people's rights and freedoms¹⁹. Not only that, but they also had to adapt their approaches in response to rapidly changing developments such as the emergence of new variants of SARS-CoV-2 causing new waves of the pandemic, most notably with the Delta and Omicron variants. Globally, there was a wide variance in the degree of stringency adopted in response to the pandemic. The spectrum of approaches can be generalised into highly restrictive regimes which heavily restricted individuals' movements and activity, moderately restrictive regimes, and low-level (or 'laissez faire') regimes which introduced minimal or no measures in response to the virus.

While states within the EU and globally adopted varying policies and measures, and at different times, we broadly categorise the levels of stringency in broad areas of pandemic governance as follows.

Table 1: Description of restrictive regimes

Regime	Schools closures	Workplace closures	Public events	Gatherings
Highly Restrictive	Require closure of all schools at all levels	Require closure for all workplaces except essential workers	All public events cancelled	Restriction to meeting one person from another household; or Restrictions on gatherings of <10 people
Moderately Restrictive	Require closure at some levels, or under certain conditions	Require closure for some workplaces (e.g., those with close social contact)	Required under conditions, or recommended all cancellation	Restrictions on gatherings of 10-100
Low-level or 'laissez faire'	No measures or recommend closing	No measures or recommend closing and work from home	No measures	No restrictions, or recommendations not to gather in groups

¹⁹ 'Interim Report on the Measures taken in the EU Member States as a Result of the Covid-19 Crisis and their Impact on Democracy, the Rule of Law and Fundamental Rights' (CDL-AD(2020)018-e) adopted by the Venice Commission at its 124th Plenary Session (Online, 8-9 October 2020), 4.

Regime	Stay-at-home	Restrictions on internal movement	International travel controls	Facial covering and masks
Highly Restrictive	Required not to leave except for essential purposes (e.g., to buy food, for medical reasons, or as an essential worker)	Restricted movement to within a certain geographic area	Total border closure or ban on entry from high-risk countries	Required outside regardless of circumstance, or required in all public or shared spaces outside the home, or all situations where social distancing not possible
Moderately Restrictive	Recommended to stay at home	Recommended to limit movement or travel within a certain geographic area	Quarantine arrivals from high-risk areas	Required in some public or shared spaces outside the home, or when social distancing not possible
Low-level or 'laissez faire'	No restrictions	No restrictions	Screening or no restrictions	No measures or recommended

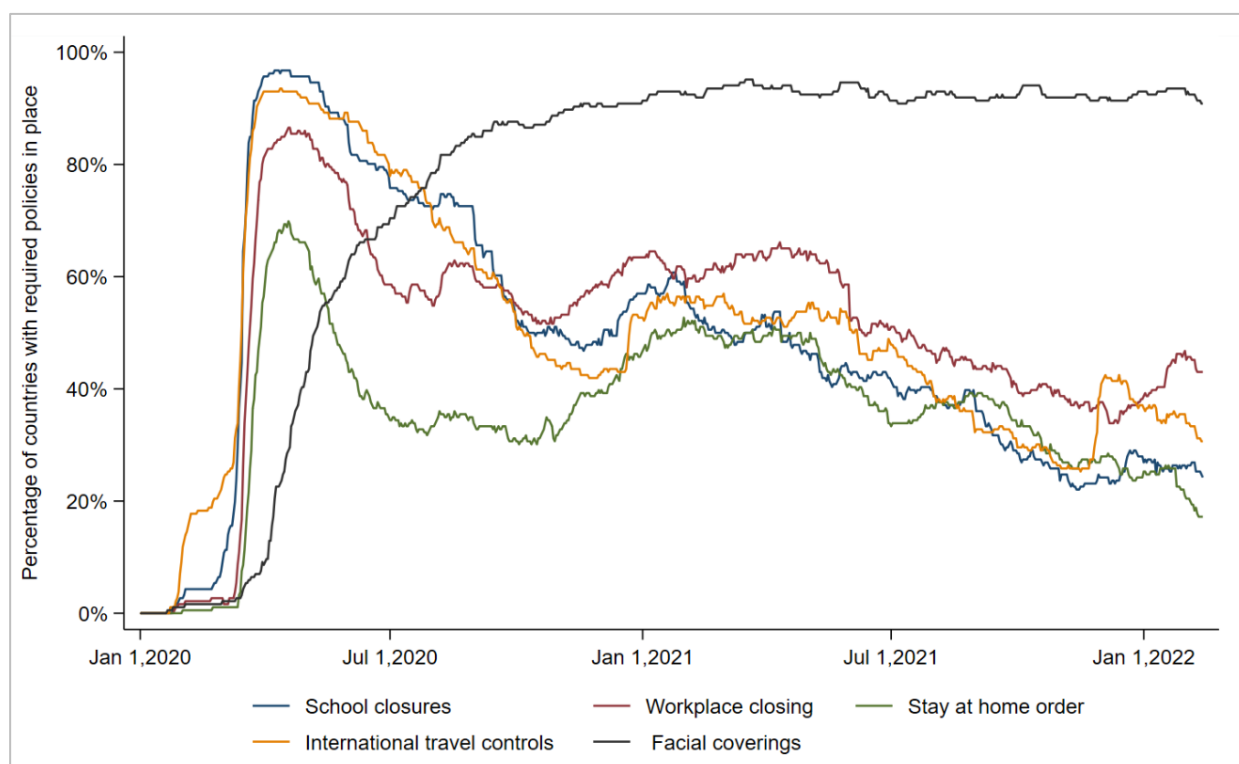
Source: This table is adapted from the methodology adopted by the Oxford Government Response Tracker (n 16), see Annex 2.

While again it is challenging to draw clear conclusions on correlative or causative relationships between the stringency of restrictions and consequent numbers of deaths due to the range of factors which can influence outcomes (see section 2.3), this section draws out some initial points and findings drawing in particular on the Stringency Index by the Oxford COVID-19 Government Response Tracker²⁰ to compare EU Member States.

Globally, a majority of states first adopted restrictions in response to the COVID-19 pandemic in February and March 2020 (see Figure 1). A great majority of countries worldwide closed schools and introduced international travel controls as a first response. Over 80% of states introduced workplace closures, followed by over 60% adopting stay at home orders. Policies on masks were so uncommon at an early stage that they were not measured by the Oxford COVID-19 Global Response Tracker. However, facial covering and mask policies soon became one of the most common policies globally and they were maintained by a majority of states after other restrictive measures were removed or reintroduced by fewer states.

²⁰ Hale, T., and others, 'What have we learned from tracking every government policy on COVID-19 for the past two years?' (Oxford COVID-19 Government Response Tracker, March 2022) 8.

Figure 1: Proportion of countries using various restrictions during the COVID-19 pandemic



Source: Thomas Hale, Emily Cameron Blake, et al, *what have we learned from tracking every government policy on COVID-19 for the past two years?* (Oxford COVID-19 Government Response Tracker, March 2022) p. 8. For methodology of the Oxford COVID-19 Global Response Tracker, see Annex 1.

As observed in Figure 1, the number of countries globally adopting restrictive policies declined over the course of 2020-2022. Many factors account for this, including the increasing levels of information available on more effective means of reducing transmission, and improvement of diagnostic tools and therapeutics, as well as concern for public support and compliance, and the influence of decisions made by neighbouring states. For example, policies adjusted from blanket closures of all businesses, to opening with conditions (e.g., restaurants must serve in outdoor spaces, and improved ventilation) and more targeted closures of certain businesses where social distancing was not possible (e.g. closures of hairdressers, restaurants and nightclubs).

By the end of 2021, decisions regarding the introduction or lifting of restrictive measures had developed, moving from 'temporary and segmented decision-making' to 'more structured and medium-term planning, with contingent decisions based on both the evolution of the pandemic and the availability of data concerning the expected effects of the measures'²¹. The advent of vaccinations from December 2021 also significantly changed the policy landscape. A number of states adopted policies which distinguished between those vaccinated and unvaccinated, allowing greater freedoms to those who had been vaccinated (see chapter 6).

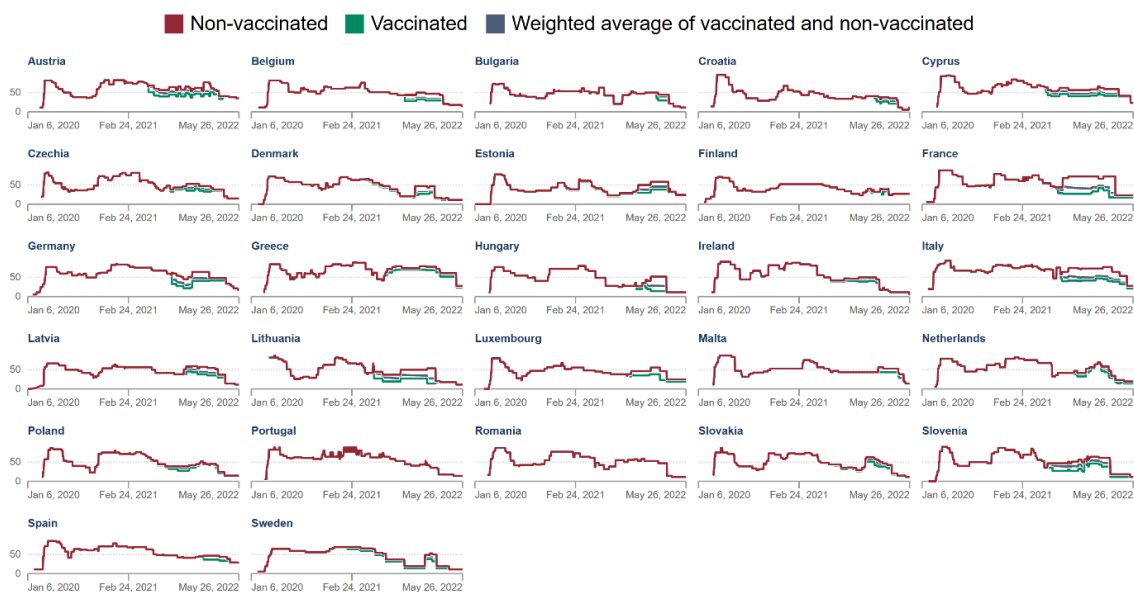
²¹ Cafaggi, F., and Iamicelli, P., 'Global Pandemic and the Role of Courts: Opening Survey' (2021) *Legal Policy & Pandemics* 159, <https://www.covid19litigation.org/sites/default/files/2022-06/global-pandemic-and-role-courts-opening-survey.pdf>.

As observed in Figure 1²², restrictive measures steadily decreased from the initial global outbreak in 2020 to the time of writing in November 2022, with periods of reintroduction coinciding with the successive waves caused by the Delta and Omicron variants of the virus in June-August 2020, October 2020 – January 2021, and June-September 2021. The global pattern of an initial delay, followed by sudden adoption of a large number of highly restrictive measures, giving way to a more ‘nuanced’²³ approach in response to subsequent waves of infection, was also descriptive of EU Member States’ responses. On one theory, some EU Member States were initially reluctant to adopt highly restrictive COVID-19 measures as they could conflict with the exercise of fundamental rights²⁴, although denialism, inertia, and lack of experience with the outbreak of highly infectious diseases also likely played a role in slow response. However, what is certain is that the shift towards more targeted policies represents increasing scientific evidence on transmission of the virus, as well as changing political attitudes to pandemic governance.

Figure 2: COVID-19 Stringency of Restrictive Measures across the EU-27

COVID-19: Stringency Index

The stringency index is a composite measure based on nine response indicators including school closures, workplace closures, and travel bans, rescaled to a value from 0 to 100 (100 = strictest).



Source: Hale, T., Angrist, N., Goldszmidt, R. et al. A global panel database of pandemic policies (Oxford COVID-19 Government Response Tracker). *Nat Hum Behav* 5, 519-538 (2021). <https://doi.org/10.1038/s41562-021-01079-8>.

²² The Oxford COVID-19 Government Response Tracker tracked nine metrics used to calculate the Stringency Index: school closures; workplace closures; cancellation of public events; restrictions on public gatherings; closures of public transport; stay-at-home requirements; public information campaigns; restrictions on internal movements; and international travel controls. See Annex 1 for information on data and calculations.

²³ Sharma, M., and others, 'Understanding the Effectiveness of Government Interventions against the Resurgence of COVID-19 in Europe' (2021) 12 *Nature Communications* 5820, <https://www.nature.com/articles/s41467-021-26013-4>, accessed 1 November 2022; Haug, N., and others, 'Ranking the Effectiveness of Worldwide COVID-19 Government Interventions' (2020) 4 *Nature Human Behaviour* 1303, <https://www.nature.com/articles/s41562-020-01009-0>, accessed 1 November 2022; Flaxman, S., and others, 'Estimating the Effects of Non-Pharmaceutical Interventions on COVID-19 in Europe' (2020) 584 *Nature* 257, <http://dx.doi.org/10.1038/s41586-020-2405-7>.

²⁴ See Engler, S., and others, 'Democracy in Times of the Pandemic: Explaining the Variation of COVID-19 Policies across European Democracies' (2021) *West European Politics*, 44:5-6, 1077-1102, DOI: 10.1080/01402382.2021.1900669.

Scientific and media outlets across Europe debated the divergent strategies adopted, ranging from highly restrictive lockdowns (as in Italy and Spain) to strategies aiming for ‘herd immunity’ and involving fewer restrictions (as initially attributed to Sweden). As shown by Figure 2, Member States have significantly diverged on the level of stringency adopted in response to the COVID-19 pandemic. A number of states (including France, Ireland, Italy, Cyprus and Greece) adopted and maintained highly restrictive policies relative to other Member States in response to the successive waves of pandemic in 2020-2022, while other states (for example, Bulgaria, Denmark, Finland, Latvia, and Sweden) adopted a lower range of restrictive policies and generally maintained a lower level of stringency relative to the rest of the EU. Greece, Germany, the Netherlands and Hungary increased the level of stringency of their restrictive measures in response to the second wave of pandemic (broadly October 2020-March 2021), as compared with their initial response. Conversely, Croatia initially introduced the most restrictive regime in the EU in response to the initial wave of pandemic, but then followed it with one of the least restrictive regimes.

In terms of the factors that influenced these changes over time, analysis by the OECD highlights that states with strong democratic institutions are more responsive to neighbouring countries’ policies than less democratic countries are²⁵. The decisions taken by EU Member States in terms of which interventions to adopt indicate that many states were likely to be influenced by what their neighbouring countries were doing²⁶. For example, the Nordic states of Denmark, Finland, and Sweden (along with Norway and Iceland) tended to have less restrictive approaches to the pandemic, while France, Italy and Spain introduced highly restrictive measures. This is not always guaranteed, however: Latvia (low-level), Estonia (moderately restrictive); and Lithuania (highly restrictive relative to other EU states) adopted different levels of restrictions at the height of each wave. While EU institutional influence over intra-border travel meant that a common policy to external borders was ultimately adopted, there is no strong implication of a common EU response within national borders that emerged over the course of the pandemic.

There is no clear correlation between states which adopted emergency regimes or declared a state of emergency and those which were likely to also adopt highly restrictive regimes. For example, in 2020, Italy, Ireland and Cyprus adopted the most restrictive regimes relative to other EU states, and for the longest periods on average but none declared a state of emergency²⁷. Ireland and Cyprus relied exclusively on ordinary legislation while Italy introduced measures under an emergency statutory regime, as well as decree-law powers under the constitution. In the same year, Bulgaria and Finland adopted two of the least restrictive regimes on average²⁸, but both declared a state of emergency under their constitutions. These disparities show that it is important to remember the wider social, economic, regulatory, and political context in which rules operate, rather than the fact (highly restrictive or laissez-faire) or form (emergency law, ordinary law) of the measures themselves.

Equally difficult to draw clear conclusions on, is the connection between stringency of measures and consequent number of COVID-19 related deaths. As of November 2022, the estimated total cumulative deaths from COVID-19 stood at 1.15 million deaths in the EU. Italy (180,518), France (158,511), and Germany (157,388) have suffered the highest numbers of deaths. However, relative to population size,

²⁵ Abiel, S., and others, ‘Explaining the Homogeneous Diffusion of COVID-19 Nonpharmaceutical Interventions across Heterogeneous Countries’ (2020) *Proceedings of the National Academy of Sciences*, 117:35, 21201–8.

²⁶ *ibid.*

²⁷ See Annex 2.

²⁸ See Annex 2.

Bulgaria (38,022), Hungary (48,245), Croatia (17,288), Czechia (41,791), and Slovakia (20,725), and as noted in chapter 1, rank among the ten worst affected states globally for their per capita mortality rates²⁹. Based on country data figures reported to the John Hopkins COVID-19 Data Tracker³⁰, and Our World in Data³¹, France and Germany are below the EU average of 2,426.3 deaths per million, while Italy is above it (Figure 3). The estimated worldwide average places Peru (6,373), Bulgaria (5,588), and Bosnia and Herzegovina (5,002) with the highest COVID-19 deaths per million. By comparison, China reports 3 deaths per million; India reports 374; the USA reports 3,167; and Brazil reports 3,196³².

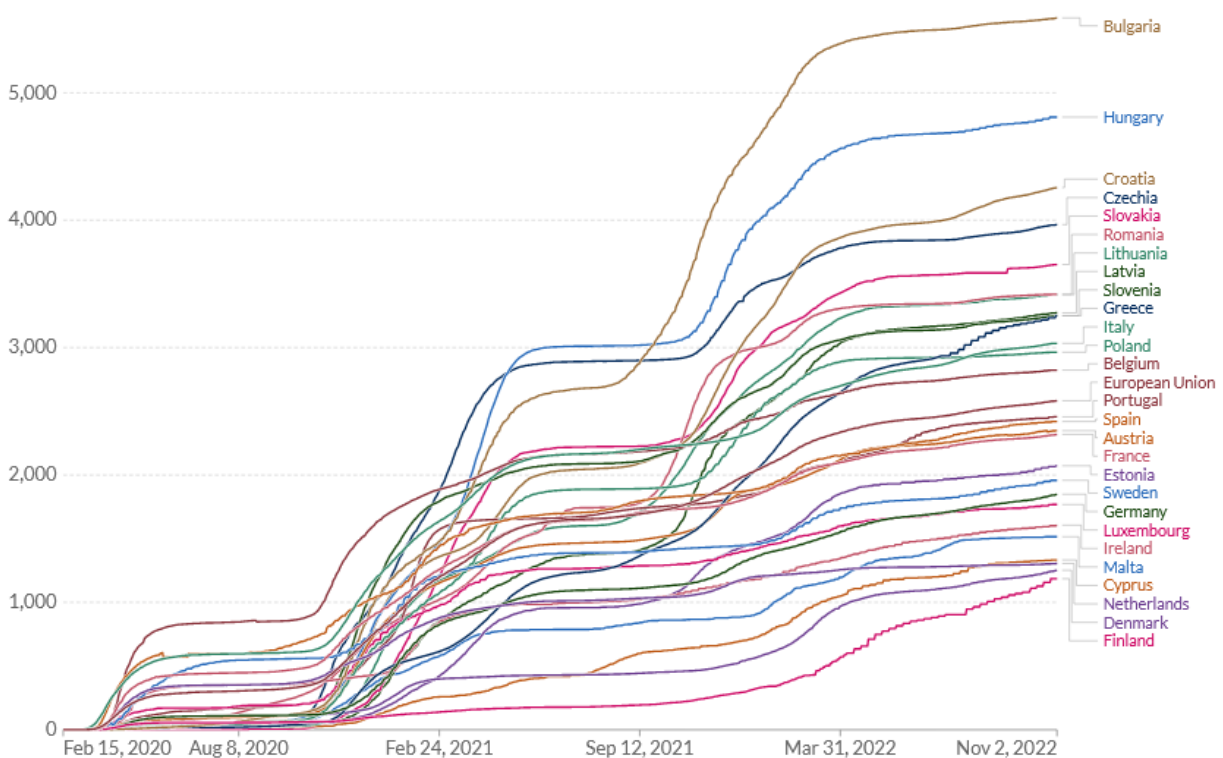
Figure 3: Cumulative COVID-19 deaths in EU-27

Cumulative confirmed COVID-19 deaths per million people

Due to varying protocols and challenges in the attribution of the cause of death, the number of confirmed deaths may not accurately represent the true number of deaths caused by COVID-19.

Our World in Data

LINEAR LOG



Source: Johns Hopkins University CSSE COVID-19 Data.

Focusing on the five EU Member States with the highest number of COVID-19 deaths relative to population, Croatia, Czechia, Hungary and Slovakia experienced the highest mortality rates in Winter 2020/2021, and Winter 2021/2022 while Bulgaria had the highest rates in Winter 2020/2021 and Summer 2021 (Figure 4). Croatia and Bulgaria had lower levels of stringency relative to other Member States during these waves. Czechia, Slovakia, and Hungary had moderately restrictive regimes in Winter 2020/2021, and lower levels of stringency in the Winter 2021/2022 (Figure 5).

²⁹ John Hopkins Coronavirus Resource Centre (n 3).

³⁰ *ibid.*

³¹ Ritchie, H., and others, 'Coronavirus Pandemic (COVID-19)' (Our World in Data).

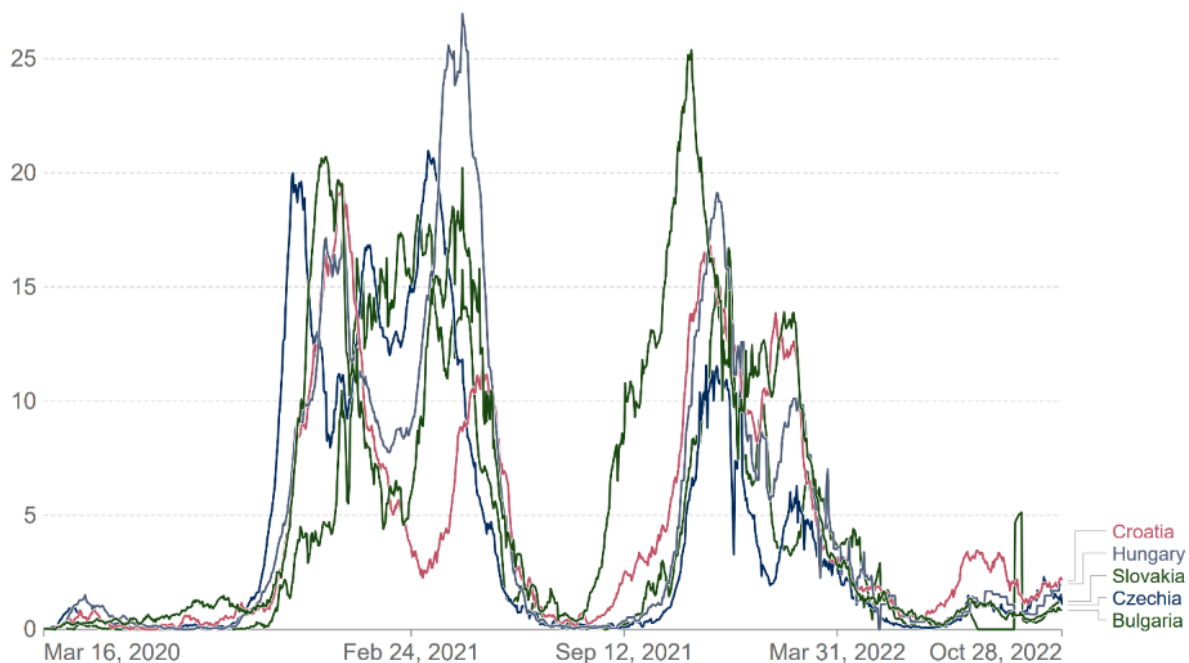
³² It should again be noted that these data sources rely on the accurate reporting of COVID-19 deaths from states. In some cases, there may not be a way of independently confirming the numbers reported.

Figure 4: Confirmed COVID-19 deaths per million in BG, CZ, HR, HU and SK

Daily new confirmed COVID-19 deaths per million people

7-day rolling average. Due to varying protocols and challenges in the attribution of the cause of death, the number of confirmed deaths may not accurately represent the true number of deaths caused by COVID-19.

Our World
in Data



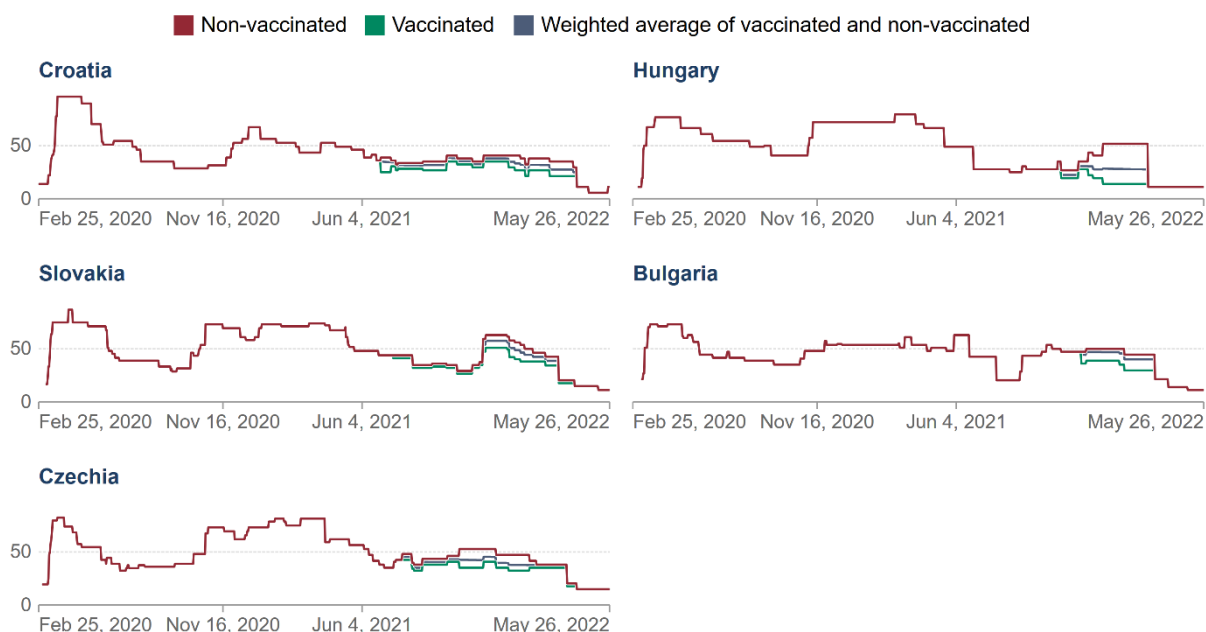
Source: Johns Hopkins University CSSE COVID-19 Data.

Figure 5: Stringency of Restrictive Measures in BG, CZ, HR, HU and SK 2020-2022

COVID-19: Stringency Index

The stringency index is a composite measure based on nine response indicators including school closures, workplace closures, and travel bans, rescaled to a value from 0 to 100 (100 = strictest).

Our World
in Data



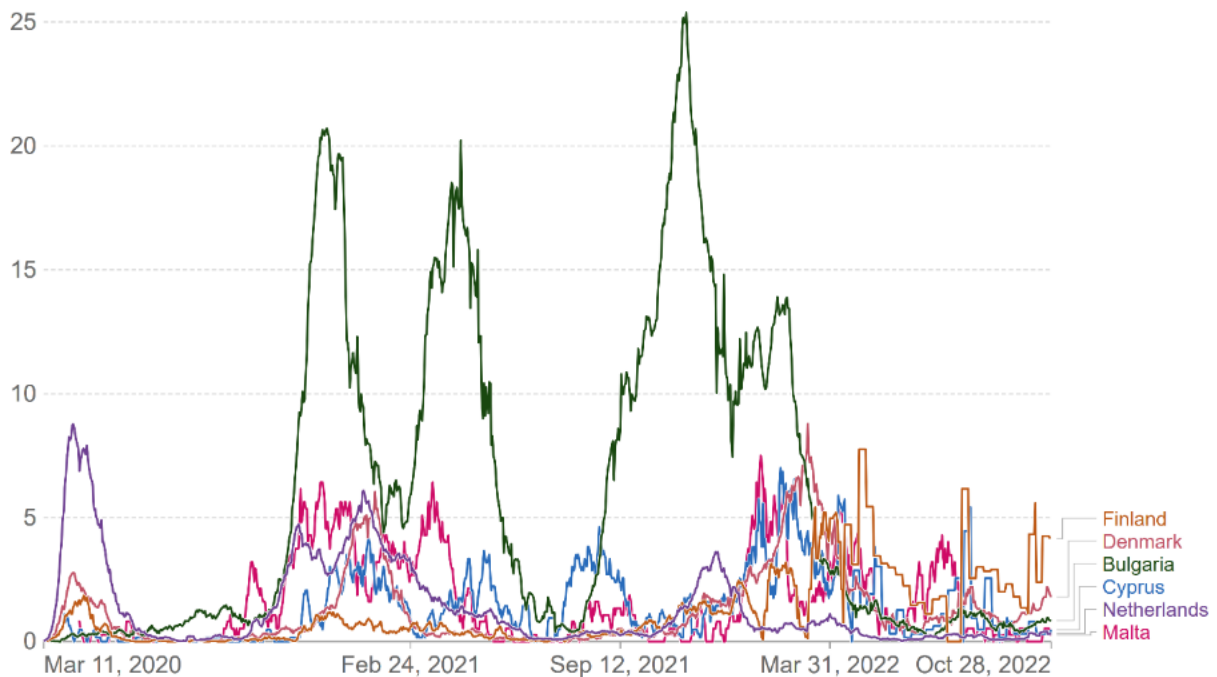
Source: Hale, T., Angrist, N., Goldszmidt, R. et al. A global panel database of pandemic policies (Oxford COVID-19 Government Response Tracker). Nat Hum Behav 5, 519-538 (2021). <https://doi.org/10.1038/s41562-021-01079-8>.

With the exception of the Netherlands, countries with the fewest COVID-19 deaths overall, also experienced their highest mortality rates during the second and subsequent waves of infection (see Figure 6, Bulgaria included for a point of comparison). As Figure 7 shows, Cyprus and the Netherlands reintroduced highly and moderately restrictive regimes respectively during the second and third waves. Finland and Denmark exemplified lower levels of restrictive measures relative to other EU Member States throughout the pandemic period. Malta initially responded with one of the most restrictive regimes in response to the first wave of the pandemic in 2020, and then introduced a moderately restrictive response from March to May 2021 and was less restrictive still in late 2021-2022.

Figure 6: Confirmed COVID-19 deaths per million in CY, DK, FI, MT and NL

Daily new confirmed COVID-19 deaths per million people

7-day rolling average. Due to varying protocols and challenges in the attribution of the cause of death, the number of confirmed deaths may not accurately represent the true number of deaths caused by COVID-19.

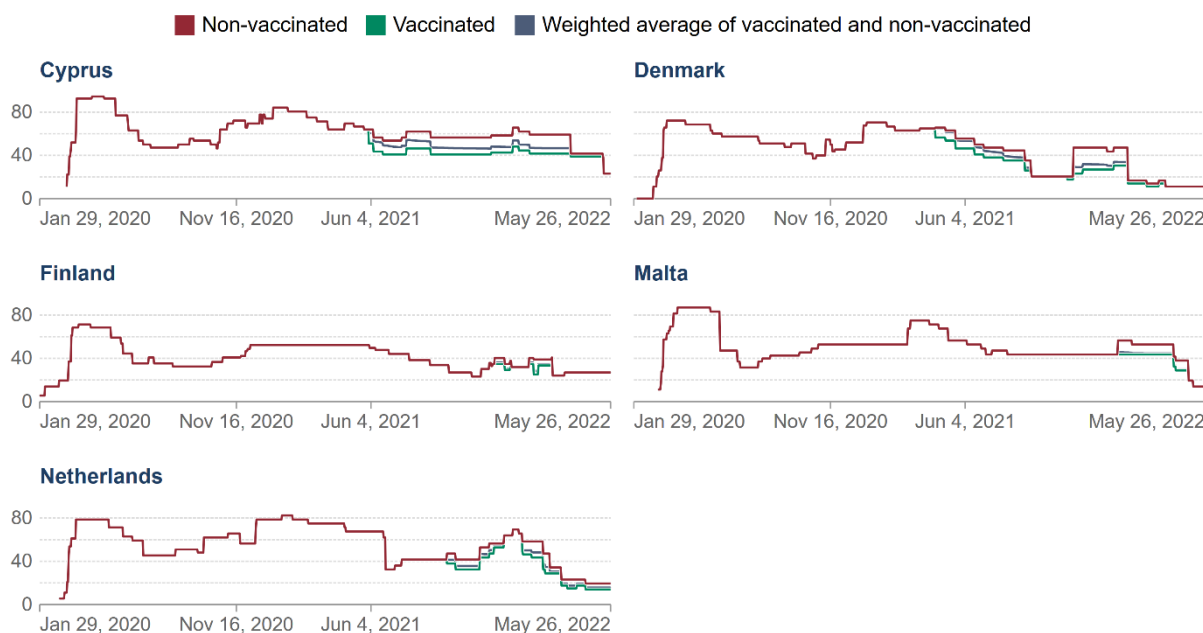


Source: Johns Hopkins University CSSE COVID-19 Data.

Figure 7: Stringency of Restrictive Measures in CY, DK, FI, MT and NL 2020-2022

COVID-19: Stringency Index

The stringency index is a composite measure based on nine response indicators including school closures, workplace closures, and travel bans, rescaled to a value from 0 to 100 (100 = strictest).



Source: Hale, T., Angrist, N., Goldszmidt, R. et al. A global panel database of pandemic policies (Oxford COVID-19 Government Response Tracker). *Nat Hum Behav* 5, 519-538 (2021). <https://doi.org/10.1038/s41562-021-01079-8>.

The most restrictive regimes (on both maximum and average, across 2020-2022³³) were those of Italy, Portugal, Greece, Cyprus, Austria, Ireland and Spain. Of these states, Italy and Greece had a mortality rate above the EU average. Portugal and Spain were close to the EU average, while Ireland, Cyprus and Malta had among the lowest cumulative COVID-19 deaths relative to population size. Conversely, among countries with the least restrictive regimes (on average, 2020-2022), Bulgaria, Hungary and Croatia had the highest cumulative deaths per million, while Finland and Denmark had the lowest. Latvia was among the lowest (on average) level of stringency across 2020-2022 but was significantly above the European average.

This exercise shows important insights: first, there appears to be no obvious correlation between **only** the stringency of restriction and cumulative deaths. Factors, not least of which is timing are also crucial: the same stringency of restrictions introduced a week earlier or a week later can have a very significant impact on cumulative deaths. Level of stringency as a single measure also masks the different internal policies which affect transmission rates: for example, states which have closed schools (a highly restrictive measure) but still permit large gatherings indoors (low-level of restriction). Second, a blunt focus on the relationship between the stringency of measures and cumulative deaths, without analysing the measures within their wider social, economic, legal and political context, does not provide meaningful findings into how to manage a pandemic through restrictive measures alone. Relatedly, it is unrealistic to compare countries against one another, as each state's epidemiological

³³ See Annex 2.

situation is unique, and an approach that may be effective at minimising deaths in one state may not be as effective in another.

Similarly, it is important to underline that progress in response to the pandemic was not always linear, as policy sometimes shifted significantly following, for example, a change of government or estimation of the pandemic threat. In addition, state responses should not be understood as monolithic, particularly in federal states where decision-making was delegated or decentralised between sub-national states or provinces, which consequently adopted a wide range of approaches, measures, or policies in response to the virus. It is important to be mindful of these limitations, but still understand that meaningful findings and lessons can be found.

2.2. Data and decision-making

In a public health emergency, the need for timely access to reliable data is clear. Beyond the fundamental question of *what* data is needed, the means must be found to collect, clean, process, store and share it. However, data, in and of itself, does not necessarily provide a certain answer to what should or should not be done. Knowing the total number of intensive care beds or ventilators in a state, for example, cannot answer the question of whether gatherings of ten people or more should be prohibited. To provide meaningful insight, data must be analysed and interpreted. Analysis may involve modelling or estimating future developments based on current and past trends, within a set range of criteria. This analysis can then be provided to decision-makers to inform the design and implementation of their policies.

The early stages of the pandemic were marked by an extreme degree of uncertainty as regards the nature and scale of the threat posed by the SARS-CoV-2 virus and the COVID-19 disease. Rapid lessons had to be learned about its virality and mode of transmission, and about the effectiveness of strategies to minimise community exposure and mitigate negative economic and social consequences. This exercise required international effort and collaboration in the collection, cleaning, storage, sharing, and analysis of data as well as dissemination of the findings of that analysis. However, it suffered from a number of challenges, from the poor quality of data collected (for example, due to lack of widespread and accurate testing for COVID-19), to delayed or hindered access to timely data. Scientists had to work under significant time constraints to produce analysis as soon as possible. Modelling COVID-19 to project trends also faced a number of challenges including availability of data, choice of signals, as well as changing policy and behaviours³⁴. In one casual description, ‘all models are wrong, some models are more wrong than others.’

Experts have raised concerns about the collection and quality of data that relate to wider issues of decision-making during the pandemic. Data disaggregation emerged as an important consideration, particularly the generation of localised data in order to reveal in detail the epidemiology of the virus, the state of hospitals and social care systems, and the impact of COVID-19 restrictions. National data and modelling can obscure local heterogeneity, not only in the impact of interventions and measures, but also in their timing. Local socio-economic and environmental factors may also be hidden in national metrics³⁵. For example, limitations on internal movement (e.g., how far from the home a person can

³⁴ As for example analysed in the US: Nixon, K., and others, ‘An Evaluation of Prospective COVID-19 Modelling Studies in the USA: From Data to Science Translation’ (2022) 4 The Lancet. Digital health e738, [https://www.thelancet.com/journals/landig/article/PIIS2589-7500\(22\)00148-0/fulltext](https://www.thelancet.com/journals/landig/article/PIIS2589-7500(22)00148-0/fulltext), accessed 9 November 2022.

³⁵ Sharma (n 24).

move) create significantly different impacts on rural and urban communities, and between wealthier and poorer communities. Moreover, socio-economic vulnerabilities need to be understood since they may determine people's ability to comply with restrictive measures, such as stay-at-home orders.

Disaggregation of data also matters in respect of gauging the impact of the virus, and state responses, on groups who experience discrimination³⁶. Restrictions resulted in both direct and indirect discrimination along the lines of gender, race, ethnicity, disability, class and other characteristics. The Fundamental Rights Agency, identified the disproportionately negative impact on groups including Roma and Travellers, refugees and migrants, LGBTI, detainees, and ethnic minorities, women and children, as well as elderly populations³⁷. For example, in Slovakia, the already marginalised Roma communities were subject to targeted lockdown measures and military policing where other communities with higher rates of testing positive for the coronavirus were not³⁸. This is not a phenomenon unique to the EU, but instead is a global occurrence where COVID-19 restrictions were felt disproportionately negatively on vulnerable populations, women, children, and minorities³⁹.

Both within the EU and beyond it, it is difficult to determine which datasets⁴⁰ were used by decision-makers. Even where common data was provided, as by the European Centre for Disease Control and Prevention (ECDC) in aggregating data provided by national authorities in a central database⁴¹, this has not always meant that decisions were the same in different member states: '[c]ulture, trust in government, domestic politics and governance all matter in explaining the diversity of member states' public policy answers'⁴².

There is a strong public perception that science and data have driven decision-making in the pandemic: 'follow the science'⁴³ was a common sentiment expressed by governments to justify their decision-making. Decisions had to be taken under rapidly changing epidemiological situations, despite (at least at the beginning of the epidemic) a lack of scientific evidence on the individual and combined effectiveness of restrictive measures⁴⁴, degrees of compliance of the population or societal impact. In the absence of a clear identification of the most effective courses of action, many governments sought

³⁶ Maria Melchior and others, 'Migrant Status, Ethnicity and COVID-19: More Accurate European Data are Greatly Needed' (2021) 27(2) *Clinical Microbiology and Infection* 160; Al Saba, R., Gougsa, S., 'Exposing Inequalities: The Experience of Minorities and Indigenous Peoples During COVID-19 Emergencies' in Grogan, J., and Donald, A., *The Routledge Handbook of Law and the COVID-19 Pandemic* (Routledge 2022); and Al Saba, R., 'Inequality and the Impact of Covid-19: How Discrimination is Shaping the Experiences of Minorities and Indigenous Peoples During the Pandemic' (Minority Rights Group International 2020).

³⁷ The Coronavirus Pandemic and Fundamental Rights: A Year in Review' (*Europa.eu*), https://fra.europa.eu/sites/default/files/fra_uploads/fra-2021-fundamental-rights-report-2021-focus_en.pdf, accessed 9 November 2022.

³⁸ Henčková, S., and Drugda, S., 'Slovakia: Change of Government under COVID-19 Emergency' (*Verfassungsblog*, 22 May 2020), <https://verfassungsblog.de/slovakia-change-of-government-under-covid-19-emergency>, DOI: <https://doi.org/10.17176/20200522-133225-0>, accessed 9 November 2022.

³⁹ See e.g. Al Saba, R., Gougsa, S., 'Exposing Inequalities: The Experience of Minorities and Indigenous Peoples During COVID-19 Emergencies' in Grogan, J., and Donald, A., *The Routledge Handbook of Law and the COVID-19 Pandemic* (Routledge 2022).

⁴⁰ For example, typical indicators include incident cases, hospitalisations, intensive care unit admissions, and deaths. When testing (e.g. PCR, and antigen tests) became widely available, and systematically applied through e.g. workplaces, this data also became available.

⁴¹ The ECDC database is accessible at <https://www.ecdc.europa.eu/en/covid-19>, accessed 10 November 2022.

⁴² Wolff, S., and Ladi, S., 'European Union Responses to the Covid-19 Pandemic: Adaptability in Times of Permanent Emergency' (2020) 42 *Journal of European Integration* 1025, <http://dx.doi.org/10.1080/07036337.2020.1853120>.

⁴³ Colman, E., and others, 'Following the Science? Views from Scientists on Government Advisory Boards during the COVID-19 Pandemic: a Qualitative Interview Study in five European Countries' (2021) *BMJ Global Health* ;6:e006928.

⁴⁴ Haug and others (n 24); Tian, H., and others, 'An Investigation of Transmission Control Measures during the first 50 Days of the COVID-19 Epidemic in China' (2020) *Science* 368, 638–642; Chen, S., and others, 'COVID-19 Control in China during Mass Population Movements at New Year' (2020) *Lancet* 395, 764–766; and Lee, K., and others, 'Global Coordination on Cross-Border Travel and Trade Measures Crucial to COVID-19 Response' (2020) *Lancet* 395, 1593–1595.

to rely on health expertise in the form of epidemiologists, virologists and latterly immunologists in the design of pandemic measures.

Ensuring that data is clearly communicated and understood is essential for both decision-makers and populations. However, scientific experts who served on advisory boards during the pandemic found it difficult to ensure that the evidence was understood by governments, and found themselves in new, ill-defined, and uncharacteristically public roles in the form of advisory bodies to national governments⁴⁵.

The creation of expert advisory groups, with different degrees of influence over the creation of pandemic measures, was a common feature of states worldwide. For example, in Greece, the National Committee of Public Health Protection related to Covid-19 was responsible for designing prevention and protection measures and ensuring alignment with the recommendations by the World Health Organization and European Union health guidelines⁴⁶. Advisory groups were predominantly constituted of virologists and epidemiologists at national level⁴⁷. For example, the National Public Health Emergency Team for COVID-19 (NPHE) in Ireland, and the Outbreak Management Team (OMT) in the Netherlands were almost exclusively drawn from the Irish Department of Health, and the Health Service as well as medical consultants and epidemiologists. Concern was also raised about the degree of democratic oversight of the de facto power exercised by both⁴⁸.

Not all Member States were transparent in respect of such bodies' membership, influence and sources of advice and information⁴⁹. In Croatia, the reputation of the advisory body to government measures was damaged when it was discovered that two experts and main public faces of government responses were not part of it⁵⁰. Full transparency of the membership of COVID-19 expert advisory groups can invite concerns, for example where the individuals—by becoming public figures and influencing polarising policies—might become targets of harassment⁵¹. However, a lack of transparency can also serve to undermine public trust and the accountability of individuals, particularly where the underlying data and analysis of such bodies is unpublished or otherwise inaccessible. Similarly, a perception that experts are not independent can serve to undermine trust in their advice, and (if accurate) also serve to undermine the quality of that opinion. Such advisory bodies need support and resources to function well, sufficient to ensure they are—and are seen to be—independent of political influence.

An argument in favour of transparency over the membership of decision-making bodies is that it also enables the identification of problems of representation and interdisciplinary expertise. Experts on wider areas of medicine relevant to the wider impact of pandemic on society (such as mental health, child health, chronic diseases, preventive medicine, and gerontology) and experts in non-medical sciences and social sciences were generally not represented in advisory bodies. Even where

⁴⁵ Colman and others (n 43).

⁴⁶ Karavokyris, G., 'Constitutionalism and COVID-19 in Greece: The Normality of Emergency' (*Verfassungsblog*, 25 February 2021), <https://verfassungsblog.de/constitutionalism-and-covid-19-in-greece-the-normality-of-emergency/>, accessed 11 November 2022.

⁴⁷ Rajan, D., and others, 'Governance of the Covid-19 Response: A Call for More Inclusive and Transparent Decision-Making' (2020) 5 *BMJ Global Health* e002655, <https://gh.bmj.com/content/5/5/e002655>.

⁴⁸ Kenny, D., 'Public Accountability in the Pandemic: Covid-19 and State Governance' (COVID-19 Law and Human Rights Observatory Blog, 2 June 2020), <http://tcdlaw.blogspot.com/2020/06/public-accountability-in-pandemic-covid.html>.

⁴⁹ Rajan and others (n 48).

⁵⁰ Selanec, N. B., 'Croatia's Response to COVID-19: On Legal Form and Constitutional Safeguards in Times of Pandemic' (*Verfassungsblog*, 9 May 2020), <https://verfassungsblog.de/croatias-response-to-covid-19-on-legal-form-and-constitutional-safeguards-in-times-of-pandemic>, DOI: <https://doi.org/10.17176/20200509-133132-0>.

⁵¹ Coleman and others (n 44).

unprecedented restrictive measures were introduced as laws, experts in human rights, constitutional law or democratic governance were rarely among key advisory groups or exerting influence on public discourse (with exceptions, such as in Germany⁵² and Finland⁵³). Experts on advisory boards also highlighted that the initial biomedical focus—the science of COVID-19—limited the usefulness of analysis in a complex world driven by changing human behaviours but added that they found it difficult to work in an interdisciplinary way where they had not previously trained for it⁵⁴.

The representativeness of expert bodies also matters in their ability to assess the actual or projected impact of measures. Globally, female representation was low on such bodies⁵⁵. A review of Global Health Security Representation found that women are in the minority in decision-making and yet comprise 70% off the global health workforce fighting COVID-19⁵⁶. Women are also more likely than men to experience economic insecurity due to the high percentages of women in the hard-hit sectors of services, healthcare and the informal sector⁵⁷, as well as social impact from escalated rates of domestic violence, and an increased burden of caring responsibilities for children and families caused by school and workplace closures.

Civil society was also rarely involved with government decision-making, or (with some exceptions) national responses⁵⁸. Experts called for a more inclusive and multidisciplinary COVID-19 response, recognising the wide health, social, and economic impacts of the pandemic⁵⁹. For example, the Council of Europe (CoE) Human Rights Commissioner called on all European countries to incorporate the views of people with disabilities in pandemic policy-making⁶⁰. However, there is no significant evidence that the constitution of advisory boards changed significantly over the course of the pandemic. Reliance on a small group of advisors and a lack of engagement with external expertise can also have unintended consequences: in one US/UK study, ‘the development of trust via regular interaction between a small group of people in an insulated environment produced unintended consequences in relation to distrust of expert outsiders, which undermined useful challenges to key mistakes’⁶¹ for example on moving towards the use of masks in public in the UK⁶².

⁵² Mangold, A.K., ‘Germany and COVID-19: A Most Eventful Year’ (Verfassungsblog, 7 April 7 2021), <https://verfassungsblog.de/germany-and-covid-19-a-most-eventful-year/>, DOI: 10.17176/20210407-170939-0.

⁵³ See e.g. Scheinin, M., ‘Finland: Soft Measures, Respect for the Rule of Law, and Plenty of Good Luck: Overview of Legal and Political Response and Adaptation to COVID-19’ (Verfassungsblog, February 23, 2021), <https://verfassungsblog.de/finland-soft-measures-respect-for-the-rule-of-law-and-plenty-of-good-luck/>, DOI: 10.17176/20210223-154147-0; and Scheinin, M., ‘The COVID-19 Emergency in Finland: Best Practice and Problems’ (Verfassungsblog, April 16, 2020), <https://verfassungsblog.de/the-covid-19-emergency-in-finland-best-practice-and-problems/>, DOI: 10.17176/20200416-092101-0.

⁵⁴ *ibid.*

⁵⁵ Dhatt R, Keeling A., Saraki, T., ‘Fighting COVID-19 with one hand tied behind our Backs?’ (Think Global Health 2020), <https://www.thinkglobalhealth.org/article/fighting-covid-19-one-hand-tied-behind-our-backs>.

⁵⁶ Women in Global Health, ‘Operation 50/50: 100 Women’, <https://www.womenin视角.org/operation-50-50>, accessed 12 November 2022.

⁵⁷ Duckworth, Z., ‘Re-Emphasizing the Gendered Impacts of COVID-19: A Round-up of Evidence from Seven Countries’ (Gender & Covid-19, May 9, 2022), <https://www.genderandcovid-19.org/editorial/re-emphasizing-the-gendered-impacts-of-covid-19-a-round-up-of-evidence-from-seven-countries/>, accessed 9 November 2022.

⁵⁸ Rajan and others (n 47).

⁵⁹ See e.g. *ibid*; Grogan, J. and Donald, A., ‘Lessons for a Post-Pandemic’, in Grogan, J. and Donald A., *Handbook of Law and the Covid-19 Pandemic* (Routledge 2022).

⁶⁰ ‘Persons with Disabilities Must Not Be Left behind in the Response to the COVID-19 Pandemic’ (Council of Europe, April 2, 2020), <https://www.coe.int/en/web/commissioner/-/persons-with-disabilities-must-not-be-left-behind-in-the-response-to-the-covid-19-pandemic>, accessed 9 November 2022.

⁶¹ Cairney, P., and A. Wellstead. 2020. ‘COVID-19: Effective Policy Making Depends on Trust in Experts, Politicians, and the Public.’ *Policy Design and Practice* 4 (1): 1–14. doi:10.1080/25741292.2020.1837466.

⁶² Greenhalgh, T. 2020. ‘Will COVID-19 Be Evidence-Based Medicine’s Nemesis?’ *PLoS Medicine* 17 (6): e1003266. doi:10.1371/journal.pmed.1003266.

The role of scientific knowledge and data *did* change over the course of 2020-2021, however. One study of four European states (Germany, Italy, the Netherlands, and the UK) found that the immense uncertainties at the early outbreak of the virus led policymakers to rely heavily on medical expertise to inform and provide justification for the severely restrictive measures imposed on their populations. However, 'later in the pandemic, gaps emerged between scientific advice emphasising caution, while politicians increasingly became inclined to promote a relaxation of restrictions to serve economic and social values'⁶³ This reflected the reality that decision-makers had to balance conflicting values in policies, sometimes based on uncertain, inconsistent, unclear or even conflicting scientific opinion. Politicians and (later) judges had to also weigh the merit of developing scientific findings and sometimes conflicting expert advice.

In consideration of the role of data, experts and decision-making, there are clear lessons to be drawn. Where COVID-19 bred 'shadow' pandemics of educational deprivation, domestic violence, unemployment, poverty, social-isolation and mental health crises, further and broader expertise in both the sciences and social sciences was needed to inform not only immediate measures, but also longer-term strategies for recovery. Clearly communicated, accessible and transparent information and analysis is essential for this.

The pandemic exacerbated and compounded pre-existing inequalities particularly among vulnerable groups such as migrants, ethnic minorities and Roma, people with disabilities and children⁶⁴. Diverse public voices should be involved in determining the need for restrictions and in articulating their legal and ethical justifications⁶⁵. Public engagement and involvement are essential to building public trust, and should be integrated into any planning and response processes⁶⁶.

A lesson for future pandemic preparedness is to systematically involve feedback as 'in most contexts, citizen engagement on state initiatives yields improved outcomes, especially in areas like health, education, water, and infrastructure'⁶⁷. Lessons for the future roles of scientific expertise are to develop interdisciplinarity through infrastructure and skills building; to ensure transparency in data, analysis, and reasoning which underlies decision-making; and to support experts in the communication of this information to the public which is also essential in the fight against disinformation⁶⁸.

⁶³ Hodges, R., and others, 'The Role of Scientific Expertise in COVID-19 Policy-making: Evidence from Four European Countries' (2022) Public Organization Review 22, 249–267, <https://doi.org/10.1007/s11115-022-00614-z>.

⁶⁴ See e.g. see, for example, the decision of the European Committee of Social Rights of International Commission of Jurists (ICJ) and European Council for Refugees and Exiles (ECRE) v. Greece, complaint No. 173/2018, § 229, 26 January 2021; 'Human Rights Protection in the Time of the Pandemic: New Challenges and New Perspectives' (Council of Europe 2022), https://www.echr.coe.int/Documents/Seminar_background_paper_2022_ENG_01.pdf.

⁶⁵ Institute of Medicine (US) Forum on Microbial Threats, *Strategies for Disease Containment* (National Academies Press 2007) 14; and Rajan and others (n 48).

⁶⁶ Institute of Medicine (US) Forum on Microbial Threats, *Strategies for Disease Containment* (National Academies Press 2007) 14.

⁶⁷ Brown, F.Z., 'Governance for Resilience: How can States Prepare for the Next Crisis?' (Carnegie Endowment 2022), <https://carnegieendowment.org/2022/05/23/governance-for-resilience-how-can-states-prepare-for-next-crisis-pub-87175>.

⁶⁸ Colman, E., and others, 'Following the Science? Views from Scientists on Government Advisory Boards during the COVID-19 Pandemic: a Qualitative Interview Study in five European Countries' (2021) BMJ Global Health ;6:e006928.

2.3. Democratic input, trust and compliance

'Trust' is multidirectional: decision-makers trust experts to understand the evidence, and trust individuals to follow government advice. The public need to trust government and other decision-makers to ensure compliance, and trust experts in the reasoning for the measures⁶⁹. Effective policymaking during the COVID-19 pandemic depended on this mutual trust between experts, decision-makers and the public⁷⁰.

When decision-makers downplay or exaggerate risks, withhold information, are not seen to take scientific and expert advice, or make decisions behind closed doors, public trust – and thus adherence to containment measures – dwindles. This, in turn, can possibly necessitate harsher control measures, which can sap police resources, inspire conspiracy myths, and can create further opposition to authority. Anecdotal evidence in the current pandemic already shows that countries which continue to operate in an open and democratic way have higher adherence to voluntary containment measures, less panic-buying, etc⁷¹.

Distrust can prompt people to ignore advice or evidence and to not comply with government instructions. Low-levels of trust in government and in science is connected with lower levels of compliance with COVID-19 measures including mask-wearing, dis-information and vaccine hesitancy: 'the pandemic has brought structural and social issues to light, including the erosion of public trust in government and in expert advice, which was compounded by a wave of mis- and disinformation'⁷². Misinformation can undermine efforts to control or mitigate the virus⁷³.

In low-trust environments, governments can be prompted to rely on coercive strategies rather than voluntary (and high-trust) compliance. In cases such as vaccination, coercive strategies (e.g., vaccine mandates) can actively work against the reason for which they were introduced, and disincentive populations from becoming vaccinated. Higher rates of vaccination depend on trust in government and the underlying science⁷⁴.

The assumption that trust is indelibly linked to an effective COVID-19 response has been borne out in studies of the pandemic⁷⁵: evidence suggests that trust is related to higher rates of compliance⁷⁶ and lower mortality rates⁷⁷. Overall resilience to COVID-19 is correlated with higher levels of trust⁷⁸. Further

⁶⁹ Cairney, P., and Wellstead, A., 'COVID-19: Effective Policymaking Depends on Trust in Experts, Politicians, and the Public' (2020) Policy Design and Practice 1, <http://dx.doi.org/10.1080/25741292.2020.1837466>.

⁷⁰ *ibid.*

⁷¹ Hunko, A., 'Lessons for the future from an effective and rights-based response to the COVID-19 pandemic' (Council of Europe 2020) Report Doc 15115, https://pace.coe.int/en/files/28654/html#_TOC_d83e1194.

⁷² OECD, 'First Lessons from Government Evaluations of COVID-19 Responses: A Synthesis' (OECD 2022), <https://www.oecd.org/coronavirus/policy-responses/first-lessons-from-government-evaluations-of-covid-19-responses-a-synthesis-483507d6/>, accessed 1 November 2022.

⁷³ Mian, A., Khan S., 'Coronavirus: the spread of misinformation' (2020) 18 *BMC Med* 89, <https://doi.org/10.1186/s12916-020-01556-3>; and Editorial, 'Coronavirus misinformation needs researchers to respond' (*Nature*, 27 May 2020).

⁷⁴ Schmelz, K., 'Enforcement May Crowd out Voluntary Support for COVID-19 Policies, Especially Where Trust in Government Is Weak and in a Liberal Society' (2021) *Proceedings of the National Academy of Sciences*, 118:1, e2016385118; see further chapter 6.

⁷⁵ Jasanofs, S., and Hilgartner, S., 'A stress test for politics' in Grogan, J. and Donald, A., (eds) *The Routledge Handbook on Law and the COVID-19 Pandemic* (Routledge 2022).

⁷⁶ Han, Q., and others, 'Trust in Government and Its Associations with Health Behaviour and Prosocial Behaviour During the COVID-19 Pandemic' (2020) *PsyArXiv*; and Olsen, A.L., Hjorth, F., 'Willingness to Distance in the COVID-19 Pandemic' (OSF Home 2020), <https://osf.io/xpwwg2/>.

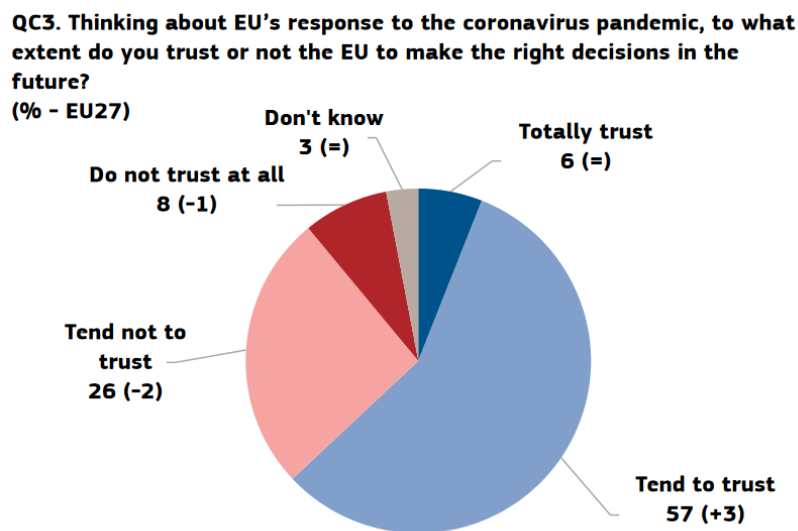
⁷⁷ Oksanen, A., and others, 'Regulation and Trust: 3-Month Follow-up Study on COVID-19 Mortality in 25 European Countries' (2020) *JMIR Public Health and Surveillance* 6 (2): e19218.

⁷⁸ Lenton, T.M., Boulton, C.A. and Scheffer, M., 'Resilience of Countries to COVID-19 Correlated with Trust' (2022) *Sci Rep* 12, 75, <https://doi.org/10.1038/s41598-021-03358-w>.

studies prior to COVID-19 point to a 'strong correlation between governmental trust and generalized trust'⁷⁹ which is instrumental in ensuring community compliance. Transparency in decision making is linked with building broad confidence in government action which in turn offers a significant advantage in achieving higher levels of compliance⁸⁰.

Studies on trust during the pandemic have highlighted early findings, including that personal exposure to COVID-19 is associated with reduced trust; conversely that when rates of infections are increasing, implementing lockdown measures increased trust, and lockdowns in other countries may also increase public trust⁸¹. The degree of public trust in government, or in science and expertise, predates pandemic governance. States which had and have high political, social and institutional trust (e.g., Sweden, Denmark, and Finland) tended towards policies which relied on trust rather than coercive or highly restrictive strategies. Satisfaction with or approval of institutional response is linked with trust in future action.

Figure 8: Eurobarometer Summer 2022 Response to trust in the EU for future decisions based on COVID-19 response



Source: Standard Eurobarometer 94 - Winter 2020 – 2021,
https://data.europa.eu/data/datasets/s2355_94_1_std94_eng?locale=en.

By Summer 2022, the Eurobarometer reported a clear majority of EU population (63%) expressed their trust in the EU to make the right decisions in the future, based on their perception of the EU's response to the pandemic (Figure 8). A majority expressed satisfaction with the actions taken by national governments (56%, Figure 10), and by the EU (56%, Figure 9) in response to the pandemic. This is a significant shift from the Winter 2020/2021 survey, in which a majority of Europeans (56%) were not

⁷⁹ Rothstein, B., and Stolle, D., 'The State and Social Capital: An Institutional Theory of Generalized Trust' (2008) *Comparative Politics* 40, 441–459.

⁸⁰ Gozgor, G., 'Global Evidence on the Determinants of Public Trust in Governments During the COVID-19' (2020) CESifo Working Paper No. 8313, <https://ssrn.com/abstract=3618837>.

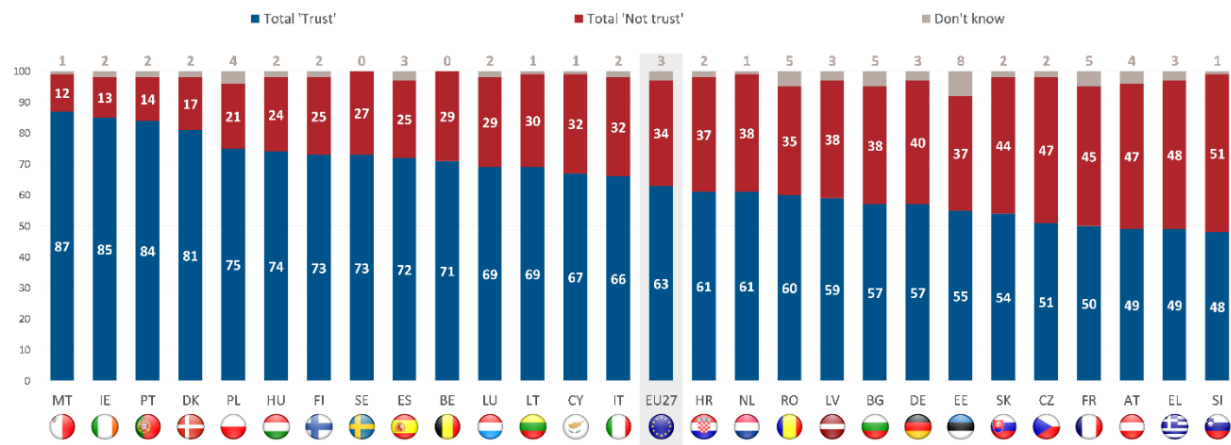
⁸¹ See Bol, D., and others (accepted), 'The Effect of COVID-19 Lockdowns on Political Support: Some Good News for Democracy?' *European Journal of Political Research*; Devine, D., and others, 'Trust and the Coronavirus Pandemic: What are the Consequences of and for Trust? An Early Review of the Literature' (2021) *Political Studies Review*, 19(2), 274–285, <https://doi.org/10.1177/1478929920948684>.

satisfied with the measures taken by their national government to fight the coronavirus pandemic (itself an increase of 19% from summer 2020)⁸².

Broken down by country, there is significant variance between states with high and low levels of trust in the EU's future decision-making, based on their response to the pandemic.

Figure 9: Eurobarometer Summer 2022 Response to trust in the EU for future decisions based on COVID-19 response (disaggregated by Member State)

QC3 Thinking about EU's response to the coronavirus pandemic, to what extent do you trust or not the EU to make the right decisions in the future? (%)

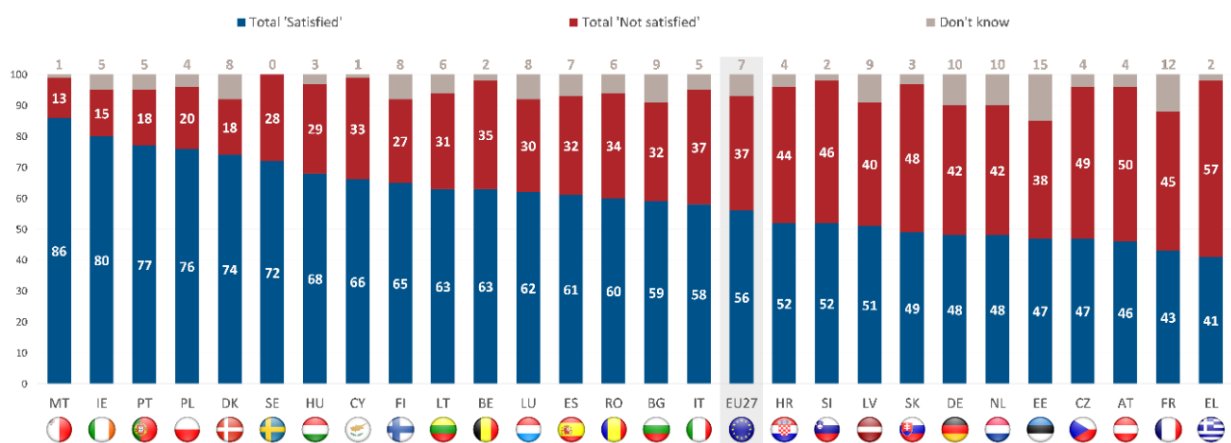


Source: Standard Eurobarometer 94 - Winter 2020 – 2021, https://data.europa.eu/data/datasets/s2355_94_1_std94_eng?locale=en.

There is also a significant variance between the levels of satisfaction in the measures taken by the EU (Figure 10) and EU Member States in response to the pandemic (Figure 11).

Figure 10: Eurobarometer Summer 2022 response on satisfaction with EU COVID-19 response

QC2.3 In general, how satisfied are you with the measures taken to fight the coronavirus pandemic by...? (% - The European Union)

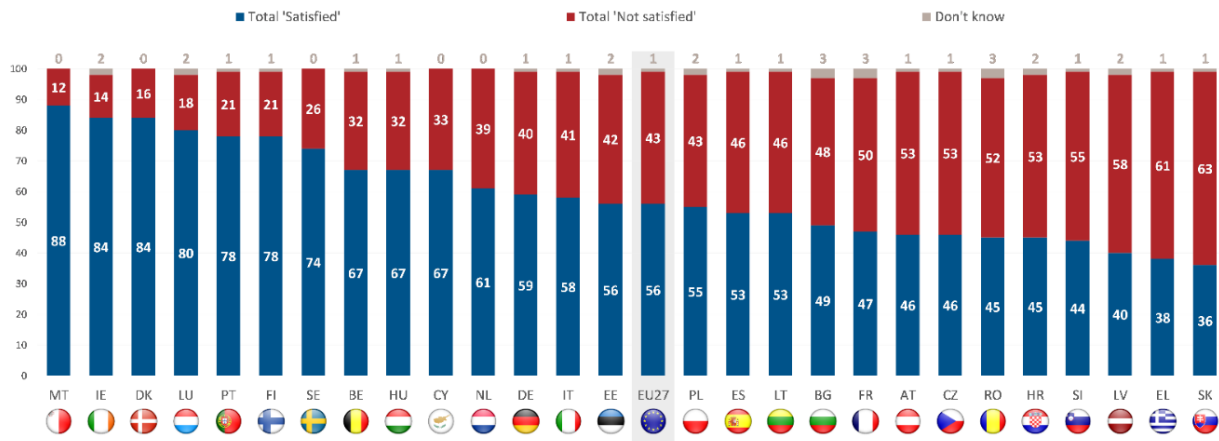


Source: Standard Eurobarometer 94 - Winter 2020 – 2021, https://data.europa.eu/data/datasets/s2355_94_1_std94_eng?locale=en.

⁸² Standard Eurobarometer 94 Winter 2020 – 2021.

Figure 11: Eurobarometer Summer 2022 response on satisfaction with national government COVID-19 response

QC2.1 In general, how satisfied are you with the measures taken to fight the coronavirus pandemic by...?
(% - The (NATIONALITY) government)



Source: Standard Eurobarometer 94 - Winter 2020 – 2021,
https://data.europa.eu/data/datasets/s2355_94_1_std94_eng?locale=en.

Among the most satisfied countries in the EU (Malta, Ireland, Portugal, Poland, and Denmark) and in their national governments (Malta, Ireland, Denmark, Luxembourg, and Portugal):

- There is a strong correlation between high levels of satisfaction in national governments and in the EU (4/5 in the top 5). The countries most satisfied with the EU also express the highest levels of trust in the EU's future decision-making;
- For the outliers, Poland expressed less satisfaction (55%) in their own government than the EU average (56%), and Luxembourg expressed higher satisfaction (62%) than EU average (56%) in the EU, but still less than with its own national government (80%);
- Malta, Ireland, Denmark, and Luxembourg had among the lowest cumulative COVID-19 deaths relative to the EU average. Portugal had just below the EU average, while Poland had just above it. This would indicate a correlation between satisfaction and lower death rates; and
- Stringency of regime does not necessarily correlate with satisfaction in either the EU or the national governments (which had implemented them): Ireland and Portugal implemented highly restrictive regimes, while Denmark and Luxembourg had less restrictive regimes. Malta introduced one of the most severely restrictive regimes, and then moderately restrictive in response to subsequent waves. Poland similarly had a highly restrictive regime, before a moderately restrictive regime from October 2020 to May 2021.

Among the least satisfied countries in the EU (Greece, France, Austria, Czechia and Estonia) and in their national governments (Slovakia, Greece, Latvia, Slovenia and Hungary):

- There is low correlation between countries with low levels of satisfaction in national governments and in the EU (1/5 in bottom 5). Low levels of satisfaction in the EU response do (unsurprisingly) correlate with low levels of trust in future EU decision-making based on EU response to the pandemic;
- All states expressing low satisfaction with national government response suffered above the EU average for cumulative COVID-19 deaths;

- Among states expressing low satisfaction with the EU response, Estonia, Austria, and France had below the EU average of cumulative COVID-19 deaths. Czechia and Greece had above the EU average; and
- There is no correlation between levels of satisfaction in national governments and stringency of restrictions: Greece and France adopted highly restrictive regimes. Austria, Czechia, Hungary, and Estonia adopted a moderately restrictive regime. Latvia adopted lower levels of restriction.

Beyond these survey measures, the perception of the legitimacy of government action is strongly connected with public access to information and understanding the justification of pandemic measures. Studies have also concluded that there is a connection between the quality of democracy and public, social and institutional trust⁸³. Past analysis indicates that democratic governments are more effective in managing catastrophic situations, such as pandemics or famines, than authoritarian regimes⁸⁴. Stronger democratic governance was significantly associated with fewer excess deaths during the COVID-19 pandemic⁸⁵. Stronger democracies are slower to react on the face of the pandemic⁸⁶, which may also correlate with the finding that higher societal and political trust is associated with later adoption of restrictive policies⁸⁷. However, the reason for this may not be obvious, nor universally applicable.

Analysis of the underlying relationship reveals a mutual effect when considering later stages of pandemic management, not just the initial response: ‘states whose democratic institutions rose to the challenge of the pandemic and ensured real-time oversight of restrictive measures, ensuring that they could be interrogated, fine-tuned and as a consequence enjoy greater public confidence’⁸⁸. In this context, attention must be paid to the ‘principles of delegation and accountability’ by which scientific expertise exerts political influence, and potential reform of the ‘institutional processes for integrating scientific and political consensus-building’, since trust in health expertise has been shown to depend on trust in wider political authority⁸⁹.

2.4. Recommendations for the future of pandemic governance

Despite the limitations on the report, there are nevertheless some initial lessons which may be gleaned from EU and international response to the COVID-19 virus which may help the development of effective strategies in the preparation, response, and review of future health crises⁹⁰. As a first point, access to high-quality and accurate data has shown itself to be essential. **It is imperative for EU, national, regional, and local authorities to share accurate and relevant data in a timely and highly accessible manner.** With access to such data, restrictive measures can take account of local conditions

⁸³ Engler, S., and others, ‘Democracy in Times of the Pandemic: Explaining the Variation of COVID-19 Policies across European Democracies’ (2021) *West European Politics*, 44:5-6, 1077-1102, DOI: 10.1080/01402382.2021.1900669; Eaton, L. A., and Kalichman, S. C., ‘Social and Behavioral Health Responses to COVID-19: Lessons Learned from Four Decades of an HIV Pandemic’ (2020) *Journal of Behavioral Medicine* 43:3, 341–5.

⁸⁴ G. Petersen, ‘Democracy, Authoritarianism, and Pandemic Management: the Case of SARS-CoV-2 Testing APSA’ (2020) doi: 10.33774/apsa-2020-wbhf.

⁸⁵ Engler (n 25).

⁸⁶ Abiel, S., and others, ‘Explaining the Homogeneous Diffusion of COVID-19 Nonpharmaceutical Interventions across Heterogeneous Countries’ (2020) *Proceedings of the National Academy of Sciences*, 117:35, 21201–8.

⁸⁷ Toshkov, D., Yesilkagit, K., Carroll, B., ‘Government Capacity, Societal Trust or Party Preferences? What Accounts for the Variety of National Policy Responses to the COVID-19 Pandemic in Europe?’ (2020) OSF Preprints Epub ahead of print 29 April.

⁸⁸ Grogan, J. and Donald, A., (eds) *The Routledge Handbook on Law and the COVID-19 Pandemic* (Routledge 2022).

⁸⁹ Ibid.

⁹⁰ This section draws from Grogan, J., and Weinberg, N., *Principles to Uphold the Rule of Law and Good Governance in a Public Health Emergency* RECONNECT Policy Brief (August 2020).

including demography, ability to work from home, general economic vulnerability, household sizes, level of labour informality, and state capacity to provide support to vulnerable populations. The localisation of emergency response can improve the speed of reaction, and allocation of resources as needed based on local awareness, but its ultimate success depends on being complimented by a coordinated national response. Neighbouring states benefit from access to data of comparable regions and conditions, aiding response in other Member States.

In terms of pandemic governance and the stringency of restrictive measures, it can be observed that the timing of restrictive measures is crucial, but that measures must also be understood and situated within their wider social, economic, legal and political context. In terms of response, **the costs of under reaction outweigh the costs of overreaction in a pandemic situation**. The rapid response of states recognising the potential threat of the virus (New Zealand, South Korea, Taiwan, Rwanda), paired with populations both understanding and willing to follow public health advice, meant that these countries could introduce lower levels of restrictions and gain valuable time for the implementation to plan further responses. However, **such rapid response requires a delicate balance between the urgency of the threat and rational weighing of the available data and analysis**. This must take into account the intensity of interventions, the likely negative impacts of restrictive measures on economies and societies. States which counted themselves among the highest infection and mortality rates in the world are case studies cautioning against delayed, internally inconsistent, and uncoordinated action. While the ‘health’ of democratic institutions and public health systems are important – the quality of government capacity for coordination and response, public health education, and mutual trust between government, expertise and the public are as essential.

Public trust is slowly earned and quickly squandered. There are essential lessons which can help support public trust, and compliance during public health emergencies. The first among them is that **public messaging about the pandemic should be clear, accessible, and consistent**. Clear and consistent messaging not only has the effect of tackling the spread of misinformation but is also critical to ensure trust and high degrees of compliance with measures. Communication must be accessible and include provision for sign language and minority language populations. The effectiveness of restrictive measures requires a high level of individual compliance which is grounded in both trust in the legitimacy of the intervention, and the clarity with which those measures have been communicated. This also requires early and regular updates on developments, policies and actions. A lack of information centrally communicated can result in inaccurate, incomplete, or false information being widely disseminated. Updates on relevant developments must be communicated by government promptly in order to avoid speculation, and to minimise the risks associated with disinformation or ‘fake news’.

A further lesson to tackling misinformation and support public trust is to **ensure high levels of transparency in the decision-making processes in both policy and legal measures taken in response to the health threat**. This includes the evidence which underlies the decisions being made; and the reasoning or rationale underlying these decisions. A related recommendation is for the scientific evidence and rationale which underlies public policy and legal measures should be made available in both full and accessible executive summary on public websites. Allowing access enables government to show the clear, transparent and evidence-based criteria to show that the response has been both necessary and proportionate. Maximum possible transparency is necessary for any pandemic-response that involves significant threats to human rights and civil liberties to enable this to be contested through democratic channels.

Transparency in decision-making also includes the identification of who is making the decisions. Such transparency allows space to identify mistakes, and to improve the representation in advisors. It is

important in this context for states to engage with external expertise, and to invite input from a broad range of stakeholders including civil society and non-governmental organisations. Similarly, it is important for Member States to **invite and respond constructive feedback and criticism of measures which have been introduced from external experts from a wide range of disciplines**. Inclusive and multi-disciplinary decision-making will ensure that interventions are adaptive to the full range of societal needs. To aid this, a wide range of academic and NGO expertise has become rapidly available online in response to policy developments. External engagement, particularly with critiques of measures and reform on the basis of strongly evidenced and reasoned proposals creates better quality of law and policy.

3. LEGAL BASIS FOR RESPONSE TO THE COVID-19 PANDEMIC

KEY FINDINGS

EU Member States relied on a range of legal bases in response to the pandemic, including the constitutional declaration of a state of emergency, a statutory emergency regime, and ordinary legislation. The most common (19 states) was a constitutional declaration of a state of emergency or a statutory emergency regime, or a combination of the two.

While concerns for the misuse or abuse of emergency powers are well founded, there is no clear or evidenced connection in EU Member States between the use of emergency powers and practices detrimental to fundamental rights and the rule of law. What is crucial is that restrictive measures are subject to appropriate parliamentary and judicial scrutiny as to their legality, necessity and proportionality; and time-limited for the period of emergency only.

During the pandemic, Member States continued pre-existing trends: those committed to high levels of political accountability tended to show this in decision-making processes; while states tending towards autocratic or anti-democratic practices continued that trajectory.

The COVID-19 pandemic caused significant challenges for parliaments and courts in EU Member States. Closure of buildings resulted in significant backlogs of court proceedings, while parliamentary activity was limited to a greater or lesser degree in all states.

Democratic digital innovation, allowing remote access to court proceedings and parliaments, varies across Member States. Support for digital literacy is needed to ensure equitable access.

The legal basis for the measures adopted by governments in response to the COVID-19 pandemic fell broadly into three categories: (1) declaration of a constitutional state of emergency; (2) emergency health regimes; and (3) ordinary legislation. Member States relied on different legal bases for action, depending on the constitutional, legal and political environment in which they operated. This chapter provides an overview of the legal bases of Member State responses over the course of the COVID-19 pandemic (section 3.1). It then considers these responses from the perspective of democracy, the rule of law, fundamental rights and constitutional states of emergency (section 3.2), emergency frameworks (3.3), and ordinary legislation (3.4). In section 3.5, it reflects on rule of law issues which have arisen in the EU, regardless of the legal basis upon which measures have been based. The chapter then reflects on oversight provided by national parliaments and courts, as well as the guidance of international bodies (section 3.6).

3.1. Legal bases for action in Member States

In democratic states founded on the rule of law and the protection of fundamental rights, all state action and authority must be within the limits imposed by the law. An early tension, and a frequent comment in the context of emergency pandemic response, is that states were unprepared for the pandemic and so struggled to find the legal basis for actions necessary to respond to the virus and so acted extra-legally. However, as underlined by the Committee on Legal Affairs and Human Rights of the Council of Europe: ‘there should and need not be any tension between effectiveness and legality’⁹¹.

⁹¹ Committee on Legal Affairs and Human Rights, The impact of the Covid-19 pandemic on human rights and the rule of law (2020) AS/JUR (2020) 13: <http://www.assembly.coe.int/LifeRay/JUR/Pdf/TextesProvisoires/2020/20200702-CovidImpact-EN.pdf>

Both within the European Union and beyond it, executive bodies were the primary decision-makers in determining the policies and measures to be adopted in response to the public health emergency. Heightened executive control in emergency situations is not unusual, nor automatically a cause for concern in terms of democracy, human rights or the rule of law. Often, it reflects the nature of an emergency situation wherein a fast response is often essential for the reducing the risk of [further] harm. While all Member States' governments adopted similar restrictive measures⁹², they varied in form (e.g., orders, decrees, statutory instruments or regulations) and legal basis.

The legal bases for Member State action can be broadly categorised as follows:

- Declaration of a constitutional state of emergency⁹³;
- Use of special legislative or emergency powers, or statutory emergency regime.; and
- Ordinary legislation.

In December 2020, Maria Diaz Crego and Silvia Kotanidis provided an overview of states of emergency in response to the COVID-19 crisis during the first year of pandemic⁹⁴. They identified that the majority of Member States (19) enacted a form of emergency scheme either in the form of a constitutional state of emergency (10), and / or in the form of a statutory emergency regime (14)⁹⁵. Five Member States declared a state of emergency and also a statutory emergency regime⁹⁶. The minority (8) relied on ordinary legislation (either pre-existing or ad hoc) which enabled governments to adopt measures in response to the pandemic.

As outlined, not all states fell strictly within one category. For example, the Portuguese response was based on constitutional emergency powers, emergency statutory regimes and ordinary legislation. Some states did, however, rely exclusively on one category of powers; for example, Austria, Denmark, Cyprus, Ireland, the Netherlands, and Sweden only relied on ordinary legislation in their pandemic response. Underlining the exceptional nature of the pandemic, the authors report that only 10 Member States had previously adopted constitutional states of emergency and/or emergency regimes (Figure 12).

⁹² See section 4 for consideration of restrictive measures.

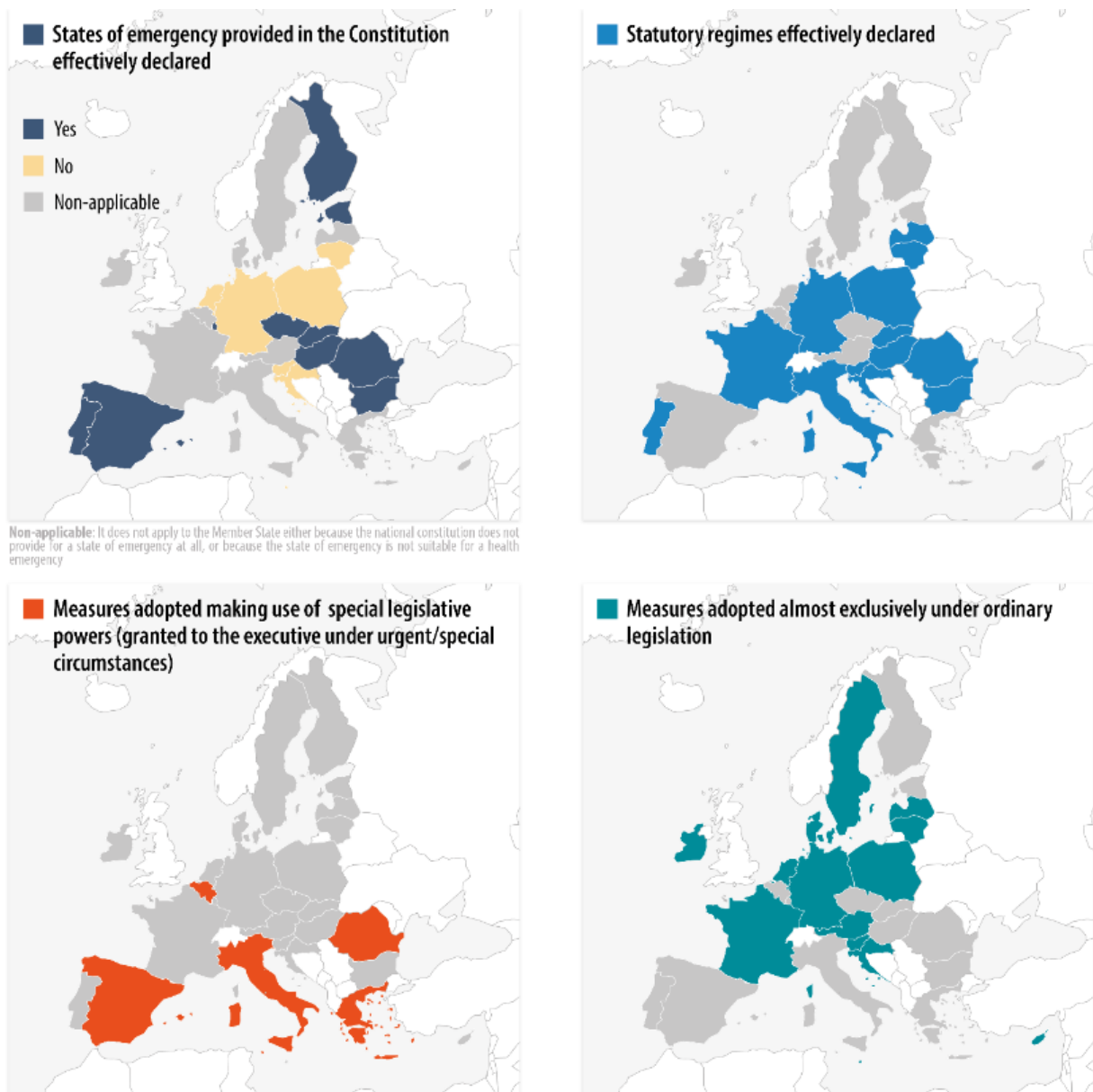
⁹³ On emergency frameworks, see Dyzenhaus, D., *The Constitution of Law: Legality in a Time of Emergency* (Cambridge University Press 2006); and Gross, O., and Fionnuala, N. A., *Law in Times of Crisis: Emergency Powers in Theory and Practice* (Cambridge University Press 2006).

⁹⁴ Diaz, M. and Kotanidis, S., 'States of Emergency in Response to the Coronavirus Crisis Normative Response and Parliamentary Oversight in EU Member States during the First Wave of the Pandemic' European Parliament Research Service (*Europa.eu*), [https://www.europarl.europa.eu/RegData/etudes/STUD/2020/659385/EPRS_STU\(2020\)659385_EN.pdf](https://www.europarl.europa.eu/RegData/etudes/STUD/2020/659385/EPRS_STU(2020)659385_EN.pdf), accessed 1 November 2022.

⁹⁵ Bulgaria, Croatia, France, Germany, Hungary, Italy, Latvia, Lithuania, Malta, Poland, Portugal, Romania, Slovenia, and Slovakia.

⁹⁶ Bulgaria, Hungary, Portugal, Romania, and Slovakia.

Figure 12: Map of legal basis for COVID-19 response in EU Member States



Source: Diaz, M. and Kotanidis, S., 'States of Emergency in Response to the Coronavirus Crisis Normative Response and Parliamentary Oversight in EU Member States during the First Wave of the Pandemic' European Parliament Research Service 2020 (Europa.eu).

For many Member States the legal frameworks established in 2020 formed the bedrock for their continued response in 2021-2022. However, of the 10 states which declared a constitutional state of emergency⁹⁷, three states lifted the state of emergency in 2020 and did not declare it again; three further Member States did so in 2021; and the final four lifted COVID-19 related states of emergency in 2022.

⁹⁷ Bulgaria, Czechia, Estonia, Finland, Hungary, Luxembourg, Portugal, Romania, Slovakia, and Spain.

In Bulgaria, the constitutional state of emergency was lifted for the second, and final time, on 14 May 2020. It was replaced by the 'emergency epidemiological situation' (a statutory emergency regime), which was lifted by the Bulgarian Council of Ministers on 1 April 2022. In Estonia, the state of emergency (*eriolukord*) ended in May 2020, though the health-related emergency (*hädalukord*) remained. No declaration of a state of emergency was made in response to the rise in rates in Winter 2020/2021⁹⁸. Similarly, Luxembourg's state of crisis ended on 25 June 2020 and was not declared again in the winter of 2020/2021.

In Czechia, the second period of state of emergency declared in response to the pandemic ended on 11 April 2021. A further declaration for 30 days was made in November 2021 in response to the Delta variant, which ended on 26 December 2021. In February 2022, the Chamber of Deputies enacted the 'state of pandemic alert', which ended in May 2022. This ended all COVID-19 measures whether or not they were introduced under pandemic law, or public health protection law. Czechia declared a state of emergency in response to the Russian invasion of Ukraine, on the expectation of refugees on 4 March 2022, though did not apply restrictive measures⁹⁹. For its part, Finland was in state of emergency from 16 March to 16 June 2020 and from 1 March to 27 April 2021. Spain ended the six-month state of alarm (a lower level of constitutional state of emergency provided for by the Spanish Constitution) on 9 August 2021¹⁰⁰.

Three states continued declared states of emergency into 2022: Romania ended its state of emergency on 8 March 2022; Portugal ended the state of alert on 30 September 2022; and in Slovakia, the state of emergency declared on 25 November 2021 ended on 22 February 2022, while the extraordinary situation (crisis situation) which had been declared on 11 March 2020.

Hungary has been in near a continuous state of emergency since 2015, when it declared an emergency in response to the Refugee/Migrant Crisis. On 1 June 2022, the government ended the COVID-related state of emergency. Following an amendment to the constitution in May 2022 to allow the Prime Minister to declare a state of danger in response to war in a neighbouring country, Prime Minister Viktor Orbán proceeded to declare a state of danger in response to the Russian invasion of Ukraine.

By contrast, a number of states introduced statutory emergency regimes, declaring the use of emergency powers under ordinary (rather than constitutional) law. In Latvia, the Cabinet declared an 'emergency situation' (*ārkārtējais stāvoklis*) in accordance with the 2013 Law on Emergency Situation and State of Exception. This provides for a special legal regime, allowing for the restriction of rights and freedoms natural and legal persons, in addition to imposing duties on them. Latvia declared a state of emergency from 12 March to 14 April 2020, from 9 November 2020 to 11 January 2021, and again from 11 October 2021 to 28 February 2022. Latvia appointed the Ministry of Health as the authority responsible for coordinating operations during the emergency¹⁰¹.

⁹⁸ Kiviorg, M., and Margna, P., 'COVID-19 in Estonia: A Year in Review' (Verfassungsblog, March 12, 2021), <https://verfassungsblog.de/covid-19-in-estonia-a-year-in-review/>, DOI: 10.17176/20210312-154029-0.

⁹⁹ Zachová, A., 'Czechia Declares State of Emergency, Expects Influx of Ukrainian Refugees' (EURACTIV, March 3, 2022), https://www.euractiv.com/section/politics/short_news/czechia-declares-state-of-emergency-expects-influx-of-ukrainian-refugees/, accessed 9 November 2022.

¹⁰⁰ Azzopardi, M.C., 'Articles of the R.D. Which Declared the State of Alarm Declared Unconstitutional' (Citizens Advice Bureau Spain, August 22, 2021), <https://www.citizensadvice.org.es/articles-of-the-r-d-which-declared-the-state-of-alarm-declared-unconstitutional/>, accessed 9 November 2022.

¹⁰¹ Maurer, A., 'Improving Urgency Procedures and Crisis Preparedness within the European Parliament and EU Institutions' (Policy Department for Citizens' Rights and Constitutional Affairs 2022), [https://www.europarl.europa.eu/RegData/etudes/STUD/2022/730838/IPOL_STU\(2022\)730838_EN.pdf](https://www.europarl.europa.eu/RegData/etudes/STUD/2022/730838/IPOL_STU(2022)730838_EN.pdf).

3.2. Constitutional states of emergency and fundamental values

A constitutional state of emergency is a special legal regime intended for use by (typically) executive powers during a situation of exceptional and extreme crisis which calls for urgent, immediate, and necessary action, and which cannot be addressed by ordinary procedures¹⁰². It can necessitate derogation from fundamental rights. The legal processes for and consequences of a declaration of a constitutional state of emergency vary significantly across Member States¹⁰³.

Member States including Estonia, Portugal and Spain have ‘tiered’ states of exception, corresponding to increasing severity of risk. For example, art. 116 of the 1978 Spanish Constitution envisages the ‘state of alarm’, the ‘state of exception; and the ‘state of siege’, which can be applied in case of neutral emergencies (as in a pandemic), political emergencies and state of war, respectively (as detailed by the Ley Orgánica no. 4/1981). Spain’s reliance on a state of alarm was criticised where it was intended to only allow the limitation of rights, rather than (as with lockdown) the suspension of rights and so should have relied on the state of exception instead. In Portugal, before the initial declaration of a ‘state of emergency’ by the President under the constitution, the Ministers for the Interior and of Health declared a ‘state of alarm’ under Framework Laws of Civil Protection and Health and the Law on Public Vigilance of Health Risks. The constitutional declaration of a state of emergency was then replaced with a less severe ‘state of calamity’, again governed by the Framework Laws of Civil Protection and Health and the Law on Public Vigilance of Health Risks on 2 May 2020.

Within EU Member States, states of emergency are generally accompanied by detailed legislation at ordinary level, or limitations (and safeguards) at the constitutional level, which regulate the transfer of powers, duration, conditions, and limits of the state of emergency. Safeguards on the declaration of a state of emergency can be both procedural (e.g., steps that must be taken, or conditions that must be fulfilled) and substantive (e.g. areas in which emergency measures cannot be taken). Most constitutions require either ex ante or ex post approval from the legislature of the declaration of a constitutional state of emergency and can also require legislative approval for any extension of a state of emergency, which is an important procedural safeguard.

By their nature, states of emergency pose a risk of the misuse or abuse of powers, or the unjustified restriction of rights, and can serve to undermine the separation of powers. The democratic system of checks and balances breaks down where an executive authority can be invoked with limited or no scrutiny; or where the exercise, extent and duration of emergency powers is dictated by the executive alone. This is particularly concerning where states have ‘intensified’ or layered emergency regimes with additional powers and less oversight. A central concern globally on the extended use of emergency powers was the risk of normalising extraordinary powers centralised in the executive. As summated by the Venice Commission, the Council of Europe’s advisory body on constitutional matters:

the longer the emergency regime lasts, the further the state is likely to move away from the objective criteria that may have validated the use of emergency powers in the first place. The longer the situation

¹⁰² The term ‘states of emergency’ is used broadly here to include constitutional and legal frameworks which designate the use of exceptional or emergency power by the executive, but please note the challenge of categorisation: ‘Models of emergency power and the observed use of power during the COVID-19 emergency may be understood as existing on a spectrum ranging from constitutional declarations of emergency to extra-legal action, incorporating a wide range of (ostensibly) applicable safeguards and spanning an even wider range of application in practice.’ Joelle Grogan, ‘The Impact of COVID-19 on Constitutionalism and Constitution-Building’ in International IDEA Annual Report 2021.

¹⁰³ For an analysis of the theory and nature of emergency powers, in addition to consideration of the underlying provisions of emergency law in the EU-27, see Diaz and Kotanidis (n 95).

persists, the lesser justification there is for treating a situation as exceptional in nature with the consequence that it cannot be addressed by application of normal legal tools¹⁰⁴.

Essentially, 'even in a state of public emergency the fundamental principle of the rule of law must prevail.'¹⁰⁵ In April 2020, 19 Member States issued a joint statement expressing that while it is 'legitimate to adopt extraordinary measures to protect citizens and overcome crisis', they nevertheless shared deep concern about the 'risk of violations of the principles of rule of law, democracy and fundamental rights arising from the adoption of certain emergency measures'¹⁰⁶.

To aid countries to navigate the challenge of a pandemic situation and ensuring the protection of fundamental values, the Venice Commission issued a 'toolkit for member states' on 7 April 2020¹⁰⁷, a condensed guide for governments tailored to the specific challenges brought about by a pandemic situation. The Venice Commission underlined¹⁰⁸ that all emergency measures, derogations, and limitations on rights should be subject to three general conditions of necessity, proportionality, and temporariness. Necessity implies that only such limitation of human rights or shift of power to the executive that is necessary to overcome the emergency should take place. Proportionality implies that such shifts must be proportionate, in both the scope and extent, to the nature and severity of the emergency. Finally, such shifts in power and limitations of rights should be temporary, i.e. limited in time to the period of emergency.

Essential to ensuring these principles is the separation of powers, and a system of checks and balances. For example, following the joint decision of the President and Government to declare of a state of emergency in Finland, a further Decree on the Putting into Operation of the Emergency Powers Act (*käyttöönottoasetus*) can be valid for six months; in Czechia, the government can declare a state of emergency for 30 days, and any extension must be approved by the Chamber of Deputies; while in Spain and Portugal, states of emergency expire without renewal by parliament after 15 days.

Hungary, alone among EU Member States, introduced a new form of a state of emergency, which was neither time limited, nor subject to meaningful checks and balances by either the courts or parliament¹⁰⁹. During the second wave of pandemic, the government introduced a third state of emergency (a 'state of danger'). A constitutional amendment passed at the same time effectively reduced parliamentary scrutiny over the decrees and broadened the conditions under which a state of danger can be declared. The decrees may suspend or diverge from the law. The law also gives exclusive authority to the Prime Minister to determine when the use of the emergency powers is no longer necessary. In its resolution of 17 April 2020, the European Parliament affirmed that it deems it totally incompatible with European values both the decision from the Hungarian Government to prolong the

¹⁰⁴ CDL-AD(2016)037-e, Opinion on Emergency Decree Laws N°s 667-676 adopted following the failed coup of 15 July 2016, Opinion No. 865/2016, 12 December 2016, para 41.

¹⁰⁵ CDL-AD(2011)049, Opinion on the draft law on the legal regime of the state of emergency of Armenia, paragraph 44.

¹⁰⁶ Statement by Belgium, Bulgaria, Cyprus, Denmark, Estonia, Finland, France, Germany, Greece, Ireland, Italy, Latvia, Lithuania, Luxembourg, the Netherlands, Portugal, Romania, Spain, Sweden at <https://www.government.nl/documents/diplomatic-statements/2020/04/01/statement-by-belgium-denmark-finland-france-germany-greece-ireland-italy-luxembourg-the-netherlands-portugal-spain-sweden>.

¹⁰⁷ Respecting democracy, rule of law and human rights in the framework of the COVID-19 sanitary crisis - a toolkit for member states, Venice Commission, Information Documents, 7 April 2020, SG/INF(2020)11.

¹⁰⁸ CDL-AD(2020)018-e VC interim report, at 7.

¹⁰⁹ Kovács, K., 'Hungary and the Pandemic: A Pretext for Expanding Power' (*Verfassungsblog*, 11 March 2021), <https://verfassungsblog.de/hungary-and-the-pandemic-a-pretext-for-expanding-power/>.

state of emergency indefinitely, to authorise the Government to rule by decree without time limit, and to weaken the emergency oversight of the Parliament¹¹⁰.

In its 2020 Reflections, the Venice Commission stressed that ‘it is essential that both the declaration and possible prolongation of the state of emergency, on the one hand, and the activation and application of emergency powers on the other hand be subject to effective parliamentary and judicial control’¹¹¹. Judiciaries may also play a role in oversight either as expressly provided for within the constitution or through normal judicial review. However, some courts may exercise judicial self-restraint or decline review for lack of competence during a pandemic.

Constitutional states of emergency can provide power to take actions deemed necessary (and proportionate) but not found elsewhere. As noted earlier, 19 EU Member States declared a constitutional state of emergency and/or an emergency powers regime during the COVID-19 pandemic, and 10 of them had not done so before. It is notable, too, that the extended duration of the pandemic meant that extensions, and further declarations, were common among Member States. In Czechia, when the Chamber of Deputies (the lower House of Parliament) refused the government’s request for a sixth extension to its state of emergency on 11 February 2021, the government sought to declare it anyway. The Chamber of Deputies annulled this as unconstitutional overreach and opted for the introduction of the Pandemic Act to address the health crisis without the recourse to extended states of emergency¹¹².

In 2022, a number of states have begun review of their emergency provisions. The Council of State in France has dedicated its 2021 Annual Study to states of emergency¹¹³. The Netherlands, Portugal and Sweden have established groups to investigate permanent legal frameworks governing exceptional circumstances. Going forward and in consideration of the legal basis for response to future emergencies, the essential question will be first, whether there is legal basis sufficient to provide necessary power; second, whether the limitations and conditions on their use are clear; third, whether the separation of powers can provide sufficient checks and balances on the use of that power; and fourth, whether or not there are mechanisms of oversight and review – particularly when the duration of emergency has extended (as during the pandemic). The use of states of emergency over the course of the pandemic is not inherently problematic (nor is it correct to conclude that reliance solely upon ordinary law during a crisis is always preferable)¹¹⁴. However, where the use of these powers represents a shift (or an attempt to shift) the balance of powers decisively or permanently towards the executive (i.e. executive aggrandisement or ‘overreach’¹¹⁵), this is deeply concerning.

3.3. Emergency health regimes and fundamental values

During the first wave of the pandemic, statutory regimes were declared or implemented by 14 Member States (Bulgaria, Croatia, France, Germany, Hungary, Italy, Latvia, Lithuania, Malta, Poland, Portugal,

¹¹⁰ ‘Texts Adopted - EU Coordinated Action to Combat the COVID-19 Pandemic and Its Consequences - Friday, 17 April 2020’ (*Europa.eu*), https://www.europarl.europa.eu/doceo/document/TA-9-2020-0054_EN.html, accessed 1 November 2022.

¹¹¹ Venice Commission, CDL-AD(2020)014, op. cit., paragraph 14.

¹¹² Vikarská, Z., ‘Czechs and Balances – One Year Later’ (Verfassungsblog, March 30, 2021), <https://verfassungsblog.de/czechs-and-balances-one-year-later/>, DOI: 10.17176/20210330-195055-0.

¹¹³ ‘2022 Rule of Law Report - Country Chapter France’ (European Commission - European Commission, June 23, 2022), https://ec.europa.eu/info/files/2022-rule-law-report-country-chapter-france_en, accessed 9 November 2022.

¹¹⁴ Grogan (n 4).

¹¹⁵ Pozen, D., and Scheppele, K. L., ‘Executive Overreach and Underreach in the Pandemic’ in Miguel Poiras Maduro and Paul W Kahn (eds), *Democracy in Times of Pandemic: Different Futures Imagined* (Cambridge University Press 2020).

Romania, Slovenia and Slovakia). These regimes allowed for the rapid introduction of measures in response to the pandemic, and typically deviated from the ordinary processes of law-making. The legal basis for the executive's exceptional or extraordinary use of power was based on ordinary legislation passed by the legislature in direct response to the pandemic through ordinary legislative processes, which created new designations of states of emergency, which were not, however, *constitutional* states of emergency. Alternatively, as in Italy, they may be based on special legislative powers. The Italian Constitution does not provide for a state of emergency; however, Article 77 of the Constitution provides for special legislative power to enact legislative decrees in the event of an emergency. These legislative decrees are temporary measures issued by the government in cases of urgency. If they are not converted into a law by Parliament after 60 days, they cease to exist.

Unlike constitutional emergency regimes, legislated emergency regimes operate within the normal bounds of constitutional checks and balances and involve the legislature delegating extraordinary or exceptional powers to the executive. They involve the contemporaneous engagement of the legislative branch in constructing the emergency regime through law-making.

Thus, legislative emergency law frameworks provide for self-designated emergency powers but are statutory delegations of extraordinary power from the legislature to the executive, and, as with the new legislative states of emergency, have been developed in the normal course of law-making. As all such legal bases operate on a spectrum, a notable distinction of these laws is that they do not necessarily provide for the declaration of a state of emergency but do authorize the executive's exceptional powers. As with statutory states of emergency, they would be expected to be subject to ordinary democratic checks and balances and a range of substantive and procedural checks, including some form of legislative scrutiny and judicial review, though this is not always the case in practice.

Several EU Member States created new statutory states of emergency in response to the pandemic. Although countries describe these as 'states of emergency', they should not be confused with constitutional states of emergency, as they are the product of ordinary legislation—not the constitution. Unlike the roles of parliament typically envisaged in constitutional states of emergency, it was notable within the 'new' legislative emergency law frameworks introduced in France and Bulgaria, for example, that the degree of parliamentary involvement was less than that under a constitutional state of emergency. In France, the Emergency Response to the COVID-19 Epidemic Act (2020-290) introduced a new 'state of health emergency', also codified in articles L.3131-14–L.3131-12 of the Public Health Code. In many aspects, this new state echoes a state of emergency in being declared by decree of the Council of Ministers (article L.3131-13) and is subject to parliamentary involvement. However, such parliamentary oversight is more limited than under a constitutional state of emergency. For example, parliament must authorize any extension of the state of health emergency after one month, and, unlike, for example, the State of Emergency Act 1955, it does not lapse after 15 days¹¹⁶. There is also no obligation to send measures that executive or administrative authorities have adopted under the act to parliament, as compared to the obligation under a constitutional emergency¹¹⁷. A number of concerns were raised in the context of the state of public health emergency in France in October 2020, highlighting the proliferation of multi-layered measures, which were subject to frequent (sometimes weekly) amendment and modification.

¹¹⁶ Platon, Sébastien: From One State of Emergency to Another – Emergency Powers in France, Verfblog, 2020/4/09, <https://verfassungsblog.de/from-one-state-of-emergency-to-another-emergency-powers-in-france/>, DOI: 10.17176/20200409-153015-0.

¹¹⁷ Basilien-Gainche, Marie-Laure: French Response to COVID-19 Crisis: Rolling into the Deep*, Verfblog, 2021/3/18, <https://verfassungsblog.de/french-response-to-covid-19-crisis-rolling-into-the-deep/>, DOI: 10.17176/20210318-154150-0.

In Bulgaria, responding to criticism of the alleged misuse of a constitutional state of emergency (which was arguably only applicable at a time of war or insurrection) in its initial response to the pandemic, the government introduced amendments to the Law on Health to introduce a new state of 'extraordinary epidemiological conditions' in May 2020. The executive unilaterally triggers this new legal framework, and there is no limit within the law on how long it may last. It also allows the restriction of fundamental rights through executive orders, in contravention of the established norm that such restrictions may only be enacted with parliamentary authorization¹¹⁸. Despite strong objection in a joint dissenting opinion, highlighting that this new framework was an ersatz state of emergency declared by the executive rather than by parliament (as the Bulgarian constitutional state of emergency requires), in Decision 10/2020 of 23 July 2020 the Constitutional Court held that the amendments to the Law on Health were constitutional.

By contrast, in the United Kingdom (UK), the Civil Contingencies Act 2004 is the main piece of legislation addressing civil emergencies such as epidemics. It was not, however, utilized during the pandemic, ostensibly because the gradual onset of the pandemic did not constitute a 'sudden, unanticipated event' as envisioned by the Act. Instead, parliament enacted the Coronavirus Act in 2020, granting the government emergency powers. However, the parliamentary Public Administration and Constitutional Affairs Committee, in its report scrutinizing the government's handling of the COVID-19 pandemic, concluded that this choice was politically motivated, highlighting that the CCA 2004 is subject to safeguards of meeting strict standards of necessity and urgency before emergency regulations can be applied, while the Coronavirus Act 2020 does not have the same safeguards¹¹⁹. As observers noted, the governments of Hungary, France and the UK (all unified executives) chose a legal basis for their pandemic response that increased the possibility of autonomous action and amended legislation to 'enhance the regulatory scope for executive rule making, while – at best – maintaining parliaments' power to reject executive measures.'

While pandemic legislation is frequently temporary in text, it risks becoming permanent in effect where governments (alone) determine when the need for emergency powers ends. The Hungarian government's extraordinary power during the pandemic was criticised for being too broad in scope and without express temporal limit to the areas where an urgent response to the pandemic was required¹²⁰.

3.4. Reliance on ordinary legislation and fundamental values

As provided by Maria Diaz Crego and Silvia Kotanidis in their December 2020 study, a number of Member States did not have an immediate set of provisions which could provide powers to government to adopt containment measures¹²¹. The EU Member States therefore adopted legislative acts that laid down a range of measures that the executive could take only once the pandemic required them. The majority of Member States, however, either relied on an arsenal of enabling laws pre-existing

¹¹⁸ Vassileva, Radosveta: COVID-19 in Autocratic Bulgaria: How the Anti-Corruption Protests Temporarily Limited the Abuse of Questionable Legislation, *Verfassungsblog*, 2021/3/05, <https://verfassungsblog.de/covid-19-in-autocratic-bulgaria/>, DOI: 10.17176/20210305-154130-0.

¹¹⁹ UK Public Administration and Constitutional Affairs Committee, *Fourth Report - Parliamentary Scrutiny of the Government's handling of Covid-19*, HC 377 (10 September 2020) para 4.

¹²⁰ Kovács (n 110).

¹²¹ Austria, Belgium, Italy, Greece, Ireland and Sweden.

the current emergency (13 Member States)¹²², or adapted pre-existing enabling laws (8 Member States)¹²³ to the new emergency. By the end of 2021, a majority of EU Member States no longer relied on constitutional states of emergency, or emergency regimes in their response to the pandemic. However, reliance on ordinary legislative powers in response to the COVID-19 pandemic raised a number of concerns throughout the EU.

The question of emergency power did not arise in some Member States, as the health crisis did not constitute an emergency under the constitution. For example, the relevant constitutional provisions in Ireland restrict the declaration of a state of emergency to times of ‘war or armed rebellion’ (Article 28.3.3°). Therefore, the statutory basis for legal action during the pandemic in Ireland has consisted of five primary statutes empowering the Minister for Health to make regulations which can impose restrictions and establish enforcement powers for those restrictions. Historical reasons, as for example in Germany, may have also played a role in the reticence to declare a state of emergency. By contrast, in Poland, the current health crisis could arguably have fallen within the provisions of the constitutional framework for the use of ‘extraordinary measures’, within which there are provisions for a ‘state of natural disaster’. Within the Statute expanding on the provisions for a state of natural disaster, ‘mass occurrence of infectious diseases among humans’ is one of the recognised conditions for declaring such a state. The Polish government, however, did not declare a state of emergency in response to the pandemic¹²⁴.

States relied on ordinary legislation, but in the absence of targeted legislation had to rely on sometimes outdated provisions: for example, Cyprus relied on the pre-independence 1932 Quarantine Law¹²⁵. The Quarantine Law removes all parliamentary competence and oversight and delegates significant power to the executive to adopt a wide range of restrictive measures. The constitutionality of the ‘ambiguous and outdated’ law has been questioned, as has been the significant degree to which the Administrative Court has limited its own competence in related cases, wherein no cases systematically challenging COVID-19 measures have been heard¹²⁶.

In Slovenia, all restrictive measures that aimed at preventing the spreading of the virus were enacted on the basis of the pre-pandemic Communicable Diseases Act (ZNB)¹²⁷. However, legal experts argued that the almost exclusive use of executive power to enact rules related to the health emergency has gone beyond an ‘acceptable legal interpretation’ of pre-pandemic legislation¹²⁸. Where pre-pandemic ordinary legislation was relied upon to provide for exceptional regulatory powers of government and also administrative agencies, it sometimes arguably provided for too great a degree of discretion for executive action. Unrestrained discretion tests the limits of legality. An alternative and preferable

¹²² This was the case for Cyprus, Czechia, Estonia, Finland, France, Germany, Latvia, Lithuania, the Netherlands, Portugal, Slovenia, Slovakia and Spain.

¹²³ Bulgaria, Croatia, Denmark, Hungary, Luxembourg, Malta, Poland and Romania.

¹²⁴ Jaraczewski, Jakub: The New Normal? – Emergency Measures in Response to the Second COVID-19 Wave in Poland, *Verfassungsblog*, 2021/3/24, <https://verfassungsblog.de/the-new-normal-emergency-measures-in-response-to-the-second-covid-19-wave-in-poland/>, DOI: 10.17176/20210324-151409-0.

¹²⁵ Kombos, Constantinos: Constitutional Improvisation and Executive Omnipotence: the Cypriot Handling of the Pandemic, *Verfassungsblog*, 2021/3/02, <https://verfassungsblog.de/constitutional-improvisation-and-executive-omnipotence-the-cypriot-handling-of-the-pandemic/>, DOI: 10.17176/20210302-154130-0.

¹²⁶ *ibid.*

¹²⁷ Bardutzky, S., and Zagorc, S., ‘Slovenia: Second Wave of Challenges to Constitutionalism’ (*Verfassungsblog*, 19 March 2021), <https://verfassungsblog.de/slovenia-second-wave-of-challenges-to-constitutionalism/>.

¹²⁸ Grogan, J. ‘Extraordinary or extralegal responses? Covid-19 and the rule of law in the EU’ (Democracy Reporting International, 2021), <https://democracy-reporting.org/en/office/EU/publications/extraordinary-or-extralegal-responses-covid-19-and-the-rule-of-law-in-the-eu>.

response would have been to enact targeted legislation, providing for the delegation of powers but with the appropriate safeguards of limited action, necessity, proportionality, temporariness, and non-discrimination, as well as legislative and judicial oversight.

Laws which have been promulgated in response to the pandemic have often been introduced at such speed as to allow little time for adequate parliamentary scrutiny; for example, in March 2020 Denmark passed amendments to the Epidemic Act in just twelve hours¹²⁹. These provisions were given such deference by the legislature, and subsequently the courts, as to mean there has been little substantive consideration of their impact, including on wider issues such as the protection of human rights. Subsequently, however, a new Epidemic Act adopted in February 2021 was reviewed by the Parliament and subject to a broad consultation of stakeholders.

The pressures of the pandemic, requiring rapid action and response, have led to concerns for the legality of measures, particularly where rules have been adopted and applied on the basis of weak or even absent underlying law. For example, in Lithuania, the government adopted and subsequently amended a 'quarantine resolution' to introduce measures that were not envisaged by the relevant law. Parliament was obliged to amend the law retroactively in order to legitimise these measures. A legislative proposal in Croatia which would have allowed the tracking of cell phone data was effectively blocked and heavily criticised for its lack of constitutionally mandated safeguards and temporal limitations¹³⁰.

Beyond legal basis, the swift adoption with little time for scrutiny was raised as an issue in Ireland¹³¹, Italy¹³², Slovenia¹³³, and Slovakia¹³⁴, while a related lack of legal certainty has also caused significant concern in Belgium¹³⁵. Such lack of scrutiny correlates with further negative consequences, including the laws having errors or creating a degree of uncertainty as to their meaning and application, and what consequences may arise from them.

Future approaches should achieve a balance between the benefits of local knowledge, expertise and adaptation, the resource and coordinating capacity of national governments, and the expertise and information-gathering role of multilateral institutions (see, for example, the practices of Austria¹³⁶, Estonia¹³⁷ and Sweden¹³⁸). Sub-national authorities should have the capacity for local adaptation to enable investment, ownership and responsibility as close to the 'front line' as possible, but with

¹²⁹ Lauts, Kristian Cedervall: Something is Forgotten in the State of Denmark: Denmark's Response to the COVID-19 Pandemic, *Verfassungsblog*, 2020/5/04, <https://verfassungsblog.de/something-is-forgotten-in-the-state-of-denmark-denmarks-response-to-the-covid-19-pandemic/>, DOI: 10.17176/20200504-133656-0.

¹³⁰ Selanec (n 51).

¹³¹ Doyle, O., 'Pandemic Response as Accentuation of Existing Characteristics: Vague Requirements and Executive Dominance in Ireland' (*Verfassungsblog*, 17 March 2021), <https://verfassungsblog.de/pandemic-response-as-accentuation-of-existing-characteristics-vague-requirements-and-executive-dominance-in-ireland/>.

¹³² Cristina Fasone, 'Coping with Disloyal Cooperation in the Midst of a Pandemic: The Italian Response' (*Verfassungsblog* 8 March 2021), <https://verfassungsblog.de/coping-with-disloyal-cooperation-in-the-midst-of-a-pandemic-the-italian-response/>.

¹³³ Bardutsky and Zagorc (n 127).

¹³⁴ Steuer, M., 'Slovakia's Democracy and the COVID-19 Pandemic: When Executive Communication Fails' (*Verfassungsblog*, 9 March 2021), <https://verfassungsblog.de/slovakias-democracy-and-the-covid-19-pandemic-when-executive-communication-fails/>.

¹³⁵ De Ridder, M., 'Belgium's Accordion Response to COVID-19' (*Verfassungsblog*, 10 March 2021), <https://verfassungsblog.de/belgiums-accordion-response-to-covid-19/>.

¹³⁶ Konrad Lachmayer, 'Muddling through Mutation Times or the Return of Federalism in Austria: From Covid-19 Response to the Vaccination Campaign' (*Verfassungsblog*, 8 May 2021), <https://verfassungsblog.de/muddling-through-mutation-times-or-the-return-of-federalism-in-austria/>.

¹³⁷ Kiviorg and Margna (n 99).

¹³⁸ Cameron, I., and Jonsson Cornell, A., Dealing with COVID-19 in Sweden: Choosing a Different Path' in Grogan, J. and Donald, A., (eds) *The Routledge Handbook on Law and the COVID-19 Pandemic* (Routledge 2022).

necessary coordination at national level, and solidarity at both EU and global levels. Essential for EU Member States in responding to pan-EU emergency threats is the need to share information, resources and, where practicable, common, coordinated or complimentary strategies.

Courts have shown varying levels of deference to executive measures: in Slovenia, the Constitutional Court declared void government measures extending school closures, as they had not been published in the Official Gazette, as required by law. In Estonia, actions by the local self-government to place additional restrictions on movement have also been criticised for lacking a legal basis, but few orders of the central government have been challenged in the courts, owing to relatively moderate and reasonable character of the measures¹³⁹.

Sweden took a different path to many other states: opting initially for a 'soft law' approach, and thereby diverging both from its Nordic neighbours and many states further afield in its approach to the containment of the virus and crisis management. The Swedish government did not impose a total lockdown, in the confidence that voluntary adherence to government recommendations over legal enforcement of restrictive measures, including mask-wearing and lockdowns, was necessary in order to be sustainable. In terms of the principle of legality, there was neither adoption of retrospective legislation nor interpretation of the law beyond what would have been acceptable in non-pandemic times. Legislation, even when adopted at speed, was temporary and did not involve wide discretionary powers delegated to government or administrative agencies.

However, criticism was levelled at the Swedish government as to whether it should have adopted and exercised more powers – particularly in the light of the decentralised powers among administrative agencies which may have, at points, hindered effective action to contain the virus and protect vulnerable communities¹⁴⁰. In relation to soft law, the issue is enforceability and the difference between recommendations to administrations and recommendations to individuals. Whereas in some cases hard law prevailed, in others (private and family life) soft law was used. A mix of the two was chosen in many areas of Sweden with hard law, general principles and more detailed soft recommendations leaving space for self-regulation by individuals¹⁴¹.

3.5. Rule of law issues irrespective of legal basis

The way in which law is used, and not only its formal status, creates fundamental concerns for rights and the rule of law¹⁴²; for example, the use of retroactive legislation to legitimise measures taken without sufficient legal basis, and in some cases despite retroactive legislation being forbidden. In Bulgaria, parliament had to retroactively legalise measures taken by the executive following parliament's earlier declaration of a state of emergency, while in Croatia, provisions giving decision-making powers to an administrative body required retrospective legislative amendment, despite a constitutional provision prohibiting retroactive legislation. In Malta, the parliament retrospectively legitimised the order by the Superintendent of Public Health to close the courts despite criticism. The Portuguese parliament retroactively ratified the government's decree-law that introduced the most significant measures, despite a constitutional prohibition on retroactive restrictions of fundamental rights. In addition, the 'chaotic body of law and administrative orders raises issues of legal security and

¹³⁹ Kiviorg and Margna (n 99).

¹⁴⁰ Cameron and Cornell (n 139).

¹⁴¹ Cafaggi and Iamicelli (n 21).

¹⁴² AS_JUR 2020 13.

certainty, as doubts on the interpretation of poorly drafted provisions and successive amendments grow¹⁴³.

There has been a systematic lack of legal certainty, undermining the efficacy of restrictive emergency measures. For example, in Czechia, over the course of two months, over 65 resolutions with the same title were adopted, and the health ministry adopted additional measures. Some government resolutions were annulled, only for the same measures to be applied by the health ministry. Explanations of measures have been both lengthy and sometimes contradictory and, on occasion, the ministers responsible have failed to clarify which specific activities were legal or illegal. While in Finland, the government's response could be described as 'more communicative than regulatory', nevertheless, the government and Border Control Agency were criticised for drafting misleading communications on border closures that appeared to be legally binding but, without supporting legal amendments, were in fact only recommendations¹⁴⁴.

Frequent changes in rules also pose significant challenges for both the public, in understanding what is expected of them, and for authorities, in enforcing the measures. Criticism of vague and unclear provisions introduced by the government were made by both the *Conseil d'Etat* and the *Commission consultative des droits de l'Homme* in Luxembourg¹⁴⁵. Elsewhere, the ambiguous meaning of the phrase 'reasonable excuse' in the Irish regulations meant it was difficult for people in the country to know whether they were committing a criminal offence by leaving their homes. Heightening confusion, in a number of countries, the rules were introduced with little or no notice, and sometimes with retrospective application. Little or no notice of frequently changing rules was reported in Italy, while the uncertainty on the meaning of legal definitions used in legislation caused uncertainty of application in Belgium. In Austria, the use of ambiguous terms (for example, relating to the exemption from the ban on leaving a residence to meet 'individual important reference persons') further compounded confusion where official announcements of measures and explanations in press conferences differed, or where they were implemented at short notice and without coordination by the relevant ministries. There have been similar concerns about the frequency of new and changing measures in Cyprus¹⁴⁶. In Greece, the government was criticised for lack of sufficient notice for the introduction of new restrictions, and the lack of public consultation, a detailed and published rationale for the restrictive measures¹⁴⁷. In Luxembourg, the Commission consultative des droits de l'Homme criticised laws which had introduced several limits to private gatherings which had cited scientific evidence that was *unrelated* to the adopted restrictions or which simply stated a generic widespread of the virus¹⁴⁸.

¹⁴³ Violante, t., and Lanceiro, R. T., 'Coping with Covid-19 in Portugal: From Constitutional Normality to the State of Emergency' *Verfassungsblog*, 2020/4/12, <https://verfassungsblog.de/coping-with-covid-19-in-portugal-from-constitutional-normality-to-the-state-of-emergency/> DOI: 10.17176/20200412-152458-0. Accessed 10 November 2022.

¹⁴⁴ Scheinin (n 54).

¹⁴⁵ Stoppioni, E., 'The Remains of the Days of Crisis: The Second Wave of Legislative COVID-19 Measures in Luxembourg' (*Verfassungsblog*, 3 March 2021), <https://verfassungsblog.de/the-remains-of-the-days-of-crisis-the-second-wave-of-legislative-covid-19-measures-in-luxembourg/>, accessed 1 November 2022.

¹⁴⁶ Kombos, C., 'Constitutional Improvisation and Executive Omnipotence: the Cypriot Handling of the Pandemic' *Verfassungsblog*, 2021/3/02, <https://verfassungsblog.de/constitutional-improvisation-and-executive-omnipotence-the-cypriot-handling-of-the-pandemic/>, DOI: 10.17176/20210302-154130-0.

¹⁴⁷ Karavokyris, G., 'Constitutionalism and COVID-19 in Greece: The Normality of Emergency' (*Verfassungsblog*, 25 February 2021), <https://verfassungsblog.de/constitutionalism-and-covid-19-in-greece-the-normality-of-emergency/>, accessed 11 November 2022.

¹⁴⁸ Commission consultative des droits de l'Homme, Opinion 7622, 3. See also Stoppioni, E., 'The Remains of the Days of Crisis: The Second Wave of Legislative COVID-19 Measures in Luxembourg' (*Verfassungsblog*, 3 March 2021), <https://verfassungsblog.de/the-remains-of-the-days-of-crisis-the-second-wave-of-legislative-covid-19-measures-in-luxembourg/>, accessed 1 November 2022.

Similar uncertainty arose in Poland, where repeated U-turns in policy, sometimes within days and hours of the announcement of new rules, have intensified confusion and uncertainty. The speed of changes was of similar concern in Slovenia, where there was little time for the consistent provision of guidance or interpretation, forcing the public to rely on ministerial explanations at press conferences, which ultimately led to contradictory interpretations of ordinances by the implementing authorities. This was not solely an EU Member State issue: WHO Director-General Tedros Adhanom Ghebreyesus identified that mixed messaging (for example calling for schools to reopen without having broader control mechanisms in place) undermined the most critical element of COVID-19 response, which is trust¹⁴⁹.

Good practices worldwide can also be emulated. New Zealand adopted a practice of 'social nudges' communicated through clear, consistent and constant government messaging. Prime Minister Jacinda Arden repeatedly underlined the central message of social responsibility, rather than relying on sanctioning measures to deter non-compliance¹⁵⁰. Iceland's 'rule of common sense'¹⁵¹ was driven by clear government guidelines, recommendations and daily advice delivered by health experts, while then German Chancellor Angela Merkel's ability to translate the science into 'easy to follow language' which encouraged the population to follow the rules was associated with a reduced infection rate¹⁵².

Measures have restricted rights through measures based on laws that are insufficiently clear in defining the scope of permissible restrictions, or through measures that exceed the scope of restrictions permitted by law. For example, in Poland, the constitution requires limitations on rights to be introduced by statute and be proportionate to their goal, yet the government introduced severe restrictions on rights on the basis of new statutory provisions that are worded in vague and very general terms, and which the restrictions are said to exceed.

In the context of enforcement of restrictive measures, a number of bodies, including the Fundamental Rights Agency, raised issues as regards human rights compliance, and the rule of law¹⁵³. Civil society organisations and the media raised issues as to enforcement of restrictive measures in France, calling on them to respect the rule of law and criticising the use of force and abusive behaviour in checks¹⁵⁴. In Cyprus, concerns were raised that restrictive measures were enforced with discrimination against refugees, migrants, people with intellectual disabilities, and children¹⁵⁵, who would not have been able to understand rules in place. Inconsistent application of rules (particularly if it is not seen to apply to those in power), arbitrary and unjustified imposition of fines, and going beyond the limits of the law undermines Member State response. Relatedly, a number of EU Member States introduced criminal or

¹⁴⁹ Keaten, J., and Cheng, M., 'WHO Chief Slams 'Mixed Messages' From Leaders on Coronavirus' (*Time Magazine*, 13 July 2020), <https://time.com/5866524/world-health-organization-mixed-messages-coronavirus>.

¹⁵⁰ Knight, D., 'Lockdown Bubbles through Layers of Law, Discretion and Nudges – New Zealand' (*Verfassungsblog*, 7 April 2020), <https://verfassungsblog.de/covid-19-in-new-zealand-lockdown-bubbles-through-layers-of-law-discretion-and-nudges>, DOI: <https://doi.org/10.17176/20200407-153019-0>.

¹⁵¹ Kristjánsson, H.D., 'Iceland's Rule of Common Sense ... and Law?' (*Verfassungsblog*, 20 April 2020), <https://verfassungsblog.de/icelands-rule-of-common-sense-and-law>, DOI: <https://doi.org/10.17176/20200420-182624-0>.

¹⁵² Bennhold, K., 'With Broad, Random Tests for Antibodies, Germany Seek Path Out of Lockdown' (*New York Times*, 20 April 2020), www.nytimes.com/2020/04/18/world/europe/with-broad-random-tests-for-antibodies-germany-seeks-path-out-of-lockdown.html.

¹⁵³ 'Coronavirus Pandemic in the EU -Fundamental Rights Implications: With a Focus on Contact-Tracing Apps' (*Europa.eu*), https://fra.europa.eu/sites/default/files/fra_uploads/fra-2020-coronavirus-pandemic-eu-bulletin-may_en.pdf, accessed 1 November 2022.

¹⁵⁴ France, NGOs Joint press release, 'Pour un respect de l'Etat de droit en matière de verbalisations/amendes' (France, Paris Observatory of Public Liberties 10 April 2020), Usage de la force, placement en garde à vue, fouilles, et nouveau délit lié au non respect du confinement, 10 April 2020 ; and France, NGOs joint press release (2020), Mesures de confinement : les contrôles de police ne doivent être ni abusifs ni violents ni discriminatoires, 27 March 2020.

¹⁵⁵ As in Cyprus: Demetriou, M.(2020), Πλήρης αδιαφορία για μετανάστες στην Κύπρο εν μέσω κρίσης του κορωνοϊού, 24Hours, 5 April 2020; Perdios, T. (2020), Επέβαλαν πρόστιμο 300 ευρώ σε άτομο με νοητική αναπηρία!, Dialogos, 31 March 2020.

administrative penalties for breach of restrictive measures which were disproportionate to the offence, for example large fines (e.g. Romania)¹⁵⁶ and extended prison sentences (e.g. Hungary)¹⁵⁷. Some sanctions are not criminal, and so avoid procedural protections which exist in the criminal law: for example, Poland has introduced disproportionate administrative fines for breach of lockdown orders¹⁵⁸.

There was evidence of the targeted policing and disproportionately penalising of minority groups including migrant communities, and indigenous peoples, and particularly racialized individuals: these groups have been subjected in some instances to violence, discriminatory identity checks, forced quarantines and fines¹⁵⁹.

Measures restricting rights of a type that is not foreseen for that purpose have been introduced. For example, in Spain, the government relied on a legal provision allowing limitations on freedom of movement to impose an almost total ban on public presence, despite there being an alternative framework that would have more clearly permitted a total ban. France initially responded to the pandemic using ordinary law but then introduced a new 'state of health emergency' law, despite the fact that emergency powers regimes already existed (including a 1955 law that was applied during the 2015-2017 state of emergency). In Hungary, the government introduced policy changes under emergency provisions that removed crucial sources of funding for local governments, a move that was identified as a covert attempt to challenge opposition-led municipalities¹⁶⁰. In Poland, attempts were made to pass unrelated bills criminalising abortion and banning sex education through emergency measures¹⁶¹.

The challenges of delegated authority can also create challenges between different levels of government and the rule of law. In the Netherlands, the Public Health Act 2008 and the Act on Security Regions 2010 provided the legal basis for the adoption of containment measures. The former Act awarded the health Minister a central role in the control of the pandemic, while the latter Act awarded the security regions were responsible for the actual implementation and enforcement of anti-coronavirus measures. Indecisiveness and lack of coordination at national or federal level, or institutional incapacity to support the coordination of policies and information flow across sub-national states or regions, caused significant uncertainty as to the applicable rules and their enforcement during the pandemic (for example, as in Germany¹⁶²). Local leaders sometimes had to assume control without the benefit of any centralised or coordinated measures.

¹⁵⁶ Selejan-Gutan, B.: 'Romania in the Covid Era: Between Corona Crisis and Constitutional Crisis' (*Verfassungsblog*, 21 May 2020), <https://verfassungsblog.de/romania-in-the-covid-era-between-corona-crisis-and-constitutional-crisis>, DOI: <https://doi.org/10.17176/20200521-133211-0>.

¹⁵⁷ European Federation of Journalist, 'COVID-19: journalists threatened with imprisonment in Hungary' (23 March 2020), <https://europeanjournalists.org/blog/2020/03/23/covid-19-journalists-threatened-with-imprisonment-in-hungary>.

¹⁵⁸ Jaraczewski, J., 'An Emergency By Any Other Name? Measures Against the COVID-19 Pandemic in Poland' (*Verfassungsblog*, 24 April 2020), <https://verfassungsblog.de/an-emergency-by-any-other-name-measures-against-the-covid-19-pandemic-in-poland>, DOI: <https://doi.org/10.17176/20200424-165029-0>.

¹⁵⁹ Amnesty International, 'Europe: Policing the pandemic: Human rights violations in the enforcement of COVID-19 measures in Europe' (24 June 2020), www.amnesty.org/en/documents/eur01/2511/2020/en.

¹⁶⁰ Hopkins, V., 'Hungary's Viktor Orban Comes under Fire for Coronavirus Response' (*Financial Times*, 19 May 2020), www.ft.com/content/9c107c3b-1ca9-4246-bb68-8ff64b111e91.

¹⁶¹ Euronews, 'Polish MPs vote to delay controversial abortion and sex education bills' (*Euronews*, 16 April 2020), www.euronews.com/2020/04/16/polish-mps-vote-to-delay-controversial-abortion-and-sex-education-bills.

¹⁶² See Mangold, A. K., 'Germany and COVID-19: Expertise and Public Political Deliberation' in Grogan and Donald (eds) (n 6).

While many of the restrictive measures adopted in response to pandemic by Member States appear to be legitimate - restricting rights only in so far as was necessary, proportionate and in a temporary manner - some do not appear to be justifiable. Measures which are disproportionate in scope or duration, or which have systematically undermined democratic processes including parliamentary scrutiny, judicial review, privacy, freedom of speech and media freedom, cannot be justified on the basis of response to the pandemic¹⁶³. Proportionality should and must be a guiding principle on the limitation of rights. For example, in Estonia¹⁶⁴ and Latvia¹⁶⁵ derogations have taken place in relation to Article 8 ECHR in relation to location tracking to control the pandemic, which it has been argued was not necessary, as it is argued that indiscriminate location tracking is not strictly necessary, and less intrusive alternatives exist¹⁶⁶.

3.6. The separation of powers, and checks and balances,

3.6.1. Parliamentary scrutiny

Pandemic governance presents a democratic challenge¹⁶⁷, as measures commonly curtail fundamental rights, which can only be restricted under justified circumstances. The urgency of response conflicts with the principles of separation and powers and rule of law where it can bypass ordinary processes and centralise discretionary power in the executive. The pressure to respond quickly to the virus meant that effective parliamentary scrutiny in the form of debate was negligible in some states. However, democratic resilience could be linked with a more effective response to a public health emergency: one study has argued that the robustness of deliberative decision-making processes was the only specific feature of democratic governance found to be associated with fewer excess deaths¹⁶⁸.

In terms of the design of emergency provisions, and as outlined above, the degree of parliamentary involvement can vary significantly across states. For example, parliamentary approval was required to be involved with the declaration or extension a state of emergency in all Member States that declared one, with the exception of Estonia and Slovakia. Parliament had to either declare (Bulgaria) or approve the declaration (Finland, Portugal, Romania, Czechia) or authorise (all already listed in addition to Hungary). The Constitution of Latvia strictly prescribes that Parliament retain legislative functions during a state of emergency, and the functioning of the Parliament as one of the constitutional bodies was vital under all circumstances and its effectiveness a priority¹⁶⁹.

Pandemic-era ordinary legislation can provide a bespoke response to the crisis, and fill gaps in legal powers where they were required but did not previously exist. However, legislation introduced in the

¹⁶³ As in Hungary, see Kovács, K., 'The COVID-19 Pandemic: A Pretext for Expanding Power in Hungary' in Grogan, J. and Donald, A., (eds) *The Routledge Handbook on Law and the COVID-19 Pandemic* (Routledge 2022).

¹⁶⁴ Maruste, R., 'State of Emergency in Estonia' (*Verfassungsblog*, 17 May 2020), <https://verfassungsblog.de/state-of-emergency-in-estonia>, DOI: <https://doi.org/10.17176/20200517-133139-0>.

¹⁶⁵ Dimitrovs, A., 'COVID-19 in Latvia: Precaution Above All' (*Verfassungsblog*, 2 May 2020), <https://verfassungsblog.de/covid-19-in-latvia-precaution-above-all>, DOI: <https://doi.org/10.17176/20200502-133227-0>.

¹⁶⁶ Siatitsa, I., and Kouvakas, I., 'Indiscriminate Covid-19 location tracking (Part II): Can pandemic-related derogations be an opportunity to circumvent Strasbourg's scrutiny?' (*Strasbourg Observers*, 5 May 2020), <https://strasbourgobservers.com/2020/05/05/indiscriminate-covid-19-location-tracking-part-ii-can-pandemic-related-derogations-be-an-opportunity-to-circumvent-strasbourgs-scrutiny>.

¹⁶⁷ Engler and others (n 24).

¹⁶⁸ Jain V, Clarke J and Beaney T, 'Association between Democratic Governance and Excess Mortality during the COVID-19 Pandemic: An Observational Study' (2022) 76 *Journal of epidemiology and community health* 853, <https://jech.bmj.com/content/76/10/853>, accessed 1 November 2022.

¹⁶⁹ Rodina et Inese, A./Libina, E. (2020). The Parliament in the time of Coronavirus. Latvia. The Latvian Parliament and the COVID-19 pandemic. E-Saeima, one of the first parliaments in the world ready to work in fully remote mode. Robert Schuman Foundation. 2020.

haste that an emergency provokes can often have legal deficiencies including vague and open-ended terms providing for the wide delegation of discretionary powers, and a lack of parliamentary oversight, especially in its application. Reliance on ordinary legislation is no obvious antidote to the overuse of emergency powers and legislation. While many such acts have sunset clauses (providing a date at which the act will expire without extension, typically by legislatures), where such acts make permanent changes to other laws or are themselves made permanent, this can introduce a form of ‘emergency creep’, infecting governance beyond the immediate pandemic crisis.

In many instances, however, safeguards were absent from legislation enacted in response to the pandemic and allowed virtually unconstrained discretion. Significant deference to government decision-making in the form of broad, discretionary, vague and open-ended provisions in COVID-19 legislation, often adopted in haste, allowed executives to take significant action with limited parliamentary scrutiny – both at the point of drafting¹⁷⁰ and of implementation and application¹⁷¹. In Germany, the initial legislative response by the *Bundestag* in March 2020 was to give the federal health ministry powers to announce COVID-19 measures by decree without set time limits (ostensibly contrary to the requirement of German constitutional law); these required explicit repeal by the Federal Parliament to end, rather than automatically expiring¹⁷². This was remedied a year later in March 2021, with the introduction of a sunset clause. In Poland, concerns were raised about the use of secondary legislation, in the form of governmental decrees that limit human rights and fundamental freedoms, which is not permitted under the Constitution, since such restrictions should be introduced by the parliament, and not by the government¹⁷³.

Wider political factors can play into whether or not there is effective capacity for the review of COVID-19 measures and their underlying legal basis. For example, in Hungary, the supermajority that Prime Minister Viktor Orbán’s party holds in the Hungarian parliament has effectively negated meaningful review of government decrees¹⁷⁴.

Social-distancing measures inevitably impacted the initial capacity of parliaments to meet and had the effect of limiting or removing their capacity to conduct oversight. Limiting the possibility for (executive) misuse of powers during an emergency is a particular challenge for courts and legislatures, but this is precisely where the rule of law operates as a safeguard and should inform responses to an emergency. The function of both legislatures and the judiciary is to provide scrutiny and oversight of the practice of governments, particularly where they may severely, and over a long period, curtail the rights and liberties of citizens and residents, in order to hold executives to account and prevent the misuse of powers. Globally, the pandemic led to the marginalisation of parliaments¹⁷⁵. At EU level, participation of EU Member States’ national parliaments in the management of the first wave of the pandemic has differed widely, depending on the constitutional and legal arrangements used to contain the spread

¹⁷⁰ Grogan, J., ‘(Un)Governing: The COVID-19 Response in the UK’ in Grogan, J. and Donald, A., (eds) *The Routledge Handbook on Law and the COVID-19 Pandemic* (Routledge 2022).

¹⁷¹ Kovács, K., ‘The COVID-19 Pandemic: A Pretext for Expanding Power in Hungary’ in Grogan, J. and Donald, A., (eds) *The Routledge Handbook on Law and the COVID-19 Pandemic* (Routledge 2022).

¹⁷² Mangold, A. K., ‘Germany and COVID-19: Expertise and Public Political Deliberation’ in Grogan, J. and Donald, A., (eds) *The Routledge Handbook on Law and the COVID-19 Pandemic* (Routledge 2022).

¹⁷³ Jaraczewski, J., ‘The New Normal? – Emergency Measures in Response to the Second COVID-19 Wave in Poland’ (*Verfassungsblog*, 24 March 2021) <https://verfassungsblog.de/the-new-normal-emergency-measures-in-response-to-the-second-covid-19-wave-in-poland/>.

¹⁷⁴ Kovács (n 172).

¹⁷⁵ See e.g. Tom Ginsburg and Mila Versteeg, ‘Binding the Unbound Executive: Checks and Balances in Times of Pandemic’ (2020) Virginia Public Law and Legal Theory Research Paper 2020-52 and (2020) University of Chicago Public Law Working Paper 747.

of COVID-19 and the extent to which they provided for some kind of parliamentary participation or oversight over the measures adopted¹⁷⁶.

A survey of EU Member States during the second wave (Winter 2020/2021), highlighted ongoing concerns with parliamentary oversight¹⁷⁷. Despite the fact that 25 of the national parliaments (except for Belgium and Bulgaria) were fully operational during the surveyed period, there was still a common concern about the lack of legislative review identified across the EU. Less than half of the EU's countries established specialised parliamentary committees published reports or regularly scheduled debates on COVID-19 measures, and in less than one-third were measures identified as having either been scrutinised (e.g., through a debate or vote in parliament) or amended by parliaments. Only the Austrian, Czech, Estonian, and German parliaments were identified as having brought significant levels of scrutiny to COVID-19 measures that severely restrict human rights. Deference to government decisions during an emergency may play a role in this, as in Cyprus, where executive reliance on pre-independence legislation has concentrated power within the government, to the exclusion of both parliamentary law-making and oversight. The parliament has exercised no substantive scrutiny or oversight of government measures¹⁷⁸.

There has also been significant criticism in Sweden for the lack of legislative oversight of the failure of government strategy (or the lack of strategy) to protect the country's elderly population. As noted at section 3.4, the Swedish response has been built on recommendations (rather than regulations) and the decisions of semi-autonomous administrative agencies, which has raised questions of electoral accountability for measures adopted. Even as late as March 2021, in Ireland¹⁷⁹ and Slovenia¹⁸⁰, where provisions for scrutiny by the legislatures do exist – for example, in the forms of debate, parliamentary questions or inquiries – these had not been used.

In Italy, where the legislative process was 'sped up' for some decree-laws, which have often passed in days, or even hours, with little or no scrutiny, efforts to improve parliament's access to evidence from advisory bodies might have improved the quality of scrutiny. Governing parties' majorities have allowed them, in the case of Hungary, to have their parliaments effectively rubber-stamp the actions of the government or, in the case of Poland, to limit the scope of oversight and influence of the opposition. By contrast, the parliament in Lithuania has increased scrutiny of COVID-19 measures, and particularly those related to economic matters and the use of EU funds in fighting the pandemic. In Romania, the Parliament has both reviewed and adopted new legislation in response to the pandemic, in addition to exercising its control function over the declaration of a state of emergency.

During the pandemic, there was also evidence of democratic innovation; for example, the *e-Saeimawas* system in Latvia, which allowed for real-time voting and engagement of parliamentarians. As the Constitution of Latvia strictly prescribes that the Parliament retains the legislative function in the state of emergency, the functioning of the Parliament as one of the constitutional bodies was vital under all

¹⁷⁶ Diaz and Kotanidis (n 95).

¹⁷⁷ Grogan (n 128).

¹⁷⁸ Kombos, C., Constitutional Improvisation and Executive Omnipotence: the Cypriot Handling of the Pandemic, *VerfBlog*, 2021/3/02, <https://verfassungsblog.de/constitutional-improvisation-and-executive-omnipotence-the-cypriot-handling-of-the-pandemic/>, DOI: 10.17176/20210302-154130-0.

¹⁷⁹ Doyle, O., Pandemic Response as Accentuation of Existing Characteristics: Vague Requirements and Executive Dominance in Ireland, *VerfBlog*, 2021/3/17, <https://verfassungsblog.de/pandemic-response-as-accentuation-of-existing-characteristics-vague-requirements-and-executive-dominance-in-ireland/>, DOI: 10.17176/20210317-154047-0.

¹⁸⁰ Bardutzky, Samo; Zagorc, Saša: Slovenia: Second Wave of Challenges to Constitutionalism, *VerfBlog*, 2021/3/19, <https://verfassungsblog.de/slovenia-second-wave-of-challenges-to-constitutionalism/>, DOI: 10.17176/20210319-151656-0.

circumstances and its effectiveness a priority¹⁸¹. Spain adopted a proportional limit on the number of attendees, while adjustments were made to rules of procedure in Germany by temporary amendment to the rules for the minimum quorum, and in Belgium, by allowing members of parliament to be considered 'present' under certain conditions, and to vote even when not physically there, in order to adapt to social distancing rules.

Other good practice principles were also evident, and could and should be implemented in future pandemics or other emergencies: for example, Finland's standing practice of requiring real-time constitutional and parliamentary scrutiny of government regulations as both constitutional requirements and mandated under the Emergency Powers Act¹⁸². The Constitutional Law Committee of the Finnish Parliament exercises continuous scrutiny over both the constitutionality and human rights compliance of legislative bills and government regulations.

Even where there is limited time for parliamentary debate, good practices worldwide can still be emulated. These include standing committees in Finland¹⁸³ and the Health Committee in Spain. Specially constituted committees can also serve an important function in focusing attention on extraordinary action during emergency, as for example in Denmark¹⁸⁴. Open calls for evidence and online publication of materials relating to both decision-making and rationale for government action can provide an important layer of transparency to decision-making during a pandemic, which is an important element for public trust and compliance. The possibility of engaging with a wide variety of expertise was evident in Sweden, which established a Commission of Inquiry constituted of independent experts, reviewing actions taken across central, regional and local governmental levels, and constituted a cross-party parliamentary commission to review the actions of Parliament during the pandemic¹⁸⁵.

For international lessons, in Singapore, all control orders had to be presented to Parliament 'as soon as possible', and they could be annulled by the passing of a resolution; similarly, any extension of powers had to be made by Parliament, not the minister for health¹⁸⁶. The collective approach of New Zealand may also prove exemplary in how to ensure accountability across the arenas of democratic, constitutional and 'learning' (that is, 'continuous improvement') accountability during a pandemic¹⁸⁷.

Ultimately, 'new' technological solutions can go hand in hand with long-standing practices to ensure parliamentary oversight during emergencies: establishing specialised parliamentary committees and inquiries and requiring mandated and regular reporting to substantiate official claims, and the evaluation the impact of law and policy with remote and digital access, are lessons from the COVID-19 pandemic.

¹⁸¹ Rodina et Inese, A./Libina, E. (2020). The Parliament in the time of Coronavirus. Latvia. The Latvian Parliament and the COVID-19 pandemic. E-Saeima, one of the first parliaments in the world ready to work in fully remote mode. Robert Schuman Foundation. 2020.

¹⁸² Scheinin, M., 'Finland's Success in Combatting COVID-19: Mastery, Miracle or Mirage?' in Grogan and Donald (eds) (n 6).

¹⁸³ *ibid.*

¹⁸⁴ Laut (n 130).

¹⁸⁵ Cameron and Cornell (n 139).

¹⁸⁶ Chua, S., and Neo, J., 'Democracy in the Time of COVID-19: Pandemic Management, Public Trust and Democratic Consolidation in Singapore' in Grogan, J. and Donald, A., (eds) *The Routledge Handbook on Law and the COVID-19 Pandemic* (Routledge 2022).

¹⁸⁷ Knight, D. R., 'Accountability through Dialogue: New Zealand's Experience during the First Year of the COVID-19 Pandemic' in Grogan, J. and Donald, A., (eds) *The Routledge Handbook on Law and the COVID-19 Pandemic* (Routledge 2022).

3.6.2. Judicial oversight

Courts play a pivotal role in ensuring the accountability of government during an emergency. However, as with parliaments, in many instances courts had limited capacity to exercise oversight over actions taken during the pandemic.

As the Venice Commission has highlighted, judicial review tends to be of a more limited degree in emergency conditions due to judicial self-restraint, especially in the context of assessing any derogation from human rights instruments¹⁸⁸. In practice, there was wide variation globally in the intensity and scope of judicial review of the compliance of new laws and their implementation with rule of law safeguards. In France, an expert argued that the *Conseil d'Etat* notably downgraded the standard of its scrutiny to a corresponding minimal control, and did not evidence significant ex-ante review of executive measures¹⁸⁹. However, even where there is competence to review government actions, accountability through judicial review can be negated by excessive deference or the lack of judicial independence; for instance, in Hungary, where judicial scrutiny of the emergency measures was de facto missing, as the Constitutional Court has been captured by the political allies of Prime Minister Viktor Orbán and lacks independence and impartiality¹⁹⁰.

Deference to decision-making in the context of pandemic can, however, be a challenging aspect to consider within the context of accountability, since there can be good reasoning behind deference to political judgement or medical or scientific expertise. A point of difficulty exposed by the pandemic is where the line of judicial oversight begins, and scientific expertise ends. A lack of coherence in government strategy (particularly where there is inconsistency or contradiction between federal and sub-state responses) can bring the judicial branch in for adjudication, calling up officials' testimony as a means of scrutinising the government response.

More concerning still, some courts – such as in Cyprus, Czechia, and Hungary - have denied that they have any jurisdiction over COVID-19 measures, thus abdicating their roles as essential safeguards against governmental overreach. Elsewhere, the intensity of judicial scrutiny has varied over time. In Slovenia¹⁹¹, the Constitutional Court has so far limited its review to formal legality and constitutionality requirements, rather than focusing on substance, and has applied only weakened proportionality tests in reviewing measures. In part due to a heavy workload, court decisions were also issued after the measure in question had already been changed or revoked by the government. By contrast, in Slovakia, the Constitutional Court has often provided effective and swift review of the constitutionality of emergency measures, particularly where parliamentary scrutiny was lacking¹⁹².

Even where jurisdiction for either the substantive and/or procedural review of emergency measures exists, some courts have been marked in their deference towards the government's decisions during pandemic. In one interpretation, this can reflect the 'political question' doctrine, which acknowledges that the democratic legitimacy of action comes from both government and parliament, not the courts.

¹⁸⁸ CDL-AD(2020)018-e VC interim report, at 7.

¹⁸⁹ Basilien-Gainche, Marie-Laure: French Response to COVID-19 Crisis: Rolling into the Deep*, VerfBlog, 2021/3/18, <https://verfassungsblog.de/french-response-to-covid-19-crisis-rolling-into-the-deep/>, DOI: 10.17176/20210318-154150-0.

¹⁹⁰ Kriszta Kovács 'Hungary and the Pandemic: A Pretext for Expanding Power' (*Verfassungsblog*, 11 March 2021), <https://verfassungsblog.de/hungary-and-the-pandemic-a-pretext-for-expanding-power/>.

¹⁹¹ Bardutzky, Samo; Zagorc, Saša: Slovenia: Second Wave of Challenges to Constitutionalism, VerfBlog, 2021/3/19, <https://verfassungsblog.de/slovenia-second-wave-of-challenges-to-constitutionalism/>, DOI: 10.17176/20210319-151656-0.

¹⁹² Steuer, Max: Slovakia's Democracy and the COVID-19 Pandemic: When Executive Communication Fails, VerfBlog, 2021/3/09, <https://verfassungsblog.de/slovakias-democracy-and-the-covid-19-pandemic-when-executive-communication-fails/>, DOI: 10.17176/20210309-153913-0.

Alternatively, it may acknowledge the lack of expertise in science and understanding epidemiological evidence. Nevertheless, the courts can play an essential role in ensuring the publication of evidence and of the rationale underlying decision-making.

In Denmark, concern arose over the separation of powers, where it was uncertain whether the courts had reduced their activity of their own accord or as a result of a government order. The government did make a recommendation to the parliament that it reduce its activity, but this was rejected¹⁹³. In Poland, ongoing concerns regarding the independence of the judiciary, including over continued efforts by the government and the ruling party to gain greater control over the courts, cast doubt on the courts' ability to effectively review government measures. Lower-level courts have, however, ruled against some measures and struck down punishments/fines on a number of occasions, citing a lack of adequate legal basis, although this may be more the exception than the rule. In Hungary, only the Constitutional Court is empowered to review laws and government decrees. The Court has not ruled any government decrees as unconstitutional, and its lack of independence makes it unlikely it will do so in the foreseeable future¹⁹⁴.

Decisions by higher national courts have raised concern even where their independence is not under question. One such decision, by the Constitutional Court in Bulgaria, all but eliminated the possibility of judicial and parliamentary review of COVID-19-related measures taken under the hastily adopted amendments to the Law on Health. The amendments created a new state of 'extraordinary epidemiological conditions' that served as the basis for government action. In their dissenting opinions, three judges argued that these amendments were uncertain in meaning and undermined the separation of powers and the rule of law. They described the Law on Health as a disguised 'state of emergency', which should properly be declared by the Bulgarian parliament, and not by the government. However, the Bulgarian Constitutional Court in its Decision 15 of 17 November 2020 declared that amendments to the Law on Electronic Communication were unconstitutional: the amendments had allowed authorities 'immediate access' to traffic data of users, without judicial oversight.

It is clear that the role of constitutional courts, in particular, in the system of checks and balances is essential. In France, the Constitutional Court defined the limits of the executive and legislative powers during the health emergency regime, and in Germany, Spain and Italy, the Constitutional Courts exercised constitutional review on the emergency measures adopted in response to the COVID-19 pandemic. In Austria, the Constitutional Court heightened its review of COVID-19 regulations, requiring legality and legal certainty and for the Ministry of Health to have provided the necessary justification¹⁹⁵. However, the time taken to review means that Courts means that the impact of decisions is not immediate.

Beyond the question of the review of COVID-19 measures, the pandemic has had broader impact on access to justice. In some states, limitations on gatherings restricted access to the courts. In the first phase of the pandemic, courts were temporarily closed (e.g., Bulgaria) and/or access was limited to extremely urgent or critical cases (e.g. Denmark). A positive development across the world was the

¹⁹³ Lauts (n 130).

¹⁹⁴ Kovács (n 172).

¹⁹⁵ Lachmayer, K., 'Muddling through Mutation Times or the Return of Federalism in Austria: From Covid-19 Response to the Vaccination Campaign' (Verfassungsblog, 8 May 2021), <https://verfassungsblog.de/muddling-through-mutation-times-or-the-return-of-federalism-in-austria/>.

efforts to introduce and support remote hearings and written submissions to continue the functions of the court while restrictive measures were in place.

The extent to which judges were able to operate in person, virtually or not at all during the pandemic largely depended on the particular state's response to COVID-19 and whether the legislative framework provided for remote hearings while ensuring fair trial standards. For some, the balance was not found justified: in France, the *Conseil Constitutionnel* declared unconstitutional provisions allowing videoconferencing in criminal and juvenile courts without the defendant's agreement, and provisions allowing for the extension (and without provision to challenge) of pre-trial detention without judicial sanction¹⁹⁶.

However, EU Member States also led best practices. In Estonia¹⁹⁷ and Hungary¹⁹⁸, the justice systems proved resilient against pandemic conditions because the systems were already digitally advanced. However, such processes and technologies require investment: the EU Commission 2021 Rule of Law Report highlighted issues with investment and funding of justice systems in Malta, Belgium, Italy, Greece, Portugal and Cyprus, which faced substantial efficiency challenges exacerbated by the pandemic¹⁹⁹. In the 2022 report²⁰⁰, concerns were continued in the context of Belgium, Bulgaria and Malta. Italy had made progress towards the digitalisation of civil courts, though was still limited in criminal proceedings²⁰¹.

A shift towards digital solutions in response to the challenges facing the justice sector during the pandemic also raises questions as to infrastructure and equal digital access, as well as the more fundamental issue of whether these solutions are fully compatible with Convention rights, including its fair trial guarantees. The limited access of many populations to an adequate and secure internet connection, in addition to the technological literacy which would be necessary to enable remote hearings. This inevitably led to a negative impact on the resolution of disputes for poor and marginalised communities, as well as compounding the severity of the economic consequences for those involved²⁰². This can require conscious effort to ensure access, for example, in Finland, the National Court Administration provided guidance and technical help for virtual and remote judicial proceedings²⁰³.

¹⁹⁶ *Conseil Constitutionnel*, Decision n°2020/872 QPC, 15 January 2021; and *Conseil Constitutionnel*, Decision n°2020-878/879 QPC, 29 January 2021.

¹⁹⁷ COMMISSION STAFF WORKING DOCUMENT 2021 Rule of Law Report Country Chapter on the rule of law situation in Estonia Accompanying the Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions 2021 Rule of Law Report The rule of law situation in the European Union SWD/2021/708 final.

¹⁹⁸ COMMISSION STAFF WORKING DOCUMENT 2021 Rule of Law Report Country Chapter on the rule of law situation in Hungary Accompanying the Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions 2021 Rule of Law Report The rule of law situation in the European Union SWD/2021/714 final.

¹⁹⁹ Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions 2021 Rule of Law Report The rule of law situation in the European Union COM/2021/700 final.

²⁰⁰ Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions 2022 Rule of Law Report The rule of law situation in the European Union COM/2022/500 final.

²⁰¹ *ibid.*

²⁰² 'A World Justice Project Initiative on Rebuilding Healthy Societies' ([Worldjusticeproject.org](https://worldjusticeproject.org/sites/default/files/documents/Twin-Cities-Introduction.pdf)), <https://worldjusticeproject.org/sites/default/files/documents/Twin-Cities-Introduction.pdf>, accessed November 1, 2022.

²⁰³ Commission Staff Working Document 2021 Rule of Law Report Country Chapter on the rule of law situation in Finland Accompanying the Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions 2021 Rule of Law Report The rule of law situation in the European Union SWD/2021/711 final.

The pandemic incentivised investment in projects to start digitalising the justice systems in Sweden, the Netherlands, Latvia, Portugal, Estonia, Denmark, Austria, Romania, Slovenia, Spain and Finland. This includes, for example, automatic transcription of recorded audio in hearings in Spain; an online database of judgments in Denmark, and the creation of a digital criminal office, including a point of access for applications and requests for legal aid, in France²⁰⁴. Such digitalisation was a priority under the European Commission's Recovery and Resilience Facility, and was included in a number of national Recovery and Resilience Plans.

At international level, between March 2020 and 30 April 2022, the European Court of Human Rights (ECtHR) processed 373 applications for interim measures to prevent irreparable harm related to the COVID-19 pandemic. The vast majority of requests were brought by individuals detained in prisons, or in reception and/or detention centres for asylum seekers and migrants. The applicants mainly relied on Articles 2 (right to life) and 3 (prohibition of torture and inhuman or degrading treatment) of the Convention and requested the Court to take interim measures to remove them from their place of detention and/or to indicate measures to protect their health from the risk of being infected with COVID-19. Many were rejected, but in some cases, Rule 39 was applied in line with the usual criteria, in the case of very vulnerable persons (unaccompanied minors or persons with serious medical conditions, pregnant women, in particular)²⁰⁵.

Ultimately, without effective review scrutiny, legal safeguards on the use of emergency powers are ineffective and rights guaranteed through constitutional and international human rights instruments are unprotectable. However, and echoing those concerns identified in the context of parliamentary scrutiny, the problems of effective judicial oversight relate not only to the legal questions of jurisdiction, but also to the practice of (often) self-imposed deference and—critically—the level of judicial institutional independence.

²⁰⁴ Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions 2021 Rule of Law Report The rule of law situation in the European Union COM/2021/700 final.

²⁰⁵ See the European Court of Human Rights' updated list: https://www.echr.coe.int/documents/fs_interim_measures_eng.pdf, accessed 10 November 2022.

4. COVID-19 RESTRICTIVE MEASURES

KEY FINDINGS

Non-pharmaceutical interventions such as washing hands, wearing masks, socially distancing and ensuring good ventilation, can help to limit the spread of infectious disease. Public health awareness, and a shift in personal and organisational behaviour to adopt protective measures including regular testing, distancing, hand hygiene and improved ventilation, reduce the need for strict bans and closures

Restrictive measures are the first tool available to Member States to slow the spread of an infectious disease; however, they inevitably have significant negative social and economic costs, particularly for the most vulnerable groups in society, and by their nature have significant implications for fundamental rights.

The guiding principles should be the least restrictive measures, ensuring that they are necessary and proportionate to the need to protect public health. Those subject to restrictions should also receive support, which in the context of a pandemic, includes economic and social support.

The rights to life, health and other freedoms are indivisible and interdependent, and should be balanced, especially in the heat of pandemic decision making, using the well-tested framework of legality, necessity and proportionality provided by international human rights treaties and national laws and constitutions.

Studies of the efficacy of restrictive measures are still uncertain, but early findings suggest that precisely targeted and well-timed interventions can avoid the necessity of introducing more severe and restrictive measures if a pandemic situation escalates.

This chapter provides an overview of the measures adopted by Member States, their adaption of time, and the degree to which States adapted their practices in response to their own, and other states' experiences. It first outlines non-pharmaceutical interventions which can help slow or limit the spread of an infectious disease, before focusing on the sub-set of restrictive measures within them (section 4.1). It considers the primary restrictive measures adopted by Member States, and examines their respective impact on democracy, the rule of law and fundamental rights (section 4.2). While acknowledging the limited nature of viable conclusions within the field, this report also briefly reports on the current state of the scientific debates on the matter of the efficacy of the various policies and measures adopted (section 4.3). It concludes on a short discussion of key findings and recommendations within the context of restrictive measures (section 4.4).

4.1. Measures to limit or slow infectious disease

Non-pharmaceutical interventions (NPIs) are actions, other than vaccination or medication, that individual can take which can help limit or slow the spread of an infectious disease. Before vaccination is widely accessible and available, or effective diagnosis or therapy a virus is identified, NPIs are the most effective means at slowing transmission. NPIs cover a broad range of actions, for example handwashing and social distancing are effective means of slowing airborne pathogens.

In the context of the COVID-19 pandemic, restrictive measures are a form of non-pharmaceutical intervention (NPI). They are distinguished from other NPIs by having the force of law, often with civil or criminal penalties for non-compliance, and restricting, prohibiting or requiring certain behaviours which are intended to slow or stop the spread of the virus. Restrictive measures have varied in legal

form within Member States²⁰⁶. However, the most common restrictive measures among EU Member States and also adopted by countries globally are:

- facial coverings and mask mandates;
- quarantine of those infected, or suspected of infection;
- isolation of high risk groups;
- restrictions on gatherings and assemblies;
- closure of schools, and non-essential workplaces;
- stay-at-home orders or lockdowns; and
- border closures or international travel controls.

Countries implemented their own combinations of restrictive measures over the course of the COVID-19 pandemic. Decision-making on the introduction, lifting, or reintroduction of restrictive measures has been complex. Most restrictive measures have a negative impact on the general well-being of people, the functioning of society, and the economy²⁰⁷. Decision-making authorities had to balance the aim to slow rates of transmission and prevent overload of on national healthcare systems, with the negative social and economic impact of restrictive measures.

4.2. Restrictive measures and fundamental rights

4.2.1. Facial coverings and mask mandates

Face masks are intended to reduce the transmission of airborne pathogens. A mask mandate is the legal requirement to wear a mask under certain conditions or locations. The use of face masks has been accepted worldwide as an effective control measure against airborne pathogens²⁰⁸. Universal mask use, including the use of non-medical (cloth) masks, has been shown to be effective in reducing the number of new infections of SARS-CoV-2²⁰⁹, and was one of the first NPIs advised by the WHO²¹⁰.

A mask mandate is the legal requirement to wear a mask under certain conditions or in particular locations. On 13 March 2020, the European Union Aviation Safety Agency (EASA) has issued a safety directive to reduce the risk of spread of the novel coronavirus through flights to and from high-risk areas. This is the first EU-wide operational measure to control the spread of COVID-19 in Europe.

Relative to other restrictive measures, wearing facial coverings has the lowest personal and economic cost. It has been recommended that in future epidemics with airborne pathogens, mandating mask-wearing in almost all, and not just some, public spaces early on will be an attractive strategy, again

²⁰⁶ See section 2 on legal basis for responses to the COVID-19 pandemic.

²⁰⁷ Chakraborty, I. & Maity, P. Covid-19 outbreak: migration, effects on society, global environment and prevention. *Sci. Total Environ.* 728, 138882 (2020); Pfefferbaum, B. & North, C. S. Mental health and the COVID-19 pandemic. *N. Eng. J. Med.* 383, 510–512.

²⁰⁸ Brooks JT, Butler JC. Effectiveness of mask wearing to control community spread of SARS-CoV-2. *JAMA*2021;325:998-9. doi:10.1001/jama.2021.1505 pmid:33566056.

²⁰⁹ Park YJ, Choe YJ, Park O, et al., COVID-19 National Emergency Response Center, Epidemiology and Case Management Team. Contact tracing during coronavirus disease outbreak, South Korea, 2020. *Emerg Infect Dis*2020;26:2465-8. doi:10.3201/eid2610.201315 pmid:32673193; and Mahase E. Covid-19: Are cloth masks still effective? And other questions answered. *BMJ*2021;372:n432. doi:10.1136/bmj.n432 pmid:33589420.

²¹⁰ World Health Organization. Mask use in the context of COVID-19: interim guidance. Dec 2020, <https://apps.who.int/iris/handle/10665/337199>.

given the comparatively low social and economic burden of this intervention²¹¹.

However, apart from a number of Asian countries with prior experience of pandemics caused by airborne pathogens, mask-wearing were not common practice globally prior to the pandemic. Mask-wearing, and in particular mask mandates, became a highly politicised issue both within EU Member States and beyond.

Objections focused on the relatively reduced effectiveness of disposable or cloth masks against COVID-19, and also highlighted issues related to supply²¹². A mask mandate would exclude people unable to afford masks, or to find them where supply was low. This is particularly the case where the mandate relates to the use of higher-grade masks (as for example considered in Austria) which could lead to inequities since masks which are higher-grade (and so more expensive, in less supply) may not be accessible to all. Where *not* wearing a mask attracted a penalty or fine, this could penalise people unable to follow the mandate with less access, or less able to afford PPE. Subsidies would be needed to support lower-income, or vulnerable groups, to avoid such inequity. In this context, the Parliamentary Assembly of the Council of Europe recommended ‘developing production capacity, distribution and considering mandating the use of high-quality masks (progressively moving to masks of FFP2 standard if possible) in high-risk situations (such as on public transport, in crowded spaces inside and outside and in schools); and providing such masks free of charge for vulnerable groups if possible)’²¹³.

Objections to mask wearing also highlighted environmental concerns and the increase in pollution caused by disposable masks (and other disposable PPE). Reusable cloths masks can reduce environmental pollution but are less effective than higher grade masks and must be washed correctly.

A further objection to mask-wearing stemmed from disinformation and misinformation, and the belief the COVID-19 pandemic did not represent a real threat to individuals. A number of public protests throughout the world targeted mask mandates as a violation of personal liberty.

There is no evidence of a successful challenges to mask mandates on the ground of a violation of fundamental or constitutional rights in the EU. In France, the Council of State found that mask mandates can only be applied outdoors when physical distancing is not possible, and it is justified by a high risk of transmission²¹⁴. The Council of Europe has not ruled on rights issues directly related to the requirement to wear a mask²¹⁵, although a case is pending which challenged the application of a mask mandate to public spaces²¹⁶.

4.2.2. Quarantine of infected individuals or those suspected of having infection

States also had powers to quarantine, or isolate, of infected individuals or those suspected of having an infection. Measures introduced include the mandatory quarantine of international travellers,

²¹¹ Sharma M and others, ‘Understanding the Effectiveness of Government Interventions against the Resurgence of COVID-19 in Europe’ (2021) 12 Nature communications 5820, <https://www.nature.com/articles/s41467-021-26013-4>, accessed November 1, 2022.

²¹² Zhang, Y., and others, ‘Non-Pharmaceutical Interventions during the Roll out of Covid-19 Vaccines’ (2021) 375 BMJ (Clinical research ed.) n2314, <https://www.bmj.com/content/375/bmj.n2314>, accessed 1 November 2022.

²¹³ Schennach S, Beating Covid-19 with public health measures, Committee on Social Affairs, Health and Sustainable Development, Council of Europe, Doc. 15444 (25 January 2022).

²¹⁴ Decision no. 460002 of 11 January 2022.

²¹⁵ In *Makovetsky v. Ukraine* (application no. 50824/21) the Court rejected the application as inadmissible. The applicant had challenged administrative proceedings for a refusal to wear a mask under Articles 6 (right to a fair trial) and 7 (no punishment without law). The Court found that process had been followed, and Article 7 was not applicable as there had been no criminal charge.

²¹⁶ *Árus v. Romania* (Application no. 39647/21).

particularly those from high-risk states still permitted to travel. Mandatory quarantine following a positive test was also introduced in a number of states. For some states, for example Austria and Czechia, exemption to quarantine following travel was allowed for those who could produce a negative test.

Quarantine raises a number of issues for fundamental rights, and rule of law. While it is considered less intrusive than lockdown, quarantined individuals are deprived of their liberty and freedom of movement for periods of time which are often not determined by a court. Quarantine is associated with significant negative psychological effects including post-traumatic stress symptoms, with some evidence that effects can last for years beyond quarantine²¹⁷.

The question of proportionality is important in the context of quarantine, particularly with regard to the consequences for non-compliance. For example, in Lithuania, following amendments to the penal code, if an individual with a positive test did not follow quarantine rules, they could face up to a year in prison²¹⁸. Penalties were similarly introduced in Estonia, Latvia and Romania. Where a number of states introduced mandatory hotel quarantines, objections were raised to the cost for the individual, particularly where measures were introduced at short notice.

A number of challenges have been raised on the legality of quarantine orders. In *Feilazoo v Malta*²¹⁹, the ECtHR considered the conditions of the applicant's immigration detention, including a period of time during which he had been placed with newly arrived asylum seekers in COVID-19 quarantine. There was no indication that such quarantine had been necessary for the applicant himself, and so the Court held that placing him for several weeks with other persons who could have posed a risk to his health constituted a breach of Article 3²²⁰.

4.2.3. Isolation of high-risk groups

High risk groups for vulnerability to COVID-19 include older populations above 60, and those with underlying comorbidities such as lung or heart disease, diabetes, or immune deficiencies. During the COVID-19 pandemic, elderly or those who were immunocompromised, disabled, or otherwise vulnerable to the disease were advised to reduce contact, or stay home, while access to nursing and care homes was restricted. Lifting bans in residential facilities was often linked to overall vaccination rates of residents and the requirement for care-workers to be vaccinated.

Isolation protocols can raise similar rights issues as identified above for quarantine strategies. They can cause severe negative social and economic impact on individuals. Without adequate support for isolated populations, including financial and social contact, the negative impact of this was discrimination, job loss, poverty, and loneliness. For example, in Sweden, a concern in terms of family and private life arose over the government-issued ban on visiting elderly care facilities. The ban applied inflexibly over the whole country, even in areas where the spreading of the disease was low, and it was not subject to periodic evaluation. It was later delegated to a public health agency to introduce local

²¹⁷ Brooks SK, Webster RK, Smith LE, et al. The psychological impact of quarantine and how to reduce it: rapid review of the evidence. *Lancet* 2020;395(10227):912–20. doi:10.1016/S0140-6736(20)30460-8 pmid: <http://www.ncbi.nlm.nih.gov/pubmed/32112714>

²¹⁸ Lithuania, Lithuanian Radio and Television (2020), Lithuania makes breaking self-isolation rules a criminal offence, 28 April 2020.

²¹⁹ *Feilazoo v. Malta* (Application no. 6865/19), judgment of 11 March 2021.

²²⁰ A further decision on the quarantine in the context of asylum and reception centres is expected in Applications nos. 50086/20 and 50898/20 E.B. against Serbia and A.A. against Serbia.

bans²²¹. A careful assessment is needed in the balance of rights between vulnerable populations, and the wider rights and interests in response to pandemic conditions. General recommendations for vulnerable populations included enhanced surveillance, comprehensive testing, and intensified infection prevention and control practices in settings that host high-risk individuals, such as long-term care facilities²²².

4.2.4. Restrictions on gatherings and assemblies of people

By restricting the number of people that can meet at any one time, the number of people that can transmit infection to others is reduced. Restrictions can limit the number of people that can gather (for example, limiting gathering above 10, 50 or 100 people), or the place in which they can gather (in a public space such as a park, or in a home or other private setting). Restrictions on gatherings can also mean the cancellation of public events. The higher the level of restriction, the fewer the number of people that may gather at any one time. For example, that no more than two people from different households could meet at any one time.

Limitations on gatherings raise a number of issues from a human rights and democratic perspective. Article 12 EUCFR guarantees the freedom of assembly and association. The ECHR protects the freedom of assembly and association under Article 11 and Article 12 respectively. These rights are not absolute, but limitations must be justified as necessary in a democratic society and proportionate to a legitimate aim. The right of assembly and association is also protected in national law.

A number of concerns have been raised both within the EU and worldwide concerning indiscriminate bans on public protests, but also how the limit on gatherings have affected important aspects of a democratic society including electioneering and trade union activity. Concerns in particular were raised where restrictions on gatherings were lifted for social gatherings, but not for public protest in Ireland and Hungary²²³. Hungary adopted one of the most restrictive approaches to public gatherings as a government decree under emergency powers stipulated that 'all assemblies are forbidden', where assembly indicated 'a public gathering held with at least two persons to express an opinion in a public affair'. It is a general ban, not a time, manner, and place restriction, and it applied regardless of whether the two or more people follow Covid-19 regulations. The decree prohibited gatherings in private spaces, as well as open-air private places if more than ten people are involved. Non-compliance was met with significant financial penalties. Heavily armed soldiers patrolled the streets in Hungarian cities to enforce curfew regulations²²⁴.

Public protest can inform a healthy critical pressure on governments and improve authorities' strategies to manage the health crisis. In some states globally, the COVID-19 pandemic has in some countries added to the demands of protestors and intensified pressure for democratic change²²⁵.

²²¹ Cameron, I., and Jonsson Cornell, A., Dealing with COVID-19 in Sweden: Choosing a Different Path' in Grogan, J. and Donald, A., (eds) *The Routledge Handbook on Law and the COVID-19 Pandemic* (Routledge 2022).

²²² European Centre for Disease Prevention and Control. Guidance on the provision of support for medically and socially vulnerable populations in EU/EEA countries and the United Kingdom during the COVID-19 pandemic, 3 July 2020. Stockholm: ECDC; 2020.

²²³ Narsee A, 'Has the Pandemic Done Lasting Damage to Democratic Freedoms in Europe?' (Carnegie Europe), <https://carnegieeurope.eu/2022/03/24/has-pandemic-done-lasting-damage-to-democratic-freedoms-in-europe-pub-86704>, accessed November 1, 2022.

²²⁴ Kovács, Kriszta: Hungary and the Pandemic: A Pretext for Expanding Power, VerfBlog, 2021/3/11, <https://verfassungsblog.de/hungary-and-the-pandemic-a-pretext-for-expanding-power/>, DOI: 10.17176/20210311-154209-0.

²²⁵ Youngs, R., 'COVID-19 and Democratic Resilience' [2022] Global policy', <http://dx.doi.org/10.1111/1758-5899.13137>.

Balancing the right to public assembly and the ability to protest, with measures aiming to ensure the protection of individuals could be considered challenging.

A number of challenges to rules related to the restriction on public gathers were raised, and guidance from the ECtHR can be provided. The ECtHR case of *Communauté genevoise d'action syndicale (CGAS) v. Switzerland*²²⁶. The Court found a violation in relation to measures introduced by a State aimed at stemming the spread of the virus. While the restrictions had pursued the legitimate aims of protecting health and the rights and freedoms of others, the Court found that they had not been necessary in a democratic society as the measure was a blanket ban, without a particularly strong justification and which remained in place for a significant amount of time.

The court highlighted that the measure was inconsistent with other government policies allowing workplaces to continue to be occupied by hundreds. The severity penalties also were found to create a chilling effect. The Court also highlighted that the quality of parliamentary and judicial review was relevant in assessing the proportionality of the measure. While the context and urgency of the situation may preclude an involvement of Parliament in the adoption of measures – this placed greater expectation on independent and effective judicial review. As no such scrutiny had taken place, this raised additional concerns for the proportionality. A number of further ECtHR cases on under Articles 9 and 11 on freedom of assembly, association and religion in the context of the COVID-19 pandemic are pending²²⁷.

4.2.5. Closure of schools

The closure of schools aims to reduce community transmission. Children, especially young children, are less likely to be able to follow public health guidelines, or social-distancing measures and so more likely to become vectors of transmission to their families.

In the EU, school closures were one of the first and most widespread restrictive measures adopted by Member States and almost all were closed by April 2020, with the exception of some nurseries and schools for the children of essential workers. The closure of schools had severe impact on social, personal and educational welfare of children and their families. Children out of school also can place them at risk of hunger, domestic violence, and increasing inequality between children with access to educational resources and support and those without such support (particularly with disabilities or from low-income, refugee, single-parent and immigrant families)²²⁸. School closure interrupts learning and can lead to poor nutrition, stress and social isolation in children²²⁹. The lack of childcare creates economic and social burdens on working families, while putting children into the care of parents and older relatives also can risk their wellbeing.

Schools operated largely without safety measures before they were closed in the first wave; closing them thus reduced transmission considerably²³⁰. Reactive closures of schools may be necessary as a

²²⁶ *Communauté genevoise d'action syndicale (CGAS) v. Switzerland*, no. 21881/20, 13 March 2022 (not final),

²²⁷ *Magdić v. Croatia*, no. 17578/20; *Association of orthodox ecclesiastical obedience v. Greece*, no. 52104/20; *Central Unitaria De Trabajadores/AS v. Spain*, no. 49363/20; *Jarocki v. Poland*, no. 39750/20; *Nemytov v. Russia*, no. 1257/21;

²²⁸ Hunko (n 72).

²²⁹ *Adverse Consequences of School Closures* (UNESCO, 2020) ; *Education and COVID-19: Focusing on the Long-term Impact of School Closures* (OECD, 2020)³; and Orben, A., Tomova, L. and Blakemore, S.-J., 'The Effects of Social Deprivation on Adolescent Development and Mental Health' *Lancet Child Adolesc. Health* 4, 634–640 (2020).

²³⁰ Sharma M and others, 'Understanding the Effectiveness of Government Interventions against the Resurgence of COVID-19 in Europe' (2021) 12 *Nature communications* 5820, <https://www.nature.com/articles/s41467-021-26013-4>, accessed November 1, 2022; Liu Y and

consequence of widespread virus transmission in the community and educational settings. Reactive school and day-care closures will probably not reduce the impact of the epidemic but may be necessary due to high absenteeism and operational issues, especially if the spread of SARS-CoV-2 coincides with the ongoing influenza season in an EU/EEA country²³¹.

Concerns that the disadvantages outweighing the advantages caused differential policies on school closures over the course of the pandemic. In the initial phase of the pandemic, closing down schools and nurseries was found to have a significant effect on reducing transmission rates²³², although it had significantly less impact in successive waves²³³. In September 2020, the ECDC did not initially recommend proactive school closure as an effective COVID-19 containment strategy due to the little (and conflicting) evidence on the effect it has on SARS-CoV-2 transmission in the community. Firstly, children (18 years and younger) mostly experienced a benign clinical course of COVID-19 and did not seem to have been the main vector of the virus. Secondly, the impact of school closure on children's education, families' economies, and on society as a whole is significant and well-documented²³⁴. By July 2021, the ECDC's recommendation is that the decision to close schools should only be a 'last resort', as the negative physical, mental and educational impact on children – as well as broader economic impact – outweigh the benefit²³⁵.

The severe impact of school closures on children and students concerns the right to education (Article 14 EUCFR, and Article 2 Protocol 1 ECHR). There are no decided cases concerning the right to education at EU or Council of Europe levels. In Germany, the Federal Constitutional Court (*Bundesverfassungsgericht*) rejected several constitutional complaints that challenged school closures and a remote schooling. The Court found that children have a constitutional right to education which was severely infringed by the prohibition on in-person teaching, but was justified by the pandemic situation²³⁶. Other states have aimed to place children's welfare in their pandemic management strategies, for example, Finland, in its hybrid strategy for managing COVID-19, stated that the best interests of the child would continue to be the top priority for decision-making²³⁷.

4.2.6. Closure of non-essential workplaces

The closure of non-essential workplaces aimed to reduce community transmission. Work-from-home policies were also intended to reduce the likelihood of transmission on public transport. In a majority of EU Member States, non-essential workplaces were closed to prevent the transmission of the virus in

others, 'The Impact of Non-Pharmaceutical Interventions on SARS-CoV-2 Transmission across 130 Countries and Territories' (2021) 19 BMC medicine 40, <http://dx.doi.org/10.1186/s12916-020-01872-8>.

²³¹ 'Guidelines for the Implementation of Non-Pharmaceutical Interventions against COVID-19' (*European Centre for Disease Prevention and Control*, September 24, 2020), <https://www.ecdc.europa.eu/en/publications-data/covid-19-guidelines-non-pharmaceutical-interventions>, accessed 1 November 2022.

²³² Sharma M and others, 'Understanding the Effectiveness of Government Interventions against the Resurgence of COVID-19 in Europe' (2021) 12 Nature communications 5820, <https://www.nature.com/articles/s41467-021-26013-4>, accessed November 1, 2022.

²³³ *ibid.*

²³⁴ 'Guidelines for the Implementation of Non-Pharmaceutical Interventions against COVID-19' (*European Centre for Disease Prevention and Control*, September 24, 2020), <https://www.ecdc.europa.eu/en/publications-data/covid-19-guidelines-non-pharmaceutical-interventions>, accessed November 1, 2022.

²³⁵ ECDC, 'COVID-19 in children and the role of school settings in transmission - second update' (8 July 2021), <https://www.ecdc.europa.eu/en/publications-data/children-and-school-settings-covid-19-transmission>, accessed 9 November 2022.

²³⁶ Bundesverfassungsgericht 1. Senat, 'Bundesverfassungsgericht - Entscheidungen - Schulschließungen waren nach der im April 2021 bestehenden Erkenntnis- und Sachlage zulässig' (*Bundesverfassungsgericht*, November 19, 2021), https://www.bundesverfassungsgericht.de/e/rs20211119_1bvr097121.html, accessed 1 November 2022.

²³⁷ Finland Government, 'Hybrid strategy to manage the COVID-19 epidemic' <https://valtioneuvosto.fi/en/information-on-coronavirus/hybrid-strategy-to-manage-the-covid-19-epidemic>, accessed 29 November 2022.

enclosed, highly populated spaces. This included restaurants, entertainment venues including clubs, cinemas, and theatres as well as other venues.

By late April 2020, a number of states started to ease restrictions following the decrease in the number of cases. Public spaces including playgrounds, services, parks and non-essential shops were re-opened, though with strict rules regarding physical distancing. Phased reopening was adopted in some states: Austria, for instance, allowed the reopening of construction, small shops and gardening centres from mid-April, but hairdressers only opened in May 2020. Policies on the closure of non-essential workplaces became a common restrictive measure across the EU through the pandemic.

The closure of non-essential business had very significant negative economic impact for businesses that were not capable of operating remotely (e.g., cinemas, restaurants, hairdressers, dentists). Low-skilled, part-time, casual and zero-hours workers particularly in the hospitality, retail and personal services industries were also most negatively impacted by these measures²³⁸. Financial support in the form of furlough schemes or unemployment support was primarily targeted at contracted employees, and so the social safety net was not offered to those most in need of it²³⁹. While employees and jobs in the formal sector were protected through government schemes, jobs in the informal sector, which make up 61.2% of the world's workforce and where women and minorities were overwhelmingly represented²⁴⁰, were more negatively impacted.

With the closure of non-essential workplaces came too the reduction or closure of public buildings, and a consequent slowing or reduction of public services. For example, despite guidance from the European Commission in April 2020 on migration and asylum in the context of the Covid-19 pandemic²⁴¹, including the obligation to ensure access to asylum even amid border closures, some member states de jure or de facto suspended asylum procedures. Italy, Spain, and Portugal took measures to protect and, in some cases, extend access to public health care and other rights during the pandemic²⁴². Substandard and crowded living conditions of asylum seekers and seasonal migrant workers, many of them undocumented, in countries across the EU put them at heightened health risk during the pandemic. National authorities in Spain²⁴³, Italy²⁴⁴, Germany²⁴⁵, and Greece²⁴⁶ resorted to indiscriminate lockdowns of reception facilities. In April, the Court of Justice of the European Union

²³⁸ See e.g. in Europe: Colin C. Williams & Aysegül Kayaoglu (2020) COVID-19 and undeclared work: impacts and policy responses in Europe, *The Service Industries Journal*, 40:13-14, 914-931, DOI: 10.1080/02642069.2020.1757073.

²³⁹ As seen globally: see Al Saba and Gougsa (n 40).

²⁴⁰ International Labour Organization, *Women and Men in the Informal Economy: A Statistical Picture* (3rd edition 2018).

²⁴¹ 'Covid-19: Guidance on the Implementation of Relevant EU Provisions in the Area of Asylum and Return Procedures on Resettlement' (European Commission 16 April 2022), <https://ec.europa.eu/info/sites/default/files/guidance-implementation-eu-provisions-asylum-return-procedures-resettlement.pdf>.

²⁴² 'Spain/Portugal/Italy: Partial Relief: Migrant Regularisations during the Covid-19 Pandemic' (*Statewatch* 8 June 2022), <https://www.statewatch.org/analyses/2020/spain-portugal-italy-partial-relief-migrant-regularisations-during-the-covid-19-pandemic/>.

²⁴³ UNHCR, 'UNHCR and IOM ask for an Urgent and Coordinated Response to the Alarming Reception Conditions of Refugees and Migrants in Melilla' (UNHCR 29 August 2020), <https://www.acnur.org/noticias/ul/2020/8/5f4a583b4/unhcr-and-iom-ask-for-an-urgent-and-coordinated-response-to-the-alarming.html>.

²⁴⁴ Wallis, E., 'Were Migrant Rights Infringed in Italy Because of the Coronavirus Pandemic?' (*Infomigrants* 7 August 2020), <https://www.infomigrants.net/en/post/26493/were-migrant-rights-infringed-in-italy-because-of-the-coronavirus-pandemic>, accessed 9 November 2022.

²⁴⁵ Auer, M., 'Will Germany Seek Safe Housing Solutions for Asylum Seekers?' (*Human Rights Watch*, 21 July 2020), <https://www.hrw.org/news/2020/07/21/will-germany-seek-safe-housing-solutions-asylum-seekers>, accessed 9 November 2022.

²⁴⁶ Sunderland, J., 'Malta: Disembark Rescued People' (*Human Rights Watch* 22 May 2020), <https://www.hrw.org/news/2020/05/22/malta-disembark-rescued-people>, accessed 9 November 2022.

(CJEU) ruled that Poland, Hungary, and the Czech Republic broke EU law by refusing to implement the 2015-2017 emergency relocation mechanism²⁴⁷.

As advised by the ECDC, closing selected businesses, such as places where people have limited possibility for physical distancing, could be more effective than closing all businesses, and therefore is a possible option for reducing transmission while avoiding large-scale economic and social impact²⁴⁸.

4.2.7. Stay-at-home orders and lockdowns

The aim of social distancing was to reduce human contact through the requirement of maintaining physical distance between people. This can be on a bilateral level between people sharing common public spaces, or at regional and national levels through stay-at-home orders or lockdowns. Lockdowns meant that individuals were restricted to staying in their homes, except for a small number of reasonable excuses or 'essential purposes' for which they could leave.

China was the first state worldwide to introduce lockdown measures in Wuhan and neighbouring cities on 23 January, and action that the WHO described as 'unprecedented in public health history'²⁴⁹. The Italian government was second worldwide, and first in Europe, to introduce a national lockdown on 9 March 2020, restricting movement except for essential purposes and ordering the closure of non-essential businesses. The first national lockdown followed smaller, local and regional lockdowns. By early April 2020, all EU Member States had either introduced lockdown measures, or (as in the case of Sweden) recommended staying at home and maintaining social distance where possible.

Consensus on the value of lockdowns is that they are effective in slowing the rate of transmission and can provide time for governments to prepare emergency response, and healthcare systems to cope with demand²⁵⁰. Research suggests that well-managed lockdowns and other means of government interventionism may lead to increased satisfaction with democracy or trust in the government²⁵¹. Nevertheless, some findings are emerging on the efficacy of different practices. The team leading the Oxford Government Response Tracker concluded that, on the basis of the evidence available, 'closure and containment policies are, on average, effective at reducing infections and deaths from COVID-19, particularly when they are deployed early, and that high levels of vaccination substantially improve health outcomes even with more infectious variants'²⁵². However, among all interventions and restrictive measures, they have raised the most concern for their legality, and compliance with rights²⁵³.

A number of bodies have questioned the proportionality of national lockdowns on the scale witnessed in a number of states worldwide, particularly when paired with the high financial, economic, and personal costs entailed in the drastic reduction of commercial, educational and social activities. Debate

²⁴⁷ 'Court of Justice of the European Union PRESS RELEASE No 40/20' (Europa.eu), <https://curia.europa.eu/jcms/upload/docs/application/pdf/2020-04/cp200040en.pdf>, accessed 9 November 2022.

²⁴⁸ 'Guidelines for the Implementation of Non-Pharmaceutical Interventions against COVID-19' (European Centre for Disease Prevention and Control, September 24, 2020), <https://www.ecdc.europa.eu/en/publications-data/covid-19-guidelines-non-pharmaceutical-interventions>, accessed 1 November 2022.

²⁴⁹ 'Wuhan Lockdown 'Unprecedented', Shows Commitment to Contain Virus: WHO Representative in China' Reuters (23 January 2020), <https://www.reuters.com/article/us-china-health-who-idUSKBN1ZM1G9>, accessed 9 November 2022.

²⁵⁰ Oraby T and others, 'Modeling the Effect of Lockdown Timing as a COVID-19 Control Measure in Countries with Differing Social Contacts' (2021) 11 Scientific reports 3354, <https://www.nature.com/articles/s41598-021-82873-2>, accessed 1 November 2022.

²⁵¹ Bol and others (n 81).

²⁵² Hale T and others, 'What have we learned from tracking Covid-19 for the past two years?' (Oxford Covid-19 Government Tracker 2022, <https://www.bsg.ox.ac.uk/sites/default/files/2022-03/What-have-we-learned-from%20tracking-two-years-of-COVID-responses-BSG-research-note-March-2022.pdf>).

²⁵³ See section 2.

ongoing through the pandemic was whether such lockdowns were justified, and if so, for what length of time. An identified concern in the length of time appropriate for lock down is:

If they are lifted too soon, or if their lifting is not accompanied by other public health measures such as effective testing, contact-tracing, and isolation, there is a risk of ‘epidemic yoyo’, where the exponential growth interrupted by lockdowns restarts once a lockdown is lifted, possibly necessitating a renewed lockdown if local outbreaks go undetected and/or cannot be brought under control²⁵⁴.

Lockdowns and economic impacts of the COVID-19 pandemic have underlined the interdependence between health and economic security²⁵⁵. Stay-at-home or lockdown measures are there for a last-resort option. Preferable is targeted implementation, both geographically and temporally, to control outbreaks²⁵⁶. Some research supported the argument that less stringent lockdowns can bring similar epidemiological effects with fewer negative economic effects²⁵⁷. Home confinement has strongly increased the rate of domestic violence in many countries, with a huge impact on women and children²⁵⁸. The OECD highlighted the need to examine the impact of lockdowns on domestic violence, alcohol consumption, youth and mental health²⁵⁹, and indeed lockdowns correlated with the exacerbation of mental health illness, domestic violence, child abuse, developmental delays, and chronic disease²⁶⁰. The UN Special Rapporteur on violence against women, who expressed horror at the ‘pandemic of femicide and gender-based violence’ caused by COVID-19²⁶¹. Following Alice Donald and Phil Leach:

Restrictions on movement, economic insecurity, a decrease in police interventions, and the closure of courts and emergency services emboldened perpetrators and aggravated the risks faced by women and girls. This ‘shadow pandemic’, resulting from a perfect storm of factors, itself exemplifies the interdependence of all human rights. Encouragingly, almost 150 states took proactive steps to prevent or respond to gender-based violence, yet the response remained uneven, not only in relation to gender-based violence but also other COVID-19 induced threats to gender equality, such as the unprecedented increase in unpaid care work, and the large-scale loss of women’s jobs, incomes and livelihoods²⁶².

Lockdowns have been challenged on a number of grounds. The ECtHR has ruled on a number of cases²⁶³ related to lockdowns through Europe. In *Terheş v. Romania*, no. 49933/20, 13 April 2020, the Court found the application inadmissible, ‘under a state of emergency, with the aim of isolating and confining the entire population on account of a public-health situation which the competent national

²⁵⁴ Hunko (n 71).

²⁵⁵ Williamson and others (n 11).

²⁵⁶ ‘Guidelines for the Implementation of Non-Pharmaceutical Interventions against COVID-19’ (European Centre for Disease Prevention and Control, September 24, 2020), <https://www.ecdc.europa.eu/en/publications-data/covid-19-guidelines-non-pharmaceutical-interventions>, accessed 1 November 2022.

²⁵⁷ E. Bendavid, C. Oh, J. Bhattacharya, J.P.A. Ioannidis, Assessing mandatory stay-at-home and business closure effects on the spread of COVID-19; *Eur. J. Clin. Invest.*, 51 (4) (2021), pp. 1-9, 10.1111/eci.13484.

²⁵⁸ Haug (n 234); Abramian J, ‘The Covid-19 Pandemic Has Escalated Domestic Violence Worldwide’ (*Forbes*, July 22, 2020), <https://www.forbes.com/sites/jackieabramian/2020/07/22/the-covid-19-pandemic-has-escalated-global-domestic-violence/>, accessed 1 November 2022.

²⁵⁹ ‘First Lessons from Government Evaluations of COVID-19 Responses: A Synthesis’ (OECD), <https://www.oecd.org/coronavirus/policy-responses/first-lessons-from-government-evaluations-of-covid-19-responses-a-synthesis-483507d6/>, accessed November 1, 2022.

²⁶⁰ Rajan D and others, ‘Governance of the Covid-19 Response: A Call for More Inclusive and Transparent Decision-Making’ (2020) 5 *BMJ global health* e002655, <https://gh.bmj.com/content/5/5/e002655>, accessed November 1, 2022.

²⁶¹ UN Women ‘Urgent action needed to end pandemic of femicide and violence against women, says UN expert’ (24 November 2020), <https://www.unwomen.org/en/news/stories/2020/11/statement-dubravka-simonovic-special-rapporteur-on-violence-against-women>.

²⁶² Donald, A., and Leach, P., ‘Human Rights – the Essential Frame of Reference in Response to the COVID-19 Pandemic’ in Grogan, J. and Donald, A., (eds) *The Routledge Handbook on Law and the COVID-19 Pandemic* (Routledge 2022).

²⁶³ See e.g. Magdić v. Croatia, no. 17578/20; and Serbia, no.s 50086/20 and 50898/20.

authorities had deemed to be serious and urgent. The applicant had been free to leave his home for various reasons and could go to different places.’

4.2.8. International travel controls or border restrictions

Introducing border controls which limit or ban individuals crossing the border in (or out) of a state were intended as a means of limiting transmission, particularly with regard to states with high levels of the virus within their populations. Despite a general reduction in the stringency of restrictive measures over the course of the pandemic, international border closures and travel controls significantly increased across states worldwide during the Delta and Omicron variants.

A number of states, including Australia, New Zealand and China, introduced border controls as a means of maintaining or aiming for COVID-Zero. In the EU, on 11 March 2020, Austria was the first state to close its border with Italy. Most states followed with the closure of internal borders, and free movement within the Schengen area was effectively suspended. Further closures during successive waves of pandemic in 2020 reintroduced internal borders, either wholly or partly to certain individuals including EU citizens and their families as well as third country nationals who are resident in the state. Border closures and lockdowns led to supply chain interruptions, and severe reduction in economic activity. Further rights concerns relate to the particular negative impact on cross-border families and workers, refugees, and migrants. Many cross-border policies were applied uniformly without consideration of individual impact. There was a lack of coordination among Member States and with the Union institutions when these measures were introduced, in addition to where some Member States have introduced unlawful and discriminatory restrictions by not allowing residents of another EU nationality to enter their territory. Towards the end of 2020 as Member States again opted to close external borders while largely persevering free movement inside the Schengen area.

International travel restrictions have been criticised. For example, targeted closures to African countries during the Omicron variant, many of which had not detected the variant, in late 2021, was inconsistent and a disincentive for countries to share information on variants, and infection rates. The effect of travel restrictions in Europe was that it promoted nationalist isolation, xenophobia and scapegoating²⁶⁴.

Where an outbreak has already reached the population, closing borders are ineffective in preventing the importation of cases or slowing growth. The WHO advised against such restrictions to countries with COVID-19 outbreaks, stating in February 2020:

In general, evidence shows that restricting the movement of people and goods during public health emergencies is ineffective in most situations and may divert resources from other interventions. Furthermore, restrictions may interrupt needed aid and technical support, may disrupt businesses, and may have negative social and economic effects on the affected countries. [...] Travel measures that significantly interfere with international traffic may only be justified at the beginning of an outbreak, as they may allow countries to gain time, even if only a few days, to rapidly implement effective preparedness measures. Such restrictions must be based on a careful risk assessment, be proportionate to the public health risk, be short in duration, and be reconsidered regularly as the situation evolves.

Border closures within the represented the challenges of preserving the fundamental freedom of movement guaranteed by EU membership against national determination of minimising risk caused by the spread of an infectious disease. The ECDC was ultimately able to aid national decision-making on determining high-risk areas, to enable a more targeted and modular approach to border restrictions.

²⁶⁴ Hunko (n 71).

4.3. Effectiveness of restrictive measures

Experts have cautioned generalisations, or assuming any certainty in the findings particularly in assigning causality. The inherent issues of access to reliable data can be an issue: for example, accurate attribution of mortality to COVID-19 may have been misattributed in early stages of the pandemic, while countries may also vary in how, when and on what basis they report deaths.

Assessment can also be challenging where countries have adopted measures simultaneously, and their impact can depend on the timing of the introduction of measures, enforcement, the levels of public compliance, the length of intervention, as well as wider factors and underlying factors including the capacity of the health system. While most states have adopted the restrictive measures examined in this section, they have done so at different times, with different rules and exceptions to the measures, and often localised or regional levels. As cautioned by one study, where levels of granularity in data is missing, rare but effective measures could be missed due to lack of statistical power²⁶⁵.

In its analysis of pandemic response, the Council of Europe has affirmed that other factors beyond an early response may correlate with lower increases of all-cause mortality rates including the level of pandemic preparedness (e.g. availability of PPE, testing for healthcare workers), the state and level of funding of the healthcare system, the availability of hospital, and in particular intensive care, beds as well as testing and contact-testing capacity²⁶⁶. Nevertheless, emerging analysis of the pandemic indicates the positive impact that interventions can have on transmission rates. Studies highlighting these elements are considered within this section.

In one study on 11 European countries published in June 2020, the authors found that interventions had a substantial effect on transmission, and estimated that 3.1 (or between 2.8–3.5) million deaths in Europe had been averted owing to the restrictive measures adopted by states since the beginning of the epidemic²⁶⁷. Further studies establish that contact-tracing, quarantine and physical distancing are effective in epidemic control²⁶⁸. It has also been observed that the NPIs adopted in response to the COVID-19 pandemic also significantly reduce the influenza burden²⁶⁹.

The timing of the introduction of restrictive measures is significant, both from the perspective of evaluating their effectiveness, and maximising the effect of the intervention while minimising its negative effects. The effect of introducing and lifting a restrictive measure is not immediate and time is required to see the effect. This is important for decision-makers but is predicated on understanding both behavioural inertia²⁷⁰ and infection and recovery periods.

Restrictive measures can be targeted and involve specific recommendations to protect the most vulnerable include enhanced surveillance of at-risk groups, comprehensive testing, and intensified

²⁶⁵ Haug (n 23).

²⁶⁶ Hunko (n 71).

²⁶⁷ Flaxman, S. and others. Estimating the effects of non-pharmaceutical interventions on COVID-19 in Europe. *Nature* 584, 257–261 (2020).

²⁶⁸ Kucharski AJ and others, 'Effectiveness of Isolation, Testing, Contact Tracing, and Physical Distancing on Reducing Transmission of SARS-CoV-2 in Different Settings: A Mathematical Modelling Study' (2020) 20 *The Lancet infectious diseases* 1151, [http://dx.doi.org/10.1016/S1473-3099\(20\)30457-6](http://dx.doi.org/10.1016/S1473-3099(20)30457-6); Chu DK and others, 'Physical Distancing, Face Masks, and Eye Protection to Prevent Person-to-Person Transmission of SARS-CoV-2 and COVID-19: A Systematic Review and Meta-Analysis' (2020) 395 *Lancet* 1973, [http://dx.doi.org/10.1016/S0140-6736\(20\)31142-9](http://dx.doi.org/10.1016/S0140-6736(20)31142-9).

²⁶⁹ Fricke LM and others, 'Impact of Non-Pharmaceutical Interventions Targeted at COVID-19 Pandemic on Influenza Burden - a Systematic Review' (2021) 82 *The Journal of infection* 1, <http://dx.doi.org/10.1016/j.jinf.2020.11.039>.

²⁷⁰ Li Y and others, 'The Temporal Association of Introducing and Lifting Non-Pharmaceutical Interventions with the Time-Varying Reproduction Number (R) of SARS-CoV-2: A Modelling Study across 131 Countries' (2021) 21 *The Lancet infectious diseases* 193, <https://www.sciencedirect.com/science/article/pii/S1473309920307854>.

infection prevention and control practices in settings that host high-risk individuals, such as long-term care facilities. The ECDC advised the use of restrictive measures should be guided by data on the local epidemiological situation, with the overall goal of protecting the most vulnerable individuals in the society²⁷¹.

At the point of escalating pandemic situation, the most effective restrictive measures which appear to include curfews, lockdowns and closing and restricting places where people gather in smaller or large numbers for an extended period of time. This includes small gathering cancellations (closures of shops, restaurants, gatherings of 50 persons or fewer, mandatory home working and so on) and closure of educational institutions²⁷². Several restrictive measures (e.g. school closure and public events ban), and lockdown in particular, had a large effect (81%) on reducing transmission under one European study²⁷³. While these interventions were successful at reducing transmission rates, they are unsuitable for long-term use²⁷⁴, when connected with falling compliance rates and the unsustainable burden on restricted populations.

Public health awareness, and a shift in personal and organisational behaviour to adopt protective measures including regular testing, distancing, hand hygiene and improved ventilation reduced the need for strict bans and closures²⁷⁵. While the effectiveness of restrictive measures is dependent on a high proportion of the population following them, the adoption of measures differed by group. For example, in a global study, complying with social-distancing measures was higher among people over 70 as compared with younger adults²⁷⁶. Low-income households and ethnic minorities were less likely to self-isolate – likely reflecting the higher percentages of these populations in essential work and frontline healthcare²⁷⁷. A further study found that COVID-19 risk perception and trust in science predicted compliance with COVID-19 preventive measures²⁷⁸.

4.4. Recommendations on future use of restrictive measures

In response to emergency, timing is essential. **Precisely targeted and well-timed interventions can avoid the necessity of introducing more severe and restrictive measures** if a pandemic spirals out of control²⁷⁹. Countries that were able to adopt and implement strategies to contain the virus appeared to have more control over infection rates as compared with those states which significantly delayed response²⁸⁰. For example, South Korea responded robustly to the first sign of concern about the SARS-CoV-2 virus to implement extensive testing, contact tracing, isolation and treatment of infected individuals. Taiwan introduced hand sanitiser and temperature checks early, having prior experience

²⁷¹ 'Non-Pharmaceutical Interventions against COVID-19' (European Centre for Disease Prevention and Control), <https://www.ecdc.europa.eu/en/covid-19/prevention-and-control/non-pharmaceutical-interventions>, accessed 1 November 2022.

²⁷² Haug N and others, 'Ranking the Effectiveness of Worldwide COVID-19 Government Interventions' (2020) 4 Nature human behaviour 1303, <https://www.nature.com/articles/s41562-020-01009-0>, accessed November 1, 2022.

²⁷³ Flaxman and others (n 268).

²⁷⁴ See e.g. Flaxman and others (n 268).

²⁷⁵ Sharma M and others, 'Understanding the Effectiveness of Government Interventions against the Resurgence of COVID-19 in Europe' (2021) 12 Nature communications 5820, <https://www.nature.com/articles/s41467-021-26013-4>, accessed 1 November 2022.

²⁷⁶ Atchison, C., Bowman, L. R., Vrinten, C., Redd, R., Pristerà, P., Eaton, J., & Ward, H. (2021). Early perceptions and behavioural responses during the COVID-19 pandemic: A cross-sectional survey of UK adults. *BMJ Open*, 11(1), e043577.

²⁷⁷ Plohl N and Musil B, 'Modeling Compliance with COVID-19 Prevention Guidelines: The Critical Role of Trust in Science' (2021) 26 Psychology, health & medicine 1, <http://dx.doi.org/10.1080/13548506.2020.1772988>.

²⁷⁸ *ibid.*

²⁷⁹ Hunko (n 72).

²⁸⁰ Harris M and others, 'Fast and Frugal Innovations in Response to the COVID-19 Pandemic' (June 2020) 26(6) *Nature Medicine* 814–17, <https://doi.org/10.1038/s41591-020-0889-1>.

of the SARS epidemic²⁸¹. A lesson here is that good timing depends on **effective mechanisms for identifying and communicating a health threat, a population with high health literacy, and rapid decision-making in determining an appropriate package of proportionate measures based on past-experience, comparative insights of other states, and projected impacts.**

Restrictive measures must take into consideration repercussions such as major social and economic impacts, mental and physical health consequences, and increased morbidity and mortality from non-COVID-19 diseases²⁸². Poor timing will result in a wasted lockdown effort with little impact on the outbreak while incurring economic losses and psychological tolls to the public and healthcare workers during extended isolation including response and 'lockdown fatigue'²⁸³.

Lockdowns should be seen as the 'nuclear option': 'highly effective but causing substantial collateral damages to society, the economy, trade and human rights'²⁸⁴. However, to avoid the adverse impact on communities, the economy, and rights, a smaller package of measures could substitute for a full lockdown when suitably combined (in sequence and timing)²⁸⁵. Essential among considerations of when to introduce (or lift) measures is proportionality. However, policy proportionality and coherence were largely under-examined in the initial phase of pandemic, despite the 'usefulness for policy debate, particularly when resources are scarce and cross-government co-ordination is crucial'²⁸⁶. This should be more closely examined in future pandemic studies.

The fraught public debate on restrictive measures served to also underscore the importance of promoting early interventions which have little or no negative social impact. NPIs (washing hands, social distancing) in general can only be effective if they are understood and practiced by the community. At an early stage of pandemic, the correct way to wear a mask was not widely understood or practiced. **Good public health education can ensure that restrictive measures are understood and correctly practiced**, without the necessity for introducing restrictive measures. This includes, for example, maintaining physical distance, good hygiene and handwashing, as well as respiratory or etiquette for coughing or sneezing.

As argued by a number of human rights scholars²⁸⁷, the rights to life, health and other freedoms are indivisible and interdependent, and should be balanced, especially in the heat of pandemic decision making, using the well-tested framework of legality, necessity and proportionality provided by international human rights treaties and national laws and constitutions²⁸⁸.

²⁸¹ Lee C, 'Taiwan's Proactive Prevention of COVID-19 under Constitutionalism' (n 81).

²⁸² Bausch, D. G. Precision physical distancing for COVID-19: An important tool in unlocking the lockdown. *Am. J. Trop Med Hyg.* 103(1), 22–24 (2020).

²⁸³ Petherick A and others, 'A Worldwide Assessment of Changes in Adherence to COVID-19 Protective Behaviours and Hypothesized Pandemic Fatigue' (2021) 5 *Nature human behaviour* 1145, <https://www.nature.com/articles/s41562-021-01181-x>, accessed 1 November 2022.

²⁸⁴ Haug N and others, 'Ranking the Effectiveness of Worldwide COVID-19 Government Interventions' (2020) 4 *Nature human behaviour* 1303, <https://www.nature.com/articles/s41562-020-01009-0>, accessed November 1, 2022.

²⁸⁵ Haug and others (ibid); Lee, K., Worsnop, C. Z., Grépin, K. A. & Kamradt-Scott, A. Global coordination on cross-border travel and trade measures crucial to COVID-19 response. *Lancet* 395, 1593–1595 (2020); Vardoulakis, S., Sheel, M., Lal, A. & Gray, D. Covid-19 environmental transmission and preventive public health measures. *Aust. N. Z. J. Public Health* 44, 333–335 (2020).

²⁸⁶ 'First Lessons from Government Evaluations of COVID-19 Responses: A Synthesis' (OECD), <https://www.oecd.org/coronavirus/policy-responses/first-lessons-from-government-evaluations-of-covid-19-responses-a-synthesis-483507d6/>, accessed November 1, 2022.

²⁸⁷ Donald and Leech, and Martin Scheinin, 'Assessing Human Rights Compliance during COVID-19' in Grogan and Donald (eds) (n 6).

²⁸⁸ World Health Organization. Statement on the fourth meeting of the International Health Regulations (2005) Emergency Committee regarding the outbreak of coronavirus disease (COVID-19), [https://www.who.int/news-room/detail/01-08-2020-statement-on-the-fourth-meeting-of-the-international-health-regulations-\(2005\)-emergency-committee-regarding-the-outbreak-of-coronavirus-disease-\(covid-19\)](https://www.who.int/news-room/detail/01-08-2020-statement-on-the-fourth-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-outbreak-of-coronavirus-disease-(covid-19)).

Decisions regarding the **future use of restrictive measures must recognise and account for the disproportionate affects that they may have on certain groups**. A reality of the measures adopted is that they have disproportionately impacted some of the most vulnerable communities, including undocumented migrants, minorities, people with disabilities, prisoners, older people, and low-income or informal workers. The ordered closures of businesses leading to mass unemployment of part-time and informal workers, coupled with school closures, have had a disproportionate impact on women and has escalated rates of domestic violence worldwide²⁸⁹. A lesson repeatedly underlined within the EU and globally is the importance of ensuring that measures adopted are non-discriminatory and protect groups in vulnerable circumstances. Already marginalised populations were not only the most negatively impacted by the pandemic in terms of infection rates and deaths but were also the most likely to have lost employment and educational opportunities, as well as being isolated from state-support schemes, access to healthcare and state services, and access to justice. In this context, diverse input – particularly from groups most negatively impacted – is necessary to ensure their legal justification: ‘All who are affected by these decisions should be treated with dignity and respect’²⁹⁰.

Following well-established boundaries on the limitation of rights, in determining restrictions, the guiding principles should be the least restrictive measures, ensuring that they are necessary and proportionate to the need for protection of public health. Those subject to restrictions should also receive support, which in the context of the pandemic, includes economic and social support. A human-rights-based approach can be the most effective strategy in combating the virus, balancing the right to health with fundamental rights²⁹¹. In the implementation of measures, concerns must also address the discriminatory application of punitive measures targeting minorities and political opponents. Indiscriminate bans on public protest, and the restriction of free speech can reduce the critical accountability of governments and the public health discourse and should be avoided.

Member States should also ensure that the restrictive measures adopted are explicitly targeted at resolving the crisis, and not the means by which government introduces unrelated policies. Similarly, policies which differentially impact on different groups, particularly those in vulnerable categories, should not be introduced without objective, and health-based justification.

²⁸⁹ UN Women (n 262).

²⁹⁰ Institute of Medicine 65(US) Forum on Microbial Threats, *Strategies for Disease Containment* (National Academies Press 2007).

²⁹¹ See e.g. Martin Scheinin, ‘Assessing Human Rights Compliance during COVID-19’, and Donald, A., and Leach, P., ‘Human Rights – the Essential Frame of Reference in Response to the COVID-19 Pandemic’ in Grogan, J. and Donald, A., (eds) *The Routledge Handbook on Law and the COVID-19 Pandemic* (Routledge 2022).

5. THE ROLE OF THE EUROPEAN UNION DURING THE COVID-19 PANDEMIC

KEY FINDINGS

The European Union has limited competences relevant to the field of public health emergencies which likely hobbled an initial, coordinated response across EU Member States.

Towards the end of 2020, the EU played a more significant role in the coordination of border policies, coordination of COVID-19 passes, and vaccine development and procurement. EU funding enabled research and development aiding pandemic response, while the European Centre for Disease Control played an important role in data aggregation and sharing.

EU institutions, notably the European Parliament, played an important role in the scrutiny of Member States' responses to pandemic from the perspective of fundamental rights. The EU Commission highlighted concerns in Member States practices in the annual Rule of Law Reports.

This chapter examines EU institutions' roles and actions in terms of policy coordination. It highlights the relatively limited competencies of the EU in the context of a public health emergency, and how nevertheless EU institutions played a role in the coordination of free movement, and vaccination (section 5.1). It then examines the role EU institutions, notably the European Parliament, played in the scrutiny and protection of democracy, rule of law and fundamental rights in the context of restrictive measures adopted by Member States and their impact on populations (section 5.2). Section 5.3 provides some initial reflections on pandemic response.

5.1. Role of the EU in policy coordination

5.1.1. EU competences in a public health emergency

The EU has traditionally been understood to have very limited powers in the field of health. This limited competence reflects the preferences of Member States²⁹², and the lack of political will to integrate in this area²⁹³, as well as the diversity of social and healthcare systems within Member States. As a consequence, the primary authority for response to a public health emergency lies with the Member States. Such limitations constrained the degree to which the EU could effectively coordinate a pan-EU policy response: for example, the decision on whether to adopt, reduce or remove restrictive measures, including those which affected free movement such as border closures and restrictions on travel, were unilaterally decided by Member States²⁹⁴.

The EU does, however, have some relevant competences within public health. The Treaties, along with the EU Charter on Fundamental Rights, provide for a high level of protection of human health in the implementation of Union policies and actions (Articles 9 and 168 Treaty on the Functioning of the European Union [TFEU], Article 35 EU Charter on Fundamental Rights [EUCFR]).

²⁹² Brooks E, Geyer R (2020) The development of EU health policy and the Covid-19 pandemic: trends and implications. *J Eur Integr* 42:1057–1076.

²⁹³ See e.g. Pernhagen KP, de Ruijter A, Flear ML (2020) Tamara Hervey and Alexia Herwig 'more competences than you knew? The Web of Health Competence for European Union Action in Response to the Covid-19 Outbreak. *Eur J Risk Regul* 297–306.

²⁹⁴ Wolff, S., and S. Ladi. 2020. 'European Union Responses to the Covid-19 Pandemic: Adaptability in Times of Permanent Emergency.' *Journal of European Integration* 42 (8): 1025–1040. doi:10.1080/07036337.2020.1853120.

Article 168 TFEU states that the Union is to complement and support national health policies, and also to encourage cooperation between Member States, in full respect of the responsibilities of Member States for the definition of their health policies and for the organisation, management and delivery of health services and medical care. Under Article 168(4) TFEU the EU has shared competence in the area of common health security concerns. The European Centre for Disease Control and Prevention (ECDC) operates under Article 168(5) TFEU, which provides for the monitoring and issuing of early warning reports to combat widespread and serious cross-border diseases. It was established in 2005 as a public health agency to protect against, and prepare for, infectious diseases. The ECDC is mandated to collect, analyse and share data as well as to provide advice to Member States in order to respond to outbreaks.

The EU can adopt health related legislation under Article 114 TFEU (single market) and Article 153 (social policy). The legal basis for the European Medicines Agency (EMA) is Article 114(4) TFEU, which provides the legal basis for the harmonisation of the single market. The EU also has significant powers to disburse funding through Horizon 2020 and Horizon Europe, for example to fund research into vaccines, treatments, medical equipment, and social science research into the social, economic, political and legal consequences of COVID-19.

More targeted support for emergencies is provided through the Civil Protection Mechanism (CPM). The CPM is a system established in 2001 for coordinating rescue and humanitarian assistance in the event of natural and man-made disasters whose scale or nature exceeds the response capabilities of the affected country. The CPM enabled the EU to organise the COVID-19 public procurement scheme. However, the design of the mechanism envisioned only a single state being affected at any one time and was limited in capacity where all Member States were affected simultaneously.

While there are no explicit provisions in the Treaties providing competence to EU institutions to regulate action during a public health emergency, a number of further articles are relevant in the context of an emergency and crisis management:

- Article 196 TFEU provides competence to support and complement Member States' action in the event of natural or man-made disasters (excluding the harmonisation of laws and regulation of Member States);
- Article 352 TFEU, the so-called 'flexibility' clause, provides residual competence for the EU to act in areas where competences have not been explicitly granted but are necessary to objectives set out in the Treaties. The clause requires unanimity in the Council and the consent of the Parliament, and the Commission is required to highlight its use to national parliaments;
- Article 222 TFEU, the 'solidarity' clause, provides for the EU and EU countries to act jointly to provide assistance to another EU Member State which is the victim of a natural or man-made disaster; and
- Article 43 TEU, the Common Security and Defence Policy, refers to provisions for crisis management but within the context of conflict prevention and peace-keeping operations. However, this provision has not been interpreted as encompassing a public health crisis.

5.1.2. Main actions taken by EU actors

The initial response of the EU was criticised, where it was an ‘underwhelming’ response in contrast to Member States’ unilateral actions²⁹⁵. The lack of clear competence, paired with a state-centric approach to emergency response, delayed the initial response by the EU. A central question was what the EU could, or should, have been doing in immediate response to the pandemic. The Commission’s advisory panel on COVID-19 was established only in mid-March 2020, nearly two months following the declaration by the WHO that the virus was a Public Health Emergency of International Concern. Despite high level commitments among Member States in the European Council, they continued to prioritise their own interests and to act unilaterally in response to pandemic in early 2020. For example, France, Germany, and the Czech Republic introduced export limits on personal protection equipment (PPE), despite the needs of other Member States²⁹⁶. Again, the CPM was not designed with a universal crisis in mind and struggled to cope with requests for the same resources from all Member States at once. While an EU medical stockpile had been approved in 2019, it had not been implemented in time to serve EU Member States having difficulty in procuring essential medical and PPE equipment in 2020.

The ECDC had been established since 2005 with the aim of collecting and analysing data, as well as providing guidance in the event of exactly such an outbreak, however, Member States relied primarily on national bodies. This also highlighted the lack of coordination at EU level, which was also evidenced when national leaders sought to legitimise their decisions by giving voice to national experts, in the absence of multinational meta-analytical infrastructure or supranational coordination mechanisms, or even coherent systems for sharing procedures and protocols²⁹⁷.

However, some early efforts at coordinating strategies were made. In April 2020, as some Member States began to reduce the initial wave of restrictions in response to the pandemic, the Commission and Council published a roadmap for a coordinated EU exit strategy from restrictive measures²⁹⁸, reflecting efforts at the EU level to find a common strategy on COVID-19, and to avoid the complexity and confusion arising from conflicting national strategies to contain the virus. It was, however, met with scepticism by a number of Member States, and soon dropped. However, the Council did ultimately adopt a recommendation (EU 2020/1475) establishing common criteria and a common framework on travel measures in response to the COVID-19 pandemic.

In the context of restrictive measures, or more broadly ‘pandemic governance’, at national level, the role of EU institutions was limited to guidance. For this reason, EU was described as acting with a ‘low level of coordination and no strategic approach on how to deal with pandemic’²⁹⁹. Most of the activities of EU institutions were recommendations to Member States on how to behave to avoid the spreading of COVID-19, and Member States acted with variance as to the stringency or laxity of approach compared with EU recommendations.

²⁹⁵ See e.g. PURNHAGEN, K., DE RUIJTER, A., FLEAR, M., HERVEY, T., & HERWIG, A. (2020). More Competences than You Knew? The Web of Health Competence for European Union Action in Response to the COVID-19 Outbreak. *European Journal of Risk Regulation*, 11(2), 297-306. doi:10.1017/err.2020.35.

²⁹⁶ Sánchez Nivolás E, ‘Coronavirus: EU ministers urge members to share supplies’ *EU Observer* (9 March 2020), <https://euobserver.com/health-and-society/147659>, accessed 1 November 2022.

²⁹⁷ Jacint Jordana and Juan Carlos Trivino-Salazar, ‘Where are the ECDC and the EU-wide responses in the COVID-19 pandemic?’ (2020) *The Lancet* pp. 1611-1612.

²⁹⁸ EU Council, ‘A Roadmap for Recovery: Towards a more resilient, sustainable and fair Europe’ (21 April 2020), <https://www.consilium.europa.eu/media/43384/roadmap-for-recovery-final-21-04-2020.pdf>, accessed 1 November 2022.

²⁹⁹ Milan Brglez, Bostjan Udovic, and amaliya macek, Covid-19 and the European Parliament (Policies): a year of perilous ad hoc solutions, 2021 14(2) *Journal of comparative politics*, p85.

While not the subject of this report, it should be noted that a strong contrast can be made between the EU's role in policy coordination regarding restrictive measures and the EU's fiscal response to the pandemic. The EU's Integrated Political Crisis Response mechanism (IPCR) to enable information sharing was activated on 28 January 2020. The European Council adopted the Resilience and Recovery Fund (RRF) providing for €750 billion in grants and loans to support all Member States. On 11 September 2020, the Council revised the EU budget to provide €6.2 billion to the European Commission to invest in the development and deployment of a COVID-19 vaccine, and to address the impact of the pandemic through the Corona Response Investment Initiative (CRII) and the Corona Response Investment Initiative Plus (CRII+). The European Council and Commission established the Next Generation EU (NGEU) agreement, the pandemic recovery plan³⁰⁰. In the context of PPE, the Commission also adopted decisions to help with the purchase of PPE, revising the EU Solidarity Fund to support this³⁰¹. The EU Solidarity Fund was revised (Regulation 2020/461).

The EU Commission has a coordinating and supportive role in the field of public health policy. The role includes the exchange of information, and maintenance of structures intended to operate during a health crisis. During the pandemic, the Commission played a significant role in financial response, including concerning the disbursement of recovery funds. 'Within the boundaries of its existing powers the Commission operated effectively', using the EU public procurement framework to buy medical equipment, interpreting state aid flexible³⁰². For example, a EU public health strategy was adopted in July 2020 (EU4Health) to boost EU preparedness and strengthen health systems, in spite of weak competences in the field³⁰³.

From the focus of policies related to pandemic governance, the primary areas of coordination were:

- Vaccinations: The Commission led the procurement of vaccines through the Joint Procurement Agreement. It also mobilised funding for the development of vaccines and diagnostics under Horizon 2020;
- EU Digital COVID Certificates: The Commission coordinated the introduction of EU COVID Digital Certificates, entering into force on 1 July 2021³⁰⁴, and managed the Gateway system enabling recognition of COVID certification across the EU; and
- Contact Tracing: The Commission set up an EU-wide system to ensure the interoperability of contact tracing and warning apps.

In terms of borders and mobility, the Commission issued non-binding guidance on matters related to EU borders including ensuring the free movement of workers (particularly in the health care and food sectors); and safe travel in the EU. These were updated over the course of 2020-2022, reflecting access to and availability of vaccines, and the introduction of COVID-19 Digital Certificates. Again, limited to recommendations and guidance, the EU Commission aimed to support a common approach to travel measures. For example, within a short period the Commission produced the COVID-19 Guidelines for Border Management Measures to Protect Health and Ensure the Availability of Goods and Essential Services, the Guidelines on EU Emergency Assistance in Cross-Border Cooperation in Healthcare related

³⁰⁰ See Tesche, T. (2022) Pandemic Politics: The European Union in Times of the Coronavirus Emergency. JCMS: Journal of Common Market Studies, 60: 480– 496, <https://doi.org/10.1111/jcms.13303>.

³⁰¹ Regulation 2020/461.

³⁰² Tesche, T. (2022) Pandemic Politics: The European Union in Times of the Coronavirus Emergency. JCMS: Journal of Common Market Studies, 60: 480– 496, <https://doi.org/10.1111/jcms.13303>.

³⁰³ Brooks and Geyer (n 293).

³⁰⁴ See Section 6.2 on COVID-19 passes.

to the COVID-19 crisis, and the Recommendation App on Contact Tracing. The EU Commission also coordinated polices aimed at limiting the spread of the virus through the temporary closure of the EU's external borders; and border management throughout the introduction of 'Green Lanes' for the transport of essential goods.

In a number of aspects of pandemic response, primarily related to the procurement of vaccines and enabling free movement, however, the primacy of Member States shifted over the course of 2020. On 24 October 2020, EU Member States committed to ensuring more coordination and better information sharing through the Council Recommendation on a coordinated approach to the restriction of free movement in response to the COVID-19 pandemic³⁰⁵. Further, the **EU Council** adopted Conclusions on COVID-19, urging Member States to act together, in cooperation with the EU Commission, to develop close and enhanced coordination on measures related to travel while safeguarding free movement and protection of public health. The Council passed a number of Recommendations related to the COVID-19 pandemic, reflecting high level political consensus for a coordinated approach to free movement; however, this was hampered to a degree by the divergence of rules and approaches to pandemic governance adopted across Member States.

Over the course of pandemic, the role of the ECDC also increased. The ECDC has competence to collect, analyse and share data. However, there were problems in respect of the consistency and quality of data on the pandemic shared by the Member States, since it is not always disaggregated by age and sex, and key information such as test criteria, which have a direct effect on the number of confirmed cases and deaths reported, was not fully or systematically shared³⁰⁶. This has been particularly problematic when EU Member States adopted different methodologies for counting deaths caused by COVID-19.

Of particular note in pandemic response was the development by the ECDC of a COVID-19 information platform³⁰⁷. The ECDC began to produce weekly common colour-coded COVID-19 risk maps, broken down by region with data provided by Member States on common criteria of testing rates and vaccine updates. Based on the information provided, a coordinated EU response through an 'emergency brake' system was established. A Member State or the European Commission could trigger the emergency brake if the epidemiological situation in a region deteriorated rapidly, or where a variant of concern or interest was detected and required the reintroduction of testing and quarantine. Under the emergency brake, measures such as testing and quarantine could be introduced, including for EU digital COVID certificate holders and essential travellers. If the emergency brake were triggered, EU countries would be expected to discuss possible coordinated measures in the Council, in cooperation with the European Commission.

Beyond this, the Commission launched the new Health Emergency Preparedness and Response Authority (HERA) in September 2021, and fully operationalised by early 2022. HERA was designed as a shared centre for Member States and EU institutions to prepare for cross-border health threats. HERA is a directorate-general of the European Commission created to prepare the EU for a future pandemic and to avoid the mistakes made during the EU's response to the COVID-19 pandemic. It aims to 'improve EU health security coordination before and during crises; bring together the EU Member

³⁰⁵ Council Recommendation (EU) 2020/1475 of 13 October 2020 on a coordinated approach to the restriction of free movement in response to the COVID-19 pandemic, OJ L 337, 14.10.2020.

³⁰⁶ Renda, A., & Castro, R. (2020). Towards Stronger EU Governance of Health Threats after the COVID-19 Pandemic. *European Journal of Risk Regulation*, 11(2), 273-282. doi:10.1017/err.2020.34, chapter IV.

³⁰⁷ Accessible at <https://www.ecdc.europa.eu/en/covid-19>, accessed 11 November 2022.

States, industry and relevant stakeholders; develop, produce, procure, stockpile and equitably distribute medical countermeasures and reinforce the global health emergency response architecture³⁰⁸.

5.2. Role of the EU in the scrutiny of democracy, rule of law and fundamental rights

From an early stage in the pandemic, it was recognised at national and EU levels that the measures to be adopted could have a severe impact on the exercise of fundamental rights, and on democratic practices. The European Parliament (EP), in particular its Committee on Civil Liberties, Justice and Home Affairs (LIBE) and Democracy, Rule of Law and Fundamental Rights Monitoring Group, undertook to monitor state action within the EU from March 2020. The EP held regular exchanges with stakeholders, and over the course of the pandemic, produced a number of studies, reports and documents on the evolving situation of the pandemic with regard to democracy, the rule of law and fundamental rights. On its own initiative, the EP has investigated and expressed concern over the quality of democracy in the EU Member States as a direct consequence of the forms of decision-making and governance adopted in response to the pandemic.

In November 2020, the EP adopted a Resolution on the impact of COVID-19 measures on democracy, the rule of law and fundamental rights³⁰⁹, calling on Member States to ensure compliance of their measures with the standards of the rule of law and human rights. Wide ranging in its calls, the Resolution highlights the disproportionately negative impact of both the pandemic and measures adopted in response to it, on groups including women, children, journalists, defendants, and asylum seekers, as well as concerns for the discriminatory treatment of groups including Romani and LGBTQ+ people. The Resolution calls on the European Commission to instigate an evaluation of Member States' measures 'in order to generate lessons learned, share best practices and enhance cooperation, and to ensure that measures taken during subsequent waves of the pandemic are effective, targeted, well justified on the basis of the specific epidemiological situation, strictly necessary and proportionate, and to limit their impact on democracy, the rule of law and fundamental rights'³¹⁰.

The **European Economic and Social Committee** similarly underlined concerns regarding the COVID-19 pandemic, producing an Advisory Opinion on the impact of COVID-19 on fundamental rights and the rule of law across the EU and the future of democracy³¹¹. It highlighted in particular the effects of pandemic on workers, trade unions, and on employment at large throughout the Union.

For its part, the **European Commission**, recognising that the pandemic posed distinct challenges to democracy and the rule of law, through the changing or suspension of checks and balances on the use of power, has monitored the application of emergency measures in Member States since mid-March 2020. Its annual **Rule of Law Reports** since 2020 have highlighted the COVID-19 pandemic as an area of concern for the protection of democracy, rule of law and fundamental rights within Member States.

³⁰⁸ (Public Health), https://health.ec.europa.eu/health-emergency-preparedness-and-response-hera/overview_en, accessed 9 November 2022.

³⁰⁹ European Parliament resolution of 13 November 2020 on the impact of COVID-19 measures on democracy, the rule of law and fundamental rights (2020/2790(RSP)).

³¹⁰ *ibid.*

³¹¹ SOC/691-EESC-2021.

In monitoring for observance of fundamental values, the Commission emphasised that the relevant tests for emergency measures must follow established expectations, including whether measures were limited in time, whether safeguards were in place to ensure that measures were strictly necessary and proportionate, and whether parliamentary and judicial oversight, as well as media and civil society scrutiny, could be maintained. However, the uncertain impact of Rule of Law reports, and whether they incorrectly communicated a kind of equivalence between states has been highlighted by experts³¹².

Further scrutiny has been actioned under the **European Semester** mechanism. The Country Specific Recommendations of August 2020 recalled that exceptional measures adopted in response to the public health emergency should be necessary, proportionate, limited in time and subject to scrutiny³¹³. These recommendations were adopted by the European Council in August 2020.

While monitoring of the situation is an essential element of democratic practice, particularly where the EU is in a position to provide guidance on comparative and pan-EU practices, there is ongoing concern about the capacity of the Union to take action against backsliding states. Decision-making at national level, and the degree of scrutiny over actions taken by executives, were still primarily rooted in domestic practices. Recommendations by EU institutions to its Member States are meaningful, only if they are actioned by Member State. Focus will now turn to the EU's future pandemic preparedness. A focus on testing, integrated surveillance systems, vaccination and tackling mis- and dis-information concerning them, in addition to the development of new therapeutics and support for healthcare systems will boost the capacity³¹⁴, but recognition of the need for interdisciplinarity in expertise, as well as the interdependencies of rights, democracy, rule of law and public health will be important to design policies, and build resilience to future health crises.

5.3. Recommendations for future EU pandemic response

The EU has been hindered by both lack of legal powers, but also (and consequently) a lack of resourcing and institutional capacity to respond in a more robust fashion to the pandemic. However, as argued by Paces and Weimer³¹⁵, the EU has had neither legal nor 'sufficiently strong democratic-political authority' to take leadership of the COVID-19 response. It should be noted, however, that the relative absence of the European Union from decision-making processes in response to the pandemic is not unusual: other global and transnational institutions have so-far played a limited role largely providing information and analysis, rather than directing or determining action³¹⁶. The measures adopted to combat COVID-19 have been bound by both national borders and the limits of political will to create transnational and coordinated solutions to the global crisis.

Nevertheless, some recommendations can be made. Reflecting on pandemic response, a number of proposals have been made and some actions have been taken by EU institutions. The Commission's proposals include actions directed at strengthening preparedness planning and response capacity at national and Union level, including the harmonisation of EU, national and regional preparedness and

³¹² See Petra Bard and Laurent Pech, The Commission's Rule of Law Report and the EU Monitoring and Enforcement of Article 2 TEU Values, [https://www.europarl.europa.eu/RegData/etudes/STUD/2022/727551/IPOL_STU\(2022\)727551_EN.pdf](https://www.europarl.europa.eu/RegData/etudes/STUD/2022/727551/IPOL_STU(2022)727551_EN.pdf).

³¹³ Adopted by the Council - OJ of 26/08/20, C 282.

³¹⁴ See e.g. EU Commission, *COVID-19: Commission calls on Member States to step up preparedness for the next pandemic phase* (27 April 2022), https://ec.europa.eu/commission/presscorner/detail/en/ip_22_2646.

³¹⁵ Paces AM, Weimer M (2020) from diversity to coordination: a European approach to COVID-19. *Eur J Risk Regul* 11:283.

³¹⁶ See the discussion of e.g. Burci, G. L., & Eccleston-Turner, M. (2021). Preparing for the Next Pandemic: the International Health Regulations and World Health Organization during COVID-19, *Yearbook of International Disaster Law Online*, 2(1), 259-282. doi: https://doi.org/10.1163/26662531_00201_011.

response plans, which would be regularly audited by Commission and EU agencies. The Commission has proposed an EU emergency system, triggering increased coordination and rapid action to develop, stockpile and procure relevant resources for a public health crisis.

The Commission has advocated for stronger mandates for both the EMA and ECDC. It recommended that the ECDC should be allowed to undertake epidemiological surveillance, preparedness and response planning, reporting and auditing, recommendations for risk assessment and management, deploying the EU Health Task Force, and building a network of reference laboratories; and the EMA's mandate should include monitoring and mitigating the risk of shortages of critical medicines and medical devices, providing scientific advice on medicines for treating, preventing or diagnosing diseases causing those crises, and coordinating clinical trials and pharmacovigilance of vaccines in the market.

Beyond this, the COVID-19 pandemic has shown both the ultimate resilience of EU systems affected by health crisis shocks, and the manifold benefits of coordinated response. Evidenced by the ultimate coordination over borders, COVID-19 passes, and areas directly related to free movement, there can be political will at Member State level to effectively, and jointly, respond to common health threats. This must be based, however, on systematic sharing of information, transparent processes for decision-making (particularly in the context of procurement) and communication in which existing competences are sufficient.

The complexity of the organisation of national health and social care systems, which necessarily rely on political decision-making in the allocation of state resources, makes national or regional governments (as in the case of e.g., Germany and Sweden) better placed than the EU in terms of competence and democratic accountability to deliver services to populations. The negative consequence, as evidenced within the EU where national governments primarily if not exclusively led responses, was the diverse and sometimes incompatible strategies adopted (e.g., mask wearing mandates and timed closure of businesses in Belgium but not in the Netherlands).

A balance should, however, be struck where, in the face of pan-EU health threats, the EU can assume a more prominent role in coordinating transborder elements of responses. The EU's capacity and resources also enable it to assume a leading role in the preparation for future emergencies: **identifying potential and emerging threats, funding research into emergency action and effective response,** and **developing coordinated strategies to mitigate risk and adverse consequences.** To achieve this, **autonomous competence to investigate, collect and analyse data would be recommended.**

6. VACCINATIONS AND COVID-19 PASSES

KEY FINDINGS

The EU has achieved a higher average rate of vaccination compared with global rates; however, there is a wide divergence in vaccination rates across EU Member States, largely correlating with levels of vaccine hesitancy.

Vaccine mandates may be justified on fundamental rights terms when connected with certain circumstances or professions. However, they have not been conclusively proven to incentivise higher vaccination rates, particularly among groups or communities which are vaccine-hesitant.

A 'one-size-fits-all' approach to encouraging vaccine acceptance and tackling vaccine hesitancy is unlikely to be effective. Attention must be paid to the underlying reasons for vaccine hesitancy, as well as the unique dynamics of the target group or population.

COVID-19 passes supported opening of public spaces, and businesses and there is some (early) evidence that they may encourage some groups to be vaccinated. However, a number of legal, ethical, scientific and technical concerns have been raised.

Scientific concerns relate to uncertainty regarding the longevity of immunity, and the encouragement of risky behaviours, while technical concerns related to the security and data privacy of digital applications. Concerns relating to the COVID-19 passes being 'discriminatory by design' and leading to exclusion of unvaccinated populations were also raised.

This chapter examines the various approaches taken by EU Member States in relation to vaccinations and related COVID-19 passes. It considers rates of vaccination in the EU, the various policies adopted in relation to rollout and prioritisation, and concerns related to mandatory vaccinations (section 6.1). The chapter then examines the differing approaches to COVID-19 passes or certificates and concerns raised regarding, inter alia, privacy and discrimination (section 6.2). Section 6.3 discusses the efficacy of vaccination policies and legislation, including in relation to COVID-19 passes, in slowing down the pandemic and addressing vaccine hesitancy.

6.1. Vaccination

6.1.1. Rates of vaccination in the EU

The first vaccine against SARS-CoV-2 was approved by the European Commission on 21 December 2020. By August 2022, 34 vaccines had been licensed to come into use globally³¹⁷. As of November 2022, between 9 and 12.5 billion doses of a COVID-19 vaccine have been administered worldwide, 68.3% of the global population has received at least one dose of a COVID-19 vaccine³¹⁸, and 65% has completed the primary course (i.e. two doses) of a vaccine³¹⁹.

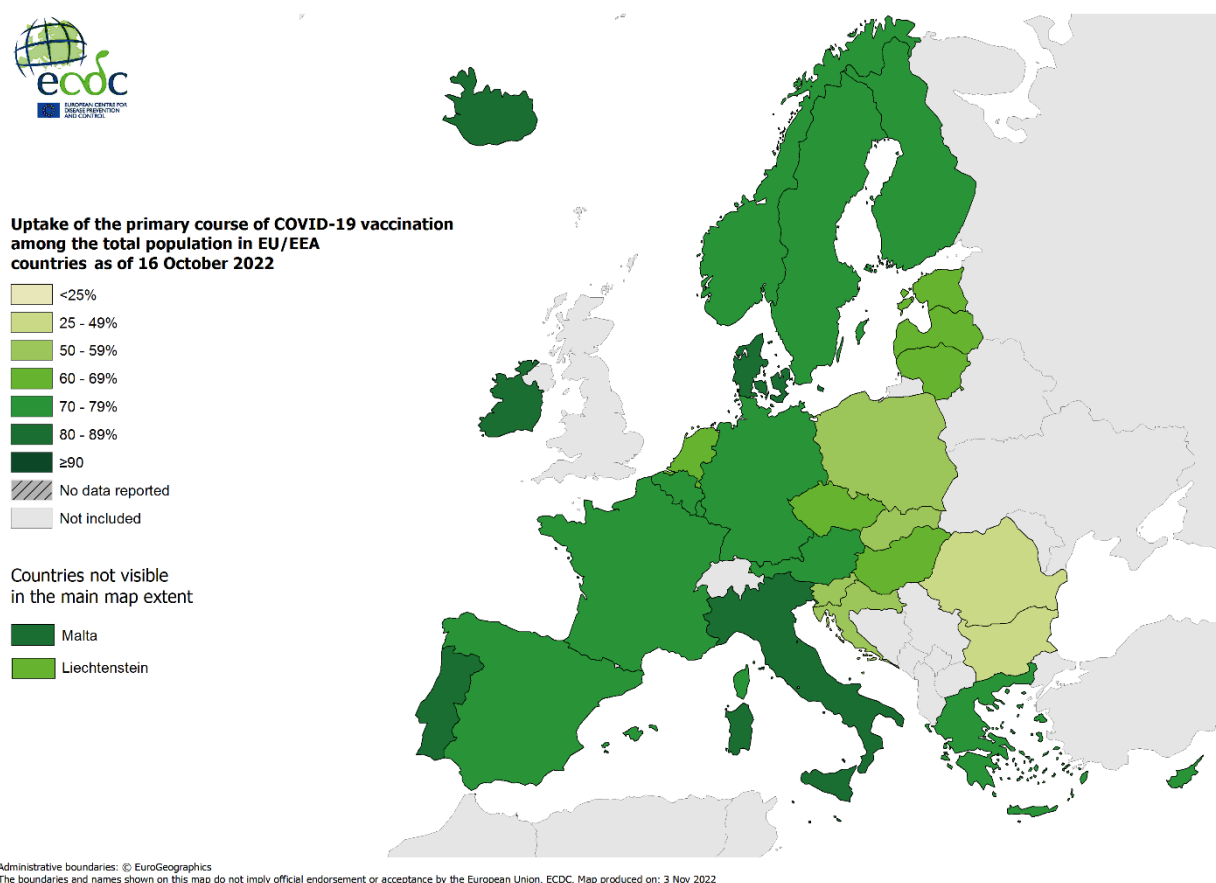
³¹⁷ 'COVID-19 Vaccine Tracker' (Shinyapps.io), https://vac-lshtm.shinyapps.io/ncov_vaccine_landscape/, accessed 9 November 2022.

³¹⁸ Mathieu, E., and others, 'Coronavirus Pandemic (COVID-19)' (Our World In Data 2020), <https://ourworldindata.org/covid-vaccinations>, accessed 9 November 2022.

³¹⁹ Holder, J., 'Tracking Coronavirus Vaccinations around the World' (The New York Times 29 January 2021), <https://www.nytimes.com/interactive/2021/world/covid-vaccinations-tracker.html>, accessed 9 November 2022.

Vaccination rates differ significantly between high-income countries and low-income states, as well as internally within states between high- and low-income groups³²⁰. As of November 2022, 75.2% of the EU population have had at least one dose, with 72.7% completing the primary course, while 56% have had one booster, and 6.2% have received a second booster (or fourth dose)³²¹. By contrast, in the same timeframe, only 23% of the African population were fully vaccinated with the primary course of any vaccine³²², although this averages the wide variance between the lowest levels, such as Eritrea (0%), to the highest, such as Mauritius (85.3%)³²³.

Figure 13: Uptake of primary course of COVID-19 vaccination in EU/EEA



Source: European Centre for Disease Control, <https://covid19-country-overviews.ecdc.europa.eu/vaccination.html>.

As Figure 13 shows, within the EU, Bulgaria (30% completed primary course), Romania (42.4%), Slovakia (51.1%) and Croatia (55.1%) are the least vaccinated Member States, while Portugal (86.7%), Denmark (81.8%), Italy (80.2%) and Ireland (80%) have the highest vaccinated populations for the primary course, as of November 2022.

By this date, among the 60+ age group, 90.7% of the EU population (ranging within Member States from 38.4-100%) had completed the primary course of the vaccine. For the first booster, this falls to

³²⁰ COVID-19 Vaccine Doses Administered per 100 People, by Income Group' (*Our World in Data*), <https://ourworldindata.org/grapher/cumulative-covid-vaccinations-income-group>, accessed 9 November 2022.

³²¹ 'Data on COVID-19 Vaccination in the EU/EEA' (*European Centre for Disease Prevention and Control*, October 24, 2022), <https://www.ecdc.europa.eu/en/publications-data/data-covid-19-vaccination-eu-eea>, accessed 9 November 2022.

³²² 'COVID-19 Vaccination' (*Africa CDC* 19 April 2021), <https://africacdc.org/covid-19-vaccination/>, accessed 9 November 2022.

³²³ *ibid.*

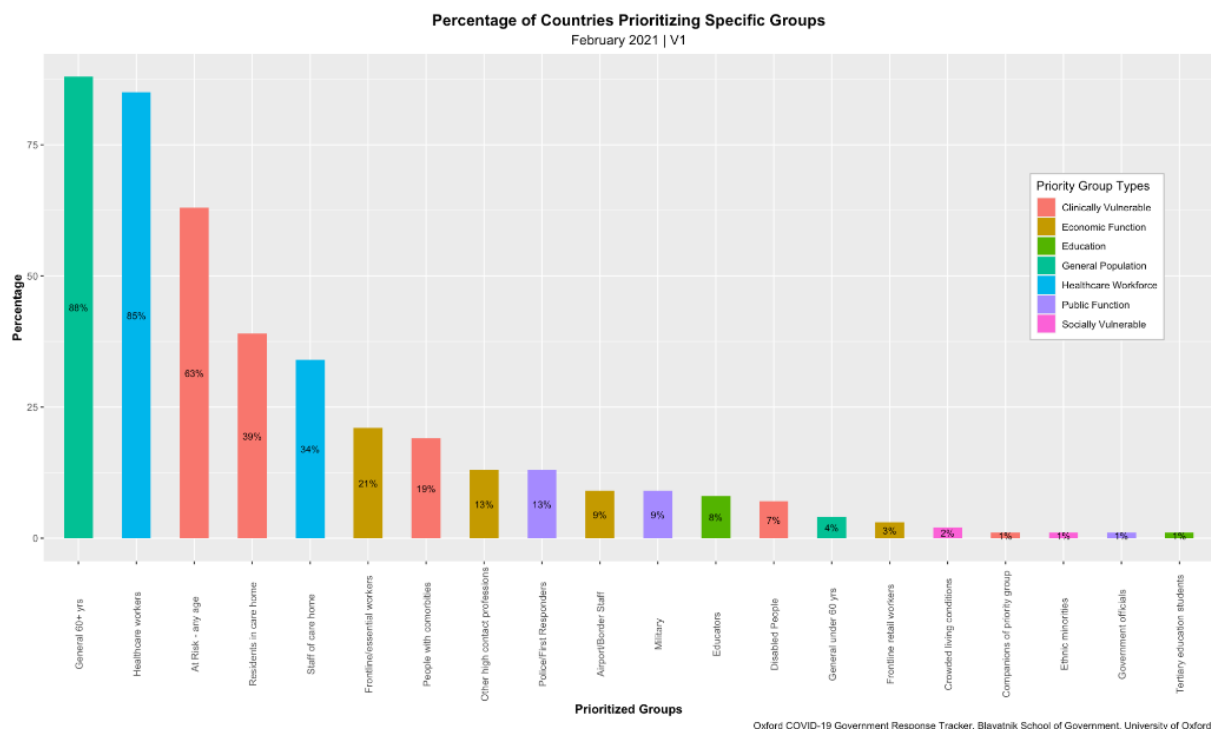
83.8% (13.6-100% in 27 countries reporting); and for the second booster, 15.7% (0.3%-68% in 25 countries reporting).

6.1.2. Vaccination policies globally and in the EU

Phased roll out of vaccines began on 27 December 2020 in the EU. Each EU Member State managed distribution domestically. Vaccination policies in EU Member States generally prioritised the elderly (with varying cut off ages), adults with comorbidities at risk of developing severe disease, and healthcare workers. A majority of states also prioritised workers in essential services, as well as social workers³²⁴. Poland and Cyprus also identified police, military and other security forces as a first priority group for vaccination.

As Figure 14 shows, these policies broadly follow global priorities for vaccination: the top three categories who received vaccinations first were the elderly, healthcare frontline workers, and clinically vulnerable people. Other categories that many jurisdictions prioritised were educators, military, border security workers and police/first responders.

Figure 14: Percentage of countries prioritising specific groups for vaccination globally



Source: Oxford COVID-19 Government Response Tracker.

A number of countries worldwide prioritised locally relevant groups and populations. For example, in Ghana, prioritisation was given to agricultural workers in order to secure the food supply chain, while Bolivia and Congo prioritised journalists and press officials. While vaccination was free in all EU Member States, it was not free in all states: for example, Botswana, India, Pakistan, and Turkmenistan required a

³²⁴ ECDC 'Overview of COVID-19 Vaccination Strategies and Vaccine Deployment Plans in the EU/EEA and the UK' (*Europa.eu*, 2020), https://www.ecdc.europa.eu/sites/default/files/documents/Overview-of-EU_EEA-UK-vaccination-deployment-plans.pdf, accessed 9 November 2022.

small fee for vaccination from individuals. Egypt mooted the possibility of charging for vaccines or requiring low-income groups to apply for a fee waiver. Data shows that while 'High Income Countries took an average of 6-7 months to go from a prioritised list to universal adult access, whereas Low Income Countries, especially those with high vaccine hesitancy, moved more quickly to universal access (approximately 2-3 months) to increase uptake'³²⁵.

Following the initial phase, EU Member States progressed to vaccination through various stages inviting certain populations to be vaccinated in succession. These groups were typically determined by risk (e.g., residents and personnel of long-term care facilities); and essential services (police, firefighters, workers at educational institutions). Further vaccination phases went on increments of age; for example, based on decreasing 5-year increments. As of November 2022, all EU countries offer primary vaccination to those aged 12 years and above.

All EU countries are recommending a first booster dose for different groups in the general population to improve protection in individuals whose immunity may wane overtime after completing the primary course. On the expectation of increasing rates of COVID-19 through Winter 2022/23, EU Commissioner Stella Kyriakides, WHO Regional Director for Europe Dr Hans Henri P. Kluge, and Director of the European Centre for Disease Control (ECDC) Dr Andrea Ammon, issued a statement in October 2022 urging healthcare workers, people over 60 years old, pregnant women and those with comorbidities and/or underlying conditions to be vaccinated against both COVID-19 and influenza³²⁶.

6.1.3. Concerns related to mandatory vaccination

A vaccination mandate is a legal requirement to be vaccinated. It may involve a penalty for non-vaccination such as a fine, or a prohibition from certain actions without vaccination. Vaccine mandates can be a condition of employment (e.g., for healthcare workers or front line workers), education (e.g. school attendance), or a general legal duty (e.g. parents must vaccinate their children). They are primarily a means of ensuring or encouraging vaccination status among populations.

Vaccine mandates have been mooted as a means of combatting vaccine hesitancy. On 1 December 2021, European Commission President Ursula von der Leyen said it was time for the EU to consider compulsory vaccination, adding that 'how we can encourage and potentially think about mandatory vaccination within the European Union needs discussion. This needs a common approach'³²⁷. The European Council echoed the 'vital importance of vaccination in the fight against the pandemic'³²⁸. Despite this, there was no common approach to mandatory vaccination against COVID-19 at EU level.

Germany and Italy introduced a vaccine mandate for certain age groups. In February 2022, Austria mooted the idea of introducing compulsory vaccination for all residents above the age of 18³²⁹, which

³²⁵ Hale T, 'Government Response Tracker Now Includes Data on Vaccination Policies around the World' (*Ox.ac.uk*), <https://www.bsg.ox.ac.uk/news/government-response-tracker-now-includes-data-vaccination-policies-around-world>, accessed 9 November 2022.

³²⁶ 'Joint Statement by Commissioner Stella Kyriakides, WHO Regional Director for Europe Dr Hans Henri P. Kluge and Director of the ECDC Dr Andrea Ammon: Working together towards COVID-19 and Seasonal Influenza Vaccinations for this Winter' (*European Commission* 12 October 2022), https://ec.europa.eu/commission/presscorner/detail/en/STATEMENT_22_6117, accessed 9 November 2022.

³²⁷ Boffey, D., and Smith, H., 'EU Must Consider Mandatory Covid Jabs, Says Von Der Leyen' (*The Guardian* 1 December 2021), <https://www.theguardian.com/world/2021/dec/01/eu-must-consider-mandatory-covid-jabs-says-von-der-leyen>, accessed 9 November 2022.

³²⁸ 'COVID-19: Research and Vaccines' (*Europa.eu*), <https://www.consilium.europa.eu/en/policies/coronavirus/covid-19-research-and-vaccines/>, accessed 9 November 2022.

³²⁹ Druml, C., and Czech, H., 'A Pandemic Is No Private Matter: The COVID-19 Vaccine Mandate in Austria' (2022) 10 *The Lancet. Respiratory Medicine* 322, [https://www.thelancet.com/journals/lanres/article/PIIS2213-2600\(22\)00063-7/fulltext](https://www.thelancet.com/journals/lanres/article/PIIS2213-2600(22)00063-7/fulltext), accessed 9 November 2022.

received overwhelming support in the Federal Council (the upper chamber of the Austrian Parliament) and included fines of up to €3600 every 3 months for people who were not vaccinated. However, the mandate was not enforced, and was withdrawn after four months with no evident impact on vaccine hesitancy³³⁰.

Several EU Member States introduced mandatory vaccination for certain categories of workers (Germany, Greece, France, Italy, Latvia and Hungary)³³¹. Most of these mandates relate to essential or healthcare workers (e.g., doctors, emergency workers, or those working in care homes). However, Hungary (until 6 March 2022) and Estonia introduced provisions allowing employers to impose vaccination requirements. Access to certain public spaces was limited to those fully vaccinated or with proof of recovery from COVID-19 in France, Germany, Italy and Latvia.

Mandatory vaccinations raise a number of legal and ethical issues where they are a non-consensual medical intervention, and relate to a number of rights protected under EU law³³²:

- *EU Charter Rights*: the right to integrity, which includes the free and informed consent of those undergoing medical treatment (Article 3 EUCFR), the right to privacy (Article 7 EUCFR), and the right to data protection (Article 8 EUCFR). However, these rights may be restricted by law if the objectives pursued are legitimate, and the measures are necessary and proportionate (Article 52(1) EUCFR); and
- *EU Treaty rights*: EU citizens have the right to move and reside freely in the EU (Article 21(1) TFEU), and discrimination on grounds of nationality is prohibited (Article 18 TFEU). National vaccination mandates could infringe the rights of frontier and cross-border workers where they may prevent the provision of services (Article 56 TFEU).

Directive 2004/38, governing the exercise of EU citizens' and their family members' rights to move and reside in the EU, allows Member States to restrict these freedoms on grounds of public health (Article 27). Article 29(1) of Directive 2004/38 states 'the only diseases justifying measures restricting freedom of movement shall be the diseases with epidemic potential as defined by the relevant instruments of the World Health Organisation and other infectious diseases or contagious parasitic diseases', and only if 'protection provisions' apply to the Member State's own nationals, as well. Article 11 of Regulation 2021/953 establishing the EU Digital Covid Certificate recognises the Member States' competence to impose restrictions on free movement on grounds of public health, and to impose conditions on free movement 'if they are necessary and proportionate for the purpose of safeguarding public health' in response to the pandemic, 'also taking into account available scientific evidence'.

Under the European Convention on Human Rights, mandatory vaccination schemes may similarly raise issues of rights compliance:

- Right to respect for private and family life (Article 8 ECHR) protecting the physical integrity of a person, and their medical decision-making;
- Right to education (Article 2, Protocol 1 ECHR) where vaccination is a condition of participation in schools and universities;

³³⁰ *ibid.*

³³¹ Diaz, C. M., and others, 'Legal Issues Surrounding Compulsory Covid-19 Vaccination' (*Europa.eu*), [https://www.europarl.europa.eu/RegData/etudes/BRIE/2022/729309/EPRS_BRI\(2022\)729309_EN.pdf](https://www.europarl.europa.eu/RegData/etudes/BRIE/2022/729309/EPRS_BRI(2022)729309_EN.pdf), accessed 9 November 2022.

³³² See further: *ibid.*

- Protection of property (Article 1 Protocol No 1 ECHR) where vaccination is required for access to work, or to perform professional duties;
- Right to data protection (Article 8 ECHR) where vaccination mandates and tracking raises issues of access to, and sharing of, personal medical data; and
- Prohibition of discrimination (Article 14 ECHR) where rules for access to services, establishments, or activities is restricted to those who have been vaccinated in ways that might disadvantage particular groups.

These rights are not absolute. A restriction of the rights can be justified if it is provided by law and necessary in a democratic society, i.e., a proportionate means of achieving a pressing social need. Prior to the COVID-19 pandemic, the European Court of Human Rights (ECtHR) recognised that action to prevent the spread of an infectious disease is a legitimate aim. The Court has held that non-consensual tests, vaccinations and screening programmes can be justified on grounds of protecting the rights of others, and public safety. However, such interventions must be proportionate: they cannot be justified if a less restrictive alternative is available³³³.

During the COVID-19 pandemic, a number of applications for interim measures against mandatory vaccinations were made to the ECtHR³³⁴. It held that the applications were outside the scope of Rule 39 on interim measures³³⁵. The Court found the applicants were not at real risk of irreversible harm. The Court has yet to rule on the substantive question of whether mandatory vaccinations breach ECHR rights.

Some guidance, however, can be found in the related judgment concerning mandatory childhood vaccinations, *Vavříčka and Others v. the Czech Republic*, delivered by the Grand Chamber of the Court on 8 April 2021. The ECHR found no violation of Article 8 (right to respect for private life). It considered that there is a general legal duty in the Czech Republic to vaccinate children against certain diseases well known to medical science, though compliance with this duty cannot be physically forced. The Court found that compulsory vaccination represents an interference with physical integrity and thus concerns the right to respect for private life. However, the Czech policy, which did not permit non-vaccinated children in nurseries (with exception for those unable to be vaccinated for health reasons), and fined parents who failed to comply with the duty to vaccinate without good reason, was proportionate and pursued the legitimate aim of protecting health and the rights of others in the community. The case indicates the wide margin of appreciation for states in areas of public health protection.

A number of decisions have been made at national level on mandatory vaccination policies. While a majority of constitutional courts have yet to decide on the merits of vaccine mandates, initial decisions indicate that they are more than likely to be considered constitutional under well-established principles of necessary action pursuing a legitimate aim:

³³³ Douglas, T., Forsberg, L., and Pugh, J., 'Compulsory Medical Intervention versus External Constraint in Pandemic Control' (2020) 47 Journal of Medical Ethics e77, <https://jme.bmj.com/content/47/12/e77>, accessed 9 November 2022.

³³⁴ Cohadier and 600 Others v. France, no. 8824/22; Abgrall and 671 Others v. France, no. 41950/21 (press release); Kakaletri and Others v. Greece, no. 43375/21 (press release); Theofanopoulou and Others v. Greece, no. 43910 (press release); Concas and Others v. Italy, no. 18259/21).

³³⁵ A third case, Thevenon v. France (application no. 46061/21) was declared inadmissible as the applicant had failed to exhaust domestic remedies.

- Germany: the *Bundesverfassungsgericht* (Federal Constitutional Court) has yet to rule on the constitutionality of sector-specific vaccine mandates³³⁶. However, the court's decision not to use an expedited procedure stated that the introduction of the vaccine mandate for certain sectors does not pose any fundamental constitutional concerns, although the right to physical integrity and freedom of occupation, in particular, might have to be considered. The very low probability of serious consequences of vaccination is off-set by the significantly higher probability of damage to the life and health of vulnerable people from COVID-19;
- France: the *Conseil constitutionnel* (Constitutional Court) upheld the constitutionality of the *pass vaccinal*³³⁷. The Conseil held that the *pass vaccinal* pursued a legitimate aim and was not manifestly inadequate to attain the goal pursued, considering the scientific evidence available;
- Greece: The Council of State considered mandatory vaccination necessary to protect public health, being imposed on a specific professional sector, with the constitutional obligation to demonstrate social solidarity and an increased responsibility to safeguard patients' health;
- Italy: The Council of State rejected the plea of workers in the medical profession on grounds that the obligation protects people individually and collectively, and represented an acceptable balance of costs and benefits³³⁸, in line with prior case law³³⁹; and
- Hungary: The Constitutional Court ruled that the obligation to be vaccinated as a health care worker is a proportionate restriction of the right to health self-determination, and considered that the restriction of fundamental rights (to life and human dignity, health, and self-determination) provided for is necessary and proportionate³⁴⁰.

6.2. COVID-19 passes

6.2.1. Policies on COVID-19 passes in the EU

COVID-19 passes refer to a range of certification which can indicate whether someone has been vaccinated, tested negative, or has recently recovered from COVID-19. The documentation was variously referred to as passports, passes, or certificates in states throughout the world. States worldwide adopted a variety of different policies as regards their status, use, and the conditions attached to their use. The introduction of vaccine passports was argued to be a tool to protect public health while also returning life to as normal as possible. The rights and privileges attached to a vaccine passport was also considered as a motivation to encourage people to become vaccinated and achieve herd immunity³⁴¹.

Regulation 2021/953 established the EU Digital COVID Certificate, which was first adopted in June 2021 by seven Member States. Forty-nine non-EU countries and territories joined the EU Digital COVID Certificate system, based on EU equivalence decisions, allowing mutual recognition of the certification

³³⁶ 'Bundesverfassungsgericht - Presse - Erfolgreicher Eilantrag zur Außervollzugsetzung der „einrichtungs- und unternehmensbezogenen Nachweispflicht' nach § 20a Infektionsschutzgesetz' (*Bundesverfassungsgericht.de*), <https://www.bundesverfassungsgericht.de/SharedDocs/Pressemitteilungen/DE/2022/bvg22-012.html>, accessed 9 November 2022.

³³⁷ 'Décision n° 2022-835 DC du 21 janvier 2022' (*Conseil Constitutionnel*), <https://www.conseil-constitutionnel.fr/decision/2022/2022835DC.htm>, accessed 9 November 2022.

³³⁸ Judgment 705/2021.

³³⁹ Judgment 5/2018.

³⁴⁰ Decision 3537/2021. (XII. 22.)

³⁴¹ Sharif A, Botlero R, Hoque N, et al, A pragmatic approach to COVID-19 vaccine passport, *BMJ Global Health* 2021;6:e006956.

on condition that this vaccine was approved by the EU. This raised an issue for Low- and Middle-Income Countries (LMIC), where distributed vaccines included the Russian Sputnik and Chinese Sinopharm vaccines which were not approved in the EU.

The EU Digital COVID Certificate service is free of charge, valid in all EU Member States, and available in digital and paper formats. In light of concerns for data privacy and security, the gateway enables all certificate signatures to be verified across the EU without further sharing of information. The personal data of the certificate holder does not pass through the gateway, as this is not necessary to verify the digital signature.

The introduction of an EU-level COVID-19 pass in the form of the Digital Certificate was intended to support free movement; and to enable restrictions to be lifted in a coordinated manner. A holder of the EU Digital COVID Certificate should in principle be exempt from free movement restrictions. It was expected that Member States should refrain from imposing additional travel restrictions on the holders of the pass, unless they are necessary and proportionate to safeguard public health.

As free movement is a fundamental right of the EU, COVID passes could not be a condition for entry, but were designed to facilitate it – particularly against the diversity of national COVID-19 documentation and policies. In response to criticism concerning the potential for discrimination against individuals who are not vaccinated, the Commission stated that the EU Digital COVID Certificate would also incorporate test certificates and certification for those who had recovered from COVID-19.

Member States only had to accept vaccination certificates for vaccines which received EU approval. Member States could also decide to waive restrictions for travellers that had received another vaccine, for instance those included on the WHO emergency list, but they were not obliged to. By February 2022, all Member States with the exception of Lithuania, Slovenia and Sweden, required travellers from other Member States to present COVID-19 passes, while 14 Member States allowed travellers to enter without quarantine if they were vaccinated, recovered, or tested negative. Four restricted this to only EU Member States which were classified as ‘low risk’.

Member States used the COVID-19 passes for domestic purposes, but these were not regulated at EU-level. Vaccination certificates for access to specific places/events (e.g., restaurants, museums, concerts, etc.) were adopted in Austria, Belgium, Bulgaria, Croatia, Cyprus, Estonia, Finland, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, the Netherlands, Portugal, Romania, Slovenia and Spain. In Poland, it was not obligatory to have a COVID-19 pass to have access to specific places/events, but those that had it were exempt from limitations³⁴².

From August 2021, the ‘pass sanitaire’ introduced in France was required for entry into all indoor venues³⁴³. The scheme ended on 14 March 2022. Italy’s COVID-19 passport was required for all workplaces, public venues and public transport from 15 October 2021. From 6 December, the pass was required for entry into cinemas, sporting events, restaurants or bars. The scheme ended on 31 March 2022. In Denmark, it was a requirement to hold a COVID-19 pass on public transport, and public spaces including bars and restaurants. Germany, France, Italy and Latvia further restricted access to certain venues to only those who were vaccinated against or had recovered from the COVID-19, and so excluded those who had recently tested negative.

³⁴² ECDC (n 324).

³⁴³ Díaz, C. M., and others, ‘Legal Issues Surrounding Compulsory Covid-19 Vaccination’ (*Europa.eu*), [https://www.europarl.europa.eu/RegData/etudes/BRIE/2022/729309/EPRS_BRI\(2022\)729309_EN.pdf](https://www.europarl.europa.eu/RegData/etudes/BRIE/2022/729309/EPRS_BRI(2022)729309_EN.pdf), accessed 9 November 2022.

By summer 2022, the use of COVID-19 passes for travel between EU Member States or entry into public venues had been phased out in all Member States.

6.2.2. Concerns related to the use of COVID-19 passes

Health data is considered as sensitive data under the General Data Protection Regulation (GDPR) and their processing can only take place under strict requirements. One of the legal grounds for processing such personal data is public interest in the area of public health. In such cases, Union law or Member State law must be necessary and proportionate and provide specific measures to safeguard the rights and freedoms of the concerned individual.

Even prior to the authorization of vaccines, the WHO cautioned against the use of immunity certificates, citing the lack of evidence about the effectiveness of antibody-mediate immunity, and that the assumption of immunity may lead to people ignoring public health advice³⁴⁴. At EU level, early concern was against COVID-19 passes as a means of lifting border restrictions. With the advent of vaccines, the WHO also extended caution to vaccination certificates in April 2021, stating that states should not require proof of vaccination as a condition of entry, 'given the limited (although growing) evidence about the performance of vaccines in reducing transmission and the persistent inequity in the global vaccine distribution. States Parties are strongly encouraged to acknowledge the potential for requirements of proof of vaccination to deepen inequities and promote differential freedom of movement'³⁴⁵. The WHO Director-General recognised vaccination certificates as a means of facilitating the lifting of public health and social measures – such as quarantine and testing – for international travel³⁴⁶.

A number of legal, ethical, scientific and technical concerns have been raised in the context of COVID-19 passes. Some of these concerns are rooted in the argument that COVID-19 passes are 'discriminatory by design' and embed inequalities against those unable or unwilling to be vaccinated. Ethical considerations relate to the global shortage of vaccines and the further worsening of existing inequalities (both in terms of accessibility and availability of covid-19 vaccines and tests)³⁴⁷.

Concerns regarding inequality and discrimination:

- COVID-19 passes favour groups with access to vaccines. Issues of the accessibility of EU-approved vaccines create inequalities. For example, urban populations had easier access than rural populations; some groups faced financial barriers against getting vaccinated (e.g., time off work);
- COVID-19 passes discriminate between EU populations with access to EU-approved vaccines. A number of EU States offered vaccines which were not approved by the EU (e.g., Hungary distributed the Russian Sputnik V vaccine), which excluded these populations from EU certification;

³⁴⁴ "Immunity Passports' in the Context of COVID-19' (Who.int), <https://www.who.int/news-room/commentaries/detail/immunity-passports-in-the-context-of-covid-19>, accessed 31 October 2022.

³⁴⁵ WHO, 'meeting of the International Health Regulations (2005) Emergency Committee regarding the coronavirus disease (COVID-19) pandemic' (19 April 2021), [https://www.who.int/news/item/19-04-2021-statement-on-the-seventh-meeting-of-the-international-health-regulations-\(2005\)-emergency-committee-regarding-the-coronavirus-disease-\(covid-19\)-pandemic](https://www.who.int/news/item/19-04-2021-statement-on-the-seventh-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-coronavirus-disease-(covid-19)-pandemic), accessed 11 November 2022.

³⁴⁶ *ibid.*

³⁴⁷ 'Covid-19 Vaccine Passports and Vaccine Hesitancy: Freedom or Control?' (The BMJ, March 30, 2021), <https://blogs.bmj.com/bmj/2021/03/30/covid-19-vaccine-passports-and-vaccine-hesitancy-freedom-or-control/>, accessed October 31, 2022.

- Members of marginalised groups are less likely to be vaccinated, and so more likely to be excluded from participation in social and public activities.³⁴⁸ Without targeted interventions to address vaccine hesitancy in these groups, inequalities and discrimination can be perpetuated by COVID-19 passes; and
- Where a COVID-19 certification could be made a condition of employment, employers could discriminate between vaccinated and unvaccinated applicants and employees.

Concerns regarding access to data and privacy:

- COVID-19 digital passes create both the risk of fraudulent certificates and exposes users' data to the vulnerability of insecure applications which were linked with sensitive personal and medical data³⁴⁹; and
- COVID-19 passes could set a precedent for invasions of health privacy³⁵⁰, whereby employers or public authorities could be given access to private medical information of individuals.

Scientific, technical and security concerns:

- Vaccinations do not provide certain and permanent protection against disease or transmission as the longevity of the antibody response achieved through vaccination is unclear. Evidence has also suggested that their effectiveness reduces over time³⁵¹;
- COVID-19 passes can create a false sense of security and encourage more reckless or risky behaviours³⁵². The use of COVID-19 certificates in determining that a person is unlikely to transmit the virus is uncertain. Where COVID-19 passes recognise recovery as a qualification, then it could encourage individuals to get infected (especially if vaccine hesitant), whereas vaccine passports encourage people to get immunised; and
- COVID-19 passes raised technical issues including the interoperability of certification across borders. Reliance on digital certificates also raises the possibility of exclusionary and discriminatory application of rules against people who are digitally illiterate (e.g., populations with less access or familiarity with mobile phones or the internet, or who experience language barriers to local applications).

Testing as a way to mitigate the concerns for discrimination and inequality which may arise, has also been criticised where it depends on access to testing, and where repeated testing could create burdens. The ECtHR rejected a number of applications for interim measures against the use of COVID-19 certificates which stipulated that only people in possession of the certificates would be allowed to attend public places and, in some cases, to use public transport. The requests were rejected for being

³⁴⁸ 'How to Lose Friends and Alienate People? On the Problems of Vaccine Passports' (The BMJ, April 1, 2021), <https://blogs.bmj.com/bmj/2021/04/01/how-to-lose-friends-and-alienate-people-on-the-problems-of-vaccine-passports/>, accessed October 31, 2022.

³⁴⁹ '12 Challenges for Vaccine Passports' (Royalety.org), <https://royalety.org/news/2021/02/12-challenges-for-vaccine-passports/>, accessed October 31, 2022.; 'Are Vaccine Passports a good Idea?' (The Economist 13 March 2021), <https://www.economist.com/science-and-technology/2021/03/13/are-vaccine-passports-a-good-idea>.

³⁵⁰ '12 Challenges for Vaccine Passports' (Royalety.org), <https://royalety.org/news/2021/02/12-challenges-for-vaccine-passports/>, accessed October 31, 2022.

³⁵¹ Cookson, C., Barnes, O., and Burn-Murdoch, J., 'Why Are Covid Vaccine Boosters Needed and Who in the UK Will Receive Them?' Financial Times (September 14, 2021), <https://www.ft.com/content/cf83b3a1-fe06-4c9f-999c-7500090aee7c>, accessed 31 October 31, 2022.

³⁵² Grover N, 'What Are the Pros and Cons of Covid Vaccine Passports?' The Guardian (February 14, 2021), <https://www.theguardian.com/world/2021/feb/14/what-pros-and-cons-covid-vaccine-passports-immunity-certificates-travel>, accessed October 31, 2022.

out of scope.³⁵³ The Court of Justice of the European Union rejected a challenge to the European Parliament's COVID rules, saying EU legislation can require that elected officials and staff show a vaccination certificate, negative test or proof of recovery to enter its buildings³⁵⁴.

While there are a number of concerns related to the use of COVID-19 passes, many can be addressed by values-driven system design (e.g., security, validation processes and data privacy policies). In addition, there is some evidence that vaccination certificates (or equivalent) can incentivise vaccination³⁵⁵. However, deeper structural inequalities related to vaccine hesitancy, and vaccine access require larger initiatives to address root causes of such inequality and discrimination.

6.3. Efficacy of vaccination policies and vaccine hesitancy

An estimated 14.4 million lives were saved during the first year of COVID-19 vaccinations globally³⁵⁶. Vaccination considerably reduces the negative effect of infectious diseases on populations and saves lives³⁵⁷. It has positive economic and health system benefits over non-pharmaceutical interventions, particularly restrictive measures.

The rate of completed primary vaccination among the EU population (72.7%) is higher than the world average (68.3%), though there is a wide internal range of rates of vaccination. While further doses of the vaccine can improve immunity, long term immunity is still uncertain³⁵⁸ as a number of studies are indicating a long-term waning of the efficacy of the immunity requiring 'boosters' or further doses of the vaccine. All EU Member States now advise further doses, particularly for those in vulnerable categories of the population. Vaccination rates beyond the primary dose are significantly lower.

Table 2: Vaccination rates in the EU (highest and lowest Member State)

	One dose	Primary dose	First booster	Second booster
EU	75.2%	72.7%	53.9%	6.2%
Portugal	94.8%	86.7%	67.2%	5.0%
Bulgaria	57.4%	30.0%	11.7%	1.1%

Source: Author's table based on [ECDC COVID-19 Tracker](#).

³⁵³ Mahut v. France, no. 55120/21; Mensi v. Italy, no. 58126/21; Livi and Others v. Italy, no. 59682/21; and Scola v. Italy, no. 3002/22.

³⁵⁴ Herszenhorn, D., 'EU Court Upholds Parliament's Coronavirus Rules' (*Politico* 30 November 2021), <https://www.politico.eu/article/court-upholds-parliaments-covid-rules/>.

³⁵⁵ Mills MC and Ruettenauer T, 'The Impact of Mandatory COVID-19 Certificates on Vaccine Uptake: Synthetic Control Modelling of Six Countries' (2021), https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1027643/S1401_University_of_Oxford_and_Nuffield_College_The_impact_of_mandatory_COVID-19_certificates_on_vaccine_uptake_Synthetic_Control_Modelling_of_Six_Countries_14_October_2021.pdf, accessed 31 October 2022.

³⁵⁶ Watson OJ and others, 'Global Impact of the First Year of COVID-19 Vaccination: A Mathematical Modelling Study' (2022) 22 *The Lancet infectious diseases* 1293, [https://www.thelancet.com/journals/laninf/article/PIIS1473-3099\(22\)00320-6/fulltext](https://www.thelancet.com/journals/laninf/article/PIIS1473-3099(22)00320-6/fulltext), accessed 31 October 2022.

³⁵⁷ W. A. Orenstein, R. Ahmed, Simply put: Vaccination saves lives. *Proc. Natl. Acad. Sci. U.S.A.* 114, 4031–4033 (2017); and M. Doherty, P. Buchy, B. Standaert, C. Giaquinto, D. Prado-Cohrs, Vaccine impact: Benefits for human health. *Vaccine* 34, 6707–6714 (2016).

³⁵⁸ Grewal R, Kitchen S A, Nguyen L, Buchan S A, Wilson S E, Costa A P et al. Effectiveness of a fourth dose of covid-19 mRNA vaccine against the omicron variant among long term care residents in Ontario, Canada: test negative design study *BMJ* 2022; 378 :e071502 doi:10.1136/bmj-2022-071502.

Within Member States, certain populations are under-vaccinated in comparison to others, particularly young people, vulnerable groups, minorities, and lower-income groups³⁵⁹. Initial challenges to vaccination policies included practical and logistical issues (e.g., shortage of equipment; limited vaccine supply; challenges to quality of data monitoring vaccine uptake; access to remote or under-served communities). Some EU Member States highlighted lessons learned for vaccination rollout, namely 'the need for extensive coordination between national and local authorities, and the multidisciplinary participation required in the planning and the implementation of the vaccination strategy'³⁶⁰. Ongoing and continuing challenges relate to vaccine hesitancy.

Vaccine hesitancy is the reluctance of individuals to receive a safe, recommended and available vaccine. The WHO has identified it as a 'top 10 health threat'³⁶¹. Vaccine hesitancy can lead to higher mortality rates than states with optimal vaccination rates if restrictive measures are relaxed. Low vaccination rates also prolong the need for measures to remain in place³⁶².

Vaccine hesitancy predates the COVID-19 pandemic³⁶³, and EU guidelines have existed in an effort to tackle it³⁶⁴. A wide range of factors can influence individual decisions to receive a vaccine, and so efforts to tackle it must respond to the unique circumstances which engender it³⁶⁵. These can include contextual influences, individual or group influences, and vaccine-specific issues. Concerns about the safety of vaccines against COVID-19, including the rapid pace of vaccine development, was one of the primary reasons for hesitancy³⁶⁶. Three unique characteristics of the COVID-19 pandemic have also been highlighted: (1) the dominance of the pandemic in public discourse, along with the fact that 'enormous socioeconomic repercussions may increase individuals' risk and threat perceptions'³⁶⁷; (2) the multiple vaccines developed and authorised at different points, creating confusion; and (3) the unprecedented speed at which vaccines were developed, which negatively influenced public perception of safety and risk³⁶⁸.

A common contextual influence is conspiracy theories, religious fatalism, media-circulated myths, or the perception that vaccines were forced on populations and violated rights³⁶⁹. Individual or group perceptions about the safety of vaccines, risk of both the disease or the likelihood the vaccine would cause other harms, fear of injections, or negative experiences or opinions of friends and families, can

³⁵⁹ Simas, C., Larson, H.J. Overcoming vaccine hesitancy in low-income and middle-income regions. *Nat Rev Dis Primers* 7, 41 (2021). <https://doi.org/10.1038/s41572-021-00279-w>; and based on a UK study, Razai M S, Osama T, McKechnie D G J, Majeed A. Covid-19 vaccine hesitancy among ethnic minority groups *BMJ* 2021; 372 :n513 doi:10.1136/bmj.n513.

³⁶⁰ ECDC 'Overview of the implementation of COVID-19: vaccination strategies and vaccine deployment plans in the EU/EEA' Technical Report (1 February 2021).

³⁶¹ F. Graham, Daily briefing: WHO calls out 'vaccine hesitancy' as top 10 health threat. *Nature* 10.1038/d41586-019-00188-9, (2019).

³⁶² Olivera Mesa, D., Hogan, A.B., Watson, O.J. et al. Modelling the impact of vaccine hesitancy in prolonging the need for Non-Pharmaceutical Interventions to control the COVID-19 pandemic. *Commun Med* 2, 14 (2022). <https://doi.org/10.1038/s43856-022-00075-x>.

³⁶³ MacDonald, N. E. *Vaccine* 33, 4161–4164 (2015).

³⁶⁴ ECDC 'Vaccine Hesitancy', see <https://www.ecdc.europa.eu/en/immunisation-vaccines/vaccine-hesitancy>, accessed 11 November 2022.

³⁶⁵ See e.g. Larson HJ, Jarrett C, Eckersberger E, Smith D, Paterson P. Understanding vaccine hesitancy around vaccines and vaccination from a global perspective: A systematic review of published literature, 2007–2012.

³⁶⁶ Wouters, O. J. et al. *Lancet* 397, 1023–1034 (2021).

³⁶⁷ Steinert, J. I., 'COVID-19 vaccine hesitancy in eight European countries: Prevalence, determinants, and heterogeneity' 8 (17) *Science Advances* DOI: 10.1126/sciadv.abm9825.

³⁶⁸ *ibid.* See also K. R. Nehal, L. M. Steendam, M. Campos Ponce, M. van der Hoeven, G. S. A. Smit, Worldwide vaccination willingness for COVID-19: A systematic review and meta-analysis. *Vaccine* 9, 1071 (2021); and D. Freeman, B. S. Loe, L.-M. Yu, J. Freeman, A. Chadwick, C. Vaccari, M. Shanyinde, V. Harris, F. Waite, L. Rosebrock, A. Petit, S. Vanderslott, S. Lewandowsky, M. Larkin, S. Innocenti, A. J. Pollard, H. McShane, S. Lambe, Effects of different types of written vaccination information on COVID-19 vaccine hesitancy in the UK (OCEANS-III): A single-blind, parallel-group, randomised controlled trial. *Lancet Public Health* 6, e416–e427 (2021).

³⁶⁹ Larson and others (n 360).

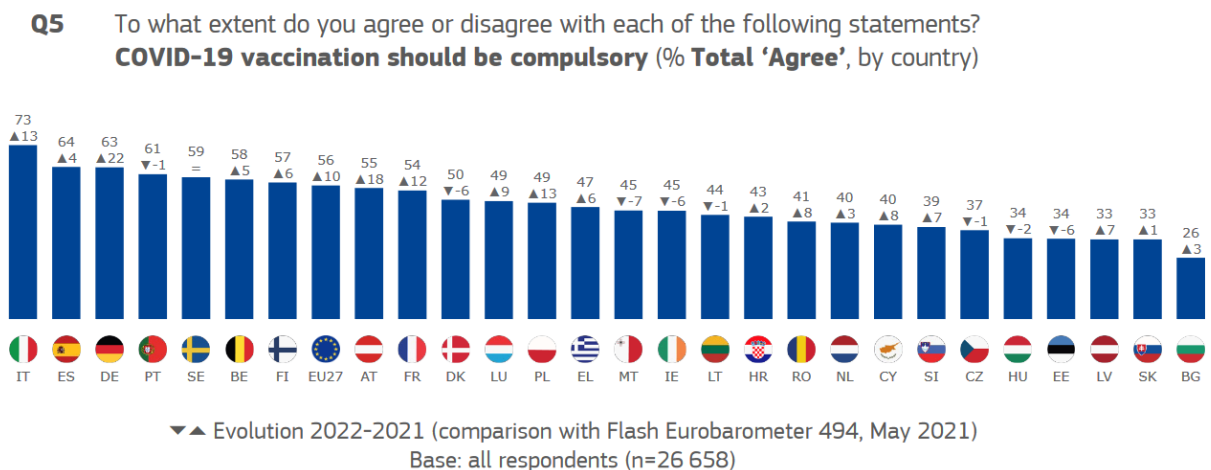
also be influential. Vaccine or vaccination specific issues include financial cost and access, as well as inconsistent advice from healthcare professionals³⁷⁰.

In the EU, national vaccination rates reflect sentiment towards vaccines. In one study of eight EU countries, 6.4% of Spanish adults, as compared with 61.8% of Bulgarian adults reported to experience vaccine hesitancy³⁷¹. This correlates with the relative levels of vaccination in both states (79.1% in Spain; 30.0% in Bulgaria). A range of strategies to encourage vaccine acceptance have been undertaken, including pop-up clinics, targeted communication strategies, outreach initiatives and intersection partnerships. A number of states introduced incentives for vaccination, and (as analysed above) others have introduced mandatory vaccination³⁷².

When surveyed, seven Europeans in ten agree that a vaccine is the only way to end the pandemic, but a similar proportion also consider that COVID-19 vaccines could have long term side-effects that we do not know yet, while more than half say that COVID-19 vaccines are being developed, tested and authorised too quickly to be safe³⁷³. More than two-thirds of Europeans agree that the European Union is playing a key role in ensuring that they can have access to COVID-19 vaccines in their country³⁷⁴.

Taking a closer look at motivation for vaccination, in a 2022 Eurobarometer survey, a greater majority of the EU population agreed that everyone should get vaccinated against COVID-19 as it was a civic duty (67% agree or tend to agree) rather than making a vaccination compulsory (56%). The percentages of those supporting compulsory vaccination also varied widely across Europe, from 73% in Italy, to only 26% in Bulgaria (Figure 15).

Figure 15: Results of 2022 Eurobarometer Flash survey on compulsory COVID-19 vaccination



Source: Flash Eurobarometer 505 Attitudes on vaccination against COVID-19 - February 2022.

³⁷⁰ 'Practical Guide for Public Health Programme Managers and Communicators Let's Talk about Hesitancy' (Europa.eu), <https://www.ecdc.europa.eu/sites/default/files/media/en/publications/Publications/lets-talk-about-hesitancy-vaccination-guide.pdf>, accessed October 31, 2022.

³⁷¹ Steinert and others (n 368).

³⁷² See ECDC 'Overview of the implementation of COVID-19 vaccination strategies and deployment plans in the EU/EEA' Technical Report (11 November 2021), <https://www.ecdc.europa.eu/sites/default/files/documents/COVID-19-vaccination-strategies-and-deployment-plans-Nov-2021.pdf>, accessed 11 November 2022.

³⁷³ Standard Eurobarometer 94 Winter 2020 – 2021.

³⁷⁴ *ibid.*

Again, this broadly aligns with underlying trends towards vaccine hesitancy/acceptance, and favours promoting a civic duty to be vaccinated, since a mandate may not address underlying reluctance. In terms of vaccine hesitancy, many EU countries highlight issues around mistrust, misinformation or low levels of information. In a number of countries, women tend to be more hesitant towards the COVID-19 vaccine, cohering with previous studies on a gender division³⁷⁵. Vaccine acceptance is also linked with higher levels of education and employment³⁷⁶.

Interventions must be targeted at the underlying determinants of hesitancy. For example, if financial cost or access in the availability of the vaccine is an issue, this indicates that logistical interventions such as reducing cost, or opening vaccination centres for longer periods out of working hours, and in publicly accessible locations would be effective.

It is recognised that belief-based determinants (conspiracy theories, or religious beliefs) can be the most challenging to address, but information campaigns built with engagement, education, and collaboration with community and religious leaders can be recommended, as the 'effectiveness of public health messages depends on the perceived trustworthiness of their sender, which may vary substantially across groups'³⁷⁷.

Within the EU, populations diverge on the efficacy of messages encouraging vaccination. For example, emphasis on health benefits and the privileges contingent on COVID-19 certification increased willingness to be vaccinated in Germany. However, messages communicating the medical benefit of the COVID-19 vaccination had a small or even negative effect in populations marked by high conspiracy beliefs and low health literacy. Trust in government similarly increased willingness to be treated in some states. As concluded, 'the heterogeneity in vaccine hesitancy and responses to different messages suggests that health authorities should avoid one-size-fits-all vaccination campaigns'³⁷⁸. In Sweden, studies showed that low vaccination coverage is associated with age (fewer vaccinated amongst young adults), income and education (fewer vaccinated amongst those with low income and education), country of birth (fewer vaccinated amongst people born outside Sweden) and pregnancy (fewer vaccinated amongst pregnant women). Similarly, low perception of risk and access issues among socially vulnerable (e.g., seasonal workers) and mistrust was identified in Spain.

While vaccinations have a significant impact on decreasing COVID-19 morbidity and mortality, mandatory vaccinations are (as noted at 6. 2) controversial and are argued to cause more social harm than good:

Restricting people's access to work, education, public transport and social life based on COVID-19 vaccination status impinges on human rights, promotes stigma and social polarisation, and adversely affects health and well-being. Current policies may lead to a widening of health and economic inequalities, detrimental long-term impacts on trust in government and scientific institutions, and reduce the uptake of future public health measures, including COVID-19 vaccines as well as routine immunisations³⁷⁹.

³⁷⁵ Steinert and others (n 368).

³⁷⁶ *ibid.*

³⁷⁷ *ibid.*

³⁷⁸ *ibid.*

³⁷⁹ Bardosh K, de Figueiredo A, Gur-Arie R, et al, 'The unintended consequences of COVID-19 vaccine policy: why mandates, passports and restrictions may cause more harm than good' *BMJ Global Health* 2022;7:e008684.

COVID-19 passes, while also contentious, have been presented as a means by which economic and social activity can return to normal with, potentially, a reduced risk of transmission and infection. As evidenced in the sections above, there has been a variance in the policies surrounding COVID-19 passes. Studies on the efficacy of COVID-19 passes are limited. Whether vaccine passports incentivise vaccination has been contested, with factors including access, prior-uptake, age and prevailing restrictive measures in the countries having influence on whether there was an increase in vaccination³⁸⁰. In a study in the UK and Israel, COVID-19 passport schemes were linked with vaccine hesitancy with populations finding their 'sense of autonomy, or free will, is unmet by government incentives like vaccine passports are less likely to take the COVID-19 vaccine'³⁸¹.

While the European Commission called for a coordinated vaccination strategy, and for member states to 'share best practices on effective ways to address vaccine hesitancy'³⁸², a number of authors have cautioned against relying on a 'one-size-fits-all' approach, highlighting the wide variance both between Member States and within them for effective approaches to promoting vaccine acceptance. Interventions and campaigns should instead be 'tailored around each country's target population and consider its specific concerns and psychological barriers, as well as education and employment status'³⁸³.

³⁸⁰ See e.g. Mills MC and Ruettenauer T, 'The Impact of Mandatory COVID-19 Certificates on Vaccine Uptake: Synthetic Control Modelling of Six Countries' (2021), https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1027643/S1401_University_of_Oxford_and_Nuffield_College_The_impact_of_mandatory_COVID-19_certificates_on_vaccine_uptake_Synthetic_Control_Modelling_of_Six_Countries_14_October_2021.pdf, accessed 31 October 2022; Grover N, Stewart H and Quinn B, 'Vaccine Passports Will Make Hesitant People 'Even More Reluctant to Get Jabbed'' *The guardian* (August 31, 2021), <https://www.theguardian.com/world/2021/aug/31/vaccine-passports-will-make-hesitant-even-more-reluctant-to-get-jabbed>, accessed 31 October 2022.

³⁸¹ Porat T, Burnell R, Calvo RA, Ford E, Paudyal P, Baxter WL, Parush A. 'Vaccine Passports' May Backfire: Findings from a Cross-Sectional Study in the UK and Israel on Willingness to Get Vaccinated against COVID-19. *Vaccines*. 2021; 9(8):902. <https://doi.org/10.3390/vaccines9080902>.

³⁸² European Commission, Communication from the Commission to the European Parliament and the Council: Preparedness for COVID-19 vaccination strategies and vaccine deployment, Brussels, 15.10.2020, COM(2020) 680 final.

³⁸³ Steinert and others (n 367).

7. CONCLUSIONS

The experience of the pandemic in the EU has evidenced that law cannot account for the unique characteristics of each public health emergency. Similarly, the number of deaths or should not be the only measure of success (or failure) of a state's response to pandemic disease; the health of the institutions that guard democracy, human rights and the rule of law matter, too, for they will be integral to success or failure in recovery from pandemic and preparation for future emergencies³⁸⁴. From this report, we can identify common elements to the response to all potential public health emergencies, from which we can glean lessons for pandemic preparedness for future response to emergencies.

In taking such lessons, and seeking best practices, from the actions of EU Member States and third countries, the emphasis should be on understanding that no law, nor policy, nor court, nor government exists in a vacuum, but rather in the complex political, economic and social environment. During a pandemic, a focus on pharmacological or digital solutions will never be a panacea: the effectiveness of measures is dependent on wider social and political context for trust and compliance. On this account, public health preparedness for future crisis will depend on underlying legal basis for action, the competencies in applying those laws, the coordination of powers across EU, national, local and regional levels, and also the information and training available on implementing best practices in policy and law-based interventions.

In the reform of national legal frameworks, the focus should be not only on textual provisions but also on the *application* of the law, the *use* of powers, the *oversight* of its enforcement, and the *process* by which laws are made in each national context, with a premium on transparency and accountability. Constitutional safeguards in the form of the requirement of parliamentary involvement in the declaration, extension and expiry of states of emergency, as well as active parliamentary oversight and judicial control over the *use* of powers for their compliance with the rule of law and human rights, form the bedrock of good practices and the effective use of safeguards, and these responsibilities should extend to legislated emergency regimes as a matter of good practice. In this context, it is also important to examine why and when emergency frameworks were or were not engaged, extended or ended, and upon what process of decision-making. Emergency or ordinary, laws designed to confront infectious disease must have appropriate safeguards to ensure conformity with the principles of legality, legal certainty, accountability, prevention of the misuse of power, access to justice, and equality before the law.

In further preparation for future pandemic response, states must review how their emergency law frameworks operated in practice. A key observation of the practices of states during the COVID-19 pandemic is that different emergency legal frameworks do not necessarily inform the observer as to the level of legislative/judicial scrutiny observed or mandated, or about the timeframe for the declaration and sustenance of a state of emergency, or its proportionality and non-discrimination. International legal frameworks have, throughout the pandemic, continued to provide guidance on essential safeguards, including necessity, proportionality, non-discrimination, human rights compliance and temporariness. However, the effectiveness of legal safeguards against abuse depends on executive observance of the rules and on the strength of the separation of powers to enforce it.

³⁸⁴ Grogan and Donald (n 60). See also Burci, G. L., & Eccleston-Turner, M. (2021). Preparing for the Next Pandemic: the International Health Regulations and World Health Organization during COVID-19, *Yearbook of International Disaster Law Online*, 2(1), 259-282. doi: https://doi.org/10.1163/26662531_00201_011.

Member States and the EU must review the capacity, efficacy and appropriateness of actions that all actors took during the pandemic. Primarily, in terms of the authority for action, broad and open-ended measures should be avoided in favour of time-limited provisions, and they should make the use of exceptional powers conditional on both constitutional and human rights compliance and real-time scrutiny (where practicable, and ex post if not), for example by specially constituted parliamentary groups or inquiries into distinct or discrete areas of pandemic management, response, action or impact. Access to justice through independent courts must always be supported: a tragedy of contemporary backsliding from the rule of law is that, although COVID-19 has proven a catalyst for further democratic backsliding, increasing attacks on and undermining of judicial independence in many states were a feature prior to the pandemic, which has had a pernicious effect on the ways the states have been able to address the pandemic.

Oversight, public engagement and democratic dialogue proved essential and also promoted innovation across socially distanced and isolated space. For example, live broadcast of parliamentary proceedings, virtual access to justice, networked communication across civil society, and accessible lines of engagement between citizens and authorities capitalised on our increasingly digitised world. However, as a qualification, such innovation has to be supported by infrastructure and education: for example, where government services during the pandemic were only provided online, they were exclusionary and isolating for the digitally disenfranchised. The effective realisation of democratic innovation requires not only adaptation and adoption but also investment in, and equitable access to, digital technologies. Above all, the EU and Member States must promote a reversal of the trend towards the marginalisation of parliaments and the passivity of courts, to the detriment of any effective separation of powers or accountability of government. A pandemic, we have learned, does not absolve these bodies of the responsibility of oversight, but heighten the need for it to be robust, independent and responsive to dynamic conditions.

While the collective global experience of pandemic reveals that there is no one constellation and timing of sanitary measures that has proven to be the most effective at containing transmission of the virus and reducing mortality, there are nevertheless clear lessons which emerged from comparative analysis on the more effective means of governance during pandemic. Rationalised approaches based on clearly communicated measures support higher levels of support and trust and – arguably in so far as comparison can be made at this stage – are *more effective*. The diversity of approaches as to when to introduce, reduce or remove measures, and how to enforce them, evidenced the uncertainty among decision-makers as to the most appropriate strategy to confront the global health crisis. However, even where there is *uncertainty* as to the most effective practice, this does not negate the need for *certainty* as to what the rules are, and what they require of people.

Analysis of the most effective restrictive measures towards COVID-19 may not be applicable in the next, although the structures, governance, and the principles which underlined effective response will be. For example, while a COVID-19 vaccine may not be effective against the next health threat, an understanding and tackling the issues of vaccine development, supply, access, vaccine hesitancy, and inequity will support the uptake of a future vaccination programme. An effective ‘pandemic regime’ for the future should not be understood as a package of powers and mandatory actions, but rather a whole ecosystem of preparation, participation, and principle. This encompasses not only pandemic preparation in the investment in public health resources and structure, as well as public health education and access to essential goods and services, but also the range of actions undertaken at the beginning (and end) of pandemic. Recognition of the endemic issues of inequality and inequity that exacerbated the negative impacts of the pandemic, and the measures which only entrenched them will aid the next response. This, in turn, needs trust across communities, institutions and states.

Trust requires transparency, not only through frequent and targeted crisis communication, but, more importantly, by engaging stakeholders and the public in risk-related decision-making. This in turn will require the voices, knowledge and experiences of the most deeply affected populations to be amplified in the debate about post-pandemic recovery. Endemic socio-economic disparities reveal a poverty in the protection of some socio-economic rights and the lack of voice in decision-making for the most vulnerable—though most affected—communities. This is not only normatively desirable but also of instrumental value, since community mobilisation, especially when informed by experience of past pandemics, has been shown to compensate for the frailties of state responses. Moreover, active political and democratic engagement across the most diverse range of society is essential to (re)build public trust in democratic institutions and their capacity to manage crisis.

Ultimately, and again, advocating best practices and lessons to be learned is only a beginning. Interdisciplinary and international studies reveal insights and can provide a powerful tool for improving national and EU response. However, whether such lessons are meaningful depends on whether a commitment to learn, and tangible reform follows.

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ANNEX 1 – METHODOLOGY FOR OXFORD COVID-19 GOVERNMENT RESPONSE TRACKER, STRINGENCY INDEX

The following is provided by the Oxford COVID-19 Government Response Tracker.

Source: Thomas Hale, Noam Angrist, Rafael Goldszmidt, Beatriz Kira, Anna Petherick, Toby Phillips, Samuel Webster, Emily Cameron-Blake, Laura Hallas, Saptarshi Majumdar, and Helen Tatlow. (2021). 'A global panel database of pandemic policies (Oxford COVID-19 Government Response Tracker).' *Nature Human Behaviour*. <https://doi.org/10.1038/s41562-021-01079-8>.

The nine metrics used to calculate the Stringency Index are: school closures; workplace closures; cancellation of public events; restrictions on public gatherings; closures of public transport; stay-at-home requirements; public information campaigns; restrictions on internal movements; and international travel controls.

The index on any given day is calculated as the mean score of the nine metrics, each taking a value between 0 and 100. See the authors' full description of how this index is calculated.

A higher score indicates a stricter response (i.e. 100 = strictest response). If policies vary at the subnational level, the index is shown as the response level of the strictest sub-region.

Since government policies may differ by vaccination status, a stringency index is calculated for three categories: those who are vaccinated; those who are non-vaccinated; and a national average which is weighted based on the share of people that are vaccinated.

It's important to note that this index simply records the strictness of government policies. It does not measure or imply the appropriateness or effectiveness of a country's response. A higher score does not necessarily mean that a country's response is 'better' than others lower on the index.

Sources

Non-vaccinated

Variable time span Jan 1, 2020 – Oct 20, 2022

Data published by Hale, T., Angrist, N., Goldszmidt, R. et al. A global panel database of pandemic policies (Oxford COVID-19 Government Response Tracker). *Nat Hum Behav* 5, 529–538 (2021). <https://doi.org/10.1038/s41562-021-01079-8>

Link <https://www.bsg.ox.ac.uk/research/research-projects/oxford-covid-19-government-response-tracker>

OxCGRT collects publicly available information on indicators of government response. These indicators take policies such as school closures, travel bans, etc. and record them on an ordinal scale; the remainder are financial indicators such as fiscal or monetary measures.

OxCGRT measures the variation in governments' responses using its 'COVID-19 Government Response Stringency Index (Stringency Index)'. This composite measure is a simple additive score of nine indicators measured on an ordinal scale, rescaled to vary from 0 to 100. Please note that this measure is for comparative purposes only, and should not necessarily be interpreted as a rating of the appropriateness or effectiveness of a country's response.

It also includes a measure of 'COVID-19 Containment and Health Response' index which is based on the metrics used in the 'Stringency Index' plus testing policy, contact tracing, face coverings and vaccine policy.

The specific policy and response categories are coded as follows:

School closures:

- 0 - No measures
- 1 - Recommend closing
- 2 - Require closing (only some levels or categories, eg just high school, or just public schools)
- 3 - Require closing all levels
- No data - blank

Workplace closures:

- 0 - No measures
- 1 - Recommend closing (or work from home)
- 2 - Require closing (or work from home) for some

Sectors or categories of workers:

- 3 - Require closing (or work from home) all but essential workplaces (eg grocery stores, doctors)
- No data - blank

Cancel public events:

- 0 - No measures
- 1 - Recommend cancelling
- 2 - Require cancelling
- No data - blank

Restrictions on gatherings:

- 0 - No restrictions
- 1 - Restrictions on very large gatherings (the limit is above 1000 people)
- 2 - Restrictions on gatherings between 100-1000 people
- 3 - Restrictions on gatherings between 10-100 people
- 4 - Restrictions on gatherings of less than 10 people
- No data - blank

Close public transport:

- 0 - No measures
- 1 - Recommend closing (or significantly reduce volume/route/means of transport available)
- 2 - Require closing (or prohibit most citizens from using it)

Public information campaigns:

- 0 - No COVID-19 public information campaign
- 1 - Public officials urging caution about COVID-19
- 2 - Coordinated public information campaign (e.g. across traditional and social media)
- No data - blank

Stay at home:

- 0 - No measures
- 1 - Recommend not leaving house
- 2 - Require not leaving house with exceptions for daily exercise, grocery shopping, and 'essential' trips
- 3 - Require not leaving house with minimal exceptions (e.g. allowed to leave only once every few days, or only one person can leave at a time, etc.)
- No data - blank

Restrictions on internal movement:

- 0 - No measures
- 1 - Recommend movement restriction
- 2 - Restrict movement

International travel controls:

- 0 - No measures
- 1 - Screening
- 2 - Quarantine arrivals from high-risk regions
- 3 - Ban on high-risk regions
- 4 - Total border closure
- No data - blank

Testing policy:

- 0 - No testing policy
- 1 - Only those who both (a) have symptoms AND (b) meet specific criteria (eg key workers, admitted to hospital, came into contact with a known case, returned from overseas)
- 2 - Testing of anyone showing COVID-19 symptoms
- 3 - Open public testing (e.g. 'drive through' testing available to asymptomatic people)
- No data

Contract tracing:

- 0 - No contact tracing
- 1 - Limited contact tracing - not done for all cases
- 2 - Comprehensive contact tracing - done for all cases
- No data

Face coverings:

- 0 - No policy
- 1 - Recommended
- 2 - Required in some specified shared/public spaces outside the home with other people present, or some situations when social distancing not possible
- 3 - Required in all shared/public spaces outside the home with other people present or all situations when social distancing not possible
- 4 - Required outside the home at all times regardless of location or presence of other people

Vaccination policy:

0 - No availability

1 - Availability for ONE of following: key workers/ clinically vulnerable groups / elderly groups

2 - Availability for TWO of following: key workers/ clinically vulnerable groups / elderly groups

3 - Availability for ALL of following: key workers/ clinically vulnerable groups / elderly groups

4 - Availability for all three plus partial additional availability (select broad groups/ages)

5 - Universal availability

Vaccinated

Variable time span Jan 1, 2020 – Oct 20, 2022

Data published by Hale, T., Angrist, N., Goldszmidt, R. et al. A global panel database of pandemic policies (Oxford COVID-19 Government Response Tracker). Nat Hum Behav 5, 529–538 (2021). <https://doi.org/10.1038/s41562-021-01079-8>.

Link <https://www.bsg.ox.ac.uk/research/research-projects/oxford-covid-19-government-response-tracker>

ANNEX 2 – OXFORD COVID-19 GOVERNMENT RESPONSE TRACKER

Table 3: Stringency Index Scores for EU Members States, Iceland, Norway, Switzerland and UK

Country	2020		2021		2022		Total Average of Stringency Index
	Average	Max	Average	Max	Average	Max	
Austria	55.35	82.41	61.54	82.41	39.70	55.10	53.16
Belgium	56.28	81.48	50.10	75.93	20.23	33.84	43.69
Bulgaria	49.18	73.15	47.57	62.96	21.46	50.00	40.68
Croatia	49.82	96.30	42.89	67.59	18.97	38.07	38.61
Cyprus	65.16	94.44	59.08	84.26	30.85	53.81	53.04
Czechia	51.69	82.41	54.50	81.48	20.81	37.83	43.73
Denmark	50.02	72.22	46.31	70.37	14.00	33.92	38.39
Estonia	40.23	77.78	38.16	64.70	24.92	45.83	35.10
Finland	41.91	71.30	42.74	52.31	27.40	36.51	38.11
France	57.92	87.96	52.62	75.00	22.48	48.23	45.96
Germany	55.73	82.41	61.78	85.19	27.20	47.48	50.02
Greece	64.33	84.26	72.24	88.89	37.52	71.54	59.54
Hungary	58.26	76.85	46.76	79.63	12.36	28.47	40.62
Ireland	66.96	90.74	58.54	87.96	13.44	42.80	48.06
Italy	70.36	93.52	63.80	83.33	30.33	53.56	56.55
Latvia	49.72	66.67	49.21	63.89	20.07	44.31	40.86
Lithuania	53.60	87.04	45.20	79.63	15.18	27.52	38.84
Luxembourg	49.96	79.63	46.04	67.59	28.19	54.52	42.14
Malta	54.53	87.04	51.80	75.00	25.54	45.63	44.95
Netherlands	59.18	78.70	57.80	82.41	23.73	69.44	48.30
Poland	56.93	87.04	52.99	80.56	20.76	48.15	44.78
Portugal	64.25	87.96	61.07	87.96	18.40	42.59	49.59
Romania	58.45	87.04	56.40	76.85	20.95	52.78	46.97
Slovakia	54.92	87.04	52.58	74.07	21.31	56.18	44.51
Slovenia	54.81	89.81	53.54	85.19	18.98	54.02	44.14
Spain	61.45	85.19	55.40	78.70	28.69	38.63	49.92
Sweden	53.54	69.44	46.12	69.44	14.44	42.38	40.08

Country	2020		2021		2022		Total Average of Stringency Index
	Average	Max	Average	Max	Average	Max	
Iceland	44.98	53.70	37.80	65.74	16.13	40.74	33.79
Norway	48.21	79.63	50.25	73.15	15.96	51.85	39.60
Switzerland	49.76	73.15	48.57	60.19	16.15	44.68	39.51
United Kingdom	61.64	79.63	57.83	87.96	17.22	42.08	47.62

Source: Table created by author based on data from the Oxford Covid-19 Government Response Tracker (OxCGRT) – credit to Thomas Hale, Noam Angrist, Rafael Goldszmidt, Beatriz Kira, Anna Petherick, Toby Phillips, Samuel Webster, Emily Cameron-Blake, Laura Hallas, Saptarshi Majumdar, and Helen Tatlow. (2021). 'A global panel database of pandemic policies (Oxford COVID-19 Government Response Tracker).' Nature Human Behaviour. <https://doi.org/10.1038/s41562-021-01079-8>.

This research study examines the impact of COVID-19 measures on democracy and fundamental rights in the EU. It considers what best practices have been evidenced, and the lessons that can be learned from comparative experience within EU Member States as well as relevant third countries.

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