



Territorial approaches to a pandemic: a pathway to effective governance?

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ABSTRACT

Pandemics, including COVID-19, highlight the issue of multilevel governance, where and how powers should be allocated, and the challenge of ensuring coherency. This issue comes clearly into focus in epidemiological units where internal jurisdictional boundaries exist, as in the case of the island of Ireland with the border between Northern Ireland/the United Kingdom and Ireland. This article evaluates the approaches to policy-making on the island of Ireland, and considers whether the two jurisdictions adequately addressed cross-border issues in light of the concept of subsidiarity. The core focus is on a COVID-19 Memorandum of Understanding (MOU) agreed between Ireland and Northern Ireland in April 2020, with consideration also of proposals for a two-island approach. The article argues that subsidiarity would call for a centralised approach or at least substantial cooperation to facilitate effective policy implementation and coherency. The MOU reflects these ideas, through supporting substantial cooperation, but with some significant weaknesses that manifest in its implementation. Alternative issues arise when considering a potential two-island approach. Together, the MOU and the alternative of a two-island approach highlight that context is a crucial consideration for subsidiarity and evaluating the approaches to cross-border issues. It can make centralisation and substantial cooperation (and therefore coherency more generally) significantly more challenging and thereby also highlights the limits of subsidiarity.

Keywords: cooperation; COVID-19; cross-border; governance; Ireland; pandemic; subsidiarity.

INTRODUCTION

Pandemics, such as COVID-19, raise numerous questions and tensions, encompassing issues of human rights, constitutional law, patenting, fairness and much more. One fundamental issue considered here is: where should decision-making powers rest – whether this be regarding restrictions, vaccinations, distribution of resources or otherwise? This article starts from the premise that this is a matter of *public* health and therefore the main roles rest with *public* bodies or decision-makers, rather than focusing on the role of private organisations or individuals (significant though they may be). Instead, the question instead turns to which public bodies, or rather, bodies at which levels?

The answer to this may appear simple at first glance. Pandemics are also a *global* public health issue, since a pandemic by its very nature crosses territorial borders and its impacts are felt worldwide. It would appear logical that an international organisation (eg the United Nations (UN) or WHO (World Health Organization)) should determine public policy, resource-building and distribution etc. However, despite some elements of cooperation or even centralisation, the pandemic was largely addressed on a territorial basis linked to existing power allocations, facilitating varying and even conflicting approaches to a global issue, including within individual epidemiological units.¹ Whilst the significance of cross-border issues,² multilevel governance and subsidiarity³ have been flagged within the literature, it has understandably been limited to date and further investigation is merited. Furthermore, the approach to centralisation within individual nation states has varied, with contrasting examples available.⁴

This article focuses on the island of Ireland, where a single epidemiological unit is divided in two by jurisdictional boundaries – with Ireland to the South and Northern Ireland (part of the United

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- 1 Eg in the US, as noted by A Delaney, 'The politics of scale in the coordinated management and emergency response to the COVID-19 pandemic' (2020) 10(2) *Dialogues in Human Geography* 141–145.
 - 2 A M Paces and M Weimer, 'From diversity to coordination: a European approach to Covid-19' (2020) 11(2) *European Journal of Risk Regulation* 283; A Alemanno, 'The European response to Covid-19: from regulatory emulation to regulatory coordination?' (2020) 11(2) *European Journal of Risk Regulation* 307; and A Renda and R Castro, 'Towards stronger EU governance of health threats after the Covid-19 pandemic' (2020) 11(2) *European Journal of Risk Regulation* 273.
 - 3 M Maggetti, 'Beyond Covid-19: towards a European Health Union' (2020) 11(4) *European Journal of Risk Regulation* 790; and M Dobbs, 'National governance of public health responses in a pandemic?' (2020) 11(2) *European Journal of Risk Regulation* 240.
 - 4 Eg Delaney (n 1 above) regarding the US and Ireland; and the articles cited in n 2 above regarding the EU.

Kingdom (UK)) to the North. Wide-ranging cross-border issues arise here, highlighted by transboundary river basins, illegal waste dumping and the movement of livestock.⁵ The Good Friday/Belfast Agreement (GFA), in conjunction with European Union (EU) membership, acted as a bridge, providing some common foundations and facilitating cooperation on cross-border matters.⁶ However, Brexit now exacerbates the challenges in addressing these and other issues, leading to increased regulatory divergence in both substantive and procedural matters, as well as affecting the political will to cooperate.⁷ It is in this context that the COVID-19 pandemic arose and was addressed by Ireland and Northern Ireland.⁸ There is some early literature on COVID-19 in Ireland and Northern Ireland (or the UK) to date,⁹ including elements regarding cross-border cooperation.¹⁰ This literature has flagged the desirability of cross-border cooperation, but also the challenges this poses and the perception of lack of cooperation to date.¹¹

This article undertakes a preliminary investigation into the policy-making approaches on the island of Ireland (until November 2021) and whether the two jurisdictions adequately addressed cross-border

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- 5 Eg M Dobbs and V Gravey, 'Environment and trade' in C McCrudden, *The Law and Practice of the Ireland–Northern Ireland Protocol* (Cambridge University Press 2022); C Brennan, M Dobbs and V Gravey, 'Out of the frying pan, into the fire? Environmental governance vulnerabilities in post-Brexit Northern Ireland' (2019) 21(2) *Environmental Law Review* 84–110; M Murphy, 'Agriculture and environment – what paths will policy take?' (2020) 15 *Journal of Cross Border Studies in Ireland* 137–148; and C M Fraser, J Brickell and R M Kalin, 'Post-Brexit implications for transboundary groundwater management along the Northern Ireland and the Republic of Ireland border' (2020) 15 *Environmental Research Letters* 1–13.
 - 6 A Hough, 'Brexit, the Good Friday/Belfast Agreement and the environment: issues arising and possible solutions' report commissioned by the Environmental Pillar in conjunction with Northern Ireland Environment Link (April 2019).
 - 7 Eg Hough, *ibid*; and Dobbs and Gravey (n 5 above).
 - 8 C O'Connor et al, 'Bordering on crisis: a qualitative analysis of focus group, social media, and news media perspectives on the Republic of Ireland–Northern Ireland border during the "first wave" of the COVID-19 pandemic' (2021) 282 *Social Science and Medicine* 114111, 2.
 - 9 Eg N Murphy et al, 'A large national outbreak of Covid-19 linked to air travel, Ireland, summer 2020' (2020) 25(42) *Eurosurveillance* 1–6; B Kennelly et al, 'The Covid-19 pandemic in Ireland: an overview of the health service and economic policy response' (2020) 9(4) *Health Policy and Technology* 419–429; P Hyland et al, 'Resistance to Covid-19 vaccination has increased in Ireland and the United Kingdom during the pandemic' (2021) 195 *Public Health* 54–56; P Cullen and M P Murphy, 'Responses to the Covid-19 crisis in Ireland: from feminized to feminist' (2020) 28(S2) *Gender, Work and Organization* 348–365; and J Morphet, *The Impact of Covid-19 on Devolution: Recentralising the British State Beyond Brexit?* (Policy Press 2021).
 - 10 Eg O'Connor et al (n 8 above).
 - 11 Eg *ibid*.

issues in light of subsidiarity.¹² To achieve this, it considers three questions: firstly, whether largely independent/unilateral approaches or more centralised approaches by Ireland and Northern Ireland are appropriate. Secondly, whether the proposed cooperative approach outlined in the Memorandum of Understanding (MOU), 'Covid-19 Response – Public Health Cooperation on an All-Ireland Basis'¹³ was sufficient. And finally, whether a two-island approach might be a suitable and viable alternative. In considering these questions, the article bears in mind the links between Ireland and Northern Ireland, and with Great Britain (GB) and the EU, whether economic, legal, political, cultural or otherwise. These questions have practical relevance due to the continuing presence of the pandemic, with the development of new variants, the rollout of vaccines and the likely need for new vaccines or booster shots, not to mind the inevitable occurrence of pandemics in the future.

Section one outlines the article's conceptual framework of multilevel governance and subsidiarity, considering the core arguments for allocating decision-making powers according to territories, epidemiological units or otherwise and the desirability of varying degrees of cooperation, communication, coordination and/or centralisation. We would note in advance that there exists a fluctuating spectrum from minimalistic cooperation through to full-blown centralisation of powers. Communication, coordination and coherency can be, in principle, guaranteed where centralisation exists, but may be very limited or non-existent if there is only tokenistic or superficial cooperation. The second section then evaluates the responses on the island of Ireland, including the MOU. It considers the measures taken in both jurisdictions, the timing and interaction of these measures, and the MOU's role since its creation. Finally, section three moves beyond what occurred, to consider the proposal of a two-island approach in light of Northern Ireland's position within the UK, the Common Travel Area and the broad links between GB and the island of Ireland. The implications of EU membership and Brexit will be considered throughout where relevant.

12 Broadly meaning that central authorities should only play a subsidiary or complementary role to decentralised or lower levels, rather than being primary or sole power-wielders. See section one below ('Subsidiarity in responding to a pandemic: territorial versus ecosystem/epidemiological units?').

13 See the [Memorandum of Understanding](#).

SUBSIDIARITY IN RESPONDING TO A PANDEMIC: TERRITORIAL VERSUS ECOSYSTEM/EPIDEMIOLOGICAL UNITS?

Governance is not simply centred on nation states, as per Westphalian sovereignty, but is dispersed vertically (from the local to the global) and horizontally (including private and quasi-private bodies).¹⁴ The result is a mish-mash of power *loci* that presents a highly complex picture.¹⁵ It raises numerous interrelated questions, including how to determine where powers ought to be located, and how to ensure coherency where powers are distributed widely. These questions arise equally in the context of the pandemic, which entails issues of public health but also the economy, international relations, food supplies, intellectual property and more. To consider these questions, we turn to the literature on multilevel governance and regulation and, in particular, the concept of subsidiarity.

Subsidiarity is rooted in theology, economics and democracy¹⁶ and focuses on 'the proper geographic distribution of power'.¹⁷ It acknowledges the existence of numerous levels that could hold the powers, but calls for lower levels to hold these powers (as close to the people as possible)¹⁸ unless there is good reason for the powers to be distributed higher up instead.¹⁹ As discussed elsewhere,²⁰ this entails consideration of: (i) the significance of the issues in question, 'what degree of homogeneity/consensus or heterogeneity/conflict exists in relation to the issues and to what extent the higher levels could

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- 14 L Hooghe and G Marks, 'Unraveling the central state, but how? Types of multi-level governance' (2003) 97 *American Political Science Review* 233, 233.
 - 15 A Estella, *The EU Principle of Subsidiarity and its Critique* (Oxford University Press 2002) 114; N Chowdhury and R Wessel, 'Conceptualising multilevel regulation in the EU: a legal translation of multilevel governance?' (2012) 18 *European Law Journal* 335, 339; and Hooghe and Marks (n 14 above) 239.
 - 16 Eg R Vischer, 'Subsidiarity as a principle of governance: beyond devolution' (2001–2002) 35 *Indiana Law Review* 103; Y Blank, 'Federalism, subsidiarity, and the role of local governments in an age of global multilevel governance' (2009) 37 *Fordham Urban Law Journal* 509; M Dobbs, 'Attaining subsidiarity-based multilevel governance of genetically modified cultivation?' (2016) 28(2) *Journal of Environmental Law* 245.
 - 17 M Landy and S Teles, 'Beyond devolution: from subsidiarity to mutuality' in K Nicolaidis and R Howse (eds), *The Federal Vision: Legitimacy and Levels of Governance in the United States and the European Union* (Oxford University Press 2001) 414.
 - 18 Estella (n 15 above) 81.
 - 19 K Van Kersbergen and B Verbeek, 'Subsidiarity as a principle of governance in the European Union' (2004) 2 *Comparative European Politics* 142, 144.
 - 20 Dobbs (n 16 above); and Dobbs (n 3 above).

accommodate the elements of heterogeneity’;²¹ (ii) the effectiveness or efficiency proffered by the different levels, including the potential for externalities and the varying capacity to internalise these externalities via centralising; and (iii) the balance between the previous two points, including potentially a call for dividing the powers over numerous levels. Applying these points to COVID-19 (or any pandemic) is not a simple matter,²² depends significantly on the context and may potentially change over time.

Furthermore, where powers remain dispersed, ensuring coherency stays a crucial concern.²³ Indeed, where good reasons exist for both centralising and decentralising the powers, the compromise position might be to retain a decentralised approach in conjunction with an array of measures to ensure coherency. This might be achieved via various cooperation mechanisms, including communication, collaboration and coordination, without amounting to outright centralisation and including through binding and non-binding measures.

Homogeneity or accommodating heterogeneity?

An initial appraisal of COVID-19 demonstrates that it encompasses numerous issues relevant to these three points. On the first point, there is the widespread recognition of the importance of public health, human life and combating diseases, and the interrelated issues such as the economy and food security. There is some homogeneity on a very general or superficial level, but when one digs deeper one finds considerable variations (eg regarding the role of the state, prioritisation of conflicting human rights, investment in health systems etc).

Even in the context of a pandemic, there are considerable differences in aims (eg targeting ‘zero-COVID’, focusing on herd immunity through facilitating the spread of the disease, or simply seeking to moderate the spread and ‘flatten the curve’ whilst hoping for a vaccine eventually) and approaches (eg physical distancing, financial supports, provision of accommodation and mandatory masks). It is important to note that each decision will entail countervailing risks or conflict with other legitimate aims, for example through using resources intended for other public objectives, or impacting on supply chains for food or medicine. The choice in aims and approaches may be ideological, or simply linked

21 Dobbs (n 16 above) 252.

22 Dobbs (n 3 above).

23 OECD, *Water Governance in OECD Countries: A Multi-level Approach* (OECD Studies on Water, OECD Publishing 2011) 19; European Commission, ‘European Governance – A White Paper’, COM(2001)428, [2001] OJ C287/1 7–8; and R Brownsword, ‘Regulatory coherence – a European challenge’ in K Purnhagen and P Rott (eds), *Varieties of European Economic Law and Regulation* (Springer 2014).

to the resources available or current understanding.²⁴ Thus, sharing of resources or developing understanding might lead to shifts in aims and approaches and thereby facilitate greater homogeneity (as well as efficiency, as discussed below), whereas ideological positions can be more challenging to influence. The identification of a single, uniform correct approach is nigh on impossible, even if specific pathways are more repugnant or acceptable than others. Consequently, some degree of heterogeneity remains highly likely.

As for whether higher levels can facilitate heterogeneity in the case of COVID-19, this depends on the nature of the heterogeneity. Policy goals regarding COVID-19 can be in outright conflict with each other – for example zero-COVID versus enabling the spread to develop herd immunity. These two aims can be maintained only if the two populations remain distinct and isolated from each other (as separate epidemiological units), otherwise there is the risk of achieving neither zero-COVID nor herd immunity, with new variations also arising and spreading throughout both populations.²⁵ However, if there are shared aims but heterogeneity in the measures or the timing thereof, this may be more easily facilitated. Indeed, as the context will vary at times in different locations, different approaches may be necessary to achieve the same aim, for example local restrictions to prevent overloading the health system.

Therefore, it is necessary to examine localities to identify the varying aims and approaches, to determine the extent and nature of the homogeneity/heterogeneity. If there are no substantial conflicts or if any potential conflicts are limited to those of approaches, understanding or resources, then centralisation may be feasible in principle. If the conflicts are ideological, then more localised approaches may be appropriate if efficient and if negative externalities can be addressed adequately.

Effective and minimising externalities?

Designing effective policy-making for pandemics raises questions of expertise and scientific understanding; resources, including medical, financial, food, water and housing; and potential externalities, including the introduction of new sources of the disease (including

24 Pandemics entail considerable uncertainties, especially at the beginning, eg regarding transmissibility, short and long-term impacts, treatments, vaccine efficacy etc.

25 New Zealand's shift in approach in autumn 2021 exemplifies this. The continued spread of COVID-19 globally and new, more virulent, variants led to fresh outbreaks within the country and the Government considered it too challenging to maintain their zero-COVID approach. B Westcott, 'New Zealand to abandon zero-covid strategy as Delta variant proves hard to shake' (CNN 5 October 2021).

new variants) and supply chain disruption (including intentionally). Considerations of efficiency may support substantial centralisation or simply light-touch cooperation and the existing context may impact significantly in practice.

Pandemics rely on scientific expertise and knowledge (including medical), which would typically indicate support, in principle,²⁶ for centralisation of these aspects, sharing and developing specialist knowledge and expertise, before basing decisions on this. This is exemplified by the existence of the WHO, but is also seen for instance in EU and United States (US) federal agencies. This is especially important for countries that might lack access to necessary resources to develop suitable expertise. However, caveats are required: first, local knowledge and expertise is also essential, for example regarding populations, behaviour and living conditions. Second, when a new disease emerges scientific uncertainty abounds – thus, having one uniform approach or relying on the majority scientific opinion may not be appropriate or adequately ‘precautionary’. This is reflected in the evolving understanding of the transmissibility of COVID-19, the development of vaccines and treatments, and the identification and evaluation of new variants. Therefore, sharing expertise, capacity-building and ensuring policymaking is well-founded is essential, but this does not negate the value of local knowledge or necessitate centralisation of the actual policymaking.²⁷

The picture becomes more complex when one looks to the issue of limited resources – each individual, population and territory has varying capacity when it comes to essential resources. This has been exemplified during the pandemic, with competition for personal protective equipment, supplies for treatment (eg ventilators),²⁸ and more recently vaccines. Wealthier countries have taken advantage of their purchasing power for instance to pre-order vaccines,²⁹ whilst developing countries are left with minimal supplies and with difficulties in distributing what they do possess.³⁰ The result is a serious, unequal,

26 The practical success and acceptability of such centralisation is questionable, eg J Lidén, ‘The World Health Organization and global health governance: post-1990’ (2014) 128(2) *Public Health* 141.

27 Dobbs (n 3 above).

28 Eg D Smith, ‘New York’s Andrew Cuomo decries “EBay”-style bidding war for ventilators’ *The Guardian* (London, 31 March 2020).

29 Eg ‘Rich countries grab half of projected Covid-19 vaccine supply’ (*The Economist* 12 November 2020).

30 Eg G Steinhauser and N Bariyo, ‘Covid-19 vaccines are now reaching poor countries, but not people’s arms’ *Wall Street Journal* (New York, 12 November 2021).

inequitable and immoral distribution of resources.³¹ In the time-sensitive situation of a pandemic, sharing resources equitably may initially impact negatively on those who have disproportionately high supplies. However, not sharing leads to higher burdens on certain populations/territories (frequently already disadvantaged, as lacking capacity to quarantine or treat patients), may lead to broader disruption of supply chains in a globalised world (where components and essential ingredients come from a diverse array of sources) and also may lead to continued spread of the disease through allowing new variants to emerge in some countries.³² Further, some simply have more than they need and effective distribution is key, for example doctors from Cuba,³³ vaccines from Romania (due to low uptake of vaccinations, sent to Ireland instead)³⁴ and ventilators and oxygen generation units in Ireland³⁵ and Northern Ireland³⁶ (due to lowering the curve sufficiently at the time, sent to India). Sharing resources equitably is not merely just, but also essential pragmatically where possible, indicating that some degree of centralisation is appropriate. Again, this is reflected in the World Bank, International Monetary Fund and G20's temporary debt relief for poor countries,³⁷ the WHO COVAX programme³⁸ and the EU's approach to the internal distribution of vaccines.³⁹ However, where sharing of resources does not or cannot

31 UN Economic and Social Council, 'Unequal vaccine distribution self-defeating, World Health Organization chief tells Economic and Social Council's Special Ministerial Meeting' (ECOSOC/7039, 16 April 2021).

32 Ibid.

33 N G Torres and J Charles, 'Despite US warnings, Cuba's medical diplomacy triumphs in the Caribbean during pandemic' *Miami Herald* (15 April 2020).

34 D McLaughlin, 'Romania plans to deliver vaccines to Ireland in coming weeks' *Irish Times* (Dublin, 30 July 2021).

35 P Hosford, 'Ireland to send 700 ventilators to India to help fight deadly new wave of Covid-19' *Irish Examiner* (Cork, 26 April 2021).

36 'Life-saving supplies flown out to India from Northern Ireland' (*UTV News* 7 May 2021).

37 'Covid-19: G20 endorses temporary debt relief for the poorest countries' (*France24* 15 April 2020).

38 WHO, 'No one is safe, until everyone is safe'.

39 The EU intended to ensure 'equitable access' across the EU: EU Commission, 'Strategy for COVID-19 vaccines', COM/2020/245 final, pt 1. While the main focus is on the EU member states, the Commission also referred to non-EU states, eg 'while leading the global solidarity effort' (pt 1) and noted its commitment to 'the principle of universal, equitable and affordable access to COVID-19 vaccines' globally, including extra support for more vulnerable countries (pt 4). See also discussion of the EU's 2014 Joint Procurement Agreement (to procure medical countermeasures), similarly aimed at equitable and cost-effective access, by E McEvoy and D Ferri, 'The role of the Joint Procurement Agreement during the COVID-19 pandemic: assessing its usefulness and discussing its potential to support a European Health Union', (2020) 11(4) *European Journal of Risk Regulation* 851.

occur (eg provision of suitable housing in the short term for massive populations), this will also impact policymaking negatively.

However, it is the issue of externalities, and in particular the spread of COVID-19,⁴⁰ that poses fundamental challenges and demands at the very least close cooperation and potentially large-scale centralisation of policymaking. Disease spreads through epidemiological units, which might entail the population of a dwelling-house, a town, a country, a continent or all of the above. Isolation or spatial-distancing approaches can temporarily sub-divide an epidemiological unit (potentially according to jurisdictional or territorial boundaries), but once these cease then the disease can continue to spread through the main unit once more. It is essential that epidemiological units at least cooperate carefully and preferably centralise some policymaking if their approach to pandemics, including COVID-19, is to be effective. If not, then the aims can be delayed temporarily, if not hindered indefinitely. For instance, country A might seek to isolate itself or impose internal restrictions, creating temporary units, but if COVID-19 persists elsewhere then, once the restrictions are removed, the disease (including new variants) may spread through country A. This is facilitated by the nature of the disease (highly transmissible) and the mobility of the global population – as exemplified by New Zealand and its reluctant shift away from a zero-COVID approach.⁴¹ However, whether country A seeks to develop herd immunity, flatten the curve or seek zero-COVID, a shift in the population can impact negatively on any of these aims.⁴²

Balancing the (re)allocation of powers?

Overall, there are push and pull factors regarding (de)centralisation of powers. Typically, substantial cooperation and especially centralising powers would improve efficiency and help internalise (and negate) negative externalities. Subsidiarity therefore would call for some degree of centralising across epidemiological units if COVID-19 is to be effectively addressed, although building in flexibility to address variations in localities. If this does not occur, substantial cooperation (including communication, collaboration, coordination or otherwise) is essential to ensure coherency and avoid policies being undermined. However, the question of homogeneity or heterogeneity of aims and approaches will vary depending on the context, with knock-on effects for the appropriate allocation of powers. Furthermore, other contextual factors may tip the balance towards or away from the centralising of powers.

40 As mentioned, other aspects such as global supply chains can be negatively affected.

41 See n 25 above.

42 Dobbs (n 3 above).

Generally, bearing in mind the nature of a pandemic, where *loci* share the same aims for the pandemic, the balance would fall in favour of centralisation, in particular, where they are located proximately and/or are in the same epidemiological unit. This would also help resolve conflicts in approach that might undermine the shared aims. In contrast, where *loci* have irresolvable conflicting aims, then subsidiarity would indicate that centralisation is unlikely to be appropriate. Further, while there should be some attempt at cooperation, this may also not be possible on more than a superficial level, instead long-term isolation from the relevant location/population might be necessary, until either the context or the aims have adapted sufficiently. For instance, if one country were ideologically in favour of facilitating the spread of the disease and aiming for herd immunity while another was seeking eradication of the disease, the latter would need to isolate the two populations from each other.⁴³ Of course, the potential for long-term isolation may also affect pandemic policy.

However, society is not starting from a blank slate. Pandemics occur in an existing context, where ideologies and beliefs are established, where resources are already distributed, and where political, economic and cultural relationships already exist. This includes territorial boundaries, as well as international and domestic laws. These relationships and other factors could (i) affect the decisions about where powers ought to be (re)allocated and/or (ii) need to be amended to facilitate the effective and appropriate allocation and use of powers. Further, if various elements need to be amended, but cannot or will not be in the time available,⁴⁴ this may affect the appropriate *loci* of powers, as highlighting conflicting fundamental aims or undermining the potential efficiency of such actions. For example, if a global approach were appropriate in a vacuum, but the constitutions of several nation states prohibited the centralising of power, this would make centralisation unavailable as an option, at least whilst the constitutions remained unaltered. However, this does not necessarily prevent less formal cooperative measures to facilitate coherency. Thus, contextual factors such as the existing territorial boundaries, legal parameters and political, economic and cultural relationships may affect the appropriate *loci* for power, or simply be a complicating factor and need to be taken into account.

43 This raises further complicated questions regarding the responsibilities of states (and individuals) not to harm others – and whether they can or should be obliged to take measures to avoid such occurrences. This is comparable with ideas of non-transboundary harm in environmental matters and nuisance for landowners.

44 This is particularly relevant in the case of pandemics, due to the time sensitivity of decision-making: amendments to legal relationships may simply take too long.

A final point regarding the passage of time must be noted. A pandemic is an evolving situation; knowledge progresses, treatments and vaccines are potentially developed and tested, and resources are created and dissipated, but also the pandemic and associated policy measures impact society more broadly, for example regarding mental health, employment, food supplies, housing and so on. Further, the context is forever shifting. Therefore, the suitability, desirability and choice of aims and approaches might alter over time. Nonetheless, overall, if policymaking is not centralised, these developments and policy responses will still require corresponding cooperation within and between epidemiological units to ensure coherency and enable COVID-19 to be addressed effectively. Without at least substantial cooperation, the alternative is either long-term isolation/the division of epidemiological units or incoherent, undermined policy.

RESPONSES ON THE ISLAND OF IRELAND – TERRITORIAL IN TANDEM?

This brings us to the island of Ireland, encompassing both Ireland and Northern Ireland. Before considering the aims and approaches, it is worth highlighting once more that there is an open land border and that the two jurisdictions share overlapping communities, economies, cultures and the like. There are also ‘cross-border interdependencies’, with individuals crossing the border daily for work, education, shopping and recreation.⁴⁵ Whether for plants, animals or humans, the island is a single epidemiological unit.

In light of this and the nature of COVID-19, one option is to close the border entirely, thereby splitting the island into two epidemiological units for the duration of the closure.⁴⁶ This measure was undertaken in numerous countries across the world, but it has its own repercussions,⁴⁷ in particular for border communities,⁴⁸ and is also clearly difficult to achieve 100 per cent in practice. It is easier to achieve in isolated jurisdictions (their own epidemiological units) such as island nations – for instance Tonga, New Zealand or Japan – but even there it can be difficult to guarantee non-transmission.

The alternative, which is considered here, is to recognise and address the existing epidemiological unit through effective cross-

45 O'Connor (n 8 above) 3.

46 This was undertaken for foot and mouth disease on the island of Ireland in the 1990s.

47 E Guild, ‘Covid-19 using border controls to fight a pandemic? Reflections from the European Union’ (2020) 2 *Frontiers in Human Dynamics* 606299.

48 O'Connor et al (n 8 above) 2–3.

border management.⁴⁹ On this basis, there is strong support for centralising approaches on the island or at least ensuring substantial cooperation.⁵⁰ However, other factors must be considered to see where the balance lies, including the overall responses and existing powers of both jurisdictions. This facilitates an evaluation of both the MOU and the subsequent implementation (or lack thereof) of the MOU.

Domestic COVID responses on a shared island – a basis for centralising?

In considering the potential reallocation of powers, it is worth highlighting that both Ireland and Northern Ireland hold core powers for public health. This is despite Ireland's position as an EU member state (health largely remains a national competence) and Northern Ireland's position within the UK. The Devolved Settlements⁵¹ divvy up powers between Westminster/the UK and the devolved administrations. Crucially, the devolved administrations, including Northern Ireland, each hold powers in the areas of human health and other objectives impacted by the public health restrictions such as education and enterprise, enabling Ireland and Northern Ireland to take their own measures and to mirror or at least cooperate with each other.

Indeed, the GFA and the related North/South Ministerial Council highlight the existence of these powers and the importance of cross-border cooperation. The Agreement provided under Strand Two for the Council 'to develop consultation, co-operation and action within the island of Ireland – including through implementation on an all-island and cross-border basis – on matters of mutual interest within the competence of the Administrations, North and South'.⁵² Not only is this to cover discussions and information exchange, but also 'best endeavours' to adopt 'common policies'.⁵³ Health is one of the key areas,

49 This is reflected in Ireland's Shared Island Dialogues on public health, see ('Working together for a healthier island') and the environment and climate ('Environment and climate – addressing shared challenges on the island') as well as all-island approaches to plant and animal diseases (eg *All-Island Animal Disease Surveillance Report* (Department of Agriculture, Food and the Marine of Ireland, Agri-Food and Bioscience Institute and Animal Health Ireland 2020)) or invasive species (eg Kate Stokes, Kate O'Neill and Robbie McDonald, *Invasive Species in Ireland* (Environment & Heritage Service and National Parks and Wildlife Service 2004) and *National Biodiversity Data Centre*.

50 O'Connor et al (n 8 above); and G Scally, 'North and Republic must harmonise Covid-19 response' *Irish Times* (London, 31 March 2020).

51 The Scotland Act 1998, the Government of Wales Acts 1998 and 2006, and the Northern Ireland Act 1998. These are supplemented by the MOUs between the UK and devolved governments. See, generally, R Hazell and R Rawlings (eds), *Devolution, Law Making and the Constitution* (Inprint Academic 2005).

52 Strand Two, para 1.

53 Para 5.

including ‘accident and emergency planning’, ‘major emergencies’, ‘co-operation on high technology equipment’ and ‘health promotion’.⁵⁴ Although not targeted at COVID-19, the foundations are there (in international law and as an exemplar) for substantial cooperation and some degree of centralisation.

Further, in their responses, the two jurisdictions have demonstrated similar attitudes and aims to the pandemic. For instance, the two governments shared the overall approach of ‘flattening the curve’,⁵⁵ similar attitudes to social restrictions,⁵⁶ intentions to support workers and businesses,⁵⁷ and a desire to keep the Irish border open. Indeed, the governments could be seen to influence each other (whether positively or negatively) throughout the pandemic, as noted below.

This similarity is also reflected in approaches to domestic decision-making, including centralisation and the type of measures chosen, although the timing, detail and extent of measures have varied. Ireland internally demonstrated a centralised approach to the pandemic, with the National Public Health Emergency Team playing a key role throughout the pandemic, alongside the Health Service Executive (HSE) and the Government.⁵⁸ This applied to lockdowns, social restrictions, criteria for opening up, vaccines, and so on. This also entailed both national and localised approaches, including, for instance, county lockdowns depending on the rate of infections, or restrictions on visiting care/nursing homes. Effectively, these were treated as individual epidemiological units within the country. Households, and later bubbles, were likewise treated as epidemiological units. Similarly, the approach to tracing and close contacts reflected the central focus on such units, but also the fluid nature of some units and their potential to overlap. Thus, the rules, criteria and enforcement measures were centralised, but the targets for restrictions were on a national, local and/or individual basis. Furthermore, the Government determined, for instance, the core financial supports and criteria for individuals and businesses, and restrictions (or not) on evictions.⁵⁹

54 North/South Ministerial Council, ‘Health’.

55 Besides being implicit in measures across the island, see eg “‘We are beginning to flatten the curve’ – CMO” (*RTE* 25 January 2021); and M-L Connolly, ‘Coronavirus: NI outlook positive as curve “flattens”’ (*BBC News NI* 21 April 2020).

56 Eg A Nolan et al, ‘Obstacles to public health that even pandemics cannot overcome: the politics of COVID-19 on the island of Ireland’ (2021) 32(2) *Irish Studies in International Affairs, Analysing and Researching Ireland, North and South* 225.

57 Eg ‘COVID-19 cross border workers’ (EURES Cross Border Partnership, 27 March 2020).

58 Eg Delaney (n 1 above).

59 Eg the Residential Tenancies and Valuation Act 2020.

Very little flexibility was available to local decision-makers, whether county councils, other public bodies or educational institutions, to act out of line with the national policy, for example through opening or shutting a facility other than in accordance with national criteria, or deeming someone to be a close contact unless confirmed as such by the HSE. It was still open to individuals and local authorities to act within their existing powers to, for instance, provide outdoor activity spaces, adapt roads and other public areas for enhanced cycling, pedestrian access or dining, and such like.⁶⁰ However, while these powers were essential, they would be insufficient to provide the more targeted or nuanced support discussed in a 2020 report from the Organisation for Economic Co-operation and Development (OECD).⁶¹ Instead, the broad stroke of the national Government was applied across the country, reflecting perhaps the time pressure initially and the political difficulties in adjusting supports in particular after they have been announced or experienced.

Northern Ireland largely took similar approaches across the two years, including centralising measures, flattening the curve, local and national lockdowns, travel restrictions, social restrictions and so on. Variations have arisen regarding the specific details (eg limits on distance from home or limits on the number of excursions) or timing of measures, but the fundamentals remain common.⁶² Further, whilst politics was a significant feature at times, many of the variations can be understood due to differences in prevalence of the disease, as well as healthcare capacity.

In light of these similarities and the shared island (entailing an epidemiological unit), either centralisation of decision-making or very substantial cooperation would appear suitable and necessary.⁶³ The basis for doing so already existed within the GFA and the North/South Ministerial Council, but it remained too vague and general. Further,

60 NB decision-makers were still obliged to comply with their legal obligations, including under EU law. Changes to a road, including making it one-way and expanding cycle lanes, without undertaking necessary environmental assessments were considered a breach of EU law: J Kilrairie, 'Residents win legal challenge against two-way cycle lane' (*RTE* 30 July 2021).

61 D Allain-Dupré et al, 'The territorial impact of COVID-19: managing the crisis across levels of government' (OECD November 2020).

62 Nolan et al (n 56 above); and O'Connor et al (n 8 above).

63 O'Connor et al (n 8 above) 9. See also n 49 above. As mentioned, the alternative is to close the border and thereby split the island into two epidemiological units, at least temporarily. This was done to a large extent with foot-and-mouth disease previously, but the context has changed considerably since then (post-Troubles, but now with Brexit and Protocol tensions): this is a human disease and it is airborne – all of which impact on the nature of buffers needed and the desirability of such measures.

whilst much work continued behind the scenes, due to the collapse of the Northern Irish Government there was no plenary meeting after November 2016 until July 2020.⁶⁴ There was a need for something more tailored for the pandemic.

Memorandum of Understanding

From before even the first confirmed case on the island, the two Ministers for Health indicated their intentions ‘to work closely together’.⁶⁵ This approach was confirmed by the two Ministers, as well as Northern Ireland’s First Minister and Deputy First Minister and Ireland’s Taoiseach and Tánaiste in March, who announced that they would do ‘everything possible’ to coordinate and cooperate in dealing with the virus.⁶⁶ Yet, it must be noted that then Taoiseach Leo Varadkar announced the first lockdown in Ireland on 12 March 2020 from Washington, without first having briefed the Northern Executive, stating in the speech that they ‘will be briefed’.⁶⁷ Swift action was required, but this would not have prevented at least providing the information in advance of an announcement on a global stage.

However, in April 2020, the respective Departments of Health in Northern Ireland and Ireland signed the COVID-19 MOU, acknowledging the need for cross-border cooperation and collaboration in dealing with the pandemic.⁶⁸ Indeed, the MOU notes that, as the pandemic ‘does not respect borders ... there is a compelling case for *strong cooperation* including information-sharing and, where appropriate, *a common approach* to action in both jurisdictions’ (emphasis added).⁶⁹ Thus, the two Health Ministers ‘affirmed that: “*Everything possible will be done in co-ordination and cooperation*”’.⁷⁰

The MOU expressly was building upon existing cooperation between the two jurisdictions in the area of health reflected in the GFA and, for instance, in the provision of hospital treatments to residents from each other’s jurisdictions. It was to entail sharing of information, regular engagement between the relevant parties, reporting and so on. Building upon the underpinning principles in section 3 (agility,

64 North/South Ministerial Council, ‘Publications’. An institutional meeting did take place in March 2016.

65 ‘Ministers for Health Simon Harris and Robin Swann Speak on Covid-19’ (Gov.ie 27 February 2020).

66 ‘Meeting of Irish Government and Northern Ireland Executive Ministers concerning North South cooperation to deal with Covid-19’ (Gov.ie 214 March 2020).

67 ‘Statement by the Taoiseach on measures to tackle Covid-19’ (Gov.ie 12 March 2020).

68 See MOU (n 13 above) pt 1.1.

69 Ibid pt 1.2.

70 Ibid pt 1.3.

openness, consistency and trust), section 4 outlined the ‘commitments’ under the MOU related to areas of modelling; public health and non-pharmaceutical measures (eg social distancing); common public messages; behavioural change; research; ethics (including collaborating on decision-making frameworks); and supporting cooperation (including regarding procurement). However, it is worth noting that, despite the principle of consistency, section 7 provides for the possibility to take different approaches in the two jurisdictions. Specifically, ‘for justifiable reasons the public health approach and measures adopted in the respective jurisdictions may not always mirror each other in identical fashion’. Common approaches therefore are not guaranteed. However, it continues by noting that ‘strong collaborative arrangements, including good information-sharing, should help to mitigate possible negative consequences’.

Whilst not amounting to centralising powers, the MOU is therefore quite wide-sweeping and the rhetoric weighs heavily in favour of strong cooperation, collaboration and indeed coordination or common approaches where possible (and appropriate) – something that would appear logical in light of the nature of the pandemic, the practical links between the two jurisdictions and the shared epidemiological unit of the island, even whilst still maintaining claims to sovereignty and political independence. In other words, an approach on the face of it that would seem to comply with subsidiarity.

However, there are four substantial limitations to the MOU. First, although identifying potential areas of cooperation, the MOU remains vague in what it seeks to achieve: where are the details on cooperation, beyond regular communication and sharing information? It is an outline framework that needs to be developed and fleshed out. Second, its scope is unclear and limited. Does it predominately apply to social restrictions and scientific research or also to elements such as border controls, financial supports and the like? Not only is there no substantive content on these issues, but it is unclear whether the MOU even extends to these. Third, the MOU entails a ‘gentleman’s agreement’ rather than a binding document, reflected in its very provisions. Sections 4 and 8 expressly note that the MOU creates no legally binding obligations on any party, despite section 4 outlining the ‘commitments’ of the parties – these are simply political commitments. This also explains in part the lack of specificity. Without consequences for breach, there is less reason to include specific obligations or, for instance, to include criteria for lockdowns or easing up social restrictions. Fourth, in addressing the Irish border, the MOU does not deal with the very real significance of Brexit, Northern Ireland’s position in the UK, or Ireland’s EU membership. Overall, at times the MOU is much like a New Year’s good resolution: great intentions, but

capable of being cast aside when inconvenient. In particular, the MOU provides little incentive to cooperate at a high level consistently or deterrence from acting unilaterally. The question remains as to how it operates in practice.

Implementing the Memorandum?

There has been considerable debate, anxiety and media reporting regarding public policy responses on the island of Ireland, including regarding the cross-border approach, the degree of similarity with (and/or disparity between) approaches in Northern Ireland and Ireland, and the significance of this.⁷¹ The perception throughout the pandemic has been that, despite general similarities, there have been significant variations in approach, substance and/or timing, with the border being inadequately addressed.⁷² These perceptions have been supported, for instance, by the publicity surrounding high rates of incidence in locations such as Donegal, Derry and Monaghan. However, there can be considerable differences between what is reported, perceptions and what actually has occurred.⁷³ The discussion that follows is based on a composite of existing data compiled by authors such as Nolan et al⁷⁴ and O'Connor et al,⁷⁵ as well as fresh empirical research focused on key official websites and national newspapers until November 2021.⁷⁶

The starting point must be to acknowledge that there has been some significant ongoing cooperation on the island.⁷⁷ This is seen in joint statements to the public.⁷⁸ It is further reflected both in commentary in official documents, such as reports to the North/South Ministerial

71 Eg O'Connor et al (n 8 above).

72 Eg ibid 8.

73 Ibid 8; and Nolan et al (n 56 above).

74 Nolan et al (n 56 above).

75 O'Connor et al (n 8 above).

76 Official sites searched included: gov.ie; citizensinformation.ie; executiveoffice-ni.gov.uk; health-ni.gov.uk; irishstatutebook.ie; merrionstreet.ie; nidirect.gov.uk; northernireland.gov.uk. Newspapers included *The Journal*; the *Belfast Telegraph*; the *Irish Times*; and Reuters. Archives of the sites were also examined, as the pages were updated and revised frequently over the two years.

77 Nolan (n 56 above).

78 Eg agreement to make a joint public appeal by both governments for the Easter weekend in April 2020: '[Tánaiste co-chairs Covid 19 joint ministerial conference call](#)' (*Gov.ie* 9 April 2020); and joint statement by the two Chief Medical Officers in January 2021: '[Joint statement: Chief Medical Officers urge everyone to stay home](#)' (*Gov.ie* 15 January 2021).

Council,⁷⁹ and also in the similarities and parallels between official policy and announcements North and South.⁸⁰ This is not to claim that there has been either substantial coordination or the development of common policies – this largely does not appear to have been the case⁸¹ – but there was at least considerable communication between key actors. Even without reports indicating high levels of communication, it would not be realistic to believe that both jurisdictions would independently decide and announce the same measures on the same day without such advance communication.⁸² Further, a subsequent MOU was signed in November 2020 regarding critical care,⁸³ supplementing the original April 2020 one. Subsequently, there was also collaboration in developing proximity apps and the sharing of data of passengers entering each jurisdiction.⁸⁴

Nonetheless, cooperation has not been ideal⁸⁵ and considerable variations have also existed since the MOU's creation in April 2020. O'Connor et al provide a clear timeline of measures and announcements in Northern Ireland and Ireland between March and September 2020.⁸⁶ Nolan et al focus on specific issues and also compare UK-level

79 Primarily seen in the health and safety sectoral meetings and subsequent communiqués, as well as the plenary meetings: see North/South Ministerial Council, 'Publications'. Key politicians and the two Chief Medical Officers engage with these, and the reports consistently emphasise the cross-border communication that occurs.

80 Nolan et al (n 56 above).

81 This is reflected across the responses North and South, but also in the continued statements on 'consider[ing] how agreed collaborative approaches can contribute to', seen, for instance, in both the North/South Ministerial Council *Twenty-Fifth Plenary Joint Communiqué*, 18 December 2020, and the *Twenty-Sixth Plenary Joint Communiqué*, 30 July 2021.

82 Nolan et al (n 56 above).

83 Memorandum of Understanding, 'Covid-19 response – cooperation on an all-island basis in regard to provision of critical care between the Department of Health, Ireland, and the Department of Health, Northern Ireland'.

84 North/South Ministerial Council, *Health and Food Safety Joint Communiqué*, 14 October 2021. This, however, mirrors earlier comments by the same groups, indicating that progress is slow when it comes to actually finalising or agreeing substantive measures: North/South Ministerial Council, *Health and Food Safety Joint Communiqué*, 26 March 2021.

85 Eg the Foreign Affairs Minister and the UK Secretary of State for Northern Ireland agreed the need to intensify contact between the governments on the island, *six months after* the conclusion of the MOU in October 2020: 'Joint statement on Covid-19' (*Gov.ie* 12 October 2020). Further, in February 2021 the governments agreed to adopt similar approaches – something already proposed in the MOU: 'Joint statement following Quad meeting on COVID-19' (*Gov.ie* 1 February 2021).

86 O'Connor et al (n 8 above).

measures during a similar period.⁸⁷ These variations continued over the course of the pandemic.⁸⁸ In some instances, these may appear minor. For instance, the two jurisdictions have effectively been leap-frogging each other, for example regarding lockdowns and the easing of restrictions.⁸⁹ However, although the measures are relatively similar, even small time disparities in when the measures are adopted can be significant, for instance in incentivising cross-border travel by individuals who wish to shop or simply to get to school or work, when their own localities are heavily restricted.⁹⁰

At other times, the variations are more blatant and of substance, for instance, with contrasting policies arising regarding easing up or intensifying restrictions,⁹¹ dining out, international travel,⁹² contact tracing,⁹³ and the role of vaccination certificates.⁹⁴ With most variations

87 Nolan et al (n 56 above).

88 As confirmed by the empirical research undertaken for this paper. For instance, between March and October 2021, the two jurisdictions announced general plans for opening up; review periods; the return of students to school; the return of sports matches; socialising between households; and opening up of the hospitality sector.

89 Eg varying dates for different students to return to schools: ‘Executive agrees a number of early relaxations to Covid-19 regulations’ (*Executive Office* 16 March 2021); ‘Letter to school principals 23 February 2021’ (*Gov.ie* 24 February 2021); ‘Government announce the further reopening of primary schools’ (*Irish National Teachers’ Organisation* 8 March 2021); and ‘Government announces phased easing of public health restrictions’ (*Gov.ie* 30 March 2021) This could also indicate a level of competition between the jurisdictions, which can lead to swift and decisive measures or alternatively a ‘wait and see’ approach – both of which have their advantages and disadvantages in a climate of uncertainty.

90 M McDonagh, ‘Covid rules: “People were travelling over the border from Donegal all the time”’ *Irish Times* (Dublin, 13 October 2021).

91 Eg at the end of November/early December 2020, Northern Ireland initially introduced further restrictions: ‘Executive agrees two-week circuit breaker’ (*Executive Office* 19 November 2020); while Ireland relaxed measures ‘Dáil speech by the Taoiseach Micheál Martin on COVID-19’ (*Gov.ie* 24 November 2020); and ‘Special measures for the Christmas period come into effect’ (*Gov.ie* 17 December 2020).

92 Eg with Ireland adopting the EU system, ‘Ireland to phase in EU “traffic light” travel system from Sunday’ (*Reuters* 4 November 2020).

93 K O’Sullivan, ‘North and South’s diverging Covid systems are harming response to case surges’ *Irish Times* (Dublin, 16 October 2020).

94 Eg O’Connor et al (n 8 above). Unlike in Northern Ireland, proof of vaccination was required for dining in restaurants and accessing certain venues in Ireland, as laid out in Health Act 1947 (ss 31AB and 31AD) (COVID-19) (Operation of Certain Indoor Premises) Regulations 2021 (Revised), SI 385/2021. Further, Ireland retained social distancing requirements on public transport and more generally in autumn 2021: ‘Measures in place from 22 October’ (*Gov.ie* 19 October 2021); in contrast with Northern Ireland, eg ‘Statement on Executive decisions – social distancing’ (*Executive Office* 27 September 2021).

in policy content, there is an incentive for individuals to travel to avail of laxer conditions (for those who seek them),⁹⁵ not to mind providing counter examples of policy measures that may undermine trust and compliance within an individual's own jurisdiction. Although there may have been extensive communication and there may be good reason for the variations, perhaps because of lower or high case numbers in one jurisdiction (or part thereof) and limited or extensive resources, the simple existence of a variation can lead to incoherency and pose cross-border issues.

This brings us to the final point, which is the failure for the main part to address cross-border issues directly. This for instance is seen in the inapplicability of internal travel restrictions in Ireland on those from Northern Ireland for a considerable period of time,⁹⁶ the inability of those living in one jurisdiction (subject to lockdown) but working in the other (not subject to lockdown) to avail of payment support, the differing unemployment supports for cross-border workers,⁹⁷ or closing one's eyes to the potential for individuals to travel from overseas through one jurisdiction to the other (eg from London via Belfast to Dublin, or from Paris via Dublin to Belfast)⁹⁸ despite having different rules on incoming passengers.⁹⁹ Further, the situation in some border communities merited joint action, if only due to the very challenging circumstances there: Donegal, for example, was repeatedly in the news in 2020 and 2021 for high case numbers, cross-border travel between Derry and Donegal, and later the low uptake

95 Eg McDonagh (n 90 above).

96 “‘The virus does not respect the border’ – Community “frustrated” laws cannot be enforced on NI day trippers’ *Irish Examiner* (Cork, 26 April 2020).

97 Prior to the MOU, the Irish Government announced that cross-border workers resident in Ireland could be eligible for the PUP (pandemic unemployment payment), but that cross-border workers resident in Northern Ireland would not be: ‘Covid-19 cross border frontier workers’ (*Gov.ie* 30 March 2020). Northern Ireland provided support for the latter category, but it was considerably lower in Northern Ireland and this situation remained the case after the MOU was signed (see *ibid* and n 57 above).

98 This was acknowledged at times, but still inadequately addressed: J Power, ‘Covid crisis: UK travel ban extended until December 31st’ *Irish Times* (Dublin, 22 December 2020).

99 Eg ‘COVID-19 (coronavirus)’ (*Tourism Ireland* 27 September 2021); and M Fagan, “‘Thousands will fly from Belfast next month,’ Irish travel agents warn’ *Irish Examiner* (Cork, 11 May 2021).

of vaccines.¹⁰⁰ Hence, in June 2021 we saw the two Chief Medical Officers call for caution by those crossing the border,¹⁰¹ but this was a limited and rare proclamation on the border. There is clear need for more consistent, widespread, substantive cooperation, going beyond general communication towards joint action and coordination. One major positive counterexample is the expansion of the EU COVID vaccination certificate to Irish passport holders vaccinated in Northern Ireland.¹⁰² However, this is a cumulative requirement and does not address any others resident in Northern Ireland.¹⁰³

Consequently, the MOU's strengths and limitations on paper are reflected in practice. Communication has typically been strong, with information shared and updates provided between the key scientists, medical officers and politicians. However, communication is the most minimal level of cooperation, without deep collaboration or coordination – common policies have been mentioned and discarded, despite the rhetoric in the MOU and the occasional incoherency of policy on the island. The practice is such as to fall far short of what is desirable in light of subsidiarity, indicating that further detail and legally binding commitments, if not full-blown centralisation, might be necessary.

Contextual factors: challenges for cooperating?

So, if the two governments recognise the need for cooperation, why not commit legally to it and not simply politically? Why not create specific, binding obligations tailored for COVID-19? Or indeed, why not at least keep to the political commitments? Beyond the general dislike of being bound legally and the delays involved in developing international agreements, a number of key reasons arise in this context that may explain the governments' seeming reticence. First, the surrounding uncertainties, including how long the pandemic might last, the economic and broader health implications, and the availability of effective vaccines or treatments, make such agreements challenging to design. What if one government's situation changes or they wish to

100 Eg McDonagh (n 90 above); A Molloy, 'Delta in Donegal – "If there's an outbreak in Derry, it will impact here ... the border is irrelevant"' (*Independent.ie* 6 July 2021); M Fagan, 'Interactive map shows Ireland's Covid hotspots as rates of infection accelerate' *Irish Examiner* (Cork, 6 July 2021); 'Covid-19: Republic's case rates highest near Derry border' (*BBC News* 3 July 2021); and P Cullen, 'Covid-19: hard-hit Monaghan, Donegal have lowest inoculation rate' *Irish Times* (Dublin, 8 September 2021).

101 See 'Joint statement' (n 85 above).

102 'EU Digital COVID Certificate Third Country portal launches today in Ireland' (*Gov.ie* 29 September 2021).

103 'Covid-19: EU vaccine cert opens for Irish passport holders in NI' (*BBC NI News* 30 September 2021).

adapt their approach? Second, politics plays a substantial role, whether this is not wanting to be seen to be working with (or bound to) other political groups or indeed simply other countries/jurisdictions.¹⁰⁴ For instance, it does not necessarily sit well with Unionists or their voters to be bound in policymaking to actors in Ireland, especially if this is simultaneously conflicting with policy made in Westminster or generally across the rest of the UK. This makes all-island policy more sensitive for others and challenging to propose or implement. Third, Northern Ireland does not have the power to create legally binding international agreements – this remains a reserved power within the UK.¹⁰⁵ And fourth, both Northern Ireland and Ireland have close links with other territories, including most obviously GB and also the EU, reflected in the Common Travel Area between Ireland and the UK, and the free movement of persons in the EU. People, animals and goods are travelling overseas regularly, in particular between the island of Ireland and GB. However, to take a joint approach and treat the island as one unit for the purposes of the pandemic might lead to travel restrictions within the UK (between GB and Northern Ireland) or within the EU (between Ireland and the rest of the EU) to safeguard the island and/or to safeguard the rest of the UK or the EU, reflecting the challenges of Brexit and the Northern Ireland Protocol for the border.

The first point is a practical issue that could be addressed in the design of the documents, whether in providing for review clauses or otherwise. However, the remaining three reasons centre largely on Northern Ireland's (and to a lesser extent Ireland's) relationship with GB, and on Ireland's (and to a lesser extent Northern Ireland's) relationship with the EU. While the UK Government could in principle conclude an agreement on behalf of Northern Ireland, it still does not address the other embedded elements. Thus, the legal, political, cultural and economic aspects impact the application of subsidiarity and raise the question of whether the island is the appropriate level for situating policymaking powers.

104 Further, by avoiding legal commitments and being willing to break or at least bend the political ones, there was the potential for political one-upmanship whether by individual politicians, parties or governments (since both governments involve more than one political party) – as highlighted by the competitive aspects noted above. This, however, is a double-edged sword and is also not something that will be argued as a reason to avoid making commitments – it is therefore less likely to pose a fundamental constraint by itself.

105 Whilst Ireland is also bound by EU law, this does not prevent the conclusion of such agreements where they do not conflict with EU law; as mentioned, health is largely a national competence, so this would seem initially to facilitate independent action.

A TWO-ISLAND APPROACH?

A key alternative approach to that of focusing solely on the island of Ireland is to focus on what has been referred to as a ‘two-island approach’ or, more accurately, on an approach for Ireland and the UK. This has been mooted by political commentators, scientists, journalists and even the politicians themselves, with varying degrees of approbation.¹⁰⁶ It is also something that the GFA could facilitate, as Strand Three addresses the relationship between the UK and Ireland and provides mechanisms for engagement between various British and Irish institutions, including the British–Irish Intergovernmental Conference and the British–Irish Council.¹⁰⁷

There are clear advantages to such an approach that relate directly to many of the challenges for an all-island approach. From a legal perspective, the power to negotiate international agreements (including therefore with Ireland regarding public health cooperation) rests with the UK Government rather than devolved administrations,¹⁰⁸ enabling for strengthening approaches relative to those found within the MOU. Furthermore, it is the UK Government that determines the funding available to the devolved administrations,¹⁰⁹ including funding for developing public capacity, for providing support for businesses and individuals whilst restrictions are in place and in the aftermath of the pandemic, and for purchasing PPE and/or vaccines. Without this funding, public health policies may simply be empty words.

From a political perspective, individuals in Northern Ireland in particular may be more amenable to adopting an approach that is agreed in a collaborative manner between the UK (including the devolved administrations) and Ireland and applies uniformly across

106 As early as March 2020, key politicians (Tánaiste, First Minister, Deputy First Minister, Secretary of State for Northern Ireland and the two Health Ministers) on the island noted a ‘compelling case’ for cooperation between North and South, but also between Ireland and the UK as a whole: ‘[Statement on response to COVID-19 on the island of Ireland](#)’ (Gov.ie 31 March 2020); ‘[DUP says a two-island approach to international travel is worth “exploring”](#)’ (*The Journal* 14 February 2021).

107 See Hough (n 6 above).

108 Eg D Torrance, ‘[Reserved matters in the United Kingdom](#)’ (House of Commons Library, CBP 8544, 5 April 2019); and [Memorandum of Understanding and Supplementary Agreements between the United Kingdom Government, the Scottish Ministers, the Welsh Ministers and the Northern Ireland Executive Committee](#) (October 2013) 8.

109 This is typically according to the Barnett formula. M Keep, ‘[The Barnett Formula](#)’ (House of Commons Library, CBP 7386, 23 January 2020) s 1.2.

the two islands, rather than following either Ireland or England to the exclusion of the other.¹¹⁰

Further, economically and culturally, the links are not simply present between Northern Ireland and Ireland, but also between both of these and GB and within all of GB. This is reflected in the Common Travel Area as noted, but also for instance in the level of economic interdependence between Ireland and the UK even after Brexit in that GB and then Ireland are the primary markets for NI produce such as agri-food produce, and goods and workers cross the borders daily (in all directions). The combination of these factors is reflected in the reluctance to impose restrictions on people travelling between GB and the island of Ireland, not to mind the fuzziness of restrictions when individuals could travel from GB to Northern Ireland without isolating and also from Northern Ireland to Ireland, but not GB to Ireland. Consequently, not only is there a case to be made that the jurisdictions comprise a single epidemiological unit, or at least two with overlapping boundaries, but also the political and legal relationships would indicate that this might be a viable alternative and appropriate in light of subsidiarity.

This would not necessitate an identical or a joint approach, but could entail substantial cooperation, including communication, collaboration and coordination on the nature of restrictions, border controls, vaccination programmes and the sharing of resources to facilitate all of the above. If common approaches are not always the case, at least cooperation could avoid conflicts. The eventual aim would be to create a single epidemiological unit encompassing the two jurisdictions that has either eradicated COVID-19 or has developed sufficient resistance within the population (through vaccination and/or antibodies) to ensure herd immunity, with measures in the meantime to protect the vulnerable, slow the spread of the disease and ensure the functioning capacity of the health system (to address existing needs and those posed by the pandemic).

However, key interrelated challenges arise relating to overlapping boundaries once more and also ideologies. These include the complexities of UK constitutional law and devolution; membership of the EU and Brexit; politics/political relations on the two islands; conflicting aims and approaches regarding COVID-19, including underpinning ideologies; and globalisation, which has been addressed above.¹¹¹

First, UK constitutional law and the relationship between the UK Government and the devolved nations is complicated. Whilst the UK

110 See *The Journal* (n 106 above).

111 This factor affects Ireland, Northern Ireland and Great Britain differently, but a deeper investigation of this point is beyond the scope of this article.

Government retains the powers to conclude international agreements, controls funding to the devolved administrations and, ultimately, there is (Westminster) parliamentary sovereignty,¹¹² nonetheless devolution exists and the devolved nations have their own views and voices.¹¹³ This has been reflected in varying approaches at times to COVID-19 across the UK.¹¹⁴ Further, the UK Government is also dependent on the devolved administrations to implement and uphold UK-wide policy or agreements. Overall, logically there should be a preference for collaborative approaches between the devolved and centralised administrations to developing policy, as reflected in the development of common frameworks for post-Brexit,¹¹⁵ but in practice these can be slow and difficult to achieve even where similar aims are supposedly held.¹¹⁶

Second, Ireland and the UK/devolved administrations are not the only actors involved. In particular, the EU and Brexit must be considered.¹¹⁷ Ireland remains an EU member state, whereas the UK is no longer one, despite the halfway-house status of Northern Ireland due to the Northern Ireland Protocol.¹¹⁸ Ireland must abide by EU law, including for instance facilitating the free movement of goods and persons. It must also protect the borders of the EU because, for example, Ireland (and Northern Ireland) is bound to impose sanitary and phytosanitary checks on imported animals and plant products and controls on the importation of medicines and medical devices. The corollary is that Ireland garners the benefits of EU membership, including here access to medical equipment or vaccines procured by the

112 M Elliott and R Thomas, *Public Law* 4th edn (Oxford University Press 2020) 5 and 77ff. The limits of devolution vis-à-vis parliamentary sovereignty are reflected in the Sewel Convention (HL Deb 21 July 1998, vol 592, col 791) and *The UK Withdrawal from the European Union (Legal Continuity) (Scotland) Bill* [2018] UKSC 64.

113 G Anthony, 'Devolution issues, legislative power, and legal sovereignty' (2015) *Le Droit Public Britannique: État des Lieux et Perspectives* 95.

114 J Sargeant and A Nice, 'Coronavirus lockdown rules in each part of the UK' (*Institute for Government* 19 October 2021).

115 Joint Ministerial Committee (EU Negotiations), 'Communiqué – Common Frameworks: Definition and Principles' (16 October 2017).

116 House of Lords, Common Frameworks Scrutiny Committee, 'Common frameworks: building a cooperative union' (First Report of Session 2019–21, HL Paper 259, 31 March 2021).

117 Eg M Dayan, 'How will Brexit affect the UK's response to coronavirus?' (Nuffield Trust October 2020) 13–14.

118 McCrudden (n 5 above). To avoid a hard border on Ireland and ensure peace, the Northern Ireland Protocol treats Northern Ireland somewhat as part of the EU single market and requires NI to comply with some EU laws – Dobbs and Gravey (n 5 above). The Trade and Cooperation Agreement is of limited relevance to the discussion here.

EU on behalf of the member states, as well as recognition of vaccination status. Although early on each member state was taking its own approaches when it came to restrictions (or the lack thereof), there are now some elements of harmonisation¹¹⁹ including the EU vaccination certificate.¹²⁰ Whilst Ireland and the UK can share resources and cooperate to a large degree regarding COVID-19, the distinction created by EU (non-)membership¹²¹ creates too great hurdles at times for full centralisation, for instance access to the EU Digital COVID certificate for the purposes of travel.¹²² EU–UK data-sharing, which is of considerable significance, highlights these differences and also the potential for (temporary) resolutions that facilitate cooperation.¹²³

Third, as with an all-island of Ireland approach or considerations of devolution, nationalism and unionism, a two-island approach raises political issues and not simply legal ones. A collaborative approach might be broadly acceptable, but if there were centralisation, where would the decision on behalf of everyone be made? Are devolved nations to have an equal say as Westminster and Dublin? Are Westminster and Dublin to have an equal say? What would the optics be? Each grouping would be seeking to not appear as if they were adopting policies or approaches determined or even heavily influenced by others and simultaneously might also need to not appear to be dictating policy for others. For example, Dublin would not wish to appear weak vis-à-vis Westminster or stepping on toes when it comes to Northern Ireland; Westminster would not wish to appear weak vis-à-vis Dublin or the devolved administrations (for the sake of their own electorates), but would also wish to not step on the toes too much of the devolved administrations (for the sake of the union). Furthermore, in the context of Brexit, ‘taking back power’ and the desire to reclaim sovereignty, it will be important for the UK Government in particular not to seem overly swayed by Dublin or indirectly by the EU.

Finally, there is simply the difficulty that the fundamental aims of the various administrations are not consistently the same or compatible. In particular, England, which accounts for approximately 82 per cent of the population in the UK and approximately 75 per cent of the

119 Paccès and Weimer (n 2 above); and Renda and Castro (n 2 above).

120 European Commission, ‘EU digital COVID certificate’.

121 Eg Dayan (n 117 above).

122 ‘The EU vaccine “passport” and what it means for travel’ (*BBC News* 6 August 2021).

123 Eg Commission implementing decision pursuant to Regulation (EU) 2016/679 of the European Parliament and of the Council on the adequate protection of personal data by the United Kingdom, Brussels, C(2021)4800final. This remains conditional on the UK at least maintaining equivalence with the EU’s standards: N O’Leary, ‘EU warns over post-Brexit data agreement with UK’ *Irish Times* (Dublin, 26 August 2021).

population across the two islands, has shifted its aims on occasion. Early statements and behaviour indicated that the UK Government was seeking to develop herd immunity by letting the disease spread, whilst providing some protection to the identified vulnerable population.¹²⁴ Whilst the UK Government abandoned this, switching to the ‘flatten the curve’ approach, it appears that herd immunity may have become the underpinning aim once more – via a combination of enabling the spread and vaccination – with a considerable easing-up of restrictions, emphasis on individual responsibility and acknowledgment of the inevitable increase in deaths.¹²⁵ This raises numerous concerns, including that vulnerable people may not yet be sufficiently vaccinated (or even identified as vulnerable), the number with ‘long-COVID’ will increase, hospitals may become swiftly overburdened, and new variants may continue to develop.¹²⁶ Further, from a governance perspective, it raises the question of how this will impact or be impacted by contrasting policies in the rest of GB or in Northern Ireland or Ireland. The populations are not fixed and it is questionable whether herd immunity will be achieved in the short or long term in England¹²⁷ and also whether this will lead to the further spread of the disease across the islands – especially if individuals might be incentivised to travel to England to enjoy looser controls, before returning to Wales, Scotland, Northern Ireland or Ireland.¹²⁸

Each of these elements makes a two-island approach much more complex than it might first appear. Of the hurdles examined, the most challenging elements are not the legal restrictions but the political (not wishing to be seen to be influenced or controlled by others, or aligning with or going against specific bodies), economic (the financial costs of the restrictions, whether and how resources should be shared and the significance of cross-border travel) and ideological (whether herd immunity should be facilitated by allowing the spread of the disease or not). In principle, if each part of the UK and Ireland succeeds in developing herd immunity through spread of the disease and/or vaccinations and boosters, then the aims will no longer be in conflict with each other and a more centralised approach would be possible.

124 Eg C O’Grady, ‘The UK backed off on herd immunity. To beat COVID-19, we’ll ultimately need it’ (*National Geographic* 29 March 2020).

125 ‘Guidance: moving to step 4 of the roadmap’ (*Gov.uk* 27 August 2021).

126 ‘Covid: why are UK cases so high?’ (*BBC News* 22 October 2021); and A Kleczkowski, ‘Relaxing restrictions hasn’t made COVID cases spike – but this doesn’t mean herd immunity has arrived’ (*The Conversation* 15 October 2021).

127 While those recovered from COVID-19 have antibodies that provide some protection, it is now clear that individuals can contract the disease a second time. Further, new variants are emerging and will continue to do so.

128 Or in other directions if approaches shift.

However, even the vaccines are shown to already require boosters for new variants and uptake is slowing down, whereas immunity from contracting the disease does not last indefinitely. Consequently, for the foreseeable future a centralised or joint approach is not feasible where aims conflict. A choice is left: segregate the jurisdictions indefinitely, change aims to mirror each other or engage in strong cooperation to help ensure coherency and avoid aims being undermined. Thus, strong cooperation becomes increasingly challenging, but also fundamental to any jurisdiction seeking to tread its own path.

CONCLUSION: COOPERATION AND COORDINATION IN A FRAGMENTED, GLOBALISED WORLD?

Subsidiarity appears complex, but is simply a logical tool that argues for centralisation or at least cooperation where questions of efficiency and difficulties of negative externalities demand it. The complexity is the natural mirror of the situation at hand, exemplified by pandemics.

The nature of a pandemic, as well as globalisation with shifting populations and long supply-chains, means that decision-making needs to look beyond the existing territories to epidemiological units. An approach is needed that recognises the overlapping of these units – as broad, coherent and cooperative as possible – not just for restrictions, but also for resources, vaccinations, food supplies and so on.¹²⁹ From the perspective of efficiency and effectiveness, this could entail decision-making ideally at a global level or at least on the basis of epidemiological units, preferably through centralisation or at least substantial cooperation.¹³⁰

However, subsidiarity also takes into account contextual factors, including current legal, political, economic and cultural conditions and relationships. Relevant powers are not currently fully centralised or on the basis of epidemiological units, but instead are primarily aligned to fragmented jurisdictional boundaries. Subsidiarity does not necessitate dispensing with existing territories or allocations of powers, but it requires the recognition of the limits of individual, artificial boundaries to deal with pandemics. The choice could be to map the territories (whether via centralisation or substantial cooperation) onto the epidemiological units or to somehow impose restrictions on the

129 Eg S Scarpetta, 'Access to COVID-19 vaccines: global approaches in a global crisis' (OECD 18 March 2021).

130 Cf Allain-Dupré et al (n 61 above) OECD report.

epidemiological units to map them onto the territories, for instance through isolating country A from B.¹³¹

The island of Ireland exemplifies both the value of and challenges for centralising, or even substantial cooperation. There is clear merit in a cross-border or all-island approach – whether through centralising or substantial cooperation – reflected in its single epidemiological unit status, links on numerous fronts and provision in the GFA for cooperation on public health, as recognised in political discourse on the pandemic. Yet, the current MOU is clearly insufficient in nature and substance, reflected in its limited implementation and lack of focus on border communities. A revised MOU would benefit from greater specificity and binding commitments, including perhaps being bolstered by a binding agreement between the UK and Ireland (with Northern Ireland's accord). Alternatively, or alongside this, Ireland and Northern Ireland could establish mirroring policy and legislation, with a cross-border body tasked with ensuring they function smoothly in parallel. This is legally possible under domestic and EU law (within limits) and is supported by the GFA.

However, when examining potential reasons for the current MOU's limitations, the thread starts unravelling. Legal issues are only one factor, with political, economic and cultural aspects also key. This has been exacerbated more recently with the continuing conflicts over the Northern Ireland Protocol, and building all-island cooperation (without GB also) currently¹³² seems increasingly unlikely. It becomes clear that the existing context, including the very relationships between Ireland, Northern Ireland and the UK as a whole, make the implementation of subsidiarity sufficiently challenging that it might be necessary to rethink the appropriate *loci* for powers or who should be cooperating.

Consequently, it might be necessary to include GB alongside Ireland and Northern Ireland in a two-island approach instead, reflecting the more complex (legal, political, and economic) relationships across the island and the overlapping epidemiological units. This could resolve several of the challenges to cooperation on the island of Ireland and, if possible, would still be an appropriate application of subsidiarity. However, new challenges arise there once more due to the context, including internal UK politics, Ireland and the UK's contrasting relationships with the EU, relationships globally and, most fundamentally, potentially conflicting aims or core approaches to COVID-19. Although complex, if Ireland and all of the constituent parts

131 The latter may be desirable temporarily where conditions are significantly different (eg COVID-19 is present in one part, but not yet the other) or long-term where the fundamental aims conflict.

132 This flags the importance of developing general foundations for cooperation (beyond the limited ones in the GFA) when conditions are most favourable.

of the UK could resolve their differences regarding the underpinning aims and approaches to COVID-19, this would make a two-island approach both more feasible and more appropriate. Without resolving these differences, cooperation is simultaneously more challenging and more important.

However, the story does not end there and Ireland and the UK must look beyond their territories once more and engage globally if there is to be an effective, long-term resolution to this pandemic or others in the future.¹³³ An all-island or even two-island approach, in a globalised world where there is significant widespread disparity in resources and the capacity to respond to the pandemic, can only be an effective strategy in the short term. Resource-sharing and equitable treatment is required not merely for the sake of fairness and human rights, but also to ensure herd immunity (through vaccination or otherwise) or eradication globally.

This analysis of the island of Ireland also provides insights into subsidiarity's application. The initial evaluation of COVID-19 was premised largely on the nature of a pandemic, taking into account the potential for limited resources or conflicting aims. Despite some caveats, it demonstrated a clear need for centralising powers or at least substantial cooperation within a single epidemiological unit. However, applying the concept to specific jurisdictions demonstrates that the context can have a major impact on the initial identification of power *loci* and also demand a review of the original conclusions. For instance, contextual factors may indicate that other fundamental beliefs and aims (eg sovereignty and identity) should weigh on the considerations of democracy and homogeneity/heterogeneity (subsidiarity's step 1), despite being less directly relevant to COVID-19; some contextual factors may arise that are too challenging to amend (at least in the short-term) and may affect the efficiency and effectiveness (subsidiarity's step 2); and thereby, together affect the balance of whether (de)centralisation or alternative forms of cooperation should occur or are even possible. Thus, a clear conflict may arise in subsidiarity's application, between what ought to arise in a relative vacuum and what ought to arise in context.

Finally, the island of Ireland highlights that the desirability under subsidiarity to centralise powers or at least have substantial cooperation with other *loci* is not limited to just one level or space. For instance, for Ireland, while the most obvious focus is centralising or cooperating with Northern Ireland, it is necessary also to consider the UK and the EU due to the overlapping relationships and indeed effectively overlapping epidemiological units. The context could also change the desirability of

133 Dobbs (n 3 above); and UN Economic and Social Council (n 31 above).

which *loci* to consider cooperating or centralising with. What if Ireland and Northern Ireland had fundamentally opposing aims vis-à-vis the pandemic and they decided to close the border, thereby attempting to divide the island into two epidemiological units? Whom might each cooperate with instead? Nobody or those with whom they have close relationships, shared aims and could perhaps create new units within a globalised world? The natural choice for Northern Ireland would remain GB/the UK, provided the context permitted. For Ireland, the natural choice of the EU is complicated by the variations in aims that arose across the EU member states.