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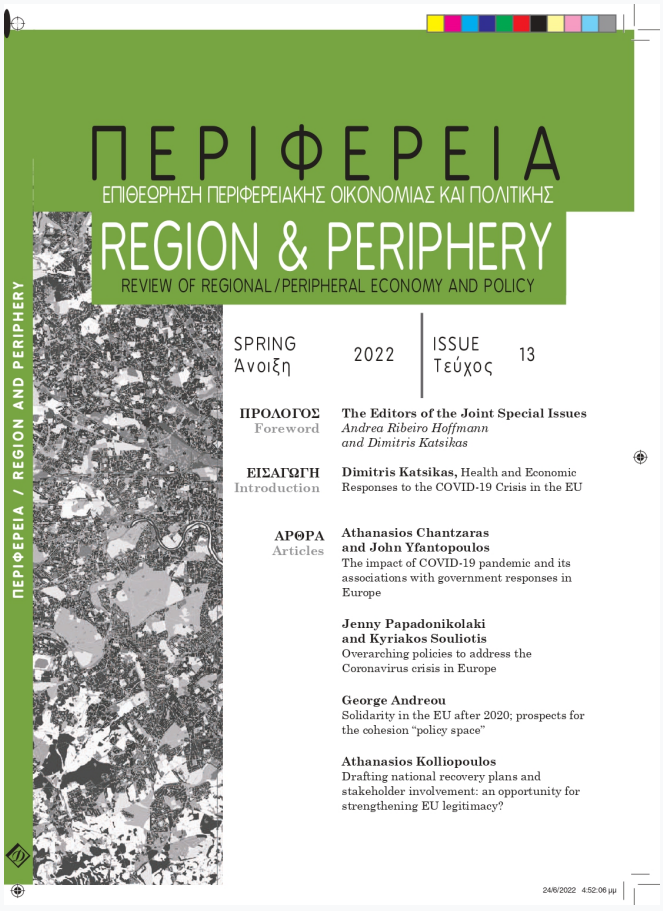

Γενικές Πολιτικές Αντιμετώπισης της Πανδημικής Κρίσης στην Ευρώπη

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Overarching policies to address the pandemic crisis in Europe

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Abstract

COVID-19 pandemic has had a devastating impact on our world, affecting societies, economies, and healthcare systems across the globe, while changing many social, economic, and healthcare determinants. Europe is facing one of the most critical crises in its recent history, not only because of the economic challenges that the COVID-19 pandemic has created but also because of its significant political dimension. The aim of this paper is to provide a descriptive analysis of the different strategies European member states developed to monitor and contain the outbreak during the first wave, and the policy response of the European Union (EU) altogether. Despite the different approaches and time response in tackling the pandemic at its very beginning, EU quickly demonstrated a successful policy response that helped maintain the structure of the economy and sustain societies in the face of this exogenous shock.

KEY-WORDS: Health policy, COVID-19, European Union, pandemic crisis, public health

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Περίληψη

Η πανδημία COVID-19 προκάλεσε καταστροφικές συνέπειες στις κοινωνίες, τις οικονομίες και τα συστήματα υγειονομικής περίθαλψης σε όλον τον κόσμο, καθώς επηρέασε πολλούς κοινωνικούς, οικονομικούς και υγειονομικούς προσδιοριστές τους. Η Ευρώπη βρέθηκε αντιμέτωπη με μια από τις πιο σημαντικές κρίσεις στην πρόσφατη ιστορία της, όχι μόνο λόγω των οικονομικών προκλήσεων που δημιούργησε η πανδημία COVID-19 αλλά και λόγω της σημαντικής πολιτικής της διάστασης. Ο στόχος του παρόντος είναι να παρουσιάσει τις διαφορετικές στρατηγικές που ανέπτυξαν τα ευρωπαϊκά κράτη για την παρακολούθηση και τον περιορισμό της πανδημίας κατά το πρώτο της κύμα, καθώς και την πολιτική απάντηση της Ευρωπαϊκής Ένωσης συνολικά. Από την αποτίμηση των στρατηγικών αντιμετώπισης της πανδημίας στην Ευρώπη προκύπτει ότι ενώ οι παρεμβάσεις των κρατών - μελών διέφεραν τόσο ως προς το περιεχόμενο όσο και ως προς το χρόνο ανταπόκρισης, η ΕΕ κινητοποιήθηκε άμεσα και με τρόπο που συνέβαλε στη διατήρηση, στο μέτρο του εφικτού, της οικονομικής και κοινωνικής ζωής, οι οποίες διαταράχθηκαν από την πρωτοφανή αυτή απειλή.

ΛΕΞΕΙΣ - ΚΛΕΙΔΙΑ: Πολιτική υγείας, Covid-19, Ευρωπαϊκή Ένωση, πανδημική κρίση, δημόσια υγεία

1. Introduction

The COVID-19 pandemic has had a devastating impact on our world, sweeping societies, economies, and healthcare systems across the globe, and altering social, economic, and healthcare determinants. States were taken aback by the severity of the shock and the unavailability of adequate resources and solutions to contain the virus. Therefore, they found themselves challenged to protect their citizens' health. The pandemic revealed a new global phenomenon: the politicization of the COVID-19 pandemic (Flores et al. 2022).

The EU entered the pandemic affected by years of economic crisis in some of its member states. Since 2007, the global financial crisis and then the Eurozone debt crisis imposed a significant economic burden on Europe - and especially country-members of the Eurozone - that was greater than even that of the Great Depression of the 1930s (Crafts 2013; Copelovitch et al. 2016). The global financial crisis found most European Union member states unprepared and unable to meet the crisis. National public debts and unemployment rates increased while public revenues and the average family income decreased. In the context of the crises, several EU countries - some under bailout agreements (Hungary, Latvia, Romania, Greece, Ireland, Portugal, Cyprus) and others due to pressure from the markets (Spain, Italy) - had to implement a package of policies characterized by austerity interventions, which often included drastic cuts in public spending.

Under the pressure of the economic crisis, most health systems faced persistent and significant budget cuts. Some governments significantly curtailed resources for public health, either directly or indirectly, by limiting public participation, reducing budget for healthcare provision or disinvesting in health system capacity. It is indicative that after 2007, 18 out of the 28 EU Member States reduced public expenditure on health (Eurofound 2013). As a result, citizens' health and access to health services were directly affected, whilst high unemployment rates and cuts in social protection spending exacerbated deterioration of health indicators and inadequate access to services.

Despite this bleak image, European healthcare systems appeared overall resilient. In 2019, the GHS Index (GHS Index 2019) ranked most European healthcare systems in the top 20 among 195, in terms of the overall score, with the UK ranking second after the United States. Regarding prevention capacity, Sweden, Netherlands, Denmark, France, Finland, the UK, Norway, and Slovenia were considered most prepared. In terms of early detection and reporting for epidemics of potential international concern, according to the GHS Index, Latvia, UK, Denmark, Netherlands, Sweden, Germany, Spain, Lithuania, Italy, Greece, Ireland, Estonia, France, Slovenia, and Croatia were considered the most prepared.

On 17 November 2019, the first-ever case of COVID-19 was traced in China (UCSD 2021; SCMP 2020). By January 2020, 41 patients admitted to hospitals were identified as confirmed novel coronavirus cases (Huang et al. 2020). In Europe, France was the first European country to be hit by the new coronavirus with the first case reported on 24 January 2020 and the first death on 15 February (Bernard et al. 2020). The WHO declared the outbreak a "Public Health Emergency of International Concern" (PHEIC) on 30 January 2020 and a pandemic on 11 March 2020 (WHO 2020). On January 30, there were 98 cases and no deaths reported in 18 countries outside China. On March 11, WHO reported over 118,000 cases in over 110 countries around the world. Europe reported 5,338 infections and 242 deaths (Reuters 2021), with Italy leading the devastating toll. On March 13, the WHO's director-general announced that Europe had become the epicentre of the coronavirus pandemic, with more reported cases and deaths than the rest of the world combined (apart from China).

As of April 13, 2022, 497,960,492 COVID-19 cases and 6,181,850 COVID-19 related deaths have been reported in Europe (WHO, 2022). Life expectancy has been directly affected by COVID-19, and in almost all European countries life expectancy rates declined, with countries like Italy, Spain, Poland and the UK returning to 2010 levels (OECDa 2021). In parallel, a significant negative impact has been observed on mental health, with the prevalence of anxiety and depression doubling in countries like Belgium, France, and the UK (OECDa 2021; Eurofound 2021). The rapid increase in deaths and the imposition of strict lockdowns and social distancing measures further burdened the situation (Santomauro 2021; Scholz 2021; Souliotis et al. 2021).

In addition, access to primary healthcare services was severely affected by COVID-19, whilst essential hospital services were postponed or canceled. Primary healthcare face-to-face consultations decreased considerably (Mughal et al. 2021). For instance, the UK reported significant reductions in consultations for cardiovascular, respiratory, and mental health conditions (Mansfield et al. 2021), while in Portugal, the number of diagnostic exams for diabetes care declined by 24% (OECDa 2021). In addition, elective surgeries declined in all countries (Meredith et al. 2020).

Finally, despite the heterogeneity of the pandemic's economic impact, all economies were affected. In the first quarter of 2021 euro area real GDP was 4.9% below its pre-pandemic level, having declined by 6.5% in 2020 (Muggenthaler et al. 2021).

The present article aims to provide a brief description of the different strategies European member states implemented domestically, as well as the common EU response, to monitor and contain the spread of the virus during the first wave of the pandemic. This review may inform future policies on optimal management of exceptional public health challenges.

2. Early response

At the very beginning of the outbreak, countries in Europe addressed the unprecedented challenge individually and did not appear willing or able to coordinate their policy responses (Souliotis 2020). This resulted in a belated and fragmented response by many countries that negatively impacted on the speed and extent of the outbreak.

We have identified three groups of countries based on their very early response and government decisions. The first group covers countries like the Nordics and the Baltics, which, despite their very low mortality rates during the first wave, opted to respond to the threat of the pandemic quickly. The second group of countries refers to countries like the UK and Sweden, which based their policy response on the theory of "herd immunity", implementing less restrictive measures and mild recommendations. The third group of countries refers to countries like Germany, Austria, Spain, Italy and Greece, which moved swiftly to more stringent measures with lockdowns (Table 1).

Table 1 Number of days that had passed between the third death caused by COVID-19 in each country and the implementation of each measure in that country

	Date of 3rd confirmed death	Events Suspended	Schools closed	Non-essential shops closed	Non-essential movement banned	Borders closed	1st lockdown	Duration (days)
Italy	25-Feb	05-Mar	05-Mar	10-Mar	10-Mar	-	09-Mar	70
France	03-Mar	29 Feb	16-Mar	14-Mar	17-Mar	-	17-Mar	55
Spain	06-Mar	10-Mar	15-Mar	15-Mar	16-Mar	16-Mar	14-Mar	56
UK	09-Mar	17-Mar	23-Mar	21-Mar	24-Mar	-	24-Mar	49
Belgium	12-Mar	14-Mar	15-Mar	17-Mar	17-Mar	20-Mar	18-Mar	47
Germany	12-Mar	20-Mar	15-Mar		22-Mar	16-Mar	16-Mar	76
Greece	15-Mar	08-Mar	10-Mar	16-Mar	23-Mar	15-Mar	23-Mar	42
Poland	15-Mar	09-Mar	16-Mar	15-Mar	25-Mar	15-Mar	13-Mar	29
Sweden	16-Mar	11-Mar	-	-	-	-		
Austria	17-Mar	10-Mar	15-Mar	16-Mar	16-Mar	-	16-Mar	28
Portugal	20-Mar	11-Mar	16-Mar	16-Mar	16-Mar	16-Mar	18-Mar	45
Hungary	21-Mar	11-Mar	16-Mar	17-Mar	28-Mar	17-Mar	28-Mar	13
Czech	25-Mar	11-Mar	11-Mar	14-Mar	16-Mar	16-Mar	16-Mar	27

Source: Oxford COVID-19 Government Response Tracker, HSRM, Politico

2.1 The Nordics and the Baltics

Countries in northern Europe have generally experienced much lower mortality rates throughout the pandemic than central and southern Europe, with some nations experiencing almost no excess deaths at all. Despite their constitutional and government structure differences, Denmark, Norway, Iceland, and Finland share some common characteristics in terms of their healthcare systems (Saunes et al. 2021). Healthcare among these countries is considered a public responsibility; their healthcare systems are predominantly tax-financed, providing universal coverage to all citizens and there is a high degree of decentralized governance. Most of the decisions during the pandemic were, and are still, subject to parliamentary discussions and supported by the entire government and coalition parties. In fact, the political system of these countries is often led by majority or minority coalitions. That is why these countries have been labelled "consensual democracies" (Jonsson 2014). Not surprisingly, the Nordic countries' population show high levels of trust in their governments and demonstrate a high degree of confidence in their partner states (Kvittignen 2017).

First confirmed cases were observed in all four of the aforementioned countries in late February 2020, and by mid-March 2020 these countries had implemented several strict policy measures, such as closure of public spaces and some non-essential businesses, restrictions on economic and social activities, borders' closure, and increased testing. As early as end of January, Norwegian municipalities and the Directorate of Health were temporarily authorised to make binding decisions using the Infection Control Act, and the first strict physical distancing measure was introduced on 12 February (HSRM 2022; Askim & Bergstrom 2021). In Finland, strict measures were also introduced following the government's decision to announce a state of emergency for the first time since World War II. Policy aims for the Nordics were the same: to ensure sufficient capacity in their healthcare system, to prevent deaths from COVID-19, and to prevent new cases, in other words, reduce the spread of the virus (Saunes et al. 2021). Denmark began to relax its social distancing measures in mid-April and Norway and Finland followed in early and end of May 2020 respectively. During the second wave, as of August 2020, when infections and deaths began to increase, they gradually re-imposed social distancing measures and recommended using a face mask. In mid-December 2020, Denmark confirmed that new cases had reached their pick (25,046 confirmed cases, +22% versus previous week) and implemented a national lockdown as of 25 December 2020 (Gordon 2021). By February 2021, the number of deaths reached its highest level ever in the country (WHO 2022).

In addition, apart from social distancing measures, these countries implemented economic assistance programs very early on. For instance, Denmark implemented a very ambitious financial assistance program and provided great social support, securing wages compensation and maintaining jobs through tripartite agreements with employers and unions.

Similar to the Nordics, the Baltic countries introduced stringent measures early in the pandemic. Despite having been hit by the financial crisis and having a low healthcare spending rate relative to their GDP (Estonia 6.3%, Latvia and Lithuania 6.8% versus Finland 9.1%, Netherlands and Denmark 10%), they responded quickly to slow the spread of the virus (Webb, Winkelmann, Scarpetti et al. 2021).

During the first wave, they recorded relatively lower mortality rates than most other European countries. Estonia reported 63 deaths, Lithuania 33, and Latvia 32 deaths (WHO 2022). As such, their healthcare systems' resilience wasn't fully tested in the first months. Within a few days of the first reported case, all three countries declared a state of emergency. For instance, Lithuania entered an emergency mode two days after its first reported case (Webb, Winkelmann, Scarpetti et al. 2021). The Baltics developed their initial response on an early communication approach, while they established an intergovernmental communication path and, in some cases, coordinated actions (Latvian Public Broadcasting 2020; Republic of Latvia 2020). Apart from social distancing measures and early national lockdowns, extensive government communication, public awareness campaigns, and efforts to enforce proactive recommendations were implemented. Similarly to the Nordics, the Baltic countries also implemented early financial assistance programs to support healthcare systems, employment and businesses (HSRM 2022; Bolt et al. 2021).

In December 2021, as a new wave of the pandemic loomed globally, the Nordics' and the Baltics' daily infections rose steadily, and thus new restrictions were imposed. Between December 2021 and March 2022, the Nordics experienced the highest number of deaths ever reported in their territory, with Norway reaching 1,370 deaths and 1,124,500 infections, Finland 1,811 deaths and 708,208 infections and Denmark 2,810 deaths and 2,549,370 infections respectively (WHO 2022). On the other hand, the Baltics seemed to flatten their COVID-19 curve, having reintroduced physical distancing and other measures to prevent transmissions due to the increasing number of cases recorded since September 2021 (HSRM 2022).

2.2 United Kingdom and Sweden

UK and Sweden are the two European countries that built their initial strategy to control the pandemic outbreak on the theory of "herd immunity" and delayed the uptake of more drastic measures. Namely, they aimed at broadening the peak of the pandemic and allowing immunity to develop among the population. For instance, the UK government allowed 60% of its population to be exposed to the virus hoping to build herd immunity (Bhatia 2020).

UK's initial response to the pandemic outbreak has been one of the most criticized responses, with the government implementing health policy measures rather "too late, too little, too slow" (Scally et al. 2020). By August 2020, the United Kingdom reported one of the highest numbers of infections per capita and the highest number of excess deaths (ECDC 2020; Suleman 2021). UK couldn't have predicted that a country considered to have one of the highest ranked healthcare systems globally in terms of rapid response and mitigation of pandemics would have been the most affected in Europe (GHSI 2019; ECDC 2021).

More specifically, UK's initial response plan had four phases: containment, delay, research, and mitigation (Department of Health and Social Care 2020). In the containment phase, early cases were detected and close contacts were followed up to delay the spread of the virus for as long as possible. Testing in the community and tracing of contacts was implemented early on in this phase. The delay phase was aimed at slowing the spread of the virus, delaying the peak away towards summer, although public laboratories had reached capacity and tests results lagged often over 4 days and in some cases over a week (HSRM 2022). The research phase was aimed at providing a better understanding of the virus and the actions needed to reduce its impact on the population. The mitigation phase was aimed at providing the best care to people infected by the virus. During the delay phase, in which the country entered on March 12th, 2020, testing rates scaled-down and were limited only to people in hospitals with symptoms. People with symptoms were advised to self-isolate for seven days at home (Mahase 2020; Scally 2020). Social distancing measures were recommended, and people were asked to avoid crowded places. Many big events like football games and concerts were voluntarily postponed (The Football Association 2020).

The Government proceeded to a late mandatory lockdown on March 26, 2020, 18 days after the first reported death, and many days after other EU countries had implemented this measure (Table 1). Different restrictions were applied in different parts of the UK. Most restrictions were lifted in the second half of July 2020, with Northern Ireland lifting most of the restrictions in mid-August 2020 (Sargeant 2021). These different local approaches raised a lot of criticism as they created confusion among the population and health experts (Association

of Directors of Public Health 2020). The country announced a second national lockdown in December 2020, given the pressure on the healthcare system resulting from the rapid increase of daily infections. On December 31st, 2020, the UK reported a record of 81,519 daily new cases (WHO 2022). UK test capacity had risen from around 20,000 per day in mid-April to more than 1,000,000 per day in March 2021, reaching a peak of 2,000,000 per day in early January 2022 (UK Coronavirus Dashboard 2022).

The UK was the first country in the world to approve the COVID-19 vaccine and by mid-February 2021 15 million doses had been administered (BBC 2020). By end of July 2021, 81.4% of UK citizens were vaccinated with the first dose and 66.6% had received the second dose (UK Coronavirus Dashboard 2022).

The social policy response to support businesses, employment and protect income was much swifter. The Government announced an extraordinary economic package to support businesses and the NHS. Free school meals for vulnerable students throughout summer, weekly food packages to vulnerable citizens, and temporary accommodation for the homeless were provided early in the outbreak.

Very much like the UK, Sweden had one of the worst per-capita COVID-19 mortality in Europe at the beginning of the outbreak (Gordon et al. 2021; Mishra et al. 2021). Unlike the other Scandinavian countries, during the first wave, Sweden maintained a less harsh strategy with a more relaxed approach to contain the pandemic and implemented the least restrictive social-distancing measures. Although the EU imposed internal border restrictions on people travelling from Italy in mid-February 2020, external border closure for non-essential travelling in mid-March 2020 and a mandatory 14 days quarantine, Sweden kept its borders open and did not apply any quarantine requirement.

The rationale was that, on the one hand, social distancing measures wouldn't be successful in the long term, given that eventually people would not comply, and, on the other hand, measures like closing borders would cause great economic damage to the country. For Sweden's Public Health Agency, closing borders, social distancing measures, and lockdowns were considered "ridiculous" and lacked a scientific basis (Paterlini 2020). Instead of implementing social distancing measures, the Swedish government relayed to citizens personal responsibility to slow the spread of the virus, while asking citizens to comply with authorities' recommendations. In addition, Sweden recorded a very low testing rate. Even though the country was hit again by a second wave between October 2021 and May 2021, the Swedish government didn't impose a lockdown as the case in the rest of Europe. It is worth noting that masks were only recommended, and Swedish authorities discouraged people from wearing face masks (The Science 2020).

The first vaccine dose was administered in early 2021. By end of July, 61% of Swedish citizens were vaccinated with the first dose and 41% had received the second dose. By end of April 2022, around 73% of Swedish has been fully vaccinated with the two doses and 51% have been administered with the third dose (Swedish COVID-19 Data Portal, 2022).

2.3 Rest of Europe

We grouped the countries below based on the similarities they demonstrated in coping with the pandemic. They considered the coronavirus a serious threat from the start and witnessed their health systems being challenged to their limits, with some of them almost collapsing. Countries like Spain, Italy, France and Portugal experienced dramatic increases in their mortality rates and then introduced strict measures. Countries like Germany and Greece experienced very low mortality rates during the first wave, nevertheless, they implemented unprecedented containment measures, including lockdowns, closure of schools and universities, closed borders and mandatory face masks.

The first European healthcare systems to collapse in the pandemic's early stages, were those of Italy and Spain, which experienced an uncontrolled transmission of the virus. Italy was the first European country to enter lockdown on March 9, 2020, starting from Northern Italy and expanding nationwide the day after (Borrelli 2020). People were allowed to leave their homes only for work or health reasons. Spain and Portugal followed a few days after, and by the end of March 2020, almost all European countries had implemented partial or nationwide, mandatory, or voluntary lockdowns.

Although Italy declared a state of emergency at the end of January 2020 (Ministero Della Salute 2020), the severity of the situation was probably underestimated, resulting in a two-weeks delay in entering national lockdown (Falkenbach & Caiani 2020). In addition, the highly decentralized healthcare system allowed regions to try different containment policies (Pisano 2020). As a result, the virus spread throughout the entire country, affecting, in the beginning, mainly the regions of Lombardy, Piedmont, and Liguria. Within the first two months of the pandemic, Lombardy, the hardest-hit region in the country, reached a peak of more than 23,000 deaths (Bosa et al. 2022). By the end of March 2020, Italy reported more than 15,000 deaths and over 124,000 infections and by mid-June deaths rose to 34,610 and infections to 238,671 (WHO 2022). Nursing homes were severely hit by the pandemic and according to a survey around 9.1% of nursing homes' residents died in Italy with the highest number being recorded in Lombardy (14%) (Bosa et al. 2022). In May, restrictions eased, as in the rest of Europe. Italy entered the second wave of the pandemic in September 2020 and its third wave in November 2021 and imposed a lockdown in December 2020 and in March 2021.

Spain was also amongst the countries that were severely hit by the pandemic early on. By mid-June Spain reported 30.781 deaths and over 360,000 infections. Within a week (16 March-23 March), the number of deaths increased by 272.8% and the number of infections by 543.8% (WHO 2022). On March 14, the country declared a strict national lockdown and by the end of March lockdown measures were tightened requiring everybody to stay at home (HSRM 2022). Similar to Italy, Spain experienced a high number of deaths in care homes, which has reached 9.9% of the residents living in care homes, with 52% of these deaths taking place until the end of June 2020 (Comas-Herrera et al. 2022). According to the Spanish Ministry of Health, it is estimated that from April 2020 to June, 27,359 people died in nursing homes, which accounts for 69% of all COVID-19 deaths (Dubin 2020). The main reason of this tragedy was the very low availability of testing, the lack of protocols for infected staff and the lack of isolation spaces.

Despite the very clear signs of Italy's and Spain's tragedy, the French healthcare system did not frame the pandemic as a public health and multi-dimensional problem until mid-March 2020 (Rozenblum 2020). Delays in implementing a national lockdown and other containment policies resulted in more than 13,000 deaths by the end of March 2020 (WHO 2022). France imposed a lockdown on the 17th of March. Before that, travel restrictions were imposed, mainly for countries with a high prevalence of the virus like China, large meetings were banned, whilst schools and universities closed, visits to nurse homes were banned to protect older people and teleworking became mandatory. New measures and a new lockdown were implemented at the end of October and another one at the end of March 2021, following the rise of infections and deaths.

On the other hand, Germany entered the pandemic with a very detailed and comprehensive plan and rolled out a high-intensity testing scheme very early on. German scientists had created one of the first reliable means of detecting the virus before the declaration of COVID-19 as a pandemic by the WHO (Eckner 2020). The first case was reported on January 27, 2020 and by then, the country's infrastructure was ready to address the pandemic. Non-emergency operations and procedures were postponed. On March 22, Germany enforced strict physical distancing guidelines, banning groups of more than two people in public and shutting down some businesses. Social distancing guidelines and high testing capacity allowed the country to successfully control the pandemic, reduce transmission rates and never come close to reaching healthcare system's capacity limits (Czypionka & Reiss 2021). By the end of March, Germany had reported 162,483 infections and 5,640 deaths. Nevertheless, the country reached a new record of coronavirus infections, despite having ample vaccines with the deaths reaching 79,607 between October 2020 and the end of May 2021 (WHO 2022).

Greece managed the crisis in a paradoxically exemplary way during the first wave of the outbreak, making the country a rare coronavirus success story. Having recently emerged from a decade of recession, Greece had a vulnerable healthcare system (Kanavos & Souliotis 2017; Ziomas et al. 2018; Souliotis et al. 2018), gravely affected by the cost-containment policies implemented under the Economic Adjustment Programs (European Commission 2011). Nevertheless, the country demonstrated a swift and effective response (OECD 2021b). The early success story is attributed to the Greek Government rapidly deploying a plan of drastic and comprehensive responses on the recommendation of its scientific advisers. 13 days after the first coronavirus case was confirmed, Greece went into full lockdown. Such early social distancing measures resulted in both low mortality and morbidity numbers due to COVID-19 (Gountas et al. 2020). By the end of September, Greece was among the countries with the lowest mortality rates and the lowest number of infections. Between February and September, Greece reported 405 deaths (WHO 2022).

After the implementation of the first European lockdown in Italy in March, many countries followed throughout 2020 and 2021 in response to the pandemic. The stringency of the lockdowns differed from country to country, with some countries shutting down their entire economy. Despite the hope that the advent of the covid vaccine will stop the virus, all European countries faced a serious second and third wave of infection, while the discussion around mandatory vaccination was highly politicized. Despite the European society's shock by the pandemic, a significant number of European citizens seemed and still are very reluctant to get vaccinated. Therefore, vaccination rates have remained insufficient to prevent the spread of the disease. By April 2022, 73.2% of the total EU population have been fully vaccinated, with Portugal, Spain and Malta recording the highest vaccination rates at 92.6%, 90.6% and 86.3% respectively, while in Romania and Bulgaria only 42.3% and 29.8% of the populations respectively are fully vaccinated.

3. A united Europe – a coordinated and effective response to the pandemic

Historically, the European Union (EU) is built around the development of an economic union and an internal market with very limited role in health policy. It is not a sovereign state. It is more of a sui generis organization, which cannot be considered a federation or an association (Phelan 2012). It is more what the former President of the European Commission, Jacques Delors called "an unidentified political object" (IGC 1985; Magnette 2009).

The EU was characterized by a weak and limited role in social and public health policy before the pandemic (Brooks, 2021). In line with the subsidiarity principle, according to which the European Union acts only in cases where it considers that better results will be achieved at the European level, the Union operates complementary to national health policies, promoting cooperation between member states in public health. Therefore, responsibility for healthcare policy remains at the national level. According to the Treaty of the Functioning of the European Union (TFEU Art. 168), European institutions have limited power to act in the public health field, by only supporting and coordinating members states. Therefore, a central European response wasn't legally feasible.

The outbreak of the pandemic revealed the fragmented governance within the EU to tackle public health emergencies (Gontariuk et al. 2021). EU was expected to create an immediate and harmonized response that would result in collective actions. COVID-19 differed from previous public health emergencies like H1N1 and SARS as it exceeded member-states' health and social policy capacity and required an urgent and joint response. Nevertheless, several member states, like, Germany, France, and Czech Republic acted alone in an effort to protect their national market and banned exports of personal protective equipment, whilst Belgium, Hungary and Bulgaria put in place an export ban of certain medicines, thus putting solidarity under question (EUobserver 2020, Pirker 2020).

However, member States soon realized that they must work together, to coordinate, and collaborate in different aspects of the pandemic, from shortages in healthcare capacity to economic measures, to support jobs, ensure the sustainability of the healthcare systems, and protect the most vulnerable and those affected by the crisis. The EU had already learned its lesson from previous healthcare crises like SARS in 2003 and H1N1 in 2009. The SARS outbreak and the H1N1 epidemic resulted in the creation of the European Centre for Disease Prevention and Control and the creation of the Joint Procurement Agreement mechanism in 2014 (Brooks and Geyer 2020). During the EU Health Ministers' meeting, on 6 March 2020, it was stressed that "the best contribution to protecting the health of EU citizens is by strengthening solidarity, cooperation and exchange of information" (Council of the EU 2020). They also agreed to ensure a coordinated response to tackle COVID-19.

The European Commission operated effectively (Tesche 2022). It closely monitored the situation before WHO declared the outbreak of the pandemic. In February 2020, it activated the EU Civil Protection Mechanism to repatriate European citizens from the Diamond Princess cruise ship in Yokohama, Japan, where COVID-19 cases had been detected onboard (The Guardian 2020).

Immediately after that, it called on member states to share information and epidemiological data and assess their needs. It then moved to centrally negotiate procurement of personal protective equipment, vaccines and therapies and stockpile supplies. It also activated the general escape clause of the Stability and Growth Pact to respond to the pandemic, providing member states greater flexibility to implement extra-ordinary fiscal measures (European Commission 2020a) while funding research projects to develop treatment and diagnostics for the virus. Through the Coronavirus Global Response, €15.9 billion pledges were made for universal access to tests, treatments and vaccines against coronavirus and for the global recovery. Backed by the EU SURE instrument, member states were able to provide strong support to businesses and workers.

As the first wave of COVID-19 passed, more Europe-centred measures were needed to tackle the pandemic and support European economies. In May 2020, the European Commission proposed a revised Multiannual Financial Framework (MMF) and an emergency recovery tool, the Next Generation EU (NGEU), which would mobilize €1.8 trillion from the EU budget in different EU programs (European Commission 2020b). The recovery packages aimed to alleviate the consequences of the pandemic by creating or replacing jobs affected and restoring damage caused by the pandemic (Fernandez, 2020). The novelty of the NGEU was that it allowed the EU to borrow from the markets by issuing bonds with different maturities between 2028 and 2058. A key tool of the NGEU is the Recovery and Resilience Facility (RRF) of €723.8 billion (€338 billion in grants and €385.8 billion in loans). The EU would distribute the funds of the RRF based on the recovery and resilience plans submitted by the member states.

The road to the agreement wasn't an easy one. Strong divergences existed, and the structural and political differences between the "southern sinners" and "northern saints" surfaced (Tesche 2022). Austria, Denmark, Sweden, and the Netherlands, the so-called "frugal four", opposed the idea of supporting transfers from the wealthiest economies to the most affected. Following negotiations and an intense political background, with member states threatening to veto the process, compromises were made, and an agreement on all technical aspects of the plan was reached and adopted in July 2020, during the second-lengthiest summit in the history of the European Union.

The Commission took over the vaccine procurement initiative for its member states to prevent wasteful competition for scarce vaccines between member states and protect smaller countries from being charged higher prices (Bongardt & Torres 2021). It secured 4.2 billion doses of COVID-19 vaccines for its member states through negotiations with vaccine developers. As noted above, by April 2022, 73.2% of the EU citizens had been fully vaccinated (ECDC 2022).

An ambitious new health strategy also kicked off early in 2021, the EU4Health Programme, earmarking a budget of €5.3 billion to allow member states to make long-standing changes in public health and pave the way to a European Health Union (European Commission 2020c). But the most important initiative towards deeper integration in the field of public health and towards a European Health Union is the establishment of the new Health Emergency Preparedness and Response Authority (HERA). HERA's mission is to prevent, detect, and rapidly respond to health emergencies and will operate in two modes: the preparedness phase and the crisis phase. HERA's main goal is to ensure the development, production and distribution of medicines, vaccines and other medical countermeasures that were often lacking during the first phase of the response to COVID-19 (European Commission 2021).

4. Conclusion

The COVID-19 pandemic has undeniably been one of the most challenging crises the EU has had to manage, not only in terms of health response, but also in terms of solidarity and policy coordination. During the first months of the pandemic, divergent strategies to monitor and contain the spread of the virus and different capacities were revealed, while solidarity was questioned. Thus, criticism and scepticism of a fragmented EU governance arose (Anderson et al. 2020).

Nevertheless, the European Commission not only fulfilled its commitment to coordinate and support member states in "protecting and improving human health" (TFEU, Article 6), but operated effectively (Gontariuk et al. 2021; Tesche 2022; Towenend et al. 2020).

The present paper underscored two central European initiatives that demonstrated the need for expanded coordination and more centralised healthcare provision in the EU. First, European member states agreed on a joint plan to tackle the pandemic and help their economies recover, despite initial delays in a joint regional response. Second, the European Commission successfully implemented the Joint Procurement Process for personal protective equipment, vaccines and therapies to safeguard equity in access across member states, irrespective of size or economy. This helped sustain the collective public health response in the continent as well as manage the extent of the outbreak.

The pandemic has also demonstrated how dependent European member states and institutions are on each other's effectiveness and how important cooperation is between member states. Recent healthcare history, from SARS and H1N1 to COVID-19, has shown that healthcare threats and challenges can only be effectively dealt with through cooperation. In addition, governments

should no longer consider healthcare spending as a burden or a cost, but as an investment to society and the economy as well. This healthcare crisis highlighted the importance of the healthcare sector to Europe's economic performance and stability. High performing healthcare systems contribute to economic development and wealth (WHO 2008). Therefore, a new European healthcare narrative and bold policy decisions are needed towards an integrated European health policy and eventually a European Health Union.

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