European Committee of the Regions

Commission for Natural Resources

NAT

Regional health policy responses to the COVID crisis

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It does not represent the official views of the European Committee of the Regions.

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List of acronyms

CCB	**Critical Care Bed**
CoR	European Committee of the Regions
COVID	COrona VIrus Disease
CPM	Civil Protection Mechanism
CRII	Coronavirus Response Investment Initiative
CRII+	Coronavirus Response Investment Initiative Plus
EC	European Commission
EP	European Parliament
ESI	Emergency Support Instrument
EU	European Union
EUSF	European Union Solidarity Fund
FFP	Filtering Face Piece
JRC	Joint Research Centre
LRAs	Local and Regional Authorities
NUTS	Nomenclature of Territorial Units for Statistics
PPE	Personal Protective Equipment
RT-PCR	Reverse Transcription-Polymerase Chain Reaction
WHO	World Health Organization

Summary

The COVID-19 pandemic was unexpected and fast-evolving. As such, it thoroughly tested the EU response capacity as well as the ability of public authorities at all levels to cope with the emergency. The COVID-19 pandemic was also asymmetric across the EU in terms of incidence and impact. It affected countries and regions at different times and with varying intensity.

This study has four objectives: 1) to illustrate some of the structural characteristics of regional health systems that may be related to the asymmetric incidence of the pandemic across European regions and to quantify the impact of COVID-19 at the regional level; 2) to provide examples of regional responses; 3) to review those EU measures which provided immediate support to regions; and 4) to propose policy recommendations with a view to improving the future EU response in comparable emergency situations.

In March 2020, globally, Europe was the area worst affected by COVID-19. Since then, over a period of almost five months, the situation has evolved rapidly. In mid-July, even the three EU countries most affected by COVID-19, namely Italy, Spain and France, were no longer amongst the ten hardest hit countries worldwide. But even though the pandemic slowed down consistently in the EU from mid-May onwards, new cases and deaths are still occurring at the time of writing (end of July). In mid-July 2020, the cumulative number of confirmed COVID-19 cases in the European Union was about 1.3 million and the death toll totalled nearly 135 000. Over 69% of the COVID-certified deaths are found in Italy, Spain and France. The most affected region in the EU is Lombardy, in Italy. With 16 775 deaths, this region accounts for 12% of total EU deaths.

The reasons behind the asymmetric incidence and impact of COVID-19 across EU regions are multiple and complex, and cannot be translated into simple cause and effect relationships. Asymmetry also prevents a fair comparison of healthcare systems' ability to cope with the crisis because the hospital and/or intensive treatment of a few dozen patients is not comparable with the simultaneous treatment of hundreds of patients, as was the case in some regions.

The analysis of health systems' existing assets before the crisis combined with the examination of cases presented in this study indicate that the essential conditions for fighting COVID-19 effectively at the territorial level were the availability of hospital beds, critical care beds and healthcare workers. Data also suggest that those regions characterised by high numbers of people aged 65 or over, and by high concentrations of long-term care beds in nursing and residential care facilities, were hit hardest by COVID-19. While the acquisition of medical

equipment, enlisting of healthcare workers and acquisition of protective material was prioritised by the majority of regions, analysis based on the examples provided in Part 2 show that across regions the same level of attention was not paid to the fragility of vulnerable groups, such as the elderly living in nursing and residential care facilities. Data confirm that the elderly are the group most affected by COVID-19. By considering the seven European regions with the highest excess mortality rates over the period March–April 2020, people aged 65 years or more represent 82%–92% of all deaths.

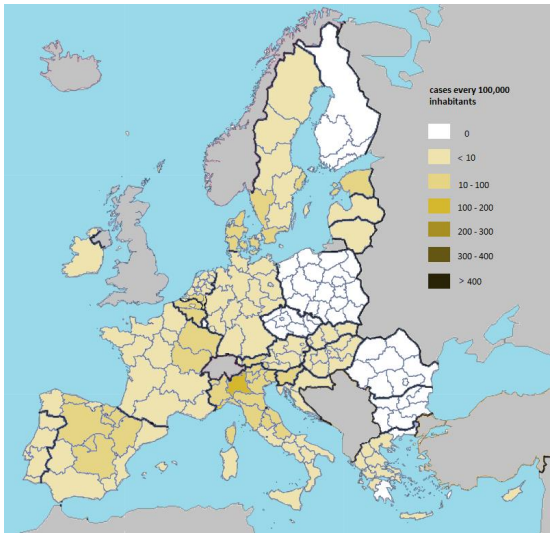
The impact of COVID-19 at the territorial level is quantified in terms of cases and deaths. In the EU, the first cases started being reported at the end of January 2020. As at 21 February, the EU had 38 cases, for the most part in Germany and France. But it is in the northern regions of Italy (in particular Lombardy, Veneto and Emilia-Romagna) that, in the last week of February, the COVID-19 outbreak was significant. In the same period, outbreaks started developing in Germany (North Rhine-Westphalia) and Spain (Madrid and other regions in the north-east of the country). In France, the spread of COVID-19 started only at the beginning of March. Belgium also began reporting cases in March.

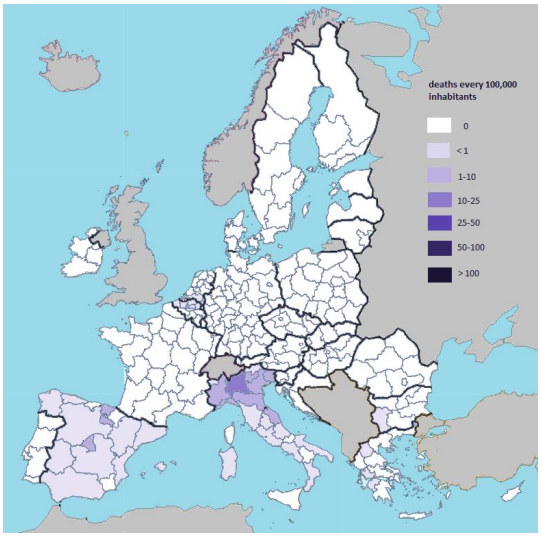
In mid-March, the COVID-19 outbreak was concentrated in the north of Italy. Cases recorded in Lombardy at that time were in the thousands. Italy was the first EU country to impose a lockdown on citizens and other major restrictive measures. It was also the first to suffer from the lack of medical equipment, protective material and healthcare professionals.

On 11 March, WHO declared the coronavirus outbreak a pandemic. In the course of the following 30 days, the spread of COVID-19 across Europe was extensive. Lockdown measures were introduced across the Union. In mid-April, the north of Italy, several regions of Spain, the whole of Belgium, Ireland, the Stockholm region in Sweden, the north of Portugal, Baden-Württemberg, Bavaria, Hamburg and Saarland in Germany, and Tirol, Vorarlberg and Salzburg in Austria were hard hit by the COVID-19 outbreak. In mid-May, the situation had worsened in the above-mentioned areas, but at a slower pace than in the previous month. Several eastern European regions as well as regions in Greece remained relatively untouched.

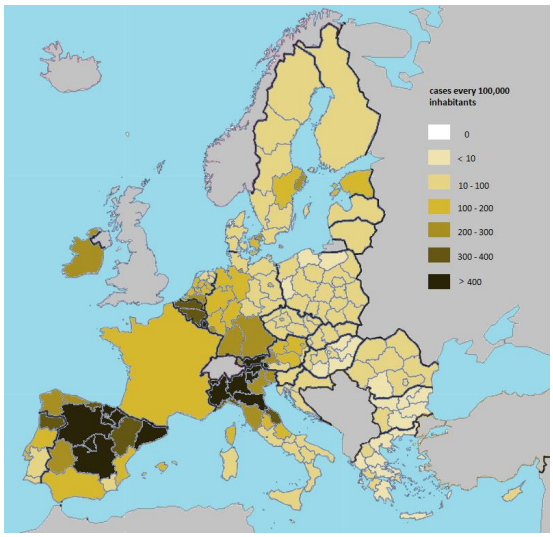
The first COVID-19 certified death occurred in France on 15 February. A significant number of deaths caused by COVID-19 started being recorded in March. By mid-March, Lombardy already had 1 218 deaths, Emilia-Romagna 284 and Madrid 213. Other small clusters of deaths were in the Brussels Region, Baden-Württemberg, Bavaria, and Noord-Brabant.

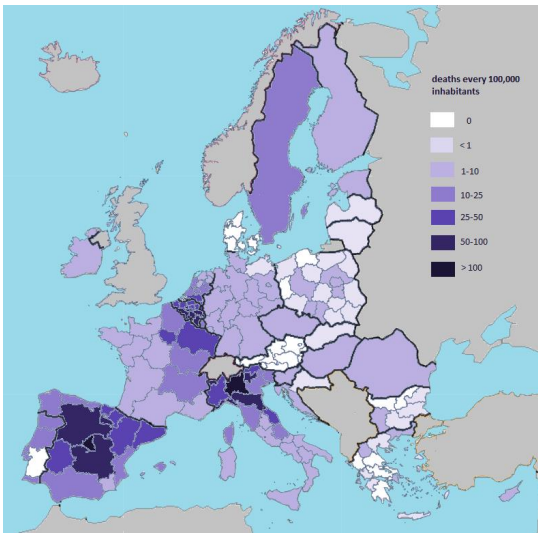
Cumulative cases **Cumulative deaths**



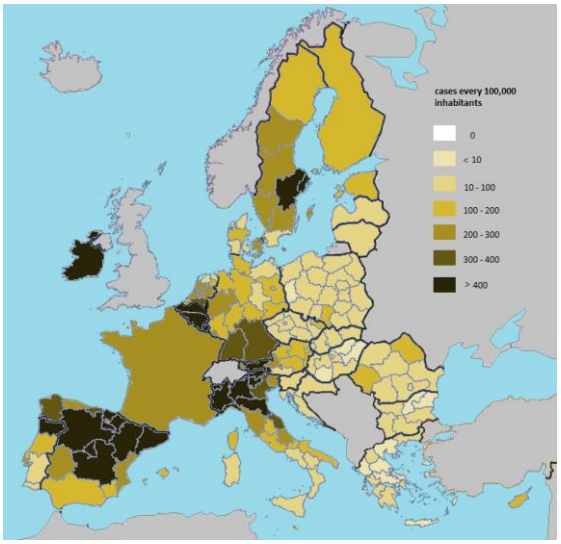


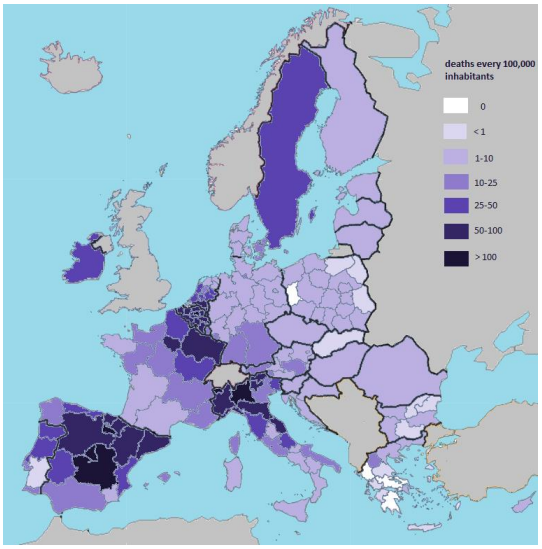
mid-March 2020





mid-April 2020





Mid-May 2020

As is true for the number of cases, one month later the situation had drastically changed. In mid-April, deaths caused by COVID-19 were widespread across the EU, with few exceptions. In mid-May the situation had clearly worsened. All regions had experienced COVID-19 certified deaths with the exception of Lubuskie in Poland, and Ipeiros, Sterea Ellada and Peloponnisos in Greece. The most dramatic situations were found in several regions of Spain, the northeast of France, the north of Italy, and Belgium.

European regions reacted to the COVID-19 pandemic in different ways. Building on the COVID-19 platform initiative of the European Committee of the Regions, ten experiences of regional and local authorities were selected in mid-June and further elaborated to take account of the variety of preliminary responses occurring at the territorial level. These responses are made up of health-related measures (e.g. purchase of medical equipment, reorganisation of space in hospitals, contingency plans for elderly nursing facilities, hiring of medical staff) and emergency-related measures addressing social (e.g. solidarity-based initiatives, support to vulnerable groups, accommodation for the homeless, food delivery points), economic (e.g. financial support to businesses, support for safe reopening), and logistical aspects (coordination bodies or task forces, IT infrastructure deployment and distribution of devices, reorganisation of transport). Clearly, the response was more comprehensive where the impact of COVID-19 was higher. However, all regions, including the less affected ones, implemented measures to support their local economies which were in any case disrupted by the COVID-19 outbreak. In addition, some regions made early plans for their recovery which are forward-looking and based on the lessons learnt during the COVID crisis.

There was a delay among public authorities at all levels in realising the severity of the COVID-19 outbreak. Since late February 2020, the European Commission has been proactive in arranging support. In some cases, this support was not up to the immediate needs of regions, for example with regard to the procurement and/or distribution of personal protective equipment. In other cases, it has met expectations, for example with regard to the flexibility granted in the use and management of Structural Funds, from which some regions have already benefited.

Solidarity-based mechanisms across the Union did not work well and prevailing national interests obliged the Commission to issue guidance reaffirming the principles of the internal market. Because of this, a more central role of the EU with regard to the immediate procurement and distribution of medical equipment in emergency situations appears appropriate.

Another critical area identified relates to cross-border healthcare cooperation. While there are examples of successful cooperation across borders, there is evidence that the full potential of Directive 2011/24/EU on the application of patients' rights in cross-border healthcare has not been exploited. In fact, pooling the hospital resources and the medical expertise of less affected regions in order to relieve the most affected health systems could be one effective way to address future health emergencies. Such an approach would also strengthen EU solidarity and, ultimately, identity.

In addition, there is evidence that the range of responses and lack of common strategies at the territorial level hampered the containment of COVID-19. This was particularly manifest in border territories. The case studies show that some regions adopted contingency plans for specific aspects, for example, the care of people living in elderly nursing facilities, while others did not. In order to harmonise responses and strengthen COVID-19 containment efforts, it would be helpful to support the preparation of contingency plans at the regional level which build on the lessons learnt since March 2020 in the framework of this pandemic. In that connection, a technical working group could be established at EU level to comprehensively review regions' responses in a limited number of areas, such as the management of nursing facilities, the conversion of production lines to supply personal protective equipment and medical devices, and cross-border arrangements in bordering territories.

Finally, so as not to fall into a business as usual approach, it is suggested that recovery plans at all levels (EU, national and regional) give social justice and inclusion the same (economic) importance granted to innovation, digitalisation and the green transition. In fact, evidence shows that leaving the most vulnerable behind has a cost and that a prevention strategy, rather than a curative approach, could prove more socially and economically beneficial.

Part 1 Analysis of regional health statistics and of the impact of COVID-19

This part focuses on the presentation and analysis of regional statistics related to i) selected structural characteristics of health systems, and ii) cases of and deaths from the coronavirus disease (COVID-19). The aim is to highlight some of the factors which may have influenced European regions' exposure to COVID-19 and to quantify the intensity of the health crisis at the territorial level. The analysis covers EU Member States and refers to the period March–July 2020.

1.1 Framing the EU outbreak of COVID-19 in a global context

Figure 1. Global dashboard, number of confirmed cases and deaths, 1 June 2020

Global ranking	Country	Number of cases	Number of deaths
1	United States	1.790.172	104.381
2	Brasil	514.849	29.314
3	Russia	405.843	4.693
4	UK	276.156	38.571
5	Spain	239.479	27.127
6	Italy	233.197	33.475
7	India	**190.609**	5.408
8	France	189.009	28.805
9	Germany	183.410	8.540
10	Peru	**164.476**	4.506
19	Belgium	58.381	9.467
22	Netherlands	46.645	5.975
25	Sweden	37.542	4.395
29	Portugal	32.500	1.410
34	Ireland	24.990	1.652
36	Poland	23.786	1.064
38	Romania	19.257	1.266
44	Austria	16.731	668
47	Denmark	11.869	574
57	Czech Republic	9.268	320
64	Finland	6.859	320
71	Luxembourg	4.018	110
73	Hungary	3.876	526
80	Greece	2.917	175
84	Bulgaria	2.513	140
86	Croatia	2.246	103
92	Estonia	1.869	68
96	Lithuania	1.675	70
99	Slovakia	1.521	28
102	Slovenia	1.473	108
110	Latvia	1.066	24
118	Cyprus	944	17
130	Malta	618	9

Data source: Johns Hopkins University, retrieved from "Il sole 24 ore" website

Chinese authorities reported a cluster of pneumonia cases in late December 2019. In early January 2020, the Chinese Government shared with the international community the sequence of a new virus causing severe acute respiratory syndrome. The disease caused by this novel coronavirus was named COVID-19.

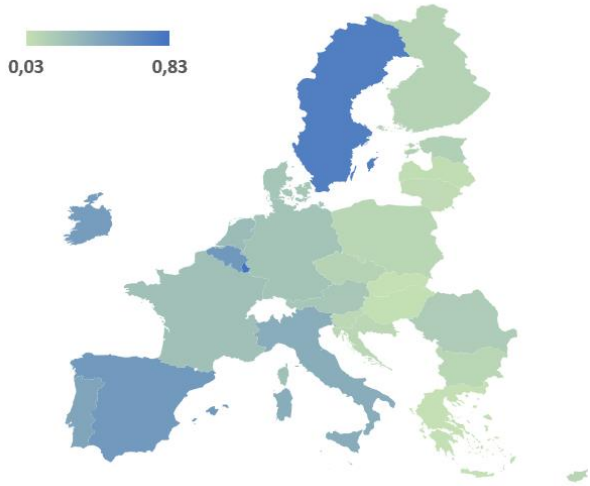
The first three cases of COVID-19 in the EU were reported by France on 24 January 2020, in Île-de-France (2 cases) and Nouvelle-Aquitaine (1 case). The first death was also in France, on 15 February. As of 21 February, 47 cases were known across Europe, out of which 38 were in the EU (Belgium: 1, Finland: 1, France: 12, Germany: 16, Italy: 3, Spain: 2, and Sweden: 1) (Spiteri *et al.*, 2020).

Globally, on 1 June 2020 and around four months after the outbreak of COVID-19 in the European Union (EU), four Member States were amongst the ten hardest hit countries: Spain, Italy, France and Germany (**Figure 1**). At the end of June 2020, EU countries were progressively moving down in this global dashboard due to the viral spread in countries like India, Peru, Chile and Iran. In mid-July 2020, globally, none of the EU Member States were amongst the ten countries hardest hit by COVID-19.

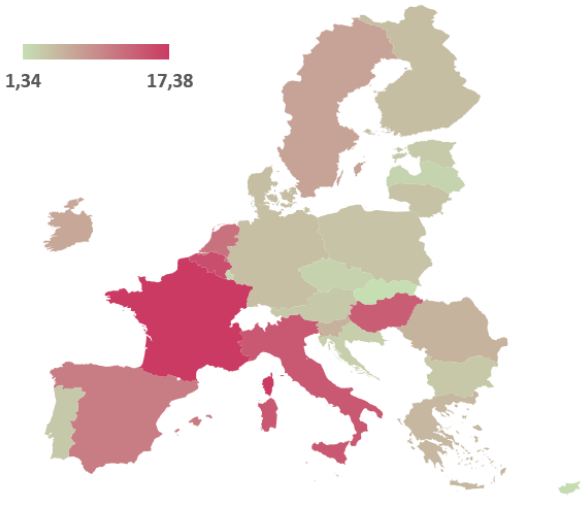
Map 1[1] illustrates the differentiated impact of COVID-19 across EU countries as of mid-July 2020. The number of cases is expressed as a share of each country's population. Incidence of COVID-19 evidently increases from east to west. No specific tendency is noted on a north-south axis. Sweden, which almost doubled the number of COVID-19 confirmed cases from 1 June to mid-July is, together with Luxemburg, the country with the highest incidence across the EU.

[1] **Data sources for all maps included in this study, with the exception of Map 3, are**: Eurostat for population data; EC-JRC ECML Covid website for number of COVID-19 cases and deaths. The following national sources were used to fill data gaps on COVID-19 cases and deaths: THL, Finland; French Government dashboard; and RIVM, the Netherlands.

Map 1. Number of cases, % of population, mid-July 2020



Map 2. Fatality rate, % of cases, mid-July 2020



In terms of fatality rate (**Map 2**), intended to demonstrate the ratio between the number of COVID-19 certified deaths and the number of confirmed cases, the highest values are found in France (17.4%), Belgium (15.5%) and Italy (14.4%).

As of mid-July 2020, in the EU, there were almost 1.3 million COVID-19 confirmed cases and about 135 000 COVID-19 certified deaths. Over 69% of these deaths are concentrated in three countries: Italy, Spain and France. The most affected region in the EU is Lombardy, Italy, which accounts for 12% of total EU deaths.

1.2 Health statistics and the asymmetric incidence of COVID-19 across regions

COVID-19 affected countries and regions at different times and with varying intensity. The ability of national and regional health systems to cope with the resulting health crisis was not uniform across the EU. This section illustrates some regional structural characteristics which may have affected a region's exposure to COVID-19 as well as its capacity to react.

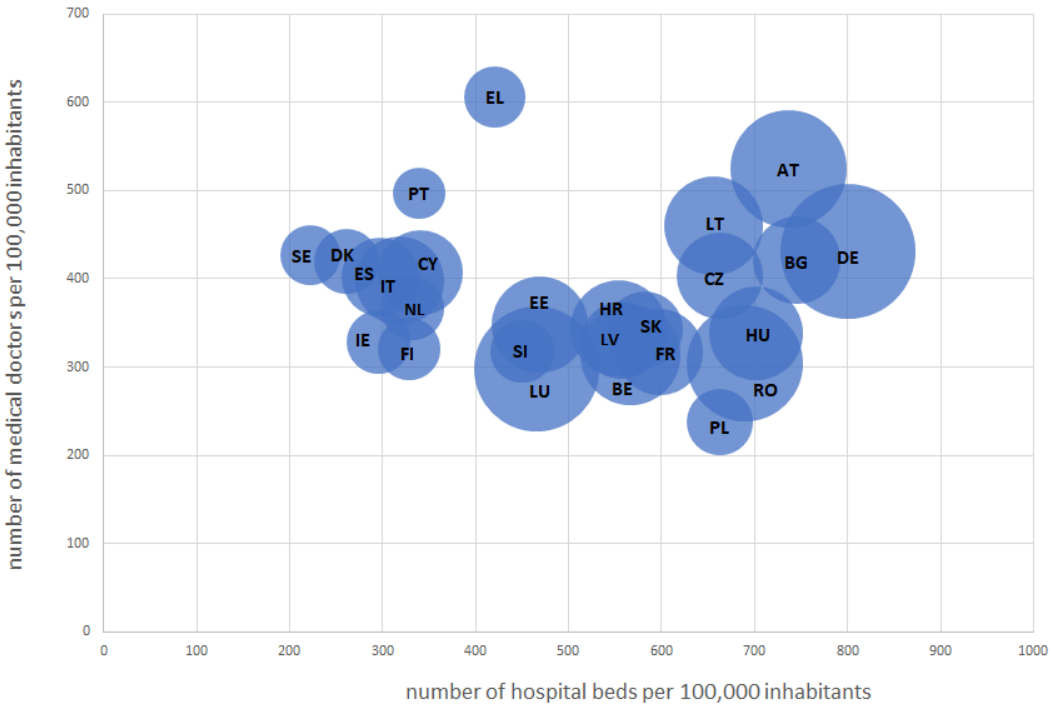
Before analysing regional data, it is essential to look at the availability of critical care beds (CCBs) within health systems, information which is only available at the national level. CCBs are used for the treatment of patients with artificial ventilation, that is, intensive care. During the COVID-19 crisis, the risk of saturation of available CCBs was one of the main drivers of political decision-making. The number of available CCBs told policymakers whether a regional or national health system would reach breaking point. It determined national and regional authorities' efforts to increase available CCBs through the conversion of existing health structures, the building of new structures and/or the setting up of temporary arrangements; required the transfer of patients within regions, across regions and across countries; and, finally, forced governments to impose lockdowns in an attempt to relieve pressure on overwhelmed healthcare structures and workers.

While information on CCBs is important, it has to be used with caution because it dates back to 2012 and situations may have changed since then. For example, a report by the Italian Ministry of Health (2019) indicates the country's availability of 8.4 CCBs per 100 000 inhabitants in 2017, meaning a reduction of over 30% compared to the 2012 data.

Available CCBs are presented in **Figure 2** in combination with data on total hospital beds and medical doctors. All three variables are expressed per 100 000 inhabitants. CCBs are represented by the size of circles: the bigger the circle, the higher the number of critical care beds available per 100 000 inhabitants.

On its left side, Figure 2 outlines a group of countries with a relatively low number of medical doctors, hospital beds and CCBs. This group includes Cyprus, Denmark, Finland, Ireland, Italy, the Netherlands, Spain and Sweden. These countries are potentially more fragile than better equipped countries as regards coping with the outbreak of a pandemic. Among the best equipped are Austria and Germany, which can be found on the upper-right side of Figure 2 and are characterised by relatively big circles, meaning a good availability of CCBs.

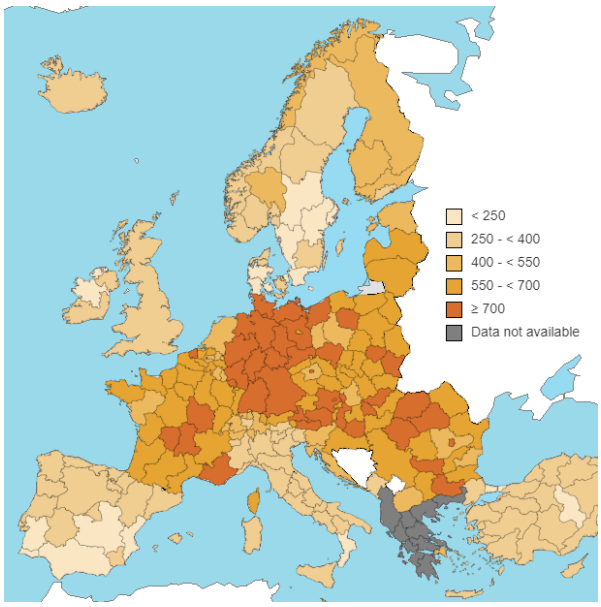
Figure 2. CCBs, available hospital beds and medical doctors, per 100 000 inhabitants



Data sources: Rhodes, Ferdinande, Flaatten *et al.* (2012) and Eurostat (reference year is 2017).

Still, for some EU countries, national data on availability of hospital beds is not instructive because this availability is often unevenly distributed across the territory. This is illustrated in **Map 3**.

Map 3. Available beds in hospital per 100 000 inhabitants, by NUTS2, 2018

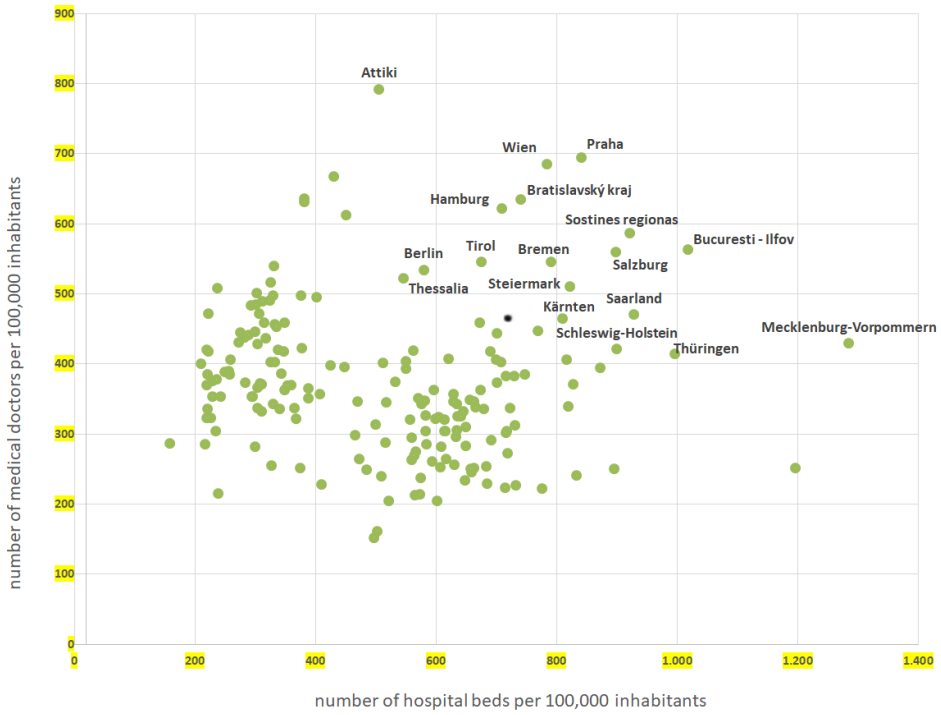


Source: map extracted from Eurostat Regional Yearbook 2018.

Map 3 also provides evidence of a higher number of hospital beds in eastern (less affected by COVID-19) and continental regions than in northern and southern European regions. Among the continental regions, Île-de-France, Wallonia and Flanders (all of which were hard hit by COVID-19) are characterised by a lower number of available hospital beds compared to the national average. Regions in Spain, Italy, Sweden, Ireland and Denmark are amongst the worst equipped across the EU.

By further plotting the information on hospital beds with the number of medical doctors, it is noted that regions characterised by a high number of both assets experienced a few dozen/hundreds of COVID-related deaths. Reference is made to named regions in the upper right part of **Figure 3**. Once again, the presence of several regions from Germany and Austria in this group is noted. Still, data on German regions are limited to those where the NUTS1 level coincides with the NUTS2 level. However, these data are important. Germany experienced a high number of cases (199 726 cases as of mid-July), comparable, for example, to the situation in France (173 304 cases), but had a very low fatality rate (4.5% versus 17.4% in France). In practice, excluding the existence of a statistical distortion of German data on deaths, it can only be concluded that German regions' health structures and medical staff were successful in containing COVID-19.

Figure 3. Number of doctors and of hospital beds per 100 000 inhabitants, by NUTS2



Data source: Eurostat. Available beds in hospitals: the reference year is 2017. Medical doctors: the reference year is 2017, or latest available year.

Apart from health systems' assets available to citizens before the crisis, which, as discussed above, is likely to have influenced the exposure of a region, several other hypotheses related to population structure and distribution are made to explain the asymmetric impact of COVID-19. For example, JRC suggests that, especially at the start of the epidemic, the degree of urbanisation at the regional/provincial/county levels had a substantial impact on the ability of coronavirus to spread (Goujon *et al.,* 2020). In addition, the OECD reports that according to evidence collected in the UK, the incidence of COVID-19 is more significant in deprived and highly populated areas (OECD, 2020). An analysis made by Insee (2020) for Île-de-France, the most affected French region, draws similar conclusions. The department of Seine-Saint-Deni, which records the highest rise in mortality within Île-de-France, is the most affected by poverty, is highly populated and is characterised by overcrowded dwellings.

JRC also concludes that in all countries, fatalities are concentrated among people aged 60 or over and that the diffusion pattern of the disease does not seem to depend on the share of the elderly in the population (Goujon *et al.,* 2020). However, clear evidence is found in this study when considering the share of the population aged 65 or over and the number of long-term care beds in nursing and residential care facilities (**Figure 4**). This latter information is considered very relevant in this context because there is evidence that these facilities became clusters of cases of COVID-19 across the EU. **Box 1** gives information about the Italian experience.

Box 1. Survey on COVID-19 in nursing and residential care facilities in Italy

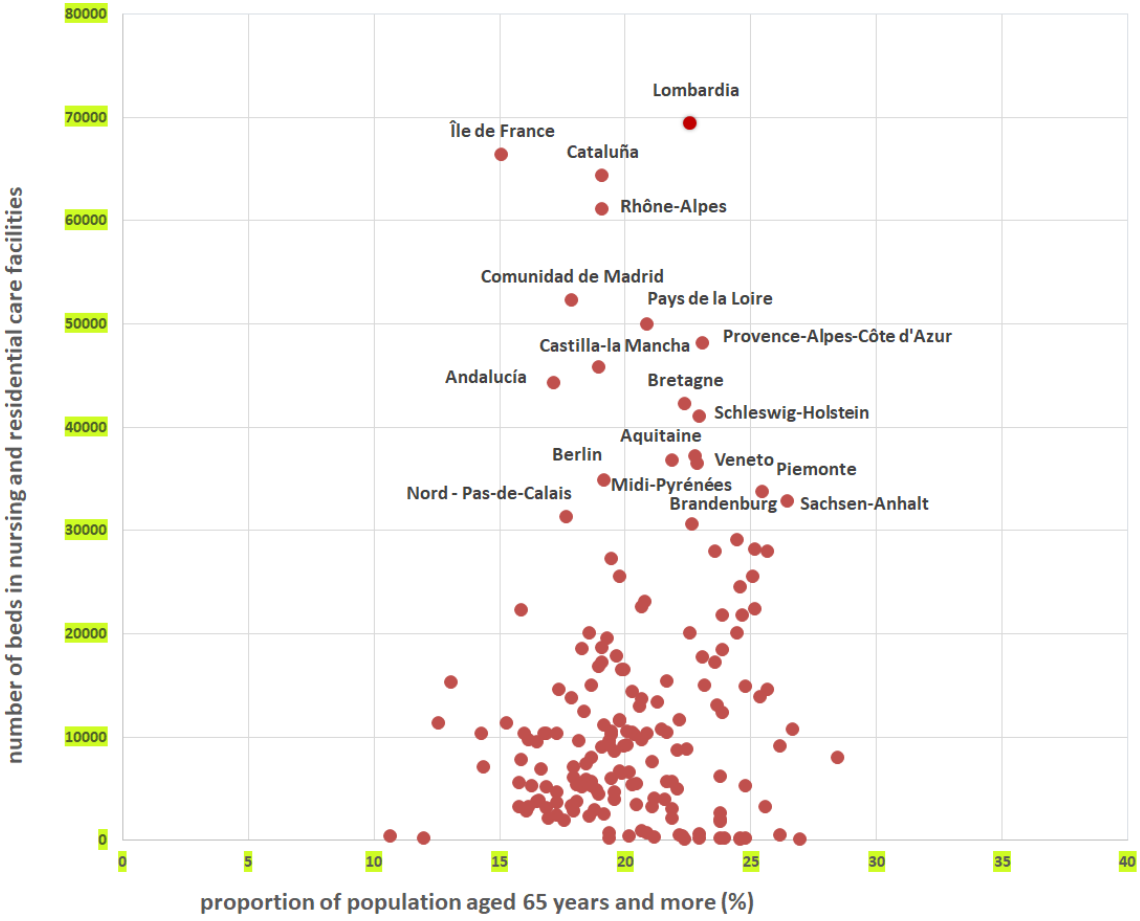
The survey was completed by 1 356 facilities, equivalent to 41% of contacted facilities. These facilities had 97 521 patients at the beginning of February 2020 out of which 9 154 died over the period 1 February–26 March/5 May (depending on the date of reply to the questionnaire). The fatality rate is 9.1%. The highest number of deceased people is found in the facilities of Lombardy (41%), Piedmont (18%) and Veneto (12%). The most significant challenges faced by these facilities during the COVID crisis include:

- Lack of personal protective equipment (77% of the respondents).
- Lack of healthcare personnel (34%).
- Difficulty in isolating affected patients (26%).
- Inability to carry out throat swabs (21% – this info is underestimated because the question was added at a later stage).
- Scarce information received on procedures for the containment of the outbreak (21%).
- Difficulty in transferring patients who required more care to hospitals (13%).
- Lack of medicines (10%).

Source: Istituto Superiore della Sanità (2020)

Figure 4 clearly highlights, in the upper and right side, a number of regions which were hard hit by COVID-19 and that are characterised by a high share of people aged 65 or over, and/or a high concentration of long-term care beds for vulnerable people. Examples include Île-de-France, Madrid, Catalonia and Lombardy. In fact, Lombardy, the hardest hit region in the EU, has a high share of aging people (22.6% of its inhabitants are aged 65 or over) and the highest concentration across the EU of long-term care beds in nursing and residential care facilities.

Figure 4. Population aged 65 and over (share over total) and number of long-term care beds in nursing and residential care facilities



Data source: Eurostat. Available beds in nursing and residential care facilities: most of the information contained in this dataset is not updated (the reference year varies from 2012 to 2017, depending on the country) and some countries do not provide the breakdown of facilities at NUTS2 level (e.g. Germany). No data for CY, DK, NL and PT. Proportion of population aged 65 and over: the reference year is 2019.

It is evident that the reasons behind the asymmetric incidence of COVID-19 across EU regions are multiple and complex, and cannot be translated into simple cause and effect relationships. Asymmetry of incidence also prevents a fair comparison of healthcare systems' ability to cope with the crisis because the hospital, and often the intensive treatment of a few dozen cases, is not comparable with the simultaneous treatment of hundreds of patients which occurred in some regions.

1.3 Measuring the impact of COVID-19 at the regional level

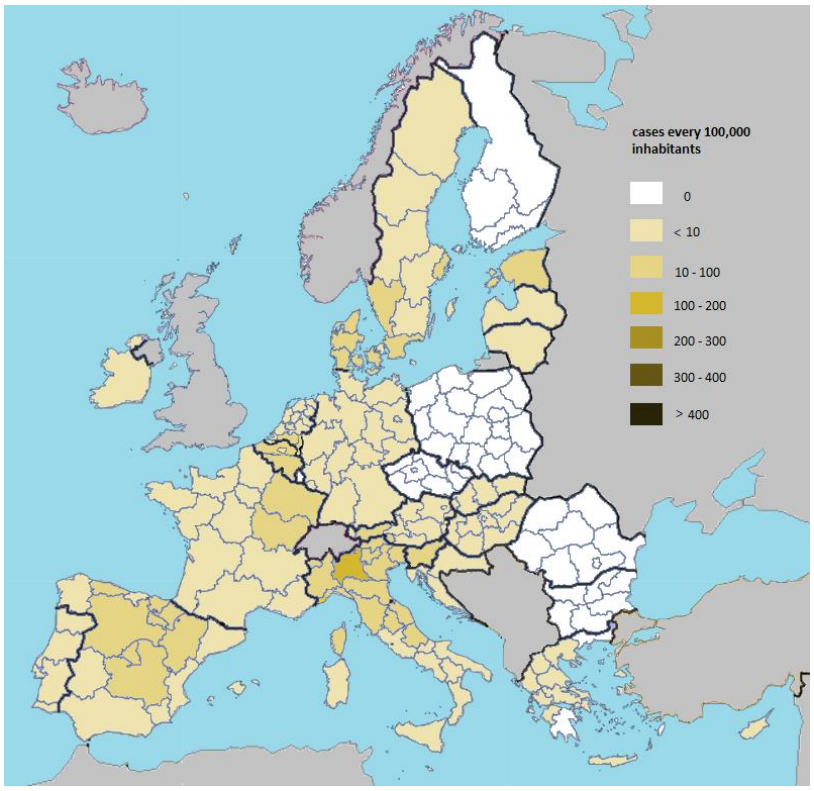
In the last week of February 2020, a rapid and significant outbreak of COVID-19 occurred in the north of Italy, first in Lombardy and Veneto and then in Emilia-Romagna. At the end of February, small clusters also started to appear in France, particularly in Hauts-de-France and Auvergne-Rhône-Alpes; in Germany, particularly in North Rhine-Westphalia and, to a lesser extent, in Bavaria and Baden-Württemberg; and in Spain, particularly in Madrid, Rioja, the Basque Country and Navarre.

Belgium only started reporting COVID-19 cases in March but in Flanders the number of infections grew rapidly within a few days, to reach a total of 973 infected people in mid-March. The northern regions of Italy experienced an even more devastating increase in cases (**Map 4**). By mid-March, Lombardy had 13 272 confirmed cases, Emilia-Romagna 3 093 and Veneto 2 172. By mid-March, France had clusters in several of its regions, such as Grand Est (1 378 cases) and Île-de-France (1 209), and in Germany, North Rhine-Westphalia was the region with the highest number of cases (1 407). At that time, in Spain, only Madrid had a high number of infected people (3 544) while in Sweden, Stockholm had only a few hundred infections. Across the EU, by mid-March 2020 there were 49 657 cases.

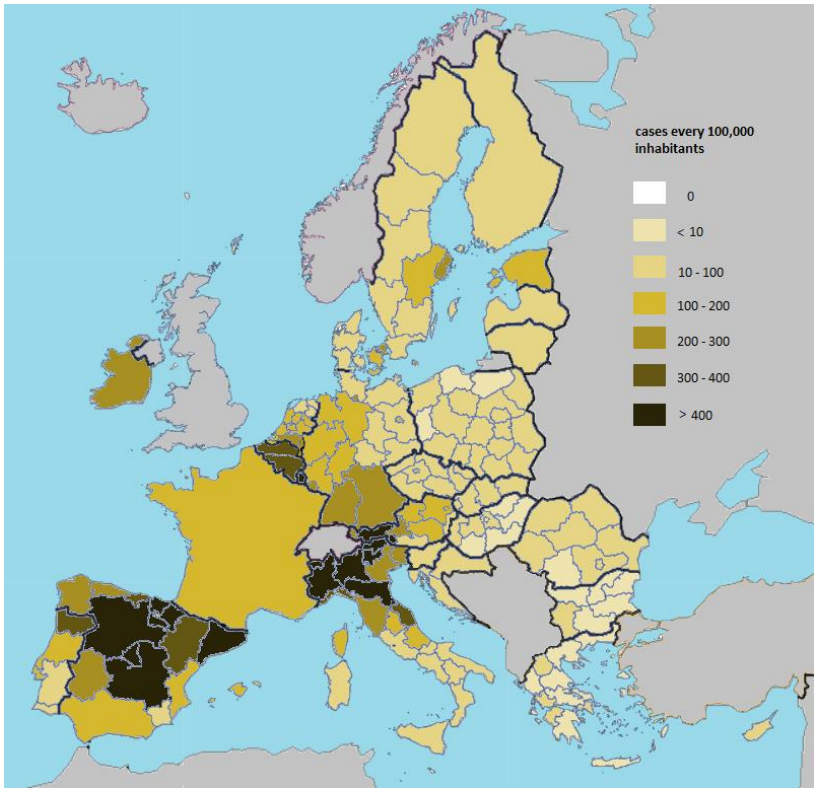
On 9 March 2020, Italy decided to implement lockdown restrictions. Italy was the first EU country to impose a lockdown on citizens and other important containment measures. It was also the first to need significant quantities of medical equipment and protective material as well as the support of additional healthcare workers. On 11 March, WHO declared the coronavirus outbreak a pandemic.

In the course of the following 30 days the spread of the infection across Europe was extensive. Lockdown measures were introduced all across the EU. In mid-April, **Map 5** shows that the north of Italy, several regions of Spain, the whole of Belgium, Ireland, the Stockholm region in Sweden, the north of Portugal, Baden-Württemberg, Bavaria, Hamburg and Saarland in Germany, and Tirol, Vorarlberg and Salzburg in Austria had all been hard hit by the COVID-19 outbreak. In the EU, the number of cases by mid-April was 750 228.

Map 4 . COVID-19 cases as of mid-March, per 100 000 inhabitants



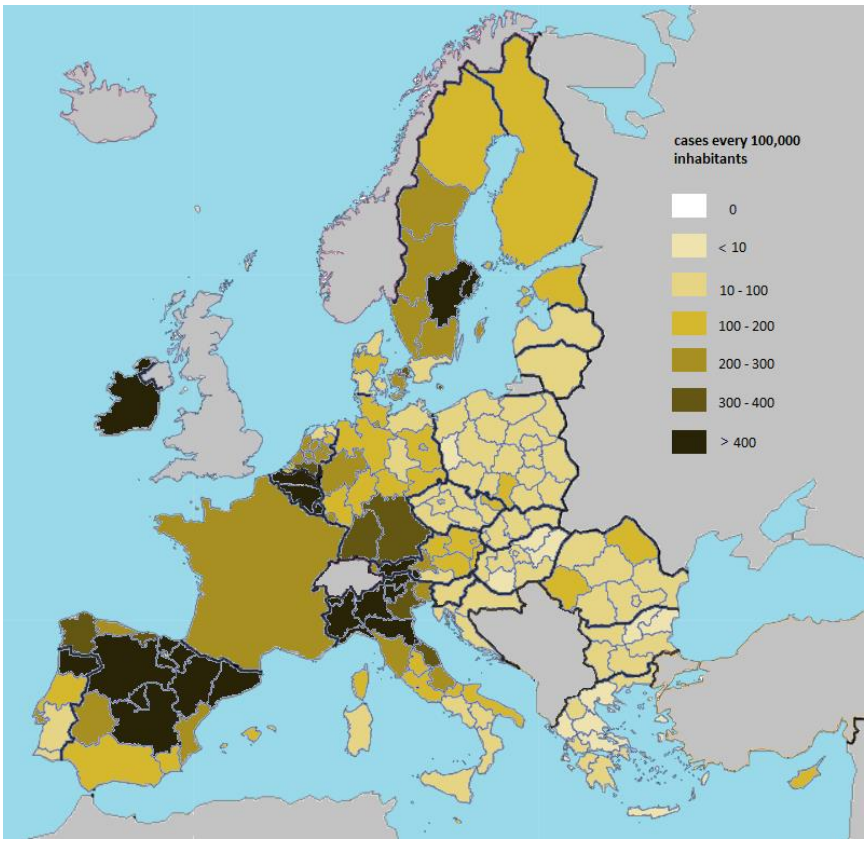
Map 5 . COVID-19 cases as of mid-April, per 1 000 inhabitants



By mid-May (**Map 6**) the situation had worsened in the above-mentioned areas but at a slower pace than in the previous month (an exception is noted in Stockholm and Västsverige which experienced major increases, continuing also in June–July 2020). Eastern European countries, some southern regions in Italy, Algarve and Alentejo in Portugal, as well as Greece, Latvia and Lithuania remained relatively untouched. In the second half of May restrictions on citizens started to be lifted and businesses were allowed to reopen. This occurred gradually and at different times across the EU.

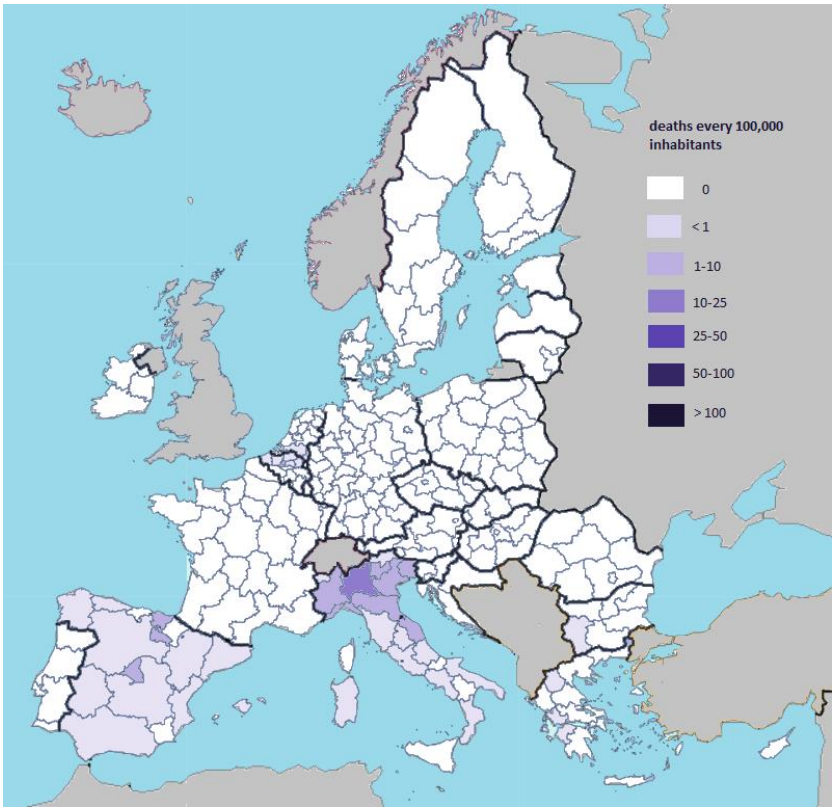
Across the EU, by mid-May 2020 there were 1 050 015 cases. This number grew to 1 173 390 in mid-June and to 1 297 666 in mid-July.

Map 6. COVID-19 cases as at mid-May, per 100 000 inhabitants



As early as mid-March (**Map 7**), a significant number of deaths was being recorded in northern Italy, with Lombardy experiencing 1 218 deaths, Emilia-Romagna 284, Piedmont 81, and Veneto 63. Another important cluster of deaths was found in Madrid, where there were 213 COVID-19 certified victims. A few deaths also begin occurring in the Brussels Region (13) and Noord-Brabant (13). France has no official reporting for this period but it is likely it already had a number of deaths on this date. In mid-March, there were 2 162 cumulative deaths in the EU.

Map 7. COVID-19 deaths as of mid-March, per 100 000 inhabitants

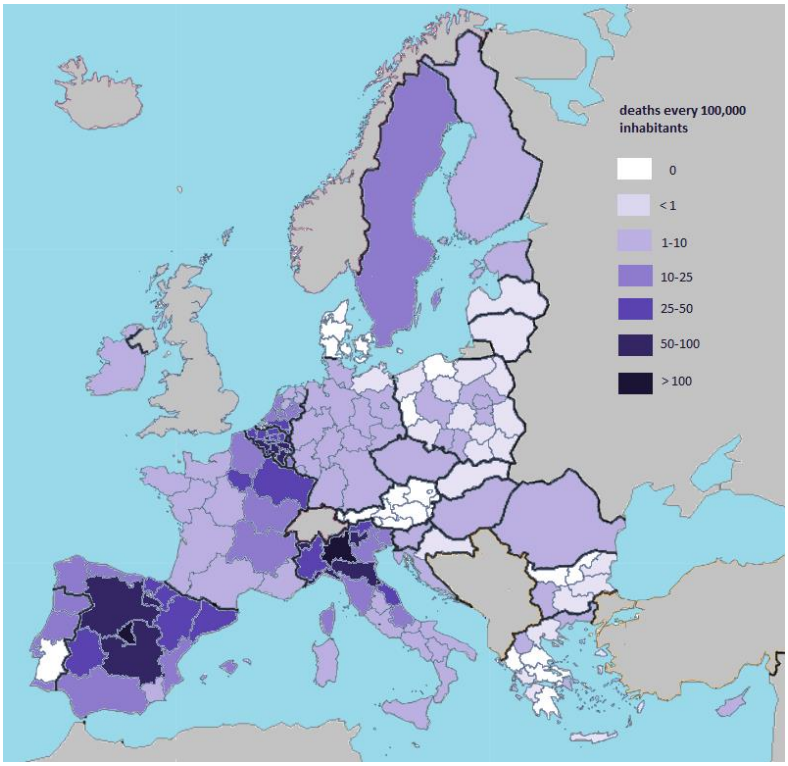


As is true for the number of cases, one month later the situation drastically changed for deaths as well (**Map 8**). In mid-April, the three clusters in northern Italy, central Spain and Belgium-Netherlands were confirmed. In addition, France entered the picture, with Île-de-France and Grand Est recording 4 140 and 2 249 deaths, respectively. More generally, it is noted that fatalities caused by COVID-19 were now widespread across Europe, with a few exceptions in Denmark, Austria, Poland, Bulgaria, Greece, and Alentejo in Portugal. The total number of deaths in the EU in mid-April was 66 001.

In mid-May the situation had clearly worsened across the EU (**Map 9**). All regions apart from a small number of exceptions had COVID-19 certified deaths. Exceptions include Lubuskie in Poland, and Ipeiros, Sterea Ellada and Peloponnisos in Greece. The most dramatic situations were found in several regions of Spain (in particular, Madrid and Catalonia), in the northeast of France (in particular, Île-de-France and Grand Est), in the north of Italy (in particular Lombardy and Piedmont) and in Belgium. By this date, the number of deaths had increased to 110 050.

Although deaths continue to occur at the time of writing (mid-July 2020), the situation illustrated in Map 9 is still more or less valid. By mid-July, overall deaths in the EU had totalled 134 691.

Map 8. **COVID-19 deaths as of mid-April per 100 000 inhabitants**



Map 9. **COVID-19 deaths as of mid-May, per 100 000 inhabitants**

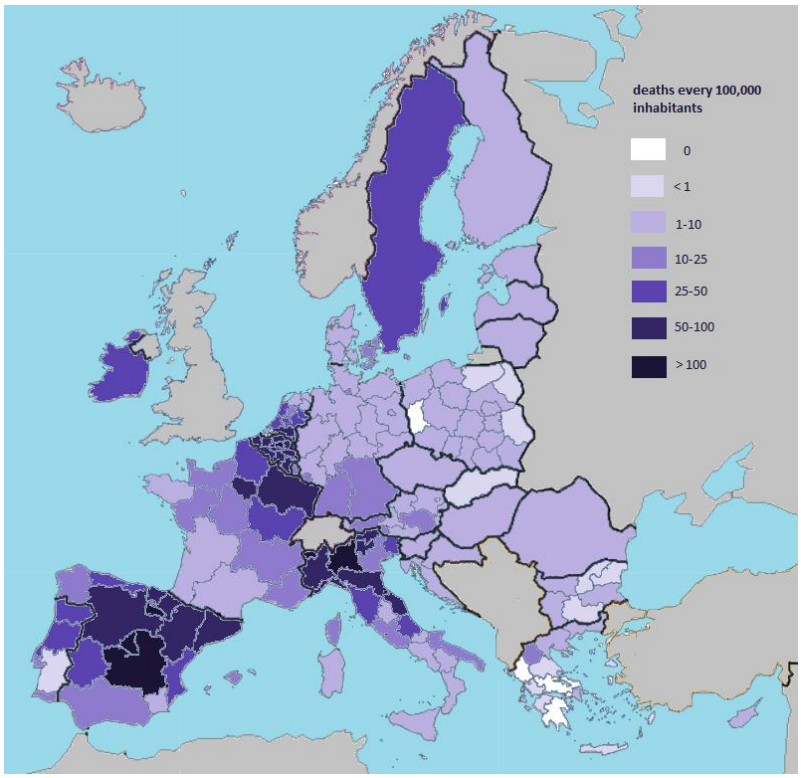


Figure 5 and Figure 6 show the ten most impacted regions across the EU in terms of COVID-19 certified deaths and confirmed cases. The following exceptions in the data need to be noted: data for Belgium and Germany are considered at NUTS1 level; data from French regions on COVID-19 cases are not available.

As of mid-July 2020, the most impacted regions for deaths caused by COVID-19 were in Italy, Spain, Belgium and France (**Figure 5**). Among these regions, the highest occurrence of deaths is found in Lombardy, where 167 out of every 100 000 inhabitants died because of COVID-19. A high occurrence is also found in Castilla-La Mancha (149). When the ranking is done according to the number of COVID-19 confirmed cases, the most affected regions are in Italy, Spain, Germany, Belgium and Portugal (**Figure 6**). Among these regions, the highest occurrence of cases is found in Madrid where 1 096 out of every 100 000 people were COVID-19 certified.

Figure 5. Most impacted regions for number of COVID-19 certified deaths

Region	Cumulative deaths	Fatality rate (%)
Lombardia (IT)	16.765	17,6
Comunidad de Madrid (ES)	8.444	11,6
Île-de-France (FR)	7.513	-
Cataluña (ES)	5.678	8,6
Flanders (BE)	4.910	13,8
Wallonia (BE)	3.391	17,3
Emilia-Romagna (IT)	4.271	14,7
Piemonte (IT)	4.118	13,1
Grand Est (FR)	3.591	-
Castilla-La Mancha (ES)	3.031	16,5
TOT	61.712	

Figure 6. Most impacted regions for number of COVID-19 confirmed cases

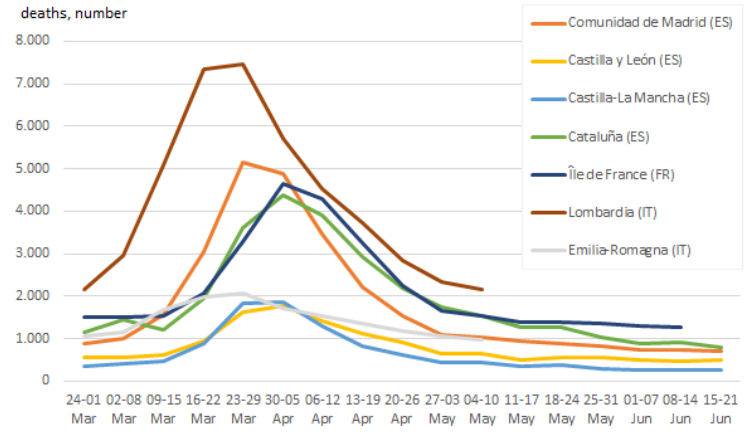
Region	Cumulative cases
Lombardia (IT)	95.236
Comunidad de Madrid (ES)	72.797
Cataluña (ES)	65.852
Bayern (DE)	49.427
Nordrhein-Westfalen (DE)	45.233
Baden-Württemberg (DE)	36.162
Flanders (BE)	35.581
Piemonte (IT)	31.515
Emilia-Romagna (IT)	28.989
Lisbon (PT)	23.008
TOT	483.800

Data source: EC-JRC ECML Covid website.

As discussed earlier, the presence of high numbers of people aged 65 or over and of high numbers of long-term care beds in nursing and residential care facilities characterise some of the most affected European regions. The analysis of weekly deaths data from the end of February to the end of June 2020, broken down by age and gender, confirms that the elderly were the most affected group. By considering the European regions which show at least one weekly increase of 500 or more deaths over the reference period (i.e. seven regions), the occurrence of excess mortality with a 2-week time gap is observed (**Figure 7**). The first peaks materialised over 16–22 March in Lombardy and Emilia-Romagna. Madrid and Castilla-La Mancha reached their peaks over 23–29 March. One week later, it was Île-de-France, Catalonia and Castilla and Leon's turn. Data analysis shows, in these seven regions, that proportionally to their age and gender group, male deaths

are higher than female deaths, although absolute numbers point to the contrary. **Figure 8** illustrates the example of Madrid, and the other six regions show similar results. Finally, in all cases, deaths of people aged 65 or over represent the majority of total deaths. Their share ranges from a minimum of 82% in Île de France to a maximum of 92% in Castilla and Leon, Lombardy and Emilia-Romagna. JRC analysis made using a sample of 574 000 cases confirms that the COVID-19 fatality rate is higher among men for all age groups and that fatalities are uniformly concentrated in the older population across all Member States (Goujon *et al.*,2020). Analysis of excess mortality in Île-de-France by Insee (2020) also found that it increased with age and was higher among men than women.

Figure 7. Regions with weekly increases of over 500 deaths, total deaths



Data source: Eurostat

Figure 8. Regions with weekly increases of over 500 deaths, total deaths

Data source: Eurostat

Part 2 Examples of regional response to COVID-19

This part presents ten examples of regional responses to the COVID-19 pandemic. The examples cover regions from different EU countries and with diverse exposure and impact. A few of them are at the sub-regional level (counties/big cities). Cases focus on measures and initiatives undertaken at the territorial level in addition to measures decided by central governments. They were selected in mid-June from the contributions uploaded on the CoR's COVID-19 platform. For the most part, these contributions have been further elaborated through desk review of publicly available information, documents and press releases.

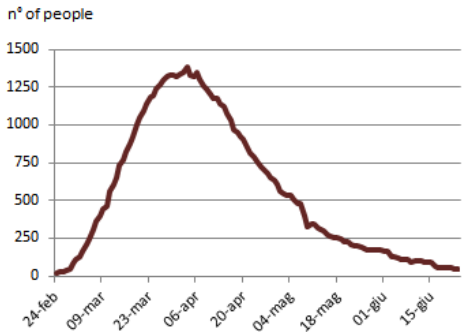
1 Lombardy Region, Italy

Facts and figures

Lombardy is the region most affected by COVID-19 in the EU. By mid-July, the region's death toll of 16 775 persons was equivalent to 48% of total national deaths and its 95 316 cases were equivalent to 39% of national cases. The peak of infections was on 20 March, when 3 251 new cases were registered compared to the previous day. Lombardy is the best equipped Italian region with respect to CCBs, with over 1 000 units versus approximately 5 100 units at the national level. Nevertheless, its regional health system was under great pressure since demand for CCB intensive care was over 1 000 units for 29 consecutive days.

Number of cases, by province, mid-July

Number of people in need of CCBs, Feb–Jun 2020



Source: data are from the Italian Department for Civil Protection website

The response

Health-related measures

- Coordination of response and strengthening of the regional health system. In January 2020, the region established a crisis unit. At the beginning of March, the unit started coordinating the response of individual hospitals across the region. Non-COVID-19 patients in need of care were moved to 18 hospitals, leaving the other 150 health structures exclusively for the treatment of COVID-19 patients. Over the month of March, the region managed to increase the number of its CCBs to 1 400 (ilPost press release dated 04/05/20).
- Logistics. The region arranged free accommodation for the several categories of people involved in the emergency such as health personnel and volunteers (including those coming from outside the region). In that connection, it finalised a framework agreement with the regional confederations of commerce and industry.
- Fundraising. The region has collected donations worth about EUR 107 million. This amount is being spent on medical equipment to support the work in hospitals and other health structures but also to purchase millions of protective masks for distribution to vulnerable people and people on duty such as volunteers and public utility staff. Donations were also used to convert an existing building into a hospital for intensive care. The hospital was finished at the end of March and cost some EUR 21 million but was not as useful as expected because of the steady reduction of patients in need of intensive care.
- Conversion of production lines. Since 16 March 2020, the region has been seeking firms willing to convert their production lines to supply technically suitable PPE. On 5 May, the region decided on the allocation of EUR 10 million to support the conversion of micro as well as small and medium enterprises.
- Public procurement of medical equipment. The region launched an international call for tenders, through its central purchasing company, for the procurement of several PPE and medical equipment. The call, with a deadline of 31 March 2020, was published through several EU networks (for example, one call was posted on the Enterprise Europe Network).
- Premiums for health workers. The region has allocated EUR 82 million for distribution to health workers involved in the emergency.

Emergency-related measures

- Structured support for the regional economy. Regional Law N°9 of 4 May 2020 set aside EUR 3 billion for the economic recovery of the region. Out of this amount, EUR 400 million is allocated to local authorities for public works and infrastructure as well as other interventions such as energy efficiency, sustainable mobility and also internet/wireless infrastructure, while EUR 2.6

billion is in support of the regional economy (including EUR 400 million for strategic investments).

- Safe reopening. On 5 May 2020, the region allocated more than EUR 19 million to support the safe reopening of businesses. The "safe-working" measure is aimed at contributing 60%–70% of the costs enterprises have to face to reopen in accordance with safety requirements.

Lessons learnt

- Preparedness is difficult to achieve even for a regional health system with a good reputation. Lombardy is a dramatic and much debated case. For example, it is argued that the high privatisation level of its health system negatively affected the response capacity, that general practitioners were left without sufficient guidance and PPE, and that not enough tests were carried out for early diagnosis. The outbreak of the pandemic within nursing and residential care facilities is currently being officially investigated by the competent judicial authorities.
- In Italy, containment and mitigation measures were the earliest and amongst the most restrictive in the EU. In the contribution to the CoR's COVID-19 platform, it is mentioned that the European Conservatives and Reformists members from the region would have expected that, in the context of a Europe-wide emergency, these same rules to be applied within the Union's borders (this was probably so as not to negate local/regional/national efforts). Similarly, agreed international rules for commuting workers should have been applied from the very beginning of the crisis.
- If EU solidarity came late, international solidarity was forthcoming. Lombardy received supportive medical teams from Cuba, Albania and Poland in late March. Teams from Romania and Norway did not arrive until 7–9 April, as part of the European Medical Corps of the EU Civil Protection Mechanism.

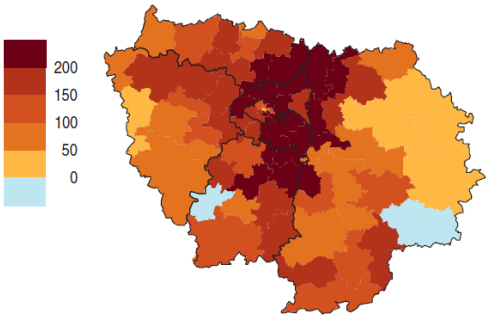
Sources: Regione Lombardia website; contribution of Matteo Luigi BIANCHI to the CoR COVID-19 platform.

2 Île-de-France Region, France

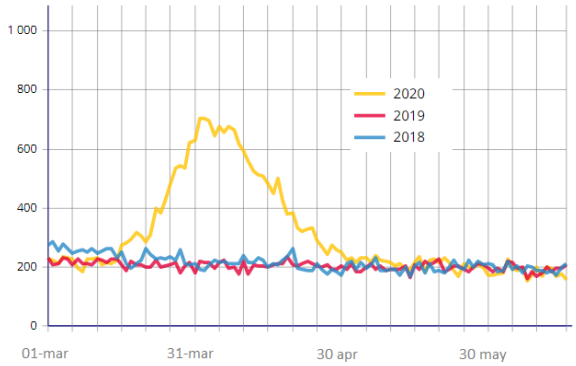
Facts and figures

Île-de-France is the French region most affected by COVID-19. According to a press release dated 28/05/20, the region had 149 071 COVID-19 confirmed cases. If this figure is correct, it would be the highest among all EU regions. As of mid-July, the regions' death toll of 7 519 persons is equivalent to 25% of total national deaths. Over the period from 2 March to 10 May 2020, the region had an excess mortality of 11 300 persons which represents an increase of 79% compared to the same period in the last five years (the national average increase is 22%) (Insee, 2020). Regional excess mortality started rising between 16 and 29 March, especially in the region's northern areas, and reached a peak in the first half of April.

Excess mortality, by department, 30 Mar–12 Apr 2020



Daily deaths, 2018/2019/2020



Source: figures are extracted (and adapted) from Insee website and Insee (2020)

The response

Health-related measures

- Medical equipment and centralised purchase. The region purchased 30 million masks with the financial contribution of the EU. The first 10 million units were distributed to healthcare professionals, municipalities, associations, nursing homes and other vulnerable groups, or entities performing essential functions. In addition, the region allowed communities and enterprises to place orders for protection equipment and other material (e.g. disinfection materials, rapid tests) on its regional purchasing platform.
- Strengthening of the regional health system. The region established an emergency equipment fund of EUR 10 million for the purchase of equipment by healthcare professionals. It paid nursing students to volunteer in private and public hospitals. It financed a platform (Covidom) for the home monitoring of COVID-19 patients. It arranged for the provision of

accommodation in high-school premises (9 200 beds and 45 individual rooms) for health professionals as well for those hospitalised for reasons other than COVID-19 (in order to relieve hospitals). It also strengthened its support to an association providing psychological assistance to health professionals. Finally, it used its resources (regional vehicles and staff) to help directly in the emergency.

Emergency-related measures

- Reorganisation of transport. The region converted its school transport to increase transport services to hospitals. It also organised 22 temporary bus lines to facilitate the travel of healthcare professionals.
- Digital learning. Early in 2019, the region started a digital shift of its high schools. Further to the emergency, the existing digital workspace (a platform allowing students and teachers to interact) was strengthened and a web conference module added. Some 190 000 pupils received tablets and computers. Both measures benefitted from the support of EU funding.
- Solidarity and support for vulnerable groups, including women vulnerable to domestic violence. The region provided in-kind support to charity associations (e.g. 80 tonnes of food and 100 000 masks), established an emergency fund for humanitarian associations, and provided the facilities to accommodate homeless people. In order to promote solidarity, the region set up a platform called *COVID-19 solutions* which was designed to link providers of solidarity-based solutions with potentially interested users, such as older people and health professionals. For instance, a SME proposed, free of charge, cybersecurity solutions to hospitals.
- Financial support to the business sector. Various financial instruments were mobilised, including the ERDF co-funded Zero Rate "Rebound Loan" (from EUR 10 000 to EUR 300 000) to support the cash flows of micro and SMEs; and the Île-de-France and communities' resilience fund for advances from EUR 3 000 to EUR 100 000 at zero rate to support the relaunch of business activities. The region also provided support to companies which modified their production line in order to manufacture material or equipment for the fight against COVID-19.
- Support to the agricultural sector. The region and the Chamber of Agriculture set aside EUR 3.5 million to support direct sales (EUR 1 million), economic recovery of the sector (EUR 1.5 million for cash grants to farmers obliged to destroy their unsold produce), and relaunch of activities (EUR 1 million for public purchase of plants and trees). Large food market wholesalers, in partnership with the region, launched a platform "Rungis delivers to you" in order to supply fresh regional products to citizens confined in their homes.

Lessons learnt

- Île-de-France's immediate response for containment and mitigation of the COVID-19 outbreak was focussed on digitalisation. Important emphasis was also given to solidarity-based actions.
- On 11 June, the region approved the first part of a comprehensive recovery plan worth EUR 1.3 billion which is clearly based on the lessons learnt during the crisis. The region's medium-term response focuses on economic recovery through innovation; on return to work and job creation through modernisation of training; on support for purchasing power and socially-oriented interventions, including in the housing domain; and on green investment and transport.

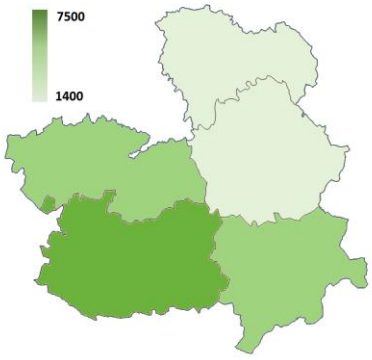
Sources: Région Île-de-France website; contribution of Frank CECCONI to the CoR COVID-19 platform; Public Health France website.

3 Castilla-La Mancha Region, Spain

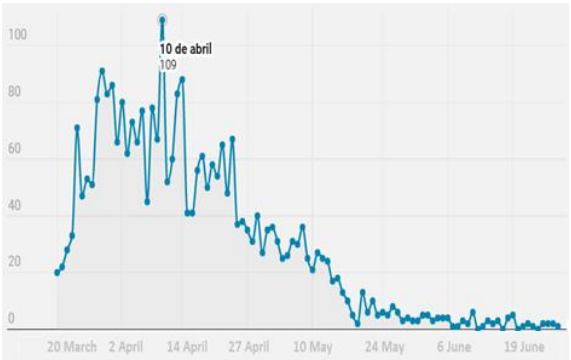
Facts and figures

In Spain, as of mid-July, Castilla-La Mancha is the fourth region for the number of confirmed cases (18 413, or 7% of national total) and third for the number of deaths (3 032 victims, or 10.7% of national total). The peak of infections was on 20 March (+ 947 cases with respect to the previous day) while the peak of daily fatalities (109 deaths) was on 10 April.

Number of cases, by province, mid-July 2020



Daily deaths, Mar–Jun 2020



Source: figures are extracted (and adapted) from Castilla-La Mancha website

The response

Health-related measures

- Strengthening of the regional health system. The region's priority has been to contain the pandemic through the strengthening of its health system. In that connection, it designed contingency plans to adapt hospitals. There were 164 CCBs before the COVID-19 crisis and 535 at the end of June. The region plans to keep this number unchanged in the future (CLM press release dated 24/06/20). Similarly, the number of ventilators in the public hospital network was quadrupled during the crisis period.
- Health personnel. Castilla-La Mancha was the Spanish region employing the largest number of healthcare workers during March–April 2020. The region ultimately had a workforce of over 4 200 health professionals.
- Nursing homes. The region established a contingency plan for the care of COVID-19 affected persons in elderly nursing homes, making arrangements for their individual care if they were not meeting the medical criteria for hospital admission.
- Diagnostic testing. Among Spanish regions, Castilla-La Mancha has performed the highest number of rapid diagnostic tests proportionally to its population (i.e. 62 500 tests). These tests detect the infection in 15 minutes, thus increasing the possibility of early diagnosis of COVID-19.
- Medical equipment and cooperation with the private sector. Regional projects for the rapid manufacturing and purchasing of medical supplies were coordinated by the region. Public-private cooperation led to the manufacturing of 20 000 protective visors for healthcare staff and the production of 1 million masks. Overall, by the end of June 2020, the region had distributed over 18.5 million protection items (CLM press release dated 27/06/20). Free distribution of masks reached 835 146 citizens.

Emergency-related measures

- Reinforcing the capacity to reach out to the territory. There are 919 municipalities in the region, many of which are located in rural areas and characterised by geographical dispersion. The environmental services of the region carried out daily interventions in about 200 towns in order to disinfect care homes and health centres, distribute medicines, and transport people in need. They also monitored the respect of confinement rules.
- Food delivery points. In liaison with town councils, the region worked to establish a network of food delivery points for families at risk of social exclusion as well as for students in need. By the end of April, more than 6 000 students had benefitted from this type of aid (CLM press release dated 28/04/20).

- Information technology. The focus was on speeding up the deployment of fibre-optic networks and handing out equipment (tablets, PCs) to families/students and connectivity devices to schools in order to implement remote learning. The same support has been provided by network service providers to hospitals to enable patients to communicate with their families.
- Business support. The region coordinated an initial financial aid mechanism of EUR 15 million in order to back credit operations of up to EUR 300 000 for regional SMEs and the self-employed. At the beginning of May, it also designed an Extraordinary Plan of Measures with an initial allocation of EUR 127 million (expected to rise to over EUR 220 million) which is aimed at benefitting 32 000 businesses and 105 000 workers. It included a non-refundable financial aid of EUR 25 million for those SMEs and self-employed people who resumed their activities and retained their employees as soon as the lockdown was lifted.

Lessons learnt

- The region understood the importance of protecting the residents of nursing homes and prepared a contingency plan accordingly.
- The region put forward a recovery plan for its economic sectors ahead of the announcement of any forthcoming EU financial support for recovery purposes.
- The president of the region, Emiliano García-Page, believes that the response from EU institutions needs to be strong and solutions need to be consensual, living no space for an individualistic approach. In his own words, if Europe does not tackle the problem, then Europe becomes a problem.

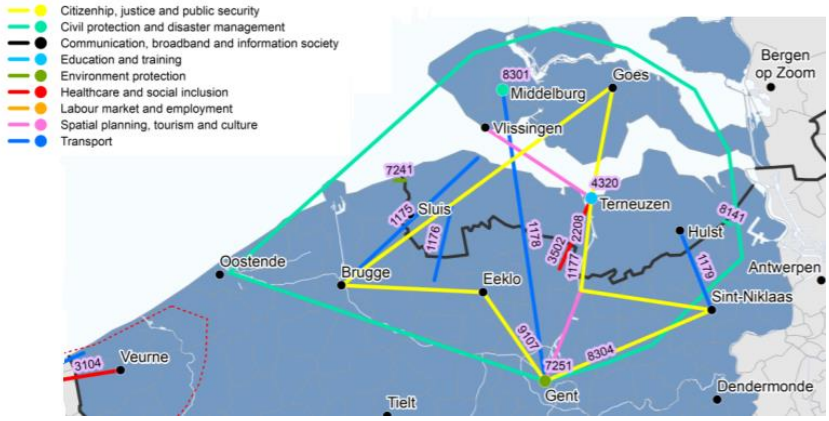
Sources: Region of Castilla-La Mancha website; contribution of Emiliano GARCÍA-PAGE SÁNCHEZ to the CoR COVID-19 platform.

4 Euregio Scheldemond, Belgium-Netherlands

Facts and figures

Euregio Scheldemond is a partnership between the provinces of Zeeland (the Netherlands), East Flanders and West Flanders (Belgium). By mid-July, Flanders were the worst hit area in Belgium with 35 442 cases and 4 909 deaths, while Zeeland Province was much less affected with only 763 cases and 70 deaths (JRC and RIVM data). On 20 March, the Belgian Government closed its borders for non-essential inbound and outbound travel (press release dated 20/03/20) and border information points became unavailable.

Cross-border public services on the Dutch-Belgian border, 2018



Source: the map is extracted from ESPON (2018)

The response

Emergency-related measures

- Unaccounted situations in existing cooperation agreements. Closure of borders between territories with interlinked arrangements and networks developed over the last three decades created a number of issues. Working permits solved the problem of regular cross-border workers (and an intergovernmental level agreement between the two countries filled a legislative vacuum on the taxation of cross-border smart-working arrangements) but, for example, rules for crossing the border for other reasons were left vague. In 2018, the euregio had 16 cross-border public services along the Dutch-Belgian border. These services are "*provided or made possible by public authorities on both sides of the border for an undefined time and with a target group on both sides of the border*" (ESPON, 2018). In addition, there are several "divided villages" in the area, i.e. "*villages that stretch across the border and are split by it. Inhabitants of these villages cross the border for their daily activities*" (ESPON, 2018).
- A cross-border Task Force. In order to improve coordination among the partners of all euregios, a Task Force with members from the Dutch, North-Rhine Westphalian and Belgian governments was set up. Euregios provide input into the Task Force on cross-border problems caused by COVID-19 and the Task Force streamlines communication to the relevant departments in the relevant governments. In this way, departments receive notices only from the Task Force and not from every euregio. An example of the problems handled by the Task Force relates to the self-employed who became eligible for support measures both in Belgium and the Netherlands but according to different principles (registered residence in one case and social security status in another case), which caused inconsistencies.

Lessons learnt

- Emergency situations across borders create bottlenecks which are unexpected, even when there is well-established cooperation. In order to solve these practical problems, public authorities across borders need to know what is happening on the other side in order to take decisions, hence the need for a coordination group which is kept informed by the actors of the concerned communities on both sides of the border.
- Before the reopening of borders, euregios were asked to inform the task force about "*specific domains or guidelines the governments should pay attention to and be cautious about when they ease the situation. For example, opening schools while the border is still closed will generate more cross-border complications for those bringing children to school or picking them up*" (Hamelink, 2020).

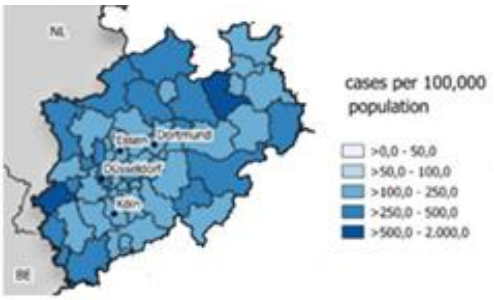
Sources: Council of Europe "Comité européen sur la démocratie et la gouvernance et COVID-19"; Rijksinstituut voor Volksgezondheid en Milieu data online accessed on 13/07/2020; ESPON, 2020; contribution of Stuey HAMELINK to the CoR COVID-19 platform.

5 North Rhine-Westphalia Region, Germany

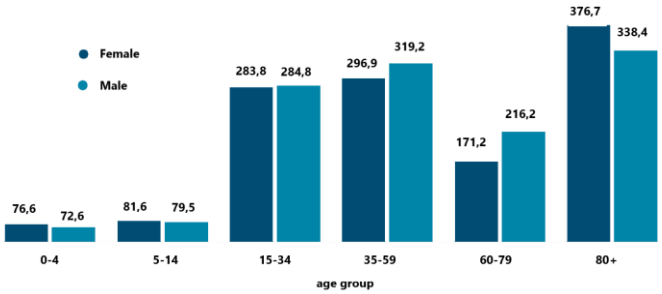
Facts and figures

The district of Heinsberg, in North Rhine-Westphalia, is considered the German epicentre of COVID-19. There, the first cases were detected at the beginning of March (Euractiv press release dated 23/04/20). In mid-July, North Rhine-Westphalia was ranked second in the country for the number of confirmed cases (45 388 or 22.7% of national total) and third for the number of deaths (1 711 or 18.8% of national total). The peak of cases was reached on 23 March (+ 2 070 compared to the previous day) while the peak of deaths (68) was on 22 April. In late June 2020, the region again experienced a rise in the number of cases due to localised outbreaks, such as the one which occurred in a meat processing plant in Rheda-Wiedenbrück.

Cumulative cases, by county, mid-July 2020



Cases per 100 000 inhabitants, by gender, mid-July 2020



Source: figures are extracted (and adapted) from RKI (2020) and RKI COVID-19-Dashboard

The response

Health-related measures

- Readiness. On 13 March, the region alerted hospitals to postpone unnecessary interventions in order to keep their capacity free for patients infected by COVID-19. It also announced a decree severely limiting visits to nursing homes and hospitals (NRW press release dated 13/03/20). On 17 March, EUR 150 million for hospitals and other medical and nursing care facilities was provided.
- A virtual hospital. The region anticipated the pilot of a virtual hospital to optimise the treatment of COVID patients throughout its territory. The virtual hospital provides medical advice on the treatment of respiratory patients, for example to healthcare professionals located in small hospitals. This remote support makes it possible to treat patients where they are hospitalised, limiting transfers and taking advantage of the nursing resources available on site (NRW press release dated 25/03/20).
- Veterinary offices to help with diagnostic testing. In order to increase its capacity to analyse swab samples, the region asked its Chemical and Veterinary Examination Offices (CVUÄ) to support the work of testing laboratories. CVUÄ started work on 30 March and could process a total of 1 500 samples per day at the locations of Arnsberg, Detmold, Krefeld and Münster. This allowed for the faster return of results to local authorities and clearer assessment of the spread of coronavirus (NRW press release dated 27/03/20).
- Admitting COVID-19 patients from other countries. On 27 March, the region announced the acceptance of COVID-19 patients from Italy (10 persons from Lombardy and Piedmont regions) and from France (4 persons). These patients were distributed across several clinics in different cities (NRW press release dated 27/03/20).

Emergency-related measures

- Closed schools, but not for all. Further to the lockdown decided on 13 March, the region left schools open for the children of those persons working in critical infrastructure sectors such as energy, water, health, food, IT, transport, media and governance (NRW press release dated 18/03/20).
- A cross-border Task Force. A special COVID-19 cross-border task force was created to coordinate actions between North Rhine-Westphalia and its neighbouring regions in Belgium and the Netherlands. The Task Force first met remotely on 20 March. It was meant to exchange information, synchronise activities and clarify issues of common interest for crisis management. Its establishment followed talks between the region's government and the prime ministers of the Netherlands and of Belgium (NRW press release dated 20/03/20).
- Aid scheme for businesses. Through its regional Emergency Aid 2020, the region provided financial support to 426 000 small businesses, freelancers and self-employed people. Aid ranges from EUR 9 000 to EUR 25 000, depending on the number of employees. Applications could be submitted over the period 27 March–31 May. Financial support provided under the scheme totalled EUR 4.5 billion.
- Since April, seasonal workers from other EU countries, especially Romania and Bulgaria, started arriving in the region to help with the harvest as well as the planting of crops. "*According to the Ministry of Agriculture, around 53 000 seasonal workers will be needed in North Rhine-Westphalia by summer; around 8 500 workers are already on the farms in North Rhine-Westphalia.*" (NRW press release dated 09/04/20).

Lessons learnt

- The region has a low fatality rate (3.8%) which may imply an effective response capacity. In addition to responding internally, the region has taken action at the cross-border level and has relieved the pressure on some Italian and French hospitals by accepting their COVID-19 patients.
- This case provides the example of a region with an apparently effective response to COVID-19 being dependent on the support of other EU countries for non-COVID related issues, in the specific case for maintaining its agricultural production.

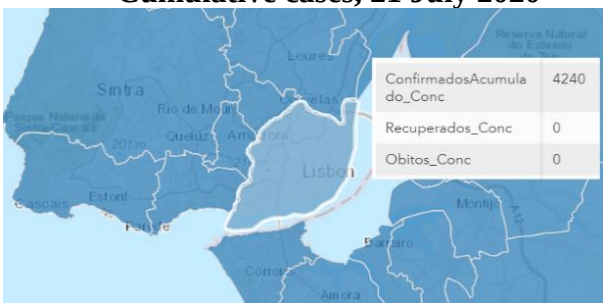
- The region's situation is well-represented by the words of Armin Laschet, minister-president of North Rhine-Westphalia, echoed last May by the press: "*Germany will only overcome the corona crisis if European freedom of movement for people, goods and services is fully restored"* (press release dated 15/05/20).

Sources: North Rhine-Westphalia website; contribution of Dietmar BROCKES to the CoR COVID-19 platform.

6 City of Lisbon, Portugal

Facts and figures

Cumulative cases, 21 July 2020



Source: map extracted from esriportugal.hub

Lisbon municipality had 4 240 confirmed cases on 21 July 2020, or 8.7% of the national total. Cases started being recorded at the beginning of March. There is no quantification of deaths at the municipal level.

The response

Health-related measures

- COVID-19 screenings. In liaison with Public Health Authorities, the city created two dedicated screening centres.

Emergency-related measures

- Support to essential workers. In liaison with the Ministry of Education, the city ensured that nine public schools were left open for the children (aged up to 12 years old) of workers of the health services, police forces and fire brigades.
- Social measures. In order to ensure continuity of service delivery during the crisis, the city made a total emergency transfer of EUR 600,000, which supported various organisations taking care of vulnerable groups such as the homeless, persons with disabilities, families on low incomes, and children. An additional EUR 25 million was allocated to the Social Emergency Fund

supporting families, social institutions and the purchase of goods, services and equipment necessary to face the emergency situation.

- Maintaining school meal distribution. Since meals provided at school (breakfast, lunch and mid-afternoon snacks) represent an important form of support for many families, the city decided to also continue providing this service during the school closures. Meals were provided in take-away form and families could pick them up at any of the collection points set up in some of the schools.
- Home support for senior citizens. The city and its local partners ensured the continuity of home support (which includes warm meals, personal hygiene and medication) to the over 4 000 pre-existing beneficiaries of this service. They also extended this support to senior citizens who were previously using daycare centres and to those who did not have sufficient autonomy to cook their own meals.
- Support for the homeless. The city opened two new shelters for homeless people. These shelters had approved contingency plans and reinforced sanitation measures in place as well as isolation spaces for suspected cases of infection and quarantine.
- Close cooperation with boroughs. The city partnered with its 24 local boroughs to support the acquisition of basic goods (medication, food) for those most in need, namely the elderly, patients with chronic conditions, and people put under home quarantine. Dedicated phone lines were created to provide company and psychological support to those in isolation (this includes WhatsApp connections between the young and the old).
- Solidarity network. Volunteers were identified and mobilised to support the most vulnerable sectors of the population (senior citizens, persons with disabilities, patients under quarantine). Volunteer tasks included shopping (food and medication), pet care (e.g. walking dogs) and maintaining contact (e.g. as a way of preventing or detecting cases of domestic violence).
- Transport. Parking fees were temporarily suspended. All public vehicles in service were frequently disinfected while the use of shared bikes and taxis supported by the city was recommended.
- Information. A web platform was created to show which local shops were open to sell food, medication and other essential purchases.
- Municipal interventions in the economic sector. The city exempted commercial establishments in municipal spaces that closed at the time of the lockdown from paying rent. Similarly, social, cultural, sporting and recreational institutions located in municipal spaces were exempted. Payment for the use of public space was also suspended, retroactively, from 1 March to 30 June. In addition, the city used the implementation of its investment plan, also covering municipal companies and totalling an estimated EUR 620

million, as a way to strengthen public service provision, support employment and preserve the productive capacity.

- Helping start-ups, micro and SMEs. The city set up a support team to provide all necessary information and consultancy services to businesses to mitigate the impact of the crisis on their viability, including continuing their activities by means of technological solutions. A marketplace was created, combining the needs of companies, institutions and municipalities with the skills and possibilities offered by the entrepreneurial ecosystem in Lisbon.

Lessons learnt

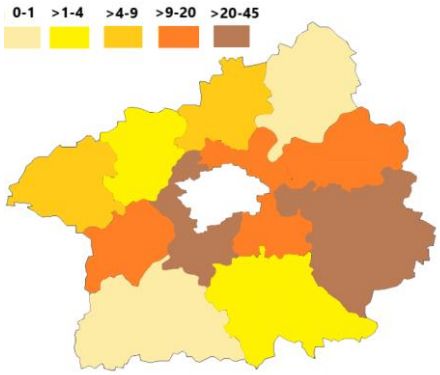
- Measures undertaken by the city of Lisbon reflect the important role municipalities had in supporting their citizens, in particular the vulnerable ones which would be most affected by isolation and closure of service providers. Maintaining services for these categories of people and reaching out to the marginalised ones was essential.
- The city of Lisbon has tried to initiate support locally for recovery, and to lead the way to more comprehensive policies that can mitigate the crisis, by reaching out to all its economic agents, from businesses to social entities and families.

Source: this case is almost exclusively based on the contribution of Fernando MEDINA to the CoR COVID-19 platform.

7 Central Bohemia Region, Czechia

Facts and figures

Cumulative cases per 100 000 inhabitants, mid-July 2020, by district



Data source: Regional Hygiene Station of the Central Bohemian Region website.

The first COVID-19 cases in Czechia were confirmed on 1 March 2020. Central Bohemia had its first cases on 8 March 2020. It was one of the four regions where the infection arrived from Prague. More specifically, the cluster was in a construction site in the capital where more than 40 companies were involved. Workers living outside the city caused the spread of the virus to their places of residence in Central Bohemia, Olomouc, Zlín and Hradec Králové (press release dated 29/06/20). In mid-July 2020, the region had a cumulative number of 1 371

cases, or 10.2% of national total, and 24 deaths. By this date, it was the third region in the country for the number of cases after Prague and Moravia-Silesia.

The response

Health-related measures

- Distribution of PPE. The regional government rushed to distribute 55,000 FFP2 masks which were sent from a central regional warehouse to hospitals and other public institutions (the Ministry of Health distributes medical equipment to its directly managed hospitals, regional hygienic stations and laboratories where tests for coronavirus are carried out). More supplies arrived from China.
- Distribution of safety equipment. The region secured 126 000 litres of disinfectant for public transport operators, expected to be sufficient for 60 days. It was distributed all across the region by the Association of the Central Bohemia Transport Companies and firefighters. Other safety equipment and disinfection liquids were immediately distributed where needed.

Emergency-related measures

- Coordination. The Government of Central Bohemia set up a Crisis Management Committee to coordinate and supervise the measures decided upon at the national and regional level to fight the outbreak of COVID-19 in the region.
- Information. The region launched a dedicated COVID-19 website including the latest news, a list of testing labs, self-quarantine recommendations, and voluntary actions undertaken in towns and municipalities (facemask sewing, food deliveries, repairs, shopping, etc.). A specific COVID-19 helpline was made available for citizens' enquiries including measures for the elderly (shopping, food delivery, psychological help and housekeeping assistance for small tasks).

Lessons learnt

- Even in less affected regions, the spread of COVID-19 represented a serious threat and required intervention by the regional government in the areas of distribution of medical protection equipment and of safety material, of provision of information to citizens, and of service provision for vulnerable groups.

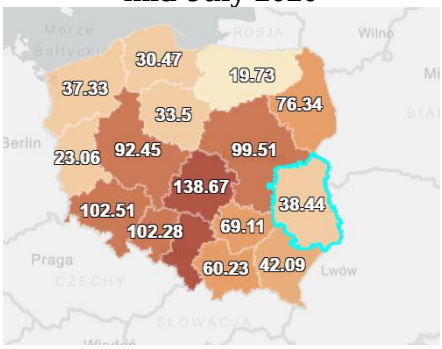
- On 12 March, the national government declared a state of emergency. Because of the lockdown, even those regions not hard hit by COVID-19 were economically impacted and required recovery measures and initiatives. The Regional Authority expects regional investment and innovations to be key to recover from the crisis.

Source: this case is almost exclusively based on the contribution of Jaroslava POKORNÁ JERMANOVÁ to the CoR COVID-19 platform.

8 Lubelskie Province, Poland

Facts and figures

Cases per 100 000 inhabitants, mid-July 2020



Source: map extracted from the Polish Government website

COVID-19 had a relatively low impact on Lubelskie region. Cases and deaths started being recorded in the second half of March. By mid-July, the region had 849 cases and 20 deaths.

The response

The region focussed on the use of EU funds to respond to the emergency. On 2 April 2020, it adopted an anti-crisis package based on four pillars.

Health-related measures

- Pillar I of the anti-crisis package provides for the allocation of approximately EUR 11.2 million to hospitals in the region in order to purchase medical equipment to fight coronavirus.
- Under Pillar III, the reallocation of resources within the ESF (approximately EUR 1.3 million) allows for the purchase of medical equipment and for payment of medical staff wages. Also, ERDF resources (approximately EUR 9.4 million) are being used to purchase diagnostic and medical equipment, including ventilators.

Emergency-related measures

- Under Pillar IV, the region exempts those businesses operating in offices/on premises which fall under its budgetary authority from paying rent for three months.
- Pillar II of the anti-crisis package relates to the provision of aid to businesses which are beneficiaries of the Regional Operational Programme (ROP) and have been affected by the epidemic. In particular, it provides for the extension of deadlines for projects' implementation and submission of payment requests, as well as the granting of an additional grace period for the repayment of loans and guarantees received under the ROP, and the extension of deadlines for the calls for proposals planned for 2020.

Lessons learnt

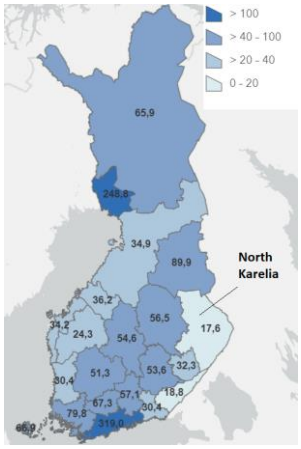
- The region aimed at making the most out of the ongoing EU funding programmes to face the COVID-19 crisis, especially with a view to giving economic support to businesses and purchasing power to hospitals.
- According to the regional government, EU intervention is needed to make it easier to use EU funds for emergency reasons, in particular with respect to increasing the EU co-financing rate; flexibility in changing allocations between priority strands of a programme; non-application of sanctions if results are not achieved as planned, where the pandemic affected implementation; extending the timeline for expense eligibility in the 2014–2020 financial plan; exemption of allocations to fight COVID-19 from complying with requirements related to thematic concentration and climate; and flexibility in allocating more resources to those companies which are directly involved in the fight against COVID-19.

Sources: Lublin Coronavirus Update March 30; contribution of Jarosław Piotr STAWIARSKI to the CoR COVID-19 platform.

9 North Karelia Region, Finland

Facts and figures

Cases per 100 000 inhabitants, by hospital district, mid-July 2020



Source: map extracted (and adapted) from the Finnish Institute for Health and Welfare (THL) web GIS service

By mid-July 2020, the region had 29 cases and was among the least affected areas in Finland. Cases started being recorded in the second half of March 2020. In the country, deaths are specified by hospitals district and not by region. The Kuopio University Hospital catchment area, which also includes North Karelia, had reported 25 cumulative deaths by mid-July 2020 (THL online data).

The response

Emergency-related measures

- The region suffered mainly from an economic point of view and because of the side-effects of measures such as the closure of external borders. Therefore, the Regional Council of North Karelia mainly focussed on developing a "survival plan" in cooperation with municipalities, entrepreneurs and business organisations. The plan, published on 9 June 2020, is aimed at finding solutions to quickly revitalise the region. It envisages the implementation of measures in nine sectors: technology industry, climate and energy, emissions and waste, tourism, services, creative industries and culture, construction, transport and logistics, and well-being (this last sector includes solutions to health problems caused by the epidemic). Measures are expected to be carried out in 2020 by local companies in cooperation with municipalities. In addition, municipalities are called on to make investments through public procurement and to enlarge participation in calls for tender by small businesses by breaking down the size of their procurement lots.
- Structural Funds have been used to support development companies owned by municipalities. These publicly-owned companies have in turn supported private companies established in the region. The Regional Council of North Karelia also supports local businesses directly by granting funding for different types of small development projects.

Lessons learnt

- The Regional Authority's strategy is to turn the challenges imposed by COVID-19 into opportunities for growth. This is tackled, among other ways, by strengthening internal demand; adapting businesses' strategies, activities and practices to new growth in the post-coronavirus period; reinforcing those factors that bring businesses and jobs back to the region; and increasing self-sufficiency in the primary sector.

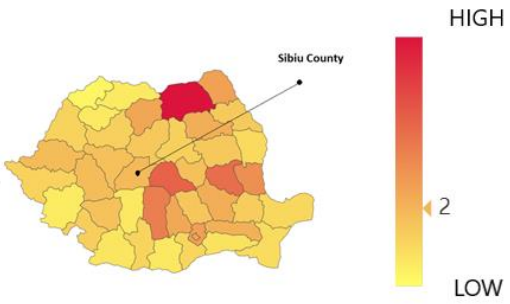
Sources: contribution of Tiina MOISALA to the CoR COVID-19 platform; PASSPARTOOL Interreg Europe news dated 16/06/20.

10 Sibiu County, Romania

Facts and figures

Sibiu County had 792 confirmed cases on 22 July 2020 (2 for every 1 000 citizens) and no deaths. Sibiu City has been included by the European Best Destinations Organization, within the framework of the European Destinations of Excellence network, among the 20 places least affected by COVID-19. These places have up to 600 times fewer COVID-19 cases and have established specific protocols for the safety of visitors (Forbes article dated 01/06/20).

Cases per 1 000 inhabitants, by county, 22 July 2020



Source: map extracted (and adapted) from https://datelazi.ro/

The response

Health-related measures

- Strengthening the capacity of Sibiu County Hospital. On top of the funds allocated from the public health system, approximately EUR 1.3 million was allocated from the county budget and from donations of businesses and individuals for the procurement of PPE for hospital staff, testing equipment and medicines; and for expanding the hospital's intensive care capacity. Procurement guided by the needs of the hospital management was also supported by the Sibiu Community Foundation. Volunteers from the private sector produced and donated several thousand visors to the hospital in the first week of April. In addition, at the end of April, the County Council obtained

sponsorship for equipment for the hospital from a pharmaceutical company enabling hyper-immune plasma therapy to be carried out locally.

- Testing devices for the county hospital. Another foundation (CON-A) donated a RT-PCR testing device, while with the support of county and central authorities, the hospital managed to purchase reagents and other necessary consumables. A second PCR device was purchased using central government funds and co-financing from Sibiu County Council. The first tests were performed in early April, with priority being given to medical staff.
- Reorganisation of space in the county hospital. The hospital management implemented organisational arrangements to reduce COVID-related risks such as the creation of separate circuits for COVID patients; the transfer of cancer patients to other buildings; non-intersecting shifts of medical staff; and the creation of new structures for epidemiological screening.
- Disinfectants. A joint public and private effort allowed the local production of hand disinfectant. Sibiu County Council brought local partners (Sibiu Chamber of Commerce, Industry and Agriculture, "Lucian Blaga" University from Sibiu, Sibiu Community Foundation and the National Red Cross Society - Sibiu branch) together and organised the collaboration under the aegis of the "Solidarity for Sibiu" initiative. The first 500 litres were produced in April for use by social care centres, homes for the elderly and local public authorities.
- Logistics. Sibiu County Council, with the help of local entrepreneurs and later with government support, organised accommodation for the medical staff of Sibiu County Hospital and of the ambulance service. As these persons were exposed to a high risk of infection, they were given the possibility of staying away from their families when not on duty.
- Physiological support. A free telephone line service managed by the Dr. GH. Preda Psychiatric Hospital in Sibiu, which comes under the authority of Sibiu County Council, was set up to support people facing anxiety and depression. The service registered 250 calls from all over the country, including coronavirus patients hospitalised in Suceava, a county severely affected by the pandemic.

Emergency-related measures

- Organisation of the imposed lockdown. Sibiu County Council organised the lockdown imposed on people coming from countries with a high degree of risk (995 people as of early May 2020). The working group set up for this purpose identified 762 places which matched the legal requirements (the maximum total number of people simultaneously in institutional lockdown was 558).
- Support for vulnerable groups confined in isolation (e.g. elderly people without relatives, people with chronic diseases or in a difficult financial situation) through the distribution of food and other services. The Red Cross distributed 4 500 kg of perishable and non-perishable food in urban and rural

communities. The support came through the *Food Bank* campaign, which carried out its activities on the premises of the Transylvania Hall Public Service, which comes under the authority of Sibiu County Council. In addition, the *We Help You from Sibiu* initiative mobilised thousands of volunteers who worked closely with the Sibiu Red Cross and responded to a multitude of specific needs. This also included the donation of laptops for children from disadvantaged groups so that they could attend online school lessons.

Lessons learnt

- Sibiu County's experience demonstrates the need to pool all available resources together when facing a complex and serious emergency, by creating strong links among actors that allow a rigid and fragmented system to be transformed into a responsive system. Key to managing the crisis generated by COVID-19 was the collaboration between the county public authorities, private enterprises and civil society, along with substantial governmental support.

Source: this case is almost exclusively based on the contribution of Doris Cristina BANCIU to the CoR COVID-19 platform.

Part 3 Review of EU response to COVID-19

This part presents the policy and/or legislative actions initiated at EU level in late February, March and April 2020 to support health and emergency responses across the Union. It is a requirement of the terms of reference of this study to focus on this initial period of the COVID-19 outbreak. For the same reason, financial support is excluded if not explicitly intended for strengthening health systems. Finally, only those measures which are believed to have affected LRAs' capacity to react to the COVID-19 crisis are described.

Actions are listed chronologically as per the summary overview below.

Health policies	
28/02/2020	Joint Procurement Procedures for the supply of PPE.
13/03/2020	Commission Recommendation on conformity assessment and market surveillance procedures for PPE and medical devices.
16/03/2020	COVID-19. Guidelines for border management measures to protect health and ensure the availability of goods and essential services.
19/03/2020	Creation of a RescEU stockpile of medical equipment.
20/03/2020	Guidance on the requirement to authorise the export of PPE to third countries.
24/03/2020	Revision of standards for protective equipment.
01/04/2020	Guidance on the use of the public procurement framework in emergency situations.
03/04/2020	Guidance on EU emergency assistance on cross-border cooperation in healthcare related to the COVID-19 crisis.
Emergency policies	
16/03/2020	Temporary restriction on non-essential travel to the EU.
30/03/2020	Guidance on the exercise of the free movement of workers during the COVID-19 outbreak.
01/04/2020	Regulation on specific measures to mobilise investments in the healthcare systems of Member States and in other sectors of their economies in response to the COVID-19 outbreak.
01/04/2020	Regulation on the extension of the scope of the European Union Solidarity Fund.
08/04/2020	Temporary Framework for assessing antitrust issues related to business cooperation in response to situations of urgency stemming from the current COVID-19 outbreak.
14/04/2020	Regulation activating the Emergency Support Instrument.
17/04/2020	Joint European Roadmap towards lifting COVID-19 containment measures.
24/04/2020	Regulation on the Coronavirus Response Investment Initiative Plus.

3.1 Health policies

28 February 2020

Joint Procurement Procedures

Provisions for joint procurement are included in Article 5 of Decision 1082/2013/EU on serious cross-border threats to health. A description of this joint procurement voluntary mechanism is part of a Joint Procurement Agreement which is currently signed by 37 countries, including all EU Member States. Further to the COVID-19 crisis situation, the Commission took the decision to launch Joint Procurement Procedures, i.e. calls for tenders for the supply of protective and medical equipment. Calls are followed by the awarding and signature of framework contracts under which Member States can place their orders.

At the beginning of July 2020, five calls for tenders had been launched and coordinated by the Commission. Framework contracts were signed for the first four calls and countries have placed some orders. The first call was launched on 28 February for gloves and protective clothing. Luxembourg then placed an order for gloves. On 17 March, two calls were launched, one for ventilators and the other one for facemasks, gloves, spectacles, face-shields, surgical masks and protective clothing. Estonia, Belgium and Latvia placed orders for masks and spectacles, Bulgaria for ventilators. A fourth call was launched on 19 March for laboratory equipment, including testing kits. This last contract has been awarded and countries have been able to place orders since 7 May 2020. A fifth call was launched on 17 June for intensive care medicines.

Article 5 of Decision 1082/2013/EU specifies that the procedure is for the use of Member States. Regions indirectly benefit from joint procurement when they are the target beneficiaries of the medical equipment purchased by the respective national governments. Apparently, the first procurement procedure was not successful because no tenders were received (MedTech Europe, 2020). In general, there is evidence that the perception of delay in the procedures launched and coordinated by the Commission in early March made some Member States look for alternatives (see here a press release dated 22/03/20 on the case of Estonia).

13 March 2020

Commission Recommendation (EU) 2020/403 of 13 March 2020 on conformity assessment and market surveillance procedures within the context of the COVID-19 threat.

The Commission issued this recommendation to facilitate placing protection material on the market. According to this recommendation PPE and medical devices, at the discretion of national market surveillance authorities, can be placed on the market even if they have not gone through the conformity assessment procedure as described in Regulation (EU) 2016/425, Directive 93/42/EEC or Regulation (EU) 2017/745 (Art.7); or have not completed the CE marking process (Art.8).

As evidenced in our cases, regional authorities commonly took the initiative to incentivise the production of PPE within their territories, favouring the conversion of businesses' production lines. The Commission's recommendation, in the short term, may have accelerated placing equipment that pre-existed before the crisis, or new equipment produced ad-hoc during the crisis, on the market.

16 March 2020

Covid-19. Guidelines for border management measures to protect health and ensure the availability of goods and essential services.

These guidelines set the principles for health-related measures to be carried out at borders to protect health but at the same time preserve the single market. Similarly to the guidelines concerning the exercise of the free movement of workers during the COVID-19 outbreak, these guidelines reiterate that screening tests for travellers and quarantine for suspected cases are more effective measures than refusal of entry. The guidelines also specify that "*Member States should preserve the free circulation of all goods*". If measures are taken by Member States, they have to be transparent, duly motivated, proportionate, relevant and mode-specific, as well as non-discriminatory. If border control has been established, Member States have to set "green lanes", or border-crossing points. On this aspect, the Commission issued further guidance to Member States.

The case of Euregio Scheldemond is an example of unilateral closure of borders within the EU. Although the decision of the Belgian Government did not apply to the transportation of goods, the case provides evidence of the negative impact such a unilateral decision had on territories that span borders. One week earlier than Belgium, on 13 March, Slovakia, Malta and Czechia announced the closure

of their borders to EU citizens. Other Member States followed some days later. The Commission continued to declare that these unilateral decisions on travel bans were ineffective in the fight against COVID-19, but this did not prevent negative effects on the circulation of persons and goods.

19 March 2020

Commission Implementing Decision (EU) 2020/414 amending Implementing Decision (EU) 2019/570 as regards medical stockpiling rescEU capacities

Entering into force on 21 March 2019, RescEU was meant to create a European reserve of capacities within the Civil Protection Mechanism (CPM) of the EU. The CPM is based on the voluntary offering of support by individual countries. It is therefore possible that when several countries are simultaneously facing the same emergency, Member States requesting assistance do not receive the necessary support.

A common reserve of capacities has the scope to enable the EU to assist affected countries when solidarity among Member States is not possible or sufficient. During the COVID-19 outbreak, this situation occurred towards the end of February 2020, when Italy called for a show of solidarity. As COVID-19 was rapidly spreading across the Union, EU solidarity was lacking. In fact, some Member States such as Germany and France also decided to ban the exports of protective masks to ensure their internal supply. It is in this context that the Commission decided on 19 March 2020 to create a RescEU stockpile of medical equipment with an initial allocation of EUR 50 million. With respect to COVID-19 emergency, RescEU is therefore operating as a common European reserve of medical equipment and a distribution mechanism. It is activated upon the request for assistance by countries and has two functions: 1) coordinating the delivery of equipment donated by individual Member States to other countries, and 2) distributing the equipment which is purchased using EU budget. European reserves are located in Germany and Romania. These two hosting countries are responsible for procuring the EU-funded equipment. Distribution to the countries with the highest need is managed by the Emergency Response Coordination Centre of the CPM (EU press release dated 02/05/20).

The first deliveries of 330 000 FFP2 protective masks were made in April-May 2020 to Italy, Croatia and Spain. In May 2020, RescEU coordinated the delivery of medical ventilators offered by Denmark to Italy and arranged the delivery of FFP2 masks to Lithuania (EU press release dated 20/05/20). In an EU press release of 21/04/20, it is noted that "*Italy has now received several offers of assistance via the EU Civil Protection Mechanism, including medical teams of*

doctors and nurses as well as bilateral offers of personal protective equipment from several EU Member States".

RescEU provided direct but late support to regional health systems. For example, the first dispatch of 90 000 protective masks to Lombardy's hospitals, arrived from Romania only on 25 April 2020. A few days later, more masks were dispatched to Spain, Croatia and, again, Italy.

On 2 June 2020, the Commission proposed to strengthen the mechanism with an additional EUR 2 billion over the 2021–2027 period. Recognising the inability of the Union to directly provide equipment during the COVID-19 crisis, the aim is to create a quick response capacity at EU level, based on a common European reserve of medical equipment and emergency-related transport facilities. The EU will directly procure this equipment and will fully fund the development and operational cost of RescEU (EU press release dated 02/06/20 and the Commission proposal for a Decision of the European Parliament and of the Council amending Decision 1313/2013/EU on a Union Civil Protection Mechanism).

In addition, it is noted that the Commission has set up a COVID-19 Clearing House for medical equipment. It is a temporary mechanism (for 6 months) to complement the Commission's work on joint procurement and stockpiling of medical equipment via RescEU. The Clearing House is conceived as a way to bring together the various relevant services within the Commission. It is organised into five product-related clusters: personal protection equipment, ventilators, other medical and hospital supplies, test materials, and therapeutics and vaccines. It has the scope to facilitate and accelerate the availability of products. It also "*monitors imports, export restrictions, production capacity in third countries and supply chains, including transport and logistics bottlenecks. It also helps foresee and resolve blockages due to regulatory or technical reasons*".

With regard to the use of the CPM during the COVID-19 outbreak, the mechanism allowed the repatriation of more than 10 000 Europeans on 47 flights. For example, it was used by France to bring back Europeans from Wuhan, China. Italy, UK, Austria, Germany and Denmark also used the mechanism for the same repatriation reasons. In addition, the mechanism was the way to provide support to China with more than 56 tonnes of protective equipment. Equipment was contributed by Austria, Czechia, Estonia, France, Germany, Hungary, Italy, Latvia, and Slovenia. Additional equipment to China followed, including from Italy, on 14, 19 and 23 February 2020 (EU press release dated 24/02/20). Unexpectedly, a few days later, on 26 February, Italy made its own request to the mechanism to obtain protective equipment. On 6 April 2020, still through the CPM, China donated 200 000 masks and 50 000 test kits for COVID-19 which

were allocated and delivered via the mechanism to Italy (press release dated 06/04/20).

20 March 2020

Communication from the Commission, Guidance note to Member States related to Commission Implementing Regulation (EU) 2020/402 making the exportation of certain products subject to the production of an export authorisation, as last amended by Commission Implementing Regulation (EU) 2020/426.

The Commission provided non-legally binding guidance on its Implementing Regulation, and amendment, on the requirement to authorise export of personal protective equipment to third countries. The aim was to avoid export of essential equipment which was needed to meet EU internal demand. In fact, the Communication explicitly mentions that the intervention of the Commission was to maintain the integrity of the internal single market: "*The Implementing Regulation was adopted with the understanding that Member States should revoke any restrictive national actions taken, formally or informally, concerning either exports to third countries or trade between the Member States within the Single Market, going beyond actions designed to ensure priority access to such material by those who need it most (e.g. hospitals, patients, healthcare workers, civil protection authorities)*".

The export authorisation requirement was temporary (a duration of 30 days, but subject to renewal). On 24 April, it was adjusted by reducing the list of products requiring authorisation. The measure remained temporary and finally came to an end on 25 May 2020. The European Commission's assessment of the measure was positive: *"According to the reports submitted by Member States, exporters requested more than 1 300 authorisations based on the regulation that entered into force on 26 April. Some 95% of all applications have been approved. Also based on Member States' reports, more than 13 million protective masks, around 1 million protective garments and more than 350 000 protective masks and visors have been exported from the EU since 26 April.*" (EU press release dated 26/05/20).

The Implementing Regulation had the scope to ensure an adequate supply of PPE in the internal market, as such it is considered to have had a positive impact on regions, although its effects cannot be quantified. The regulation was also a way to publicly warn those countries, including Germany and France, that had "*abruptly banned exports to guard their own supplies*" (Euractiv press release dated 13/03/20).

24 March 2020

Revision of standards for protective equipment

The Commission asked the European Committee for Standardization and the European Committee for Electrotechnical Standardization to revise standards for protective equipment. The aim was to facilitate the production of these materials by new producers willing to convert their production lines. This initiative complements Commission Recommendation (EU) 2020/403 on conformity assessment.

In normal conditions, standards have to be purchased and used in line with the intellectual property right rules of those who develop the standards. Because of the exceptional circumstances, standards covering common filtering masks, medical gloves and protective clothing were made available for free to potential manufacturers. This was meant to facilitate production of protection items and therefore their placement on the internal market, according to quality standards (EU press releases dated 20/03/20 and 25/03/20). Because of the scarcity of protective material on the market, several regions started producing these items internally. Therefore, the availability of standards is expected to have facilitated these processes.

In addition, "*On 23 April the Council and the European Parliament adopted the postponement by one year of the application of the Medical Devices Regulation, to allow health institutions and economic operators in Member States to prioritise the fight against the coronavirus pandemic, whilst continuing to ensure patient health and safety until the new legislation enters into force*" (EU public health dedicated webpage).

1 April 2020

Communication from the Commission on Guidance from the European Commission on using the public procurement framework in the emergency situation related to the COVID-19 crisis.

These guidelines, published on 1 April 2020, explain the options and flexibility available under the existing EU public procurement framework for the purchase of the supplies, services, and works needed to fight COVID-19. This is another initiative which has the aim of facilitating the purchase of protection items and services/works to fight COVID-19 using existing instruments. It is highly relevant for regional and local authorities which are among the public buyers referred to under paragraph 2 of the Communication.

3 April 2020

Communication from the Commission, Guidelines on EU Emergency Assistance on Cross-Border Cooperation in Healthcare related to the COVID-19 crisis.

Adopted by the Commission on 3 April, the guidelines call on national, regional and local health authorities to use existing structures and mechanisms for offering hospital bed capacity across borders to patients in need; and to share the medical expertise and skills of their available healthcare professionals. The Commission commits to coordinate requests and offers of help for patients in need of intensive care; coordinate and co-fund patients' transport; and clarify administrative issues related to reimbursement procedures for treatment in another Member State and patient mobility across borders. The guidelines also stress that existing cross-border agreements and arrangements, including those established through Interreg, should be used as far as possible to provide support to neighbouring territories.

Another important aspect addressed by the communication relates to the movement of healthcare professionals. Apart from their free movement, the Commission calls on health authorities to mutually recognise health professional qualifications and allow for agile procedures in accepting the contribution of medical staff coming from another country.

At EU level, cooperation across borders is facilitated through the Health Security Committee, chaired by the Commission, and the EU Early Warning and Response System. Funding of cross-border cooperation may occur through the Solidarity Fund (see Regulation (EU) 2020/461 under section 3.2 below), Structural Funds and the Emergency Support Instrument (see section 3.2 below).

Examples of existing cross-border healthcare cooperation are named in the communication. Another example relates to the transfer of COVID-19 patients from French regions to other regions in Europe. There were three transfers of French patients over the period 21 March–3 April 2020, two from Grand Est and one from Bourgogne-Franche-Comté, out of a total of 183 people (French Government dashboard).

3.2 Emergency policies

16 March 2020

Communication C(2020) 2050 final on 'COVID-19: Temporary Restriction on Non-Essential Travel to the EU'

In order to avoid patchy decisions across the Union, on 16 March, the Commission called upon the European Council to adopt the decision to apply a restriction of 30 days on non-essential travel from third countries into the EU+ area. The EU+ area includes Schengen Member States (all Member States with the exception of Ireland) and the four Schengen Associated States (EFTA countries). The overall aim was to limit the spread of the virus. The governments concerned agreed to this proposal on 17 March.

The European Commission communication on the closure of external EU borders was accompanied on 30 March by guidance on the implementation of the temporary restrictions on non-essential travel to the EU (C(2020) 2050 final). Since then, the Commission has implemented three assessments of the application of the temporary restrictions on non-essential travel to the EU: on 8 April 2020 (COM(2020)148), on 8 May 2020 (COM(2020) 222 final), and on 11 June 2020 (COM(2020) 399 final). On 30 June 2020, the Council agreed to start lifting, as of 1 July 2020, travel restrictions for residents of some third countries.

30 March 2020

Communication from the Commission, Guidelines concerning the exercise of the free movement of workers during COVID-19 outbreak (2020/C 102 I/03).

On 30 March 2020, the Commission published the (non-binding) "Guidelines concerning the exercise of the free movement of workers during COVID-19 outbreak". These guidelines were intended to invite Member States that had closed their borders to allow the free movement of workers in critical occupations. For other workers, the Commission invites Member States to allow these workers to cross their borders if work in the sector concerned is still allowed in the host Member State. In addition, there is a specific call by the Commission to consider seasonal agricultural workers as workers that exercise critical occupations.

1 April 2020

Regulation (EU) 2020/460 of the European Parliament and of the Council of 30 March 2020 amending Regulations (EU) No 1301/2013, (EU) No 1303/2013 and (EU) No 508/2014 as regards specific measures to mobilise investments in the healthcare systems of Member States and in other sectors of their economies in response to the COVID-19 outbreak (Coronavirus Response Investment Initiative).

On 13 March, the Commission adopted a proposal for a Regulation of the European Parliament and of the Council for a **Coronavirus Response Investment Initiative** (CRII) aimed at the rapid mobilisation of financial resources to fight the emergency. The proposed package provided for the reallocation of all the unspent budget from the European Structural and Investments Funds (about EUR 37 billion, out of which EUR 8 billion had already been transferred to Member States and will not have to be refunded) in the 2014–2020 period. An additional EUR 54 billion is available from the 2020 cohesion envelopes of Member States. The proposal was approved by the European Parliament on 26 March. The Council adopted the package on 30 March 2020 and the regulation entered into force on 1 April 2020.

The Emilia-Romagna and Tuscany regions in Italy (EU press release dated 28/05/20) benefitted from the reallocation of EUR 30 million from the European Regional Development Fund (ERDF). These two regions were the first "*to use the flexibilities provided under the Coronavirus Response Investment Initiative (CRII). Emilia Romagna will fund a call for projects for industries and research centres to finance short-term projects to develop and test innovative service and product solutions during the emergency and the gradual reopening phases. Tuscany will provide regional SMEs easier access to liquidity to keep their business running at time of economic uncertainty*".

1 April 2020

Regulation (EU) 2020/461 of the European Parliament and of the Council of 30 March 2020 amending Council Regulation (EC) No 2012/2002 in order to provide financial assistance to Member States and to countries negotiating their accession to the Union that are seriously affected by a major public health emergency.

Also on 13 March, the Commission adopted a proposal for a Regulation to extend the scope of the **European Union Solidarity Fund** (EUSF), established in 2002, to also cover major public health emergencies besides natural disasters. The aid amount for each country is calculated as a percentage of total public spending. The available budget for 2020 is EUR 800 million. Member States could apply

from 1 April up to 24 June 2020. Eligible expenses include those made for health and civil protection public measures but also cover a wide range of costs related to medical equipment, development of vaccines, sanitation of buildings, medical assistance, etc. Once applications are assessed, the Commission will propose an amount of aid for the approval of the European Parliament and the Council. Once awarded, the aid is given in the form of a lump sum. The responsibility for the use of the funds, including selection of operations, lies with the recipient country. As of mid-July 2020, the award procedure had not yet been completed.

08 April 2020

Communication from the Commission on a "Temporary Framework for assessing antitrust issues related to business cooperation in response to situations of urgency stemming from the current COVID-19 outbreak"(C(2020) 3200).

Adopted on 8 April 2020, this temporary framework was aimed at ensuring the supply and adequate distribution of scarce essential products and services during the COVID-19 outbreak. The Commission describes those cooperation activities among businesses which do not infringe antitrust rules and specifies that ad-hoc guidance will be provided with respect to specific initiatives, with the overall aim of not creating obstacles to fighting the coronavirus. The Commission also warns that any breach of antitrust law which takes advantage of the exceptional circumstances caused by COVID-19 will not be tolerated. The example of charging prices above normal competitive levels is given, as it actually occurred in the case of medical equipment such as protective masks (article dated 25/02/20 on an example from Italy).

14 April 2020

COUNCIL REGULATION (EU) 2020/521 of 14 April 2020 activating the emergency support under Regulation (EU) 2016/369, and amending its provisions taking into account the COVID-19 outbreak.

On 16 April 2020, the **Emergency Support Instrument** was activated with a budget of EUR 2.7 billion for the year 2020. This instrument comes on top of the Civil Protection Mechanism, RescEU and the Joint Procurement Procedures. Most of the budget will be used to pursue the European Commission strategy for producing vaccines in the EU and securing their supply to Member States. In addition, an allocation of EUR 200 million is made available to cover the costs of the transport of medical goods and equipment; of healthcare personnel for temporary exchange and reinforcement to relieve the burden on the medical workforce; and of patients affected by the coronavirus to relieve pressure on health structures. The regulation applies retroactively and therefore the instrument

will cover costs incurred since 1 February 2020 and up to 1 January 2022. A pre-allocation of financial resources (all of which are covered under the EU budget for 2014–2020) was not made.

On 17 June 2020, the Commission presented to Member States the procedures and criteria to apply for funding under the mobility package (EU press release dated 18/06/20). Its usefulness for regions is therefore not yet clear.

17 April 2020

Joint European Roadmap towards lifting COVID-19 containment measures

This roadmap was jointly presented by the European Commission and the European Council further to the call for a strategy to overcome the crisis, made by the members of the Council at their meeting of 26 March 2020. The roadmap is meant to guide the progressive lifting of restrictions and the reopening of activities. It is based on three principles: actions shall be guided by science and have public health as a primary goal; coordination; and solidarity and respect between Member States. The roadmap is centred around seven measures: making data available and sharing it at all administrative levels; using mobile apps to track infection and issue warnings while respecting data privacy; testing capacity and methodologies; capacity and resilience of health systems (in this regard, financial resources are mobilised through the Emergency Support Instrument and the Coronavirus Response Investment Initiative); medical and personal protective equipment capacity; vaccines; and effective treatments and medicines.

24 April 2020

Regulation (EU) 2020/558 of the European Parliament and of the Council of 23 April 2020 amending Regulations (EU) No 1301/2013 and (EU) No 1303/2013 as regards specific measures to provide exceptional flexibility for the use of the European Structural and Investments Funds in response to the COVID-19 outbreak.

On 2 April, the Commission adopted a proposal for a Regulation of the European Parliament and of the Council for introducing exceptional flexibility and simplification measures related to the use of Structural Funds as envisaged in the previous Coronavirus Response Investment Initiative. This new package, named **Coronavirus Response Investment Initiative Plus** (CRII+) was adopted by the European Parliament on 17 April and by the Council on 23 April. It entered into force on 24 April 2020. Eligible expenditure is set to start from 1 February 2020 and co-financing requirements are waived. In addition, flexibility is allowed in

terms of moving resources between funds, category of regions and objectives, and administration is greatly simplified.

The Assembly of European Regions has noted that this initiative may centralise the use of cohesion funds and marginalise the role of regional and local actors (AER, 2020). However, regions have already started taking advantage of this measure, providing evidence of its utility. For example, the Warmińsko-Mazurskie region in Poland had the modification of its Regional Operational Programme approved by the Commission "*to use around EUR 15 million of EU cohesion policy funds for the purchase of medical equipment*" (EU press release dated 08/07/20). One week later, the Commission announced the modification "of thirteen 2014–2020 Regional Operational Programmes and two national Operational Programmes in Greece. These modifications make EUR 1.14 billion available to address the effects of the coronavirus crisis in the Greek economy through the funding of entrepreneurship support actions" (EU press release dated 13/07/20).

Part 4 Conclusions and recommendations

The COVID-19 pandemic thoroughly tested the EU response capacity as well as the ability of public authorities at all levels to cope with an unexpected emergency. The severity of the situation was not immediately understood. However, since early March 2020 and up to the end of April, which is the period analysed by this study, the European Commission has been proactive in arranging support and in providing guidance. In some cases, this support did not meet the needs of regions, for example with regard to the procurement and/or distribution of PPE. In other cases, it has met expectations, for example with regard to the flexibility granted in the use and management of Structural Funds, from which some regions have already benefited.

The ten cases presented in this study demonstrate the complexity of the response at the territorial level. Because of the asymmetric incidence and impact of COVID-19 across regions, such a response was inevitably diverse. Health-related measures and emergency-related measures in the social and economic domains are found in regions significantly affected by COVID-19. In regions where the incidence of COVID-19 was light and the impact indirect (e.g. in the tourism sector), emphasis was on emergency measures to sustain businesses in the short term.

On the basis of the evidence collected, a number of critical areas where LRAs' immediate responses would have benefitted from more effective EU support are identified. For each of these areas, conclusions and recommendations are highlighted. However, it is to be noted that policymaking these days is extremely dynamic and suggestions are easily prone to becoming outdated. For example, on 15 July 2020, the Commission published a Communication on short-term EU health preparedness for future COVID-19 outbreaks (COM(2020) 318 final) where it plans concrete actions up to October 2020 in order to face potential new waves of COVID-19. In this communication, new proactive measures are put forward with regard to, for example, public health surveillance, medical countermeasures, healthcare facilities and workforce, non-pharmaceutical domains, and protection of vulnerable groups.

Critical area 1: insufficient procurement of medical supplies and other medical devices

Procurement of PPE and of other medical supplies was one of the major concerns of national and sub-national governments during the COVID-19 crisis. Even if there was a delay in understanding the extent of the emergency, from the end of February national and regional authorities started their obsessive search for medical equipment suppliers, each following their own modalities and using their own instruments. A rather chaotic situation developed, that facilitated overpricing, unfair trade, and/or procurement/delivery of inappropriate (e.g. low quality) equipment.

The Commission initiated a joint procurement procedure early, but ultimately the mechanism culminated in delays which were not compatible with the urgent need for medical equipment and devices. The newly created RescEU stockpile also started delivering equipment late. The Commission tried with all means possible to compensate for these shortcomings and facilitate the supply of equipment in the territories with the highest need. First, it warned EU countries to revoke any national action limiting the supply of PPE to the Member States with the greatest need. Then, it tried to speed up the use of existing PPE which had not yet gone through all the steps of authorisation and therefore could not be formally put on the market. In addition, it asked for the revision and public publishing of standards to facilitate the production of PPE by new producers. Finally, it published guidance to explain to public authorities the options and flexibility available under the existing EU public procurement framework for the purchase of the supplies, services, and works needed to fight COVID-19.

Recommendation 1: There is the need for centralised procurement and distribution capacity at EU level which is promptly activated in emergency situations. This would allow for true EU solidarity. Besides political will, this option requires the examination of the legal basis for the EU to take up this role in this policy area.

Critical area 2. cross-border healthcare faced issues during the pandemic and its potential has not been fully realised

The asymmetry of the incidence of COVID-19 emphasised the importance of cross-border healthcare. Some of the overwhelmed health systems were able to get a bit of relief through the support of other regions' health systems. The Commission, with its guidance on EU Emergency Assistance on Cross-Border Cooperation in Healthcare, tried to support the implementation of this practice. It also tried to smooth difficulties arising from the unilateral closure of national borders which affected cross-border cooperation in many countries and in many domains, including healthcare. However, there is no evidence that the Commission's intervention, by means of its guidelines, was effective.

There are successful examples of cross-border health cooperation built within the framework of Interreg programmes. But cross-border health cooperation as intended by Directive 2011/24/EU on the application of patients' rights in cross-border healthcare goes beyond healthcare across neighbouring regions. This opens up a potential that, according to the relatively low number of COVID-19 patients who were transferred across countries, was evidently left underexploited.

Recommendation 2: It is necessary to understand what did not work and what did work well in cross-border healthcare cooperation and substantially support the replication of successful initiatives while systematically removing the bottlenecks generated by the emergency. Pooling the hospital resources and the medical expertise of less affected regions in order to relieve the most affected health systems could be one way to address future public health crises. Such an approach would also strengthen EU solidarity and, ultimately, identity. The full potential of cross-border healthcare cooperation should be exploited to this end.

Critical area 3: diversity of responses and lack of common strategies constrained the containment of COVID-19

Regions faced some common critical issues during the pandemic but responses varied. When these diverse responses were across border regions, inconsistencies created additional difficulties and complications for citizens who are used to carrying out their daily activities on both sides of a border. Different approaches for crisis management across borders also increase the risk of negating containment efforts made on one side if the same efforts are not made on the other side. Coordination task forces were, for example, established at territorial level to overcome bottlenecks created at borders by the emergency. Provided that common rules across the Union would benefit the consistency of the response, it could be useful for regional authorities to learn about the most successful

approaches implemented by their colleagues Europe-wide, and understand if these approaches are replicable in their respective contexts. This could support the preparation of standard contingency plans at the regional level in specific areas such as the management of nursing facilities, the conversion of existing production lines to ensure local supply of medical equipment and material, and cross-border arrangements in neighbouring territories. This last aspect could build on existing initiatives such as the "b-solutions" pilot which defines practical solutions to concrete cross-border issues in a compendium of 43 cases.

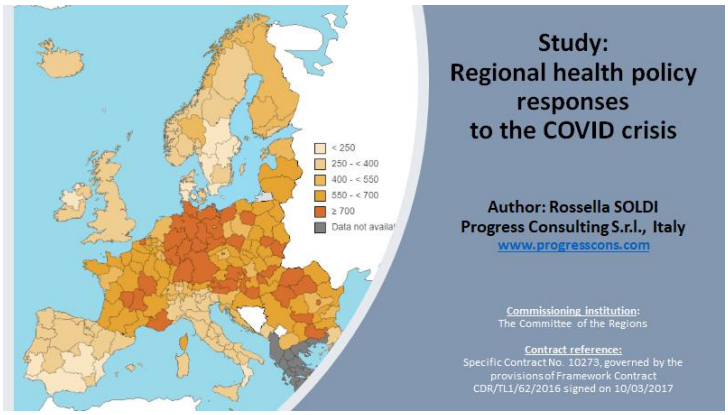
Recommendation 3: A technical working group could be established at EU level to comprehensively review regions' responses in a limited number of areas including a) management of nursing facilities, b) conversion of production lines to supply PPE and medical devices, and c) cross-border arrangements in bordering territories. The outcomes of the work of the working group could substantially support regions in developing standard contingency plans in these areas. Concurrently, it could contribute to better harmonising responses across territories and hence provide more effective barriers for the containment of COVID-19.

Critical area 4: solidarity is not yet perceived as an investment for sustainable development.

Leaving the most vulnerable behind is not a viable strategy for the future. Vulnerable groups easily became clusters of COVID-19 cases either because they were not properly protected or because they could not actually implement social distancing and other safety/precaution measures. Cases in Part 2 provide evidence of several social measures undertaken by regional and local authorities to support vulnerable groups. As these measures have a cost for public administrations, a prevention strategy could prove more socially and economically beneficial than a curative approach.

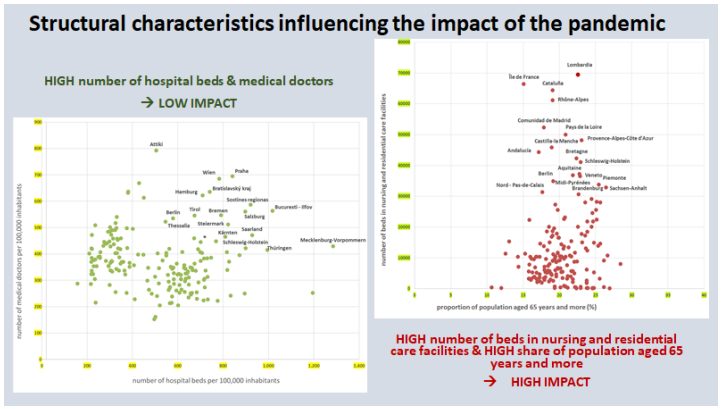
Recommendation 4: With a view to moving away from a business as usual approach while ensuring sustainable development, the EU, Member States, and regional and local authorities should consider, in their recovery plans, giving social justice and inclusion the same (economic) importance as innovation, digitalisation and green transition. This means for example, providing for minimum quality standards and conditions for older people and with regard to housing for all.

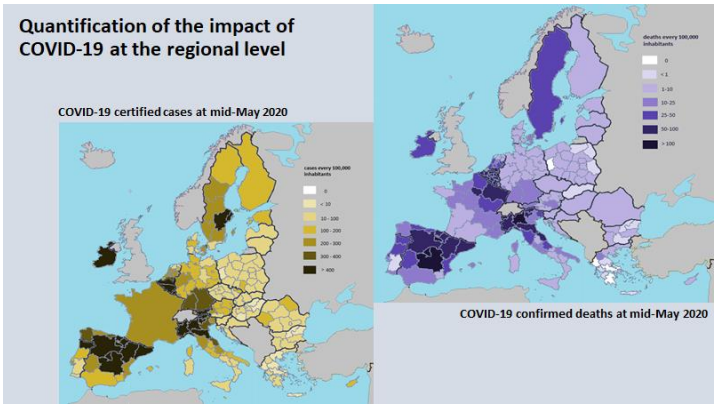
Annex I – Presentation of the main findings and recommendations



OBJECTIVES

- Illustrate some of the **structural characteristics of regional health systems** that may be related to the asymmetric occurrence of the pandemic across European regions and **quantify the impact of COVID-19 at the regional level**.
- Provide **examples of regional responses**.
- Review those **EU measures which provided immediate support to regions**.
- Propose **policy recommendations** with a view to improve future EU response in comparable emergency situations.





Quantification of the impact of COVID-19: the ten most affected regions as at mid-July 2020

Region	Cumulative cases
Lombardia (IT)	95.236
Comunidad de Madrid (ES)	72.797
Cataluña (ES)	65.852
Bayern (DE)	49.427
Nordrhein-Westfalen (DE)	45.233
Baden-Württemberg (DE)	36.162
Flanders (BE)	35.581
Piemonte (IT)	31.515
Emilia-Romagna (IT)	28.989
Lisbon (PT)	23.008
TOT	483.800

Region	Cumulative deaths	Fatality rate (%)
Lombardia (IT)	16.765	17,6
Comunidad de Madrid (ES)	8.444	11,6
Île-de-France (FR)	7.513	-
Cataluña (ES)	5.678	8,6
Flanders (BE)	4.910	13,8
Wallonia (BE)	3.391	17,3
Emilia-Romagna (IT)	4.271	14,7
Piemonte (IT)	4.118	13,1
Grand Est (FR)	3.591	-
Castilla-La Mancha (ES)	3.031	16,5
TOT	61.712	

Ten cases provide the evidence of a variety of preliminary responses of regions over the period February – May 2020

- Health-related measures (e.g. purchase of medical equipment, re-organisations of space in hospitals, contingency plans for elderly nursing facilities, hiring of medical staff).
- Emergency-related measures addressing social (e.g. solidarity initiatives, support to vulnerable groups, accommodation for the homeless, food delivery points), economic (e.g. financial support to businesses, support for safe-reopening), and logistic aspects (coordination bodies or task forces, IT infrastructure deployment and devices' distribution, re-organisation of transport).
- All regions, including the less affected ones, implemented measures to support their local economies which were in any case disrupted by the COVID-19 outbreak.

Overview of EU measures taken over the period February– May 2020

Health policies	
28/02/2020	Joint Procurement Procedures for the supply of PPE.
13/03/2020	Commission Recommendation on conformity assessment and market surveillance procedures for PPE and medical devices.
16/03/2020	Covid-19 Guidelines for border management measures to protect health and ensure the availability of goods and essential services.
19/03/2020	Creation of a RescEU stockpile of medical equipment.
20/03/2020	Guidance on the requirement to authorise the export of PPE to third countries.
24/03/2020	Revision of standards for protective equipment.
01/04/2020	Guidance on the use of the public procurement framework in emergency situations.
03/04/2020	Guidance on EU emergency assistance on cross-border cooperation in healthcare related to the COVID-19 crisis.
Emergency policies	
16/03/2020	Temporary restriction on non-essential travel to the EU.
30/03/2020	Guidance on the exercise of the free movement of workers during the COVID-19 outbreak.
01/04/2020	Regulation on specific measures to mobilise investments in the healthcare systems of Member States and in other sectors of their economies in response to the COVID-19 outbreak.
01/04/2020	Regulation on the extension of the scope of the European Union Solidarity Fund.
08/04/2020	Temporary Framework for assessing antitrust issues related to business cooperation in response to situations of urgency stemming from the current COVID-19 outbreak.
14/04/2020	Regulation activating the Emergency Support Instrument.
17/04/2020	Joint European Roadmap towards lifting COVID-19 containment measures.
24/04/2020	Regulation on the Coronavirus Response Investment Initiative Plus.

Recommendations

- **R1**. Regions need better access to necessary medical and protection equipment in emergency situations. Centralised procurement and distribution capacity at the EU level is required. This would allow for true EU-solidarity to intervene.
- **R2.** Asymmetric occurrence of the pandemic suggests that pooling the hospital resources and the medical expertise of less affected regions to relieve the most affected health systems could be one way to address future public health crises. Such an approach would also strengthen EU solidarity and, ultimately, identity. The full potential of cross-border healthcare cooperation should be exploited towards this scope.
- **R3**. Responses at the territorial level should be more standardised in key areas such as management of nursing facilities, conversion of production lines, and cross-border arrangements. This would improve containment capacity. A technical working group could identify models for the development of regional contingency plans in these areas.
- **R4**. With a view to move away from a business as usual situation while ensuring sustainable development, recovery plans should give social justice and inclusion the same (economic) importance as innovation, digitalisation and green transition.

Annex II – List of references

EC/EU documents referred to in Part 3 of this study may be accessed through the hyperlinks included in the text and are not listed here.

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European Committee of the Regions

Created in 1994 following the signing of the Maastricht Treaty, the European Committee of the Regions is the EU's assembly of 329 regional and local representatives from all 27 Member States, representing over 447 million Europeans.

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