

Good Public Governance in a Global Pandemic

Edited by
PAUL JOYCE, FABIENNE MARON,
and PURSHOTTAMA SIVANARAIN REDDY



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Part I
Introduction

Introduction

Fabienne Maron

IIAS Scientific Director,
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An infectious outbreak can conclude in more ways than one, historians say.

But for whom does it end, and who gets to decide?

How Pandemics End

The New York Times

At the time this special IIAS report was finalized, the epicentre of the COVID-19 pandemic had already moved from East Asia to Europe and had moved again to the Americas (USA, Mexico, and Latin America). Now, the pandemic started a second phase of contaminations around the world. As the epicentre moved, the new cases of COVID-19 were occurring in a relatively large number of countries and many other countries were reporting relatively small percentages of the world's new cases. There were still few grounds for complacency about the public governance of the COVID-19 pandemic. The World Health Organization was warning leaders and governments that things could get worse. It called on governments and individuals to play their part. It told government leaders and governments that they had to focus in order to suppress transmission of the virus and to save lives. There was a need for strong leadership and comprehensive strategies. Basically, the World Health Organization was saying that pandemic was still not under control and some governments were not getting it right. Individuals, it stressed, should behave responsibly by following public health principles, each person aware of their shared interests with others in the community.

Why has the International Institute of Administrative Sciences (IIAS) produced a special report on the COVID-19 pandemic? Essentially, it was intended that this special report is useful in helping leaders and governments understand better what has worked and why and facilitate the drawing of immediate lessons for their handling of COVID-19 and lessons for future pandemics.

The International Institute of Administrative Sciences, as a learned society for Public Administration, dealing with real societal problems, wanted to do what it could to help as the national governments of the world sought to protect human life from the ravages of the coronavirus crisis. The perspective of this report is therefore a practical one. This is not a report prepared by academic

‘spectators’ contemplating out of ‘pure’ curiosity what is happening, but a report of academics and practitioners that is intended to support the work of all those public leaders and public administrators bearing a responsibility for the public governance of action in response to the pandemic.

In order to compile this report on the public governance of the COVID-19 pandemic, the IIAS and its entities’ network was mobilised. A large number of academics, scholars, and practitioners of public administration from across the world collaborated to establish what was happening in the different countries and to evaluate the consequences of the measures taken at the different phases of the pandemic. The idea was to study the variety of situations and the diversity of responses.

The aspiration guiding the editors was the provision of an authoritative and factual account of measures and policies developed by governments for responding to the COVID-19 pandemic.

The editors used a set of questions to provide a conceptual framework for contributors who were asked to think about priorities, health care systems, resources, measures, agility and adaptability of government, the role of experts, communication, democracy, and transparency. Contributors responded by describing the institutional and socio-economic context of government responses as well as by identifying the ‘early lessons’ for public governance of the pandemic.

As the final part of the editing of this special report was being completed, it was obvious that some of the variety of situations and the diversity of responses that had been expected was in fact observable in the complex and novel events and developments of the pandemic in the period from January through to May 2020. It was also obvious that well designed measures, or combinations of measures, together with decisive and credible leadership at national level, could either suppress the virus or bring it back under control. This special report returns to the analysis of these matters and their lessons in the concluding chapter.

This special report is one of the COVID-19 related initiatives taken by IIAS as a learned society. IIAS is connecting people to evaluate and learn about the impact of coronavirus and how to adjust and refine models of public governance to deliver more effective preparation for, and countering of, pandemic threats. IIAS has begun a dialogue with its members and partners and organised e-sessions on the theme of COVID-19. It has created resources on COVID-19 that are available via the IIAS platform. IIAS, IASIA and the IIAS regional groups (EGPA, LAGPA, AGPA) have also been adapting to the new context created by the pandemic. For example, it has been finding new ways of supporting PhD students, teachers, scholars and researchers, it has been further developing e-learning, and delivering virtual tutorials for doctoral students and young researchers.

A Dangerous Virus: Introduction to IIAS Special Report

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Introduction

The emergence of COVID-19

The coronavirus pandemic began at the very end of 2019. On the 31 December 2019, the World Health Organisation (WHO) was notified of a group of pneumonia patients that warranted greater monitoring in Wuhan City in Hubei Province in China. The Chinese Government, on 7 January 2020, alerted the WHO that a novel type of coronavirus had been identified as the underlying cause of the pneumonia.

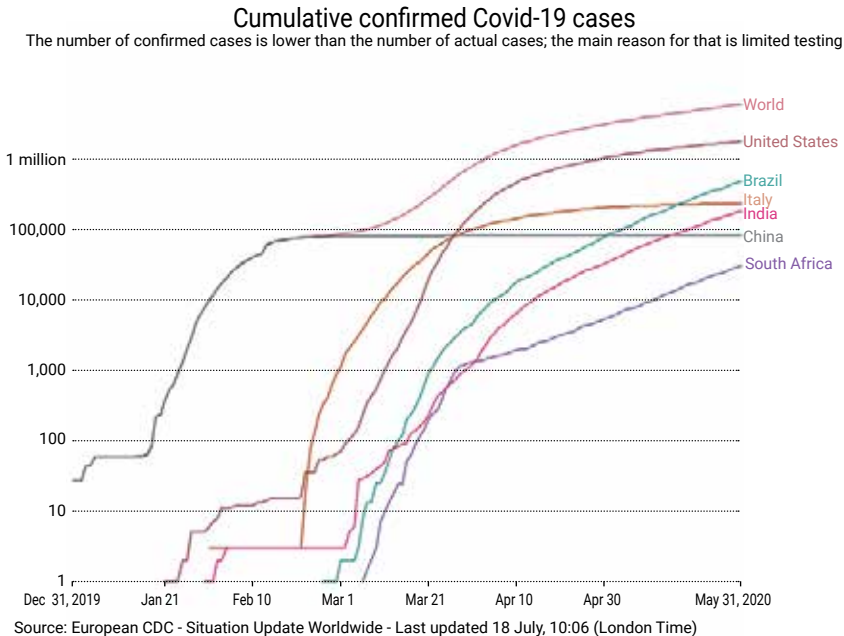
During January the bulk of the world's COVID-19 cases were concentrated in China, but a small number of cases were also confirmed in other east Asian countries (including South Korea and Japan). The epidemic was declared a public health crisis on 30 January 2020 and the WHO confirmed the new coronavirus disease as COVID-19 on 11 February 2020 (WHO, 2020c). Finally, on 11 March 2020, the transmission of COVID-19 was sufficiently widespread throughout the world for the Director General of the WHO to pronounce that it was a pandemic.

The WHO had been promoting a determined response to COVID-19 just a few weeks into 2020. It can be inferred that the Director General of the WHO

was disappointed by the progress being made by governments in February, because when he declared a pandemic on 11th March, he also expressed concern at what he described as the levels of inaction. He called on countries to prepare and get themselves ready for COVID-19.

According to WHO data contained in its situational reports, in the course of five months to the end of May 2020, a total of nearly six million people were infected and a third of a million people died. As shown in Figure 1, the cumulative number of confirmed cases rose sharply in March (Our World in Data, 2020), when a number of European countries, especially some of the bigger countries, notably Italy, Spain, France and the UK were the new epicentre of the COVID-19 pandemic. Some of the smaller European countries, such as the Netherlands and Sweden, also suffered rising and eventually high mortality rates. In May the number of new confirmed cases began to soar in the Americas. At the end of May, the number of cases was still relatively low in south-east Asia, the eastern Mediterranean and Africa.

Figure 1 - Five months to the end of May 2020 (Our World in Data)



Source: Our World in Data (2020)

COVID-19 turned out to be highly contagious, capable of spreading very rapidly through a community. It was virulent in these early months, causing very harmful effects to human beings, including death. It produced high

mortality rates among the elderly and people with certain other health problems: “The crude clinical case fatality is currently over 3%, increasing with age and rising to approximately 15% or higher in patients over 80 years of age. Morbidity associated with COVID-19 is also very high. Underlying health conditions that affect the cardiovascular, respiratory, and immune systems confer an increased risk of severe illness and death” (WHO, 2020a p. 3). The World Health Organization described COVID-19 (Coronavirus Infectious Disease 2019) as a dangerous virus.

Just a health crisis?

The United Nations (UN) pronounced COVID-19 as the worst disaster faced by the international community since the Second World War (Kalla & Laher, 2020, p. 39).

Within months of its outbreak COVID-19 had spread over a vast geographical area and at the same time caused major economic, social and political disruption. International pandemics have occurred for hundreds of years (WHO, 2009, p. 13) and have increased considerably of late due to, among other things, international travel and integration; urbanisation; variations in land usage and the ongoing and increased exploitation of the natural environment (Madhav et al., 2017, p. 1). Porta (2014) pointed out that pandemics are recognised and acknowledged by their geographic impact as opposed to just how severe the illness is. She adds by way of example that unlike the annual influenza epidemics, pandemic influenza is “where a new influenza emerges and spreads around the world, and most people do not have immunity” (WHO, 2010).

A pandemic which is as aggressive and as virulent as COVID-19 is, of course, a health crisis that threatens human lives and health. As a health crisis it afflicts all types of people even if does this unevenly (e.g. there are variations in mortality rate by age, income levels, ethnicity, and gender). It can also be a public services crisis by threatening to exceed the limits of the capacity of hospitals to treat all those becoming seriously ill. There is no doubting that many government leaders quickly saw that COVID-19 was also threatening their countries with an economic crisis.

By late May 2020, it was obvious that economic activity had been negatively impacted. This was especially so where government leaders had turned to the use of lock downs to slow down the spread of the virus. As a government ordered a lock down, closed schools and universities, closed workplaces and (partially) closed down transport systems, economic activity as well as social interaction were abruptly interrupted. Governments knew that they could bring the transmission of the virus under control, but at a very high price. The price was not just the drop in GDP per capita, but also in the detriment suffered by people and communities that were already economically disadvantaged.

This was a health crisis that could also become a crisis of public governance. There were calls for whole-of-society responses to COVID-19. Mobilizing such a response would test the relationship between government and the public and between government and interest groups. It was a health crisis that could cause the public to lose confidence in its government, especially where the public began to question the government's credibility as well as its effectiveness. At a national level, it could test relationships as governments attempted to curtail or suspend various aspects of personal freedom, to seek necessary citizen support for government measures - such as physical distancing. The ability of governments to mobilise the cooperation of important interest groups tested, for example, its relationship with private sector businesses and employers. Across the globe, citizens will have made judgements about the consequences of government responses and evaluated how effective their government's actions in the COVID-19 crisis has been. In some cases, public approval of the government increased, as government exceeded the public's expectations; and sometimes public approval of the government declined in the light of government failures.

At some point - during or after the pandemic - there could be a crisis in international solidarity. This could be, for example, a crisis in the extent to which government leaders approved of and supported the work of the World Health Organisation. There might also be a crisis in relation to the sourcing of personal protection equipment from other countries and in the search for and distribution of drugs for treating ill people and vaccines to provide immunity from COVID-19. Then there is the ongoing humanitarian aspect of international solidarity; UNDP Administrator, Achim Steiner, highlighted the risk of reversibility of progress because of COVID-19:

For vast swathes of the globe, the pandemic will leave deep, deep scars, ... without support from the international community, we risk a massive reversal of gains made over the last two decades, and an entire generation lost, if not in lives then in rights, opportunity and dignity. (WHO, 2020b, p. 1)

So, in summary, COVID-19 threatens the world in terms of its impacts on health, public services, economy, public governance, and international solidarity. But it is important not to lose sight of this pandemic as a health crisis, because to lose sight of this is to risk losing governmental focus on saving lives and protecting the health of people.

Public Governance Overview

Good governance

There are many different definitions of "good governance". Good governance can be defined as meaning governance that has the practical effect of producing good outcomes for the public. A different meaning identifies

good governance with a situation or event in which government follows a set of principles considered to be ideal. For example, the following is a policy statement of good governance: governments should make decisions based on principles of transparency, accountability, and responsiveness; a concern for efficiency and effectiveness; respect for the rule of law; and a commitment to creating a corruption free administration. This notion of “good governance” is normative and a matter of public policy.

The normative approach to defining good governance can be applied in the field of health protection as in other facets of communal living. The WHO (2009, p. 15) emphasised that actions impacting on civil liberties/individual rights have to be reasonable; responsible; proportional; equitable; non-discriminatory and adhere to national and international laws.

There can be definitions of good governance that combine the production of practical good for the public and observance of ideal principles. For example, good governance could be defined as governance that meets public needs and desires through the decisions and actions of government officials that are responsive and accountable.

Effective government

Just to make things really confusing, government effectiveness can be seen as delivering desirable outcomes for the public, as in this definition by Levi (2006), “effective—that is, capable of protecting the population from violence, ensuring security of property rights, and supplying other public goods that the populace needs and desires” (p. 5).

One way of keeping “government effectiveness” distinct as a concept from that of “good governance” is by defining it as an evaluation based on a subjective appreciation of actual governments. The “government effectiveness” indicator published by the World Bank has often featured in discussions of international comparisons of government effectiveness. The formal definition of this indicator is as follows: “Government Effectiveness captures perceptions of the quality of public services, the quality of the civil service and the degree of its independence from political pressures, the quality of policy formulation and implementation, and the credibility of the government’s commitment to such policies” (Worldwide Governance Indicator, 2020). This may not seem immediately to be a subjective appreciation because it is published in the form of an estimate or a percentage rank; as an estimate it offers a score for government effectiveness of individual countries with values in a range of approximately -2.5 to 2.5. But it has been produced based on surveys of perceptions. Consequently, it has had some of the character of a subjective appreciation.

This Worldwide Governance Indicator definition of government effectiveness makes the civil service's degree of "independence from political pressures" one of the dimensions of this concept of effective government. Why include this as an aspect of effective government? Arguably, this is because it has a particular type of democratic constitution in mind. (On critical reflection, it is also a logically odd aspect of a democratic set of relationships if the politicians are elected officials whose function is to ensure that appointed government officials carry out the will of the public. In practice it can be reconciled with the idea of democracy by saying that this just means that appointed officials work on the basis of implementing laws passed by the legislature and thus there are limits to what appointed officials can be asked to do by elected politicians.)

Governance, collective action and democracy

It may be argued that governance is about collective action and that governments should lead the public in achieving collective well-being. For example, Baez Camargo (2020) proposed the following:

- Harnessing social norms and behavioural insight to promote the public good. Tight social links associated with high levels of social capital and trust are critical for overcoming communal action difficulties;
- Moving governance beyond the government and empowering the people. There is a need for sustained public responsiveness and education to alert the populace to critical universal threats requiring a global response;
- Populism and isolationism flaws highlighted. COVID-19 attacks people in all social classes, people of various political affiliations, and people of different races. It exposes demagoguery. Decisions based on science and evidence should be demanded from the political leadership as opposed to populist or political statements; and
- Value of public goods communicated. There is global awareness of the need to protect public goods and redirect public resources to effective health governance systems as opposed to funds being diverted due to corruption.

Thinking about governance is prone to getting entangled and confused when immersed in debates about whether a certain type of democracy is better or worse than another type or whether this constitution is more or less democratic than another. It can also get entangled and confused in social science arguments about choosing *between* ideal type concepts of governance based on hierarchical relationships, market relationship and network relationships. Some see networks as somehow a more democratic form of governance than hierarchies and markets. This may occur because the critical governance relationship in a state – that between government and the public – is not at issue in their thinking. Once the relationship of government and

public is brought (back) into the picture, then, saying that networks are more democratic than hierarchies and markets looks more problematic.

It can be argued that the possibility of using overlapping definitions of good governance, government effectiveness, and democracy) makes it important to be clear in any analysis of the governance of COVID-19 about when the focus is on good governance (defined as practical effects that are good outcomes for the public), on effectiveness (a subjective evaluation of the performance of government), and on democracy.

The focus in this special report is on good governance and principles of sound governance in relation to responding to COVID-19. The concern in the final chapter is with good government and sound government, democratic or not.

Preparedness and creativity

The United Nations made the point, in effect, that it was regrettable that the global partnerships for the delivery of Sustainable Development Goals by 2030 and the Paris Agreement on Climate Change, had still so much more to do: “we could better face this challenge - with stronger health systems, fewer people living in extreme poverty, less gender inequality, a healthier natural environment, and more resilient societies” (UN, 2020, p. 2).

Many years before, the WHO (2009, p. 17) had emphasised the need for more resources for pandemic preparedness and capacity development at national level. It might be imagined that prior planning and investment were indispensable for government preparedness to mount an effective response to COVID-19. Countries could, for example, plan for and invest in creating and maintaining public health services, a system of well-resourced and modern hospitals, stockpiles (e.g. personal protection equipment, drugs), and an infrastructure of scientific and medical expertise for government advice on pandemics.

Much was subsequently made of the greater preparedness of some governments for responding to the sudden national threat posed by COVID-19 because of relatively fresh memories of severe acute respiratory syndrome (SARS) and Middle East respiratory syndrome (MERS). It appears to be easier to ensure preparedness where the danger is more vivid in the minds of government leaders.

But no matter how much planning and investment had been done, there are limits to the amount of preparedness that can be achieved. Very importantly, government planning for a pandemic encounters some degree of uncertainty about its exact timing, nature, and impact and this calls for a government capacity for flexibility. So, when a pandemic did occur and a government was confronted by a need to act urgently, it would need to be ready to improvise

some aspects of its response. The United Nations described the COVID-19 situation as “unprecedented” and stressed the need for creativity. It said (2020) “in the face of such an unprecedented situation in recent history, the creativity of the response must match the unique nature of the crisis – and the magnitude of the response must match its scale” (p. 1). This, arguably, implied the need for public governance that was flexible and agile, able to adapt to the challenges; it implied a public governance capable of innovative moves in responding to the dangers posed.

Legal contexts

Some countries have constitutional frameworks that provide the conditions for declaring a state of emergency and laws and regulations that define detailed obligations for each emergency situation. Other countries have no clear definition of a state-of-emergency at national level, but the legal framework defines the authorities responsible for managing the crisis and the regulations that apply in case of emergency (for example, see the case of Germany and its Länder). Some other countries have the possibility of using legally defined exceptional powers of the President (for example, France) or the Prime Minister or of the Government (for example, Belgium).

Some countries have hugely complex laws and regulations for managing a pandemic. New legislation and regulations may be introduced in haste and create some inconsistencies and confusion with pre-existing laws. In some countries, public authorities (at all levels of governance) have taken regulatory actions that extend the limits of their legal authority in ways that may be controversial. Very many different areas of law may be affected:

- the legal framework for reallocating human resources for health during an epidemic (mobilisation of health care staff, mobility, working day, etc.);
- legal aspects of contract rights and obligations for private companies: review contract conditions (e.g. liability clauses – ‘force majeure clauses’ etc.);
- regulations in terms of health-data protection (human rights protection);
- the legal framework for procurement procedures for acquiring medical material and protection, respirators and all the necessary equipment for facing the pandemic
- the legal regulations for producing and delivering of pharmaceutical products and medicine;
- digital health services and patients’ security;
- the adaption of legal regulations for the employers and employees concerning security, protection and new modes of delivery and working methods.

Key decisions

The United Nations urged national level decisions to cushion the effects of COVID-19 on people's lives but also their livelihoods and the economy. Governments needed to decide on the public health measures to deploy and the adjustments to make in hospital capabilities and resources. They also had to make decisions about participating in international efforts, and instigating, the search for drugs to treat individuals and for vaccines to create immunity. So, there were key decisions to be made about how much government should seek to shield and cushion individuals and business interests, what public health measures to put in place, what changes to make in the posture and capabilities of hospitals, and how much to invest in drug and vaccine development.

As a very preliminary mapping of the strategic options that existed (and that could be used in sequence or in combination), Table 1 sets out some choices using two dimensions (prevention/treatment and individual/whole-of-society). The choice between options should reflect the priorities set by government, which should have been communicated honestly and transparently to the public. Naturally, in a pandemic, governments will often say their priority is to protect the public and save lives. But many, if not all, governments will also have the economy's recovery as a top priority. One of the many challenges to government leaders is deciding how to pursue two or more priorities and avoid them becoming contradictory.

The choice of different priorities and their relative importance to politicians may affect the speed of decision making in relation to an epidemic. New Zealand, for example, moved very quickly to put in place measures to protect the public from the virus entering the country as a result of international travel. In the New Zealand case, the speed of government action in terms of measures to control international travel may be seen as an indicator of the political will underpinning the priority of protecting the lives and health of New Zealanders.

The WHO made efforts to learn lessons from the results of government responses to COVID-19 in east Asia. So, instead of just saying get hospitals ready to cope with a large influx of seriously ill people and invest in finding new drugs and vaccines, the WHO repeatedly extolled the virtues of testing and contact tracing so that individuals infected with COVID-19 can be isolated to disrupt the transmission process. As just one of many examples, it can be seen that in the following advice the Director General argued for an aggressive response of testing and tracing:

So activate your emergency plans through that whole government approach ... Increase your testing capacity... If countries act aggressively to find, isolate, and treat cases, and to trace every contact, they can change the trajectory of this

epidemic. If we take the approach that there is nothing we can do, that will quickly become a self-fulfilling prophesy. It's in our hands. (WHO, 2020e)

Table 1 - Government Choices and Measures

Function of measures		
Focus	Prevention	Treatment
<i>Individual Focus</i>	Test, trace, isolate individual cases (Public Health measure) Vaccines	Treat seriously ill in hospital Intensive care units Treat using anti-viral drugs (health services)
<i>Whole-of-Society Focus</i>	Lockdowns Ban large gatherings Close schools Close workplaces Close public transport system (Social distancing measures can be done either by passing legislation or by giving advice) Vaccine (to create "herd immunity")	

Source: Authors

Note for Table 1. Measures are illustrative and can be used in combination (e.g. lockdown and treatment in hospital).

The WHO advice to governments was to tailor its response to match the stage of development of COVID-19 infection. It strongly recommended the use of containment measures such as test, trace, and isolate at a stage before the virus gets established in a country. It was suggested that it might be possible by so doing to avoid the clumsiness and collateral social, psychological and economic damage of a lockdown of the whole-of-society. But if a government finds that the virus is established in a country, then a lockdown and social distancing may be needed to get levels of infection and the rate of reproduction of virus down to a low level. Then, before the next wave can strike, test, trace and isolate can once again be deployed. The use of test, trace and isolate offers a possibility of suppressing the virus well and long enough that the development of new drugs for treatment of individuals and the use of new vaccines to protect individuals and society can be brought to bear on the situation.

If a government takes the view that there is very little it can do to slow or halt the spread of COVID-19, then it may focus on trying to ready the hospital system to cope with large numbers of very ill people, many of whom might need treatment in Intensive Care Units and access to ventilators. Even if a government decides that it will mainly rely on hospitals to help the society weather the storm of infection, it may fear that the hospitals will not have sufficient capacity and then may look for measures to mitigate the epidemic.

By this it is meant that the government does not believe it is able to defeat the virus but hopes to reduce the numbers of people ill at the peak of a wave of infection. So, it may set out to manage the wave of infections and not actually suppress them.

It can be mentioned here that governments choosing to prevent deaths and save lives through public health measures should think about whether such measures are best organised and delivered locally (sub-nationally) or whether the national government will attempt to manage the measures centrally. There can be benefits from setting up test, trace, and isolate services at the local level, such as taking advantage of the local knowledge of a community.

Readiness to learn

In the early months of 2020, it was commonplace for scientific and medical experts to explain that COVID-19 was a new infection and that there was much that was still unknown about it.

China's Government was the first confronted by the need to react very quickly to the aggressive and virulent virus – a virus so aggressive that simply did not allow governments to take their time in carrying out analysis and reflection before deciding what to do. It had to learn fast and apply what it was learning in real time. China was just the first. In the end it was going to be necessary for all governments to learn from other governments and learn from their own trial and error experiences in responding to COVID-19.

At a quite early stage in this global human crisis, ideas were emerging about the governance of the COVID-19 epidemic within individual countries and the strategies that might prove best for responding to it and exiting from it. The pattern of spread made it possible for lessons in the public governance of COVID-19 to be learnt from the successes and failures of the countries that were earlier in the epicentre of the international transmission of the infection wave.

It was to be expected that there would be major variations in the ability and willingness of governments to take part in the race to learn about COVID-19 and how to respond to it. All manner of things could also be expected to detract from both the ability and willingness to learn.

The delivery by government of its response

A number of factors might have been important in the actions and events of government responding to COVID-19. According to a WHO official:

What's been remarkable in this is that countries have done slightly different things according to their context but what countries that have been successful have done is they've taken all of those measures; they've been very, very serious about community engagement, they've been very,

very serious about educating people and bringing the community along with them, they've been clear in their communications, they've let the response be driven by science. They have implemented and tried to sustain surveillance and finding the virus at all times during the response even though it's very, very difficult when you have very intense transmission. They have focused on targeting their public health and social measures and sustaining those measures and only lifting those measures when they see indications that they're making progress. (WHO, 2020d)

The factors that are important for an effective government response to COVID-19 might be complex to understand - especially if they interact to produce success in practice. It might take much analytical work in the future to properly disentangle what factors mattered and how they related to each, but some possible factors include:

- a. Effective and credible governance processes
- b. The speed of political decision making and the agility of the civil service in adapting and responding
- c. Government communications to the public
- d. Governmental and societal persistence and patience
- e. Public trust in government and support for the measures being deployed
- f. The use of scientific knowledge to design government strategies and responses
- g. Applying global lessons but adapting the lessons to a local context

Implementation challenges

Many countries went into a lock down quite quickly. In contrast, it was frequently said that managing a transition out of a lock down would be slower and a difficult and complex process. If there was no "one size fits all" (WHO, 2020c), the need to analyse the situation and design a transition path would be part of the complexity of the transition.

Health systems did not just have to cope with treating those who were very ill with COVID-19. It was also understood that there were still many other health needs and elective surgery plans to be taken into account when devising the re-purposing of the health systems to cope with the emergency situation.

In developing countries, troubled by losses in income and having limited access to societal social protection, the impact of COVID-19 on education, health, food security and human rights could prove severe (United Nations Development Programme [UNDP], 2020, p. 1). Poor access to basic essentials like water and even soap and inadequate communal facilities and resources might exacerbate the situation.

Communicating with the public

Most commentators accept that communications with the public to ensure trust and support for what the government is doing is crucial. Public trust in the government will probably be important for the success of some public health measures being used by government as part of a strategy for responding to an epidemic. Public trust and support for government might be boosted by government investing time and effort into community engagement, which might itself depend on very effective government communications (Bol et al., 2020). It might be expected that communications need to be open and honest. Community engagement might also be expected to be boosted by government responsiveness to community concerns and preferences, and this might require effective channels for government to listen to the public.

In some countries, communicating with the public may be done through regular press conferences that may be televised. These may be backed up by televised ad campaigns, emails, and letters. It may be necessary to create special new channels for communicating to the public. In the case of Belgium, a crisis management unit (COVID-19 emergency unit) was established to better communicate with the citizens and ensure the coherence of the government message regarding the measures and public policies.

Coordinating, monitoring and evaluating

The locus for coordinating, monitoring, and evaluating the government response to a pandemic can be through a central ministry (health, interior, prime minister) or a specific department or agency (civil protection). Other countries developed multi-ministry task force/or a National Ministerial Committee (e.g. Singapore, Ethiopia, ...) for coordinating all the efforts in combatting the pandemic spread and impacts. In the case of Singapore, the rationale was to develop the ability to recommend and implement whole-of-government (WOG) policies to deal with issues related to COVID-19.

Sub-national authorities (regional, provincial, and local) can also play an important role in managing a pandemic. The sub-national level may be involved directly in decision-making or may be involved through consultation mechanisms. They may have operational and monitoring responsibilities. The precise details of their role depend on the institutional setting (which may take a variety of forms such as federalism, centralised government, decentralised government, and so on).

Build back better

In March 2020, the United Nations (2020) called on countries to learn from the COVID-19 crisis and “build back better”. This learning could be building

greater public governance capacity. It could be building greater social and economic resilience. It could be about fixing all the problems exposed by COVID-19.

The virus had very quickly exposed some chronic problems in social structures; where there were communities consisting of poor people living in overcrowded housing, infection and mortality rates soared or were the places where new outbreaks of the virus occurred despite the government having been able to control or even suppress it. The differential impact of the virus on black people in the US, for example, pointed to issues of equality and justice for all its citizens.

Joined-Up Responses

Government and public support

Pan Won – Soon, Mayor of Seoul in Korea has pointed out that transparency and speed have been two key factors that has assisted the City in “bending the curve” against coronavirus infections through pre-empted measures, which limited infections to 361 without any fatalities. Korea’s open democracy, mature citizenship, community spirit, personal hygiene and social distancing for two weeks contributed to the process (Andrews, 2020).

Whole-of-society approach

Preparedness for a pandemic requires the participation and involvement of all sectors of society nationally, hence the notion of a “whole of society approach” as advocated by the WHO. This includes:

- the national government leading on co-ordination/communication; legislation/policies; resources; capacity development and expected response action across sectors;
- the health sector for key clinical/epidemiological/virological information, which informs actions to decrease the spread of the virus and related morbidity and mortality;
- a diverse array of non - health sectors providing crucial services/operations to lessen health and socio – economic impacts;
- civil society organisations to raise responsiveness, candid communication and dispelling rumours and government liaison during the emergency; and
- Families/individuals who can decrease the spread of the virus through acceptance of distinctive actions, i.e. handwashing; isolation of persons with respiratory ailments voluntarily and coughing/sneezing covering the mouth) (WHO, 2009, p. 10).

Schwartz and Yen (2017) used a Taiwanese case study to demonstrate the benefits of the “whole-of-society approach” which included enhanced co-operation between state/local government and non-governmental actors resulting in a strengthened all-inclusive epidemic and response set-up.

Global solidarity

The COVID-19 pandemic has placed an intense focus on global governance systems and the effectiveness thereof in responding to the present crisis. Despite the obstacles in the path of international solidarity, there are repeated calls for more global solidarity. The spectacular success of the attempt in 2015 to unite the world’s leaders for the delivery of the United Nations’ Sustainable Development Goals shows that there is a genuine aspiration for more solidarity. The key questions are: can the possibility of a more united world be realised and can government leaders be mobilised to work across national boundaries to overcome COVID-19? It is possible, for good or ill, that the experiences of fighting the pandemic will have long-lasting implications for global governance, among other things (Kariuki, 2020).

Consequences

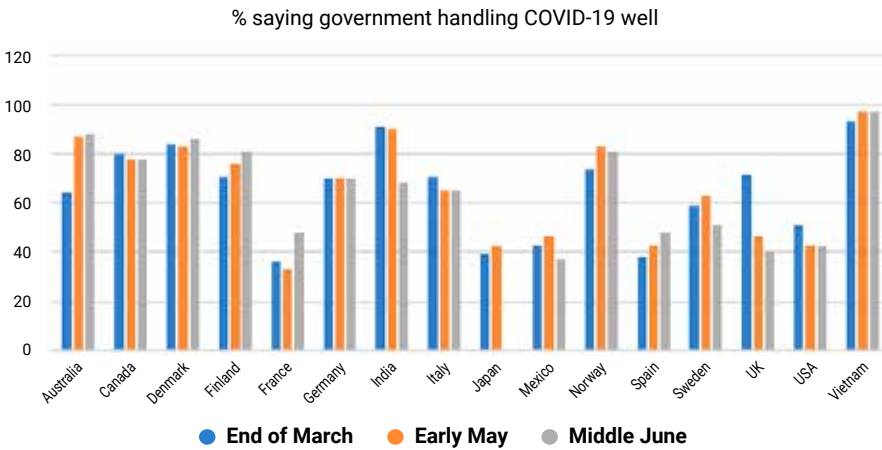
Public opinion and approval of government

There is bound to be a worry among some members of the public in some countries that their government is not doing enough to deal with the crisis and keep them protected. For example, some, possibly most, governments may wish to get society and the economy back to normal as soon as possible. Some governments may move quickly to end public health and social distancing measures brought in to protect the public. Such governments may be advised by scientists and medical experts to persist longer with the measures and be patient until the numbers of new cases occurring daily has dropped away and the transmission of the virus in the community has abated. But the government may feel a need to get the economy back to normal.

By the middle of 2020, it was clear that countries varied enormously in public perceptions of how well their governments had handled COVID-19. Although the readily available data on public perceptions presented here relates to just a small fraction of all the countries in the world, it can be seen quite clearly in Figure 2 that there was a lot of variation. Furthermore, the public perceptions of how well the government was doing looked more or less stable for some countries, but in a few there was a clear trend downwards or upwards over the period late March to the middle of June 2020.

Small percentages of people in France, Spain and Italy perceived that their governments had handled COVID-19 well. These were three countries that reported high mortality rates. Australia’s public appeared to become more positive in its evaluation of the government’s handling of the pandemic between the end of March and early May. Australia is a country which at this time had a low mortality rate. The public in the UK became noticeably much less positive about the UK government’s handling of COVID-19 in mid-June; it had a high mortality rate.

Figure 2 - Public Opinion on Government Handling of COVID-19



Source: YouGov (2020).

So, looking at these variations in public perceptions, it can be hypothesized that there will be a negative correlation between the percentage of people thinking their national government handled the pandemic well and the rate of death attributed to COVID-19.

But there were exceptions. One surprising case was Japan - a low percentage of Japan’s public thought that the government had handled it well. Yet at this time Japan had a very low mortality rate. Another exception might have been Mexico. It had a low percentage of people thinking the Mexican government had handled COVID-19 well. The death rate at this point was low. It is conjecture, but it is possible that public opinion is approximately right about government effectiveness and credibility in relation to COVID-19 and that this will be reflected in the mortality rate much further down the line.

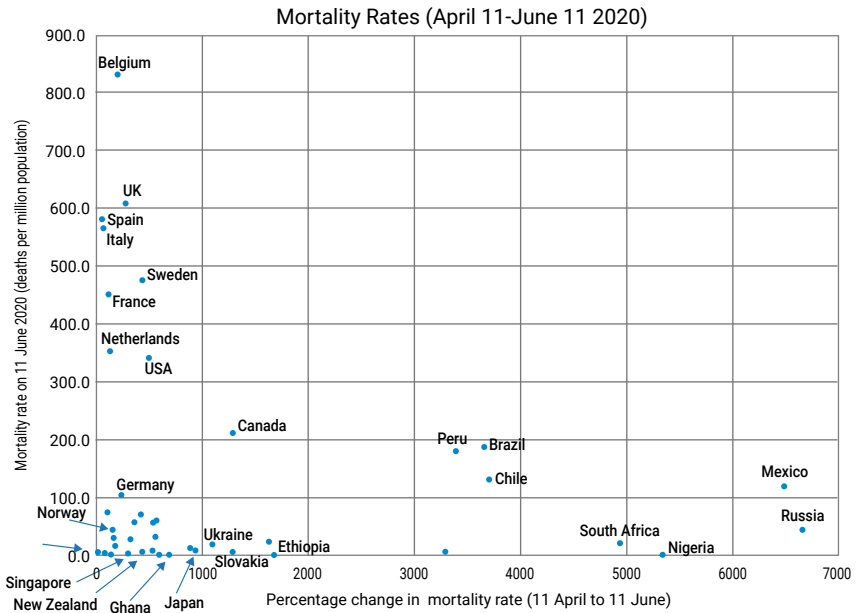
Mortality rates

From a public governance perspective, there were a number of countries that were the subject of much interest early on in the pandemic because they

were managing to keep the amount of infection and the rate of death relatively low. These countries included South Korea, Singapore Australia, and New Zealand. Then there were the puzzling cases, often in Europe, where infection rates and mortality rates climbed steeply in March and April 2020. Why did they – for example, Italy, Spain, France and the UK - have mortality rates far in excess of most other countries? What was special about this group of countries that made the COVID-19 epidemic so brutal? There were also quite different rates of increase in the mortality rate when countries were compared with each other for the months April and May, even though some of the fastest increases were occurring for countries with very low rates of mortality in March.

Answers to these questions will be explored further in the final chapter of this special report. At this point in the special report, Figure 3 is used merely to underline the existence of quite different patterns in the national mortality rates.

Figure 3 - Diversity of Mortality Rates and Trends (Early Phases to June 2020).



Note: Mortality data available at: <https://ourworldindata.org/coronavirus-data> [11 June 2020]

Source: Our World in Data (2020).

A provisional grouping of countries can be based on Figure 3. This grouping may be useful for the analysis of events between the beginning of January and until the end of May. The groupings may need to be revised as the epicentre of COVID-19 continues to change and if there are subsequent waves of infection. Four groups are identified and provide a loose fit with the data.

Group 1

This group of countries appeared to have largely succeeded in containing and controlling COVID-19. The countries included China, South Korea, Japan, Singapore, Australia, New Zealand, Germany, Norway and Finland. They appear in the bottom left of the scatterplot presented in Figure 3. It is notable that these countries are to be found in both East Asia and in Europe. It is also notable that the countries that were successful in the early phases of the pandemic conformed to no one particular type of state. It might be hypothesised that some of the countries were more authoritarian and could expect more public compliance with more stringent measures and that this was not possible in less authoritarian countries. This hypothesis does not stand up as a general explanation for this group of countries. They vary enormously in their constitutional designs and government institutions. Nor can the explanation be that they responded successfully to prevent loss of life because they had recent experience of SARS and were ready when the coronavirus emerged as a threat to the world – not all the successful countries were in the front line of earlier SARS outbreaks. Nor can the general explanation be that the group 1 countries prevented deaths and kept people safe because they were East Asian countries – because they were not all East Asian countries (Mahbubani, 2020). The final chapter of this special report will be analysing what was it about these group 1 countries that explains their good governance of the response to COVID-19. It will frame the analysis in terms of governance and no assumption will be made that good governance has to be based on particular ideas of democratic constitution, practice and culture.

Group 2

This group comprises a number of countries that appeared to lose control of the spread of COVID-19 but then had subsequently managed to halt or slow its further spread. Many lives were lost in the process. These countries include Belgium, the UK, Spain, Italy, Sweden, France, The Netherlands and the USA. They are grouped together in the scatterplot on the left hand-side in a zone that has a high total mortality rate in June 2020.

Group 3

This group consists of a quite geographically dispersed group which did not have a high total mortality rate in June 2020 but between the middle of April and 11 June, a period of about two months, there was a relatively high percentage increase in their mortality rate. They include some countries in the Americas (e.g. Mexico, Brazil, Chile, Peru) and some very big countries such as India, Russia, South Africa, and Nigeria.

Group 4

This group is the “other” group. It includes countries that had a relatively low mortality rate in June 2020. In the scatterplot they were located in a borderline

zone between the other three groups. This group, which one think might be in need of further consideration and splitting into more groups, includes the Ukraine, Slovakia, Canada, Saudi Arabia, and Ethiopia.

Overview of the IIAS special report

The IIAS Special Report furnishes an overview of the different national approaches to fighting the COVID-19 pandemic. At its core are the country reports centred on the national experiences and focusing mainly on the governmental responses. The country reports contain descriptions of the key measures implemented by the governments.

In the first section of the report (PART I), there are two papers that refer to the UN Sustainable Development Goals (SDGs). Geert Bouckaert compares the fight against COVID-19 and the implementation of the 17 SDGs making the point that they both require 'effective governance' and 'strong institutions'. John-Mary Kauzya revisits the relationships between citizens and state institutions. He analyses the governments and their relationships with citizens using the following terms: provider, defender, pacifier, collaborator, unifier, listener, enforcer of discipline, educator, strategic foreteller, and legitimate, credible trusted leader. It should also be underlined that COVID-19 was an interruption to the worldwide work on delivering the SDGs:

... because of the size, scope and pace of the pandemic, and the sizable capital outflows from developing countries, there is currently a significant risk that most political capital and limited financial resources be absorbed by the response and diverted away from the implementation of the Nationally Determined Contributions to achieve climate targets and the Sustainable Development Goals. It is vital that in the response to the crisis, countries keep the sustainable development goals and climate commitments in focus to hold on to past gains, and in the recovery, to make investments that propel us toward a more inclusive, sustainable and resilient future. (UN, 2020, p. 11)

Also in PART I, Rahel M. Schomaker, Moritz Kappler, and Michael W. Bauer use the first results of a newly developed survey. They elaborate on the pivotal role of citizens' trust in public administration and the government during the first wave of the COVID-19 pandemic. They refer to the issue of Public Administration increasing trust levels to ensure compliance and cooperation of citizens and stakeholders.

In the second section (PART II), there are eyewitness reports from civil servants and public managers. They present their point of view on the challenges of COVID-19. They identify the problems faced by the authorities in developing an effective response to the pandemic and lessons for ensuring the adequacy of actions, measures, and innovations.

In the third section, (PART III) national experiences from the different regions are reported. Contributions address national experiences of countries in Africa, Asia, Europe, North America, Latin America, and the Middle East and North Africa. This collection of country reports offers a ‘first reading’ of the responses of governments during the first phase of the COVID-19 pandemic and an overview of the various ‘logics’ behind the measures taken in response to COVID-19.

These contributions were prepared taking into account a framework devised around a Public Administration and Public Governance perspective. This framework included the following elements: institutional and organizational arrangements, preparedness of the governance system to respond to the crisis (especially, the health care system), the need for better coordination between the different sectors, coordination up and down levels of public governance, the interaction (including trust) between the different actors, the role of scientists and medical experts as advisers to governments, the communications with the public, and implementation issues.

The last section (PART IV) offers two comparative studies (Austria/Germany and Italy/ Switzerland) and a study providing a perspective on the role of ideological factors in the response to COVID-19. These illustrate the need to build on the eyewitness accounts and country reports by doing the necessary social scientific work to develop and refine models that help to understand the causes and effects and the means and ends that have been significant in national responses to the COVID-19 pandemic.

In the concluding chapter, the co-authors summarise the main elements of the challenging early period of the pandemic. They use the country reports to cast some light on the role of governance capabilities of effective governments, on the agility that learning, evaluation, and adaptability may have conferred on governments that succeeded in keeping infection and mortality rates low at least up until the end of May, and the way in which leaders may compensate for a lack of agility or cause agility to be compromised by political decision making.

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What the Coronavirus and the Sustainable Development Goals (SDGs) Have in Common: an Administrative Science Perspective

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Abstract

What have the fight of COVID-19 and the major global transformation programmes of realizing the 17 SDGs in common? Both conquering this major health crisis, which turns into a social, ecological, and economic crisis, and realizing the 17 SDGs need strong institutions with ‘effective governance’ and ‘effective government’. It could even be stated that the fight against COVID-19 would be much easier if the 17 SDGs were already realized. This contribution will critically review the notion of ‘effective governance and effective government’ which are needed for a shared agenda of handling this pandemic (and futures ones to come) and realizing the SDGs.

Keywords

Sustainable Development Goals, coronavirus, health crisis, global approach, coronationalism, global partnership

A Global and Systemic Governance Question

In Stanley Kubrick's famous 1968 movie '2001: A Space Odyssey', Dr Floyd travels to planet Clavius which is entirely locked down because, it is said, there is an epidemic affecting the whole planet. Fifty years later, what was visionary science fiction, has almost become reality. Planet Earth, or its continents, are locked down because of Covid-19 pandemic.

The impact of 'germs' affects entire societies, their systems of governance and functioning, and their power structures. According to Jared Diamond (1999) it is guns, germs, and steel that define the fates of human societies, obviously causing a lot of catastrophic transformations. This was also confirmed in Charles Mann's (2005; 2011) analyses of the history of the Americas. He explains in *1491* (2005) and *1493* (2011), how the year 1492, when Columbus discovered 'America', was a turning point, and how it affected the Americas mostly by deadly European diseases, which could not be managed.

Since human societies are also civilizations and cultures, there is also a cultural history of 'catastrophes' Walter (2008) describes how societies have shifted their paradigms to define and to capture catastrophes from a religious understanding to a scientific risk based interpretation. It is this cultural shift that was also captured by Mary Douglas (1986) in her (anthropological) work on 'risk'. Beyond an anthropological or cultural study, her work affected the field of governance and policy. Douglas and Wildavsky (1982) connected cultures of risk, and their assessments, to the governance of technological and environmental dangers, and the policies handling these.

This leads to the handling of risks of global economic, social, ecological and technological systems as a driving principle to administer, organize and govern our complex societal systems. This also leads to the questions of what sustainable global economic, social, ecological, and technological systems are, and how sustainable current goals, policies, and practices are, or not. This leads to the Sustainable Development Goals (SDGs) as a global agenda, also and especially for the field of Public Administration (PA).

From this point of view, establishing governance systems to prevent and fight pandemics, are immediately linked to establishing governance systems for realizing the seventeen SDGs, as part of a reduction of major risks of life-threatening catastrophes. Most probably, if we were to have realized already these seventeen SDGs, the risks of having pandemics would be much lower, and if they would occur, the handling would probably be much easier, with lower levels of direct and collateral catastrophic damage.

A strategic objective as the Public Administration community is therefore to use the debate about this pandemic to strengthen the discourse to realize

the seventeen SDGs, as (part of) a sustainable solution. A key question then becomes how our governance systems, including our government systems, should be (re-)organized to realize the seventeen SDGs, with a special focus on SDGs 11, 16, and 17. The focus that should be taken is a 'Whole-of-Society' approach (United Nations [UN], 2018; Cázarez-Grageda, 2018), which obviously includes a 'Whole-of-Government' approach (OECD, 2006).

This is a strategic focus for our PA-field which we need to develop and maintain in all regions. For that purpose, a strategic reflection about how our PA teaching and research should be developed for the next two decades, given the cultural and institutional regional and national differences in a globalized world. For that purpose, based on the American Minnowbrook Perspectives (1968; 1988; 2008) (Nabatchi & Carboni, 2019), the European Group for Public Administration (EGPA) developed, in 2018, the European Perspectives for Public Administration (EPPA) to anticipate and to keep the agenda of how PA will remain part of a solution for societal problems (Bouckaert & Jann, 2020). It is clear that copy-pasting past models of PA teaching and research will not match future societal and governance problems. It will be necessary to re-organize our PA teaching and research to include systematically 'futures', to connect in a much better way current and new disciplines within the academic field of PA, to take cultural differences much more into account, and to re-establish and imply in a pro-active way practice and policy makers to remain relevant in a visible way.

Global problems should also be addressed globally. However, global problems will also need regional, national, and local approaches and responses which may be varied and will be different, but that need to be integrated, coherent, consistent, and converging. Our comparative research on how four European countries (Belgium, France, Germany, and Italy, within the EU context) have initially handled the COVID-19 crisis demonstrates clearly that it was national countries driving solutions as Corona-nationalism, or Coronationalism (Bouckaert et al., 2020). National governance and national governments are necessary, however, are not sufficient at all. Pandemics cross borders and need a co-ordinated global approach, not just a national one. Closing borders is not sufficient to limit interventions to national interventions.

Developing these global, regional, national, and local approaches and responses is certainly a responsibility of our global, regional, national, and local PA communities. This is the bridge where PA academic experts and practitioners should meet. This is also the arena where regions should meet and generate dialogues to share problems and solutions for the future. This is an opportunity for PA, as administrative sciences, to remain scientific and relevant at the same time.

Alongside this logic, the focus of this contribution is on realizing the SDGs, as a frame and a condition to prevent and fight pandemics and other major and global risks in our future societies at Planet Earth.

Some Governance Lessons Learned Until Now

There is increasing evidence that COVID-19 will have dramatic impacts on our economic, social, and ecological systems with increases of e.g. poverty levels (Sumner et al, 2020), unemployment, and health (UN, 2020). Nevertheless, there is also an increasing conviction that “while we deal with the crisis, we must use the opportunity to recover better and build sustainable societies” (UN, 2020, p. 22).

There is an obvious component within Public Administration of crisis management (Boin et al, 2016; Boin & Lodge, 2016), and of crisis or innovation driven topics of change, transition, and transformation (Fernandez & Rainey, 2006; Osborne & Brown, 2005; Grin et al., 2010). Other related literature is on handling policy failures (Peters, 2015) or blame avoidance (Hood, 2010).

Some initial governance lessons from comparing four EU Countries resulted in diverging and not always optimal experiences with monitoring systems, learning, decision making, co-ordination, communication, leadership, and capacity building (Bouckaert et al., 2020).

Similar Elements of Administrating, Managing, Governing Risks, Pandemics, and SDGs: Crises as Opportunities to Realize SDGs

From 2000 till 2015, the Millennium Development Goals (MDGs) objectives were focusing on developing countries, and were designed as an initiative of the UN Economic and Social Council. These Objectives were expanded and continued as Sustainable Development Goals (SDGs) (2015-2030) around five P's: People, Planet, Prosperity, Peace, and Partnerships. These seventeen SDGs are operationalized in 169 objectives and 232 indicators which are monitored and reported to a High Level Political Forum, which also discusses Voluntary National Reviews, and intermediate evaluations.

Next to fourteen policy field related SDGs, there are three horizontal SDGs which have a governance focus to help realize all SDGs. These three specific SDGs are 11, 16, and 17, which need to be realised globally, continentally, regionally, nationally, and locally.

SDG 11 states:

“Make cities and human settlements inclusive, safe, resilient, and sustainable”.

Globally, cities are still expanding and attracting major proportions of populations. On the one hand, sizes of cities, as mega-cities, risk to become the opposite of inclusive, safe, resilient, and sustainable. On the other hand, there is an awareness that cities become major drivers of our human systems. However, cities depend not just on their proper governance, but also on their interaction with rural areas and other cities for traffic of persons, and for goods and services.

A range of issues and questions emerge when future cities have to be developed:

- is there an optimal or functional size for cities? In many countries, amalgamations have pushed for realizing economies of scale, mostly taking this into account as an economic agenda, more than a social or ecological agenda.
- how to take an increasingly hyper-diversity of populations into account? For effectiveness reasons, this probably requires a matching level of diversity of service delivery and policy instruments taking languages, religions, and ethnicities into account.
- in liberal democracies, the trust-levels are higher at the levels of local government, compared to central government. How is it possible to keep and maintain these trust-levels, given an increasingly polarized political climate which is enhanced by crises?
- how could rural regions remain attractive for populations? A major driver for domestic migration to cities is a reality of exclusion and lack of access to goods and services like hospitals, schools, or the labour market.

SDG 16 states:

“Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable, and inclusive institutions at all levels”.

CEPA, the Committee of Experts on Public Administration of ECOSOC/UN developed a set of eleven principles for SDG-governance. These principles are built around three clusters: effectiveness, accountability, and inclusion (ECOSOC/CEPA, 2018).

This implies a ‘whole of government’ approach which reaches out to a ‘whole of society’ approach.

SDG 17 states:

“Strengthen the means of implementation and revitalize the global partnership for sustainable development”.

It is interesting to see that SDG17, Partnerships, is not a means to an end, but an end objective and ultimately a goal by itself. The ultimate reason is that partnerships and all types of cooperation require and contribute to trust between actors, and therefore to societal trust between actors. It is necessary to have sufficient trust levels between citizens, but also between levels of government, and between politics and administration, and also between citizens and the public sector and its government. Crises are a kind of test for trusting governing leaders, including political leaders.

Conclusion

Three SDGs, 11, 16, and 17, need to be realized globally, continentally regionally, nationally, and locally. This will require functioning ‘hierarchies’, ‘markets’, and ‘networks’, governance and meta-governance (Meuleman, 2018) in a multilateral context, to re-establish functional and equilibrated globalism with regional and national solidarity. The field of PA needs to take the lead to develop models for implementation from a ‘whole of society’ perspective with a ‘whole of government’ approach.

To have these SDGs realized will then possibly reduce the risk of major crises, and it will enhance the capacity to handle the consequences.

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Reflections on the COVID-19 Pandemic and its Impact on the Implementation of the 2030 Agenda for Sustainable Development and SDGs

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Abstract

The values and principles of the 2030 Agenda for Sustainable Development matter even more during the ongoing COVID-19 pandemic. The pandemic has posed challenges to the values and principles enshrined in the 2030 Agenda. They include equity, equality, inclusion, effectiveness, accountability, integration, peace and security justice, respect for diversity, resilience, innovation, collaboration, partnerships and leaving no one behind. The pandemic has disrupted efforts to deliver the SDGs. It should trigger a consideration of the true meaning of SDG 16 with its concern for strong, effective, inclusive and accountable institutions. This contribution reviews the multiple relationships between state institutions and the citizens and the variety of roles the state plays, namely, provider, defender, pacifier, collaborator, unifier, listener, enforcer of discipline, educator, strategic foreteller, and legitimate, credible trusted leader. The conclusion advises governments to ensure that the citizen has access to services that go into achieving the SDGs. The state should put in place policies, strategies, and institutionalized means of ensuring social protection for its citizens - especially the very poor and vulnerable. The pandemic has provided an opportunity for governments and people to strategize on how to develop state institutions that provide for, protect, defend, collaborate with, unify, facilitate, and listen to the citizen. While this pandemic has caused suffering to people, the moment it has provided for planning and rebuilding better in pursuit of achieving the SDGs should not be lost because that is what a resilient society is always about.

Keywords

Sustainable development goals, COVID-19, impact, values, citizens, state, role/ obligations

¹ Disclaimer: Dr. John-Mary Kauzya is the Chief of the Public Service Innovation Branch in DPIDG/UNDESA. However, the ideas expressed in this paper do not represent the United Nations. They are his own reflections on the COVID-19 pandemic and the 2030 Agenda.

Introduction

The 2030 Agenda for Sustainable Development has 17 Sustainable Development Goals (SDGs) in respect of social, economic, and environmental pillars of sustainable development. The goals provide a target for a global strategy aimed at creating resilient and good societies focused on people, planet, prosperity, peace, partnership, eradicating poverty, and leaving no one behind. The Agenda embraces the values of equity, equality, inclusion, accountability, integration, peace and security, justice, respect for diversity, resilience, collaboration and partnerships, prosperity, leaving no one behind, innovation and others. A resilient good society is premised on these values and principles. In September 2019, an assessment was made of the progress made in delivering SDGs. It emerged that progress has been slow and there was concern that many countries might not achieve the SDGs by the deadline of 2030.

It is in this context that the COVID-19 broke out. What had started as a threat to the health of people in a small number of countries in January and February 2020 quickly turned into a pandemic and affected the lives of millions of people. Many people were infected and many have lost their lives; and it is not over yet. The pandemic has been very disruptive to the efforts being made to deliver the SDGs. The extent and impact of this disruption is not yet fully known, mainly because the pandemic is still raging and the virus still spreading. This contribution looks at the disruption and impact using the lenses of governance and public administration and framed in terms of the values and principles enshrined in the 2030 Agenda documents. It looks at the implications of the pandemic for the governance relationship between the citizen and the State, which is the subject of SDG 16, with its reference to effective, inclusive and accountable institutions.

A Difficult Test for the Values and Principles of the 2030 Agenda

In the socio-politico-economic, management of society, values and principles matter. They do so even more during a crisis when they are most likely to be violated. The covid-19 pandemic has posed challenges to the adherence to these values and principles.

The impact on lives has not been equal across all countries or segments of societies. The Secretary General of the UN pointed out that the world's one billion people living with disabilities are among the hardest hit by the covid-19 and called for them to have equal access to prevention and treatment. The

Pandemic is exposing the extent to which some people are marginalized and is also intensifying the inequalities that people with disabilities already face (such as poverty and higher rates of violence, neglect and abuse). The following quotation sums up the unfortunate disregard for the values of equity, equality and respect for diversity exposed by the pandemic:

“COVID-19 has ripped off any cover that still obscures the deep inequalities burdening communities of color in America — inequalities that have in a few months’ time become too obvious and too ugly for the rest of us to ignore. Americans at large are now clearly dependent for their sustenance, if not their survival, on their countrymen of color, on recent immigrants and on those with different-sounding names: the medical personnel, the food industry, public transit and nursing home workers, and many others”. (Robins, 2020)

Many societies, people and communities that were struggling not to be left behind are being pushed further behind by the impact of the pandemic. Some well-to-do nations have already shown hesitation in committing resources to less fortunate countries to assist in containing the pandemic hence endangering the principle of collaboration and partnership. According to the UN Deputy Secretary-General, the COVID-19 pandemic is “exposing the frailties and inequalities of our societies” (UN News, 2020). As governments struggle to contain the pandemic and protect the people, special care needs to be taken to ensure that good governance and the values of the 2030 Agenda do not become the victims of the pandemic. Antonio Guterres (2020), Secretary General of the UN, has stated that:

“This pandemic is not only challenging global health systems, but our commitment to equality and human dignity”.

Impact on Delivery of Services Disrupt Achievement of SDGs

Achieving the SDGs depends on the extent to which services get delivered to all. While the commitment to sustain the implementation of the 2030 Agenda to achieve the SDGs has been echoed by many global leaders, the pandemic is eroding some of the achievements that had been registered and is making the struggle to deliver the goals harder.

For example, it has jeopardized educational systems since more than 180 countries have imposed school closures.

The COVID-19 pandemic is straining health systems worldwide. The rapidly increasing demand on health facilities and health care workers has left some health systems overstretched and unable to operate effectively.

Impact on poverty and food security

The coronavirus pandemic has had severe negative impacts on economies, businesses, and social interaction and countries have sunk deeper into unemployment. For example, in the USA more than 33 million Americans have filed for unemployment during the pandemic. Guy Ryder, ILO's Director-General, has highlighted the need for a speedy response:

“Workers and businesses are facing catastrophe, in both developed and developing economies. We have to move fast, decisively, and together. The right, urgent, measures, could make the difference between survival and collapse.” (International Labour Organization [ILO], 2020).

The lockdown and containment measures taken by many countries have increased poverty levels among the world's informal economy workers in low-income countries. The measures have also, as the ILO noted, hurt informal workers in higher income economies: “in high-income countries, relative poverty levels among informal workers is estimated to increase as well as in upper-middle-income countries”. (International Labour Organization [ILO], 2020).

Unemployment and rising levels of poverty due to the pandemic have reduced the food security of many people. According to the UN Food and Agriculture Organization (UNFPA), 820 million people were already undernourished before the pandemic – including 135 million people experiencing acute food insecurity. The COVID-19 pandemic has made the situation worse by impacting on the food supply chain and access constraints at country level.

Reflecting on the Governance Relationship Between the State and the Citizens During the Pandemic

As a consequence of the struggle to contain or stop the spread and devastation of the virus, the Pandemic has challenged the governance relationship between the State and the citizens. A pandemic of this magnitude and severity has to massively test and challenge this relationship in each country and force reconsideration of the roles, obligations, responsibilities of one and the other. It was the case during the 2008 global financial crisis, and it is the case again during this COVID-19 pandemic.

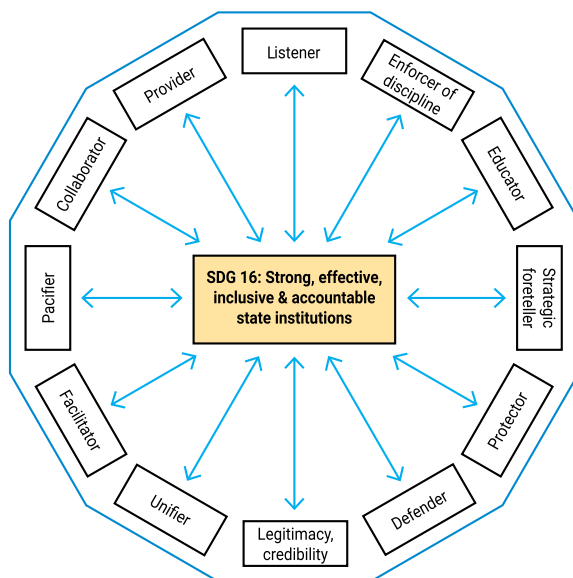
In times of crisis, citizens turn to the state as provider, protector, defender, facilitator, informer and educator, organizer, pacifier, and guarantor of the continuity of national life economically, socially, politically, and otherwise. Ironically, it is during crisis that the capabilities of the State and its institutions to effectively play these relational roles get challenged. The strength,

effectiveness, inclusiveness and accountability of institutions can be best understood by reflecting on the relational roles between the State and citizens in the context of the pandemic.

The state as provider

Normally depending on the politico-economic and ideological orientation of the country in question, the state provides certain services like health, education, infrastructure, information, and justice (free, subsidized, or fully paid for by the citizen as a consumer). But in a severe crisis such as the current pandemic the relationship of provider can be stretched. From Rwanda and Uganda where government is distributing foodstuffs and other essentials (maize flour, beans, sugar, salt, soap etc.) to the poor and vulnerable; to the USA where the Federal Government promised to give money to people and businesses based on income levels and family size to cushion them against the difficulties caused by the pandemic; governments, irrespective of their economic development levels, are manifesting their provider relationship with their citizens.

Figure 1 - 12-points relationship between State institutions and citizens: the gauge of SDG 16



Source: The diagram was designed by the author

The state as protector

The state as protector of its citizens, especially the very poor and vulnerable, including children, the elderly, people living with disabilities and others is called upon to protect citizens during a nation-wide crisis. However, in the perspective

of a resilient society and a resilient state, the role of protection need not be invoked only during a crisis. The modality of social protection and social security needs to be set forth strategically to make life predictable for such vulnerable sections of the society both during normal times and during crisis.

The state as defender

During the COVID-19 pandemic the role of the State as defender of its citizens has manifested itself prominently. The State defence mechanisms in many countries have been deployed to defend the citizens. In China, Italy, USA and other countries, the Army and police have been mobilized to engage in activities that defend the population against the COVID-19. In China, the army constructed hospitals and deployed medical experts and volunteers in hospitals and treatment centres to fight the virus. In the USA the Army deployed field hospitals, for example in New York, and its scientists joined other researchers in the search for a vaccine against the virus.

The state as pacifier

The current COVID-19 pandemic crisis where the cure is unknown and the spread of the virus is rapid, there is a tendency for the population to panic. The state in such cases needs to play the relational role of “pacifier” to calm down the emotions of the citizens thus creating enabling conditions for a rational search for a cure or solution to the crisis. This largely depends on the leadership of the State and the nature and content of the messages conveyed to the citizens with empathy, integrity and humanness.

The state as a collaborator

To address the crisis, the State needs to be a collaborator, creating partnerships with civil society and the private sector. It needs to do this not only in a whole of government but a whole of society approach, to engage all active people in the efforts of finding solutions and saving people. Beyond the national level, collaboration and partnerships need to be established with global actors in a whole of the world approach, especially if the crisis is a global one such as the COVID-19 pandemic. Government medical researchers are working with their counterparts in the private sector and civil society to find a vaccine for the virus. Governments are collaborating with WHO and other International organizations in efforts to contain the virus. It is understood that in an interconnected world this Pandemic cannot be solved by a single country on its own. The 2030 Agenda had already foreseen that partnership needs to be the prominent approach to the achievement of SDGs. SDG 17 is focused on partnerships.

The state as unifier

A crisis such as the current COVID-19 pandemic can easily divide a society as people look for who to blame for the cause of the crisis. This can be on geographical, racial, religious, economic, gender or age-group basis. In such

cases, the State has to relate to the citizen as unifier and not allow the country to face disintegration in addition to being under the threat of the crisis. It is in such efforts to maintain the unity of the country that a whole of society approach can be of great use.

The state as facilitator

As the crisis spreads many individual citizens, many private enterprises (e.g., small and medium and even big business enterprises) will be struggling to find solutions not only to the crisis but also as means for their survival. In this case the State needs to facilitate their efforts. The state may also first rescue those that are sinking before facilitating them to stay afloat thus combining the roles of facilitator and rescuer

The state as listener

The governance relationship between the State and the citizen during a crisis of this magnitude must be based on listening to each other. A crisis normally produces a lot of noise and listening is most likely to be a victim of the crisis. The citizen needs to listen to the State and to channel their demands through designated channels and the State needs to listen to the citizens because in most cases citizens do understand the problems and challenges of the crises and often have solutions to propose. Among citizens there are experts who have knowledge about the crisis. Some are health and medical workers who clearly understand how to handle health challenges, some are researchers who can deploy their research acumen to arrive at a solution. Some are sociologists who may have clues as to how society should handle the challenges caused by the crisis, and so on and so forth. It is, therefore, of great importance that mutual listening becomes prominent in the relationship between the citizen and the State.

The state as enforcer of discipline

As the COVID-19 Pandemic has shown, some citizens may not follow the guidelines given by the national or local authorities and in this way could endanger the rest of the population. From Wuhan in China where tens of millions of people were put under lockdown and drones were seen enforcing the lockdown telling people to stay inside, to Italy where the whole country was put under lockdown, and to the USA where the New York Governor ordered a containment zone in New Rochelle, efforts of enforcing the discipline and measures of containing the pandemic are demonstrating the role of the State as enforcer of discipline to protect the citizen. While the controversial and stringent measures of lockdown have been adopted by many countries around the world in an effort to stop the spread, they have been seen as not only controversial, but also as violating human rights and freedoms by others. For example, in Malawi the court blocked the Lockdown (Aljazeera 2020). Nevertheless, autocratic and

democratic States around the world have demonstrated the necessity of such measures to enforce protective discipline. Liberal democracies are worried that democracy and freedom could easily fall victim of the fight against the COVID-19 pandemic. Autocratic States are worried that over emphasizing the democratic freedoms of individuals could jeopardize the safety and health of the citizens. Somewhere in the middle of these two worries lies the necessity of enforcing discipline to ensure the survival of all citizens. A lapse in this relational role could easily create situations where the virus spreads faster than it can be contained.

The state as educator and informer

There is a lot of rumours around the COVID-19 pandemic. These rumours normally cause fear and jeopardize the efforts of fighting the virus and containing the pandemic. The citizen looks to governments to provide credible information based on facts. Credibility here depends on the trust the citizens have in government. But it also depends on the way, and through whom, the government provides constant information to the citizens. Normally when they are experts, in the case of the COVID-19, if they are medical and public health experts the facts and information, they provide without contradicting themselves are most likely to be believed and followed. These days data and information can be easily and rapidly gathered, analysed and shared using information and communication technologies. But so can false information and manipulated data. Playing its relational role of informer and educator the State must master these modern technologies and structure their operation in such a way that they constantly counter false information and manipulated data with facts and reliable data sources.

The state as a strategic credible foreteller

Being a scientific foreteller or prophet who has the ability to guide the citizen through the unknown and finding the solutions to tomorrow's problems today is critical. "If we wait for a pandemic to appear, it will be too late to prepare" (Bush, 2005). Playing this role calls for having sufficient data and analytic capability to enable the state to analyse and understand different sources and trends of problems nationally and globally that can degenerate into crisis and to make provision for them even before they occur. It also calls for putting in place infrastructural arrangements that enable the State to continuously monitor the pandemic and putting in place means (including budgets). In the case of the COVID-19 pandemic, a robust public health institutional infrastructure should have been in place to guide governments and other actors to identify the pandemic early enough and act quickly to avert the negative impacts. The COVID-19 pandemic has exposed the weaknesses of state institutions in this regard and should cause evaluation and reflection in order to put in place an institutional infrastructure that can avoid a repeat of such a pandemic.

Legitimacy, credibility and trust as the bedrock for State/citizen positive relationships: The effectiveness and inclusion of state institutions thrives on the trust of the people. This largely depends on whether the citizens perceive the State institutions and leadership as legitimate and whether there is a high level of trust between the citizens and government leadership and public service. The way the crisis gets handled may enhance or diminish the trust the citizen has in government institutions and leadership. A crisis even as serious as the current pandemic can provide an opportunity for enhancing the trust the citizen has in government. Finally, legitimacy, credibility and trust are necessary for the citizens to have hope and to offer obedience, discipline, support, and collaboration all of which are important for the State to relate well with the citizens in times of crisis.

Conclusion

The COVID-19 pandemic is primarily a health and medical crisis. However, its management has far reaching implications for the relationship between the State and the citizens as well as on the functioning of the state institutions. As such, the pandemic provides a moment for the State and citizens to reflect on the governance relationships needed for resilience, sustainability, and the wellbeing of societies. This COVID-19 pandemic, has provided a moment for each government and indeed the whole world to put in place governance and public health infrastructures that can foresee and identify pandemic quickly and respond to them quickly to minimize the suffering of citizens. It is serving to alert us to the need for strong, effective, inclusive and accountable institutions (as emphasised by SDG 16). This requires the state develops processes and capabilities to play its relational roles vis a vis the people, especially in a crisis such as the one the world is going through currently.

It should not take a pandemic or a crisis for the State to figure out how to provide critical services to its citizens. 193 Member States of the UN had already agreed that Governments have to champion the achievement of the SDGs leaving no one behind. This translates into ensuring that the citizen has access to services that go into achieving the SDGs. Long term policies and strategies need to be designed, agreed and implemented to effectively provide services especially to the needy and vulnerable populations. In playing out its relationship as provider, the state ought to balance ensuring that the citizen has access to services and avoiding creating a dependency syndrome and a widespread mentality of entitlement among citizens.

The COVID-19 pandemic has underscored the need for the state to put in place policies, strategies and institutionalized means of ensuring social protection for its citizens especially the very poor and vulnerable. Social protection has to

be designed to cover as large a percentage of society as possible, reduce poverty and inequality, promote economic investment and growth, and support social inclusion, social cohesion, state building and political stability. The biggest lesson learnt here is that the State should not wait for a crisis to put in place social protection mechanisms. Rather the social protection mechanisms should be designed with possible crises such as the COVID-19 pandemic built in to avoid panicky search for protection solutions when a crisis arises. Even though the COVID-19 pandemic has disrupted capacities for providing services and caused setbacks in achievement of the SDGs, it has provided an alert and an opportunity for governments to strategize on how to develop state institutions that provide for, protect, defend, collaborate with, unify, facilitate and listen to the citizen. It has highlighted the need for legitimate, credible and trusted leadership in all institutions of governance across all sector and levels of society for challenges such as this pandemic to be addressed. While this pandemic has caused suffering to people, the moment it has provided for planning and rebuilding better should not be lost. That is what a resilient society is about. This may not be the last pandemic the world has suffered. What matters now is to get out of it better equipped to achieve the SDGs and better prepared to manage the next one with less or no damage.

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Citizen's Trust in Public Administration in Times of Crisis – Evidence from the COVID-19 Pandemic

Administrative Behaviour in Times of Crisis

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Abstract

Each crisis is dreadful in its own special way, and so is the COVID-19 pandemic. Both the lockdown and the first careful exit-steps in their entire complexity increase scope and scale of PA's tasks and responsibilities, challenging not only health authorities, but all parts of the administrative system. Taking stock of first empirical insights from a newly-developed survey, we elaborate on the pivotal role of citizens' trust in public administration and the government in the COVID-19 pandemic, changing patterns of trust in the context of the crisis, and potential leeway for administrations to increase trust levels to ensure compliance and cooperation of citizens and stakeholders involved in PA crisis reaction.

Keywords

Citizens, trust, crisis, COVID-19 pandemic, administrative behaviour, evidence

Introduction

Each crisis is dreadful in its own special way, and so is the COVID-19 pandemic. Beyond its lethal nature and truly global spread, one of its characteristics lies within the detachment of cause and effect. The cause, i.e. SARS-CoV-2, can clearly be attributed to health issues, though the COVID-19 pandemic challenges entire public administration (PA) systems well beyond the health sector. Both the lockdown as executed and the first careful exit-steps in their entire complexity increase scope and scale of PA's tasks and responsibilities, challenging not only health authorities, but all parts of the administrative system, from security administration to public service delivery, with the entire world remaining in "very turbulent water" (Kluge 2020).

Addressing administrative reaction in the time of the pandemic, a feasible strategy is to take stock of what previous crises have taught regarding the challenges for administrative systems (Boin & Lodge, 2016; Lalonde, 2007). Generally, "crises" in the sense of exceptional situations that challenge the PA can be grounded in both, either in an objective fact, or in a social construct, as "endemic problems periodically rise to the level of what we characterize as 'crisis' (Koven, 2018, p. 1). Being textbook examples for "nonroutine" or "wicked" problems (Kettl, 2005; 2006), crises are "characterized by high consequentiality, limited time, high political salience, uncertainty, and ambiguity" (Moynihan, 2008, p. 351).

Thus, the question arises how the PA should react to ensure high performance in times of crisis. In a nutshell, PA's crises reaction can either uphold the present path of behaviour, or be innovative, including even in engaging in disruptive adjustments in procedures and structures. Accordingly, there is an inherent trade-off between a desired return to the *status quo ante*, and a more progressive approach with crises as the source of change and innovation.

Since response speed is critical for success, complex restructuring and the implementation of new procedures is mostly out of reach. Consequently, the conservative approaches promise the less risky and allegedly more efficient and more effective option. Paradoxically, it is exactly these new problems that arose from and develop within extraordinary circumstances whose mastery may require new and distinctive strategies (Hartley et al., 2013; Kettl, 2006; Lalonde, 2007).

Crisis reaction can either be executed in strengthening the centre's top-down steering capacity or in empowering decentral capacities, intensifying horizontal information exchange (Moynihan, 2009, p. 897). The aggregation of competences or centralization is frequently discussed as superior in terms of

speed of response and coherence of decisions that are of utmost interest since a crisis may pose “a serious threat to the basic structures or the fundamental values and norms of a system” (Boin & Lodge, 2016, p. 2). Hence, there is a lot at stake, and one may refuse to jeopardize it by the usage of *a priori* not finally defined strategies. It is a general characteristic of crises that the correspondent high levels of ambiguity and uncertainty cry for clarity and, therefore, provide breeding ground upon which the appeal of strong leadership can gain momentum (Peters et al., 2011).

Nonetheless, decentrally structured networks stand out for their capability to adapt effectively to local circumstances. The consideration of peculiarities regarding space and time may give such design of crisis management an edge, as managing a crisis successfully “requires gaining consensus or at least acquiescence across the society and decentralization may be a useful strategy for producing that legitimacy for the proposed changes” (Peters et al. 2011, p 18). Following these lines, cooperative measures that include the civil society as an active and responsible partner of public crisis management, have the potential to spread the administrative burden over more shoulders. Such joint strategy might be of particular interest in crisis situations such as the one the world is witnessing today in which every aspect of the PA system is “under attack” and PA’s capacity is becoming a scarce resource. Furthermore, the inclusion of the civil society may allow for a new quality of the existing capacity inasmuch such cooperation allows for broadened knowledge exchange, sharing resources, and creating new ways of thinking (Edlefsen & Staemmler, 2018; Bovaird, 2007; Ostrom, 1996). On that account, innovative collaborative action is more than just a deviation from the conservative path, but it allows for “the identification and the embedding of practices and behaviours by the network to improve crisis response” (Moynihan, 2008, p. 351), hence depicting a valuable strategy for coping with crises (Torfing, 2016).

Citizens’ Trust in PA

Along these lines, it is trust that becomes of pivotal relevance for administrative behaviour in crisis reaction for several reasons. Trust substitutes for control, thereby enhancing in particular performance of cooperative management whenever citizens’ cooperation and compliance may be conducive (Edelenbos & Klijn, 2007; Klijn et al., 2010; Schomaker & Bauer, 2020). This is once more important as cooperative approaches of public management come along with very restricted enforcement mechanisms, but rely on compliance (Chanley et al., 2000; Scholz & Pinney, 1995). Along the same lines, the positive effect of trust as generally decreasing transaction costs results from compliance and cooperative behaviour without applying

additional (costly) safeguards as e.g. monitoring or sanctioning mechanisms (Klijn et al., 2010). Thus, independent of the crisis reaction governance chosen, trust is pivotal since it increases the probability of citizens “to comply, obey rules and regulations” (Van de Walle, 2017, p. 118).

In general, trust can be defined as a “psychological state comprising the intention to accept vulnerability based upon positive expectations of the intentions or behaviour of another” (Rousseau et al., 1998, p. 393). Within the context of the PA, in particular the following factors are discussed as being trust-creating: reliability, predictability, ability, consistency, competence, routine, and integrity (Bouckaert, 2011). In an attempt to cluster these drivers of trust, one may follow Rousseau et al. (1998) by differentiating citizen trust in a calculative and in an emotional type which are based on the – perceived or experienced – ability, benevolence, and integrity (ABI) of the trustee (Mayer et al., 1995).

The calculative type of trust is rational in nature and depends on the expected returns; a simple weighting of costs and benefits. Informing the variables of the underlying calculation, (credible) information takes a pivotal role in the creation of trust and may come along either as product of personal experience (Van Ryzin, 2006; Kampen et al., 2006; Grimes, 2017) from former interactions or through indirect information (such as available performance information) (van der Meer, 2017; Kumlin & Haugsgjerd, 2017; Radin, 2006; Van de Walle, 2017; Van Ryzin, 2011). Indeed, calculative trust can be steered relatively well by the PA but comes at a (transaction) cost. Calculative trust, requires an effective control, reward and deterrence system that allows for the trustor (the citizen) to form expectations about potential gains and losses resulting from specific behaviour (Van de Walle, 2017; Williamson, 1993). Second, there is strong evidence that both negative personal experience and negative impersonal information have a greater effect on trust levels compared to their positive counterparts (Kumlin, 2007; Kampen et al., 2006; Van Ryzin, 2006).

Emotional trust is built through a complex and lengthy process in which trust is based on common identification, including the reciprocal understanding and appreciation of one another’s needs and interests (Lewicki & Bunker, 1996). Beyond performance measures, trust built upon a common cognitive frame allows to evaluate if the counterpart acts in line with someone’s own ideas of “...normatively desirable behaviours or end states” (Edwards & Cable, 2009, p. 654). Accordingly, the fit of values between the citizen and the PA allows trust to occur. Rousseau et al. (1998) argue that only repeated personal interaction including procedurally evinced integrity and reciprocal care and concern – ‘at best’ in a risky and uncertain environment (Oomsels & Bouckaert, 2014) – may lead to the establishment of emotional attachments. Emotional trust is more resilient than the calculative one, but is complex to establish; especially for the PA having countless different relationships (Lyon et al., 2011).

Citizen Trust in the PA in the Times of the COVID-19 Pandemic

Following these arguments, the importance of trust in the ability, benevolence, and integrity of the PA increases in times of crisis, in particular if innovative and network-oriented crisis reaction takes place, as it ensures citizens' compliance, decreases transaction costs of information and monitoring, and enables functioning networking activities with different stakeholders. Nonetheless, there are valid arguments to expect a general negative trend of citizen trust in the PA in the time of the COVID-19 pandemic.

As for calculative trust, this crisis is unprecedented in many ways, at least in scope, and does hardly allow to derive credible knowledge from former experiences. If information is available at all, it is at best vague and predominantly negative, informing about increased mortality rates, overburdened and dilapidated public institutions, social isolation, and so forth. Wide-ranging personal experience of citizens with administrative behaviour in times of crisis is also limited, as in most countries worldwide crises of a larger range – maybe with the exception of natural hazards that are mostly somewhat regionally restricted – are more the exception than the rule. Considering the strong effect of negative information and a lack of experience dims the hope for the necessary high trust levels. Some scepticism seems called for trust through the venue of emotions. Integrity and value-congruence, as major indicators, need time and repeated interaction to develop; that is certainly not available in the time of the current crisis. Furthermore, at least for citizens of democratic states, partial restrictions of civil liberties and rights, as applied in the lockdown, may have a tang of being “rather authoritarian”, having a negative effect on emotional trust.

To shed empirical light on the theorized trajectory of citizen trust in the PA in the time of the COVID-19 pandemic, we developed a survey that scrutinizes trust in government and PA, including modules on overall trust levels as well as changes, satisfaction with national communication strategies, multi-level dynamics, and potential shifts in the receptiveness to authoritarian approaches. Addressing both – trust in PA and “the government” – jointly, but trying to disentangle the views of citizens regarding different levels may not be uncontested. Nonetheless, there is fair evidence that drivers of trust are very similar regarding trust in PA and other public institution (Camões & Mendes 2019), even if in the citizens' view in many cases there is no differentiation (regarding type or level of public institution), government is government (Glaser & Denhardt 2000; Glaser & Hildreth, 1999).

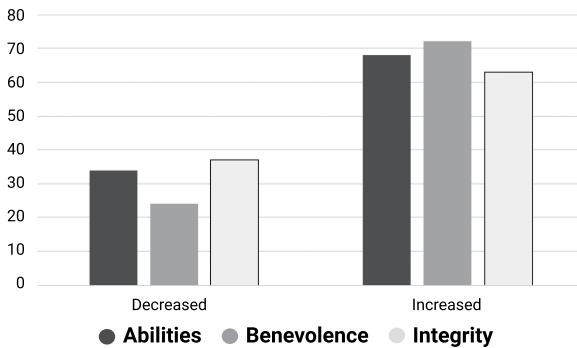
The survey was issued on the 10th of April, with the first phase being treated as a pre-test, and was conducted in English only. So far, 522 respondents

mostly from Austria, Germany, Belgium, New Zealand and the USA took part in the survey. Accordingly, preliminary findings need to be interpreted with the necessary caution due to, first, the relatively small sample size and, second, the variety of countries within the sample. Nonetheless, some interesting and relatively robust “first lessons” can be drawn, in particular in triangulation with other empirical data on the current pandemic.

In the survey, the participants were given the following statements, addressing all trust-relevant aspects (ability, benevolence, and integrity – ABI)¹ of the trustee (Mayer et al., 1995) that should be rated on a three-point scale (decreased; remained the same; increased): *Comparing today with before the coronavirus crisis, please indicate how your attitude has changed. “I think the state has abilities to counter such crisis” (abilities), “I think the state is concerned with my welfare” (benevolence), “I think state action follows sound principles” (integrity).*

As can be drawn from figure 1 – partly contradicting the theoretical derivations – if trust level changed at all², they increased during the pandemic. Even if the single dimensions of ability, benevolence, and integrity perform slightly different, in all categories trust levels increased.

Figure 1 - Changes in ABI trust aspects



These – even only preliminary findings – may be explained to a certain degree by the trust-related concepts of uncertainty and communication.

First, in the light of a rather general “rally round the flag effect”, it is the relation between the degree of uncertainty and the wish for strong leadership,

¹General, trust or trustworthiness can largely be understood as a concept based on ability, benevolence, and integrity (Mayer et al., 1995). On that account, rather than directly asking for trust, in our analysis the general level of trust is approximated by the single ABI components.

²Neural responses – indicating that the COVID-19 pandemic did not change the level of trust – constitute for the lion share of the answers for each of the single trust dimensions; in detail: i.e. 52.0 % regarding benevolence, 40.5 % regarding abilities, and 49.5 % regarding integrity.

coherence in decision making, and clear responsibilities that may contribute to the explanation of the rather unexpected finding above. The tremendous degree of uncertainty and the subsequent desire for clarity and leadership may have gained such a high level that trust is generated even in the absence of the “usual venues”. Such desire for leadership and the willingness to sacrifice basic civil rights and liberal values may even allow to perceive authoritarian state action as being in line with someone’s one norms and values that is the foundation of emotional trust.

Following this argumentation, we tested for correlations the level of uncertainty (approached through levels of anxiety “*Do you think your personal health is still endangered/under threat by the coronavirus?*”), the willingness to sacrifice some human rights (“*I am willing to sacrifice some of my human rights if it helps prevent the spread of the virus*”) and the desire for stronger centralization (“*Some say the coronavirus crisis shows that competences need to be further aggregated and centralized, others insist that flexibility and decentralization are key to successful crisis reaction. Regarding your interaction with the bureaucracy of your state in the coronavirus crisis. At what level do public authorities function better?*”).

The correlations scrutinized exhibit highly significant relations between higher levels of uncertainty on the one hand side, and higher levels of desire for centralization and the level of agreement to be willing to sacrifice own human rights, respectively, on the other hand side. These findings may provide some explanation for the – at first sight – contradictory findings of increasing trust levels during the current crisis.

Second, a complementary explanation may come from the role of information on trust levels. About 70% of respondents are “somewhat confident” to “completely confident” that the government keeps them fully and frankly informed about things that might concern them. As at least calculative trust can be knowledge-based, circulating about credible information of the counterpart’s next ‘move’; including intentions and behaviour, the perceived quality and quantity of information may act as a driver of trust in this case (Van de Walle 2017). Thus, feeling well-informed may directly affect the trust level. Again, potential correlations are scrutinized through linear-by-linear associations tests.

Remarkably, correlations scrutinized exhibit a highly significant relation between the confidence level of being well informed (*How confident do you feel that your government keeps you fully and frankly informed about things that might concern you?*) and both absolute trust levels and changes in trust levels during the COVID-19 pandemic; each one indicating a large effect size ($r > .50$). Accordingly, higher confidence in the information gained is strongly

associated with higher levels of trust and, therefore, may further contribute to the paradox of increasing trust levels during the current COVID-19 pandemic.

Furthermore, having a look at the consequences of the high trust levels, we find evidence that confirms the assumption of trust as serving as a lubricant for state-citizens interaction. Approaching the relationship between trust³ and compliance (approximated by the “*willingness to sacrifice human rights if it helps to prevent the spread of the virus*”), the correlations conducted show that average trust levels significantly predict the level of compliance with a medium effect size ($r \sim .30$).

The findings as presented are in line with empirical evidence from other surveys tackling the current pandemic. Trust levels of citizens – proxied by the evaluation of governmental or administrative handling of the crisis – increased during the crisis, with that effect being notably strong in democracies, but also in semi-authoritarian regimes as the Philippines (Gallup, 2020; 2020a). Also self-declarations of compliance by citizens depict the same picture. The willingness to sacrifice some civil or human rights if that helps to prevent the spread of the COVID-19 virus has increased since the pandemic started: while in March 2020 75% of the individuals surveyed were willing to sacrifice these rights, the share rose to 80% (average for global data) in April (Gallup 2020a).

Summing up, our findings underpin the relevance of trust in public administration (or “the government” in general), notably in times of crisis: the higher trust levels are, the more likely compliance of citizens and successful networking with non-state actors is. Even in the absence of many trust generating factors, trust levels are increasing in the current COVID-19 pandemic. What do these findings imply for those in the crisis now and for the future? While the COVID-19 pandemic is by no means over, and some lessons may only be drawn in the aftermath, the insights so far may reveal some leeway for PAs and governments to increase trust and therewith ensure compliance and cooperation in crisis response at reasonable (transaction-) costs. Providing transparent information about the ability of the PA concerning the execution of anti-virus measures may be amongst the most intuitive – and easiest – actions to be undertaken, as it is able to foster calculative types of trust directly. Furthermore, drawing to joint values in the anti-virus strategy seems to be a promising path, fostering emotional types of trust, at least indirectly: In the absence of experience, if information about the aims of lockdown- or anti-virus-measures is given, arguing with joint values as e.g. the aim of saving lives and protecting vulnerable groups, individuals may be more likely to build emotional trust due to value-congruence.

³A single trust level, here, is an additive index including the ABI components.

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Part II
Eyewitness Reports

Australia - the COVID-19 Pandemic

Australian Capital Territory

Rebecca Cross

ACT's Coordinator-General COVID-19 Response, Australia
Interview conducted by John Halligan,
Professor, Canberra University, Australia

The Australian Capital Territory (ACT) is smaller than most Australian state-level jurisdictions in terms of population but has a more complex range of functions covering state and local government roles. The administration operates under a unique organisational structure that emphasises integration and a whole of government focus for the directorates (i.e. departments).

The perspective is primarily that of the ACT's Coordinator-General COVID-19 Response, Rebecca Cross, supplemented by observations by Katy Haire, Director General, ACT Education Directorate. The report draws on a podcast with the two senior executives and discussions with Ms Cross. The Coordinator-General's role crosses the spectrum of COVID-19 response and recovery efforts and includes non-health responses, economic support, sound governance and decision-making and supporting a strategic approach on longer term issues e.g. community resilience and community recovery.

Biggest Problems Faced by Public Servants and Managers

Things were moving a lot faster. In the very early days when National Cabinet was meeting two, sometimes three times a week, all levels of government experienced a pace of change that was very difficult to keep up with. You would just get things set and then there would be a new decision, new restrictions. Knowing when and how to respond was tricky. The position has settled a little bit since then but is still incredibly fast. The challenge was when the National Cabinet was meeting three times a week, and there needed to be briefings before and debriefing to officials afterwards.

The relevance of existing procedures and routines had to be addressed and adapted. Business continuity plans existed, but nothing for the length and breadth of this type of crisis.

The ACT government seeks to work as one service by being consistent in messaging to staff and across the Territory; and meeting the needs of staff, in particular their work locations. Service delivery had to be handled in new ways. Challenges included determining which work should be face-to-face and the requirements needed for a home office where home IT was not available.

There were innumerable specific questions for executives and managers that were overshadowed by the pace of the response (e.g. the need to get schools online within a week), and unimagined dilemmas (e.g. what to do about international students). Securing and increasing the supply of PPE (personal protective equipment), in particular for front line acute health staff and primary care staff, was a priority. Always present have been the costs of the health imperatives in terms of the ACT's economy and the impact on workforce.

Developing an Effective Response to the Pandemic

There has been a regular process of meetings to ensure information is flowing, and that people know what they need to know. National coordination mechanisms became crucial with the advent of the National Cabinet (the first ministers of the nine federal, state and territory governments). Ahead of every meeting there is a pre-brief, where all relevant people, maybe 15 depending on the agenda, brief the Chief Minister. Following the National Cabinet, the Directors General receive a debrief from the Head of Service. The Security and Emergency Management Committee of ACT's Cabinet reviews the outcomes to get appropriate governance around the decisions. This updates ministers on what is happening. The Coordinator-General follows up by meeting with representatives of every directorate at the deputy level and making sure that the information is flowing. The Coordinator-General's group meets daily, and Directors General meet at least daily. It is a really quick information flow, and it makes sure that effort is not wasted with people going off in the wrong direction or missing things.

Part of the Coordinator-General's role is to make sure that everyone is working together. Because the pandemic crosses so many parts of the community and the economy it is really important that ACT works as one government. That is how the ACT government operates regularly. The public service is smaller, so it can connect up and work across directorates really effectively.

The connection between the different parts of the ACT government is very real and it is real time. During the bushfires, senior executives could organise responses on the phone. There weren't whole layers of bureaucracy and protocol. It was just simple decision making and problem

solving that cut through a whole lot of time-wasting. So that is at the whole of government level.

There is also a really strong sense of immediacy and closeness to where ACT services are being delivered, such as education through schools. There are 88 schools in ACT, and the Director General can speak to about 25% of principals on a phone hook-up that can be organised in about an hour. The ACT is much closer than working in a bigger system, where organising a meeting of principals might take weeks.

Lasting Lessons

The lasting lessons arise in the areas of flexibility in delivery and working, using online services, and more generally reassessing the need for face to face contact. The crisis has provided a significant test for how quickly something can be done, the shift to flexible working and ways for better supporting people affected by the pandemic. The ACT has the advantages of small scale, lean administration and consequently a culture that emphasises agility. The integrated administration allows for internal communication on a whole of government basis and a focus on one message that can be carefully co-ordinated for government: ministers and directorates.

Access Canberra brings together ACT Government Service and Specialised Centres, call handling, online services and regulatory functions in a single unified service. It became less necessary to visit a shop front, an Access Canberra Service Centre to undertake transactions because scores of payments could be made online. There were now more online services: 50 were transferred.

The ACT was in a good position to move to remote learning because it was ahead of other jurisdictions in terms of adopting and using digital technology. Students in secondary school had laptops already and knew how to use quite sophisticated technology. One example of quick innovative thinking was to recycle the laptops from last year's senior students who had left school to provide to the students in primary schools. Around 4,000 Chromebooks were distributed to the primary students, so that they could be ready for doing online learning. Within a couple of days of the decision to shift to online learning, 5,500 teachers, close to every classroom teacher, were doing online professional learning to improve their skills, so that they would be ready for supporting students in the online environment.

The longer-term advantage from using digital technologies smartly is that it gives the chance to reach the kind of education nirvana, where you have personalised learning. You have students learning working at their own pace, you have teachers able to use the digital technologies to do some of the

planning, and providing the content, and the information that they would have done in the classroom. There was also a rollout for children who were working from home who didn't have Wi-Fi access. Dongles were delivered to about 600 families without access.

Another durable innovation is telehealth, the continuing availability of a range of telephone consultation services. Consultations by telephone or video call cover GP and other services, including outpatient services (e.g. mental, health and chronic disease treatment).

The ACT has created a community panel at a whole of government level that can pose questions like, Is the messaging getting through? What are people concerned about? The last survey reached 1200 people within 24 hours and a representative sample of Canberrans. 91% of them agreed that they were being kept well-informed and 87% believed the ACT government is responding appropriately. ACT is the only jurisdiction that has done this at a whole of government and whole of community level. This was useful during both the bushfire and the pandemic crises.

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Challenges, Practices and Reflections Local Public Management Agencies in the Prevention and Control of COVID-19 Epidemic

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Wuhan, where the Chinese cases of COVID-19 was first reported and later spread intensively into the whole country, has been a typical representative of China's fight against COVID-19 pandemic. In the early morning of January 23, 2020, Wuhan government began to lockdown the city, starting an emergency period of epidemic prevention and control. After more than three months, Wuhan City reported no new patients for the first time on March 18, 2020. On April 26, all the hospitalized patients of COVID-19 in Wuhan were cured. Faced with arduous task and many difficulties in prevention and control, the managers of the city adopted effective measures and accumulated rich experience.

Major Tasks and Requirements for Local Managers

Firstly, how to cure patients, improve the cure rate and reduce the mortality rate. They had to consider how to quickly and effectively integrate and increase medical resources, including beds, doctors and nurses, medical equipment, protective products, and how to improve the ability to treat.

Secondly, how to ensure an effective lockdown to cut off the source of infection, block the transmission route, and reduce mutual infection. They might have to control all traffic forms, such as moving in the city, long-distance buses, trains and flights, close all communities, all shopping malls and supermarkets.

Thirdly, how to restore production and social activities in an orderly manner in different stages of epidemic situation.

The Main Challenges Encountered by Local Managers

Firstly, how to ensure a good communication between the government and the public, the cooperation by the public to make the control effective. For example, some local residents who did not understand or refused to follow control measures appear to be uncooperative. Some are dissatisfied with grassroots managers because their voices were not heard and responded to. Some individual residents whose behaviours were out of control required timely psychological counselling and intervention.

Secondly, how to guarantee an effective supply of the daily necessities and other public services for those in the lockdown? For example, the managers had to figure out ways to ensure the supply of basic food, daily necessities, and medicines for all affected, and to satisfy the needs of special groups such as lonely elderly and disabled people for special services.

Thirdly, how to make the authoritative information disclosure more timely and comprehensive and transparent, making the government more credible?

Fourthly, how to organize a work team with strong executive ability at the front line of prevention and control. There is a gap between the number and quality of grassroots managers and the needs of emergency governance. Therefore, it was necessary to rebuild the executive agency for the special situation and replenish front-line staff by a large number.

Countermeasures Adopted by Local Governments

Firstly, local governments implemented a complete lockdown and ensured an effective control according to law. Both the Hubei Province and Wuhan Municipal Government established their unified emergency command institutions (COVID-19 Prevention and Control Headquarters) to issue orders and notices to manage tasks and behaviours in emergency. The authority enforced laws and regulations strictly, and handled non-compliance behaviours according to law. Local civil servants and public managers help local residents understand the necessity of lockdown measures by means of education, self-example, and consultation. They also worked out precaution plans for the risks that may be caused by the epidemic. The functions of public welfare organizations, scientific research institutions, and voluntary groups were integrated. Those who suffer from psychological problems could receive counselling and intervention.

Secondly, local governments met the residents' basic living needs in the lockdown. They increased the amount of supply, by offering market-based

subsidies for commodities such as vegetables, meat, eggs, and milk to curb price hiking. The Internet, WeChat, Alipay and other information technological tools were employed for organizing online group-purchase and distribution of living goods in communities. Specified personnel were appointed to provide the basic and necessary services for special groups such as the lonely elderly, the disabled, and patients.

Thirdly, local government provided channels for public opinion and ensured the timely and transparent information disclosure. They published news through television, broadcast, internet, WeChat, new media and the other means, to refute in time the rumours and misinformation online, thus easing public confusion. The principal leaders of governments participated in news conference regularly to respond to major concerns. They praised the excellent medical workers and the splendid practitioners of all walk of life through the mainstream media and set them as role models.

Fourthly, local governments made full use of information platforms such as the Internet and big data make governance more intelligent. They published information, responded and collected statistics through Smart Community apps, WeChat groups and the other channels. They employed AI-based phone-calls to know about public health, concerns and collect statistics automatically. Health codes (green code) could be generated with the help of the internet and big data, to facilitate the management of the flowing of people around the country.

Fifthly, local governments re-organized the front-line work teams. They sent staff members of provincial and municipal governments to the front-line communities to strengthen the front-line work force. For example, 580,000 governmental employees of Hubei Province sent participated in community management and serving residents together with community workers, property companies and volunteers. Party members and leaders who did not work well and fail to do their best were held accountable.

Sixth, local governments restored the economic and social activities in an orderly manner. From 0:00 of March 25, Wuhan began to restore the traffic step by step with urban public transportation coming first, followed by intra-provincial transportation, railways and flights, and inter-provincial long-distance passenger transportation. The traffic returned to normal basically on April 8. They also encouraged the resumption of production in an orderly manner, to restart production and reopen markets gradually by considering the risks of the concerned regions. Reopened enterprises were ordered to implement closed-off management. Shopping malls, supermarkets, and vegetable markets were told to open gradually. Schools were open in an orderly manner. On May 6, the graduating classes of high schools and junior high schools returned firstly.

Reflections

Firstly, we should focus on the two priorities of patient treatment and prevention and control, and promptly carry out these measures and offer support to those in need.

Secondly, we should strengthen community governance system, and bring various resources (including personnel, materials, funds, etc.) to communities, enhancing the implementation capacity at the grass-roots level.

Thirdly, we should emphasize law-based governance and science-based management, review experience and lessons in a timely fashion to improve governance capacities.

Fourthly, we should give full play to the role of social institutions and market-based organizations and give them more opportunity to participate in the co-construction and co-governance.

Fifthly, we should attach importance to and take advantage of the Internet, big data and other scientific and technological tools, making prevention and control more professional and intelligent with the help of digital government and smart community apps.

Sixth, we should launch training programs for civil servants and the public to increase their emergency management capabilities and share with them more public health knowledge.

The Croatian Experience in Fighting the COVID-19 Pandemic

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In the Republic of Croatia, by 24th May, 2020, there have been 2,244 (51/100,000) of COVID-19 cases reported, 99 deaths (2.3/100,000) and 61,482 RT-PCR tests performed (14/1,000). The first case of the ongoing pandemic was reported in Zagreb on 25 February, when a patient who had come from Italy tested positive. The response to the outbreak was centrally driven by Civil Protection Headquarters established by the Government. The situation in Italy and Croatia's proximity to it made us take the situation very seriously. We have introduced rather strict measures for infection reduction. Early detection and contact tracing have been performed by epidemiology service of public health institutes (21 county institutes and the National Institute). Croatia has had a long tradition of epidemiology service and has one epidemiological team (a medical doctor specialised in epidemiology, a sanitary engineer, and a sanitary technician) per 45,000 inhabitants. We believe that such an effective epidemiology service has prevented the overcrowding of intensive care units.

There was not a single day during the outbreak when over 100 patients used respirators (national capacity is 800). After several weeks, an almost complete lock-down was introduced – educational facilities were closed and switched online, public transport was temporarily stopped, restaurants and coffee-shops were closed, and all sports and leisure activities were restricted. Migrations between counties were banned (electronic passes issued by civil protection headquarters required to travel outside county of residence).

The main challenges to public servants were communication with citizens, the distribution of measures and responding to citizens' questions. Fortunately, the Government had a strong support by all the media and citizens cooperated surprisingly well. The Government set up a website koronavirus.hr for all information for the citizens, as well as a new phone line 113 that had volunteers answering their questions. On 14 April, the Government launched a WhatsApp digital assistant named Andrija, after Andrija Štampar, whose purpose was to give personalized advice to citizens who thought they

might be infected and to relieve human medical workers of the pressure of attending to phone calls 24/7. The main difference from the other existing chatbots was that Andrija not only provided information but also helped with decision making: after answering a set of questions, the user was advised what to do (whether one should call a doctor, visit an emergency room or stay at home). Andrija was also intended in case 112 and 113 phone lines were overwhelmed, which, fortunately, did not happen. Andrija had 70,000 users per week and responded to one million requests. During the outbreak, Andrija was continuously developed by adding new updates (measures for elderly care homes, measures for border crossing etc.).

Yet another, maybe even bigger challenge was how to control the outbreaks in elderly care homes, as spots in the highest risk of lethal outcome. Therefore, the strictest measures were introduced in these facilities. The employees were encouraged to have seven-day work sheets without leaving facilities to avoid catching the SARS-CoV-2 infection from their families. We educated nurses to take swabs and transport them to laboratories to be tested as soon as possible. There were special phone lines between elderly care homes, laboratories and epidemiology service. So far, we have had outbreaks in four elderly care homes and the one in the public limelight is the County Elderly Care Home in Split. The case was politicized, and the media made allegations using words like “war, breakthrough, guilt, responsibility”. It made the personnel of elderly care homes quite anxious and they made pressure to be tested, frequently without epidemiological indication. It was very difficult to deal with the panic and to communicate that despite all preventive measures in place there would inevitably be some infections and deaths in elderly care homes. Nobody wanted to hear those messages.

In the second half of April and in May the number of new cases dropped down and the Government decided to withdraw some of the restrictive measures. We presumed that introducing the measures was the challenging part, but it has turned out that relaxing the measures is more complex regarding communication and coordination. After several weeks of lock-down citizens became quite impatient and it seems they did not respond well to gradually going back to the “new normal”. Since the general election is set in early July, there has lately been a lot of politization. The right-wing party that runs the current Government was accused of using the Civil Protection Headquarters to achieve its political agenda (i.e. opening the churches for mass services before opening schools, having non-working Sundays, etc.). Another line of public discourse we are facing now is “we were cheated, there was no need for such restriction”. Such a reaction is expected and is similar to the reaction to the vaccination programme: when it is successful, there are opinions that it is not needed. Maybe the successful response to the pandemic will become its own victim.

In the following period public servants will be faced with negotiating the salary decrease announced by the Government (economic consequences of the crisis). In such a scenario, it will be challenging to mobilize public servants to respond effectively in the possible second wave of the pandemic, as they did in the first wave. Opening borders for tourists is another possible threat to the now favourable epidemiological situation. We hope that the summer months will slow-down the virus spread as is the case with all respiratory infections.

Finally, we can conclude that strict measures, early detection of spread routes, prompt government reaction, extensive media coverage, public health system organization and citizens' cooperation have to be credited for successful containment of the pandemic in Croatia so far.

COVID-19 Pandemic: Early Lessons for Public Governance in India

Policy and Implementation Challenges & Operational Modalities

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Prime Challenge

With the onset of COVID-19, the main challenge faced by public administrators in India was to choose between protection of life or livelihood.

Health infrastructure and facilities in the country has been abysmally poor in relation to the huge population and the requirement to deal with the unprecedented health crisis emanating from novel corona virus. In the event of the pandemic spreading widely, demand on medical facilities is likely to increase outstripping the currently available health facilities in the country, causing massive health hazard leading to inadequacy of medical service and consequent colossal fatalities. To prevent the happening of such a disastrous situation, the possible option was to keep people indoors within their homes.

On the other hand, confinement at home implies considerable disruption, albeit halt, of economic activities. This would hurt the economy and inflict the livelihood of many, especially the vulnerable and the marginalized people.

Placed in such a quandary, the prime challenge for decision making by the administration was whether to go for lockdown or allow herd immunity to build up for fighting the novel corona virus.

Weighing between priority for life or livelihood, the approach taken was to go for entire lockdown in the entire country. If life could be saved, then livelihood could be provided. If life is lost, livelihood becomes irrelevant.

Other Challenges

Having decided on a lockdown, there were various other challenges that had to be addressed. These challenges faced by the administration are described in succeeding paragraphs.

Overriding authority

In the federal government structure of India, health is a subject that falls within the jurisdiction and authority of the provinces or states. To tackle this devastating COVID-19 pandemic, the provisions of the National Disaster Management legislation was invoked and power vested to the national or central government to issue orders, guidelines and protocol for combating COVID-19; and which the states must follow.

Simultaneously, in a vast country such as India and having a federal structure, coordination between the national and state or provincial¹ governments, various ministries and para-statal agencies is easily said but difficult done.

Health infrastructure

There being lack of preparedness for health facilities and services to fight COVID 18, the increase of hospital beds, procurement of ventilators, personal protective equipment and masks, creation of intensive care units, arrangement of testing laboratories, purchase of test kits, ensuring safety of doctors, nurses and health workers became daunting tasks. Roping in the private sector for hospital and laboratory and setting standard operating procedures have been other attendant challenges.

Social aspects

Building public awareness on the need for staying indoors and do's and don'ts ranked high in order of priority to effectively implement the lockdown. In this connection, engagement of experienced and suitable civil societies to build public awareness and distribute masks and hand sanitizers assumed relevance and importance.

Further, making availability of food and its distribution; and maintaining a regular supply of electricity, water and conservancy services posed another significant task. Strengthening of the public distribution system², enlarging

¹ A region or geographical domain within the Union of India administered by the provincial government

² Public Distribution System facilitates supply of food grains through four hundred thousand fair price shops located across the country.

the scope of Essential Commodities Act³, and coordinate with the states in this regard turned to be imminent requirements.

Enforcement

In addition to the challenges described in the foregoing paragraphs, enforcement of lockdown became a paramount issue. Hence, mobilization, training, deployment and coordination of police supported by para-military force, as required, had to be planned in coordination with the states and standard working protocol developed.

Unorganized sector & informal economy

A unique feature of the Indian economy is a large unorganized sector that significantly contributes to the country's gross domestic product. This sector includes tiny, micro, cottage, and small scale industrial, service and trading establishments. People working in this sector are large in numbers and mainly daily wage earners and migrant labour. Providing shelter and food to these vulnerable work force and arrangement of transport for migrant labour to return to their home states have been a colossal challenge to address by public administration at national and provincial levels.

Monitoring & Coordination

Monitoring the impact of lockdown, number of tests, progress of contact tracing, determination of extent of spread of novel corona virus, degree of COVID-19 infection in different states, districts and cities, rate of recovery from corona virus, and fatalities is an uphill exercise. Gathering information from the states by districts and by cities, studying and analysing the data, and collating for an aggregate analysis to draw decisions on means to tackle the situation as it emerges, and communicating information to the public is concomitant to the other onerous exercise.

Rebooting the economy

Long period of lockdown causes social frustration and economic distress. To reboot the economy while maintaining the health safeguards, phasing lockdown, and providing gradual relaxation posed another challenge. To revive the economy, financial stimulus packages required to be worked out, laying the procedures, unshackling different erstwhile controls and pushing the right button to meet the objectives in short- and medium-term time horizon.

³ Legislation to ensure the delivery of certain commodities or products, the supply of which if obstructed owing to hoarding or black-marketing would affect the normal life of the people. This includes foodstuff, drugs, fuel (petroleum products) etc.

Exit strategy

Recognizing that world has to live with COVID-19, the newly emerged challenge is to plan a novel regime for social, economic, religious, and other activities, considering the path contemplated by other countries, and adapting to local situation, as well as, working out practices and procedures with an indigenous approach.

Conclusion

Having discussed the different challenges before the public administrators in light of COVID-19 pandemic, the main issue has been decision making and follow up with effective implementation, drawing a fine balance between protecting life and safeguarding livelihood. Besides, close monitoring of the impact of measures taken and changes or modifications, if any required, as the situation meanders and mutation of corona virus happen is an ongoing challenge.

Romania - the City of Cluj Napoca Facing the COVID-19 Pandemic

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Introduction

Cluj-Napoca is the second largest city in Romania, the historical capital of Transylvania, with a population of approximately 400,000 inhabitants, including students. Romania has a population of 22.1 million inhabitants, out of which 3 million Romanian citizens live in different countries of the European Union. Romania has a population density of 85 people per square kilometer with a continuous decreasing trend. The most important challenge of this pandemic was to quickly solve the problems related to the lack of medical and protective equipment and in the same time imposing relatively severe quarantine and isolation measures.

Key Challenges

Insufficient medical and protection equipment

The immediate challenge during the first phase of the pandemic was the difficulty of purchasing medical equipment caused by tremendous demand at national, European, and global level. The onset of the COVID-19 pandemic found the hospitals in Cluj in a severe shortage of protective equipment for medical staff and also in a shortage of intensive care equipment for treating patients infected with COVID-19.

The problem was overcome by the rational use of protective equipment and its purchase on the domestic and foreign markets (in this sense, the city authorities rented a TAROM aircraft to bring a special order of protective equipment from China). The problem of medical equipment has been alleviated gradually through the purchase of equipment on the internal and external market, donations and the use of European funds specifically dedicated for this purpose. It is important that there were no deaths due to the lack of intensive care equipment. We didn't lose anyone who could have been saved.

Insufficiency of hospital beds in view of a potentially aggressive evolution of the number of patients infected with COVID-19.

Given the explosive evolution of the COVID-19 pandemic in Spain and Italy, countries from which a considerable number of Romanian citizens were to return, a significant increase in people infected with COVID-19 was forecast, especially during the Easter holidays. Consequently, we prepared two backup scenarios: we took over a private hospital with 180 beds and we set up a field hospital (with 358 beds) in the Multipurpose Hall in Cluj-Napoca in order to treat COVID-19 patients with mild forms or asymptomatic.

The difficulty of providing hotel units for the quarantine of Romanian citizens who returned from the “red zones” of COVID-19.

Although there was a financial resource to cover the cost of accommodation and the hotel units lacked bookings, there was initially a major reluctance on their part to rent hotels for quarantine. The reason? The risk of future customers avoiding these hotel units after the COVID-19 pandemic! The impediment has been overcome by hard and intensive work of persuasion with medical and public interest arguments, including community recognition of the civic spirit they would have demonstrated.

Resolving the risk of panic due to the potential shortages of food and medicine.

During the onset of the COVID-19 pandemic, there was a fear that the pandemic would be accompanied by a shortage of food and medicine. The risk was mitigated by a constant public communication to assure citizens that there is no such risk of food and medicine rationalization, after discussions and precautionary measures taken by the supermarket networks and pharmacies.

Supporting people over the age of 65, who had neither relatives nor other forms of assistance.

The authorities have established extremely restrictive measures for people over 65 years of age (for example, they were allowed to go out only between 11 am and 1 pm, initially). In order to identify all the people over the age of 65, who had neither supporters nor any other form of assistance, a special telephone line (green line) was set up where those in need could call the City hall. The total number of people registered in this way, including those in the official records of the Directorate of Social Assistance and religious units, was constant between 2,200 and 2,500, with a daily support for about 850 people. Without the support of the civil society and the religious units, we couldn't have been able to do so.

Rethinking the functioning of the city hall under the restrictions imposed by COVID-19.

Up to this pandemic, no public servant worked from home. Under these conditions, we analyzed each job description of public servants and arranged for a number of 110 people to work from home, using online and digital procedures.

Accelerate all digital procedures in the public administration of Cluj-Napoca. Conducting the meetings of the local council as well as the meetings of the urban planning commission in online format, on a videoconferencing platform.

The administrative decision we imposed was clear: all citizens have the right to request and receive in digital format the answer to all solicitations and requests addressed to the Cluj-Napoca city hall. Before the COVID-19 pandemic, the Cluj-Napoca city hall implemented 162 online and digital procedures in the relations between citizens and administration, being, in many digital procedures, the first in Romania in terms of implementation (online participatory budgeting, Antonia, the first virtual public servant, the issue of urban planning certificates in digital format, etc.).

In this regard, we have extended and institutionalized three types of electronic signatures, depending on the importance and complexity of the administrative act or procedure: the standard digital signature, the advanced digital signature and the qualified digital signature. The advantages of such procedures are clear: debureaucratization of administrative services, elimination of stamps from the administration's activity (and, implicitly, elimination of potential sources of small-scale corruption, given that each stamp can be a source of corruption), saving time and financial resources for the citizen.

Inclusive digital education.

The closure of schools has led to the complete relocation of school activities to the online environment. The city hall purchased, through the schools, 2098 tablets for students from families who do not have a computer, laptop or tablet at home. Investing in education is the most effective investment in the world as it is safe from the risk of bankruptcy. Inclusive education ensures equal opportunities for all children offering the chance of a better paid job and a better quality of life. The Cluj-Napoca city hall was the first in Romania to provide access to online education for all students in secondary education.

Providing accommodation in hotel units for medical staff directly involved in treating people infected with COVID-19.

This action did not involve the spending of public money and was conducted through the "One Cluj" platform, a platform that brought together local public

administration authorities, over 70 non-governmental associations and organizations, universities and the business environment.

Difficulties related to the closure of schools and kindergartens.

In order to reduce the negative impact of such a decision, the normative framework was adopted. Therefore, during the state of emergency, one of the parents has the right to paid days off in order to ensure the supervision of the children.

Difficulties related to the negative impact of the covid-19 pandemic on the revenues of the budget of Cluj-Napoca .

By the end of April 2020 alone, the impact of COVID-19 on the city budget (decreases in specific revenues and COVID-19-related expenditures) was 7 million euros, about 10% of the investment budget from local funds.

Lessons Learned

The greatest lesson of this pandemic is that... we will have other pandemics! We will need to take actions in advance in order to prevent the spread of a future pandemic. We have now reacted more or less productively and with long-term negative consequences for investment and jobs. Restarting our economies will not be as simple as directly affecting them through military decrees and ordinances.

Also, more than ever, a global, effective and coordinated response to the pandemic is needed: it is inefficient to solve the COVID-19 crisis in one country or continent without solving it in other countries or other continents. In the age of globalization, “an outbreak of infection somewhere, in a short time, becomes an infection everywhere”!

The COVID-19 pandemic also left a “positive legacy”: prioritizing investment in the health system, the explosion of the digital revolution to an unprecedented level, the widespread imposition of telemedicine and work from home, an unprecedented awareness of the importance of personal and collective hygiene.

The COVID-19 Pandemic in South Africa: Early Lessons for Public Governance

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Introduction

In December 2019, the world faced a new and invisible threat that has had an unrivalled impact on health systems globally. The Novel Corona Virus (COVID-19) has impacted on daily life for billions of people, and this has been no different for South Africans. Since its discovery in Wuhan City, in Hebei Province in China on 9 December, there are currently almost 5 million cases and over 320 000 deaths globally – with about 16000 infections in South Africa, which together with Egypt, Morocco, Tunisia, Ghana, Nigeria are amongst the highest in the continent. The positivity rate in South Africa remains around 3.5% and mortality rate around 1.9%.

This pandemic has redefined the way government infrastructure and health systems function. South Africa is especially vulnerable due to a high population of citizens who live with compromised immune systems and co-morbidities. The economic inequality also presents a unique challenge in attempting to curb the spread of the virus. This paper will examine the impact COVID-19 has had on health infrastructure and systems and highlight government policies in place to counteract the spread of the virus and flatten the curve of infection.

South Africa: Socio – Context and Challenges

COVID-19 presents a number of challenges to the health system and public governance which has created an increased risk for COVID-19 infection among the population. These areas of contention are rooted within several different aspects within the country: some are socio-economic issues which pose a challenge to minimising the spread; and others are deep-rooted health inequalities that place large portions of the population at risk. This section will explore these challenges and the lessons that have emerged from them.

Water and Sanitation

The guidelines that have been used on a global scale to moderate the spread of the COVID-19 virus include the implementation of social distancing, engaging in the regular practice of handwashing and sanitising, and disinfecting all contact surfaces as often as possible (World Health Organization [WHO], 2020a). This WASH principle which stands for water, sanitation, and hygiene (WHO, 2020a), is seen as the most crucial counteractive measure available in combating COVID-19. In order to be compliant with these principles, access to clean water and adequate sanitation are crucial (WHO, 2020a).

In South Africa, this poses a level of difficulty due to inadequate water infrastructure in place which affects large sections of vulnerable populations, and as such, makes attempting to contain the spread of the virus a problematic task. Due to this lack of infrastructure, poor water quality or limited access to water is a reality for some communities. Compliance to social distancing also comes into question as water sources are commonly shared within communities (National Business Initiative [NBI], 2020). The combination of these factors presents a difficult task for public managers in curbing the spread of infection and protecting vulnerable populations.

High Prevalence of Human Immunodeficiency Virus (HIV) and Tuberculosis (TB) within the Population

South Africa accounts for 20% of both the HIV and TB population globally, making it an epicentre for both these pandemics (Wild, 2020). While there has been no definitive research done on what the possible effects COVID-19 could have on these vulnerable populations, there are several causal links that suggest the effects could be devastating.

Firstly, TB is a respiratory disease that often leads to a decreased capacity of lung function and weakens the body's response to fighting off infection. Many forms of TB are drug resistant and are a co-morbidity found in individuals living with HIV (Boffa et al., Mhlaba, Sulis, Moyo, Sifumba, Pai, & Daftary, 2020). It was found that of the current TB population in South Africa, 60% were also living with HIV (Boffa et al., 2020). Their reduced immunity and weakened lung capacity would therefore increase the probability of more serious COVID-19 symptoms being experienced, and therefore places this group at risk.

Due to the influx of COVID-19 and the prioritization of treatment for patients with this virus in all branches of healthcare within the country, it could mean that other illnesses and conditions such as TB and HIV could

be deprioritized by the health system and could lead to an interruption of treatment for individuals currently living with TB and HIV (Boffa et al, 2020). This implies that these individuals would return to their communities without receiving treatment, which may lead to long standing effects on the community and these vulnerable populations well after COVID-19 has been controlled (Adepoju, 2020). The level of monitoring and evaluation of these populations pre-COVID-19 could also prove difficult to return to as these individuals avoid returning to their usual routine of treatment and examination due to the fear or stigma of having COVID-19 (Adepoju, 2020).

Inadequacies of Health Infrastructure

The health system within South Africa was already facing challenges in terms of infrastructure and resource management. Before the COVID-19 pandemic, there were issues around the error margins within healthcare facilities, a need for improvement in the quality of care and extended delays in healthcare services (Maphumulo & Bhengu, 2019).

To address the fundamental inequity in access to quality health care, government has embarked on a program of fundamental transformation of the health service through the introduction of the National Health Insurance as a way to usher in Universal Health Coverage for all citizens. This program is aimed at addressing various shortages in supply of medicine, human resources to address staff attitude and morale, poor infrastructure and reduce patient waiting times, and overall improvement in quality of care.

With the current pandemic, a shortage of resources has already been noted by all key stakeholders involved. At present, healthcare workers face a shortage of personal protective equipment (PPEs), putting them at risk for contracting COVID-19 (Pikoli, 2020). Accessing facilities and health care workers currently tending to individuals infected with COVID-19 is a struggle in townships and rural areas (Pikoli, 2020). In addition, curbing misinformation and ensuring the readiness of facilities are also challenges in limiting the spread of the virus as protocols around the prevention of infection may be more difficult to adhere to in certain facilities which simply lack the resources needed to carry out these regulations (Elovainio & Pick, 2020).

Poverty, Inequality and Unemployment

The majority of the population is afflicted by the legacy of apartheid, i.e. inequality, poverty and currently unemployment has risen above 30%. More than 30 million people live below the poverty line. Approximately 18 million of the population subsist on the government social grants and many survive on unsustainable jobs from the informal economy. Living conditions in rural,

urban and informal settlements are suboptimal with overcrowded households and poor sanitation. All these conditions are an obstacle in the containment of a highly infectious disease outbreak.

Lessons Learned

The lessons that can be taken from this pandemic are fundamental in nature as it has shed light on the need for essential measures to be put in place in order to make a lasting and significant impact in flattening the curve of infection. The first lesson that should be taken is ensuring that the spread of misinformation does not severely impact on the efforts made in ensuring adequate education of all members of public. However, disinformation and fake news undermine the messaging and have to be curbed swiftly before it breeds cynics and mistrust. Ensuring that the public understands the reasoning for the emphasis of measures such as washing and sanitising hands, use of face masks, coughing etiquette and social distancing, has been key in ensuring that these are adhered to. Regular, timely, and consistent communication is vital to gain the trust of society and enables them to embrace the containment strategy and play their role in combating the spread of infection. Transparency makes everyone feel the decision-making process is inclusive. National unity, social solidarity and partnership between government and society is vital for the successful campaign to defeat the outbreak.

The investment in fighting this pandemic has also seen a significant increase in the quality of care being received by patients. The coordination and partnership between the public and private sector have to be consolidated quickly to ensure common treatment protocols and unified standards in testing, treatment and care. This has ensured that patients who were infected received adequate care without a delay in health service delivery (both private and public). Underlying comorbidities were also monitored and noted to determine the role these played in the effects of the COVID-19 infection. These seemingly insignificant acts of rigour contribute to wider global efforts made in understanding every sphere of this virus.

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Making Sense of South Korea's Response to COVID-19

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Background

South Korea's agile and hitherto successful response to COVID-19 is an object of global interest. Scholars explain the country's response in terms of various factors including a tradition of strong central government, a docile and order-minded citizenry, and even a Confucian culture. As a former health official and still a participant in a broad international and national policy process, I would point to more immediate and easily identifiable institutional factors and behavioral features.

South Korea's experience of MERS outbreak in 2015 gave painful but precious lessons that propelled the country to improve its capacity to respond to public health risks. The Korea Centers for Disease Control and Prevention (KCDC) established an Emergency Operation Center (EOC) and Laboratory Analysis Center, and introduced an Emergency Use Licensing system in collaboration with the Ministry of Food and Drug Safety, which turned out to be the most significant institutional background for the prompt response to the current COVID-19 outbreak. Also, among the post-MERS improvements were an increase of negative pressure rooms, the reinforcement of field response teams, and the strengthening of inter-ministerial cooperation. The improvements were internationally recognized through the WHO IHR (2005) Joint External Evaluation (JEE) in 2017.

South Korea's Response

On January 3, 2020, three days after China first reported the outbreak of the disease to WHO, the EOC of the KCDC implemented enhanced entry screening on travellers from Wuhan. Two days later, the KCDC alerted clinicians to look out for patients with respiratory symptoms with a history of visit to Wuhan. This information gathering effort was supported by the Drug Utilization Review system, which provided the travel histories of patients at health facilities. The organization simultaneously issued guidance to clinicians at national designated isolation hospitals and, a few days later, to local governments. On January 20, a person who returned from Wuhan turned out to be the first laboratory confirmed case. The government scaled up the alert level from Blue (Level 1) to Yellow (Level 2 in the 4-level national crisis management system). The alert level was raised to 3 on January 27 and to 4 on February 23.

January 27 was a historic day – the day of the globally heralded Seoul Station meeting, where KCDC officials met with a score of pharmaceutical company executives and announced the KCDC's intention to put into action the Emergency Use Licensing system for testing kits. The KCDC informed the companies of the full genomic sequences of the virus shared by China on Jan 12. The supply of new real time PCR-based testing kits began in early February, after emergency use authorization by the Ministry of Food and Drug Safety. The early expansion of testing labs was also a notable feature of South Korea's response. The number of labs increased from 18 on January 31 to 46 on February 7, 77 on February 25 and to 114 on March 9 with the capacity of testing 20,000 samples per day. Initially, 18 public health laboratories were involved in COVID-19 testing. To make testing widely available, hospital laboratories and private testing laboratories participated in the network from February 7. Innovative drive-through and walk-through sampling methods also contributed to the speed and efficiency of testing. The total number of tests reached 747,653 with 1.5% confirmed positive by May 16.

As for treatment, the efficient classification of patients into mild and severe and their distribution to “community treatment centers” and COVID-19 hospitals respectively have proved to be successful in preventing the overwhelming of hospitals and ensuring proper treatment of severe patients. The system is also aimed at ensuring the hospital accessibility of non-COVID-19 patients. Apart from this nifty institutional design, the massive participation of medical staff from public hospitals and volunteers was essential to stopping the spread of the disease in Daegu.

Implications

South Korea's response is often praised as open, transparent and democratic. No travel restriction has been implemented except against travellers from Hubei, against whom a travel ban was imposed as late as on February 4. In that respect, South Korea has been compliant with the WHO COVID-19 Emergency Committee's negative advice on travel restrictions. Instead of a travel ban, a Special Entry Procedure was introduced on February 4 against travellers from China and was expanded to travellers from all countries on March 19. A 14-day self-quarantine was expanded to all incoming travellers from April 1.

One of the lessons of the MERS experience was that risk communication was a determining factor. In the current crisis, political interference in risk communication has been minimized, this has contributed to enhancing public trust in government action. Unlike in the MERS crisis, the "control tower" was the KCDC.

Some people think South Korea's success has been due to a strong central government tradition, but the truth is that unique public-private and central-local cooperation frameworks have been decisive in both extensive testing, tracing and effective treatment., South Korea decentralized testing by empowering local public health institutes from the outset, and to designated hospitals and private testing laboratories as early as on February 7.

South Korea's practise of tracking infected persons may raise the eyebrows of people who take privacy seriously. The so-called COVID-19 Smart Management System operates based on the cooperation of the National Police Agency, the Credit Finance Association, the three mobile carriers and 22 credit card issuers. While no name of the tracked person is publicized, which is often misunderstood, the current system has the danger of allowing overcurious people to stigmatize confirmed cases. Now discussion is underway to find a de-identification method that would enable effective tracing while minimizing encroachment on privacy. On the other hand, no COVID-19 app is used in South Korea except the Safety Protection Mobile App for controlling people forced into self-quarantine.

While South Korea's response has been praised for its speed and efficiency, it has not made sufficient efforts to share epidemiological and clinical findings and results of public health response measures with the international community. The government needs to closely collaborate with national experts who have participated in the COVID-19 response and build a collective knowledge platform to be shared internationally. Now we are in an era of "planetary co-immunism" where the world has awakened to the urgent need to cooperate globally and mobilize collective knowledge in responding to a ferocious revolt of the nature (see <https://www.berggruen.org/the-worldpost/articles/weekend-roundup-planetary-co-immunism-is-on-the-way/>).

Spain: How to Activate 2030 Agenda in Times of Pandemic?

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Different social dynamics linked to processes such as globalisation, climate change, social and political crises or demography are marking the present, shaping the future and posing major challenges, including for public administrations.

In this context, the OECD (2017) highlighted the changes affecting public administrations: technological change, digitalisation and increased interconnection; diffuse limits for an increasingly interconnected society (the New Governance comes from the idea that the administration does not have a monopoly on creating public value, instead, this is created by a network of public agencies, organisations, companies, institutions and citizens) and finally the consideration that although the public administration is one actor among many, it is a central player in a public value chain.

The 2030 Agenda for Sustainable Development, NNUU (2015) is approved in this scenario and recovers processes of reflection that had been promoted by national, international and academic bodies regarding the reform of relations between public administrations and society. The Sustainable Development Goals (SDGs) do not imply substantially new elements for Public Administrations, but are based on already existing lines of work, such as the objective of making public institutions more effective, open, inclusive and accountable. However, they emphasize some principles, such as comprehensive and leave-no-one behind approaches or multilevel and multi-actor co-responsibility, which have profound implications and require new approaches and ways of working.

Today, because of the pandemic originated by the SARS-CoV-2, it is necessary to incorporate new elements into the analysis such as the increased complexity caused by an unprecedented health, social and economic crisis and the uncertainty in unknown scenarios.

The 2030 Agenda must hold the key to address the current crisis, because it proposes goals for progressing in the resolution of difficulties in the social, economic and environmental spheres. It is an ethical, universal agenda that

aspires to sustainable development for all countries and all people. The 17 Sustainable Development Goals are very suitable for facing the complexity of global problems as they are indivisible, of a transversal nature and strongly interrelated; therefore, the SDGs cannot be achieved in isolation, but all of them together, in a coherent and interconnected manner, both within States and in relations between States. Indicators may need to be reviewed and time frames adjusted, but it is still a good plan of action that has the consensus of virtually all the countries of the world.

Influencing institutions (SDG 16) and means of implementation (SDG 17) is the key to achieving the 2030 Agenda. As Ban Ki-Moon noted, “To successfully implement the 2030 Agenda for Sustainable Development, we must move quickly from commitments to action. To do this, we need strong, inclusive and integrated partnerships at all levels”, and in the same vein, the Action Plan for the implementation of Agenda 2030 in Spain is included, a commitment to promote partnerships for SDGs among all actors as vectors for transformation.

For years, the National Institute of Public Administration has been interacting with society and other institutions; weaving alliances with counterpart institutions, both national and international, especially in the Ibero-American sphere; with social organizations, mainly from the area of disability; contributing to the institutional strengthening of countries in Latin America and the Caribbean or the Maghreb, within the framework of Spanish cooperation; articulating a network of researchers in the field of public administration, or developing seven official university master’s degrees with the Menéndez y Pelayo International University last year. The Institute’s mission is to meet the needs of citizens by contributing to the process of transforming public administration into an organization committed to the ethical values that should guide public policies: effective equality, inclusion, diversity, sustainable development, responsibility, representativeness, transparency, participation and integrity.

That is why INAP has joined the Alliance for the Day After, an initiative launched at the end of March by three institutions from the world of academia and research (Spanish Network for Sustainable Development (REDS), SDSN’s antenna in Spain; Innovation and Technology for Development (itdUPM), Global Health Institute (ISGlobal) together with a private sector company IBERDROLA that started with a virtual meeting that brought together more than 2,000 people live. The alliance is constituted as a great space for analysis, reflection and action, with a vocation to anticipate and present proposals for that “day after” by acting from now on. In the alliance, which is in the process of being constituted, institutions from academia, the private sector, public administrations and the third sector participate. The disaster caused by the SARS-CoV-2 has highlighted the need for solidarity, unity of action and cooperation.

INAP shares with the promoting organizations that, in order to overcome a crisis, it is fundamental to have common, clear and shared objectives, and this is precisely the philosophy of the Sustainable Development 2030 Agenda, the problems of today's world are interconnected and require a global and holistic response through multi-stakeholder partnerships.

The Day After Alliance is complemented by a platform conceived as a space for work, learning and collaboration and is made up of four thematic communities (development cooperation, transformation of cities, ecosystems and health, and inequality and new economic model), a data laboratory, a turquoise Agora, which is a space for making the debate visible, InovAcción, a space for ongoing demonstration projects and Colab, a space for activating collective intelligence and co-creation.

The Day After Alliance becomes an opportunity to address new ways of working and collaborating with the rest of the actors, to accelerate the change towards the compliance of the Sustainable Development Goals.

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Spain: Telework as a Public Innovation Strategy

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“Human beings have always been much better at inventing tools than using them wisely”

Yuval Noah Harari “21 lessons for the 21st Century” 2018

The COVID-19 pandemic has led to the widespread introduction of telework in Spanish public management. Before this pandemic, telework in public sector in Spain was a rare exception, except for the executive level, which has always practiced it, even without any right to digital disconnection. Until lockdown, this mode of work was only provided to specific people to allow them to reconcile their work with their family life, a challenge that has been very present in the latest reforms of the Spanish public employment status and which until now had resulted in making working hours or weekly working day more flexible, new work permits and new administrative situations.

This limited development of telework in public management can be surprising if we take into account that since 2015 the basic legislation on administrative procedure imposed on all public administrations the conversion of formalities, documents and files into electronic formalities, documents and files. Although significant progress has been made in digital administration, telework has not been adopted as we would expect: the pandemic has had to arrive so that many public institutions have introduced in their management the communication, collaboration, storage and learning utilities of telework.

If we want to consolidate with strategic vision this change, we should ask ourselves first for the reasons that have so far prevented the systematic implementation of telework in the Spanish administrations.

The first reason is that social changes are slower than technological changes.

Second, the delay in the implementation of telework reveals a weak internalization in public institutions of an approach specific to “economic rationality”. Administrations have not clearly seen the opportunities that telework provides for saving current expenditures. Teleworking can promote a more rational use of office spaces by adopting coworking models, rationalize opening hours and reduce maintenance and security services.

Third, the lack of a systemic thinking and internalize transversal sustainability goals, that in the business world are managed as “corporate social responsibility” and that are reflected in the EFQM or CAF models of excellence as “Results for society”. Public institutions may find on telework the opportunity to commit to the 2030 Agenda and its Sustainable Development Goals (SDGs), some of which concern telework: reduce the number of deaths and injuries caused by road accidents (3.6); reduce the number of deaths and diseases caused by air pollution (3.9); ensure the full and effective participation of women and equal leadership opportunities (5.5); achieve higher levels of economic productivity through technological modernization and innovation (8.2); reducing the negative per capita environmental impact of cities, granting particular attention to air quality (11.6); incorporate climate change measures into national policies, strategies and plans (13.2); and finally, create effective and transparent institutions at all levels (16.6).

Fourth, in Spain the presence at the public offices is valued more than necessary. ¿Why is presence at the workplace so highly valued, above professional behaviour or results? Because in most public offices, compliance with the day hours and the weekly working day is practically the only formal assessment parameter for public employees. In fact, the performance assessment of public employees based on objectives, product, outcome or impact, or professional behaviours, is really extraordinary.

Fifthly, we appreciate uniformity more than equality and often confuse them. This trend reflects mistrust in people who exercise public power, either out of technical incompetence or for their lack of ethics or honesty. Uniformity seeks to avoid arbitrariness but in exchange for effectiveness, results orientation, and respect for social diversity. This general mistrust in public management also casts suspicion on telework which, by its nature, cannot be extended to all public employees, which entails discrimination and diversity of treatment.

To counteract any of these weaknesses, some form of transparent and objective assessment of public employee’s performance could be implemented.

Despite the basic statute of the public employee, approved in 2007¹, requires the evaluation of performance in its subjective scope, basically confined to the administrative field rather than the provision of services, only some public institutions have met this requirement. Most of them still do not formally assess people's performance and they simply control almost exclusively the compliance of the weekly working day and the working day in the workplace. Needless to mean that this model of personal responsibility hardly promotes efficiency, commitment and innovation, but it's very comfortable for the employees and for the public executives themselves. What changes with telework is trust in people, their empowerment and their directing to achieve goals, results or impacts. For it to work, the results of the evaluation need to be associated with a system of incentives and rewards.

In a post-coronavirus scene, we should take advantage of the irruption of telework to consolidate it as a more rational, flexible and task-oriented work modality. Can telework become a strategy to change the public management and direction model in Spain?

¿Are we ready for the change?

¹ This Statute was initially adopted in 2007 but is currently regulated by Royal Legislative Decree 5/2015 of 30 October approving the consolidated text of the Law on the Basic Statute of public employees (Boletín Oficial del Estado No. 261 of 31 October 2015).

Spain: Responses to COVID-19 Pandemic: Early Lessons for Public Governance Transparency and Good Governance

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COVID-19 has shown to be a challenge not only for our personal and professional lives but also for the role developed by Public Administrations in guaranteeing the citizen's right to receive adequate, accurate and updated information on this sanitary crisis.

Transparency, more than ever, is a key element not only to help citizens to fight against the virus- that is why public campaigns in media are very helpful - but also to reinforce the citizen's trust in decisions taken by our Governments in order to believe that the end of the crisis is possible and near.

Citizens need to receive information as an essential tool to avoid fake news – so frequent these days in social networks and WhatsApp– but it has to be connected with clear, coordinated between responsible units and understandable messages sent by Public authorities. There is nothing stronger against fake news than the truth and clarity in the message. If true, clear and easily accessible public information is available, we could fight against misinformation that only provokes confusion.

We are also aware these days about an increased number of public appearances providing data and information about the measures taken by their Departments. In my opinion, the needed transparency in the evolution of the situation and the steps taken to fight against the virus are not strictly connected to a high number of data and information that, on the contrary, could probably create confusion and contradictions. Transparency is not only

equivalent to the disclosure of a lot of document and/or data, but in doing so in a clear, structured and understandable way. The right to know is connected to the right to understand the information provided.

The information made public has to be understandable. This is a key aspect that needs to be safeguarded. In this sense, Spanish civil society organisations have provided good examples on how information given by the Government can be public and available in a different way in order to reach most of the population. CIVIO Foundation is a good example and their factsheet (CIVIO, 2020) on the measures adopted to prevent COVID-19 are of the utmost interest. This exercise, apparently simple, has not been done by public authorities but by civil society organisations compromised with transparency of public decisions, a question of great importance, even more in these days, in order to give confidence and legal safety to citizens.

But transparency is also to provide information that answers the citizens' interests and not only those considered interesting by public authorities attending to criteria that are not always coincident with those of the citizens. There are some good examples in Spain but it is specially remarkable the work done by the Directorate General of Transparency and Open Government of the *Junta de Castilla y León* in providing in an open data format, information about the evolution of the virus in its territory (Junta de Castilla y León, 2020) (impact considering age and gender, in the primary assistance...) as well as other data related or linked to the situation like the impact in the labour sector.

The alarm status in Spain has also had other implications, on which the citizens might not be aware of but not that less important. Since March 14th, the administrative and procedural terms- except in those procedures linked to measures related to the alarm status as well as those related to the protection of fundamental rights- are interrupted. This interruption, in connection with the exercise of the right to access to public information guaranteed in the Transparency, right to Access to Information and Good Governance Act has a concrete consequence: the term to provide an answer to a request for information is interrupted until the end of the alarm status. For that reason, any request for information referred to public decisions related to the COVID-19 crisis and submitted these days will have an answer only with the cease of the alarm status. An extended delay that is clearly not connected with the need to an immediate response in this situation and which impact is worse in the absence of a comprehensive transparency of public information of interest.

For that reason and even when the current crisis makes incompatible the ordinary development of work linked to the procedure of a request for information, I really understand that it would be desirable to identify those

requests related to information on this crisis and give them a priority status. It is also desirable that the answer given make real the aim expressed by the Transparency Act with these words:

Transparency, access to public information and the rules of good governance must be the basic pillars of every political action. Only when the action of public authorities is subjected to scrutiny, when citizens can know how decisions affecting them are made, how public funds are managed, and under what criteria our institutions act, will we be able to speak of the outset of a process in which the public authorities begin to respond to a society that is critical, exacting and demands that public authorities enable participation. Countries with higher levels of transparency and rules of good governance have stronger institutions, which foster economic growth and social development. In these countries, citizens can judge, more accurately and using better criteria, the capacity of their public authorities and decide accordingly. Better supervision of public activity contributes to the necessary democratic regeneration, promotes the State's efficiency and effectiveness and fosters economic growth.

This crisis will be hopefully over soon and, even its consequences will remain, Public accountability cannot be affected, even more when related to a question of general interest as public health.

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Tunisia's Success in Shielding the Elderly from the Ravaging Epidemic of Coronavirus

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There are 31 elderly care institutions in Tunisia: 12 public and 19 private institutions for a total resident population of 560 and 254 people respectively. There are also 21 day-clubs for the elderly all run by the Ministry and which were closed during the lockdown. This small number of total resident population in elderly care institutions reflects strongly held social values of taking care of the elderly in their natural social habitat and family environment. Notwithstanding, the Ministry for Women, Family, Childhood, and the Elderly took its utmost precautions to care for its resident clients as well as other elderly in precarious situations.

As of May 24th, 2020 when the pandemic was already dwindling down across the country, the elderly that reside in accommodation facilities run by the Government or the private sector had been spared by the COVID-19 epidemic in Tunisia and no cases had been recorded. For this, drastic measures were taken to ensure their protection. Indeed, and since March 13, even before the announcement of total lockdown nationwide, the ministry had already started implementing a complete strategy to protect the elderly against COVID-19. Of the total number of 1021 tests done, no resident tested positive. The only 8 positive cases detected through the Ministry's channel were of former patients of elderly care institutions, detected as part of the ministry follow-up strategy. It is worth mentioning that COVID-19 testing in Tunisia is done only on cases with a perceived risk or exposure.

The care system for the elderly in Tunisia is regulated through Law No. 114 of October 31, 1994 relating to the protection of the elderly and relevant texts, especially Order No. 1017 of 1996 related to setting conditions for accommodation in institutions for the care of the elderly and Order No. 1766 for the year 1996 related to setting conditions for the creation of private institutions for the care of the elderly, and specifying the conditions for the private sector to operate such institutions.

As a result of the exceptional circumstances experienced by Tunisia, during the Corona epidemic outbreak (COVID-19), the Ministry of Women, Family, Childhood and the Elderly implemented a number of procedures, mechanisms and measures as part of the framework of an overall strategy to protect the elderly from the ravaging effects of the pandemic. The set of urgent and exceptional measures covered the following elderly segments:

- Residents of public and private institutions of care for the elderly.
- Elderly people placed with foster families.
- Indigent, low-income, and special needs elderly.

For the first target segment living in public and private institutions, the Ministry undertook the following measures:

- Complete isolation of residents from the outside environment including a full ban on outside visits. Residents were however provided with facilitated social media access to allow them to communicate with relatives.
- Setting them up on mobile payment services to enable them to receive their retirement pensions, social benefits, and other money transfers. These services were set up during the crisis in coordination with banks and the National Post Office.

As for health measures enforced in elderly care institutions and other than the standard ones, the following were mandated:

- Care teams were required to remain in residence for shifts of 72 consecutive hours. This lowered the risk of outside contamination through the care teams.
- Elderly care institutions were required to transport their personnel by their own sterilized vehicles. Personnel were not allowed to move around freely like through public transportation for example.
- Personnel were subjected to clinical investigation in case of any doubt or perceived health risk.
- Moreover, several regulatory measures were enforced to protect the physical premises of elderly care institutions. The Ministry coordinated with the Ministry of Environment, local departments of health, and municipalities to sterilize the premises of care institutions (public and private) on a daily basis and to provide the necessary protective equipment and cleaning and sterilization materials (Disinfection gel, masks, tissue and hygienic paper, etc.) to all public and private institutions.

As for elderly people who live with foster families, a five-month advance of the grant paid for such families was disbursed upfront to foster families in

addition to a one-off extraordinary circumstantial direct cash assistance worth 200 dinars.

For the third category of indigent, low-income and special needs elderly who live in their normal social habitat, the Ministry staged a media campaign under the slogan “We are with you; you are not alone” and established a dedicated hotline to receive social and health requests from the elderly. They were immediately retrieved and placed in safe environments whenever they were in situations where there was a risk of violence or any type of threat. This service was available throughout the week and during the entire period of comprehensive quarantine. Other measures taken include:

- Coordination of in-kind aid distribution by civic society organizations and associations.
- An exceptional circumstantial financial aid of 200 dinars for the benefit of low-income people and an additional 50 dinars for the needy without income.
- Continued supply of electricity and running water for two months even in the case of non-payment of utility bills (for the benefit of the destitute and those with limited income who cannot afford it).
- Accommodation of homeless people in dedicated shelters.
- Accommodation of the elderly in risk situations of violence and other threats in dedicated shelters.
- Supply of medicine and medical equipment to spare the elderly the hassle of moving for that purpose.
- Provision of social and health services by mobile teams.

For these two categories of non-resident elderly, the Ministry has 31 mobile teams that roam the country to investigate individual situations.

Turkey's COVID-19 Pandemic Response from a Practitioners' Perspective

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Initial Feelings after receiving Hearsay of COVID-19

As an academician, I found myself in a peculiar position at the very beginning of the COVID-19 crisis. When the first news and official explanations of the Pandemic appeared on the media, we were trying to plan and realize participatory meetings with the citizens about organizations of thematic discussions related to the City of Ankara since I am the vice head of the Citizen's Assembly¹. I had been involved with this organization as a consequence of my practitioner's background in city planning and administration. Since our activities about the city agenda and urban issues are based on face-to-face interaction and various types of meetings such as general assemblies, focus groups, and advisory bodies, etc. announcements about stopping such meetings right away for a seemingly indefinite period sent a mild shock among our stakeholders. I had the same observation for the civil servants and municipal administrators with whom we were working together closely. Thus, the first reaction to the information disseminated about the precautions taken in Turkey was a feeling of loneliness and frustration against the loss of some types of collective decision-making and working methods. The sense of being stripped of ordinary collective cultural, administrative skills later mixed with the hardships of getting the job done without disease transmission. Nevertheless, the initial anxiety in executive and managerial ranks was substituted with some agile organization movements, especially in healthcare and crucial logistical sectors. Yet, it was not overcome easily in some other areas such as higher education (Bulut Sahin, 2020), and industrial production of commerce.

¹ In Turkey, a citizen assembly (or Kent Konseyi in Turkish) is a participatory local government level organization in which all the representatives of universities, NGOs, public institutions, unions and chambers are free to join and put forward mainly advisory decisions for the mayor and elected city council. In that sense, it is a complementary body of participatory nature.

Muddling Through for Higher Stakes vs. Working under Usual Stakes

The following weeks proved to be full of dichotomies and tensions for the people working in public domains for various reasons. First of all, the flow of information through the usual bureaucratic circulars and other channels was not adequate to not only give necessary details and know-how about the measures being taken but also lacking directions to change the behaviours of citizens to comply with the new rules of life. Nearly at all phases and tiers of administration, some adaption strategy and a renewed understanding of service provision were needed not only for public services but also for all the services provided by the private sector and NGOs under public scrutiny.

Adaptation for the street and middle-level bureaucrats were relatively more straightforward and rapid than the general public because changing citizen behaviour has been much more challenging. For instance, in most of the incidents of misuse of official power during the control efforts of the public servants reflected in social media in measures of lockdowns and curfews later proved to be related to the information gap between citizens and the government declarations. Then, the reassuring explanations of the Minister of Health and the members of the Scientific Committee of the Ministry of Health mostly resolved this issue by persuading the Turkish people to the necessity of the precautions.

However, another intergovernmental challenge emerged at the beginning of April 2020. Turkey has been struggling with the repercussions of many governmental and political changes altogether in the last decade, including a failed coup, an overhaul of the governmental system from a parliamentary to a (semi)presidential one, and metropolitan administration reform. There were significant trust issues among public officers at all levels. Hence, the civil servants found themselves in the middle of political contradictions that avoided proper collaboration among different tiers of the government.

This challenge became most visible between the Presidential Office's efforts to provide aid to people under lockdown through provincial administrations, and the activities of the metropolitan municipalities under the rule of the opposition parties to organize solidarity campaigns vexed each other (BBC, 2020). Most of the bureaucrats had to mitigate this political and administrative burden imposed upon them via informal channels and behaviour. They also had to find innovative solutions for incompatible administrative processes. Nonetheless, despite successful healthcare solutions during the Pandemic, there were some fundamental failures, such as the distribution of masks to the general public.

Lessons Learned?

Although the Turkish administrative experience at the ground level has to be studied thoroughly later based on detailed accounts of the cases, few lessons could be noted. The first one is the importance of the versatility of the administrative structures and human capacity under crises like COVID-19. Under transition periods, an exciting combination of tensions and innovation capacity emerges simultaneously as a result of political and administrative change. The second one is the prevalence of synchronizing organizational behaviour with the citizens' reactions and responses via a robust and incrementally operated communication strategy to boost the emergence of new collectivities in crisis management. Lastly, it is evident in the Turkish Case that a new type of managerial and public policymaking capacity is needed in public agencies under crisis conditions that necessitate an agile reflex to re-organize collective forms for decision making and service delivery (Mergel, Whitford and Ganapati, 2020).

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Part III
National Reports

Africa

The COVID-19 Pandemic and the Ethiopian Public Administration: Responses and Challenges

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Abstract

Since the outbreak, in the early January 2020, in China, the Coronavirus has been spectacularly spreading all over the world affecting socio-economic development and political environment. Using secondary and primary dataset and content analysis thereof, this article explores how the Ethiopian public administration is responding to the virus. It finds that the Ethiopian government/civil service predominantly using the top-down institutional approach. The paper concludes that the unresolved socio-economic and politico-administrative wicked problems and the cultural contexts are significantly constraining the capacity of public administration and civil service to respond to the pandemic. The key challenges are discussed, normative solutions are suggested and lessons are drawn.

Keywords

Public Administration, response, challenges, coronavirus, Ethiopia

Highlights

The Coronavirus has been affecting the socio-economic wellbeing of citizens and political environment.

Appropriate interface between a macro institutional approach and behavioural public administration, effective public leadership at all levels, and dialogue and innovative approaches are needed to resolve socio-economic and politico-administrative wicked problems.

Introduction

The COVID-19 virus has affected socio-economic development and political environments all over the world. For example, the scheduled Ethiopian National election, in August 2020, is postponed creating a constitutional and political crisis.

Ethiopia confirmed the first COVID-19 case on 12 March 2020 (Ministry of Health [MOH], 2020). Since then, (as of 19 May 2020) 365 people are infected and five have died (Worldometers, 2020). Yet, given the weak institutional capacity, it should be noted that Ethiopia with a total population of 109,224,559, according to the 2018 World Bank estimate, has a high vulnerability to the pandemic.

To prevent the spread of the pandemic, the country established a National Ministerial Committee on 16 March 2020. As the concern is mounting, the government and the parliament declared a state of emergency respectively on April 8-10 2020, and the council of ministers issued regulation 11 April 2020. Furthermore, to increase the national public health preparedness and coordination capacity, the World Bank allocated an amount of \$82.6 million: a 50% loan and a 50% grant (Ministry of Finance, 2020).

The Ethiopian Public Health Institute is responsible for the surveillance of COVID-19 in all hospitals. Recently new testing centers were established in some selected towns. The MOH is the only official institution responsible for providing regular updates and in each instance it urges prevention and protection.

Using a secondary dataset (World Bank database, official documents and press release), unstructured interviews with 12¹ civil servants² (two women) and personal observations in Adama City, this paper describes and explores the preparedness, responses and key challenges of public administration and the civil service to prevent the spread of the pandemic.

The Response of Public Administration

Ethiopia focuses on preventing the virus than containment. The National Ministerial Committee among others emphasizes prevention and protection; a 14 days mandatory quarantine of passengers arriving to Ethiopia, avoiding public/religious meetings/ gathering; health sector capacity building; regulating market to avoid unethical exploitation of the situation; and supporting regions' preparedness to prevent the disease (Office of Prime Minister, 2020). Similarly, the emergency proclamations and the regulation

¹2=federal civil, 3=Oromia Regional Bureaus; 7=local governments in the Oromia National Regional State

²8=telephone interview and 4 face to face interview keeping physical distancing

among others emphasizes avoiding handshakes, reducing the number of public transport passengers to 50%, keeping adequate physical distancing, providing cleaning and handwashing facilities in each public institutions. The regulation specifies that the national committee is responsible for the overall coordination and leadership; establishing committees at federal, regional, local and city administration levels and providing necessary instructions and evaluating their reports; depending on the context uplifting or increasing the restrictions and the obligation imposed by the regulations; and imposing uniform structures and regulations and system for regions and city administrations. Efforts are also made to reorganize the marketplace to minimize public overcrowding both in the urban and rural areas.

The federal civil service bureaus and offices, the regional equivalents and local governments focuses on institutional related factors such as establishing a pandemic prevention and control committee; providing public education; approving special leave particularly for staff having blood pressure, diabetes, heart cases, asthmatic and other respiratory cases; providing institutional transportation; rearranging office space to ensure physical distancing; ensuring individual and workplace cleaning and sanitation services; improving service public service process and providing facilities (comprising supplying cleaning and protection facilities, adequate physical distancing and customer sequencing); and reporting civil servants infected by the virus (Oromia Public Service and Human Resource Development Bureau, 2020).

Furthermore, some civil service institutions were closed (e.g. higher education institutions, primary and secondary schools) while some others were operating with less than 50 % workforce, suggesting public services were substantially reduced. Interviewees also reported, due to emotional stress, the number of citizens seeking public service was also proportionally reduced. The problem is worse, when the competence and commitment of the civil servants is low, which an interviewee claims was missing among many civil servants even under normal circumstances.

Industries, factories, and private institutions were also partially or fully closed, having huge implications on economic growth and citizens' income. However, recently, to lessen the economic impact, the government requested the industries and factors to continue their production, putting in place all preventive measures. Officially, the government also announced that it was going to provide funding to improve economic resilience. Besides, officially the government, for example, the Oromia National Regional State, also emphasized the need for increasing agricultural productivity. The banks were also reduced the interest rate. Yet, the small and informal business may not benefit from financial measures, having implications for the poor, women, and the disadvantaged.

The roles of religious leaders were also remarkable. Using mass media, religious leaders and other actors are continuously addressing the public although the religious institutions are also officially closed.

The Unprecedented Challenges

Public administration and politics

Six broad politico-administrative challenges could be distinguished. First, despite a series of politico-administrative reforms and capacity building programs the Ethiopian public administration is weak. Second, the dysfunctional distrust among political parties since the 1990s and citizen's distrust in government and public administration, due to historical and sociological factors, disturbs institutional response to the pandemic (Mo Ibrahim Foundation, 2020). Some local government level interviewees mentioned many citizens, including the civil servants, distrust government and public administration, including awareness-raising campaigns. Likewise, a regional level interview also reported that many citizens were not complying with policies and decisions and thus the interviewee suggested the government should take the required legal action.

The third challenge is related to the lack of adequate inter-sectorial cooperation and coordination among relevant public sector institutions (Peterson, 2015), including the One Water, Sanitation and Hygiene actors. According to the interviewees, the cooperation and coordination challenge is huge at the local government and village administration levels, which are also confirmed by other past studies (Butterworth et al., 2013; Debela & Troupin, 2016). Fourth, the armed fighting between government and other forces, in some areas, and the ongoing political instability could further constrain the institutional capacity of government and other actors to reduce the impact of the pandemic (Human Rights Watch, 2020).

Fifth, the influence of the deep-seated top-down planning and hierarchical politico-administrative culture inherited from the previous regimes (Hagmann and Abbink, 2011; Holcomb & Ibssa, 1990) and prevalence of neopatrimonialism in the public sector (Bierschenk & Olivier de Sardan, 2014) is allegedly constraining the willingness and capacity of local actors. As already mentioned, the institutional arrangement of the national taskforce and the sub-committee at national, regional and local levels is predominantly top down.

The sixth major challenge is concerned with citizens' expectation and behavioural dimensions. It is apparent that citizen expectations, particularly the poor and the disadvantaged, in Ethiopia, are much higher than the capacity of public administration to respond. Concerning the civil servants,

the overarching focus on the structural- instrumental approach and the inadequate attention to the behavioural dimension of public administration is a critical issue. The majority of interviewee mentioned those civil servants on leave were not staying at home; they were walking on the streets, visiting their friends and families and playing games. In addition, some interviewees, at local government level, have significant concerns about the corruption in the public sector. They point out that the leave and stay at home policy allowed officials to systematically side-line young, healthy, competent and critical civil servants, who were challenging them and fighting corruption in the sector. The federal and regional level interviewees were however not in agreement with the increase in corrupt practices. Instead, they noted that the community and voluntary services have increased.

Health institutions

On all accounts the institutional capacity of the Ethiopian Health Institution is weak even when compared to the Sub-Saharan African (SSA) average. For example, in 2014, the domestic general government health expenditure per capita of Ethiopia was about three and a half (19.20) less than the SSA average (69.19). Likewise, while the domestic general government health expenditure of Ethiopia was 27.62%, the SSA average was relatively better (35.07%). (World Bank, 2020).

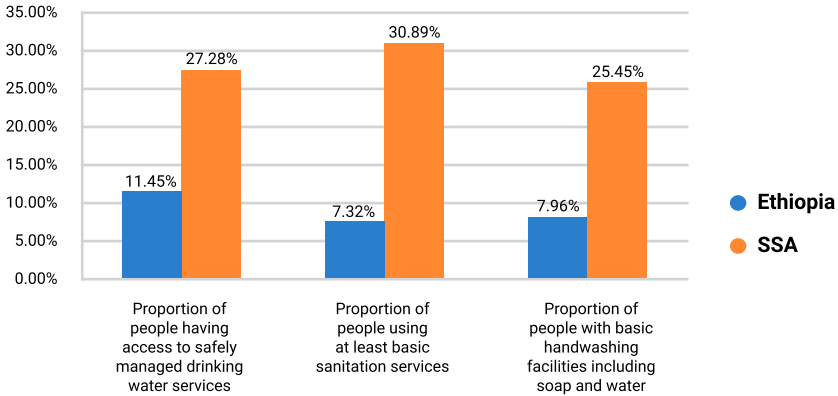
The inadequate number and the quality of medical staff is also a critical concern. Concerning the quantity, according to the World Bank database, the proportion of physicians (per 1,000 people), and nurses and midwives (per 1,000 people), in 2017, in Ethiopia was only 0.1 and 0.84 respectively. Indeed, while writing this paper, government, multilateral and bilateral organizations are mobilizing resources to improve the institutional capacity of the health sector. The retired but strong health professionals are also returning to their jobs.

Access to improved drinking water and sanitation

One of the basic recommended actions to fight the pandemic is to regularly and adequately wash hands (at least for 20 seconds) with water and soap. However, since access to improved drinking water sources and sanitation services is low, in SSA in general and in Ethiopia in particular, practicing this recommendation could be extremely difficult for many people (see figure 1).

Furthermore, there is substantial urban-rural inequality on access to basic services, people living in urban areas having relatively better access. Other socioeconomic inequalities at local and house levels will compound the wicked problems. Local level interviewees mentioned that, due to the inadequate budget, local government public institutions were not able to provide basic sanitation facilities to civil servants and citizens that are seeking their services.

Figure 1 - Access to drinking water and sanitation services (2017)



Source: World Bank (2020).

Urban housing condition

People living in urban areas could have more infection risks. In 2014, the World Bank database shows, nearly 74 % of the urban populations in Ethiopia were living in slums, which is far higher than the average percentage of urban population living in slums in the SSA (55.3%) (World Bank, 2020). Under such living conditions, controlling the outbreak of the virus would be extremely challenging. The lack of adequate basic urban infrastructures, inadequate institutional capacity and the difficulty of physical distancing in practice, the high number of homeless people and street children, increases the wicked problems. Interviewees also indicated that the urban housing condition were also extremely dangerous for the majority of civil servants who are living in rental houses, particularly for those living in a shared compound, and in slums, pointing out to the fact that providing annual leave for the civil servants may not reduce the risk of contracting the virus. The decision of the government to prohibit increasing house rents and forcing people to leave the rented house for any reason to some extent could protect the wellbeing of citizens and civil servants.

Cultural factors

On Hofstede's individualism vs collectivism dimension of national culture, the country scored low (20), and thus Ethiopia is considered to be a collective society, suggesting the society gives more weight to group well-being than individual freedom (Hofstede, 2020). This cultural context may have both positive and negative influences on preventing the virus. On the positive side, the collective culture could help to assist people, particularly the very

poor and the disadvantaged. This was mentioned by some interviewees while other interviewees insisted that the relative capacity of a citizen to help other citizens is insignificant. Of course, the public sector, the private sector, CSOs and individuals are providing support to the people most in need.

On the very negative side, the collective culture can open ground for the spectacular spread of the virus. Partly due to cultural values, as revealed by many interviewees, the society did not comply with health professionals' and official prescriptions and advice. Similarly, during the initial period, citizens were not complying with the advice of religious leaders; they were going to religious institutions. However, over a time the influence of religious leaders appears to be more significant than the public sector. Yet, as one interviewee reported, though slightly reduced in urban areas, the social gatherings remained unchanged in semi-urban and rural areas. This cultural context could discourage committed civil servants from providing services on one hand and increase their vulnerability to the diseases on the other.

Urbanophobia and basic need supply

The virus has reversed rural-urban mobility; rural people appeared to abandoning traveling to urban areas. This holds true for rural people who are living in urban peripheries, who can travel on foot or horseback to cities. These dynamics could be called urbanophobia. The pandemic also affected urban-to-urban mobility. The urban-urban movement was also constrained due to restricted transportation services. Both urbanophobia and the limited urban to urban movement could limit the spread of the diseases.

On the one hand, the interviewee mentioned, the restricted movement appears to be significantly affecting the flow of basic items (food items) from rural areas to urban, and urban to urban, although there is no extreme shortages at the time of writing this paper. According to interviewees, the follow of raw agricultural products in rural areas and rural towns remains unchanged.

Another concern is that those civil servants and citizens who are living in urban peripheries and who do not have transportation services were not able to adequately access basic items in the urban centers. In addition, as reported by interviewees, the pandemic has increased the level of inflation.

A stay at home policy has also consequences. At an individual level, some interviewees mentioned while it has improved family relations and savings, in contrast, others claim the policy has increased their expenses, and the emotional stress has increased interfamily conflicts. At the organizational level, the pandemic significantly weakened employee relations. Interviewees pointed out that, given the unfeasibility of working from home and even at the workplace

due to huge emotional stress and depression, the physical and emotional support from their institutions to ensure their wellbeing was inadequate. Some local interviewees have also expressed concern about their jobs and salary if the pandemic continues for a longer time. As yet, the government has not decided to implement salary cuts and civil service retrenchment.

Internet and mass media

During this very critical time, the role of effective and timely communication to educate people, to share information, to change the behaviour of citizens is significant. However, it would be difficult to reach all citizens in Ethiopia. First, the huge majority of people do not have access to the internet and mass media (radio and television). Second, the shutdown of internet and phone communications, due to armed conflict between the government and other forces, in some parts of the country, combined with other factors affected public services and escalated human rights violations; including arbitrary unrest and intimidation by security forces (Bader, 2020; Human Rights Watch, 2020). The government has restored the system in the last week of March 2020. Third, while Ethiopia is a diverse country, many media remained monolingual. For example, the cellphone-based educational message by Ethiotelcom communication was only in Amharic. Some governmental televisions were also using a single language. Indeed, the private and some religious mass media have attempted to fill the gap.

Comforting the responses and the challenges: what is to be done?

Many governments, including the Ethiopian government, officially claim that they have been made sufficiently prepared since the outbreak of the disease in China. However, in practice, it should be noted that downplaying the pandemic, particularly during the initial period, was the global politico-administrative crisis. At least, governments could have tracked the travellers' database allowing the government to have travel records and furthermore people that they have had contact with. More importantly, however, at this point, blaming actors and blame-shifting cannot be a solution. This is a time to learn and unlearn - first- things -first, to successfully preventing the diseases.

The deep-seated socio-economic and politico-administrative contexts, the multiple variables at a play and perhaps the non-linear connectivity between the variables, and the pandemic have increased the wicked problems; policymakers, and public administrators do not have ready to apply a set of solutions (Peters & Tarpey, 2019; McConnell, 2018). Besides, the wicked problem can significantly weaken the coordination capacity of the government

(Christensen et al., 2019). Yet, to minimize the wicked problems and for ‘public sector to prove its legitimacy’ (Bouckaert, 2019, p. 14), some normative solutions could be made, but “the power to decide rests with the political decision-makers” (Cox III et al., 2011, p.141).

One of the normative solutions is expectation management. Although functional distrust is laudable, to improve democracy, according to scholars such as Bouckaert & Van de Walle (2003), the government can improve trust in government/public administration by conditioning citizens to change their demand/expectations. To achieve the desired outcome, dialogue and innovative approaches need to be emphasized.

The second suggestion is enhancing public service motivation and improving behavioural change at all levels. As pointed out by Cox III et al. (2011) the public administration work the way it does because of the civil service suggesting that public administration should ensure effective public leadership (Broekema et al., 2019) and increase civil servants public service motivation, maintain positive work-related relationships and actions (positive behavioural change) (Perry & Van de Walle, 2008; Paarlberg et al., 2008). The government should also properly enforce the policies.

The third proposition is balancing vertical and horizontal coordination at all levels of government. To increase the vertical and horizontal coordination capacity, in particular, the top-down approach, depending on the context, should be sufficiently equilibrated by the bottom-up approach. Christensen et al. (2019) claim better collaboration and coordination at all levels is substantially helpful to address wicked problems.

Another normative solution is harnessing the role of mass media, and religious institutions and community leaders to inform, to educate, and change the behaviour of actors and to mobilize resources, particularly at the local level. It is also vital to note that these actors should be inclusive and effective. Furthermore, all actors, including political parties should refrain from using the pandemic as a political instrument and at least protect human rights if it is difficult to fulfill it, during the crisis period. The constitutional separation between state and religion should not also be compromised.

Conclusions and Lessons

The unresolved socio-economic and politico-administrative wicked problems, the cultural context and the inadequate behavioral change were significantly constraining the capacity of government to respond to the pandemic that has disrupted the economic, social and political context in Ethiopia. However, the role of mass media, religious and community leaders is

remarkable. Overall women, the poor, the disadvantaged, internally displaced people and those relying on informal business could be severely affected. Of course, the limitation of the paper referring to the use of a secondary dataset and unstructured interviewees and personal observation and relying on response approaches of only one Ethiopian Region should be noted. Future nationwide behavioral public administration studies may apply a mixed research design.

Nevertheless, five lessons are drawn.

Lesson 1: Need to resolve the politico-administrative and socio-economic wicked problems

Lesson 2: Necessity to strengthen solidarity, among all actors at global, national, regional and local levels to prevent the Coronavirus and other diseases in the future.

Lesson 3: Need for strengthening politico-administrative relations to improve policy and administrative and coordination capacities.

Lesson 4: Need to strategically mobilize Mass Medias, religious and community leaders to upsurge resilience and support the most vulnerable.

Lesson 5: Need to integrate a macro institutional approach and behavioral public administration, and effective public leadership at all levels.

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National Experiences and Responses of Nigeria in Dealing with the COVID-19 Pandemic

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Abstract

The index case of the coronavirus pandemic in Nigeria was announced on February 27, 2020, since then 11,116 cases have been confirmed, 3,329 patients discharged with 315 deaths (June 5, 2020). Nigeria has a fragile health care system and experts predicted that the country could be overwhelmed by the pandemic. Indeed, a modelling study showed Nigeria among African countries with medium risk, variable capacity and high vulnerability. This paper examines the country's preparation, responses and experiences (government measures and public policies), in dealing with the pandemic as well as the key challenges and early lessons learnt. The paper notes that though the national response to the pandemic is led by the Federal government through the Presidential Task Force (PTF), Nigeria does not have a comprehensive strategic national policy to deal with the coronavirus pandemic. We conclude that dealing with the pandemic requires collective efforts of policy and a resilient healthcare system.

Keywords

Challenges, healthcare, pandemic, public policies, preparedness

Introduction

At the end of 2019, a new pandemic appeared on the world scene in the shape of the novel coronavirus. The COVID-19 pandemic has significant implications for public governance. This emerging condition has quickly overwhelmed the world and most countries are vulnerable including Nigeria, Africa's biggest country by population estimated at 200 million and its largest economy by Gross Domestic Product (GDP). It has the world's 10th largest proven oil reserves and abundant natural resources. Combining oil and gas wealth with the entrepreneurial efforts of its predominantly young population, Nigeria still struggles with infrastructural development over two decades of democratic presidential civilian rule since return to democracy in 1999.

Nigeria has prospects of strong economic growth, however, challenges that hinder the country's economic development still remain. Risks to Nigeria's economic growth include the prevalent poverty and unemployment level in the country. The country faces the challenge of slow industrialization due to poor infrastructure, access to energy and finance, insecurity, weak policies and overall weak institutional/governance framework. The poverty condition rate in over half of Nigeria's thirty-six states is on top of the national average of 69 %. High poverty reflects rising unemployment rate, calculable at 26.1 % in 2020.

The essential gross domestic product growth (GDP) is projected to rise to a pair of 2.9 % in 2020 and 3.3 % in 2021 (African Development Bank [AfDB], 2020). This relies on implementing the Economic Recovery and Growth Plan set up for (2017-20), that emphasizes economic diversification (AfDB, 2020). All of these have been disrupted by falling oil costs and the unfolding Covid-19 coronavirus and Nigeria is heading towards recession triggered by the falling prices of crude oil in the global market plummeting to \$25 per barrel. Nigeria is the most impacted by COVID-19 in West Africa, followed by Ghana and is overall 5th in Africa. These justify examining how this large economy in the continent is responding to the pandemic.

Health Care System

The Nigeria health care system has suffered several down-falls (HERFON, 2020). Despite Nigeria's strategic position in Africa, the country is greatly underserved in the health care sphere. Health facilities (health centres, personnel, and medical equipment) are inadequate in the country, especially in rural areas. While various reforms have been put forward by the Nigerian government to address the wide-ranging issues in the health care system, they are yet to be implemented at the state and local government area levels.

The Nigerian health care system remains weak as evidenced by lack of coordination, fragmentation of services, dearth of resources, including drug

and supplies, inadequate and decaying infrastructure, inequity in resource distribution, and access to care and very deplorable quality of care. Nigeria thus entered the coronavirus crisis as a medium risk with variable capacity and high vulnerability nation (Gilbert et al., 2020; Nkengasong & Mankoula, 2020) and it is feared Nigeria may be swamped if the virus spreads uncontrollably among the nation's massive vulnerable population due to the fragile health care system and weak governance structures.

COVID-19 Pandemic Crisis: Nigeria's Preparedness

In the beginning of pandemics like this, nobody knows what is happening. Preparation is critical for response. Nigeria does not have a comprehensive strategic national policy to deal with the coronavirus pandemic. Although the national response to the pandemic is led by the Federal government through the Presidential Task Force (PTF), coordination and synergy between the arms of government and sub-national entities is poor. For example on January 30, 2020, prior to Nigeria's index case on February 27, 2020, the country's upper legislative chamber (Senate) drew the nation's attention to the global pandemic through a motion titled: "Coronavirus Outbreak and Preventive Response towards Stemming its Spread in Nigeria" (Yiaga Africa, 2020) and expressed concern at the lack of significant action on the part of the executive in its preparedness and response to the increasing threat posed by the spread of COVID-19, and called attention to the lack of proper screening of travellers coming into the country (Order Paper, 2020).

It was not until on March 9, 2020 ten days after reporting the first case that the President set up a joint inter-ministerial Presidential Task Force for the control and management of the Coronavirus. The 12-member task force chaired by the Secretary to the Government of the Federation, included the Director-General, Nigeria Centre for Disease Control (NCDC) and World Health Organisation Country Representative, and had a mandate of six months to deliver on the assignment.

The government statement said it was taking the action given the current global outbreak of the novel Coronavirus and its potential of causing significant disruption to health services in the country as well as impacting negatively on the economy and to prepare for the unlikely but probable major outbreak of the disease in the country. This will require a multi-sectoral inter-governmental approach as advised by the World Health Organisation similar to that adopted for the HIV epidemic in the last two decades. While the PTF provides a daily briefings and responds to policy challenges, the NCDC issues daily COVID-19 situation reports providing a summary of the epidemiological situation and response activities.

Though the President has a team, quite unlike other heads of government, it took much criticism and calls from parliament, and the general public before the President addressed the state on March 28, 2020, a month after the index patient was confirmed. The Federal Government made an initial provision of N920million (\$235,511) for health agencies to plan and guard against the spread of COVID-19 in Nigeria.

Medical Equipment

Preparedness is incredibly necessary as early detection of COVID-19 is essential for prevention of onward transmission. According to the WHO protocols, planning is vital to maximizing restricted supplies using sensible procurement;; designing and defining appropriate quarantine and infection protocols (including procedures for enforcing social distance); building coaching of medical employees within the correct protocols of quarantining people at risk of infection, warehousing of Personal Protective Equipment (PPEs), Laboratories and testing kits, masks, huge health education, enlightenment and sensitization of the population (Nkengasong & Mankoula, 2020). What has been Nigeria's preparedness in terms of stockpiling, provision of medical equipment, laboratories and training in the light of the country's acknowledged fragile health care system?

The Nigeria Centre for Disease Control (NCDC), Nigeria's public health institute disclosed that the National Reference Laboratory, in Abuja, capital of Nigeria was equipped with technical and human resources needed to diagnose COVID-19 (Nigeria Centre for Disease Control [NCDC], 2020). The centre additionally disclosed that the Irrua Specialist Hospital (South-South Nigeria) and the Central Research Laboratory, University of Lagos Teaching Hospital (LUTH), South-West Nigeria have the capability to diagnose COVID-19. Laboratories for testing were increased to eleven by upgrading existing laboratories across the state. The federal agency additionally developed a Surveillance and Outbreak Response Management System (SORMAS) for case-based data for epidemic prone diseases in eleven states of the federation. Additionally, the National Incident Coordination Centre (ICC) was established for eruption state and response activities that will enable the federal agency to collect intelligence reports daily, determine close at hand public health threats and make sure that eruption responses are well coordinated and controlled. Employees and public health volunteers were additionally trained by the centre.

Medical assistance was received from the Chinese government, Jack Ma Foundation and a consortium of Chinese corporations in the form of:

infrared thermometer, hand sanitizers, facemasks, hand gloves, antiseptic wipes, 107 boxes of medical supplies and equipment, comprising surgical masks, medical disposable protecting covering, face shields and detection kits medical consumables, personal protective equipment (PPE) with over one million medical masks for doctors, and ventilators, amongst alternative things valued at over \$1,300,000 (Ibekwe, 2020; Africa Press Office, 2020). Nigerian Billionaires and corporates donated N43billion (\$110million), and the EU, Euro 50million (N21million) (Central Bank of Nigeria [CBN], 2020a).

There are only 169 ventilators in sixteen out of the 36 states, an average of 10 ventilators in each of the states, and in real terms, some of the states do not have more than five ventilators. A hospital-grade ventilator is between \$25,000 (N9.175million) and \$50,000 (N18.350 million) each. According to the Lagos State Commissioner for Health, Prof. Akin Abayomi, experts project that 10,000 ventilators may be required nationwide to cope with the pandemic as the number of confirmed cases from the deadly COVID-19 pandemic increase in the country.

First COVID-19 Case

The index case of the coronavirus pandemic in Nigeria was announced on February 27, 2020, since then 11, 116 cases have been confirmed, 3,329 patients discharged with 315 deaths (June 5, 2020) including a prominent official of the government, Abba Kyari who was Chief of Staff to President Muhammadu Buhari. He died on April 17, 2020, having been tested positive for coronavirus on March 23, 2020. The index case, an Italian filled out the form he was given on arrival. Once he started having symptoms, he did not engage in self-medication; additionally the doctor he visited also took the patients' travel history and was ready to forthwith connect him with the isolation centre in Lagos that expedited safe movement and testing.

Government Measures and Public Policies

Travel ban

By March 20, 2020 when government announced restrictive entry into the country for travellers from 13 countries including China, Italy, Iran, South Korea, Spain, Japan, France, Germany, the United States, Norway, UK, Netherlands and Switzerland the country's National Centre for Disease Control had already confirmed 8 cases (CNN, 2020). Nigeria coronavirus initial cases were travellers coming into the country from high-risk countries. Interstate travel bans have not been effective. The virus has been transported to other states by infected travellers (some asymptomatic).

Lockdown

The national government announced the lockdown of Lagos and Ogun states and the Federal Capital Territory for an initial period of fourteen days (later extended twice) utilizing the Quarantine Act 1990 CAP 384 LFN. The lockdown was later extended to Kano city after a streak of mysterious deaths. The lockdown led to the partial closure of the Federal bureaucracy as junior and middle level officers were asked to stay at home and work from home. Only senior officers and those on essential duties went to work. Sub-national entities variously implemented lockdowns modelling the national government. Markets, shops, private offices, places of worship and schools were affected by the lockdown. Most institutions of learning do not have the relevant technology for e-learning.

Supporting the poor and vulnerable

Nigeria just like all countries worldwide is not accustomed to lockdown. As the lockdown strategy began to be enforced, companies and markets were shut, artisans, petty traders and alternative informal sector workers lost their livelihoods. The national government declared palliatives to cushion the result of the confinement. The Ministry of Humanitarian Affairs, Disaster Management & Social Development activated the National Social Register of Poor and Vulnerable Households to combat poverty and commenced conditional money transfer programme and paid out N20, 000 (\$51.25) to individual beneficiaries.

The initial tranche covered 2 .6 million citizens. It was later expanded by 1 million from (2.6 million to 3.6 million). State governments, company organisations, civil society organisations, faith-based organisations, celebrities and philanthropists additionally provided varied forms of palliatives to the vulnerable. Sub-national government, celebrities, law makers, corporates, civil society organisations and philanthropists complemented the government by providing palliatives to the poor and vulnerable and frontline health workers. The management of the palliatives was chaotic and not effective.

Health response: testing and contact tracing

Nigeria's initial policy was one of targeted testing to detect, test, and isolate cases as early as possible in addition to implementing the standard World Health Organisation (WHO) protocols: Hand washing, use of hand sanitizers, facemasks, social distancing and lockdowns. This involved identifying those who are most likely to be infected, namely those who have just come back from other countries and those they have been in contact with. The Nigeria Centre for Disease Control led this initiative with 12 functional COVID- 19 testing laboratories, with a capacity to test 1,500 samples daily. This notwithstanding, Nigeria is struggling

to ramp up the number of COVID-19 tests and sits among countries with the least number of standard coronavirus tests conducted worldwide.

As at May 2, 2020, Nigeria has only carried out 17, 566 reverse transcription polymerase chain reaction (RT-PCR) tests, which translates to 72 tests in every 1 million Nigerians (Ibekwe, 2020). Even then, this is only in urban areas. The rural areas are completely neglected. Inadequate Personal Protective Equipment (PPEs) has exposed health care frontline workers to the virus.

A total number of 113 health workers have been infected with novel coronavirus since outbreak in Nigeria. According to the Minister of Health Osagie Ehanire, this is about 6% of the COVID-19 cases in the country as at April 27, 2020. Kano, a city in North West Nigeria with a cultural and religious conservative population put at between 18-20 million people is an example of how the fragile health care system has been overwhelmed. The testing centre broke down just as ‘mysterious deaths’ in hundreds were recorded daily. Leader of the Presidential Task Force Committee, Nasiru Sani Gwarzo after investigation revealed that the coronavirus pandemic is responsible and the cause of the waves of mysterious deaths recorded in the city.

Economic measures

Kristalina Georgieva, Managing Director of the International Monetary Fund (IMF), said Nigeria’s economy is being threatened by the twin shocks of the COVID-19 pandemic and the associated sharp fall in international oil prices. By International Monetary Fund (IMF)’s estimation, Nigeria’s economy is expected to shrink by 3.4 percent this year and the nation of 200 million people could face a recession lasting until 2021. A recession is in progress and it may be Nigeria’s worst in 30 years. This means by the time the lockdown is lifted, Africa’s largest economy may be facing a recession that could last until 2021 (Olorounbi, 2020). To address the economy, the following policies measures were undertaken.

The Nigerian Parliament passed an Emergency Economic Stimulus Bill (2020) to provide for:

- a. Temporary financial relief on corporate tax liability and individuals;
- b. Protection of the employment status of Nigerian due to economic realities caused by the outbreak of COVID-19;
- c. Provision of moratorium and mortgage obligations for individuals;
- d. Suspension of import duty for medical necessities required for treatment and management of COVID-19;
- e. Catering to the general well-being of all Nigerians pending the eradication of COVID-19.

Whereas the bill, if it becomes law, could forestall job losses within the formal sector, it contains no provisions for casual employees (the informal sector, who are most vulnerable and the most impacted).

Equally, noting that COVID-19 pandemic has critical adverse consequences for the Nigerian economy, the country's apex financial institution, the Central Bank (CBN) issued policy measures in response to COVID-19 eruption and spill overs. The measures included: Extension of the moratorium on all principal repayments; charge per unit reduction from 9 % to 5 % per annum; creation of an N50 billion targeted credit facility for households and tiny and medium-sized enterprises; credit support to health care business to satisfy the potential increase in demand for health care services and products; regulative forbearance to any or all Deposit cash Banks; and strengthening of the Central Bank of Nigeria, Loan to Deposit Ratio (CBN LDR) policy (CBN, 2020b).

Challenges

Key challenges to the response include:

- Poor community awareness, ignorance and denial of the pandemic;
- Cultural and religious conservatism;
- State-centric and uncoordinated response: On the basis of responsiveness, accountability, transparency and inclusiveness of government responses, the national parliament has been more responsive and proactive than the executive. However, the indefinite suspension of parliamentary/legislative activities to curtail the spread of the coronavirus robbed it of an opportunity to hold the executive accountable;
- State – society trust deficit;
- Limited public health facilities and personnel – including laboratories and isolation centres;
- Increasing attrition of health service providers;
- Overwhelming informal economy, poverty and exclusion.

Exit Plan

The national government has set up a committee on Economic Sustainability headed by the Vice President, Yemi Osibanjo (and comprising ministers: Finance, Budget and National Planning, Industry Trade & Investment, Labour & Productivity, Works and Housing, Humanitarian Affairs, Disaster Management and Social Development, Petroleum and Governor of the Central Bank) to develop a comprehensive economic policy to fit the realities that

would be thrown up by the coronavirus pandemic. A broad vision that takes into account how to implement an inclusive strategy that focuses on mass local productivity and mass employment and assist the Nigerian economy take advantage of the challenges of these times and convert those challenges to opportunities. This blueprint is still being awaited.

In the midst of rising cases the president announced exit measures saying that: No country can afford the full impact of a sustained lockdown while awaiting the development of vaccines. After gauging that factories, markets, traders and transporters can continue to function while at the same time adhering to NCDC guidelines on hygiene and social distancing, the President said the goal of government was to develop implementable policies that will ensure the economy continues to function while still maintaining aggressive responses to the COVID-19 pandemic. The government therefore, approved a phased and gradual easing of lockdown measures in FCT, Lagos and Ogun States effective from Monday, 4th May, 2020, to be followed strictly with aggressive reinforcement of testing and contact tracing measures while allowing the restoration of some economic and business activities in certain sectors (Presidential Broadcast, April 27, 2020).

The decision to relax the lockdown is clearly based on the impact of the pandemic on the economy and the well-being of the population rather than on science and data (health implications). The decision appears pragmatic as lockdown fatigue is evidently palpable among the population.

Early Lessons

The early lessons learnt include the importance of:

- Adopting technology in governance structures- virtual governance was limited;
- Synergy between national and sub-national entities;
- Having an empowered and enlightened citizenry;
- Resilient and functional institutions: health, housing, social nets.

Conclusion

The progress made by any country in flattening the curve has been through collective efforts of policy and the importance of public healthcare system. The comparatively low numbers in Nigeria has been baffling considering its vulnerable health care system and uncoordinated response devoid of any particular model. Perhaps the country's low Covid-19 cases so far can be explained by inadequate testing and tracing.

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The South African Response and Experience in Dealing with COVID-19

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Abstract

Following the first democratic elections held on 27 April 1994 in South Africa, the Government ushered in a methodical progression of innovative policies designed to ensure a more justifiable social order and enhance the living standards of the masses. South Africa is stable politically, and has a sophisticated economy and private sector, infrastructurally sound and not dependant on donors. Rudimentary services like access to water, electricity and quality health and education is still a major challenge. South Africa is particularly vulnerable to COVID-19 as there is a significant part of the population who live with compromised immune systems and co-morbidities. Despite the challenges in the health sector, the Government response to COVID-19 was robust and resilient in terms of the measures and action taken to combat the pandemic. The United Nations Secretary General, Mr. Antonio Guterres, pointed out that the country displayed considerable “determination in addressing the pandemic” and will have to in a “very smart and targeted way progressively re-open society and the economy to minimise the social and economic impact of COVID-19” (Daily Maverick, 2020).

Keywords

COVID-19, containment, 2002 Disaster Management Act, pandemic, South Africa

Introduction

The first Coronavirus case reported in South Africa occurred on March 5th, 2020. Since then, there has been a concerted effort made by all spheres of government to ensure that the spread of the virus was curtailed and the number of people who became infected was contained as far as possible. The primary goal of this effort was to ensure the protection of the general population. Several guidelines and protocols were then put in place to achieve this. All planning undertaken in curbing the spread of the virus has been done strategically in a phased approach, i.e. preparedness, containment, mitigation, and recovery.

All planning currently in place and the formulation of all planning hinged on one specific principle: containment. The ideal goal is to completely halt the spread of COVID-19, but slowing its spread is also critical. The idea is to lower the peak COVID-19 impact, especially when the country moves into the winter season, during which the influenza virus causing the common cold impacts on the population and increases hospital admissions and results in complex pulmonary infections and increases mortality rate.

The effectiveness of public health measures such as lockdowns, rapid detection, isolation, and case management will be decisive factors in reducing the risk of exposure, especially for the vulnerable populations susceptible to COVID-19. At least 13.5% are HIV positive and 454 000 people suffer from Tuberculosis (TB) (Naidoo et al., 2017) of the projected South African population of 58.78 million (Stats SA, 2019). While the necessary resources have been invested in optimising the health system's preparedness to cope with the outbreak by increasing the number of critical care units, achieving the goal of slowing the spread of virus also eases pressure on the healthcare system infrastructure and ensures that the virus can be dealt with methodically and effectively.

Government Response

The Director General of the World Health Organisation (WHO) issued a statement declaring coronavirus a Public Health Emergency of International Concern and called for sharing information and research, stating that “the global community should continue to demonstrate solidarity and cooperation, in compliance with Article 44 of the IHR (2005)” (WHO, 2020). In response, the Emergency Operational Centre was activated to be on alert in South Africa.

After the first case in South Africa and after monitoring the spread of disease, a national state of disaster was declared on March 25 under the 2002 Disaster Management Act. This declaration allowed for the South African government to start to put in place necessary regulations and guidelines that were aimed at

containing the virus. Enabling a national state of disaster allowed for several containment measures to be put in place by government. Amongst these was the decision to restrict public travel by permitting mobility to essential service workers only, and to the public under emergency circumstances (e.g. the loss of a loved one). This ensured that social contact was limited and ensured the protection of vulnerable populations such as the elderly and individuals with underlying co-morbidities. Travel bans on international travel were also put in place as an additional measure to curb the spread of the virus.

To ensure oversight of these steps, a National Coronavirus Command Council (NCCC) was affected to manage it daily and submit reports to cabinet for final decisions to be taken. The NCCC consists of 19 cabinet ministers, their directors-general, and the National Police Commissioner. The Council provided the necessary guidance to government on the implementation of lockdown regulations and the formation of vital infrastructure such as the mobilisation of testing stations and the creation of quarantine facilities across the country. A Ministerial Advisory Committee (MAC) was also created consisting of 50 experts from government institutions, health services, and academia who advise the Minister of Health on COVID-19. MAC receives questions/queries from the Minister/Director General, and they gather reliable evidence and make recommendations which constitutes the country's response to the pandemic. It consists of four committees, namely, Research, Health, Clinical and Laboratory (news24, 2020).

The major achievements of the lockdown have been well demonstrated. The exponential growth of the infection curve caused by the imported cases that introduced the outbreak was interrupted, and epidemiological flattening of the initial phase of the curve was achieved. The lockdown was the most extreme form of measures for stopping the virus spreading; in a way, "stop transmission and you stop the virus" (Altman et al., 2020). Additionally, the lockdown procured time for South Africa to make further preparations to face the oncoming surge.

More than 11 million citizens have been screened for symptoms of the virus, about 40,000 contacts have been traced and quarantined at home, or in 376 quarantine sites identified across the country. This work has added 30,000 beds to the country's health system capacity including a field hospital, established on site to isolate and treat the thousands that will contract the virus. Almost half a million people have also been tested for COVID-19, with teams going out to targeted communities rather than waiting for patients to arrive at a healthcare facility.

The response to the pandemic has huge implications for the allocation of resources. Cabinet has taken a decision to reprioritise and allocate more resources to address the pandemic. A new Division of Revenue Bill will be tabled, in which

previous allocated budgets will be reviewed. More resources will be directed to strengthening the health program in response to the pandemic, address the sectors in distress, such as food insecurity and hunger, by increasing social grants to the vulnerable and introduce a living allowance for the unemployed. Workers affected by the loss of revenue due to the lockdown will receive support through the Unemployment Insurance Fund. A package has been designed to rescue businesses in distress due to the lockdown. The Minister of Finance announced that over \$ 30 billion will be tabled in the adjustment budget after the president announced the emergency relief package.

This has demonstrated that the COVID-19 has ramifications beyond the health sector but affects the entire economy that has suffered major contraction besides the recession that preceded the outbreak. Decisions to be taken involve multi-departmental and multisectoral collaboration.

Lessons From Elsewhere

Any strategy undertaken by a government should be informed by several different factors, namely: the projections of infection within that country supported by data management, the effectiveness of current lockdown measures in place, the demographic context of the country, disruption of social stability, and the urgent need to prioritise economic recovery.

One country that South Africa has examined closely as a mean to inform the measures being taken to curb the spread of COVID-19 is China. The response from China was similar to that of South Africa and was effective in slowing the spread of COVID-19.

Lessons learned from China

The Chinese government, much like South Africa, chose to protect its citizens over the economic repercussions that are associated with a lockdown and implemented a nationwide campaign to curb the spread of the virus (Lianlei, 2020). The epicentre of the virus, Wuhan, was put under complete lockdown to slow the spread nationally. Medical staff from other provinces from China were brought in to deal with the pandemic and medical supplies and care units were increased substantially to deal with the spread of the virus (Lianlei, 2020). Screening of residents also took precedence to ensure all citizens infected by the disease were provided with the required treatment. These lockdown measures then expanded nationally, and non-essential facilities and services were closed. Facemasks and screening measures became compulsory and all medical treatment was covered by the government (Lianlei, 2020). This strategy proved to be successful as China was able to peak relatively early and the rate of infection began to decline afterwards (Lianlei, 2020).

Implementation Challenges

The real challenge is lack of precise data for ensuring demand analysis. No country has the same underlying conditions and therefore the outbreak patterns differ markedly. Models are not precise as the outbreak has arisen recently and every country is learning from its own experiences. There are many variables and unknown factors to be considered. The scarcity of concrete data creates huge uncertainty that make models unhelpful in initial stages of the outbreak. Current models have indicated that South Africa has delayed the surge, but the exact timing of the peak can only be predicted as a pessimistic scenario (i.e. mid-June to July) or optimistic scenario (August to September).

The context to the measures taken in South Africa are unique to the current socio-economic landscape of the country. Several issues have arisen which have hindered the success of implementing a complete lockdown, namely, social distancing and accommodating the economic disruption that came from lockdown.

The present inequality within South Africa stems from inadequate dwelling areas that are a reality for a large portion of the African citizens. Measures such as social distancing could prove to be tenuous at best as shared resources and a lack of policing could place citizens within these circumstances at a higher risk for infection (Maringira, 2020). The poverty faced by these communities also means that many people in these circumstances purchase items on a daily basis and cannot afford to stock up on grocery items; this implies that these individuals are also unable to fend for themselves. This is summed up in a statement by President Ramaphosa: “The pandemic has resulted in the sudden loss of income for businesses and individuals alike, deepening poverty and increasing hunger” (Republic of South Africa, 2020).

Pandemic Governance and Implementation Chain

The overall health response is led by the Minister of Health and the Members of the Provincial Executive Committees (MECs). Synchronised guidance, coordination and governance is provided through the National Joint Operational and Intelligence Structure (Natjoints), the Ministerial Advisory Committee and its partners. The Natjoints comprises of representatives of several Government departments tasked with COVID-19 operations coordination, notably a, containment of public health infection, control of borders, high density policing operations and route security. An Incidence Management Team (IMT) was established at all levels with clear roles and responsibilities. The terms of Reference were drafted for the IMT to ensure each functional area of the IMT

is fully engaged. Clear decision-making pathways and execution guidelines were put in place to ensure that a comprehensive situation report is issued and widely disseminated.

As soon as the WHO declared the PHEIC, South Africa's National Emergency Operations Center (EOC) has been activated and an Incident Management Team (IMT) has been set up. The IMT is the technical arm and its primary functions include (but are not limited to): developing functional areas with clear deliverables and focus around partner coordination, leadership, health operations information and planning, operations support, technical expertise, finance and administration and logistics.

When the number of cases started to increase; the National Coronavirus Command Council was established. This Council, chaired by the President, consisted of the Deputy President, 18 ministers, Directors General who would invite a number of scientists, medical professionals, economists, and government officials who were leaders in their respective fields to make submissions. Technical processing of submissions to the NCCC is done through a Committee of Directors General and Heads of Security Forces named NATJOINTS, chaired by the Secretary of Defence. Through the NATJOINTS, all departmental submissions were integrated to ensure that government protocols and regulations were established and contextualised to the needs around curbing the pandemic. A team of fifty medical experts and scientists constitute a Ministerial Advisory Committee that generates advisories to the NCCC via the Minister of Health. The Minister of Health receives daily reports from the IMT which consists of the National Institute of Communicable Diseases and provincial teams involved in the management of COVID-19. Inter-ministerial committees are constituted by Clusters of ministers to address sectoral issues for submission to NCCC.

The NCCC receives comprehensive submissions from the Minister of Health, Inter-ministerial Committees, as well as the submission from NATJOINTS before any deliberations and decisions are made. This Council continues to conduct regular reviews on global trends and evidence within South Africa to ensure all solutions decided upon have a scientific background. This Council has been an effective component in ensuring the suppression of the COVID-19 outbreak.

The three spheres of government are now charged with the responsibility to mobilize and lead the whole government and whole society response. Provincial and District Coronavirus Command Councils have been established, led by Premiers and Mayors, respectively.

Coordination structures at national level have been cascaded to the provincial level through a Provincial Joint Operation Centre (ProvJOC), with the Health Streams, Provincial Emergency Operation Centre with its IMTs,

incorporating the multi-sectoral, multi-disciplinary provincial outbreak response teams which is in turn cascaded to district and sub-district levels. Multiple sectors and partners are engaged in the COVID-19 response led by the National Department of Health and government agencies as well as the private health sector, research community, UN agencies and development partners. The WHO has deployed experts who work together with the NICD technical experts to guide the scientific analysis and direct response at District levels.

Communication

A stakeholder engagement process was initiated by the President to consult with various social partners, involving inter alia, the following: political parties, business, religious and traditional leaders, civil society formations, National Economic Development and Labour Council (NEDLAC) and other multi - sectoral bodies.

The President makes regular addresses to indicate the strategic directions on the campaign and ministers address the nation to deal with sector specific details.

A country-wide risk-communication and community engagement strategy for COVID-19 was affected, including particulars of expected public health measures (existing procedures for pandemic influenza can be used). Swift behaviour assessments were conducted to comprehend key target audiences, influencers, concerns, perceptions, and preferred communication channels. Local messages, pre-test and roll out more precisely aimed strategic stakeholders and groupings at risk were also implemented, through house visits in some cases. Powerful community groupings (notably religious/community leaders, politicians, community volunteers/activists and health workers,) and resident networks (traditional leaders/healers and youth/women and business groups) were identified in order to engage them in local risk communication.

Rapid clearance processes were established for timely dissemination of messages and materials. Lastly, large scale community engagement for social and behavioural change approaches were established to ensure preventive community and individual health and hygiene practices were adhered to in line with the national public health containment recommendations.

Monitoring and evaluation

There are several factors to the monitoring and evaluation framework put in place to determine the effectiveness of decisions made by government in managing the pandemic. Several decisions around monitoring the spread of COVID-19 were taken to examine the efficacy of current structures in place in curbing the spread of the virus. One such decision related to screening, which has taken place on a national level, to consistently monitor the spread of infection and ensure the reduction of transmissions within communities.

The implementation of the COVID-19 Response Plan was monitored grounded on crucial performance indicators and generate steady situational reports at all levels. This was further consolidated into district, provincial and national situational reports and widely disseminated and actioned. Patient care needs were being closely monitored (COVID-19 related and the essential services) against the health system capacity. Systematic operating l reviews were conducted to assess implementation progress and the epidemiological situation. These reviews were used to adjust operational plans as necessary.

Local government and local responses

Since the discovery of the first case within South Africa, all sections of government were mobilised to provide a co-ordinated and effective response to the COVID-19 pandemic. Decisions made at a national level with regards to the lockdown, screening and testing were implemented with immediate effect by local government structures. The overarching objective of national planning around COVID-19 was to strengthen all national and subnational mechanisms to ensure the timely detection, management, and containment of COVID-19 cases.

Local government structures were also required to implement testing and screening within communities for effective detection of the virus. This then also informed the resources required by each community to treat positive cases. An effective communication strategy between national and provincial government has ensured that all national directives are applied and enforced with immediate effect. Local reporting on positive cases, recoveries and deaths has also allowed for national government to contextualize the measures taken to curb the spread in each province. An area which requires improvement is ensuring adequate infrastructure is in place to manage the influx of cases and to also inhibit interprovincial travel as some provinces have been unable to effectively reduce the spread of the infection.

Government effectiveness

While the government has been able to successfully implement a lockdown strategy as a means of curbing the spread of the COVID-19 virus, there were several issues that arose which inhibited the effectiveness of government interventions.

While all contingencies are in place to deal with COVID-19, other viruses which are equally lethal to this population have not been prepared for adequately (Hofman & Goldstein, 2020). Infectious diseases such as measles and influenza become an area of concern as winter approaches, and vaccines against these illnesses are in short supply as a result of the COVID-19 preparation measures taken which have diverted health resources in an effort to curb the spread of this disease (Hofman & Goldstein, 2020).

At present, South Africa has one of the highest rates of infection for HIV and AIDS in the world and individuals living with this virus already live with a compromised immune system (Hofman & Goldstein, 2020). With a lack of resources, the provision of treatment and testing facilities could become limited, which could result in a number of HIV positive individuals not receiving treatment and becoming high-risk for a number of highly infectious diseases, including COVID-19 (Hofman & Goldstein, 2020).

Budgets and resources

It is quite difficult to accurately project the funding needs to the COVID-19 response, as seen in many other countries. Based on the National COVID-19 Epi model, the additional cost of response at national and provincial levels has been estimated between \$ 72 and \$ 96 billion, between April and September 2020. This considers the projected number of cases by severity and the required number of general and ICU hospital beds as well as ventilators, equipment, staff and testing capacity and their ability to be re directed towards the COVID-19 crisis.

Whilst these estimates could serve as a navigating instrument, the projection team is wary that it is quite difficult to accurately predict how the COVID-19 pandemic will pan out in South Africa - and how the internal and external factors will affect the response measures and associated costs. National Treasury's revision of the fiscal framework in view of COVID-19 response includes estimating the additional health care costs needed for different phases of disease progression, and reprioritizing expenditure towards the identified health care costs including the funds from existing Conditional Grants on HIV, TB, Malaria and Community Outreach Grant.

The costs of several key resources are presently subject to tough market forces as a significant country internationally are competing for the same medical products. Furthermore, the upturn in lead times on distribution as a result of the travel and trade ban in the manufacturer's countries implies that even if the funding is made available, the supply might be incomplete or not meet the time deadline. One thing is clear is that government, through National Treasury, will continue to assess the situation and adequately resource the health sector's response to COVID-19 and ensure effective financial resources are mobilized. The gaps in the resources requirement will be identified and plugged, if required from the private sector and international development partners.

Exit Strategy and Lessons Learned

While the country is still implementing a phased lockdown approach and is easing more stringent lockdown regulations, an "exit" strategy is still being examined and determined based on scientific evidence and models that are

also informing the current response to the COVID-19 pandemic. What South Africa has achieved which would be a learning lesson to other countries as an effective strategy in the continuum of care pathways for infected cases which is constantly being updated as new information becomes available.

This strategy ensures early case detection which has developed clear protocols on community-based screening, referral pathways, quarantine, and isolation. It also ensures sufficient training is provided to community healthcare workers involved in screening. The availability of test kits is also monitored as well as the quality and safety regulations in place for testing. It also maps vulnerable populations who are at risk of local transmission and then focuses resources involved in screening and testing within these areas.

Case management has also been implemented to ensure the appropriate management of all COVID-19 infections. Case management protocols and guidelines have been updated at all levels of care (including home care). A Clinical Guideline Working Group has been established and made available to all relevant parties. These cover management of mild, severe, and critical disease (and include home management for mild cases). Human resources at all level of care in case management, IPC, referral protocol and intensive care have been capacitated. Online training programmes have been developed, with support from academic institutions and professional associations. Comprehensive care is also being provided to individuals who are infected with COVID-19.

Lastly, clear clinical pathways and a monitoring system for the outcomes of cases and contacts was established. Dedicated teams were established and equipped to transport and treat suspected and confirmed cases and referral mechanisms have been put in place for severe cases with comorbidities. Advice on care and rehabilitation after the discharge of recovered cases is also being provided as well as advice on the necessary measures for isolation. Guidelines on the safe and dignified burial of patients who have passed away has also been established and an ongoing analysis of information being provided through the appropriate health systems ensures that all corrective measures put in place are accurate and contextualised to adequately respond to curbing the spread of COVID-19.

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Uganda's National Response to the COVID-19 Pandemic: Measures and Implications for Public Governance

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Abstract

This paper analyses Uganda's response to the COVID-19 pandemic. Uganda responded to the pandemic decisively –with context-specific measures which were underpinned by science rather than fiction –thus registering quick wins and militating against high infection and death rates which are a norm in other jurisdictions. The efficacy of Uganda's response is attributed to early preventive strategies that were implemented prior to the identification of first COVID-19 confirmed case, the leadership and decisiveness from the topmost decision making organs, unwavering commitment by political and technical officials, the scientific and social experience of handling previous viral epidemics, consistent communication of the guidelines to the populace, effective coordination of the different institutions and actors, and the involvement and vigilance of the masses. However, the responses were constrained by structural and practical challenges such as the limited resources for the health sector, limited inter-governmental coordination and some hiccups in the implementation processes. The early lessons from the Uganda's experience underscores the critical role of leadership support, effective coordination and communication mechanisms; and the imperative to pursue whole and multi-level involvement of institutions and actors– including the population– in the fight against global pandemics.

Keywords

COVID-19, pandemic, response, lessons, public governance, Uganda

Introduction

The World Health Organisation declared COVID-19 a global pandemic on 11th March 2020. The declaration was a wake-up call to Governments, to craft context-sensitive responses to the global health threat. Uganda reported its first case on Saturday 21st March 2020 and as of 4th May 2020, a total of 89 cases out of whom 55 had recovered from COVID-19 with no death registered death (Museveni, 2020c).

Uganda's national response has been spearheaded by the President, H.E Yoweri Kaguta Museveni, assisted by technocrats from the Ministry of Health (MoH) and other line Ministries. He delivered the first national televised address on the health threat on 18th March 2020. The address marked the beginning of a national-level offensive against COVID-19. As of 18th March 2020, the country had not registered any COVID-19 confirmed cases. However, health experts had 'prophesied' that the epidemic would certainly arrive in Uganda.

The Presidential address hinged on the imperative to prevent the 'unwanted visitor' from reaching Uganda—the assurances from health experts notwithstanding—and to suppress transmission in case the virus found its way into the country. This is a dual approach of responding to the virus as it is epitomised in the following excerpt from his speech:

We must do everything possible to ensure that this enemy [COVID-19] does not come here [in Uganda], does not find dry grass already piled up and ready for flaming. What is the dry grass that can help to sustain fire of a corona virus epidemic? It is the big masses of people, gathered together and in close proximity. (Museveni, 2020a).

Evidently, before the unwanted visitor arrived, the Government of Uganda was implementing preventive approaches while putting in place health care, treatment and recovery measures.

It is against this background that this paper shares the experiences of Uganda's national response to COVID-19 and delineates early lessons for public governance. From the standpoint that public governance means the "formal and informal arrangements that determine how public decisions are made and how public actions are carried out, from the perspective of maintaining a country's constitutional values when facing changing problems and environments" (OECD, 2011, p. 2) the paper explains the institutional arrangement and efficacy of decision making and implementation approaches deployed by Government to handle COVID-19.

Public Governance and Uganda Institutional Arrangements

The Government adopted a cocktail of approaches to decision making and implementation including, the “whole of government approach” involving the three arms of government as well as a multi-sectoral approach involving local governments and other actors.

Three arms of government

The *Executive* was responsible for all policy and strategic decisions which were centrally announced by the President, after seeking for guidance from the Cabinet. For Cabinet to be more fruitful, an inter-ministerial subcommittee chaired by the Prime Minister was set up to review strategies and approaches used in the fight against COVID-19 and thereafter present to cabinet for approval. The strategies aimed at: limiting the spread of infection; and ensuring that resources are available to manage the pandemic, the essential services run with minimal interruption, the public is regularly informed and the impact on people and companies is minimised.

The *Parliament* remained open during the COVID-19 pandemic period to execute its legislative, oversight, representational, and appropriation roles. Parliament approved a supplementary budget of USD 82.2 million on April 4, 2020 to facilitate COVID-19 activities and nominated, Members of Parliament (MPs) to serve on the National Taskforce.

The *Judiciary* suspended open court hearings but remained open to handle serious matters and applications. For instance, Court heard a petition from two MPs seeking to halt the Parliamentary Commission from paying USD 5400 to MPs as a COVID-19 fund. On April 29, 2020, the High court ordered all MPs to deposit the money with either the Parliamentary Commission or the District or National COVID-19 Taskforce.

National taskforce on COVID-19

During the formation of the national taskforce on COVID-19, government deemed it necessary to have a wider representation for such a committee that drafts strategies and approaches for Cabinet. A Multi-Sectoral Committee comprising all the ministries under the inter-ministerial committee and other institutions such as the Public Sector Foundation, Civil Society, and political parties represented in Parliament was formed.

The National Taskforce has a number of sub-committees headed by Cabinet Ministers. These committees generated business for the national taskforce and translated the broad policy directives into standard operating procedures

(SOPS). The sub-committees have been active and successful in generating short term interventions.

The National Taskforce is supplemented by the National Response Fund Group which was set up to mobilize resources. The group comprised members of the public sector ministries, business community and civil society organizations. The group has so far mobilized USD 1.89 billion in cash and several items worth billions. The strategic support at the highest political level and the efforts at the national level have enabled other actors to gain the necessary momentum towards fighting COVID-19.

District taskforce on COVID-19

Government also attempted decentralized governance whereby the District Taskforces were responsible for case management, surveillance, health promotion, resource mobilization, risk communication, enforcement of control measures, and safe food distribution. The Districts were facilitated with USD 17.8 million for COVID-19 activities and as Leftwich (1994) noted they implement directives from the centre. The District Taskforces are politically led by the Resident District Commissioner (RDC) and technically the Chief Administrative Officers. However, there has been administrative confusion and clashes in a number of districts between the office of the elected District Chairperson and RDCs over leadership and resources management.

Analysis of the National Responses to COVID-19

The national response to the epidemic can be analysed at two levels: (a) policy and strategic oversight level responses; and (b) technical level responses.

Policy and strategic oversight level responses

The policy and strategic oversight level responses can be gleaned from the various presidential addresses in which he issued directives whose breach was construed as 'attempted murder'—and triable in courts of law— because non-compliance would compromise the lines of defence against COVID-19, endanger the health of the populace, and most likely lead to death. The President, using his military approach and portraying himself as never a loser in military exploits, regularly referred to the virus as an 'enemy', the entire struggle as a 'war' and the responses (or directives) as 'battlefronts'. By drawing parallels between fighting COVID-19 and the war situation, and providing an optimistic picture about the outcomes, the President was lessening anxiety among the population. The strategic responses can be nested into pre-patient zero and post patient zero directives.

Pre-patient zero directives

The initial presidential address of 18th March 2020 and the subsequent address of 22nd March 2020 contain pre-patient zero directives. These directives were issued after impromptu consultations with religious and cultural leaders, the Ministry of Education and Sports, the Parliament with guidance from the Ministry of Health. These directives in the first address were to last 32 days while the directives in the second address were not given a time frame.

- *Closure of high concentration points i.e. educational institutions and communal prayers as well as conferences.*
- *Suspension of mass gatherings or gatherings of more than 10 people such as burials and wedding.*
- *Outbound travel ban for Ugandans to 16 countries– on account of having many cases of COVID-19. Ugandans in those destinations were free to return on condition that they would undergo mandatory quarantine for 14 days.*
- *Suspension of entertainment and social clubs bars and sports.*

In the address of 22nd March 2020, the President added by closing the international airport and ground crossing points for passengers.

Post-patient zero responses

The other strategic directives are contained in the President Addresses of 25th March, 30th March, 14th April, and 30th April 2020. By 25th March 2020 Uganda had registered 14 COVID-19 confirmed cases. The directives were:

- Suspension of public transport.
- Prohibition of private vehicles from carrying more than three family members
- Suspension of non-food shops and markets, except supermarkets.

By 30th March 2020, Uganda had registered 33 COVID-19 cases and Government instituted lockdown to interrupt human to human transmission. In his address on the 30th March 2020 the President termed COVID-19 as war which Uganda can defeat with the cooperation of everyone. As he noted, “people are talking about convenience, this is war. It is not about convenience anymore, it is survival. A big struggle is upon us, lives will change, some sectors will definitely get a setback, but we shall defeat COVID-19” (Museveni, 2020, April 30). Although the President recognised that sectors like travel, tourism, and hospitality will experience a slowdown, but he chooses saving lives over the performance of sectors. This lockdown was summarised as a ‘stay home’ directive. The 14-days lockdown was largely on the advice of the health experts.

The 14 day lockdown was extended for 21 days with effect from 15th April 2020. The purpose of the extension was double-barrelled. In his remarks he

said that the intention was: “To defeat this virus decisively or if not defeated totally, to prepare better as to how to cope with it.” (Museveni, 2020, b). The extension was consistent with scientific evidence pointing to the fact that the incubation period could be longer than 14 days and that some cases tend to be asymptomatic. Also there was a phenomenon of increasing COVID-19 cases from truck drivers originating neighbouring countries. Therefore, the extension was intended to offer government time to prepare the health system to deal with the problem.

In his address to the nation on 4th May, the President eased lockdown for sectors essential for survival such as the “factories, construction, food markets and shops, cargo transport and essential services,” but extended the lockdown by 14 days for the rest of the sectors to allow the MoH to conduct a rapid assessment survey to establish the COVID-19 prevalence so as to inform the next course of action.

From the Presidential directives above, it can be deduced that the game plan at the policy and strategic oversight level is a clear manifestation of how science—rather than fiction or emotions—was shaping the responses. Uganda capitalised on her response plan(s) for the previous viral epidemics—Ebola, Marburg and AIDS— to launch an offensive against COVID-19 and achieve quick-wins. Also the game plan shows an incremental approach—limited changes or additions to existing policies. The routine Presidential addresses often with corrective actions in the previous directives show existence of a robust monitoring of adherence by the population and implementers by Ministry of Health.

Although some strategies were borrowed from China and South Korea such as the decongestion of high concentration points, they differed with emphasis to prevention rather than cure for fear of overwhelming the fragile healthcare system.

Finally, the African cultural context in general, and Uganda cultural context in particular, shaped the strategy. The concept of scientific weddings and scientific burials was to respond to a contextual reality. In the Ugandan cultural context, these events attract hundreds of people and therefore pose a potential for quicker human to human transmission.

Technical level responses by Ministry of Health

These responses were by the Ministry of Health focusing on public health aspects of the pandemic. The MoH prepared a National COVID-19 Preparedness and Response Plan aimed at reducing the importation and transmission of COVID-19 as well as reducing related morbidity and mortality. Some of the measures included:

- Institutional quarantine of individuals considered to be high risk
- Dissemination of key messages on public health measures e.g. wash hands, wear masks, social distancing and stay at home.
- Management of the suspected and confirmed cases
- Surveillance and screening services at points of entries
- District surveillance and laboratory focal persons to collect samples from suspected cases and send them for testing through the 100 transport hubs.
- Establishment of COVID-19 treatment centres in the 14 regional referral hospitals in addition to national facilities.
- Engagement of local factories to produce face masks, personal protective equipment and hand sanitizers.

Implementation of the National Response

The policy implementation framework developed by Brynard (2005) and supplemented by Molobela (2019) guided the evaluation of the effectiveness of policy implementation.

Content

The content of the response was primarily regulatory aimed at preventing and containing the spread of COVID-19. The measures specified how one was to behave guided by rules of conduct with proper punishment caused by failure to comply. Some of the measures were already part of the national public health system, but some of the existing regulations were surpassed by the implementation and enforcement of new ones. The content of some regulations changed so fast as possible once non-adherence was cited. Some measures like lockdown was a good crisis response however, they stayed for long-people got bored and started abusing them rendering enforcement problematic.

Context

The country is getting closer to the elections in 2021 which makes the political environment very sensitive. The city dwellers who are often politically hostile to the ruling government were not allowed to engage with the opposition political leaders. The ruling government took advantage of the pandemic to score political points by monopolising the distribution of food and other relief items. Even activities at the sub-national level were and are still very dependent on the centre for policy and resources. Notably, the distribution of food was poorly managed characterised by delays and bad quality food and the receiver of the food was at the mercy of the supplier.

Commitment

There has been clear commitment by officials and leaders who have been entrusted with providing political leadership and supervision. The President, Prime Minister and various Ministers have been involved in developing SOPs and communicating to the masses. For instance, the Minister of Health has been idolized by Ugandans as a heroine for the hands on, selfless political and technical approach. Even with other major challenges, e.g. the invasion of locusts, the leadership has not diverted their attention from COVID-19 while at the same time, those matters were equally resolved.

Capacity

The expertise in the MoH and actors like the armed forces shows that the Country has ample expertise to handle pandemics of global magnitude however, the country does not have enough resources, medical equipment and supplies. The President has appealed to the public for supply of motor vehicles to assist the MoH. The President's appeal for donations and borrowing for COVID-19, is a manifestation that government coffers are not well resourced. While it is patriotic for citizens to support government efforts, it presents a risk where some business giving donations may turn up for business opportunities and the state could appear to be already compromised. The food relief distribution has shown limited capacity in planning, purchasing, and distribution to those deserving.

Clients and coalitions

There is a high level of compliance and appreciation from the public. Where there was no compliance to directives, security agencies came in, but in some instances using excessive force during the beginning thereby giving an ugly face to the response. The formation of the various committees at the national and local levels with various actors is commendable. However, there is limited evidence to suggest that there were deliberate consultations with think tanks, researchers and academia outside the medical sciences. Fighting such an epidemic needs input from behavioural scientists, management gurus, economists and policy analysts to inform the decisions taken.

Communication

The media including community radio stations, newspapers, and social networks have been used as part of the communication strategy. The message has been to the most extent clear and consistent to the key target audiences. Even where there was lack of clarity, the actors would come back to explain in very simple terms with understandable illustrations and examples which demonstrated flexibility. This was also supplemented by SOPs developed by the line ministries. All COVID-19 response messages were and are still

centralised. The local governments and institutions are platforms and agents of dissemination.

Coordination

Coordination consists of inter-organisational and intra-organisational coordination. At the East Africa Community level, not much has been done, other than negotiations and common understanding on managing trans-border operations such as cargo movement and tracing of COVID-19 cases. The lack of co-ordination has exposed the region to a wider, cross-border spread of the virus. At the national level, there is coordination led by the Prime Minister. The national task force seems to be well coordinated apart from the food relief distribution. At the local government level, the structure of the District Disaster Management Committee chaired by the District Chairperson was adopted however, the District Taskforces on COVID-19 are chaired by the RDCs. This has strained coordination at district level thereby constraining feedback and reporting to the national taskforce. Notably, the Local Council system which appeared a long forgotten tool has been extremely useful for surveillance, reporting, food distribution, vulnerability profiling and mapping, and identification of cases.

Early Lessons

The leadership provided by the President-highest political office in giving strategic directives and directly engaging in implementation through the national taskforce, RDCs and security agencies is significant in the fight against the pandemic. The use of the Presidential authority and the military approach made it possible to attain quick decisions and wins although it minimised the involvement of elected leaders at national and sub national levels to engage in regular decision making.

The centralised and repetitive communication to the population involving all media houses by authoritative political and technical leaders enhanced public trust and compliance. Ugandans are always looking forward to the Presidential addresses and press releases from line ministries and taskforces.

The Inter-governmental coordination and leadership is critical in managing global emergencies. While Uganda succeeded to contain the spread of COVID-19, the cross-border cargo drivers continued to spread it within East African Community. Stopping COVID-19 could have been possible if the East African Community collaborated and implemented standardise measures and regulations.

Intra-government coordination in response to emergencies needs to take into consideration the already existing structures and systems and accountability mechanisms. While there has been successful coordination at

national level headed by the Prime Minister and guided by the technical input from the MoH, at the District level, the COVID-19 taskforce being headed by the Resident District Commissioner rather than the elected District Chairperson seem to have constrained coordination.

The Information Communication and Technology Sector and online services have gained more prominence. Online platforms have become avenues where citizens get quick alerts and also send their concerns to government. The traditional media-radios and televisions have reacted by diversifying their services to attend to people's immediate information needs on COVID-19. There are education learning sessions for children and prayers on televisions and radios so as to attend to people's spiritual needs.

The lockdown and the need for social distancing have created immediate changes in the governance and management of services. For instance, the bodaboda (motorcycles) industry has transformed into a courier service industry as of now where the raiders are entrusted with purchase and delivery of goods. This calls for trust and accountability in the industry. Homes have turned into prayer places with implication to the universal religious doctrines and practices. Another lesson is that Public Service can truly be effective as evidenced by the great work done by the MoH as well as the armed forces who enforced compliance with the Presidential directives. The Uganda's national experience shows the critical role of Higher Education Sector in national-level governance in that the views of the health academics shaped the responses through research and representation on committees of the Ministry of Health.

Countries must always be prepared for health emergencies with contingency resources, food reserves, emergency health services and ability to ensure human rights are preserved. In Uganda there is need to fully implement the National Policy for Disaster Preparedness and Management (2013). There is need to optimally utilise the expertise of the National Emergence Coordination and Operations Centre and other fields for solutions.

Uganda's national experience also shows the need for emergency response to be meticulously phased. The early response to the Covid-19 pandemic in Uganda was timely but then some strategies stayed too long. It is time to look for ways of living with the virus through treatment and other preventive measures and eliminate measures like lockdown.

Concluding Remarks

At the moment it is premature to judge the efficacy of Uganda's COVID-19 response measures. However, there is anecdotal evidence that the response is working if effectiveness is judged by keeping the infections at a minimum

and preventing deaths from COVID-19. However, the responses are being constrained by structural and practical challenges such as the limited resources for the health sector, limited inter-governmental coordination and some hiccups in the implementation processes. The early lessons from the Uganda's experience underscore the critical role of leadership support, effective coordination and communication mechanisms, the imperative to pursue whole and multi-level involvement of institutions as well as the need for emergency response need to be meticulously phased.

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Asia

Responses of the Central Government of China to COVID-19 Pandemic: Major Decisions and Lessons

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Abstract

With nationwide arduous efforts for months, China has got the COVID-19 pandemic under control in a relatively short time. In its institutional context, the central government of China made a series of important decisions and policies to prevent and control the pandemic. Major decisions includes timely lockdown of infected regions, setting up a system of leading and coordinating organizations, developing a national strategy of prevention and control, mobilizing all-round participation, organizing nationwide assistance, ensuring material supply, organizing and supporting scientific research, strengthening communication with the public, carrying out plans for “exit” from the pandemic, and expanding international cooperation. To ensure the decisions/policies were effectively implemented, the central government of China made institutional arrangements to strengthen the implementation chain and adopted a top-down combination approach. Some responses of the central government of China to the pandemic could provide lessons to practitioners of public administration in other countries.

Keywords

COVID-19, China, government, responses, lessons

Highlights

Facing a potential pandemic or any other potential public crisis with much uncertainty, government leaders need to have strong awareness of risks and resolution to make difficult decisions based upon their value judgments, following principles different from those for decision-making in normalcy. A sound system of organizations adapted to national/local context is to be set up for undertaking adequate and effective response actions, and a precise approach is to be adopted when advancing towards an “exit” from the pandemic.

As the country which first identified and reported the novel coronavirus and infected cases, China was stricken severely by the COVID-19 pandemic. According to WHO's official updates of the COVID-19 pandemic, by 19 of May, confirmed cases amounted to 84,500, and deaths amounted to 4,645 in China (WHO, 2020). Under leadership of the Chinese government, with nationwide arduous efforts for months, China has put the pandemic under control in a relatively short time and is gradually getting back to normalcy. The performance of the Chinese government in responding to the pandemic is acknowledged by the international community and Chinese people. Officials and experts of international organizations like UN and WHO, many countries, and academic journals like *The Lancet* have expressed their appreciation of the policies and efforts of the Chinese government. According to a survey jointly conducted by Singapore's leading social research agency Blackbox Research and international online panel specialist Toluna in 23 countries and regions on citizens' satisfaction with their own governments'/authorities' responses to the COVID-19 pandemic, Chinese mainland ranked the first (Blackbox Research, 2020). Responses of the Chinese government, especially decisions and actions of the central government of China could be a meaningful case for academic discussion in public administration and provide lessons to practitioners of public administration in other countries.

Institutional Context for the Central Government Responses to the Coronavirus

The Chinese government attaches great importance to prevention and control of infectious diseases. Based upon lessons from responses to SARS in 2003, China has established a sound system for public health emergency management. In terms of laws and regulations, China made *Infectious Disease Prevention and Control Act* in 1989 (amended in 2004 and 2013), and *Emergency Response Act* in 2007. The State Council promulgated *Regulations on Public Health Emergency Management* in 2003. These laws and regulations provide a sound legal base for responses to public health emergencies. In terms of organizations, besides specialized departments for disease control and prevention set up in administrative organizations in charge of public health at national, provincial, municipal, and county levels, centres for disease control and prevention have been set up at these levels of government. In 2004, China established a web-based nationwide direct reporting system for epidemic and public health emergencies connecting hospitals at township and higher levels. Once a case of infectious disease is found in one of these hospitals, it should be reported directly to the National Centre for Disease Control and Prevention within 2 hours if it's an infectious disease in Category I, or within 24 hours if it's an infectious disease in Category II. All governments at county

and higher levels have developed public health emergency response plans in which organizations of commanding and coordination, detailed action schemes, material and resource reserves, and training and drills for responses are specified.

Major Decisions and Policy Actions of the Central Government

The top leadership of China attached great importance to prevention and control of the COVID-19 pandemic when informed of its outbreak in Wuhan. On 20 of January, when human-to-human transmission of the virus was confirmed, President XI Jinping gave important instructions to various levels of government. He made it clear that life safety and health of the people should be put as top priority. He urged that full efforts be made to curb the spread of the pandemic, cure infected patients, identify routes of infection and transmission, monitor infected cases, release information on the pandemic to the public, and strengthen international cooperation. Under President Xi's leadership, the central government of China made a series of important decisions and policies to prevent and control the pandemic.

Timely lockdown of infected regions

To cut off the route of transmission of the virus to curb the spread of the pandemic, the Chinese government accepted the suggestion of scientists and made a decisive order to lockdown Wuhan, a mega-city with over 10 million population where infected cases were first found and reported, as of 23 of January. All public transportation in Wuhan was suspended, and airport and railway stations were closed. Within 10 days almost all cities in Hubei Province and some other cities with a high level of risk in China were locked down. Except those who had to go outside for special reasons such as getting food and drugs, or getting to work, most people across China were required or recommended to stay at home and avoid going to crowded places.

Setting up a system of leading and coordinating organizations

On 20 of January, China established the State Council Joint Prevention and Control Mechanism, headed by National Health Commission and composed of 32 Ministries/Commissions, responsible for organizing and coordinating prevention and control of the pandemic across China. On 25 of January, the top decision-making organ, the Standing Committee of the Political Bureau of the Central Committee of Communist Party of China (CPC) decided to establish Central Leading Group for Responses to

the COVID-19 Pandemic. Headed by the Premier, the Leading Group was authorized to undertake unified leadership and command of prevention and control of the pandemic. The central government required that Leading Group for Prevention and Control of the COVID-19 Pandemic be set up at each level of local government as the local decision-making organization. The central government also set up and sent Central Directing Groups to those severely stricken cities/provinces to strengthen direction and oversight of prevention and control.

Developing a national strategy of prevention and control

The Chinese government developed a clear national strategy of prevention and control from the very beginning of its response. On 25 of January, President Xi put forward the overall principles of prevention and control as “to be confident, to pull together and help each, to be based upon science, and to adopt a precise approach”. The top leadership of China defined prevention and control of the pandemic as “a people’s battle, a national battle” against the pandemic, and laid stress on unified leadership, unified command, and unified actions in the whole country. According to the national strategy, it’s crucial to concentrate efforts on controlling the sources of infection and cutting off routes of transmission. The central government raised “4 early” requirement for infected cases, that is, to identify infected cases early, to report cases early, to isolate infected people early, and to cure infected people early. In terms of treatment of infected people, a “4 concentration” strategy was developed as “concentration of patients, concentration of medical experts, concentration of resources, and concentration of treatment”. The national strategy provides clear guidelines of actions to local governments.

Mobilizing all-round participation

Regarding prevention and control of the pandemic as “a people’s battle and national battle”, the Chinese government mobilized and organized various forces to participate in the battle against the pandemic. Major forces include: 1) medical institutions and workers; 2) civil servants and administrators in relevant public institutions; 3) people from relevant enterprises, non-governmental organizations, and volunteers; and 4) medical professionals and soldiers from the army. By early February, more than 1400 medical professionals from the army were sent to Wuhan and other severely-stricken cities.

Organizing nationwide assistance

In Wuhan and some other cities in Hubei Province where infected cases were first identified and reported in China, the pandemic was so serious at the initial stage that medical resources of these cities were in severe shortage.

To have all suspected cases checked and all infected cases treated in time, the central government mobilized and organized resources from all over China to race against the clock to assist those cities. More than 30,000 medical workers from 29 provinces, autonomous regions, or municipalities directly under the State Council were sent to assist Wuhan. A “one province for one city” pairing assistance mechanism was adopted to organize medical workers from 16 provinces to assist 16 other cities in Hubei Province.

Ensuring material supply

To ensure supply of medical materials, daily necessities, and other important goods during lockdown, several task forces were set up under the State Council Joint Prevention and Control Mechanism to coordinate sectors of transportation, production, market sale, and telecommunications. China took advantage of the system of e-commerce and online shopping for material supply.

Organizing and supporting scientific research

To make responses to the pandemic based on sound scientific researches, the Chinese government organized experts in related disciplines and institutions to do researches for prevention and control of the pandemic. For example, no sooner was the novel virus identified in January than the Chinese government established a high-level professional task force to trace the source of the virus. In about a week, scientists determined preliminarily the pathogen. After that, several task forces were organized and supported to do researches to develop diagnosis kits, screen drugs, and develop vaccines. Based upon findings from those researches, the National Health Commission (NHC) of China edited and updated diagnosis and treatment manuals for medical workers and prevention and protection manuals for the general public.

Strengthening communication with the public

To enhance public awareness of risks, relieve anxiety and even fear among the public, and win public support for policies of prevention and control, the central government of China adopted measures to maintain communications with the public. Major measures included: 1) To disclose information on a daily basis. By 8 o'clock every morning, NHC released information and data on the pandemic, and in every afternoon, the NHC held a press conference to release updated information on the pandemic and answer questions of public concern. 2) To invite experts to interpret and explain the updated information, give guidance on prevention and protection, and provide advice and consultation through mass media. 3) To refute in a timely manner various rumours and correct inaccurate messages through mass media.

Carrying out plans for “exit” from the pandemic

According to estimates of the pandemic development, the central government of China began to make plans for resumption of work and production in low-risk regions in early February. With the pandemic eased in most regions of China, the central government advanced a gradual exit from the pandemic. China adopted a precise and differentiated approach when advancing resumption of economic and social activities. That is to make differentiation between regions, sectors, populations with different levels of risk. For example, all regions are classified by county as that with low risks, medium risks, or high risks. In regions with low risks, prevention and control measures should be adjusted first to start with recovery of normal economic and social order under the condition that the curve of pandemic will not rebound. For sectors in which production activities take place outdoors or workers do not need close contact, resumption of work and production is advanced first while resumption is advanced later for sectors like sports games and shows.

Expanding international cooperation

As an essential response to the pandemic, the Chinese government strengthened cooperation with international community throughout the whole process of the pandemic prevention and control. On 11 of January, the Chinese scientists shared genetic sequence of the novel coronavirus with WHO and uploaded it to a global database of flu. Since early January, China has kept WHO and several countries informed of epidemic prevention and control in China. China invited experts from WHO to visit Wuhan, Beijing and some other cities in 20-21 of January and 16-24 of February. When the pandemic was eased in China but got worse in some other countries, the Chinese government actively provided assistance to those countries and international organizations by sharing experiences in pandemic control and medical treatment, sending medical experts, and supplying medical materials. According to official data of the Chinese government, by 10 of April, the Chinese government had provided medical materials to more than 130 countries and international organizations, sent 13 medical teams to 11 countries, and organized over 70 video conferences to share experiences with experts and officials of over 150 countries.

Implementation of Policies of the Central Government

There were several challenges in implementing the policies of the central government. Firstly, the time when the pandemic was confirmed and broke out was right in the holiday season of the Chinese New Year’s Day in the lunar calendar, which is the most important traditional festival of the Chinese. In this

season every year, hundreds of millions of people travel and get together with their families and friends. It was a big challenge to implement the policy of home quarantine and keeping social distance. Secondly, the novel coronavirus is a totally new virus and even scientists have a limited knowledge of it. It was hard for all civil servants and the general public to come to a clear understanding of government policies on prevention and control. With the deepening of research and more scientific findings about the virus, some measures of prevention and control had to be adjusted, which brought about difficulty in implementation. Thirdly, at an initial stage, China faced a shortage of medical materials like diagnosis kits and personal protection equipment such as facial masks.

To ensure the policies were effectively implemented, the central government of China made institutional arrangements. Firstly, the central government strengthened the implementation chain. At central level of government, the State Council Joint Prevention and Control Mechanism was set up. In each ministry, a leading group and a task force for pandemic prevention and control were established. At local levels, every local government set up a leading group and a task force for pandemic prevention and control. Besides, the central government set up and sent Central Directing Groups headed by a Vice Premier or a State Councillor to those severely epidemic-stricken regions. As the ruling party, the CPC has a system of party organizations from the central level down to neighbourhood level. These party organizations have played an active role in supporting the implementation of the central policies. Secondly, the NHC sent Supervision and Guiding Groups to local regions to have oversight, evaluate, and provide guidance on implementation. Thirdly, an accountability mechanism was established by which officials with poor performance in policy implementation were removed from their posts according to legal procedure.

In fighting against the pandemic, China adopted a top-down combination approach. On one hand, to mobilize nationwide resources and efforts to deal with the COVID-19 pandemic, the central government has exercised centralized and unified leadership, determining overall principles and strategies, providing guidance and support, and organizing and mobilizing nationwide resources for prevention and control of the pandemic. On the other hand, within the policy framework of the central government, each local government has much discretion and can act flexibly based upon local context. For example, in mid-February, as most public transportation was suspended, migrant workers who had gone to their hometown on Spring Festival holidays could not get back to the places where they work. Municipal governments in those coastal provinces rented coaches to pick up workers directly from their hometowns.

Discussion and Lessons for Other Countries

China was severely stricken by the COVID-19 pandemic. With strong leadership and action by the Chinese government, China got the pandemic under control. The policy responses of Chinese government to the pandemic can be a meaningful case for academic discussion. Given differences between countries, no country can copy policies/actions of others. However, some policy responses of the Chinese government could be informative lessons for other countries. Here are some points from Chinese experiences.

Strong awareness and resolution of top leadership is crucial for adequate responses

To contain the spread of the highly contagious COVID-19 pandemic, it is necessary to mobilize nationwide resources and all-round efforts. That calls for the authority and influence of the top leadership of a country. Upon being informed of the COVID-19 pandemic in Wuhan, the top leadership of China attached great importance to it, and developed strategy and made overarching arrangements for pandemic prevention and control. That was of decisive significance for the public to be aware of risks and to be confident in overcoming the pandemic, and for administrators and relevant actors at local levels of government to take effective actions. The Chinese experience indicates the importance of strong awareness of top leadership and effective manners of leadership in responding to nationwide emergency.

It is the choice of value that determines the choice of policy

The COVID-19 pandemic has imposed multi-dimension impacts on the society. To take actions as responses to the pandemic, decision-makers have to make difficult choices between different goals and values. From the beginning of planning policy responses to the pandemic, top leaders of China have made it clear that saving lives and ensuring the people's health should be the top priority. It was based upon this value choice that the central government made a decisive order to lockdown Wuhan, that every level of government took actions of prevention and control at huge economic and social costs, and that the government covered all the cost for medical checking of suspected cases, for medical treatment of infected cases. Because of this people-centred value choice of the government, the general public gave their strong support for policies of pandemic prevention and control. A lesson from the Chinese experience is that value choice is the foundation of policy choice, and decision-makers should give more weight to public values in time of crisis.

It's wise to adopt appropriate principles of decision-making under uncertainty

At the initial stage when COVID-19 pandemic broke out, even scientists knew little about the novel coronavirus. Facing a pandemic with much uncertainty, the Chinese government followed some principles of decision making such as precautionary principle and output value priority principle (Dror, 1986). Policy measures based on these principles like lockdown of cities and home quarantine turned out to be effective for cutting off routes of virus transmission and containing the spread of the pandemic. The Chinese government's experience of adopting appropriate decision-making principles could be a lesson for policy-makers of other countries when making decisions under uncertainty or adversity.

An effective response to pandemic relies on a sound system of organizations

As mentioned above, to make effective policies and have them implemented in a timely manner, the Chinese government set up a sound system of organizations, some organizations for decision/policy making, some for implementation, some for supervision and guiding, and some for mobilization of resources and the public. These organizations at various levels have played a fundamental role by activating and coordinating joint actions of the whole country fighting against the pandemic. How to set up a system of organizations based on its own political and institutional context in response to the pandemic or similar emergent incidents is a question for other countries to consider.

A precise approach is to be adopted when advancing towards an "exit" from the pandemic in order to balance between pandemic control and economic development

Obviously, strict actions like lockdown cannot last long, as the socio-economic system cannot afford it. Decision-makers have to face difficult trade-offs. To make a balance between pandemic control and economic and social development, the Chinese government adopted a precise approach, by which different actions are taken for different regions, sectors, populations based on the level of risks faced by them. Those with relatively low risks can loosen restrictions and get back to normalcy first while those with medium risks or higher risks have to maintain restrictions longer. Even for those with low risks, the "exit" proceeds step by step. For example, in cities with low risks, local government has scheduled a timetable for students to go back to school. Students who will graduate this summer go back to school first,

students of high schools or in higher grades go back second, and students in lower grades go back last, with one or two weeks in between. This precise approach for advancing to an “exit” from the pandemic could be a lesson for other countries.

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India - COVID-19 Pandemic: Early Lessons for Public Governance

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Abstract

When COVID-19 spreads across the world, preparedness to cope with this pandemic was inadequate in India. A towering challenge was a decision between protection of life and livelihood.

To prepare the nation to combat the challenges ahead, a call was given for a day-long self-imposed curfew. On success of this curfew, the administration took swift actions to fight the lethal invisible enemy.

The central government laid down policy guidelines, coordinated with different ministries, other agencies, and the states, and monitored implementation by the state governments. In implementation of the policies and strategies, local governments are involved, and civil societies are engaged, with support from the central government.

Pursuant to the speedy measures, the country made good progress to combat the pandemic. It is cooperative federalism, efficiency of administration and public health responses to this unprecedented crisis that has turned to be India's saviour before a vaccine is discovered.

Keywords

Life, livelihood, institutional arrangement, administrative initiatives, follow-up

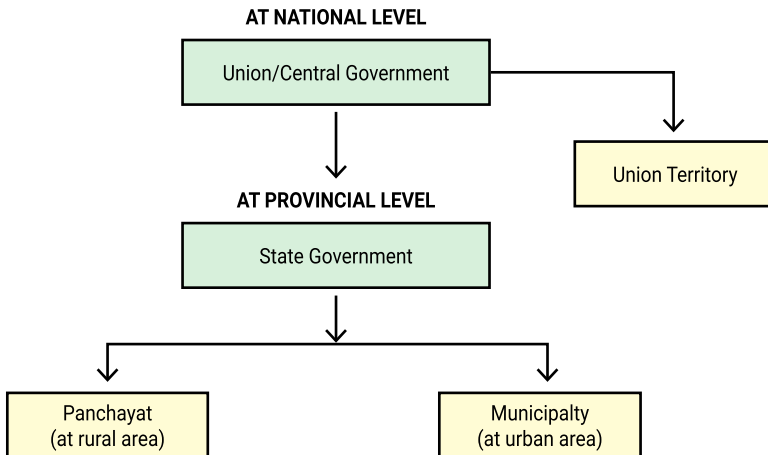
Introduction

Situated in South Asia, and bordered by Bangladesh, and Myanmar on the east, Bhutan, Nepal, and China on the north, and Pakistan on the west, India is spread over an area of 3,287,240 sq. km. India comprises 28 states or provinces (i.e. a region or geographical domain within the Union of India administered by provincial government). and 8 union territories, which denote political subdivisions administered by the central government. India is the abode of about 1.37 billion people (calculated using census data from 2001 and 2011 for decadal population growth rate and a linear projection used to arrive at population figures for the year 2019); spread over 728 districts covering about 650,000 villages.

Government Structure

India has a federal structure of government. The union or central government is at the national level, state government at the provincial level, and panchayats and municipalities at the local level in rural and urban areas respectively. The three-tier government structure of India is presented in Figure 1.

Figure 1 - Three-Tier Government Structure of India



The Seventh Schedule of the Constitution of India provides separate powers and subjects for the central government and the state governments. Health is one of the functions assigned to the state governments. In other words, health is a subject, which falls within the powers and jurisdiction of the state governments. The central government sets policies and guidelines for the state governments in regard to establishment and operation of health infrastructure

and facilities. Also, the central government plans and launches nation-wide health service programs in collaboration with the state governments; and which the state governments implement. For the union territories the responsibility for health matters lies with the central government.

Status of Health Infrastructure & Facilities

The overall status of health infrastructure and facilities in the country is not up to the desired level. Health infrastructure of India needs radical reforms to deal with emerging challenges. Government hospitals lack resources and proper infrastructure. There are shortage of rooms, beds, and medicines. In this scenario, the role of the private sector is continuously increasing. Simultaneously healthcare facilities are becoming expensive and non-accessible to the poor.

In the rural areas, government hospitals are generally few. Even the hospitals that exist in the rural areas are usually devoid of most of the medical facilities. Moreover, in the rural areas large numbers of people are poor and these areas are most prone to different types of epidemics as the people are unaware of better hygiene practices and disease preventive measures.

However, the National Rural Health Mission launched in 2005 by the central government aimed to provide accessible, affordable and quality health care to the rural population, especially the vulnerable groups; and has impacted on the lives of rural masses significantly. Similarly, to meet the health care needs of the urban population with a focus on the urban poor, the National Urban Health Mission was launched by the central government in 2013 to make essential primary health care services available to the poor and the marginalized and reduce their out of pocket expenses for treatment.

Onset of COVID-19 Pandemic

While COVID-19 spread its virulent tentacles in many parts of the world, little was known about the spread of the disease in India. The first instance of COVID-19 arose in at the end of January 2020 in India. On 10 March 2020 India reported 50 COVID-19 cases. On 11 March 2020 the World Health Organization (WHO) declared COVID-19 as a global pandemic.

Patients found to be COVID-19 positive require to be placed in isolation wards. Additionally, for critical cases, intensive care is needed. Based on the data available from the National Health Profile of 2019, it is observed that 713,986 total government hospital beds were available in India at that point of time, which translates to 0.55 beds per 1000 population. In regard to the population aged 60 and above who are especially vulnerable to this virus, availability of beds in India was 5.18 beds per 1000 population of this age group.

Since initially almost all suspected cases of novel corona virus were referred to government hospitals, it became important to enhance the medical capacity to provide necessary healthcare for the affected individuals.

To fight Covid-19, the central government released a three-phase (Phase 1 up to June 2020, Phase 2 July 2020 to March 2021 and Phase 3 April 2021 to March 2024) Emergency Response and Health System Preparedness package to the states aimed at boosting national and state health systems to support procurement of essential medical equipment and drugs, and strengthening surveillance activities, including setting up of laboratories and bio-security preparedness. The key activities under Phase 1 include support to states and union territories for development of quarantine centres, dedicated Covid-19 hospitals, isolation blocks, Intensive Care Units (ICUs) with ventilators, oxygen supply in hospitals and sources of supply, strengthening laboratories, hiring additional human resources and providing incentives, strengthening identified laboratories and expanding diagnostic capacities and mobility support for sample transport.

Challenges Posed by COVID-19

Infiltration of COVID-19 into India is unprecedented and the country had been taken by surprise. To combat a pandemic as threatening as COVID-19, the administration faced several towering challenges.

A major challenge has been implementing social distancing to “flatten the COVID-19 curve”, and prevent the inadequate and ill-prepared health system from being overburdened. Along with this challenge, dissemination of information about preventive measures such as hand washing and not touching the face turned to be a critical issue. Especially, with high population density, diverse traditions and practices, low awareness about hygiene, particularly in rural areas and urban slums, the challenge compounded.

On the other hand, safeguarding the economy and protection of livelihood of the people has been equally paramount. The importance of assurance of livelihood assumes greater importance because of large number of workers in the unorganized sector, sizeable number of daily wage earners, and the informal trade & business sector that contributes significantly to the country's economy. It may be underlined that to prevent the spread of contagious novel corona virus, the sole way out available to the administration was to confine people to their homes. In other words, the only option was to declare a “lockdown” of the entire country. This implied the shutting down of all activities except the essential services, such as, sale of food and grocery items, health care services and medicine supplies, power and water supply, sanitation and conservancy services, that are absolutely necessary for day-to-day life. All other economic

activities such as construction, manufacturing, service industries, transport, etc. remain closed. Closure of economic activities imposes a heavy toll on a developing economy like India.

Thus, the issue was to choose between life and livelihood. Indeed a tough call to take. To prepare the people of the country to cope up with the upcoming challenges, a unique call was given by the Prime Minister on 19 March 2020 to observe self-imposed curfew on Sunday, 22 March 2020 from 7 am to 9 pm. The Prime Minister termed this curfew as “Janata Curfew” implying curfew by the people and for the people in an attempt to contain the spread of the novel corona virus. People were urged to remain at home during the curfew hours, except those associated with emergency and essential services. Also, citizens were urged that at 5 pm on the “Janata Curfew” day, they should stand in their doorways or balconies and clap and ring bells to encourage the people working day and night in hospitals and essential services, in the times of novel corona virus, and serving others.

“Janata Curfew” was a litmus test for the nation in its preparation to fight novel corona virus. It was an innovative move of the administration to mobilize and motivate the population to stand together. By and large, “Janata Curfew” was strictly followed across the country, and a success.

Administrative Initiatives & Actions

Observing the encouraging response to “Janata Curfew”, the administration swiftly took further actions to fight the lethal invisible enemy, novel corona virus. These actions were an:

- Embargo on all domestic and international flights;
- Stoppage of passenger rail traffic that annually carries almost an equivalent of the entire world’s population;
- Imposition of nation-wide lockdown, commonly referred to as lockdown 1.0, for 21 days from 25 March, 2020 to 14 April, 2020 prohibiting people from leaving their homes, except for essential provisions and medicine.

Though health is a state subject, but to control the epidemic, the directives of the central government had to be observed by all states. Further, to ensure that the actions have the legal support and do not infringe upon the right of freedom of movement enshrined in the Constitution, the Order for nation-wide lockdown was issued by the Ministry of Home Affairs, (termed as Interior Ministry in some countries), of the Government of India (i.e. the central government) under the provisions of the Disaster Management Act, 2005. This legislation empowers the central government to notify through the official gazette the establishment of an

authority to be known as the National Disaster Management Authority. The Prime Minister is the ex-officio chairman of the Authority, and appoints members of the Authority. The National Disaster Management Authority is empowered to lay down the policies, plans and guidelines for disaster management for ensuring timely and effective response to disaster.

In addition to the actions described in the foregoing paragraphs, other initiatives taken by the administration of the central government through different ministries include:

- Ministry of Health & Family Welfare - organization of sources of supplies of essential medical items, and coordination with its various agencies, other ministries and the state governments to mitigate COVID-19 and, from time to time, provide guidelines to the state governments with respect to health management;
- Ministry of Food & Public Distribution - Plan and ensure availability of essential food items;
- Ministry of Agriculture & Rural Development - Resolve ways for harvesting the “rabi” crops that are agricultural crops sown in winter (mid-November) and harvested in the spring (March/April) in India or winter crops;
- Ministry of Finance - Development of economic distress relief package to provide fillip to industries and the labour, especially of the unorganized sector;
- Ministry of Information & Broadcasting - Communication and dissemination of information of government decisions;
- Ministry of External Affairs & Ministry of Civil Aviation - Coordination and arrangement to evacuate Indian students and citizens stranded abroad;
- Ministry of Home Affairs – Preparation and communication of all lockdown-related advisories, notifications and guidelines to states and other ministries.

Institutional Arrangement

Being a federal administrative structure, action in terms of and implementation is the responsibility of the state governments. In implementation of policies and strategies to contain the novel corona virus, local government at the district and municipal levels are intrinsically involved.

Central Government (at National Level)

It is evident and follows from the above discussions that a number of ministries are involved, and coordination among them is ensured by a Task Force consisting of representatives and officials of various ministries of the

central government, including other relevant agencies such as the National Institution for Transforming India (NITI Aayog) that replaced the former Planning Commission. The ring formed by secretaries of key ministries, includes health, finance, external affairs, defence and home affairs and involved in regular review of the preparedness of states and union territories in terms of requirements like testing kits, Personal Protective Equipment (PPE), masks, ventilators and even hand sanitizers. The backbone of the core team is the cabinet secretary who is the senior most civil servant and administrative head of the Cabinet Secretariat, which is under the direct charge of the Prime Minister. He is the fulcrum for coordination with various ministries, state governments, bureaucrats and other agencies, and taking key decisions in consultation with the Prime Minister's Office (PMO). The cabinet secretary has two key teams working under him - one collates all pandemic-related data from the health ministry and various states and compares it with the global figures, and the other tackles issues raised by the states and the problems faced by them. All work and activities are monitored from a control room set up at the office of the cabinet secretariat which is the administrative headquarters of the central government.

Besides, from the health perspective senior ranked officers are assigned nodal responsibilities and work with experienced and reputed health experts and different agencies under the Ministry of Health & Family Welfare. The Indian Council of Medical Research also has a significant role and is in close coordination with its parent ministry – Health & Family Welfare – to organize and provide guidelines for testing, test kits, tracing, PPE and advisories on dealing with COVID-19 cases.

While the PMO, led by a senior bureaucrat, having experience of disaster management, is seated on the saddle to manage and control the novel corona virus induced situations, individual states are assigned to different ministers of the central government. The ministers receive daily reports from the states using digital technology. This facilitated the bypass against the traditional lengthy state-to-centre communication channel. The respective ministers coordinate with all the District Magistrates, who are the public administrator and chief executive of districts, Superintendent of Police, the head of police force for the district, and Chief Medical Officer of each state on a daily basis regarding measures taken to contain the spread of COVID-19, quarantine facilities and lockdown-related problems, and report to the PMO.

It may be underlined that the PMO depends on multiple layers of information sources to keep tab on how things are unfolding on the ground in terms of outbreak, hotspots, containment and problems like supply of essentials goods. The reporting and monitoring mechanism has significantly reduced reaction time and slip-ups.

State Government (at Sub-National Level)

Following the pattern at the national level, the state governments formed a Task Force to implement the policies and guidelines of the central government, monitor the ground situation, report to the central government and take appropriate remedial actions, as necessary. The key departments of the state government such as health, food, home, finance, etc. form the team with the Chief Secretary, who is the senior most officer of the Indian Administrative Service in the state, and the Chief Executive Officer of the state/provincial government, taking the lead.

At the district level, the District Magistrate, Superintendent of Police and the District Chief Medical Officer form the core working team. Similarly, at the municipal level, it is the Municipal Commissioner, who is the Chief Executive Officer of the municipality, and senior officers from health, sanitation, conservancy and other related sections form the core team. Both, the district and the municipality, keep close contact and liaison with the state government.

Civil Society

NITI Aayog engaged civic societies registered with it and having adequate experience, expertise and outreach to work with the district administration to plan and monitor a coordinated response. The major activities involved in awareness creation among the public to fight COVID-19, distribution of dry food ration and hygiene kits, engaging self-help groups for mask manufacture.

Novel Initiatives

Considering the difficulties that people are suffering due to lockdown and to effectively and appropriately address the situation as emerges, the National Preparedness Survey conducted by the Department of Administrative Reforms and Public Grievances, which is under the overall charge of the Prime Minister assisted by a junior minister, invited suggestions from bureaucrats across the country. Several suggestions were received from about 266 bureaucrats. These suggestions covered:

- Meeting an acute shortage of medical staff, equipment, and facilities like intensive care unit beds at hospitals, ventilators, ambulances, oxygen cylinders;
- Creation of quarantine, isolation and testing facilities;
- Indigenous production of testing kits, Personal Protective Equipment (PPE), and ventilators;

- Regular mapping of quarantined people by creating a database shared at district level;
- Coordination with big data analytic firms for studying state-wise patterns, identifying areas of infection and disseminating the information through media;
- Identification and classification of infected locations by extent of infection through colour coding - red, orange and green zones having varying levels of restrictions aimed to contain the spread of novel corona virus;
- Flagging hardships faced by people in their daily lives because of the lockdown;
- Development of standard operating procedures and guidelines for inter-state movement of people considering temporary/migrant workers' exodus after the nationwide lockdown
- Phase-wise relaxation of lockdown;
- Firmly dealing with instances of non-adherence to lockdown;
- Strengthening research facilities to develop vaccines to fight COVID-19.

Follow-Up Actions & Outcome

Subsequent to close of lockdown 1.0, the period of lockdown was extended two times in consultation with the state governments. The third extension of the lockdown is imposed but with more relaxations than that given in the previous lockdown periods. The gradual phasing out of restrictions is to follow.

Pursuant to the speedy action and measures taken, the country made good progress to combat the pandemic. Private hospitals were roped in, beds increased in government hospitals with oxygen, ICU and ventilation facilities, laboratories for testing facilities increased, private sector laboratories added, production of N 95 respirator and surgical masks and PPEs rose, and campaign for communicating to public of "Do's" & "Don'ts" to prevent COVID-19 infection strengthened. Digital applications are developed and used to locate and track people's location/movement to identify spread and potential hotspots and notify individuals of the potential risk of infection. National preparedness improved significantly.

Inter-state transportation of stranded migrant workers is arranged to bring them back to their homes. Also, for rebooting the economic and stimulus package of INR 20 trillion, (27 trillion of US\$) representing about 10 per cent of the country's gross domestic product has been worked out.

Conclusion

Though there could be certain administrative delays as alleged by some political parties, subtly but definitively, the COVID-19 crisis has changed the way government works. It is cooperative federalism, efficiency of administration and public health responses to this unprecedented crisis that has turned to be India's saviour before a miraculous vaccine is discovered.

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Towards an Integrated Policy, Strong Governance, and High Citizen Awareness on Disaster Response: Case Study of COVID-19 Control Measures in Indonesia

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Abstract

This article examines three investigated variables, namely regulatory framework, governance in action, and citizen awareness, as the basis to explore the lessons of Indonesia in managing the fighting against the spread of the pandemic. The result analysis shows that the disharmony among the laws and regulation increase the complexity of the control measure and weaken the vertical and horizontal coordination. Moreover, the absence of strong leadership and lack of bureaucratic capability hamper the agility of governance. The society preparedness aspect highlighted the emergence of innovation from various stakeholders and, on the contrary, also portrayed the lack of compliance culture. Therefore, this paper suggests to enact an integrated policy, establish a health emergency governance with strong leadership from the President, provide an accountability system in budget allocation and policy implementation, and increase policy enforcement and extensive education to society.

Keywords

Large-scale social restriction, governance, integrated policy, citizen preparedness, leadership, COVID-19

Highlights

Indonesia has implemented large-scale social restriction at the provincial and or local government levels to prevent the spread of the COVID-19, although remains varied in the scale and level of implementation

The lessons learned from Indonesia's case study highlights the urgency of an integrated policy and strong leadership to improve the quality of intergovernmental relations among ministries and central to local government, transparent and accountable budgetary system to prevent abuse of power; and extensive community education to improve citizen awareness in the crisis situation.

Introduction

Managing an effective disaster response in the largest archipelago country in the world, with 268,1 million inhabitants like Indonesia, is unequivocally challenging (Worldometer, 2020). After more than three decades of authoritarian and centralized government, Indonesia has finally introduced decentralized governance following the reformation movement in 1998. As of 2018, Indonesia has 34 provinces, 416 regencies, 98 cities, 7,240 subdistricts, and 83,706 villages (Statistics Indonesia, 2019a). The main challenge for the government amidst the COVID-19 pandemic is to utilize all resources to maintain good governance from the central government to the village level promptly. Furthermore, it is even more challenging, especially considering the informal workers, who dominate Indonesia's national labour force (equal to 57.27% compared to formal workers in 2019 (Statistics Indonesia, 2019b) have become the most affected group during the COVID-19 outbreak as they relied merely on daily wages and were not protected by the social security system (Indraini, 2020; Amnesty, 2020).

Indonesia confirmed the first coronavirus cases in its territory on March 2, 2020 (Gorbiano, 2020). The number of Indonesia-confirmed cases jumped to 23,165 as of May 25, with 1,418 deaths and 5,877 numbers of recovered cases (COVID-19 Task Force, 2020) . As of May 25, 2020, the case-fatality is 6,1%, which places the mortality rate in Indonesia is the highest among the other Southeast Asian Countries (John Hopkins University, 2020). Within the country, Jakarta is increasingly considered the epicentre of the virus above all other provinces.

Before the government announced the first cases in early March 2020, the government was still in denial as several ministers stated that the virus could not survive in tropical climates (Detikcom, 2020a; Nurita, 2020; Antara &

Aziz, 2020; Anwar, 2020). During this period, President Joko Widodo was more concerned about its impact on trade, investment, and tourism, not really on the COVID-19 itself. The central government allocated more than 20 million USD tourism incentives aimed to attract a higher number of international visitors to selected destinations presumed to be located outside the pandemic epicentre (Bisnis.com, 2020).

Using the case study of Indonesia, this article is expected to fill the gap of scientific literature, which examines COVID-19 response from the perspective of governance, including regulations, central and regional relations, as well as state-society relations. Meanwhile, previous studies were mostly focusing on health management and economic issues. For the purpose of the study, we analyse three variables, namely regulatory framework, governance in action, and citizen awareness behind the large-scale social restrictions policy imposed by national and local governments against the COVID-19 pandemic.

The structure of this article is as follows: Firstly, this paper analyses the regulation in responding to COVID-19 to provide the national control measure’s contextual information. Secondly, the explanation about governance will discuss intergovernmental relation issues and bureaucratic capability. Thirdly, this paper will highlight the citizen compliance culture, diversity of the citizen, and contextual issues related to religious and societal culture that may increase the challenge to stop COVID-19 transmission. The following table (Table 1) summarizes the three investigated variables and indicators used in the analysis.

Table 1 - Overview of Three Investigated Variables

Variable	Indicators	Description
Regulatory Framework	Relevant laws and regulations on large scale restrictions policy	Laws and regulations which serve as the primary legal basis for defining and implementing large scale social restrictions
	Relevant laws and regulations on the structure of national Covid- 19 taskforce	Laws and regulations which serve as the primary legal basis for the structure of national Covid-19 taskforce
	Relevant laws and regulations on intergovernmental relations during a crisis	Laws and regulations which serve as the primary legal basis for handling the crisis, particularly, central and local intergovernmental relations
Governance in Action	Coordination among ministries and central government agencies in practice	Coordination among ministries at the central level Collective leadership among top executives

Table 1 - Overview of Three Investigated Variables

Governance in Action		Coordination among ministries at the central level Collective leadership among top executives
	Coordination between central and local government in practice	Intergovernmental relations between central and local governments
	Bureaucratic capability	Legal and social accountability, healthcare system, and capability to implement the designated policy
Citizen Awareness	Compliance culture	Citizen awareness about public health measure to cope with COVID-19 transmission
	Income of the society	Disparity of income level across different societal groups
	Contextual existing condition	Annual "Mudik" culture

Regulation: Large Scale Social Restrictions

We examine key laws and regulations that remain pivotal to understand the large-scale social restrictions imposed by the central government. Amidst high public pressure, after refusing the capital lockdown option (Gorbiani & Sutrisno, 2020), finally President Joko Widodo, on March 30, 2020, stated that the central government decided to combine the large-scale social restriction with civil emergency policies to prevent coronavirus spread. In addition, he also emphasized that the power to initiate the health-quarantine policy lies under the central government (not local governments) and requested governors and mayors to maintain the same vision. This statement was made following the facts that a number of local governments, including Jakarta, Bekasi, Bogor, Tegal, Garut, and Tasikmalaya (Detiknews, 2020b), have already initiated local quarantine to curb the spread of the virus without prior consultation with the central government. It is important to note that following a widespread public outcry against the enactment of civil state emergency policy, the Presidential Spokesperson finally made a correction in front of the media implying that the civil state emergency policy will not be implemented in a short time unless the restriction policy is considered to be ineffective (Ihsanudin, 2020).

The large scale social restrictions, according to the Government Regulation No. 21/2020 (as a derivative to Law No 6/2018 on Health Quarantine), shall incorporate at least the following three measures: temporary school and office

closings, limitation on religious activities, as well as restrictions on activities held in public places. To examine the Indonesian context, it is important to highlight the following key regulations underlying the policy implementation: The Law No. 4/1984 on the Plague of Infectious Disease, The Law No. 24/2007 on Disaster Management Law, the Law No. 23/2014 on Local Government, and the Law No. 6/2018 Health Quarantine. All of these laws become the primary legal basis for government intervention in health-related crises.

From the regulatory perspective, there is a disharmony between the most recent Law on Health Quarantine (Law No. 6/2018) and the other three rules that were set earlier (The Law No. 4/1984 on the Plague of Infectious Disease, The Law No. 24/2007 on Disaster Management Law, and the Law No. 23/2014 on Local Government), especially in defining the distribution of roles between central and local government. Law No. 6/2018, on the one hand, is considered very centralized, emphasizing the central government's full authority to establish and to revoke public health emergency status, as well as to approve or decline social restrictions proposals submitted by local governments. In other words, the local governments only play as a supporting actor in handling the crisis. On the other hand, the other three laws clearly reflect the spirit of decentralization, integrating the pivotal role of local governments in crisis management. In addition, this conflicting nature can also be observed from the Presidential Decree No. 12/2020 on the Declaration of COVID-19 as National Disaster. By intention, Law No.6/2018 was not included as one of its bases as it may jeopardize the legitimacy of the Decree, which by default, tends to support a more decentralized standpoint.

These conflicting regulations have created a bewildering situation, particularly among central and local authorities, and thus become an unnecessary obstacle for effective government intervention. Moreover, in practice, a very centralized reviewing procedure by passively waiting for the local governments to submit their social restrictions application has reduced the agility of the government's mitigation response, which is very detrimental in the middle of a pandemic outbreak. As a promising alternative, given the limited number of local resources, consistent with the central government's top-down preferences, the decision to determine which regions and cities to be affected by social restrictions policy shall also be taken by the central government based on the assessment conducted by a credible group of experts.

According to the Presidential Decree No. 7/2020 on COVID-19 Taskforce, which was then revised by the Presidential Decree No. 9/2020 on COVID-19 Taskforce, the general structure of the COVID-19 Taskforce consists of two following components, namely: Steering and Organizing Committee. These two components remain the same following the amendment, however significantly changing in terms of structures and responsible authorities. According to the

prior regulation, four ministers were responsible as the steering committee without a hierarchical order and clear coordination line among them: Coordinating Minister for Human Development and Culture; Coordinating Minister for Politics, Law, and Security; Minister of Health; and Minister of Finance. The updated regulation established a more specific organizational hierarchy among the four ministers: One chairman, two deputies, and one secretary, successively. The list of steering committee members was longer than before, incorporating twenty-six ministers, five heads of central government agencies, two chiefs of armed forces and national police, and governors from all over Indonesia. The Head of Indonesian National Board for Disaster Management leads the organizing committee with five deputies (consisting of senior officers equivalent to minister's secretary or secretary-general level) and thirty-three members (representatives from twenty-six ministries and seven central government agencies) under his command.

Moreover, at the regional level, despite the Government Regulation No. 21/2020 on Large Scale Social Restrictions in the Acceleration of COVID-19 Handling explicitly requires the role of governors (or mayors) to submit a social restrictions proposal in a specific location within their respective regions to be further reviewed by the Minister of Health, interestingly, the Law No. 9/2015 on Local Governments (as a revision to Law No. 23/2014) was not used as the basis for issuing the government regulation at the central level. Intergovernmental coordination among central government agencies and ministries, as well as between central and local government, will be further explored in detail under the following section.

Governance: Intergovernmental Coordination and Bureaucratic Capability

At the practical level, the complex structure of COVID-19 national task force, as imposed by the Law, has created a substantial obstacle for the organizing committee to manage and lead the day-to-day operations as indicated by a series of observable disputes between them and other related ministries, as well as divergence among the responsible ministries. On April 6, 2020, for instance, the Head of Data, Information, and Communication Centre at the National Board for Disaster Management criticized the non-transparent attitude adopted by the Ministry of Health in COVID-19 data sharing (Widhana, 2020). Furthermore, the Minister of Tourism and Creative Economy contradicted in public the statement made two days earlier by the Minister Coordinator for Maritime Affairs and Investment who had a plan to re-opening the borders to receive more international tourists amidst uncertain pandemic situation in the name of economic recovery (Rahmat, 2020). The

Coordinating Minister for Politics, Law and Security was also seen to have a disagreement with the Acting Minister for Transportation in implementing President's direction to (totally) prohibit the tradition of Mudik by the end of Ramadan (fasting month for Muslim) which involves annual massive people's mobility to their hometown (Kumparannews, 2020). Inconsistent statements on the Mudik ban also occurred earlier when the State Secretary decided to correct earlier statements made by the Presidential Spokesperson in front of the media (Ihsanuddin, 2020). Finally, the Ministry of Health and the Minister Coordinator for Maritime Affairs and Investment issued two clashing policy directions on whether to forbid or to allow online motorcycle taxis to transport passengers during the social restrictions period (Mufti, 2020).

Weak intergovernmental coordination and poor public communication at the national level is arguably resulted from the absence of a legitimate authority able to supervise and to eliminate sectoral ego among the ministers. The Head of the Indonesian National Board for Disaster Management is not equipped by the Law to handle the situation. In this situation, the role of a president is even more crucial than before. Unfortunately, despite the COVID Task Force is placed under the President, however, the President's role, especially in leading and supporting the daily operations, is not explicitly mentioned within the Law.

The intergovernmental relations issue among the responsible ministries and central government agencies within Indonesia's national coordinated COVID-19 response can be scrutinized from the Presidential Decree No. 7/2020 on COVID-19 Taskforce, Presidential Decree No. 9/2020 on COVID-19 Taskforce (Revision), Presidential Decree No. 11/2020 on Determination of Public Health Emergency, and Presidential Decree No. 12/2020 on Declaration of COVID-19 as National Disaster. The President signed the first decree on March 13, 2020, specifying the structure of the COVID-19 Taskforce at the national level, which was then revised one week afterward on March 20, 2020, by the Presidential Decree no.9/2020. Meanwhile, the latter two were dealing with administrative matters as a legal procedure to justify, among others, the required state budget allocation for supporting the overall designated programs.

Harmony in the interactions between central and local authorities remains pivotal to ensure the effectiveness of policy implementation strategy in response to the COVID-19 pandemic. According to Presidential Decree No. 12/2020, every policy made by the governors as the Head of the COVID-19 Task Force at the regional level must always be coherent with the central government's policy. However, the obscurity of clear collective leadership at the national level has undermined local governments' attempt to fulfil the given mandate. Furthermore, in the context of the central-local relations, the Minister of Home Affairs should play an essential role in facilitating coordination between

the centre and the regions based on the principle of “the general government affairs” (Law No. 23/2014 article 9 and article 25).

The second issue concerns the bureaucratic capability issue. The government has successfully convinced the majority members of parliament to agree on a particular regulation under Law No. 2/2020 on the Enactment of Government Regulation in Lieu of Law No 1/2020, which was signed on May 16, 2020. The central government has gained exclusive authority (discretionary power) in the following four ways: 1) To gradually increase a deficit to more than 3% of gross domestic product; 2) To eliminate the constitutional role of house representatives in budgeting; 3) To reallocate budgets between institutions, and 4) To gain the flexibility of procurement standard for three years.

The central government argued that the issuance of Law No 2/2020 aims to strengthen economic stability in the absence of regulations to govern the financing of natural or non-natural disasters. However, it is important to note that such unlimited authority increases social and legal accountability risks, as well as the potential abuse of authority. Therefore, accountability standards in financing during crisis times are needed. Currently, the Constitutional Court has already begun hearing requests for judicial review against the regulation. The petitioners argue that there was no urgency to issue a regulation that takes away too much power from parliament and provides unnecessary impunity to policymakers (Saputra, 2020).

The flexibility given to the local governments to refocus their activities and to reallocate the state budget to cope with the COVID-19 crisis will become a new problem if implemented without proper technical budget distribution. The distribution of disaster-related safety net assistance is a relevant example that, unfortunately, the quality of the recipient data relies on local administrations while, in fact, only several regions have already updated their socioeconomic data (Putri & Ramadhan, 2020). The absence of a valid, integrated, and updated database will trigger a rent-seeking mentality.

Furthermore, the health system also influences bureaucracy capability. The Indonesian health system has a mixture of public and private providers and financing. In line with the decentralized government system, the public system is administered from central, provincial, to the district government. Indonesia is still struggling to increase national health insurance (JKN) coverage since membership requires a self-enrolment method, and contribution to pay the fee makes the middle-income group, particularly non-poor families who work in the informal sector, be the missing middle problem (Dartanto et al., 2020). The government uses a single risk pooling mechanism, which makes provinces or districts with limited health infrastructure might receive less government subsidy compared to well-developed areas (Mahendradhata et al., 2017).

In response to COVID-19, the government has assigned 132 hospitals in 34 provinces as referral hospitals (Ministry of Health, 2020a). There are already 89 laboratories that have actively conducted COVID-19 examinations (COVID-19 Task Force, 2020). Under Minister of Health Regulation No.59/2016 and Minister of Health Decision No 238/2020, hospitals can submit claims for COVID-19 patient hospital bills to the Ministry of Health after verified by BPJS Kesehatan (Ministry of Health, 2020b). Although the number of health facilities for handling COVID-19 continues to grow, there are still capacity issues that often make it difficult to get a hospital room (Susetyo, 2020).

Lack of Citizen Awareness

COVID-19, in some cases, successfully breaks the resistance to change of the society, which instantly creates innovation and changes their daily habit. A number of traditional and modern markets have made innovations to cope with COVID-19 by adopting online business strategies amid the pandemic (Tarmy, 2020). Salatiga Regency and Karawang Regency are two examples of local governments that allow traditional market sellers to operate with physical distancing protocols (The Jakarta Post, 2020; Farhan, 2020). Furthermore, Sleman Regency, Purworejo Regency, Magelang City have allocated retribution incentives and exemption to affected market sellers and private sectors during large-scale social restriction policy implementation (Shofihara, 2020; Mahmudah, 2020; Wicaksono, 2020; Kharisma, 2020).

However, on the other hand, although most local governments, including Jakarta, have already imposed sanctions for violating the restriction, more than 40,000 violations of the social restriction guidelines were recorded between April 10 and May 17 in Jakarta (Paat & Tambun, 2020). Similar situations are also found in various cities, such as Garut Regency and Bandung City (Karang, 2020; Perdana, 2020). These violations still occur due to low public awareness. The local government considers that society discipline is critical in implementing the large-scale social restriction policy (Ladjar, 2020). Despite widespread violation described above, the central government has started the transition to the new normal period as a national policy effective since early June 2020 regardless of the actual number of COVID-19 transmission in the respective regions (Pranita, 2020).

Based on the Ministerial Decree No. 63/2000 issued by the Minister for Village concerning the new normal protocol at the village level, the central government emphasizes significant roles of village administrators and (in) formal leaders in the society (including tourist attraction coordinator, village market coordinator, worship coordinator, social activity coordinator, and the chief of village) to monitor the enforcement of the health protocol among their neighbourhood. Prior to the re-activation of public activities and services, those

above-mentioned key actors must provide the required supporting facilities to effectively implement the health protocol.

Socioeconomic disparity affects the readiness of the community. Many informal workers are still doing activities outside to sustain their life (Marison, 2020). Annual culture and customs such as 'mudik' are also a challenge since the people are still looking for all the ways to anticipate existing regulations. Besides, widespread misconception among the public, particularly among uneducated people, about their above-average immunity to physical diseases and viruses has complicated the situation (Aida, 2020). The challenges in this implementation are in line with the thoughts of (Pierre & Peters, 2005) that overloaded government and ungovernable society can hamper governance.

Lesson Learned

Based on COVID-19 control measures in Indonesia, there are three exit strategies to increase the effectiveness of the current policy. Firstly, the government needs an integrated policy to increase harmony among laws and regulations. Secondly, the establishment of health emergency governance with strong leadership from the President is very crucial. Also, an accountability system in budget allocation and policy implementation is essential to increase the social and legal accountability. Thirdly, the government needs to increase policy enforcement and extensive education to society.

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Japan's Response to the COVID-19

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Abstract

The basic policy measure of Japan's response to the COVID-19 was soft requests, and coercive measures such as city lockdowns were not used. Institutional framework of Japan's infectious disease control was established at the Cabinet level in response to the 2009 H1N1 influenza. Because of that lesson, the Expert Committee for the Control of the COVID-19 played active agenda framing roles, even though the range of knowledge incorporated was limited. The COVID-19 was also used as an opportunity for building a resilient economic structure and accelerating digital transformation through cabinet-wide collaboration. In addition, various dynamics between central and local governments were observed. Those include the cases where the local government acts as a laboratory of policy, where the local government has different incentive from the central government and insists on stronger measures, and where local governments have different incentives among them but are forced to be aligned with strong measures.

Keywords

Soft requests, Expert Committee, active agenda framing role, digital transformation, dynamisms between central and local governments

Highlights

The basic policy measure of Japan's response to the COVID-19 was soft requests, and coercive measures such as city lockdowns were not used.

The Expert Committee for the Control of the COVID-19 played active agenda framing roles, even though the range of knowledge incorporated was limited.

Introduction

In Japan, the outbreak of the COVID-19 was relatively early, but it spread rapidly after late March 2020, lagging behind Europe and the US. Subsequently, a state of emergency was declared by the central government on April 6, 2020, and on April 16, its coverage area was extended across the country, but the basic policy measure was soft requests. Coercive measures such as city lockdowns were not used.

I would like to analyse the experience of the response to the COVID-19 in Japan in the following way. In Section 1, institutional framework of Japan's infectious disease control that was established through the response to the 2009 H1N1 influenza and other measures is analysed. Then, in Section 2, the central government's response to COVID-19 is examined, focusing on the relationship between experts and politics and the system for a cross-sectoral response. Section 3 also examines the relationship between central and local governments. Finally, in Section 4, the character and the issues of Japan's response to the COVID-19 are summarized.

Institutional Context - Experience of the H1N1 Influenza Response

In May 2005, the WHO published the WHO Global Influenza Preparedness Plan in response to the outbreak of H5N1. In response to this development, the central government of Japan formulated an Action Plan for Dealing with the New Influenza in November 2005. A Headquarters for the Promotion of Countermeasures within the Ministry of Health, Labour and Welfare (MHLW) was established with the Minister as the head of the Headquarters. An inter-agency mechanism, that is, the Relevant Ministries and Agencies' Countermeasure Meetings on H1N1 and Avian Influenza was established.

Subsequently, in February 2009, because the new strain of influenza affected the health and lives of a large number of people and had an enormous impact on social and economic activities, it was important for not only the national government but also local governments, firms, and related organizations to take comprehensive measures. Therefore, in addition to revising the Action Plan for the New Influenza, various guidelines related to the new strain of influenza were formulated, and the specific contents of the various measures related to the new strain of influenza and the roles of related organizations were presented (Relevant Ministries and Agencies' Countermeasure Meetings on H1N1 and Avian Influenza 2009).

Shortly after the revision of the action plan and the release of the guidelines, the new strain of influenza (A/H1N1) broke out at the end of April 2009 and became a global pandemic. With regard to the crisis management measures taken by the MHLW, various problems were pointed out. For example, experts, who were appointed to the Government Expert Advisory Committee in May 2009, pointed out the following challenges regarding the role of the expert. 1) The expert advisory committee members should actively contact the media and other media when necessary, not only when requested by the media to express their opinions. 2) Although experts literally had frequent discussions with the government secretariat (Cabinet Secretariat and MHLW), experts did not have the opportunity to raise their opinions directly with politicians. Experts should proactively reach out to politicians along with the secretariat to express their professional opinions (Omi et al. 2010).

Based on this experience of a new influenza, the Ministerial Conference on Countermeasures against New Influenza was established in September 2011 as an inter-ministerial mechanism at the ministerial level. This was to be headed by the Prime Minister with all Ministers of State as constituents. But at this point, the New Influenza Expert Committee was set up within the MHLW. Then in May 2012, the Act on Special Measures against New Influenza, etc. was enacted. Based on the Act on Special Measures, the Advisory Council on Countermeasures against the New Influenza was established in August 2012. In addition, Advisory Committee on the Basic Response Policy was established under the Advisory Council and the Office of Countermeasures for New Influenza was established in the Cabinet Secretariat.

Response to the COVID-19

Establishment of the initial system

A cabinet decision on January 30, 2020 established the Headquarters for the Control of COVID-19 as a ministerial-level, cross-ministerial framework. The head of the Headquarters was the Prime Minister, the deputy head was the Chief Cabinet Secretary and the Minister of MHLW, and the members of the headquarters were all other ministers of state. In addition, the decision of the Headquarters for the Control of COVID-19 on February 14, 2020, established the Expert Committee for the Control of COVID-19 and appointed 12 experts as members (Headquarters for the Control of COVID-19 2020). In addition, a Cluster Response Team was set up on February 25 as a working unit within the MHLW. It consisted of a data team and a risk management team, with about 30 participants from the national institutes and universities.

The initial regimes of Headquarters for the Control of COVID-19 and the Expert Committee for the Control of COVID-19 were established based on ad

hoc cabinet decision and headquarters decision, respectively, and were not based on the Law on Special Measures against New Influenza, which had been prepared in the 2012, as the COVID-19 was interpreted as outside of the scope of new influenza.

The role of expert committee: the relationship between science and politics

Under this ad hoc regime, the Expert Committee for the Control of COVID-19 began to operate and held its first meeting on February 16, 2020. What is interesting about the operation of the Expert Committee is that it does not merely passively respond to the government's requests to consultations, but also tries to actively frame agenda and make proposals to the stakeholders in society in the form of "Situation Analysis and Recommendations". This can be said to be based on the aforementioned professional reflections on the response to the 2010 H1N1 influenza.

For example, at the 8th meeting of the Expert Committee on March 19, 2020, the "Situation Analysis and Recommendations for Countermeasures against COVID-19" was presented, which showed the following. 1) The number of new cases of infection outside of Hokkaido is gradually increasing, particularly in urban areas. 2) There is possibility of an explosive spread of infection (overshoot). 3) There is need to establish a medical system that prioritizes the severely ill (Expert Committee for the Control of COVID-19, 2020a). This "Situation Analysis and Recommendations" seems to have played an important role in putting the concept of a possible "explosive spread of infection (overshoot)" on political agenda.

Political decisions at the ministerial level by the Headquarters for the Control of COVID-19 were made on the basis of the "Situation Analysis and Recommendations" of the Expert Committee. However, the active agenda framing role of Expert Committee based on did not always work. These roles were sometimes overridden by politics. For example, at a press conference on February 29, 2020, Prime Minister Abe, recognizing that "the next week or two are on the brink of rapid expansion or being able to come to an end," announced a policy that included "requests to cancel, postpone, or reduce the size of nationwide sporting and cultural events that attract large numbers of people," and "requests that all elementary, junior high schools and high schools across the country be closed temporarily from next Monday until the start of spring break" (Prime Minister's Office, 2020). The Expert Committee had not given any particular direction on school holidays at that moment.

Institutionalization of the regime based on the revision of the act on special measures against new influenza, etc.

The initial regime of the Headquarters for the Control of COVID-19 and the Expert Committee for the Control of COVID-19 were based on ad hoc cabinet decision and decision of the Headquarters for the Control. But later the Law on Special Measures against New Influenza and Other Influenza was amended to make COVID-19 subject to the amended law. As a result, the revised Law on Special Measures against New Influenza and Other Infectious Diseases came into effect on March 14, 2020, which also covers new COVID-19. Based on this revision, it became institutionally possible to declare a state of emergency for the COVID-19.

And in accordance with the revised law, it was decided to reorganize the Advisory Council and the Advisory Committee on the Basic Response Policy under it. The reorganized Advisory Committee has official role to play in the step for making decision on the state of emergency by the Headquarter for the Control for COVID-19. Subsequently, based on the discussions at the Advisory Committee on the Basic Response Policy on April 7, 2020, the Headquarter for the Control of Covid-19 decided to declare a state of emergency from the date to May 6, 2020, and to revise the Basic Response Policy. Similarly, based on the discussions at the Advisory Committee on the Basic Response Policy, a proposal to change the emergency evacuation zone for the declaration of a state of emergency, a proposal to extend the declaration of the state of emergency to the end of May 2020, a proposal to limit the area in which emergency measures should be implemented and a proposal to lift the state of emergency nationwide were decided, respectively on April 16, May 4, May 14 and May 25.

Thus, under the institutionalized regime after the revision of the Act on Special Measures against New Influenza and Other Infectious Diseases, the Advisory Committee on the Basic Response Policy has assumed an official role. However, the role of the Advisory Committee was a classic one of responding to the government's requests for consultation and not actively framing the agenda. On the other hand, active agenda framing function was retained by the persistence of the Expert Committee for the Control of COVID-19. For example, the Expert Committee held its 10th meeting on April 1, 2020, and issued the "Situation Analysis and Recommendations". Here, Situational Analysis noticed the rapidly increasing number of infected people, especially in urban areas, and the number of infected people suspected to be introduced from abroad, and recommendations were made, including the need to respond to clusters in the city at night and to address the possibility of exceeding the limits of the health care supply system before overshooting occurs (Expert Committee for the Control of the COVID-19, 2020b). This analysis prepared the ground for the declaration of the state of emergency on April 7.

Inter-agency coordination - emergency economic measures, etc.

COVID-19 infections not only pose a health risk in terms of infection, but also economic risks and other risks. It also encouraged increased digitalization. As a result, the government needed an inter-agency response to COVID-19.

For example, at a press conference on February 29, 2020, Prime Minister Abe emphasized the socio-economic benefits of promoting remote responses in all areas of society, utilizing IT technologies such as telework, and promoting future oriented reforms all at once (Prime Minister's Office 2020). The strongest inter-ministerial character was noticed in the cabinet decision on April 7, 2020, "Emergency Economic Measures for COVID-19 - Protecting the Lives and Livelihoods of the People and Revitalizing the Economy". Here, in addition to addressing measures to prevent the spread of infection, the development of a medical supply system, and the development of therapeutic drugs, it referred to the maintenance of employment, the continuation of business, and the recovery of economic activities by the public and private sectors. It considered the construction of a strong economic structure, including supply chain reform, strong support for the return and diversification of production bases in Japan from the perspective of economic security, and the facilitation of the business activities of firms operating overseas. Finally, it talked about a Digital New Deal, meaning the acceleration of a digital transformation (Cabinet, 2020). Building a strong economic structure and accelerating digital transformation is an attempt to use the infectious disease crisis as an opportunity.

The Relationship Between the Central Government and Local Governments

Various dynamics can be observed in the relationship between central and local governments, and between local governments in responding to the COVID-19. The first is the case where the local government acts as a laboratory of policy for the central government. Second is the case where local government has different incentive from the central government and insists on stronger measures. Third is the case where individual local governments vary in terms of their incentives.

Local government as a testing ground

In Hokkaido, 22 new cases of the new COVID-19 were confirmed during the holiday season ending February 24, 2020, bringing the total number of infected people to 30. Because of that, Hokkaido government established a COVID-19

control team on February 25, 2020 (Nihon Keizai Shimbun, 2020a). In response to this move by Hokkaido, the MHLW in central government decided to dispatch a team of infectious disease experts to Hokkaido to analyze patient data in collaboration with Hokkaido and consider measures to prevent the spread of infection (Nihon Keizai Shimbun, 2020b).

On February 26, 2020, Hokkaido asked municipalities in Hokkaido to close public elementary and junior high schools from February 27, 2020 to March 4, 2020 (Nihon Keizai Shimbun, 2020c). In addition, on February 28, 2020, Hokkaido government issued a “COVID-19 Emergency Declaration” calling for people to refrain from going out on weekends due to the spread of the new coronavirus (Nihon Keizai Shimbun 2020d). Such voluntary measures by Hokkaido can be considered as experimental measures taken in the area of spread of infection in cooperation with the central government.

Tension over the declaration of a state of emergency: Tokyo Metropolitan Government and the central government

On January 30, 2020, the Tokyo Metropolitan Government set up the Tokyo COVID-19 Control Headquarters (headed by Tokyo Governor Koike). In light of the increase in the number of infected people, on March 23, 2020, the Tokyo Metropolitan Government released its New Response Policy. In the announcement of the policy, Governor Koike stressed that there was concern in Tokyo that an “overshoot” was causing an explosive increase in the number of infected people, and that there was a possibility of a “lockdown” depending on the state of affairs, but that this must be avoided at all costs (Nihon Keizai Shimbun, 2020e). Tokyo Governor Koike met with Prime Minister Abe on March 26, 2020. She said after the meeting that the Prime Minister was “expected to consider” the declaration of a state of emergency (Nihon Keizai Shimbun, 2020f).

As the central government moves forward with its consideration of declaring a state of emergency, Tokyo Governor Koike announced on April 3 that the Tokyo Metropolitan Government will make public in advance the details of its request to implement a state of emergency if the central government declares a state of emergency due to the spread of the COVID-19 (Nihon Keizai Shimbun, 2020g). Initially, the Metropolitan Government put together a response plan to call for a wide range of industries to take temporary closures, but the central government continued to resist them (Nihon Keizai Shimbun, 2020h). After the coordination between the Tokyo Metropolitan Government and the central government, on April 10, 2020, the Tokyo Metropolitan Government announced the “Emergency Measures in Tokyo to Prevent the Spread of the COVID-19” and specified the target facilities.

The spillover of stricter measures - the dynamism among local governments

Immediately after the declaration of the state of emergency on April 7, 2020 by the central government, the seven prefectures that were subject to the declaration of the state of emergency were not in total agreement. The six prefectures, other than Tokyo, were of the opinion that requests for temporary closures had to be combined with compensation (Nihon Keizai Shimbun, 2020i).

Soon, however, the attitude of local governments changed. On April 10, 2020, Saitama Prefecture requested that commercial establishments, hotels and nightclubs that do not handle the necessities of life be closed (Nihon Keizai Shimbun, 2020k). On April 10, 2020, Kanagawa Prefecture also requested commercial facilities that do not handle daily necessities suspend their operations (Nihon Keizai Shimbun, 2020l).

On the other hand, there were local governments that did not immediately make policy changes. For example, on April 10, 2020, Governor Morita of Chiba Prefecture said, “Chiba Prefecture cannot be the same as Tokyo,” and reiterated his idea that the prefecture would not request temporary closure for the time being (Nihon Keizai Shimbun, 2020j). However, the next day, Chiba Prefecture also changed its attitude on this measure. On April 11, 2020, Chiba Prefecture Governor Morita announced his intention to ask businesses in the prefecture to close their operation, aligning the prefecture with Tokyo and Kanagawa and Saitama prefectures (Nihon Keizai Shimbun, 2020n).

Conclusion and Remaining Issues

In this final section, I would like to comment on the character and effectiveness of Japan’s response to the COVID-19 and identify some of the issues that emerged.

First, in terms of the character and effectiveness of Japan’s response, it can be noted that COVID-19 emerged relatively early in Japan, and the pace of the outbreak was slow compared to the spread in countries in Europe and the US. It was not until April 7, 2020 that the declaration of a state of emergency, was announced. After the declaration of the state of emergency, the basic policy measures were requests and not coercive measures. It may be asked, how effective has this “Japanese model” been? While it is commendable that the relatively soft measures of the Japanese model did a lot to suppress the number of new cases (see Table), the result is that containment has not always been sufficient and the declaration of a state of emergency has been extended until May 25.

Secondly, there were issues about the testing system and the medical system. The number of tests is insufficient in Japan when compared internationally. In terms of the medical system, the number of beds in Japan is relatively large, but, when compared internationally, it is noted that the number of ventilators and intensive care units per population is not sufficient.

Third, mainly from a medical perspective, it can be said that there has been a certain amount of active input from experts on policy making through venues such as the Expert Committee for the Control of the COVID-19 reflecting the lesson of the response to the 2010 H1N1 influenza. However, the inputs were to provide advices from a medical point of view. On the other hand, there was a lack of transparency regarding the inclusion of non-medical knowledge. Although four economists were added to the Advisory Committee on the Basic Response Policy in May 2020, no non-medical experts have been added to the Expert Committee for the Control of the COVID-19 which has been playing an effective agenda framing role.

Fourth, compensation has been a key issue in requesting a temporary closure of economic and social activities. This has been a key issue in the coordination of measures between the central and local governments. For example, on April 8, 2020, the National Governors Association held a task force meeting in response to the declaration of a state of emergency over the COVID-19 and compiled an urgent proposal calling on the central government to compensate companies for their losses in response to requests to cancel events or take temporal closure (Nihon Keizai Shimbun, 2020m).

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Responses of Singapore to COVID-19 Pandemic: The Whole-of-Government Approach

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Abstract

The COVID-19 outbreak is a global pandemic of unprecedented global scale, across multiple fronts which requires a coordinated response among all government agencies. The Multi-Ministry Task Force was formed to oversee Singapore's whole-of-government (WOG) effort. With travelling restrictions, isolation protocols and efficient contact-tracing, Singapore saw early success, bringing the outbreak under control with businesses and schools remained opened for months. However, the wide-spread among the migrant workers led to stricter "circuit breaker" measurements. Today cases are still rising in the foreign workers dormitory, but fatality rate remains low at 0.07% and the healthcare system is still functioning well. While the early measurements has overlooked the most vulnerable migrant workers group, this report hopes to share how rapid and progressive responses in accordance to the fast evolving situation, can be achieved through a coordinated WOG approach; and to show how digital solutions can augment government's efforts.

Keywords

Whole-of-government, coordination, preparedness, ICT, digitisation

Introduction

Singapore was among the first countries to get hit by the novel coronavirus. It confirmed its first COVID-19 case on 23 January. As at 18 May, there were 28,343 cases, and 22 people have died from complications.

Singapore began screening all inbound travellers from Wuhan in early January. A multi-ministerial task force was formed on 22 January 2020. The task force is co-chaired by the Ministry of Health (MOH) and Minister of National Development (MND) and incorporated all relevant ministries and a range of expertise and jurisdictions (Figure 1). It has the ability to recommend and implement whole-of-government (WOG) policies to deal with issues related to COVID-19.

Early on, Singapore successfully brought the outbreak under control, and schools and businesses remained opened for months. However, later, the virus began to spread widely within the overcrowded foreign dormitories. This led to the extreme “circuit breaker” measures, which included closing of schools and workplaces, and only allowing essential businesses to continue. Although cases in Singapore are still rising, they are largely contained and isolated within the foreign workers community, which make up more than 90% of the cases.

This paper begins with an overview of the whole-of-government approach used in Singapore. This is followed by a look at what happened in terms of the evolution of the government response through three stages of transmission. It finishes by highlighting some aspects of the Singapore experience matters that might be of interest to civil servants and public administrators in other countries who wish to learn lessons from the successes of other governments in responding to the covid-19 pandemic.

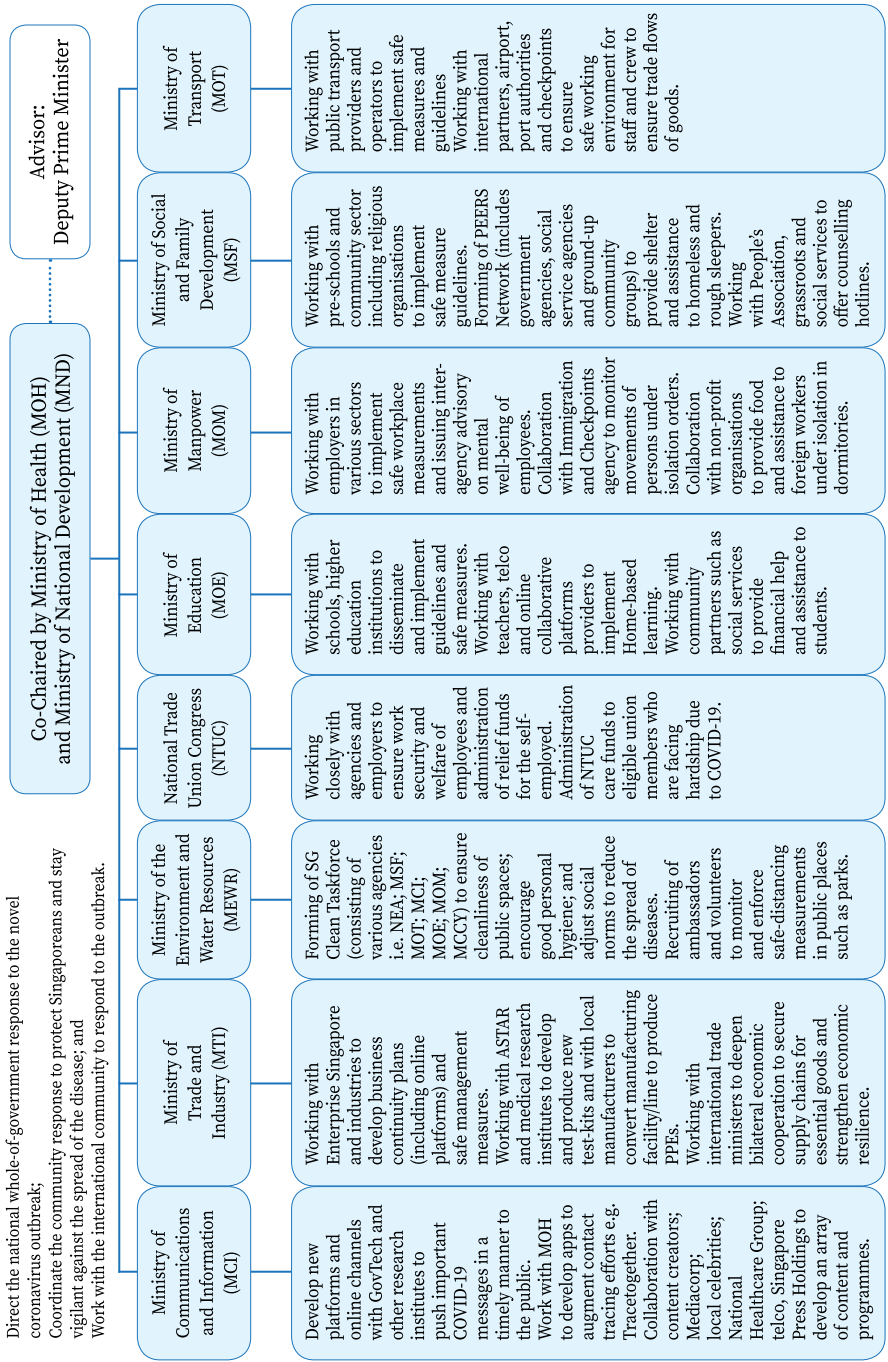
Singapore’s Coordinated Whole-of-Government Approach

Singapore’s WOG approach (Summarised in figure 2) to combating the pandemic was based on four main thrusts: pandemic preparedness; progressive management of resources; incremental policies supplemented with financial assistance; and leveraging of ICT for rapid, large-scale social orchestration.

Pandemic preparedness

The Severe Acute Respiratory Syndrome (SARS) epidemic hit Singapore in 2003 which infected 238 persons and led to the loss of 33 lives. After SARS was contained within two months, several key measures were introduced to

Figure 1 - Multi-Ministry Taskforce on COVID-19



Source: Author

Figure 2 - Singapore WOG approach to containing COVID-19

Phases of Transmission	January to February: Imported Cases	March to 7 th April: Community Transmission	7 th April to 1 st June: Outbreaks in Migrant Workers Community
Main Control Measures	<ul style="list-style-type: none"> From screening to banning of travellers from China. Enforcement of isolation protocols (Quarantine, LOA and SHN) on residents and long-term pass holders returning from China. Contact tracing conducted by police force and Ministry of Health through interviews, CCTV and digital footprints. 	<ul style="list-style-type: none"> Travel Ban imposed on all COVID-19 affected countries including in ASEAN. Residents returning from affected countries placed on SHN in designated hotels. Contact Tracing augmented by <i>TraceTogether</i> App. Safe-distancing measures to limit crowds. 	<ul style="list-style-type: none"> Circuit Breaker or partial lock-down of economy. Banning of all short-term visitors from entering. Gazetting of foreign worker dormitories as isolation areas and placing workers with mild symptoms in made-shift accommodation and healthy ones in other housing avenues. Wide-scale testing of migrant workers, frontline healthcare workers and high risk groups. Mandate contact tracing with <i>SafeEntry</i>.
Financial Assistance	<ul style="list-style-type: none"> Unity budget: support for household, businesses and workers as well as increase of budget for healthcare sector. Testing waived for everyone and treatments paid for residents and long-term pass holders. S\$100 per day allowance for employees and self-employed under isolation protocols. 	<ul style="list-style-type: none"> Resilience Budget: Enhanced Support for households, workers, SMEs, Tourism and Hotel industry. Deferment/ waivers of fees, loans and tax rebates. Withdrawal of treatment payments for residents and long-term pass holders who travel after 27 March. 	<ul style="list-style-type: none"> Solidarity Budget: Further support for households and workers, waiver of foreign workers' levy. Continued payment of wages to migrant workers. Working with non-profit organisations to provide food, healthcare and other needs.
Business and Societal Responses according to DORSCON Level	<p>DORSCON Level raise to orange:</p> <ul style="list-style-type: none"> Masks to be worn only when ill. Cancellation or deferment of large-scale events. Suspension of inter-schools and external activities. 	<p>DORSCON Level remain at orange:</p> <ul style="list-style-type: none"> Deferment and Cancellation of all private and public events/functions with 250 or more participants to subsequent limiting social gatherings to groups of 10. 	<p>DORSCON Level remain at orange:</p> <ul style="list-style-type: none"> Masks to worn at all times when outside. Closure of all schools and shifting to home-based learning Closure of all workplaces and implementation of working from home except for essential businesses.

	<ul style="list-style-type: none"> • Mandatory temperature screening and travel declarations at workplaces, schools and religious establishments. • Workplaces advised to implement working from home for non-essential work and staggered work arrangements. 	<ul style="list-style-type: none"> • Closure of Entertainment outlets (i.e. bars), places of worship, attractions and group-based tuition centers. • Enforce safe-distancing measures in malls and other public places. 	<ul style="list-style-type: none"> • Closure of Preschools closed except for parents in essential services with no alternative childcare arrangements. • F&B outlets only offer takeaway and delivery. • Public urged to stay at home, only go out (preferably one person) to buy food, groceries and exercise and no gatherings outside household allowed.
<i>Enforcement Approach</i>	<ul style="list-style-type: none"> • Surveillance and monitoring of people put on isolation protocols via SMS and mobile-web-based solution. • Penalties imposed on people breaching protocol orders such as revoking of residential status and work passes. 	<ul style="list-style-type: none"> • Safe-Distancing ambassadors deployed in malls, F&B outlets, markets, parks etc. • Penalties i.e. fines and imprisonment imposed on malls and establishments failing to comply with safe-distancing measures. 	<ul style="list-style-type: none"> • Penalties imposed on first time offenders without warning including not wearing masks outside. • Police officers deployed to report on <i>Oneservice</i> app to report on defiant behaviours or gatherings whether in public or private.

Source: Author

strengthen its pandemic management capabilities. One of it was the DORSCON framework which served as the foundation for the national responses to any outbreak with four levels of incremental severity based on the risk assessment of the impact of the disease and rate of transmission in Singapore (Lin et al., 2020).

The National Centre for Infectious Diseases (NCID), was converted into a 330-bed purpose-built infectious disease management facility with integrated clinical, laboratory and epidemiologic functions and staff were also sent abroad for training. Pandemic response plans were also put in place with regular simulation exercises being conducted in public hospitals to evaluate and improve the plans. When the COVID-19 task force was formed, the plans were quickly put into motion. The national strategy for pandemic response was to establish an effective community-wide surveillance system to detect, trace, and contain the disease (MOH 2014). To augment the tracing efforts and ensure public buy-in, a less invasive mobile phone app *TraceTogether* was launched with a fair level of voluntary adoption among citizens. *SafeEntry* was also deployed at venues with high human traffic or prolonged person-to-person interactions.

Progressive management of resources

Faced with scarce medical capacity amidst a global shortage of medical supplies, national efforts were made to conserve, maximise the efficiency of existing resources and prevent over-whelming of the healthcare capacity. Members of the public were initially advised to only wear masks when they were ill while the government expanded its stockpile and worked with the private sector to build up local mask production capability. This was to make sure that the public has adequate mask supplies before distributing to residents in 3 stages and making it mandatory to wear masks when outside (or else they will be fined). While working with research institutes to develop more efficient test-kits, persons displaying symptoms were only tested based on clinical assessments by a doctor. When Fortitude Kit 2.0 and serological tests were developed together with the increase of testing capacity from 2,900 to 8,000 daily within one month, wide-scale testing of vulnerable groups especially the migrant workers was then conducted. As more isolation orders were enforced due to the spike of infected cases, community facilities such as exhibition centres and resorts were being converted and used as makeshift hospitals to house persons who exhibit mild or no symptoms but still tested positive to free up hospital capacity. Only the more serious cases were admitted to hospitals.

Incremental policies supplemented with financial assistance

Policies implemented at each stage were incremental in terms of restricting movements i.e. from temperature screening and travel declarations to more stringent isolation protocols and travelling ban, finally escalated to movement controls that inhibited personal freedom. This was to ease the sudden drastic impact to business and social life as well as to modify behaviours gradually. Monitoring and enforcement approaches also progressed from issuance of advisories to deployment of “ambassadors” to imposing of harsh penalties (such as fines, imprisonment, debar and losing of permanent residence status) on offenders. Corresponding to the tightening of measures introduced, three economic stimulus packages amounting to S\$59.9 billion were rolled out (Figure 3) to cushion the impact.

The Singapore Resilience Budget was passed in March to complement the Unity Budget presented in February to address its impact on Singapore’s economy and society. After CB measurements were announced from 6th April to 4th May 2020 (extended to 1st June 2020), the Solidarity Budget was presented to save jobs and protect livelihoods of the people during CB. Hospital bills were initially paid by the government for all infected residents and long-

term pass holders. However, to deter residents from travelling, those who left from 27 March and subsequently infected, would need to bear the costs themselves.

Figure 3 - Economic Stimulus Packages in Singapore to address impact of COVID-19

Categories	Unity Budget	Resilience Budget	Solidarity Budget
<i>Family/ Household</i>	S\$1.6 billion Care and Support Package for household expenses.	<ul style="list-style-type: none"> • S\$4.6 billion Enhanced Care and Support Package for household expenses. • S\$145 million Temporary Relief Fund and COVID-19 Support Grant for workers who lost their jobs. 	S\$1.1 billion enhanced Care and Support Package.
<i>Businesses</i>	S\$4 billion Stabilisation and Support Package for businesses and workers.	<ul style="list-style-type: none"> • S\$15.1 billion to extend and enhance Job Support Schemes. 	S\$4 billion to enhance support for businesses.
<i>Sectoral</i>	S\$800 million for the healthcare sector.	<ul style="list-style-type: none"> • S\$20 billion loan for SMEs • S\$400 million enhanced job support scheme for aviation industry and S\$350 million enhanced aviation support package. • S\$90 million support for Tourism industry. 	
<i>Self-employed</i>		<ul style="list-style-type: none"> • S\$1.6 billion Assistance to self-employed. 	
<i>Fees/Loans</i>		<ul style="list-style-type: none"> • Freeze all government fees and charges, from 1 April 2020 to 31 March 2021. • Suspend all student loan payments and interest charges from 1 June 2020 to 31 May 2021. • Suspend all late payment charges on HDB mortgage arrears for three months. 	
<i>Tax/Incentives</i>		<ul style="list-style-type: none"> • Deferment of income tax payments for companies and self-employed persons. • Property tax rebates for commercial properties. • Rental waivers. • Legal relief for breach of contracts. 	Foreign Workers Levy waiver.
<i>Total Amount</i>	S\$6.4 billion	• S\$48.4 billion	S\$5.1 billion

Source: Author's compilation

Leveraging of ICT for rapid, large-scale social orchestration

Finally, Singapore's administrative healthcare capabilities in public health had been strengthened by the strategic deployment of digital solutions and dissemination of information through digital platforms such as the daily WhatsApp updates. The success of the deployment of such digital driven measurements was not only dependent on its broadband and network infrastructure which were capable of accommodating to the increased data traffic, but also on the ability of officers who had the skills and know-how on how to make use of them and to create content and applications on demand (Liu, Lee & Lee, 2020). Schools and workplace were able to transit seamlessly to studying and working from home by utilising available free digital solutions and tools. With the help of government grants, small and medium retail and F&B outlets were also able to quickly adopt E-commerce platforms within the well-established ICT ecosystem to create presence online or scale-up online operations.

The Three Waves of Transmission

The government's evolving response to the spread of the virus can be described in relation to each of three waves of transmission.

January to February: early detection of cases through screening, contact tracing and isolation

The first case was a 66-year-old Chinese national from Wuhan and contact tracing was triggered by the authorities to quickly identify persons he had come into close contact with and put into quarantine to avoid spread. Temperature screening was also extended to all sea and land checkpoints. With more imported cases from China, new visitors with recent travel history to mainland China were banned from entering. Preschool staff and students returning from China, had to go on a 14-day leave of absence. The Government distributed four masks to each household, with advice to wear the masks only when unwell and visiting a doctor.

However local transmission began to develop in February forming clusters in the community which prompted the Disease Outbreak Response System Condition (DORSCON) to be raised from yellow to orange¹ (Figure 4). Non-essential large-scale events were advised to be cancelled or deferred. Inter-school and external activities were also suspended. Temperature screening

¹The DORSCON framework was established after SARS to serve as the foundation for the national responses to any outbreak with four levels of incremental severity base on the risk assessment of the impact of the disease and rate of transmission in Singapore, classified as Green being lowest risk, Yellow, Orange and Red being the highest risk.

and travel declarations were made mandatory in schools, workplaces, and religious establishments. Workplaces were also advised to implement ‘working from home’ for non-essential work or staggered working arrangements.

Figure 4 - The Disease Outbreak Response System Condition (DORSCON)

DORSCON ALERT LEVEL				
	GREEN	YELLOW	ORANGE	RED
<i>Nature of Disease</i>	Disease is mild OR Disease is severe but does not spread easily from person to person (e.g. MERS, H7N9)	Disease is severe and spreads easily from person to person but is occurring outside Singapore. OR Disease is spreading in Singapore but is (a) Typically mild i.e. only slightly more severe than seasonal influenza. Could be severe in vulnerable groups. (e.g. H1N1 pandemic) OR (b) being contained.	Disease is severe AND spreads easily from person to person, but disease has not spread widely in Singapore and is being contained (e.g. SARS experience in Singapore)	Disease is severe AND is spreading widely.
<i>Impact on daily life</i>	Minimal disruption e.g. border screening, travel advice.	Minimal disruption e.g. additional measures at border and/or healthcare settings expected, higher work and school absenteeism likely.	Moderate disruption e.g. quarantine, temperature screening, visitor restrictions at hospitals.	Major disruption e.g. school closures, work from home orders, significant number of deaths.
<i>Advice to public</i>	<ul style="list-style-type: none"> • Be socially responsible: if you are sick, stay at home. • Maintain good personal hygiene. • Look out for health advisories. 	<ul style="list-style-type: none"> • Be socially responsible: if you are sick, stay at home. • Maintain good personal hygiene. • Look out for health advisories. 	<ul style="list-style-type: none"> • Be socially responsible: if you are sick, stay at home. • Maintain good personal hygiene. • Look out for health advisories. • Comply with control measures. 	<ul style="list-style-type: none"> • Be socially responsible: if you are sick, stay at home. • Maintain good personal hygiene. • Look out for health advisories. • Comply with control measures. • Practise social distancing: avoid crowded areas.

The raising of the DORSCON level led to panic buying island wide which prompted the Minister of Trade and Industry to assure the public of sufficient stockpiling and supplies of essential items via Facebook and prompted the PM

to address the nation. This incident pointed to the importance of providing the public with access to reliable, clear and timely information. Therefore, a WhatsApp subscription platform² was used to provide citizens with daily and trusted updates in four official languages to help control panic by countering fake news promptly, which strengthened the transparency and credibility of the public administration (Basu, 2020). When more clusters emerged, a stringent Stay-home notice (SHN) was also announced for returning residents with recent travel history to China. Three types of 14-day isolation protocols were implemented, providing instructions for people who had been in contact with confirmed cases or people who had travelled from Wuhan or mainland China (Figure 5).

Figure 5 - Summary of 14-day isolation protocols (Sim 2020)

	Quarantine Order	Stay-Home Notice	Leave Of Absence
<i>Issued To</i>	Close contacts of confirmed COVID-19 cases.	Residents and long-term pass holders returning from higher-risk areas.	Residents and long-term pass holders returning from mainland China.
<i>Instructions</i>	Stay at home or quarantine facility at all times, food and daily essentials provided.	Stay home at all times, make arrangements for food and daily essentials.	Stay home, except briefly for food, groceries and important matters.
<i>Leave Policy</i>	Hospitalisation Leave.	Annual/Unpaid Leave, or granted by company.	Annual/Unpaid Leave, or granted by company.
<i>Salary Support</i>	Quarantine Order Allowance Scheme.	LOA/SHN Support Programme.	LOA/SHN Support Programme.
<i>Legal Weight</i>	Under Infectious Diseases Act.	Under Infectious Diseases Act.	Advisory.

Source Sim (2020).

In addition, S\$100 per day could be claimed under the Quarantine Order Allowance Scheme or LOA/SHN Support Programme to help mitigate the financial impact to either the self-employed individuals or companies. All testing fees were waived and the government pays for hospital bills incurred by infected patients in public hospitals. People put on isolation orders are monitored through SMS and mobile-web-based solution that allows people serving their notices to report their locations quickly and accurately to the Ministry of Manpower.

² WhatsApp has the highest penetration among social messaging apps in Singapore (used by 4 million people) and fake news are easily propagated through WhatsApp

With exhaustive contact tracing by the police force that uses CCTV, digital footprint and investigative interviews with patients to identify lists of people who may have been exposed, the government was able to establish linkages between two of the largest clusters and brought the outbreak under control at the end of February. It was also the first time serological testing which tests for COVID-19 antibodies in recovered patients, was used to uncover a COVID-19 patient, who recovered before she was tested.

March to 7th April: curbing transmission of cases through travel bans and social/safe-distancing

The number of infections grew exponentially around the world with outbreaks erupting in Iran, South Korea and Northern Italy. This led to bans on travellers from these affected countries and isolation protocols were expanded to include residents returning from these countries and also visitors with recent history of travelling to ASEAN countries, Japan, Europe, UK and USA. Residents were also advised to defer all overseas travelling. Persons who failed to comply with stay-home notice (SHN) may be prosecuted under the Infectious Diseases Act. Dedicated facilities (e.g. hotels) were also arranged for residents coming back from US and UK to serve their isolation orders.

While imported cases increased as students from overseas were advised to return to Singapore, another new cluster in the community was discovered at an event of about 400 participants. As daily infection numbers went into double digits, it was decided to defer or cancel events with 250 or more participants involved. This requirement applied to all gatherings including private and public functions, food and beverage outlets, religious events and public entertainment venues. Organisers and event venue operators were also required to implement necessary measures to ensure separation of at least a metre between participants as well as putting in place temperature and health screening measures and to obtain contact details of participants.

When the first two COVID-19 deaths were announced on March 23, the government closed its borders to travellers from all at-risk countries. While local transmission was kept under control, the number of imported cases continued to rise. To augment the labour-intensive contracting effort, a mobile app called *TraceTogether* was developed to identify contacts and strangers they might have come into contact with through Bluetooth signalling technology (GovTech, 2020). Downloading of the app is voluntary and consent to send and share data has to be accepted from the user. Stricter safe-distancing measures were implemented, such as closing entertainment venues, tuition and enrichment centres and places of worship; and home-based learning (HBL) was implemented once a week. In addition, gatherings in groups were restricted to 10 persons and safe-distancing measures were

also to be implemented thoroughly in food and beverage (F&B) outlets and malls (Figure 6).

Figure 6 - Safe-distancing measures for F&B and retail outlets.

Retailers	F&B Outlets
<ul style="list-style-type: none"> • Space out the queuing of shoppers (at least 1 m. apart) for fitting rooms and at cashiers. • Use floor markers to mark queuing positions for shoppers. • Encourage the use of self-checkouts, and cashless or contactless payment to speed up the processing of payment and reduce cash-handling. • Limit the number of shoppers within the store to allow for at least a metre spacing between them, where possible. This can be done by letting shoppers into the store progressively. 	<ul style="list-style-type: none"> • Reduce the number of people gathering outside the outlet by putting in place queue management solutions. These include taking down diner details and calling them when there are seats available. • Clearly mark queueing areas and space customers out in the queue (if queues are unavoidable), at a safe distance of at least one metre apart. • Incorporate mobile ordering and payment solutions so that diners can order and make payments directly without having to wait at the cashier. • Install pre-ordering solutions for F&B kiosks to minimise physical clustering of customers waiting to pick up their orders. • Ensure a distance of at least one metre between tables or different groups of diners, although related diners (e.g. family members, couples) can be seated together without staggered seating.

The number of imported cases began to decrease by the end of March but unlinked cases in the community continued to climb so the government urged people to work from home and stay at home as much as possible.

7th April to 1st June: breaking transmission - 'circuit breaker'

In early April, Singapore was hit by a third wave of transmission when outbreaks in foreign workers' dormitories and construction sites were reported, which led to the number of cases surging to three digits daily. On 4 April, the PM announced a "circuit breaker" (CB) or partial lockdown from 7 April to 4 May, closing most work places, so that workers were to shift to remote working (apart from workers in essential services³) and all schools (shifting all students to 'full home-based learning'). The public were to only go out for essential needs such as buying food, groceries and exercise. As it is mandatory to wear masks at all times when outside, reusable masks were distributed to every person in all households. The Bill for COVID-19 (Temporary Measures) Act 2020 was also passed on April 7 to impose restrictions and penalties on the movement of people and the conducting of business during the circuit breaker period.

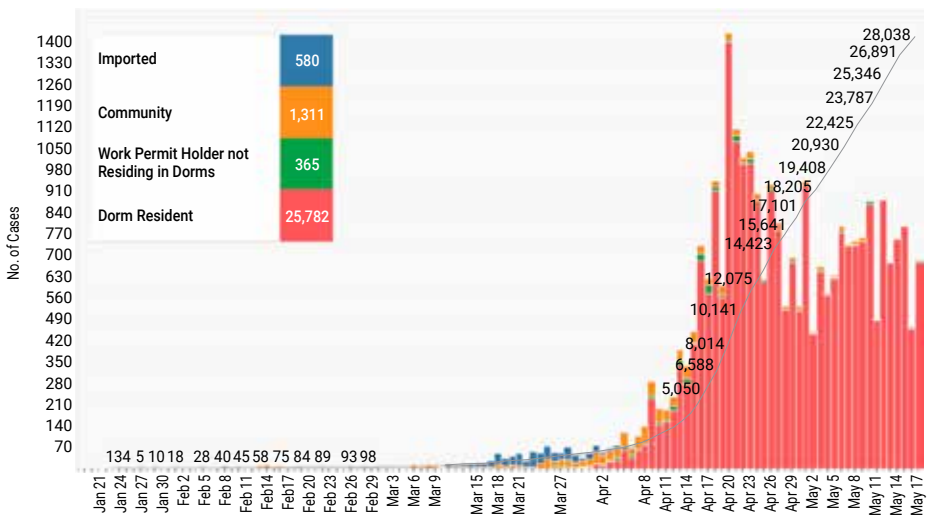
³Essential services as defined by Ministry of Trade and Industry include selected list of health and social services; food; energy; water, waste, environment; transportation and storage; information and communications; defence and security; Construction, Facilities Management and Critical Public Infrastructure; manufacturing and distribution; Banking and finance; legal services

In addition to safe distancing ambassadors deployed to conduct surveillance, the public was also empowered to report defiant behaviours via the *One Service* app. Two weeks into the CB, the measures were further extended to 1st June with more non-essential services being suspended and tighter mobility restrictions i.e. only one person to go out. Popular markets and malls that remained open implemented customer access control measurements which required customers to be registered before entry and exit using the SafeEntry national registration system.

The strategy to break the chain of transmission among the 300,000 migrant workers, was to isolate the possibly infected ones from healthy roommates while all were being tested. 25 dormitories were gazetted as isolation areas. Large exhibition centres were converted to house patients with mild or no symptoms but who had tested positive to relieve the stress on hospitals, while healthy workers were housed in floating accommodation, private properties and unused public housing. A separate inter-agency task force was also formed to work with non-profit organisations to deliver food and provide support to the migrant workers who were in isolation. Although work was halted, the government made sure their wages were paid and remitted home.

By early May, the number of daily local transmission had been brought down to a single digit again with most cases identified working in the health sector. While the number of cases amongst migrant workers continues to rise due to comprehensive testing (Figure 7).

Figure 7 - Epidemic Curve of COVID-19 Outbreak as at 17 May 2020



Source: Ministry of Health [MOH] (2020)

From 5th May, the CB measures would be easing gradually weekly. Some of the businesses deemed non-essential could resume operations with safe-distancing measures implemented and students, taking national exams, were brought back to schools in small groups from 19th May. To prepare for a safe opening, there would be a ramping up of testing in the community especially among the most vulnerable groups, i.e. frontline healthcare workers as well as residents and working staff of nursing and welfare homes, before expanding to the rest of the essential workforce and the community at large. All preschool staff would undergo a one-time swab test for COVID-19 before the centres reopened on 2nd June. In addition a set of safe management practices (such as telecommuting, wearing of masks, avoiding face-to-face business and social interactions, and SafeEntry) would be mandated to be deployed in offices and factories, schools, healthcare facilities, community care facilities, hairdressers, malls, hotels and cabs as business activities resumed.

Lessons of Singapore's Experience and Successes

"If Singapore can't do it, I don't imagine how we think we can." Ezekiel Emanuel, Vice Provost of Global Initiatives at the University of Pennsylvania (Carroll, 2020). Indeed if Singapore which is small in size, has a dominant political party⁴ and a compliant media, cannot bring the pandemic under control, it will be more challenging for other countries with bigger populations and more complex politics to succeed.

Singapore did things right at the onset of the pandemic without closing schools and shutting down businesses, through rigorous screening, contact tracing, isolation orders, social distancing, safe measurements. These responses had earned Singapore early praises and was held as the model to emulate (Bloomberg, 2020). However, when cases ballooned exponentially due to outbreaks in migrant workers dormitories, it led to partial lockdown. The outbreaks in the dormitories, which housed the 300,000 low-wage migrant workers, not only undermined earlier efforts, it exposed the major flaw in the pandemic response plan i.e. the living and working conditions of the most vulnerable group in the society.

While the painful lesson learnt from Singapore highlighted the reality of society inequality whereby social/ safe distancing measurements are ineffective amongst over-crowded communities, overall Singapore had been successful in controlling transmissions in the community. The coordinated WOG approach enabled the deployment of manpower and resources across

⁴The People's Action Party has been in power and re-elected every 5 years since independence

agencies efficiently as well as the autonomy for respective agencies to work with their stakeholders (Lee, 2018). This approach works in Singapore because of the long-time investment in time and effort to nurture inter-sectoral networks to co-design policies and provide public services (Lee and Ma, 2019) which had fostered an environment of trust between the state and society working together to curb transmission and resume normalcy.

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COVID-19 National Report on South Korea Competitive Bureaucratic Leadership Taking Lessons from Prior Experiences

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Abstract

There is no *one-size-fits-all* tool kit for COVID-19 pandemic response since each country has different institutional context to handle this crisis. In that sense, South Korea's COVID-19 policy response such as 'face mask plan', 'smartphone tracking apps', 'social distancing without lockdown' and 'confirmed patient's information disclosure' is strongly associated with Korean's unique setting of institutions. Foreign media and scholars highlighted South Korea's rapid test-track and treat methods, but there was less attention on why these strategies worked from an institutional perspective. From this perspective, this article focuses on the risk management failure of past disasters, national health care system and historical factors to argue how competitive bureaucracy can be the core resource at the early stage of response to flatten the curve of COVID-19 confirmed cases. South Korea's early response model should be understood as the institutional consequence of Korea's past experiences of similar disaster, high expectations of citizen toward competitive bureaucracy rooted from developmental state era, and its culture of collectivism with Confucian values.

Keywords

Competitive bureaucracy, institutions, time management, national health care, confucian culture

Highlights

South Korea's preparedness for aggressive and active response to infectious diseases was well institutionalized before the pandemic outbreak.

Korean case shows that how competitive bureaucracy can be the core resource for ensuring timely responses to flatten the curve of confirmed cases.

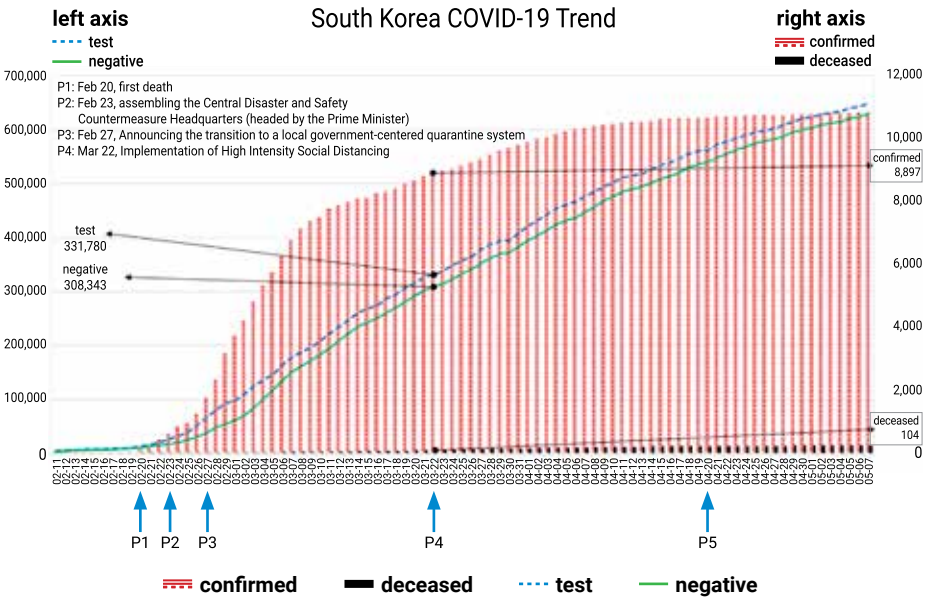
Introduction

South Korea is one of the countries nearest to China in which the COVID-19 has impacted tremendously. Nevertheless, South Korea is discussed not only as a country where the virus has first spread widely, but also as having a competitive government which indicates the government that has the power of government to, based on its given limits, take resources from in and outside of the country and improve social, economic and cultural conditions of the nation and to enhance the social quality and bring the future to more desirable ways (Im and Ho, 2012).

The Korean bureaucracy responded by mobilizing available resources effectively under the extreme time pressure. Evidently, the number of new confirmed cases of COVID-19 has decreased to less than 10 people per day with the death rate of 2.5%. Although COVID-19 has not been conquered yet, it appears as though the “thorough preventive measures” and “active leadership of the central government” are the powerful methods in handling the virus so far.

As shown in the graph, after the first patient died (P1), Korean government immediately assembled the Central Disaster Safety control tower (P2) under the prime minister. The *City of Daegu* outbreak caused the shift from central

Figure 1 - South Korea COVID-19 Trend



government-centred to a local government-centered quarantine system. High intensity social distancing policy is implemented (P4) on March 22nd, 2020 and the eased social distancing campaign is started in April 20th, 2020 (P5). The early response of the government was executed between P3 and P4. While the government was doing so, so did the citizens actively follow the guidelines, and the result showed at P4 and P5 as a comparatively flattened the curve.

Preventive Measures: Understanding Phase Between P3 and P4 “Crisis response for infectious disease” in the South Korean government

South Korea had experienced three different types of infectious virus spread in the recent years. Experiences from the SARS (Sever Acute Respiratory Syndrome) in 2003, and the MERS (Middle East Respiratory Syndrome) in 2015 and 2018 gave lessons to the Korean government on how confirmed patients should be treated, what kind of information should be shared with citizens, and which pools of experts group are immediately needed for policy decisions. For example, after the situation of SARS outbreak in 2003, retrospectively, South Korean government learned that the key element of successful prevention of spread is detecting patients with fever and a quarantine system.

South Korea started with no negative pressure room when the MERS first broke out in 2015, but the government prepared them well before the next outbreak in and out of the metropolitan area, Seoul. While the entire country was better equipped with negative pressure rooms, the designation system of an infectious disease management agency was also prepared. The newly created negative pressure rooms, the designated system for preventing virus from spreading out inside a hospital, EOC, and Korea Centres for Disease Control and Prevention (KCDC) all played a significant role in controlling the MERS in 2018 and COVID-19.

Besides other notable methods such as route tracking, social distancing, the government strengthened organizational arrangements followed by recruiting epidemiology specialists in 2018. The Emergency Operations Centre (EOC), an organization that comprehensively controls quarantine sites in preparation for the outbreak of infectious diseases, was established, and after the MERS outbreak a system called “Crisis Communication Officer (spokesperson for KCDC)” was added to facilitate crisis communication with the public. A measure for speedily approving diagnosis and test kits has been institutionalized after MERS, which helped with early mass testing in the COVID-19 outbreak. Furthermore, instead of setting up the system, the South Korean government

created several virtual scenarios and response protocols under the leadership of KCDC, on how to deal with a patient with an unidentified disease. In fact, the mock training was conducted during the meeting in December 2019. Considering the fact that the COVID-19 incident actually took place a month after the mock training, it can be seen that South Korea's preparedness efforts were timely.

The context for the national government responses to the coronavirus

Political factors

The unique response of South Korea against COVID-19 seems to be related to the previous group learning effort between the government and citizens. First of all, the government led by president Moon felt the need to promptly respond to national disasters and accidents, as it saw public anger, which began with the government's failure to respond quickly to the Sewol Ferry sinking incident in 2014 and eventually resulted in the impeachment of the former president.

The current government, which has been established after the impeachment of President Park who was mainly criticized for the incapability and insensibility in saving lives, became highly attuned to public opinion especially on the problem of life and death situations. Given this background, the South Korean government had put a lot more institutional and practical preparation effort into dealing with an epidemic situation, such as the outbreak of COVID-19, well in advance of efforts of other countries.

One of the features of the South Korean government's response to the pandemic situation was not forcefully sealing off the cities or not allowing people to go outside their homes. This governmental decision to respect the human rights of freedom even during the crisis, which was acclaimed globally, can be explained as a purposeful strategy. During the authoritarian regimes of the 70s and 80s, South Korea had experienced several state emergency situations in which the freedom of civilian mobility was strictly limited. The forceful restriction by the government, in any way, of people's mobility could have had a negative effect on controlling the citizens to remain in social distancing. The government would have been aware of this, even unconsciously, which would have prompted the central government to make recommendations or give advice rather than forcing the citizens.

Korean government support for health care: health care system

The national health system also helped to control the rapid spread of COVID-19. In terms of the Social Security System, South Korea mandates all citizens to join the National Health Insurance program. The general hospitals,

which are mostly private, are operated as non-profit corporations. The medical system is organized from the tertiary hospital to street level clinics. Local governments, cities and counties have their community health centres across the country, which provide residents with medical services at an affordable or rather inexpensive price. These characteristics made it possible for South Korea to have low diagnostic and treatment costs and drug prices, which lessened the risk of ordinary citizens avoiding hospitals due to money-related problems.

Also, after the MERS outbreak, the South Korean government decided to fully support the cost of diagnosis and treatment related to infectious diseases by passing a law, the Infectious Disease Prevention Act enacted in 2015. It also states that the medical payment and living maintenance costs of hospitalized and quarantined people can be judged by the local government, which also seems to have been effective in controlling COVID-19 spread. In other words, South Korea's preparedness for aggressive and active response to infectious diseases was institutionalized even before a major viral crisis. This played an important role in minimizing the psychological and economic burden of infected people from going to the hospital and helped prevent the spread more effectively.

Timely implementation of policies

The government's active response appears to have been effective in responding quickly to cases of infectious diseases. This can actually be seen in the case of *Daegu-Si*, a region heavily affected by the virus. At an early stage of COVID-19, the virus was well managed by the government using the contacts tracing method focusing on travellers from China based on their pre-arranged system. However, the government discovered a community contagion by a traveller from China, for which the alert level had to be elevated. This unexpected situation was caused by a *Shincheonji* church member in *Daegu-Si*, which is a religious cult practicing crowd gathering in a closed space. Even though the church tried to hide its actual membership numbers, the public authority estimated that the number of *Shincheonji* believers was about 230,000 in the whole country. Those who participated to the *Shincheonji* worship service in Daegu on that Sunday was known to be around 20,000. Due to the church's secrecy about its members, the public authority could not trace the potentially infected people. This meant that virtually all *Daegu* citizens were at risk of infection. Until May 2020, *Daegu-Si* faced a serious crisis with 6,800 cumulative confirmed cases, which accounted for 62% of all confirmed cases in South Korea at that time. Most of *Daegu* citizens actively cooperated with the health authority, but many of them feared they could not be tested due to their low priority for testing even though the treatment costs were paid by the central government.

The difficulty of tracing contacts for epidemiological investigations meant the virus kept spreading rapidly. The South Korean health system, which had only 10,000 ventilators, was at risk of collapse if the spread of the virus kept going. Along the way, the KCDC coordinated quarantine activities well, with efficient daily briefings to the public. The key factor in this successful response was the chain of command established in Korean bureaucracy. Under the authority of KCDC, employees of *Daegu* city government worked hard with the police to trace those who hid their association with the *Shincheonji*. Once the hidden people were discovered, they were tested and the places that the virus infected confirmed cases stayed in have been disinfected quickly, and the list of such locations was immediately alerted to the citizens' smartphone applications and SMS.

The volunteers and designated hospitals for this disease were key elements in the successful management of COVID-19 in *Daegu*, which were effectively coordinated by central government and local governments. In terms of technology, the administration of the government was also effective. Testing up to 10,000 people a day backed up by the provision of proper medical treatment to those in need, the government was able to slow down the virus spread, and the quarantine system has not been broken down.

Competitive Bureaucracy: Understanding Phase Between P4 and P5

The competent bureaucrats in South Korea, who intervened in a timely manner and effectively, were, arguably, a pivotal factor in the successful COVID-19 management. They worked within a competitive government that was characterized by competent civil servants in various agencies well aligned from the central government to street-level bureaucrats. The Korean bureaucrats provided proactive leadership, harmonizing central government and local government, and proved effective in dealing with this COVID-19 pandemic situation.

De-politicization of issue

On February 13, 2020, President Moon made an optimistic assessment of the situation, saying "The COVID-19 situation in South Korea will soon end." Soon after this statement, on February 18, patient no.31 was discovered. This person was a member of *Shincheonji* church and this was a dramatic turning point in the COVID-19 situation in South Korea. Before patient no.31 was found, the speed of the spread of the infection was very slow. However, after that point, only within a week, around 1,300 confirmed cases had occurred in *Daegu-Si* where the patient no.31 was living. Many of the new cases were members of *Shincheonji* church, their family members or acquaintances. Since then the infection level sky-rocketed at a national scale in South Korea. Within

a month, the number of confirmed patients reached 5,000, and the number of deaths surpassed 30.

The opposition party tried to take advantage of this situation, acrimoniously criticizing President Moon's previous optimistic statement. This was in consideration of an up-coming general election on April 15, 2020. The opposition party strongly criticized the current government's hesitation in prohibiting Chinese people entering Korea. However, Korean increasingly people placed their trust in the current government watching how sincerely and systematically the bureaucratic leadership dealt with the COVID-19 situation. The bureaucrats working at CDC did not try to politicalize the pandemic, but also focused on solving the problem. Comparing the situation in South Korea with European countries, people's approval rating of the current regime rose. As a result, the political party in government gained a landslide victory in the general election on April 15, 2020.

The low trust in politicians did not allow some politicians to take advantage of this crisis situation. This is an example showing the politics-administration dichotomy in our lives. Even though the opposition party tried to gain a political advantage, the outbreak of the virus abroad, such as in the USA as well as in Europe was even more fearsome, therefore the public opinion became more favourable to the current government dealing with the situation. Simply, South Korean government focused on problem solving by using bureaucratic leadership and the bureaucrats relied on medical professionals' perspectives to handle the uncertainty of the virus spread.

Timely shifting of strategies

From the systematic point of view, the strategy that South Korean government adopted dealing with the COVID-19 situation can be divided into two main policies, which are containment policy and mitigation policy. In the early stage of the pandemic, the government chose the containment strategy. The goal for this containment strategy is to delay the spread, rather than to exterminate the virus. Containment strategy is composed of measures such as early detection of infected patients, contacts tracing of the patients, quarantine of the contact, and wearing face masks. The Korean government advised people to wear masks, frequently wash hands, avoid unnecessary meeting, postponement of the new semester of schools, etc.

When the spread was notified, government turned to the mitigation strategy, which is composed of measures that delay regional spread of virus and minimize the health damage. Mass testing was available and appropriate medical treatments were provided according to the severity of the illness of patients. The closure of crowded facilities such as gyms, churches, etc., was recommended. The main goal of mitigation strategy is to minimize the cases of serious health damage and death in order to avoid the breakdown of medical system.

Rearranging hospitals

The South Korean government rapidly rearranged the medical system in order to face the pandemic situation. For example, KCDC designated hospitals by naming them a ‘citizen-relief hospital’ per districts. The government announced this measure on February 25, 2020. The measure was implemented to prevent the spread of infection within the hospital, especially among patients with respiratory symptoms. Citizen-relief hospitals were divided into two types, type A and B. The type A hospitals operated by separating the respiratory-only external patient care area from others according to the conditions of the medical institution. The type B hospitals screened the general patients and respiratory disease patients, and if the COVID-19 infection is suspected, then the treatment is practiced at clinics outside the hospital called “selective clinics” and run respiratory wards. In early May 2020, there are 343 “citizen-relief hospitals”. This measure is to protect people not only from the infection but also from being in pandemic fear.

Mask distribution

Deciding on the distribution method for the masks to those in need was a crucial problem to be solved, as a fear-buy phenomenon in many countries occurred. In South Korea, there was a public anger about the difficulty of obtaining a mask in the first period of the crisis because there is incredibly high demand compared to the supply of masks. The government decided to address this problem by enlisting the cooperation of pharmacies which can be found every street corner. As a result, people bought their public masks at a reasonable price (1 euro) from pharmacies.

In order to avoid a long waiting line in front of the pharmacies, the “5-day Mask distribution policy” was adopted using the ID data base in the government agency on March 5, 2020. It limits the purchase of masks to two public masks per person, and purchases can only be made on a designated day (which was one of the weekdays according to year of birth), as the daily production of masks was not enough to cover so many people at once. This became possible by pharmacies checking the ID of buyers and doing this checking by means of their access to the public data base. The Korean bureaucracy came up with this particular approach to mask distribution on the basis of the medical context, and not by the political context. In other words, these policies were made only to overcome the situation based on the medical professional’s advices, not to exploit the situation in a political purpose. These policy decisions and their implementation were made in a row of central, provincial, and medical centres by the top-down approach, which means that the central government took a significant role in managing mask distribution issue.

Economy-conscious perspective

Minimizing economic shock is an important area of the crisis management. Since the economy of South Korea heavily relies on trade, travel restriction was not in effect until the latter period when reinforcement measures have to be added. Internally, most businesses, such as in restaurants, cinema, and shopping centres were allowed to continue with normal economic activities. The government did not restrict the uninfected people's economic activities nor impose a level of control that would seal off the city itself.

Apart from the domestic market, South Korea could not avoid the global trade market freezing due to the COVID-19 and most of its export-oriented industries went through serious economic damage. In the meanwhile, though, South Korean export oriented industry in April 2020 seems to have handled COVID-19's impacts well enough to rank first among OECD countries (-1.2 percent), which seems to have been attributed to the fact that the central government, which was committed to dealing with the virus, has not given up on this economic and diplomatic aspect.

Politeness culture

Korean people are very polite. According to Brown & Levinson (1978), politeness and a tendency to keep up appearances is a conventional phenomenon, but Korean's politeness is quite incomparable. While the Western people look for their politeness in their personality and autonomy, Korean people tend to be polite in many more aspects.

As well as a culture of politeness, in Korea there is a concept of *Chemyon* meaning saving face (Im, 2019). Politeness and saving face can be used to suggest an explanation of why Korean people are highly likely to comply with government policies and guidelines. This is the reason why, unlike in the U.S and European countries, every government measure on covid-19 was advised, not compelled by legal force. So, the Korean government could implement a social distancing policy through guidelines without any substantive penalties at first. The government relied on people to use their free will to make it a success. Likewise, Koreans have kept to the guidelines on wearing a mask in a public space. This is because they are sensitive to how other people would look at them if they weren't wearing masks.

Considering economic & diplomatic aspects

First of all, the Government of South Korea did not take an aggressive stance on initializing banning entry to the country of travellers from the outside country, even when majority of Western countries had already adopted such a policy. There was criticism by the people for the government's decision to not

take a prompt action on entrance prohibition from China, especially Wuhan region in January. Despite public calls for a full entry ban on Chinese people in the early days of COVID-19 incident, South Korea later banned Wuhan province people only, which seems to be due to the economic and diplomatic reasons.

The second stance that the South Korean government took to minimize the economic damage was to operate quarantine measures based on people's free will, not by law enforcement. The South Korean government designed quarantine measures that respected people's free will. This was different from Western countries that used police to control internal travel and activities. Korea's restrictions on travellers arriving at ports of entry – restricting movement for 14 days - were also limited to infected and inbound travellers from the second stage of the time framework. Also, when certain places were detected to be infected, after disinfection processing of the place, those areas were not only let open for business, but also suggested and announced to be a 'safer to use' spaces because it was thoroughly disinfected by the supervision of government service. Civilians were allowed to move on their will, freely.

Conclusion

Different societies have found different answers due to the “different ways of structuring organizations, different motivations of people within organizations and different issues people and organizations face within society” (Hofstede, 1983). South Korea's COVID-19 speed in implementing policies should be seen as being a consequence of past experiences of similar disasters, the high expectations citizens have of a competitive bureaucracy that emerged after the 1970s and 1980s, and values of collectivism derived from a Confucian culture (Ho & Im, 2015).

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Oceania

Australia's Response to the COVID-19 Pandemic

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Abstract

The Australian response to the coronavirus pandemic has been one of suppression through imposing tight restrictions on external borders and strict limits on social distancing and interaction. The handling of the crisis within a decentralised federal system has been generally competent and effective in flattening the curve for infections and containing the number of deaths. Political executives at the federal and state/territory levels have generally displayed commendable individual and collective leadership and made judicious use of the advice from health experts and committees. Public services have engaged in transformative behaviour in responding to crisis conditions. Australia has emerged as a low risk country.

The toughest restrictions are being relaxed incrementally with action on large gatherings now occurring, although external borders remain closed. The emphasis has been shifting from public health to economic recovery. In exiting the crisis, new debates have exposed tensions about the economic-health trade off and the position of people lacking social and employment support, and new uncertainties and anxieties have emerged about the possibility of a second wave and economic prospects in a recession.

Keywords

COVID-19 response, crisis federalism, national cabinet, expert advice, public service

Highlights

The first highlight is that the Australia's response to the pandemic was to act early and decisively on external borders and limits on social interaction, which has paid off. A second highlight has been the workings of the federal system, which has adapted to effectively address the exigencies of a mega-crisis to contain infection and the death rate.

Introduction

The COVID-19 pandemic has been the most complex issue confronting Australia, combining the most significant health emergency since the Spanish flu of the late 1910s, and the biggest economic crisis since the 1930s. The efficaciousness of whole of government national responses and the expert advice that underpinned them have featured prominently. This review focuses on the handling of the health pandemic and is unable to accord the same attention to economic issues or the recent moves toward.

Institutional Context for Government Responses and Pandemic Preparedness

It has been argued that Western intelligence agencies had been warning politicians for decades of the ‘growing risk of a pandemic to global strategy’, yet official views were that the coronavirus was unimaginable (Bradbury, 2020, p. 16). The Department of Health had an Australian Health Management Plan for Pandemic Influenza for a number of years. The Auditor-General had critiqued the preparedness in two reports, in particular lack of action on the National Medical Stockpile. The management plan was described as ‘anodyne’, and the preparations as ‘largely ineffectual’ (Bradbury, 2020).

There was however an elaborate apparatus in place for processing international and national data and for national communication among Australia’s governments. The machinery for handling a pandemic was triggered by the rapidly changing position in China. The Communicable Disease Network advocated a national response, and recommendations for travel restrictions followed (Murphy, 2020). The first Australian Health Sector Emergency Response Plan for Novel Coronavirus was quickly produced (the COVID-19 Plan in February) that specified an escalating series of responses, from self-isolation of suspected cases to people working from home. The Pandemic Health Intelligence Plan was subsequently agreed to by National Cabinet.

Major Government Decisions in Responding to the Coronavirus Pandemic

- National Incident Room (Department of Health) was activated and the Australian Health Protection Principal Committee supported border controls for Wuhan flights (January 20)
- Chief medical officer declared the coronavirus to be a disease of pandemic potential (January 21).

- States of New South Wales and Victoria report first cases (January 25).
- State of Queensland confirms first case and declares a public health emergency (January 29).
- Most arrivals from China denied entry and travellers must self-isolate for 14 days (February 1).
- Government activates the health emergency response plan and declares that the coronavirus will become a global pandemic (February 27). (The WHO did not do so until 12 March).
- Extensions to the China travel plan announced (February 27) with arrivals from Iran, South Korea and Italy blocked (respectively February 29, March 5, March 11).
- \$17.6 billion economic stimulus package (March 12).
- National Cabinet established to coordinate the whole of government national response (March 13).
- National Cabinet decisions: overseas arrivals required to self-isolate for 14 days; ban on non-essential outdoor gatherings of 500 or more people (March 13).
- Non-essential indoor gatherings of more than 100 people banned (March 18).
- Minimum space requirements (4 sq. metres per person) for non-essential gatherings (March 20).
- Borders closed to all but citizens and residents (March 19).
- Encouragement to work from home. Non-essential businesses closed. First state initiates school closures (March 24).
- Most gatherings (indoors and outdoors) limited to two people.
- Australians returning from overseas required to spend 14 days quarantined in a hotel (March 29).
- JobKeeper program provides eligible businesses with payments for employees (March 30).
- States impose own social distancing restrictions (March 31).
- First closure of a state's borders (April 5).
- The Pandemic Health Intelligence Plan agreed by National Cabinet (April 16).
- First state to ease restrictions from late April (April 26).
- Three-step framework to achieve a COVID-safe Australia and lift restrictions by July, which detailed a pathway for states/territories (May 8).
- States and territories moving at their own rate through stages 2 and 3 during June and July.

Committees and bodies responsible for decisions, coordination and oversight.

The main federal decision makers have been the prime minister, the minister for health and the chief medical officer drawing on advice from a range of expert committees. There is also provision for other bodies to be part of whole of government decision making (e.g. National Security Committee of cabinet).

National Cabinet comprising the prime minister, state premiers and territory chief ministers became a key cross-party decision maker for many purposes from mid-March (Prime Minister, 2020a). Regular meetings have been held since. Coordination and oversight have occurred through the National Cabinet and the associated apparatus, which is also replicated at the state/territory levels.

The Communicable Diseases Network, an advisory sub-committee of the AHPPC has regularly reported to the chief medical officer. The Australian Health Protection Principal Committee [AHPPC] (2020), the key decision-making committee for health emergencies, is composed of state/territory chief health officers and chaired by the Australian chief medical officer. It advises the Australian Health Ministers' Advisory Council and National Cabinet.

A key minister for economic purposes has been the federal treasurer and his department, and other ministers and counterparts at federal and state levels have had roles. Networks of experts and bodies have provided support including through the Council of Australian Governments (COAG), now supplanted by the National Cabinet.

Lesson Learning from Other Countries

Australia has had a long tradition of learning from elsewhere (Halligan, 2020) and registered early the responses of selected countries that terminated travel from China and other countries.

Countries were monitored as to how they handled their responses, such as Japan, Singapore, South Korea and New Zealand, including ones that adopted a hard-line approach and early intervention. A country with a successful model was New Zealand, which pursued a policy of eliminating the virus that caused COVID-19. Australia's tracing app has been modelled on Singapore's TraceTogether App. Much was also made of not following a number of international approaches.

Major Implementation Challenges for the Government

The federal government had to overcome leadership mindsets, including undervaluing the advice of experts (Craft & Halligan, 2020), and a badly conflicted and ideologically wrought governance system.

Achieving intergovernmental and cross-party cooperation in a federation where eight states and territories have had the responsibility for implementing most measures (e.g. health, schools, social distancing etc) has been a challenge that has largely been overcome. This was worked through by a combination of working together through the National Cabinet on major matters and acceptance of state discretion and variations.

Managing tensions between levels of government with differing approaches to internal state borders and schools emerged as the crisis receded. In making decisions based on local advice and conditions, the states/territories varied in their responses to the level of restrictions and the timing of their modification. The federal government never supported the closure of internal borders whereas most states/territories closed them to inter-state travel. With the relaxation of restrictions on intra-state travel and the use of recreation areas, the differences became apparent. States with low infection rates were reluctant to open a border with high-infection states (the largest states of New South Wales and Victoria). By mid-May pressure from ministers and private sector organisations intensified for the resumption of domestic travel and support for the tourism industry. Another point of inter-governmental tension was with schools, the debate centring on whether and when to shut them and when they should be re-opened.

Obtaining a consistent public response was sometimes problematic (e.g. iconic locations like Bondi Beach), but self-isolation was generally high. There was a hesitant take-up of the COVIDSafe tracing app (but eventually over 6.3 million did).

There were medical supply chain issues as demand for coronavirus tests increased. This also applied to the supply of ventilators and the need to increase the number available for intensive care units across Australia. Issues with supply partly arose because countries that produced medical consumables imposed export controls to retain them for their own use. There was also the question of managing the demand for testing with many people early on being tested unnecessarily.

Finally, public services had to respond to an emergency of unprecedented scale through internal mobilisation, redeployment, whole of government coordination, timely expert advice and innovations in service delivery that took into account social distancing.

The Implementation Chain Used to Implement Major Decisions

Federal departments, such as Health and Treasury, were pivotal for many purposes.

State/territory governments have been central because they have been largely responsible for the health systems and implementation of most measures. A flexible collaborative approach was adopted by the federal government through the National Cabinet (with exceptions noted later) rather than being top-down.

COAG was initially used with its specialist groups of ministers and officials in addition to meetings of first ministers but was rapidly supplanted by regular meetings of a new entity, the National Cabinet. The National Partnership on COVID-19 Response between the Commonwealth, states and territories was agreed in March and updated in April.

Balancing National and State/Territory in Managing Change

There was a combination of top-down and use of state/territory governments. The federal government had learnt recent lessons when it was ineffective in coordinating on bushfires and in relations at state and community levels.

The balance has varied with the measures but state borders, administration of distancing, handling of the health response on the ground were state and territory level responsibilities.

The three-step plan provided for jurisdictions to be able to act according to their public health situation and local conditions, and that they could decide about movement between the steps. They were expected to maintain case numbers and to contain outbreaks, but this was enabled by enhancements to the testing regime, health surge capacity, and the ability to identify people exposed to the virus (Prime Minister, 2020c).

With the inauguration of the regular meetings of the prime minister, premiers and chief ministers through the National Cabinet, a collective and collaborative basis became routine.

Government Communication with the Public

There have been regular national press conferences by the prime minister and the chief medical officer from mid-March. The minister for health and the

treasurer (on the economic stimulus) were also active. These press conferences have been replicated by state premiers and chief ministers, with often daily weekday presentations by them and their chief health officer incorporated in television news and widely reported in other media. Other experts may be used as well to provide information, expertise and authority. These communications have been generally effective (apart from cases of confusing messages about restrictions) with constant updates of coronavirus cases, deaths, changes to restrictions and issues with public behaviour.

Polls have indicated high approval levels for the actions of the several government and public trust. By mid-May people were confronting the future as the lockdowns started to be relaxed. A mood of pessimism and anxiety was apparent among many members of the public as they confronted their work prospects (Essential Research, 2020).

Monitoring and Evaluation of the Implementation of Major Decisions

There is constant monitoring by networks of health officials and specialists who report to the federal government and state/territory governments. The National Cabinet has regularly reviewed progress with COVIDSafe Australia as restrictions were eased and the impact of the changes assessed. The chief medical officer and health specialists in conjunction with their equivalents in the states and territories play central advisory roles. Treasury reviews the effects of its stimulus packages, such as Jobkeeper which have led to modifications (notably the \$60 billion error in the forecasting).

Jurisdictions are continuously monitoring cases and deaths by updating figures and reviewing lessons. Cases have also been reviewed according to causation (external travel, cruise ship passengers, contacts with persons with symptoms etc.). There has been a special focus on clusters in specific locations (aged care homes, hospitals and businesses) and on means of transmission.

A broader question was the place of representative democracy, when parliaments were not convened for much of the crisis (Mills, 2020), although select committees have played an oversight role?

Reactions of State/Territory Governments to the Emergency

Australia is a diamond shaped federal system with delivery concentrated at the state level. Local government's direct role is relatively minor as the relevant functions belong to the states. Local councils have responsibility for

recreational areas (including beach closures) and other roles under delegated authority from the states. They have provided assistance to businesses and communities. In the recovery phase, funds are being distributed to local councils for roads and community facilities.

At state/territory level the responses were generally positive and responsive. The levels of agility may have varied among jurisdictions, but it is difficult to generalise about these without an extensive examination of each case. An exception is the case of the Ruby Princess cruise ship, which has accounted for about one in ten of all coronavirus cases and more than 22 deaths. The circumstances of and the handling of this case by Australian governments is the subject of a Special Commission of Inquiry in New South Wales.

Issues with Government Effectiveness and Lessons for Other Countries

There were several big issues worth noting. The first were perceptions of federal government leadership at the onset of the pandemic. The prime minister mishandled the bushfire crisis which overlapped with the beginning of the new crisis. He stumbled early on by announcing his intention to attend a large sporting gathering despite a pending ban on events with 500 plus people. This conveyed a confusing message to people being urged to self-isolate. The PM subsequently reversed his decision and increasingly displayed more effective leadership.

Second, there was the generally deleterious condition of public governance (Halligan, 2020), and the need for government to move beyond long-standing ideological and partisan divisions that had rendered politics and governance and to demonstrate adaptability to fit the circumstances. The prime minister and other ministers adopted a pragmatic approach to devising health and economic solutions and the use of the federal public service.

There have been several indicators of effectiveness that provide lessons. First, was the set of key decisions to seal the borders and impose a lockdown, which led to a flattening of the infection curve. Second, was the ability of core government advisers' (e.g. AHPPC) from an early stage to extract good expert advice from multiple sources, to interpret the situation, and to develop a constant set of responses. Third, has been the ability of political and official leadership to respond and handle a complex emergency convincingly, including public communication on a daily basis. The polls have indicated positive public evaluations of government responses despite heavy restrictions under lockdown. Fourth, has been the capacity of the public service nationally and in the states/territories to respond to an exceptional situation (Prime Minister, 2020c).

Budgetary and Resource Issues

The federal government offered to the states a joint (50/50) funding arrangement for handling the health response.

There was record financial support allocated for businesses, workers and people reliant on benefits, in total amounting to \$223 billion (later revised down by \$42 billion).

States are large organisations with scope for reassigning resources. One issue was the uneven supply of medical instruments e.g. to regional areas (i.e. non-metropolitan). At the Commonwealth level 1000s of public servants were redeployed to assist with the crisis.

Significance of Protecting the Economy and Lessons for Other Countries

Protecting the economy was a central issue from an early stage, but it did not displace the primacy given to health questions. The New Zealand approach of eliminating the virus was not followed because of the potential economic impact. The balance between health and economics has been changing with the flattening of the infection curve, and the hard reality of recession manifest.

The government made two major responses in March to handle the economic consequences of the coronavirus and avoid a recession. The \$17.6 billion economic stimulus package covered small business and welfare recipients. The second initiative was the Jobkeeper Payment, which provides a temporary subsidy for businesses affected by COVID-19. These were depicted as 'the largest and fastest injection of economic support the country has ever seen' (Treasurer, 2020). The speed at which this was developed produced a forecasting blunder that 6.5 million people would require support when the reality was 3.5.

The federal government also appointed a National COVID-19 Coordination Commission composed of business leaders and bureaucrats to facilitate a fast economic recovery, but it attracted controversy because of the biases of key members and opaque processes.

Lessons for Other Countries About Managing a Pandemic Exit Strategy

A succession of prescriptions has been advanced by political leaders. For the coronavirus restrictions to be lifted, Australia had to pass three tests in mid-April: a sustained decrease in cases; rapid response capabilities to handle

outbreaks; and an exit plan to cover the ‘steps out’ (Worthington, 2020). The prime minister outlined three key criteria for easing restrictions: an increased capacity to test and a more extensive testing regime; contact tracing to locate and isolate contacts of someone infected plus exhortations to download to phones a tracing app; and strengthening response capabilities to lockdown hotspots when outbreaks occur (Prime Minister, 2020b).

In May, the prime minister summarised the government’s five point plan for responding to the crisis.

First, we made real progress in fighting the virus, buying time to increase our health capacity. Second, we put in place our economic response to cushion the blow and build a bridge to recovery. Third, we have begun lifting restrictions, with a clear plan and framework ... Fourth, with restrictions starting to lift it will be paramount to build confidence and momentum to consolidate these gains. Fifth, continue to grow the economy, create more jobs... and keep Australians safe. (Treasurer, 2020).

The AHPPC advised that of 15 ‘precedent conditions’ (e.g. community adherence, quality of modelling, health system status, testing capacity, surge capacity and PPE stocks) required for Australia to relax restrictions, 11 were on track (Prime Minister, 2020c).

The National Cabinet (2020) specified a 3-step pathway in early May to provide states/territories with a roadmap for moving toward COVIDSafe communities in a way that suited their circumstances. The first step focuses on reopening the economy by allowing businesses to reopen, groups of up to 10 people and more travel. The second step builds on this through larger gatherings and more business reopening. Some high risk activities will remain restricted. Step 3 is about long-term COVID Safe ways of living and working, depicted as the ‘new normal’. Restrictions will be minimised. Gatherings of up to 100 people, interstate travel, growth in community sport, will occur, and the ‘travel bubble’ between Australia and New Zealand is under consideration. Restrictions on further international travel and mass gatherings will remain. National Cabinet’s objective is ‘a sustainable COVID safe Australia in July’ (Prime Minister, 2020c).

In the first National Cabinet meeting in June, there was a recommitment to the suppression strategy and confirmation that Step 3 was to be completed in July. There was also agreement on reducing restrictions on indoor gatherings and outdoor events (Prime Minister, 2020d).

In comparative terms the Australian response is considered to have been relatively successful (ignoring the odd early miscalculation and the Ruby Princess fiasco). Australia is a member of the First Movers COVID Group

along with Austria, Denmark, Czech Republic, Greece, Israel, New Zealand, Norway and Singapore. There have been 7285 COVID-19 cases, under 500 active cases and 102 deaths (12 June). However, the prospects for a smooth economic recovery from a recession are affected by the tractability of the economic issues and the potential loss of national unity with the re-emergence of fractious ideological and jurisdictional debates about directions. There is uncertainty about this more ambiguous phase and concern about a second wave of infection.

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Europe

The COVID-19 Pandemic: Croatian Government Response

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Abstract

Croatia was not well prepared for managing the COVID-19 crisis. The Croatian Government opted for professionally-driven response. Numerous measures were designed and taken gradually, because a comprehensive, tailor-made plan for managing the COVID-19 crisis had not been prepared in advance. That led to cunctatorial epidemiological measures in the period before lockdown and caused some technical problems. Lockdown was declared on 20th March. Various public, legal and political concerns have been appeared. The most relevant governance challenges were coordination and public information. Governmental response was centralised, without any substantial role of local governments. The COVID-19 crisis has slowed down the economy and caused severe budgetary problems. The relaxing measures were introduced gradually after 27th April. Finally, the main body managing the crisis, the Civil Protection Headquarters, met the allegations of being politicised. Instead of serious evaluation, the Government announced early general election to be held on 5th July 2020.

Keywords

The COVID-19 crisis, Croatia, centralised response, relaxing measures, budgetary problems, politicisation

Highlights

Plans for dealing with the most serious crisis which have medical, social, psychological and public safety aspects need to be prepared on the firm constitutional and legal basis in order to escape serious legal risks, political and public allegations, and possible subsequent damage to public budgets, institutional and political stability, and decline of democratic culture.

Special budgetary funds for emergencies might be one of the solutions for mitigating their immediate consequences.

Crisis management as a response to serious societal challenges caused by various wicked problems has become a prominent theme in administrative science. A typology of the most serious societal crisis and a comprehensive comparative

frame needs to be built for making research more relevant. Such a typology might be built by combining the most relevant aspects (for example, public safety, public health, ecological, economic, budgetary, demographic, cultural, political, legal, etc.), the magnitude and spatial extent of impacts (local, regional, national, European, etc.), organisation of government in a state (centralised, regionalised, state with strong local autonomy, etc.), political culture (authoritarian, participative, etc.), and others. Comprehensive comparative frame has to include issues such as constitutional and legal framework, institutional design, types and models of response measures, coordination, implementation, accountability mechanisms, responsibility and legal consequences, evaluation, etc. Complex theoretical frame need to be designed, including wicked problems theory, neo-institutional approaches, etc.

Introduction

The first test on COVID-19 in Croatia was done quite early, on 30th January 2020. The first case in Croatia was confirmed on 25th February 2020, it was a 25-year old employee of a large company who attended a football match in Milan, Italy, then returned to Croatia on 20th February and was hospitalised, with symptoms, on 23rd February. (Croatian Institute of Public Health, 2020).

On 4th June 2020, more than three months after the first case, the number of registered COVID-19 cases was 2,247 with 103 dead persons on permanent population of 4,290,612 (2011 census). As many as 2,105 people have recovered and 67,814 people have been tested by the same date. (Government of the Republic of Croatia, 2020a; European Centre for Disease Prevention and Control, 2020).

The preliminary concerns in the general public were based on the spatial proximity with COVID-19 pandemic main European hotspot in northern Italy and relatively late implementation of various restrictive measures. Shortly after the implementation of serious restrictions, on 22nd March, a 5.5 magnitude earthquake caused substantial damage in Zagreb and the surrounding area where lives about a quarter of the Croatian population. That made the situation with COVID-19 contagion even more serious because necessary services had to function and additional resources had to be engaged for sanitation and clearance works. Moreover, numerous hospitals in the Croatian capital were damaged.

In spite of that, Croatia has been one of the countries with rather positive crisis outputs, in terms of the number of registered COVID-19 cases and deaths, and cases and case fatality rates on 100,000 inhabitants (52.3 and 2.4, respectively). Taking the 8th place out of 31 European countries of the European Economic Area plus the United Kingdom, Croatia is thus among the European best performers. (Statista, 2020).

Croatian National Government Response

Relevant governance framework

Two main components of the governance frame relevant for the COVID-19 crisis management are the civil protection and public health. Both services have a tradition in Croatia.

The development of public health can be traced back to the 18th century, although certain institutions had functioned long before. Modernisation began in the second part of the 19th century, with the fast spreading of public health institutions and introduction of modern standards after World War II, during socialism, introduced and overseen by the world-known public health leader Andrija Štampar (Brown & Fee, 2006).

The first initiatives appeared following the Zagreb 1880 earthquake and the establishment of the civil protection service in large urban centres after World War I. Civil protection service developed during the socialist time as a part of the People's Defence System. It was highly significant during the Homeland War (1991-1995). The Croatian civil protection service has been harmonized with the European Union standards (Huzanić Jerkov, 2015) and is now a part of the EU civil protection mechanism.

Despite the constitutional guarantee of local jurisdiction and civil protection being listed as a task within the self-government scope of cities, towns and municipalities,¹ in reality this public task has been legally and institutionally divided among central, local and county governments. The basic piece of legislation is the Civil Protection System Act of 2015.² The Civil Protection Directorate within the Ministry of Internal Affairs is the main governmental body with the dominant position in a rather centralised sector. The Directorate's headquarters are in Zagreb, and five deconcentrated offices with broad regional competences have seats in Zagreb, Split, Rijeka, Osijek and Varaždin. All 576 subnational governments, i.e. 20 counties, the City of Zagreb, other cities (16), towns (110) and municipalities (428), also participate in crisis management, adding to a picture of the highly fragmented civil protection system.³

¹ https://scsr.pravo.hr/_download/repository/The_Constitution_of_the_Republic_of_Croatia.pdf, civil protection is translated as 'civil defense' (Art. 135/1), accessed on 20th May 2020.

² Official Gazette of the Republic of Croatia nos. 82/15, 118/18, 31/20.

³ Fragmentation of the Croatian public administration is among the most serious warnings of various actors, including international ones such as the World Bank. The recommendation to seriously deal with fragmentation is among those repeatedly directed at the Croatian Government by the European Commission within the procedure of the European Semester each and every year of the 2014-2020 period (Koprić, 2018). See European Commission (2020).

The public health system is regulated by the Health Care Act of 2018.⁴ The Croatian Institute of Public Health as the central institution for managing epidemics coordinates a network of 21 county institutes of public health. This Institute has a status of the state agency established for performing professional and scientific public health tasks, and functions under the supervision of the Ministry of Health. Health measures in case of infectious diseases are prescribed by the 2007 Protection of Citizens from Communicable Diseases Act.⁵

In the beginning, the Crisis Management Committee of the Ministry of Health played the main role with regard to COVID-19 contagion. Later on, it was taken over by the *Civil Protection Headquarters* of the Republic of Croatia (CPH) as a steady governmental coordination body whose members are representatives of various ministries, state institutions and services. On 20th February 2020, the Government appointed the minister of internal affairs (who also holds the position of a vice-prime minister) as head of the Crisis Management Committee. Chief of the Civil Protection Directorate was appointed as deputy head, and head of the Croatian Institute of Public Health as a new member of that body. Thus, this coordinative body got a strong political support and an institutional connection with the public health system.

Chronology and measures

The first few months of 2020 saw the performance of various preliminary tasks, from monitoring the situation and dissemination of information on COVID-19 to the preparation of necessary medical capacities for dealing with contagion to organisation of meetings at the EU level, due to Croatian presidency of the Council of the European Union (January – June 2020). Certain additional capacities were allocated and equipped in non-medical objects, in case of need. The Ministry of Health issued several decisions necessary for the mobilisation of medical professionals and other necessary staff.

On 21st February, a decision on the establishment of quarantine within the Clinic for Infectious Diseases “Dr. Fran Mihaljević” in Zagreb was issued. As of 26th February, the CPH held its sessions two times a day (9 a.m. and 4 p.m.), releasing public statements about the epidemiological crisis. An epidemic was declared on 11th March. Kindergartens, schools and universities were closed on 16th March and lectures and other educational activities were moved online or organized via TV broadcasting (for the first four grades of elementary education). On 17th March, the Government adopted the first package of financial support measures to economy.

⁴ Official Gazette nos. 100/18, 125/19.

⁵ Official Gazette nos. 79/07, 113/08, 43/09, 130/17, 47/20.

On 18th March, the Parliament amended the Civil Protection System Act, widening the competences of the CPH. A month later, on 17th April, the Protection of Citizens from Communicable Diseases Act was also amended, regulating the competences of various state bodies in dealing with the COVID-19 crisis. That was a regulatory response to serious public allegations regarding the constitutionality and legality of decisions made by the CPH which had extremely serious impact on the fundamental freedoms and human rights (Bačić Selanec, 2020).

Almost complete 30-day lockdown was declared two days later, on 20th March, including a ban on travelling to and from other countries, with certain reasonable exceptions.

On 23rd March, the CPH decided to ban internal travelling, i.e. travelling outside the place of residence, except with a special permit. Special temporary travelling permits valid for 1-14 days were issued electronically after 2nd April via new e-service handled by the Ministry of Public Administration. Although this measure restricted population movements within the country, more than 1,100,000 issued permits revealed a 'decision-making turbulence' in the COVID-19 crisis management and opened some serious questions about the preparedness of the Croatian governance system for crisis management in general (Burić, 2020).

The Government instigated the second package of support to economy on 2nd April. Various credit and support schemes have been introduced by the ministries and other governmental bodies for the economy, agriculture, fisheries, tourism, culture, and many other sectors. A number of local governments have followed this new trend.

From the 15th April the Government initiated planning of the relaxation and normalisation measures in regard to economic activities. However, at the same time, it decided on stricter measures in the social care system, especially in homes for elderly people, because of several outbreaks with serious media coverage and resonance. Despite willingness to relax the restrictive measures, the Government prolonged the 30-day lockdown, but enabled travelling within counties because many municipalities are very small and without necessary institutions, supply and other facilities for satisfying the basic needs of their inhabitants.

Other relaxing measures were introduced cautiously and gradually in the course of May. The first release step was taken on 27th April. Further steps followed weekly, but certain restrictive measures, have been preserved up to now. That applies first and foremost to educational activities in higher elementary education classes (5th-8th grade), in secondary schools and in institutions of higher education. Special permissions for travelling within Croatia are not necessary since 11th May. Intercity internal traffic was also established on the same day.

Characteristics of the government response

Despite having extensive and elaborated legal framework, including voluminous general strategic documentation, Croatia was not well prepared for managing the COVID-19 crisis. However, the governmental bodies, especially the Ministry of Health and the Croatian Institute of Public Health, monitored the development of situation in Europe as well as the domestic situation from the very beginning. Croatian presidency of the EU Council made the Croatian authorities additionally sensitive and ensured good inflow of relevant and comparatively gathered information, in spite of the dismissal of the minister of health Milan Kujundžić on 28th January. Since the new minister, Vili Beroš, served as an assistant to the previous minister, this dismissal did not have negative outcomes.

The Government did not open a debate about possible models of response to COVID-19 pandemic although there were some voices in the Croatian society advocating for a 'neoliberal' or economy-friendly response model employed in Sweden, the United Kingdom, the USA and some other countries. Instead, the Government openly announced that the epidemiologists would have the main role and that the Croatian response would be truly 'professionally-driven'. Such a decision was indisputably politically driven, made by the Prime Minister and Government. It was probably motivated by the fear of fast spreading of contagion from northern Italy to Istria, Primorje and Dalmatia and then to the rest of the country and fear of panic that possible quick disease spreading might have caused. That is why the Government established its 'scientific board' for the COVID-19 crisis.⁶

Numerous measures were designed and taken gradually, because a comprehensive and tailor-made plan for managing the COVID-19 had not been prepared before. Absence of a plan led to insufficient and cunctatorial epidemiological measures in the period before lockdown, caused some technical problems (such as those with travelling permits), as well as various public, legal and political concerns.

The unique situation of the COVID-19 crisis generated two additional challenges, coordination and public information.

During the crisis, it became obvious that the transposition and re-design of coordination of pre-existing competences and mechanisms were necessary in both horizontal and vertical component. In the beginning, the coordination role was taken from the Ministry of Health's Crisis Headquarters and granted to the Civil Protection Headquarters. In addition, the leadership and membership

⁶ The members are: Alemka Markotić, Krunoslav Capak, Dragan Primorac, Miroslav Radman, Igor Rudan, Gordana Lauc, Nenad Ban, Branko Kolarić and Zvonko Kusić.

of this body was changed by appointing a vice-prime minister as its head and by including a representative of the Croatian Institute of Public Health in the membership. Later, the Civil Protection System Act was amended only to ensure vertical coordination, i.e. the dominant role of the Civil Protection Headquarters in its relations with county, city, town and municipal civil protection headquarters.

A new concept was designed to handle public information and public relations. It included regular daily press conferences with live TV broadcast and internet and social media coverage via newly established information one-stop-shop.⁷ Press conferences were attended by the vice-prime minister (also in the role of the CPH head), the Minister of Health, head of the Croatian Institute of Public Health, head of the Clinic for Infectious Diseases “Dr. Fran Mihaljević”, and some other officials, as necessary. The problems with press conferences began when media and social networks made allegations mentioning politicisation and favouritism (in favour of the Catholic Church, etc.) in the work of the CPH. After some time, following the public demands, the governmental one-stop-shop koronavirus.hr offered the most important data about epidemics. Some other interesting data, such as those about e-permits, are still not publicly available.

The CPH has used three main implementation pillars. One consists of a network of 21 county and several hundred of local (town and municipal) civil protection headquarters. Local and county headquarters have only had monitoring and implementation roles, as they are deprived of almost all decision-making powers, except in individual cases. Another implementation pillar is a network of public health institutes led by the Croatian Institute of Public Health. The latter has been granted extensive powers to issue recommendations and prescribe detailed guidelines for various subjects and sectors. The county institutes have had the implementation role, especially in information-sharing, monitoring self-isolation measures, and performing similar tasks. The third implementation pillar has been the Clinic for Infectious Diseases “Dr. Fran Mihaljević” in Zagreb as the main medical institution with a core team of scientists working on the most complex COVID-19 related issues.

The role of local governments has been extremely narrow. Although the vast majority of them have no capacity for an effective response to emergencies, they were obliged to form their own CPHs. Some of them used the legal possibility and established a CPH as an intermunicipal body, reducing the burden. Only county CPHs and institutes of public health have had a role

⁷ The same team also served social media accounts with the same name (koronavirus). See Government of the Republic of Croatia (2020a).

in direct response to the COVID-19 crisis. In addition, counties, cities and wealthiest local governments designed local support programmes for different sectors, mainly for small and medium entrepreneurs, agriculture, tourism, etc. The ban of travelling outside the place of residence caused a major public debate about the need for decentralisation and territorial rescaling.

Evaluation is among the weakest components of government response to the COVID-19 crisis, reflecting a rather low level of evidence-based policy culture in Croatia. In its session held on 4th May, the Government's Scientific COVID-19 Council concluded that the measures were drastic, timely and well targeted and that they achieved good results in suppression of the epidemic and paved the way for sustainable recovery of the economy, which is especially important at the beginning of tourist season. The Council stressed the responsible behaviour of citizens with regard to social distancing. (Government of the Republic of Croatia, 2020b).

The crisis has revealed some shortcomings of the legal framework for dealing with health crises of this nature and extent which have significant public safety aspects. The need for amending key legal documents and subsequent constitutional debate broke out in the middle of the crisis. At the beginning of May, there were 16 proposals submitted to the Constitutional Court. Three of them requested constitutionality assessment for two key legislative acts amended in March, while 13 challenged various decisions of the CPH that have had restrictive impacts on the constitutional rights and freedoms. Having in mind that the Court has waited for the Government's official responses to these requests, it is obvious that the decisions will be published only after the lockdown.

One strain of public and parliamentary debate was focused on the constitutional, legal and political role of the CPH and the question whether this body is adequately supervised. Ensuring strict vertical and horizontal coordination, granting extensive powers to the CPH and giving high political importance to this body designed for dealing with emergencies was accompanied by its enormous public presence and visibility. Although it functioned under the proclaimed notion of "pure professionalism" there was an impression of its politicisation.

Moreover, some actors had an impression that the system of checks and balances may be damaged by such a legal and institutional arrangement, even permanently. It has certainly contributed to the already existing culture of centralistic way of dealing with public problems and authoritarian functioning of the central executive, thus eroding the sense of local autonomy and the effectiveness of parliamentary and court oversight.

Such impressions have been partly confirmed by the political decision on the self-dissolution of Parliament and early general election on 5th July 2020

(see. Jurak, 2020). A sneaking suspicion was present in the media in mid-April, while political confirmation came a few weeks later. The Parliament decided to dissolve itself on 18th May 2020.

The impression that the crisis management and the work of the CPH might be politicised was amplified by the Government's proposal to establish *mobile phone tracking* in the fight against Covid-19 and by the CPH's decision to ban the shops to be open on Sundays, which has been a hot political issue in Croatia for a long time.

The COVID-19 crisis caused severe budgetary problems, enormously decreasing the revenues and causing serious new expenditures. Moreover, it slowed down the economy to the unprecedented level, opening urgent question of governmental measures for reducing the damage, preservation of employment, social transfers, etc. During the crisis, the Government proposed budget rectification. The amendments to the budget for 2020 were adopted by the Parliament on 18th May. The Government has forecast the GDP drop of almost 9.4%. Negative difference between revenues and expenditures of about three billion euros needs to be compensated in other ways. The finance minister has announced borrowing within the country as the first measure, while borrowing abroad is the next step. The Government also relies on the EU financial compensation. Local budgets can count on the interest-free loans from the state budget for financing elementary local needs, while other solutions have not been offered yet. Many local governments rely on the state financial support, but it might not be granted. Situation is completely unclear in that regard.

Perspectives and next steps

The ban of working Sundays for shops, recommended social distancing, and avoiding of mass gatherings are among the most visible measures retained after almost complete relaxing of the COVID-19 related restrictive measures. It seems that only social distancing, sanitary-hygienic measures and loosened restrictions for visits to hospitals and elderly care homes will be retained.

The CPH has almost completely given up its previous public relation practice, contributing to the overall impression that the situation has returned to normal with signs of social distancing visible only occasionally, mainly in public institutions, shopping malls and similar places.

Taking into account heavy dependence of the Croatian economy on tourism and related activities it is not a surprise to see the Government's insistence on fast recovery of tourist visits. The pre-election campaign has expanded the political issues and displaced the COVID-19 related news in media. Management of the COVID-19 crisis is not an issue in pre-election campaign. Official data confirm that the epidemiological situation is positive.

The debate about possible second wave is almost non-existent. There are no publicly presented plans or options for response in the possible second (and further) waves, except the announcement of Professor Markotić, head of the Clinic for Infectious Diseases “Dr. Fran Mihaljević”, that a new lockdown is not an acceptable option. Only rarely do concerns about possible problems with the second wave get through the media. The media and politics suggest optimistic frames such as “victory over contagion”, “full normalisation”, and “fast economic recovery”.

Major Lessons

The Croatian experience with the COVID-19 government response indicates several major lessons:

- Plans for dealing with the most serious crisis which have medical, social, psychological and public safety aspects need to be prepared on the firm constitutional and legal basis in order to escape serious legal risks, political and public allegations, and possible subsequent damage to public budgets, institutional and political stability, and decline of democratic culture.
- Since extensive and voluminous legal frame based on bureaucratic formalism may delay and slow down the process without adding to the quality of government response, it needs to be revised regularly and evaluated against the criteria of efficient and effective government response to the most serious emergencies.
- Overcoming institutional fragmentation by designing a strong institution for governments’ response to crises may open the issue of abuse of powers and cause public concern, witnessing that democratic values need to be preserved even in emergencies.
- Budgetary instability at all governmental levels opens the issues of savings, rationalisation and possible budgetary cuts, and force a shift towards better reform programming and stricter reform implementation, including territorial rescaling and organisational improvements in public administration.
- Special budgetary funds for emergencies might be one of the solutions for mitigating their immediate consequences.
- Despite satisfactory epidemiological results, an exit strategy from a pandemic should include continuous restrictions and precautionary measures.
- Politicisation of the COVID-19 response and political utilisation of its positive results need to be avoided at all cost.

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COVID-19 – National Government Approach in the Czech Republic

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Abstract

This chapter summarizes actions of the Czech central government against the spread of COVID-19 implemented up until Easter holidays 2020. The report is based on Government resolutions, exceptional measures by the Health Ministry, and media articles. The report clearly indicates that the approach in Czechia was rather restrictive and the Government reacted rather swiftly to the thread. But this was the case of the anti-spread measures, rather than the case of economic measures which was criticized together with legal controversy about some of the adopted measures. The approach taken by the national government clearly demonstrates that the country was not sufficiently prepared for the COVID-19 pandemic on planning, organisational or financial levels and the period brought many lessons for future.

Keywords

COVID-19, Czech approach, restrictive, economic measures, unpreparedness

Highlights

No matter how prepared countries were according to international statistics on their capability to deal with viruses, the Czech case clearly indicates that reality depends on the approach taken by the central government and the intensity of the restrictive steps taken.

The Czech case shows that cooperation between the public and private sectors must also be strengthened in order to deal faster and more effectively in handling similar emergency situations in the future and that there should be some balance in timing and implementing of restrictive and economic measures.

Introduction

This report summarizes the actions taken nationally in Czechia against the spread of COVID-19, up until Easter holidays 2020 (April 9th, 2020). Czechia has an area of 78.865 km², roughly 10.69 million inhabitants and a population density of 136 people/km². It is a unitary state with a relatively high degree of decentralisation. The President is directly elected, though his functions are largely ceremonial. Governments are typically formed by coalitions, which can be quite fragile. Local government is fragmented, with the more-than 6,200 municipalities being rather dependant on state funding. Czechia is a country with relatively low public expenditures, although this may change due to COVID-19 measures. The healthcare system is based on a social health insurance scheme that provides universal coverage and a generous benefits package, with a strong regulatory role played by the Health Ministry (OECD & WHO, 2017).

For this paper Government resolutions, exceptional measures by the Health Ministry, and media articles were consulted (media data was drawn from the ‘coronavirus in Czechia’ section of iRozhlas.cz (a website of the Czech public radio broadcaster), published up to April 9th; 121 articles in total).

National Government Measures

At the beginning of February 2020, direct flights from China and the issuing of visas to Chinese citizens were suspended. On February 25th, the National Security Council (BRS) met and agreed that no restrictive measures would be adopted at that time. The national reserves of medical material were being increased and hospitals were ordered to stockpile at least four months’ worth of face masks and respirators. On February 27th, an emergency board of the Ministry of Labour and Social Affairs discussed the care of the elderly and other vulnerable groups in case of staff shortages.

The first three cases of COVID-19 were reported on March 1st. The Health Minister said that no further measures were yet planned, as few people had been infected up to that point. The BRS met again on March 2nd, recommending the suspension of direct flights from South Korea and northern Italy. The Biathlon World Cup, taking place from March 5th- 8th, was allowed to go ahead, but with no audience attendance. The Interior Minister recommended the Government consider declaring a state of emergency, but the Government declined to do so.

Further measures were discussed by the BRS on March 4th. Eight cases had been confirmed at that time. The Health Ministry agreed a ban on the export of FFP3 respirators and limited their sale on the domestic market. The BRS agreed that restrictions on public gatherings were not yet necessary, but events

with more than 5,000 people had to be reported to public health office. The main priority was to secure protective personal equipment (PPE) for health workers. Due to increased global demand, prices had risen dramatically and the Ministry decided to regulate the price of respirators.

On March 6th, it was declared that people returning from Italy had to inform a doctor, who would decide if they should be quarantined. From March 9th, random temperature checks began at border crossings. From the evening of March 10th, The Health Ministry banned all cultural and sporting events of greater than 100 people. At that time, approximately 60 cases had been recorded. The following day, students were banned from attending all schools and the Government discussed a care allowance for parents.

From 2 pm on March 12th, when 118 cases had been confirmed, a 30-day state of emergency was declared under Constitutional Act No. 110/1998 Coll., on the Security of Czechia and Crisis Act No. 240/2000 Coll., which extend government powers in emergency situations. The Government could now adopt emergency measures as laid down in its resolutions. Ministers were required to obtain Governmental approval before implementing their respective measures.

Also, on March 12th, the Government adopted 8 restrictive measures (which were refined further over the following days) to prevent the uncontrollable spread of the virus. Most of the restrictions took effect within the first ten days of the state of emergency, mainly from March 14th. From March 19th, at the request of the Government, the Speaker of the Chamber of Deputies declared a state of legislative emergency. By April 9th, the Government had adopted 218 resolutions, approximately three times more than the same time the previous year. For the types of measure adopted, see the table below.

On April 1st, the Government asked the Chamber to extend the state of emergency by another 30 days. This was approved on April 7th, but only until April 30th as the Opposition did not want the state of emergency to last until May 11th. They argued that over-extending the state of emergency was economically unsustainable and they were unable to submit bills (due to the procedure for voting on the plenary session agenda).

Due to the measures taken by the Regional Public Health Offices and Regional Emergency Board, 21 municipalities in the Olomouc region, with approximately 24,000 people, were closed for two weeks from March 16th as it was thought more than 1,000 people might have become infected. Their mayors drew attention to the lack of PPE and supplies. The restricted area was monitored by the police (including with drones), who intervened when several people tried to escape. One other small municipality (with a population of 87) in another region was also closed. There was no blanket closure of large cities.

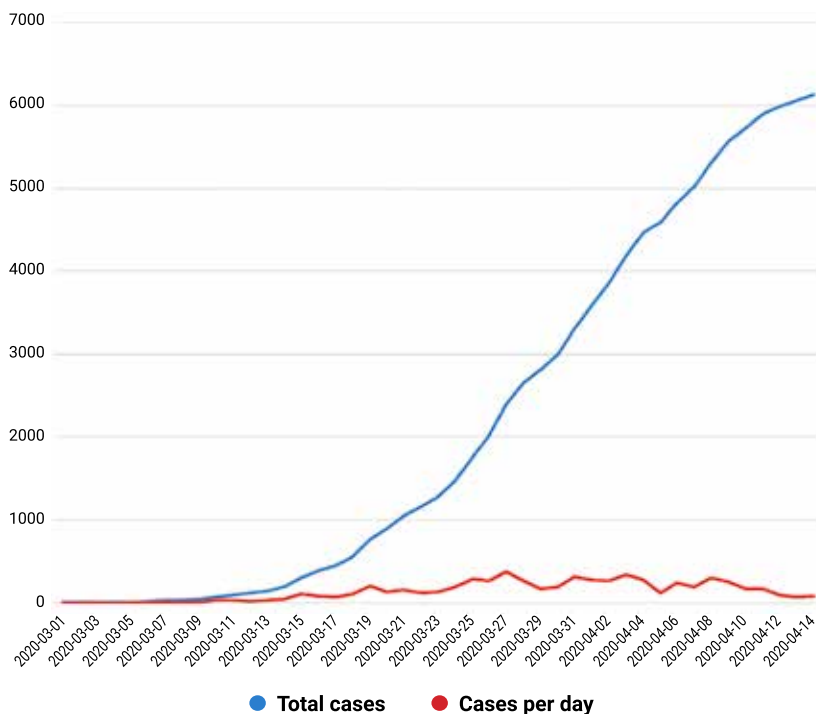
Table 1 - Government measures taken against the spread of COVID-19 after the state of emergency was declared.

Type of measures	Examples
Restrictions on citizens' rights	Reintroduction of border surveillance; restricted entry to Czechia; mandatory quarantine for returnees from abroad; restrictions on the free movement of people; certain medical and social care students were ordered to report for duties; rules for tracing infected people (only with their permission); postponement of the Senate by-election; bans on movement without covered mouths and noses and visits to hospitals and prisons. A bill was prepared allowing the national and municipal police to penalize violators of crisis measures.
Restrictions on services (public and private)	Restrictions on some medical and social services; restriction/suspension of administrative activities; restrictions on transport services; and bans on: some cultural, sporting and other activities; on public access to certain premises (sports facilities, libraries, galleries, public eateries); on students in all types of schools.
Restrictions on private services	Bans on food courts in shopping malls, markets, sales of services and retail sales (with exceptions, including foodstuffs); casinos; accommodation services; driving schools and taxis. A special shopping time was reserved for the elderly and disabled.
Public administration obligations	Coordination obligations were established for health and social services (managed by the Regions). Municipalities were to help people over 70, their Council meetings were restricted, and they were banned from collecting parking fees. Together with the Regions they were to provide care for the homeless. Beds for the infected were to be reserved and their numbers reported. Soldiers and customs officers were called up. Public procurement requirements were eased. A 'smart quarantine' was prepared (aiming to electronically trace and quickly test all contacts of infected people). Testing of this system began on March 30th.
Economic measures (medical supplies and services)	Centralised purchasing of medical supplies was increased; financial reserves for some Ministries (mainly Health and the Interior) were released; road haulage limitations were lifted; the import and export of some medicines was restricted; economic strengthening measures were adopted including, e.g., suspension of sales records obligations, rent protection, postponement of the repayment of debts, postponement of refunds in the tourism industry and an increase in the state budget deficit. Economic measures not requiring legislative changes were also adopted, e.g., budget adjustments for given programmes, with increases for Innovation programmes.

Some measures were partially eased from the middle of March, when the ban on textile sales was lifted to encourage the production of face masks by the public, with measures on administrative agendas beginning to ease from early April. However, this was to be dependent on developments in infection rates. The Health Ministry was also in contact with the European Centre for Disease Prevention and Control and WHO. On April 13th, there were 5,991 confirmed

cases of COVID-19, 467 recoveries and 139 deaths. For developments in the reference period, see the chart below.

Figura 1 - Growth of COVID-19 cases in Czechia



Source: based on data from the Institute of Health Information and Statistics (UZIS)

Criticism reported in the media

The approach taken by the various Governmental departments was widely commented on by the media, who quoted politicians, representatives of various organisations; hospitals, towns, paramedics, social workers, etc. Criticism involved:

- The lack of protective equipment (mentioned still on April 7th in relation to social services and children's doctors). The Health Ministry began distributing the first delivery of respirators among GPs from March 13th. The media reported that, ultimately, each practice received only two to three respirators. A further distribution of medical supplies was expected the following week. Face masks were ordered by the Interior and Health Ministries (later just by the Interior Ministry). Deliveries were largely

from China and the first considerable delivery did not arrive until March 21st. A number of Czech companies complained that the government had not approached them, had ignored their offers, or did not issue licenses (e.g. for disinfectant production). It was also pointed out in the media that companies linked to government members of the ruling ANO party were involved in the distribution of supplies from China and licences for disinfectant production were also granted to companies from the Agrofert conglomerate (connected to the PM). Eventually, some universities started to help (producing e.g., face mask filters, disinfectant, 3D-printed respirator parts, ventilators, mobile apps). Initiatives by members of the public were started on Facebook e.g. 'Donate a respirator to a health worker'.

- The low number of tests administered. The limited information available on which testing laboratories were accessible to the public resulted in some of them being overwhelmed, although tests could be paid for in private laboratories. Only gradually was a list of testing laboratories created. All laboratories were required to have a quality control system in place to share their results, which had to be verified by the National Institute of Public Health. Universities and the Academy of Sciences also offered to carry out tests but weren't allowed to begin until March 25th. On March 30th, some people had been waiting for their results for a week or more.
- Criticism of the Government by the Opposition for not acting earlier. At the end of January, the Opposition demanded a debate on the Government's coronavirus measures, but the Chamber did not allow it. They also criticised the Government for insufficiently addressing the impacts on social services and the economy. The Senate argued that the Prime Minister was delaying the implementation of standard crisis management procedures and the Government should have created a national strategic emergency communication system to quickly and accurately inform the citizenry. According to the Central Emergency Board (ÚKŠ), the Prime Minister did not proceed in compliance with the law because he summoned them late.
- The Defence Ministry proposed increasing the powers of the Government and Prime Minister at the expense of Parliament during the state of emergency. On its session agenda, the Government also included an item proposing the exclusion of trust funds from the implementation of an EU directive on the identification of beneficial owners (which may have been an attempt to assist the prime minister with his well-known conflicts of interest when obtaining money from European Structural and Investment Funds). A bill that would allow military intelligence to monitor internet activity was also debated. Further, the Government proposed amending the Act on the Rules of Budgetary Responsibility, allowing it to enact measures without approval from the National Fiscal Council.

- The State was publishing infection data from the regions, and not those from the municipalities, despite demands from some mayors. According to the mayors, this information could have been used to persuade members of the public to comply with the new government measures. However, according to the Health Ministry, this was sensitive information which could lead to the infected being stigmatised, a view supported by some municipal and regional officials.
- Legal controversy about the adopted measures. Up to March 24th, measures were adopted under the State of Emergency and Crisis Act. From March 24th, they were adopted under the Public Health Protection Act which, according to lawyers, led to a disentitlement to compensation for business owners and members of the public.
- The government's ignoring of municipalities, whose financial reserves were shrinking and whose mayors lacked guidance and advice from the State. Due to the manner in which the municipalities are financed (primarily from taxes), they will be directly affected by economic developments.
- Issues identified by the Czech Association of Creditors, who claimed the changes to debtors' protections limited legal enforceability.

Measures to prevent the spread of COVID-19 in Czechia and the institutional arrangements

The aforementioned measures were mostly enacted by the Government or Health Ministry (which measures the Government then adopted, even retrospectively). The Government's position had been strengthened due to the state of emergency and the fact that the Speaker of the Chamber had allowed bills to be fast-tracked (as part of the state of legislative emergency). Bills were passed (sometimes with changes) by the Chamber as well as by the Opposition-led Senate and swiftly signed into law by the President.

Government decisions often closely adhered to recommendations from expert advisory councils (consisting of medical and other experts), such as the NSC and *ÚKŠ*, and statistics produced by the Institute of Health Information and Statistics, a subsidiary of the Health Ministry.

Other measures were also initiated, implemented and coordinated by the Interior Ministry, (which coordinates the police, PPE orders, e-government). On March 30th, the COVID-19 Central Management Team was established (in parallel with the *ÚKŠ*) as a temporary advisory body to the Government, with a focus on health measures, including the implementation of the 'smart quarantine'. The National Economic Council (NERV) resumed its activities on April 9th.

Support for the economy was based on a combination of measures by the national government (mainly involving the Ministries of Finance, Labour and Social Affairs, Industry and Trade and Agriculture), and support from the Czech National Bank. The actual implementation of the measures was decided by various authorities on the national, regional and local levels. The actions taken didn't always follow the formal structures and procedures for emergency situations, which are mainly derived from the Crisis Act. Powers are also regulated by other acts (e.g., Regional Health Offices are regulated by Act No. 258/2000 Coll., On the Protection of Public Health; the Integrated Rescue System is regulated by Act No. 239/2000).

Local governments also played an important role in monitoring the situation. Various other organisations also helped e.g., Chambers of Commerce, the Confederation of Industry, the Union of Towns and Municipalities, and the Association of Local Governments. New cooperative projects between the public and private sectors were developed (e.g. when tracing those who had contact with the infected). Some universities tried to organise volunteers, cooperate with companies, produce medical aids and materials, test samples, etc. Cultural institutions also tried to help as well as the media, who kept the public informed. Members of the public also mobilised (often organising via social media) by sewing masks, helping with childcare, shopping for the elderly, etc.

Conclusion and Perspectives

The last time a state of emergency was declared was in 2013, when some regions suffered floods. Some of the restrictive measures that were used for the fight against COVID-19 had been included in previous pandemic plans (the first was approved in 2001, then again in 2006 and 2011; these were developed into ministerial and regional pandemic plans). Restrictive measures were common during the communist era but rare since then. There have been no major influenza epidemics and, although terrorist threats had been considered in policies and legislative measures, there were no major incidents in Czechia.

At the beginning of the state of emergency, the media drew attention to international statistics from autumn 2019 regarding the capability of given states to deal with viruses of international concern (e.g. the Global Health Security Index), which placed the USA and UK at the top of the chart. However, based on the current situation, no matter how prepared countries were in theory, the reality has depended on the approaches taken by governments and the intensity of the restrictive steps taken.

The approach taken by the national government clearly demonstrates that in the beginning of the pandemic, the country was not sufficiently prepared for the COVID-19 pandemic on planning, organisational or financial levels. It was

more a case of learning on the job for the departments as well as the public. Due to the COVID-19 pandemic, Czech politicians and public administration on all levels and also the society learnt clear and important lessons in a month, a relatively short time frame. The approach in Czechia clearly require that the relevant authorities must improve their planning and, further, frameworks for implementing and coordinating emergency measures need to be created. The developments in Czechia clearly shows that cooperation between the public and private sectors must also be strengthened in order to deal faster and more effectively in handling similar emergency situations in the future. Some of the newly created tools might be useable in the future, e.g. contact tracing apps, the ‘smart quarantine’ as well as the use of technology in education.

It will be easier to objectively assess the approach taken in Czechia after the crisis abates. However, it is unlikely to be possible to fully assess the effectiveness of the implemented measures. Certainly, the measures taken have, thus far, helped limit the spread of the virus and therefore reduced the potential strain on hospitals. On the other hand, the economic impact of these measures is still unclear and will be heavily influenced by the situation in other countries Czechia is strongly economically dependent on. It will also never be fully possible to compare the impact of the measures taken to a hypothetical situation where the government adopted a less severe approach.

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Finland - The National Government Experience Facing the COVID-19 Pandemic

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Abstract

Due to the COVID -19 pandemic the Finnish Government, in cooperation with the President of the Republic, declared a state of emergency on 18 March 2020. The measures that have been proposed by the Government aimed and will aim to prevent the spread of the virus in Finland, to protect the capacity of the healthcare system and to shield and protect people, especially those who are most at risk. The aim of the hybrid strategy is to curb the epidemic effectively while minimising the detrimental impact on people, businesses, society and the exercise of fundamental rights.

In Finland, the Prime Minister's Office (PMO) is responsible for government situation awareness, preparedness and security services. It also coordinates the management of different incidents and emergencies. In addition, there are several government wide groups like the preparedness organization and the COVID-19 coordination group. Regarding the implementation of the decisions and recommendations, many responsibilities in Finland lay on the municipalities.

Keywords

Preparedness, hybrid strategy, co-operation, communication, municipalities

Highlights

A Government COVID-19 Coordination Group was set up in February 2020 to implement the decisions made by the Government to curb the coronavirus epidemic and to coordinate cooperation between the ministries.

The Finnish Government organizes regular press conferences, that are broadcasted on television, almost on a daily basis and some of which are aimed at special groups e.g. a specific session organized for children and the elderly.

Introduction

The Finnish Government's goals have been to prevent the spread of the virus in Finland, to protect the capacity of the healthcare system and to shield and protect people, especially those who are most at risk. In this paper we give a glance at what the decisions and measures in Finland have been in spring 2020 to achieve this as well as to implement the Government's hybrid strategy. The aim of the strategy has been to curb the epidemic effectively while minimising the detrimental impact on people, businesses, society and the exercise of fundamental rights.

The Institutional Context for the National Government Responses to the Coronavirus

In Finland, the Prime Minister's Office (PMO) is responsible for government situation awareness, preparedness and security services. It also coordinates the management of different incidents and emergencies. The PMO houses the Government Situation Centre, which produces real-time reports and situation analysis on the basis of information provided by the competent authorities. authorities (Finnish Government, 2020a).

The Security Committee assists the Government and ministries in broad matters pertaining to comprehensive security. The Committee follows the development of Finnish society and its security environment and coordinates proactive preparedness related to comprehensive security. The Security Committee is not, however, responsible for the management or steering of incidents and emergencies.

In addition, each of the twelve ministries has a Head of Preparedness, a Preparedness Committee and a Preparedness Secretary. The Heads of Preparedness coordinate the measures between the ministries in all security situations.

Ministerial committee, meetings of Permanent Secretaries, meetings of the Heads of Preparedness, and other permanent inter-ministerial cooperation bodies may participate in the preparations to manage incidents. Depending on the kind of incident, the Security Committee may also be consulted.

There is also a long tradition of National Defence Courses. They provide civilian and military persons in a leading position with a total overview of Finland's foreign, security and defence policies. The idea is to improve collaboration between different sectors of society in emergency conditions and promote networking between people working in different areas of comprehensive security. Annually four courses are organized and exercises include training for pandemics.

In Finland the Ministry of Social Affairs and Health is responsible for the general planning, guidance and monitoring of the prevention of infectious diseases. Finland's preparedness measures are based on a national preparedness plan for an influenza pandemic. The Government Decree on Communicable Diseases was amended by adding the infection caused by the novel coronavirus on the list of generally hazardous communicable diseases. The amendment entered into force on 14 February 2020. The Ministry of Social Affairs and Health cooperates with various authorities to prevent the spread of the novel coronavirus disease.

The Finnish Institute for Health and Welfare (THL) studies, monitors, and develops measures to promote the well-being and health of the population in Finland, also in this case of COVID-19. (THL, 2020).

Important partners in material preparedness include the Finnish Medicines Agency Fimea (pharmaceutical services) and the National Emergency Supply Agency (security of supply). The Ministry has issued guidance for municipalities, joint municipal authorities, hospital districts and regional state administrative agencies regarding preparedness for the coronavirus situation.

The COVID-19 Coordination Group was set up in February. Initially it consisted of the Permanent Secretaries and Heads of Preparedness of the ministries responsible for handling the coronavirus situation but was expanded to cover the Permanent Secretaries of all ministries. The emergency management organisation within the Prime Minister's Office was also strengthened. The task of the Government COVID-19 Coordination Group is to implement the decisions made by the Government to curb the coronavirus epidemic and to coordinate cooperation between the ministries.

The Situation Centre, which operates permanently in the Prime Minister's Office, is now primarily focused on monitoring the coronavirus situation and its effects. The Situation Centre is in charge of maintaining the situational picture and communicating it to the President of the Republic, the Government and other authorities.

An Operations Centre has also been established under the Prime Minister's Office to maintain an overall picture of the progress made in implementing the Government's decisions. Communications are managed and coordinated by the Prime Minister's Office.

On 8 April 2020, the Prime Minister's Office appointed a working group tasked with preparing a plan for Finland's way out of the COVID-19 crisis and deciding on measures to deal with the aftermath of the crisis. The preparation group consists of the Permanent Secretaries of the ministries, with Permanent Secretary from the Ministry of Finance as Chair and Permanent Secretary from

the Ministry of Social Affairs and Health as Vice-Chair. The group is supported by a secretariat whose members are appointed by the ministries.

The Major National Government Decisions Taken on Responding to the Coronavirus Pandemic

The Finnish Government, in cooperation with the President of the Republic, declared a state of emergency on 18 March 2020. The Government submitted a decree implementing the Emergency Powers Act to Parliament on Tuesday 17 March 2020. The Government and the competent authorities implement the decisions and recommendations in accordance with the Emergency Powers Act, the Communicable Diseases Act and other legislation. The competent authorities issue further instructions in accordance with their responsibilities.

In Finland, the growth of the coronavirus epidemic has been halted through restrictive measures and a clear improvement in hygiene behaviour. Although the spread of the epidemic has currently stalled (situation May 2020), there is still a risk that it will escalate again.

The measures proposed by the Government have aimed and will aim to prevent the spread of the virus in Finland, to protect the capacity of the healthcare system and to shield and protect people, especially those who are most at risk. The aim of the hybrid strategy is to curb the epidemic effectively while minimising the detrimental impact on people, businesses, society and the exercise of fundamental rights. In the hybrid strategy, this will involve a controlled shift from large-scale restrictive measures to more targeted measures and to enhanced epidemic management in accordance with the Communicable Diseases Act, the Emergency Powers Act and possible other statutes.

In mid-March, passenger traffic has been restricted at the Finnish external borders, but Finnish citizens are allowed to return home. Those returning should undertake a mandatory two-week quarantine. Schools and universities were shut down. This did not apply to nurseries and day-care centres, but parents were advised to keep their children at home if possible. Primary and lower secondary schools were reopened on 14 May. Some public services (e.g. museums) were closed, and non-public sector service providers encouraged to follow suit. Public gatherings of more than 10 people were banned. Visiting elderly homes as well as care homes was forbidden.

On 24 March, cafés and restaurants were shut down except for takeaway services. The restrictions will stay in effect until 31 May 2020. The limitations do not apply to essential services, such as grocery stores and pharmacies.

At the end of March, the Uusimaa region (including the metropolitan area) was quarantined from the rest of the country for three weeks, with exceptions for essential commuting and other work-related travel.

Situation and measures taken by other countries are followed. The main attention in this is being paid to European countries. The situation in the closest neighbouring countries differs a lot and the e.g. Nordic countries have chosen different strategies. The experts from the Ministry attend meetings of the World Health Organization (WHO), the Council of the European Union, the European Commission and the European Centre for Disease Prevention and Control (ECDC).

Compared to many other countries the Finnish approach has been based more on recommendations. Relatively few changes on legislation have been made. Comparative analysis are made also when preparing the exit-strategies for Finland.

The government plans in May is to gradually lift the restrictions, for more information, please see attachment 1.

Government Communication with the Public

The Finnish Government organizes regular press conferences. They are broadcasted on television, almost on a daily basis. There has also been e.g. a specific session organized for children.

Ministries have published on their websites questions and answers on the effects of the coronavirus in their respective administrative branches. These are updated as needed and can be found also on the specific COVID19 pages of the PMO. There is also a telephone and chat service available. (Finnish Government, 2020b).

Government has also launched a “Finland Forward” campaign. It is a multi-agency project, led by the Prime Minister’s Office, that is working to support day-to-day crisis communications. Along with the health, safety and economic challenges posed by the COVID-19 crisis, there is growing concern about people’s psychological resilience and ability to cope during and after the crisis. The campaign invites everyone to participate in a communications effort aiming to strengthen people’s confidence in their ability to manage their lives and promote trust in institutions and communities in this new situation.

Local Government and the Emergency

Regarding the implementation of the decisions and recommendation, many responsibilities in Finland lay on the municipalities. Ministries and other competent national authorities provide guidance to the municipalities. The

Finnish Association for Municipalities has restricted their own communication activities to COVID-19 related issues for the time being in order to support the municipalities.

The effects of the COVID-19 differ from one municipality to another. Central government finances will be particularly hard hit, because of the downturn and the support measures. There will also be further pressures on local government finances, which were already in a difficult position last year (2019).

The Government will reimburse in full the costs incurred in the healthcare system and by public authorities as a result of the coronavirus crisis. An additional appropriation of EUR 600 million is allocated for the purchase of protective and other equipment and medicines through the National Emergency Supply Agency. The package of support intended to safeguard business activities will be increased by approximately EUR 1 billion. The Government is allocating roughly EUR 1.5 billion for helping people cope with daily expenses. The cyclical benefit expenditure in the budget can be adjusted as necessary. In addition, parents who are absent from work and not paid because they are staying at home with children under the age of 10 can apply for temporary support.

Municipalities will face significant financial difficulties as a result of the coronavirus crisis. As the first step to ease these difficulties, the Government will allocate EUR 547 million to compensate for the loss of municipal income tax revenue in 2020. The Government is also preparing a municipal support package for the May supplementary budget proposal, which will amount to a minimum of EUR 1 billion.

On the other hand, municipalities have been quick to innovate new ways of working in this difficult crisis. Especially the schools had to quickly re-organize the teaching by basically using only e-learning mechanisms. The members of staff have been relocated from one municipal service to another, e.g. from day-care to elderly care in a situation where children stay home and the people over 70 obliged to refrain from contact with others in quarantine-like conditions.

Completely new services have also been launched by the municipalities. For example, in Helsinki a new advisory service offering free business consultation for companies that have seen profits dry up because of the crisis, has been set up. Helsinki also offers hotlines to answer questions about the virus, school arrangements and services for self-isolating seniors. Helsinki has also opened two temporary digital service points to serve the city's residents who do not have their own computer or smartphone to use digital services. There has been a growing need for another digital service point due to the coronavirus crisis which has caused many services to become available online only.

The Big Implementation Challenges for the Government in this Pandemic

The sudden, unpredictable and global nature of the pandemic has caused some unusual difficulties, e.g. on supply chains, when everyone is buying at the same time. Declaring a state of emergency in Finland over coronavirus outbreak and the immediate measures taken went relatively well.

More challenges are faced when preparing the following actions, e.g. deciding on the compensations to the restaurants, which are suffering greatly because of the lock down. There are also some difficulties with communication on all the needed languages and with the clearness of the instructions and guidelines given to the people. Also in more broad sense, the whole planning for the exit-strategy is challenging as the future is so unclear regarding when the pandemic is over.

Effectiveness of the Government and the Lessons Learned

All government workers to whom teleworking is possible are now working from home i.e. approx. more than 50 % of all 74.000 civil servants are teleworking. For the rest of them it is not possible as they work for the security sector operative functions (24/7 e.g. policy, military, customs, boarder control etc.)

Civil service legislation makes it possible to transfer personnel within organisations and across the government if needed. There are some examples of that, e.g. 50 staff members of the Ministry for Foreign Affairs, who normally handle visa applications, moved temporarily to the Finnish social security institution KELA, to help with the crowing number of social benefit applications.

The Senate Properties, the state shared service provider for property services, is giving 100% discounts on rents for those SMEs who have suffered greatly from the COVID-19 and who are renting their premises from the Senate. The decision was first made for April and May and now extended to cover also June.

What Can Other Countries Learn from Finnish “Exit Strategy” from a Pandemic?

It is too early to say how the strategy will work. However, the process of preparing the strategy is something that can be shared at this point. To assure best possible knowledge the working group tasked with preparing a plan for

Finland's way out of the crisis consists of the permanent secretaries of all the ministries. To support the preparation group, a scientific panel was set up consisting of researchers/experts from different fields of expertise, such as social policy, education policy and economic policy as well as the environmental and climate sciences. During its work the group consults with representatives of the business community, municipalities, civil society organisations and environmental organisations on a broad basis.

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Appendix 1:

Situation regarding the lifting of restrictions, 15 May 2020

	1 June	31 July
Gradual opening of restaurants and other food and beverage businesses can be started, subject to certain conditions.	●	
Sports competitions and series can be resumed with special arrangements.	●	
Public indoor premises will be opened in a controlled manner.	●	
The restriction on gatherings of more than ten persons will be replaced by a restriction on gatherings of more than 50 persons.	●	
Large public events with more than 500 people are prohibited.		Prohibited until this date.
Restrictions concerning visits to healthcare and social welfare units will remain in force until further notice.	To be reviewed by the end of June.	
Recommendation on remote working (telework).	Recommendation in force until further notice, reassessed after summer.	
Recreational travel abroad.	Not recommended for the time being.	

Restrictions previously in force

Borrowing of books and other material from libraries.	Permitted as of 4 May.
Early childhood education and care and primary and lower secondary education.	Return to contact teaching as of 14 May.
General upper secondary schools, vocational schools, higher education institutions and liberal adult education.	Distance teaching is recommended until the end of term.
Commuter traffic across the Schengen internal borders.	Permitted as of 14 May, subject to certain conditions.
Outdoor recreational facilities.	Opened as of 14 May but observing the restrictions on gatherings.

France and COVID-19: A Centralized and Bureaucratic Crisis Management vs Reactive Local Institutions

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Abstract

The pandemic hit France in a tense socio-political context (“yellow vests” social movement, difficult reform of the pension system, followed by municipal elections), while the country was not well prepared to manage pandemic crises because of major budget cuts in the last decade. The crisis also reveals some weaknesses of French public hospitals, with structurally overworked emergency services. Crisis management is very vertical, with a concentration of powers at the Top Executive, which adopts drastic measures of general confinement. At territorial level, the crisis is managed by prefects and Regional Health Agencies (ARS). The confinement is successful in cutting the “pick” of contaminations and avoiding the collapse of hospitals’ emergencies. But a major undergoing issue has been the terrible shortage of masks and tests. It is worth noting the increasing involvement of quite agile local government authorities in the process of lockdown exit. It is also remarkable that the French Government has deployed a huge amount of hundreds of billions of euros in emergency subsidies and loans guarantees to prevent a crash of the economy.

Keywords

Impreparation, concentration of powers, drastic measures, agile local government, enduring shortage of masks and tests, huge economic rescue plan.

Highlights

“Be always prepared to the worst!”

“A country always manages a crisis according to its culture.”

Introduction

France was hit by the COVID-19 pandemic after Italy and Spain. The crisis appeared in France in a very tense socio-political context, and quickly revealed the lack of preparation to cope with such an epidemic. In accordance with its traditions, France reacted in a top-down manner, with a central handling by the State, strong presidential leadership, but insufficient cooperation with local governments, health institutions and socio-economic partners. Within this centralized and vertical approach, local institutions showed greater reactivity and flexibility to cope with the crisis consequences at their level. The COVID-19 crisis in France revealed the strengths and weaknesses of a system of concentration of power at the very top and insufficient cooperation with all relevant actors in the field. In addition to the sanitary dimension, the French government, in coordination with the European Commission and the European Central Bank, launched a vast rescue plan to save the economy, prevent business bankruptcies and protect citizen's jobs, according to the French culture of a Welfare and interventionist State. Yet, the practical measures are still to be taken, and hopefully in better cooperation with all stakeholders and interested parties, in order to enhance future resilience.

A Tense Context and a Lack of Preparation

In France, the COVID-19 pandemic appears in a very tense institutional, political and social context, which partly explains the authorities' reactions and their tempo. From 2017, Emmanuel Macron, the new President, backed-up by an enormous majority in Parliament, asserted a very strong leadership, oriented to "transforming" France in depth. However, the reforms carried out by his government aroused anger and unpopularity from a part of the population, leading to a multifaceted social and political crisis in 2019. Moreover, in the autumn, the pension system reform project crystallized various oppositions, in particular from health care workers denouncing the growing lack of resources in the health system. In January 2020, more than a thousand heads of hospital departments resigned from their administrative positions to demand more financial and human resources. In the medico-social sector, caregivers denounced a toxic work environment impacting their health at work and the quality of care.

The COVID-19 crisis also appears in a context a context of unpreparedness to epidemic risks due to severe budget cuts over the past decade. In 2009, when the H1N1 epidemic happened, France had a large stock of masks. But since the H1N1 infected few people, the costs of masks and vaccines stocks appeared later to be excessive in the view of decision-makers. In 2011, The French

epidemic prevention strategy was modified, while NPM-driven reforms of public hospitals changed a model relying on stocks into a model managing “just-in-time” flows (i.e. no stocks anymore). Unsurprisingly, French hospitals were confronted with a mask shortage at the beginning of the COVID-19 crisis. The strategy foresaw a massive and rapid restocking in the event of a pandemic risk, ignoring the fact that the French industry does not have sufficient production capacity in this area.

For a decade, the prevention of the pandemic risk in France has thus suffered from the consequences of budget cuts made necessary by the ontological contradiction of all successive governments between a chronic public deficit and a corollary explosion of sovereign debt and/or the declared willingness to comply with European budgetary criteria.

Moreover, the COVID-19 pandemic reveals some other weaknesses of the French public hospitals system: lack of synergies with city medicine, with emergency services being structurally overcrowded in ordinary times. This system was thus not well-prepared to handle a vast pandemic.

A Resolute Governmental Action to Handle the Crisis

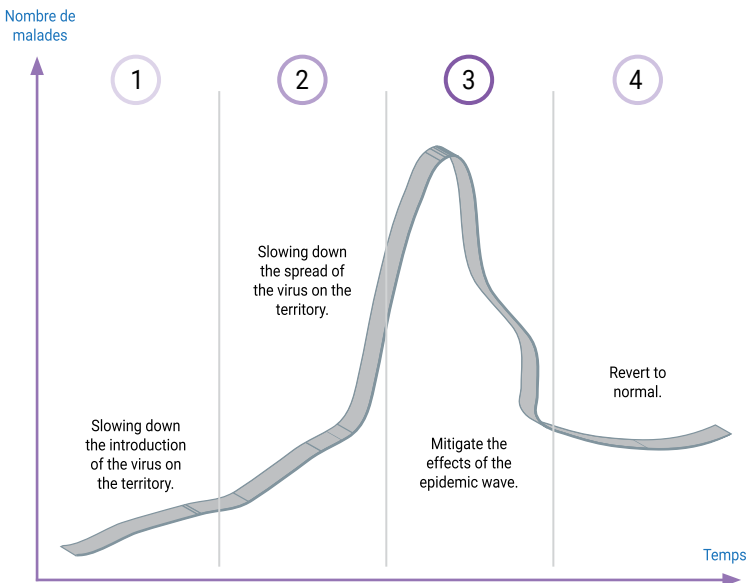
The constitutional regime of the Fifth French Republic organises the ordinary domination of the Executive branch under the authority of a powerful President assisted by a Prime Minister appointed by him and supported by an absolute majority in the National Assembly. The Constitution and the laws in force, as well as the jurisprudence of the administrative judge, offer the Executive the possibility of activating important extraordinary powers in the event of a crisis. Consequently, faced with COVID-19, France has reacted, in accordance with its political and administrative traditions, by setting up a vertical concentration of power.

The Government entered the crisis with a political problem: the pandemic hit the country during the campaign for municipal elections. After hesitation and party consultations, the Government maintained the first round (out of two) of these municipal elections, which took place nationwide on 15 March 2020. Then the strict lockdown of the population was decided the day after (16 March), suspending the electoral process in the middle, with the incumbent mayors remaining in place.

Then, Parliament, on 22 March, adopted a law establishing a “state of health emergency” for two months, allowing the Prime Minister to legislate by decree, in particular to restrict the freedom of movement and assembly of citizens. A scientific council, composed of 10 experts from various disciplines, is installed to provide “a scientific and reactive insight” into the crisis management decisions.

At the territorial level, the crisis is managed by the prefects, who are the territorial representatives of the central State in the regions and provinces, working in close synergy with Regional Health Agencies (ARS), which are the administrative structures steering the hospital system, also responsible for health monitoring and public health crisis management. The mobilization of field actors takes place within the framework of the ORSAN REB plan (organization of the health system's response in exceptional health situations - Epidemic and Biological Risk). It is based on 4 stages as shown in the following figure.

Figure 1



Source: Ministries of Solidarity and Health “Preparation for the Epidemic Risk COVID-19 - methodological guide” 20 February 2020

The first cases of COVID-19 appeared in France at the end of January. Stages 1 and 2 are successively triggered on 23 and 29 February, leading to the lockdown of “Cluster” zones, a ban on over-1000-people events (9 March), a ban on visits to age care homes (11 March) and a shutdown of all schools and universities (announced on 12 March). Stage 3 was reached on 14 March with non-essential public places shutdown and the lockdown of the population from 17 March.

The confinement is prolonged until 11 May. Movements are tightly restricted to a reduced list of cases: going to one's work if teleworking is impossible, essential purchases, health visits, compelling family reasons, participation in public service missions. Brief individual exercise is allowed within a kilometre of home. For any exit, a certificate specifying the reason must be provided.

Monitoring and evaluation of major decisions

The French government ensured the monitoring and assessment of the implementation of its major decisions regarding the pandemic by means of the classic hierarchical channels of feedback information at its disposal according to the architecture of the central State “deconcentrated services”. In each region, mayors of municipalities report to prefects, hospitals CEOs report to ARS CEOs and directors of schools and higher education institutions report to rectors (the heads of public education services in a given region).

In each important institution, a crisis unit is set up and is in charge of coordinating and analysing the flow of information. Another high level crisis unit is operational under the lead of the regional prefect, and reports to the central government, where the key roles are played by both the heads of the administrative services of the Prime Minister and the chief of staff of the Prime Minister, in constant relation with the Secretary-General of the Presidency. The President is constantly kept informed of the field developments, and takes all major decisions himself, usually within a small informal council of ministers limited to those concerned with the crisis management.

Challenges for the government

The whole of France is affected by the epidemic, including overseas regions. But the crisis is particularly tense around Paris, in the Eastern part of the country and in the island of Mayotte (Indian Ocean). In these regions, intensive care units are saturated. Increasing the number of beds in intensive care units is a major challenge, with an objective to go up from 5,000 before the start of the epidemic to 14,500 throughout the country. At the beginning of April, there were 10,000 beds. The army is providing support with a military hospital. From mid-March, hundreds of patients are transferred to less affected regions in France, as well as to Germany, Luxembourg, and Switzerland (to 20 April, more than 600 patients transferred).

As the epidemic develops, and despite a relative national unity around the outbreak of the different stages and the lockdown, the government was quickly confronted with questions and polemics about its decisions and the daily crisis management.

First of all, hospital staff, who have been mobilised for a year to protest against the deterioration of the public hospital, denounce the discrepancy between the lack of resources granted and President Macron’s speech on 12 March, which recognises that “*Free health (...), our welfare state, are not costs or charges, but precious goods, indispensable assets*”. The maintaining of municipal elections generated debate, and is suspected of having delayed Stage 3 triggering, making official messages on social distancing foggy. It also turns out that many local actors and politicians have been infected by Coronavirus.

But the major issue is the terrible shortage of masks and tests, as opposed to Germany (with which the French never stop comparing their country). In addition to the initial lack of stocks, the government is criticised for its lack of reactivity in replenishment, inefficient centralisation of purchasing, counterproductive confiscatory measures, contradictory communication on the benefits of wearing masks...

COVID-19 testing also shows great delays and becomes a major issue in the perspective of the end of lockdown. With a rate of 11.1 people tested per thousand population, France is still very far from the average OECD figures (27.7 people tested per thousand) (OECD, 2020). As the end of lockdown is announced, the government claims to drastically increase testing capacity. But it was very late in involving all the laboratories capable of carrying out these tests. Critics point out the administrative blockages at the level of the ARS, the delays in administrative authorisations by prefects, the lack of coordination between the relevant actors.

From a Centralised Crisis Management to an Increasing Involvement of Local Authorities in the Lockdown Exit

The crisis managements are centralized, with a predominant role for the State and public health services. The decision-making chain is extremely vertical, with a touch of autonomy left to local authorities. However, relations between central government and local authorities were rather tense throughout the crisis, as illustrated by a decision (mid-April) from the Council of State (supreme administrative court) to forbid mayors to “*take other measures to combat the health crisis*” than those decided by the central State. Another example is a “*war of masks*”, at the beginning of April, where the State requisitioned masks ordered by some local governments, sometimes even on the tarmac of some airports. However, faced with various State failures, local government authorities took various initiatives and demanded for more room for manoeuvre.

In the perspective of the lockdown exit, the power balance evolved in favour of local authorities, since they are an essential partner to ensure its success: compliance with barrier measures, schools reopening, local public transport...

In addition to a more macro plan, the central government also involves Regions in the economic recovery plan, which contribute 500 million euros to the “National State Solidarity Fund”.

A more local management of the lockdown exit

On 13 April, President Macron announced the gradual exit of the lockdown from 11 May, and the reopening of schools. The modalities unveiled at the beginning of May provide for a very gradual process, spread over weeks. Based

on several indicators, including active circulation of the virus, hospital stress in intensive care units and COVID-19 testing capacity, regions are distinguished by a colour, red or green. Despite common rules, “red” regions (North and East of France) are subject to additional restrictions.

At lockdown exit first, shops are reopening, schools are partially reopening, social distancing measures have to be respected in all activities, but the wearing of masks is only compulsory on public transport. Journeys of less than 100 km are authorised, but cross-regions transport remains very restricted. In addition, plans are expected to test the population more intensively, to isolate patients and to conduct surveys to identify people who may have been in contact. Elderly people and people at risk are encouraged to remain confined. Restaurants and cafés reopen on 4 June.

While the general principles of the lockdown exit were decided centrally, its implementation and operational deployment rely more on local actors, with a report setting out the broad outlines. The regional prefects, in conjunction with the ARS, play a regional steering role for actions carried out at local level. Provinces are considered to be *“the main pivot for the implementation of the national lockdown exit strategy”*, while the prefect *“ensures permanent consultation with elected representatives, which may be extended to actors representing the economic and associative fabric of his Department”*.

Resources and Organizational Capacities Developed to Cope with the Crisis

The COVID-19 crisis management by the State was characterised by a great deal of centralisation and bureaucratic rigour, leading to delays, errors and a regular lack of understanding of the various stakeholders willing to get involved. However, it mobilized a great deal of communication and unprecedented financial resources.

Political communication as part of the government's strategy

At the State level, communication has been very political. Very presidential at first, then more governmental at a second stage with a Prime Minister/Minister of Health duo omnipresent in the media. Communication is also characterized by the information being kept secret and then communicated with a surprise effect for all. In this highly personified presidential communication, attempts by the Government spokesperson and other members of the Government to explain the situation were often unsuccessful, as the presidential communication seemed secret and unexpected.

The presidential communication used many registers, but the main one was that of scientific endorsement. The Scientific Council was used to support many presidential decisions and was the symbol of a scientific presidential communication in the first phase. This presidential communication accelerated with the lockdown announcement by the President on 16 March and the shocking formula: “*we are at war*”.

State communication focused mainly on information about social distancing measures and on daily statistical information, and did not develop much other forms of communication, contrary to the very active and diversified local public communication. Lockdown conditions also used “nudges” with a paper certificate of honour specifying the reason for leaving home.

The communication focused on scientific warfare was followed by a new form of communication concerning socio-economic issues. Thus, with an address followed by more than 36 million French people, President Macron announced for 11 May the lockdown exit and the reopening of schools. This last decision was more based on political argument, focused on social inequalities caused by the schools’ shutdown. Indeed, in its April 20 report, the scientific committee suggested that school closure should be maintained. In a second stage, as lockdown exit were approaching, communication became more governmental, technical and pedagogical.

A large deployment of financial resources

The French Government announced, as early as March 16, very important measures to support the economy and protect jobs, so as to counteract the recessive effects of a complete lockdown of the Nation decided in order both to avoid the collapse of emergency services and to limit the number of deaths, “*whatever the cost*” said President Macron. As a consequence, a corrective budget law promulgated on 25 April provides for a €110 billion emergency plan to support the economy: direct financing of substitute income for the employees placed in partial activity by their employers, a solidarity fund for SMEs (financed by the State, but also Regions and insurance companies), deferment of the payment of social contributions and taxes, and a further €20 billion to strengthen the equity capital and debt securities of companies operating in strategic sectors. These immediate measures are accompanied by a €300 billion State guarantee for loans to businesses.

For local authorities, the crisis could lead to a loss of €14 billion in cumulative revenue over 2020 and 2021, according to the Ministry of the Economy. The Regions, touristic municipalities and provinces are in the front line since their resources are highly sensitive to economic cycles, unlike municipalities which are financed by taxes on real estate.

Nevertheless, the country felt in recession, and an 8-to-10% drop in GDP is expected for year 2020. The country's chronic public deficit is expected to amount to 9% of GDP. This means that France's overall macroeconomic strategy has to be rethought, under the dual constraint of an impossible tax increase in one of the most heavily taxed country in the OECD, and of an eroding credibility to borrow on financial markets since the French sovereign debt is already reaching 100% of GDP. Various political parties, civil society actors and opinion leaders are therefore calling for a paradigm shift. President Macron, the Government and the policy-makers of the macroeconomic strategy, without many public debate, have made up their mind in the course of May 2020: to prevent a crash of the economy, the State massively borrows (through *Agence France Trésor*) and the amount of the country's sovereign debt will go up to 115 % of GDP by the end of 2020. In addition, the French government, in coordination with Germany, the European Central Bank and the European Commission, is a key actor in the €500 billion rescue plan launched at European level.

A centralised and bureaucratic management at the state level, in contrast with more agile local management

Local governments and hospitals have shown an agility that contrasts with the bureaucratic rigidity of the central administration. Local governments reorganised themselves quickly to ensure the continuity of essential public services and provide new services to handle social issues and inequalities revealed by lockdown situation.

In the health and social sector, despite successive reforms that increased the control attributed to the supervisory authorities, made the management of health care institutions more "procedural", and limited their autonomy and creativity, caregivers and their managers reacted quickly and readapted management tools, communication methods and work organisation. Numerous institutions had to react upstream of the Ministry recommendations to implement barrier measures. With successive and sometimes contradictory directives from supervisory authorities, managers and caregivers found it difficult to follow them correctly. In the aged care homes, many initiatives and actions were set up to maintain the well-being of residents, accommodate potential infected residents and fight against the spread of the virus. Support and training have been necessary to rapidly support and train the field teams in the new working methods imposed by the crisis. Some institutions have set up for their staff some social support systems and financial and logistical support. To motivate and mobilize their employees, managers in the sector have devoted more time to leading their teams and creating spaces for discussion on work.

Conclusion

The COVID-19 crisis management in France followed its own national logic, with the exception of the cross-border management of certain patients. French authorities did not refer explicitly to any foreign model, even though evidence suggests that the nature and chronology of the measures taken (e.g. the lockdown) were inspired by the Italian case.

Reversely, what lessons can be drawn from the French experience? The COVID-19 crisis in France highlighted the many paradoxes and contradictions of the French politico-administrative system. The main lessons to be drawn relate to the limits of a centralized, top-down governance which insufficiently integrates all stakeholders, puts trust in danger, and is insufficiently resilient.

The centralized administrative traditions of France turned into a hyper-centralization causing rigidity and a certain lack of responsiveness, with local governments and health actors being insufficiently included in the decision-making, despite their strategic role in crisis management. It contrasted with the displayed importance of local actors, as stated in the discourse when maintaining municipal elections, or the repeated thanks to caregivers that were not enough considered before the pandemic. Public-private cooperation also showed great deficiencies, inherited from years of mistrust and low collaboration: the State rescues an economy which is fragilized by State decisions, but does not rely on the private sector, neither integrates it in renewed relations.

The French cultural attachment to the ideal of “Welfare State” emerged in social and caring discourses and led to an ambitious and generous economic support plan, that remind the one decided to cope with the Financial crisis of 2007. The values and measures displayed to cope with the COVID-19 contrasts sharply with the decade of austerity policy inherited from the 2008 crisis that weakened the actual coping capacities.

What can we expect for the future? How can we prevent actual decision from paving the way for tomorrow’s austerity cures? It would be wise to approach the economic shock from a resilience perspective. We need to project the economic situation into a longer time frame and stop considering crisis as exceptional events. But so far, future crisis are insufficiently integrated: answers to climate change, growing inequalities and democratic crisis are postponed to some future “better” days. Short-term reactions remain constrained by prevalent economic interests, as shown by the few attempts to condition State grants and aids to sustainable behaviours from businesses. Strengthening resilience will need to handle those issues and evolve from hyper-centralized power games to more autonomy given to the initiatives of public and private actors, so as to restore civic trust and confidence.

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Between Unity and Variety: Germany's Responses to the COVID-19 Pandemic

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Abstract

This chapter analyses the governance of the COVID-19 pandemic in Germany, focusing on major phases, institutional responses to the forecasted health emergency and economic downturn as well as on notable tensions in the multilevel system. The analysis reveals a repeated re-balancing between variety and unity within the German federal system due to the highly decentralized character of crisis management on the one hand and the (perceived) demand for centralized and uniform decision-making on the other. Despite the formal responsibility of the sub-national levels for taking containment measures, there has been a high degree of coordinated decision-making with a conspicuous centralizing and unifying impetus, especially regarding the most severe decisions on lockdowns, shutdowns, and the suspension of fundamental rights. However, with the pandemic ebbing away, there was a return to the federal “normality” characterized by subnational discretion and decentralized decision-making. It remains to be seen to what extent the crisis will be used in the future as a window of opportunity for more far reaching changes in the overall institutional setting – for the better or the worse.

The analysis shows that the decentralized responsibilities in pandemic management and the high reactivity of the local public health services in combination with a well-equipped hospital sector were supporting factors for pandemic governance in Germany. Shifting sufficient resources to the health sector and strengthening the pinpointed decentralized management of health emergencies in combination with a (more) pluralistic scientific debate and permanent multiple-effect risk assessments can be expected to contribute to a better preparedness and resilience of governments to cope with future crises in an efficient, effective and proportionate way.

Keywords

Multilevel governance, decentralization, local public health service, federalism, Germany

Introduction

With 83 million inhabitants and a population density of 227 inhabitants per square kilometre, Germany is the most populous member state of the EU. It has the largest economy in Europe and the fourth-largest economy by nominal GDP in the world, characterized by extensive global export and import activities. The standard of living is considered as one of the highest in the world not at least thanks to Germany's universal health care and social security system. The overall life expectancy in Germany is about 80 years (78 years for males and 83 years for females). Germany is a "unitary federation" (*unitarischer Bundesstaat*) with a strong position of its 16 states (*Länder*), but the constitutionally protected unity of law, economy and living conditions. The federal and the *Länder* levels have their distinct legislatures, their own executives, and judicative bodies. Policy making in Germany follows the principle of an "executive federalism", which stipulates that the federal level is mainly responsible for policy formulation, whereas the *Länder* level is mostly engaged in policy implementation (see Kuhlmann & Wollmann, 2019; Fuhr et al., 2018). The federal level has no hierarchical control, no legal supervision, and also no financial appropriation over the *Länder* level. Instead, the *Länder* enjoy strong autonomy yet they have limited legislative authority of their own (e.g. police, schools, and culture). As a consequence, the federal executive has only very little direct involvement in implementation and service delivery, and thus does not operate with regional or local offices (exceptions include defence, customs, inland waterways, and the federal police). However, according to the constitution, there is an overall requirement to collaborate across levels and jurisdictions in order to guarantee for unity across the federation (see Kuhlmann et al., 2020). Manifold interactions and collaborations have been institutionalized, some of which involving the *Länder* only (horizontal collaboration), whereas others involve the federal and the *Länder* level (vertical collaboration).

When on 28th of January 2020 the first COVID-19 case was detected in Bavaria, the federal authority for disease and surveillance prevention (Robert-Koch Institute – RKI) assessed the risk emanating from the virus as "low to medium". This assessment was confirmed until the 17th of March and thus (besides cancelling mass events) no country-wide measures of containment were considered to be necessary during this period. However, from the second half of March onwards, Germany pursued a strict strategy of containment aimed at slowing down the spread of the virus and avoiding a collapse of the health system. After the first COVID-19 hotspot was detected on the 26th of February in the county of Heinsberg in North Rhine-Westphalia and reports from Italian hospitals were broadcasted, the public risk perception changed and local governments started to enact containment regulations in

connection with the COVID-19 pandemic¹. On the federal level, a Corona-task force was established under the leadership of the Ministries of Interior and Health. A (small and large) Corona Cabinet which met twice a week was also established. Given the fact that the Federal Government was – from a legal point of view – not in the position to enforce containment measures, on the 8th of March the Federal Minister of Health recommended the *Länder* to cancel all public events with more than 1,000 participants. This recommendation was followed by several *Länder* governments, among others Bavaria and North Rhine-Westphalia on the 9th and 10th of March. When the Chancellor took the floor for the first time since the beginning of the pandemic, on the 11th of March, the issue became a top priority of the Federal Government's agenda. Generally, the first phase of the pandemic management was marked by a rather un-coordinated and decentralized enactment of ad hoc containment measures dispersedly implemented by some *Länder* and local governments. The Federal Government could only “plead” the *Länder* to follow its recommendations. In the second phase, by contrast, more vertically and horizontally coordinated actions were taken in compliance with the recommendations of the federal authority (RKI). The narrative of uniform action across levels with “one voice” (instead of a federal patchwork) became predominant, specifically after the RKI rated the risk level as “high” on the 17th of March. At the same time the containment measures were tightened, restrictions extended (by suspending almost all basic civil rights and liberties at least partially) and far-reaching economic rescue legislation enacted. On the 16th of March, the federal and the *Länder* governments adopted “joint guidelines to slow down the spread of the coronavirus” in order to ensure a harmonized proceeding in the different parts of the country. Nationwide shutdowns were enacted by all *Länder* and, step by step, schools and kindergartens were closed, accompanied by specific regulations on emergency childcare. A subsequent meeting of the Prime Ministers of the *Länder* and the Chancellor on the 22nd of March was dedicated to agree upon nationwide contact-bans (limited lockdowns). The measure was taken originally for two weeks and then extended for another two weeks (until the 3rd of May). Only one day after the agreement on a nationwide contact-ban, the Federal Parliament took the decision to significantly run up public debt (by 156,3 billion Euro) and thereby to suspend the constitutionally enshrined “debt brake” in order to compensate for expected revenue losses and to provide immediate financial emergency relief to large firms, small enterprises and solo-entrepreneurs. The third phase was mainly focused on how to ease the measures and exit the lockdown in a coordinated manner. In their meeting on the 15th of April, the *Länder* and the Federal Government

¹ On the 26th of February, the county of Heinsberg mandated the first closure of schools and kindergartens in Germany.

agreed upon some cautious steps of easing, such as re-opening smaller shops and schools for higher classes, whereas other containment measures (such as the contact-ban and shutdown) were extended until the 3rd of May. Further actions to lift the lockdown and shutdown were jointly decided by the Prime Ministers of the *Länder* and the Chancellor on the 6th of May (e.g. re-opening larger shops, restaurants and schools), whereas the contact-ban and the physical distancing regulations were extended until the 5th of June. Strikingly, the narrative of uniformity and speaking with one voice, which was predominant for agreeing on the lockdown and shutdown in the second phase, became more and more blurred. Instead, the federal “normality” of many voices and ways gained ground again in the debates and the decisions taken to exit the lockdown became more diverse and less coordinated (thus linking up to the first phase).

Federal Governance Between Unity and Variety

Based on the highly decentralized and fragmented structure of the German politico-administrative system, a salient feature of the Corona crisis management is the limited power of the federal level to enact measures and impose restrictions to the whole country and the predominance of sub-national (horizontally coordinated) crisis management. In times of peace, only the *Länder* and local governments (local health authorities in counties and cities) have the legal right to impose containment measures (shutdowns, lockdowns) and execute them in their own discretion. “Every public health officer of a county has more powers than the Federal Minister of Health” stated a leading German newspaper (Tagesspiegel, 2020; see Franzke, 2020), illustrating the outstanding importance of the local public health service in Germany, undiminished in the current pandemic crisis. Within the administrative federalism, the federal law on infection protection (IfSG) is executed by the *Länder* and local governments. Based on paragraph 28 of the IfSG, the *Länder* authorities have the right to impose restrictions to their populations in case of specific risk situations, such as the one caused by the SARS-CoV-2 virus. The Federal Government can give recommendations to the *Länder* and push for coordinated measures, but it is not in a position to impose these. To achieve nationwide solutions and uniform standards, the horizontal self-coordination of the 16 *Länder* plus the vertical involvement of the federal level are necessary. Against this background, initially, the *Länder* differed widely in their approach, in particular regarding lockdowns, shutdowns, and school closures. This patchwork was harmonized after several meetings of the Prime Ministers of the *Länder* and the Chancellor (see above) dedicated to agree upon nationwide joint regulations. However, some discretion was left to the *Länder* to impose

stricter or softer regulations. Although the federal diversity of solutions, specifically regarding the details of suspending basic liberties, was criticized by some observers as an untransparent patchwork and a federal mess, in practice the regulatory landscape looked quite homogeneous in the different regions, with some stricter handling in Bavaria and a more laissez-faire approach in North Rhine-Westphalia. In addition, a general convergence of containment regulations could be observed over time as a result of coordination mechanisms, but also court decisions, mirroring a typical feature of the German unitary and cooperative federalism.

In their meeting on the 15th of April 2020, the *Länder* and the Federal Government agreed upon an extension of most of the containment measures (limited lockdown, shutdown) until the 3rd of May. Nevertheless a consensus was reached regarding some very hesitant easing measures, for instance re-opening smaller shops (up to 800 m²) and schools for higher classes provided that general precaution rules are complied with (1,5 m distance between pupils). The concrete timing was left to the discretion of the *Länder*. These steps represented the smallest common denominator. The agreement was mainly possible because of the discretion and leeway granted to the *Länder* in deciding about possible deviations from the general rule and to stipulate more relaxed or stricter rules for their respective territories. Thus, variation occurred in the concrete details of the exit regulations in the different *Länder* and cities, with some of them enacting stricter and some looser rules. In North Rhine-Westphalia, for instance, big furniture stores were allowed to re-open due to the importance of the furniture industry in this part of Germany, which was not the case in the other *Länder*. In Thuringia, zoos, museums, botanic gardens, galleries and exhibitions were re-opened, while these public and cultural institutions remained closed in other *Länder*. In Saxony, church services with up to 15 attenders were allowed. However, voices in the public debate increasingly questioned why the suspension of basic constitutional rights was handled so differently from region to region. Furthermore, to counterbalance the moderate lifting of containment measures (as the price for freedom, so to speak) the wearing of facemasks in public was jointly recommended (not stipulated) by the *Länder* and the Federal Government. In the aftermath, Saxony, Mecklenburg-Vorpommern and Bavaria were the first three *Länder* to stipulate a general obligation to wear masks in public transport and shops, followed by all other *Länder*, after the City of Jena had already introduced such an obligation on the 3rd of April. In general, it became increasingly difficult to reach a common uniform solution in order to organize a coordinated and harmonized exit strategy as some *Länder* governments were in favour of proceeding faster (e.g. North Rhine-Westphalia) while others were more cautious and hesitant (Bavaria). Against this background, increasing variance and diversity of exit strategies was practiced and became legitimate, except for the solo advance of the Prime Minister of Thuringia who, on 6th of

June, was the first head of a *Länder* government to move from the “crisis mode to the regular mode”, thus leaving the general containment approach, an attempt that was highly criticized by other *Länder* governments, the Chancellor and political competitors (e.g. the Prime Minister of Bavaria). Hence, to some extent, a return to usual federal governance practice took place.

Government by Virologists?

At the federal level, internal policy advice during the corona crisis was largely concentrated in the federal authority for disease surveillance and prevention, the Robert-Koch Institute (RKI), which is directly subordinated to the Federal Ministry of Health as a higher federal authority (*Bundesoberbehörde*). Its major tasks were (1) a pre-crisis risk prognosis, including the elaboration of a national pandemic plan; (2) the monitoring and publication of infection cases, number of hospitalized cases, recoveries, and deaths; (3) the epidemic risk assessment based on which measures of containment, protection, mitigation, and recovery were recommended to politicians and communicated to the public. Whereas in the past, the RKI did not enjoy an outstanding position in policy advice and some policy makers had even ignored its recommendations, this situation changed dramatically with the corona crisis. A prime example for the previous disregard of the RKI's work is its risk analysis of 2012, approved by the German *Bundestag* in 2013, in which a scenario of a pandemic caused by the virus SARS was modelled in detail and concrete preparatory measures were recommended to the government. This analysis was never an issue on the political agenda and decision-makers did not refer to this document for taking preventive measures, such as upgrading medical staff or purchasing protective material (masks, overalls etc.).

Besides internal policy advice, medical specialists from various research institutes and university clinics played a major role, such as the direct advisor of the Federal Government, the chief virologist of the Berlin Charité, Christian Drosten, who used to be a prominent figure already during the (forecasted) Swine flu epidemic of 2009/10. The virologists' expertise was not only shaping the perception of the severity and danger of the disease but also largely determining the progressive escalation of restrictions. Strikingly, in the first phases of the pandemic the discourse was rather monodisciplinary (virologists-centred). The policy advice was predominantly based on the expertise of “leading” virologists, although these repeatedly emphasized their uncertainty in providing predictions, forecasts, and explanations. Nevertheless, drawing on evidence from science was the most common and preferred justification for any political action, which is also mirrored by typical headlines of daily newspapers, such as “the virologists govern” (Spiegel, 2020) or “the power of virologists” (Handelsblatt, 2020). Accordingly, scientific discourse in this

phase was monodisciplinary, based on single/few actors and the utilization of knowledge by decision-makers was rather technocratic and instrumental. Only at a later stage of the pandemic and with shrinking public support of the containment measures, the discourse became more pluralistic, open and controversial. Government decision-making and practice, however, continued to refer to very few experts and advisors (RKI, Charité).

Mitigation and Containment

On the 8th of March, all 16 *Länder* governments prohibited public events with more than 1.000 attendants following the recommendations of the Federal Health Minister. Containment measures were increasingly tightened by end of March. These were enacted (and later taken back) by the *Länder* and local governments in executing the federal infection protection law (IfSG; see further above) in a more or less coordinated manner. However, the measures were not as strict as for example in neighbouring France. Instead of a strict lockdown, it was opted for a more permissive contact-ban. From a legal perspective, the containment measures represent comprehensive incisions into fundamental constitutional rights and basic civil liberties, such as the freedom of movement, the freedom of assembly, professional freedom etc., unprecedented in the post-WWII history of (West) Germany. Typically, school closures, shutdowns as well as (limited) lockdowns and even mask obligations were first enacted at the city level (e.g. Freiburg, Munich, Jena), followed later on by other local governments and then by the *Länder* governments overall. Bavaria and Baden-Württemberg promoted more restrictive measures because of higher infections numbers and the proximity to the (highly affected) French Alsace region, whereas North Rhine-Westphalia, Brandenburg, Berlin and others favoured more liberal rules. The conference between the Prime Ministers of the *Länder* and the Chancellor, on the 22nd of March 2020, stipulated a so-called contact-ban (limited lockdown) aimed at enforcing social distancing nationwide. People were generally allowed to leave their homes but had to keep a distance of 1.5 meters minimum and were forbidden to appear in groups of more than 2 persons (except for families or domestic partnerships). However, in some *Länder*, such as Bavaria, Saxony, and Mecklenburg-Vorpommern more restrictive solutions were chosen. In Bavaria for instance, going out was only allowed with members of one's own household. In Saxony, departing from one's home was only allowed within a distance of 15 km and citizens opposing to the quarantine rule could be sent to a psychiatric clinic². In Mecklenburg-Vorpommern, non-residents (including those with a secondary holiday residence) were not allowed to cross the border of the *Land* anymore. School

² The 15m-rule was stipulated by the administrative court in Saxony based on an urgent application sued against the directive.

closures, also within the competency of the *Länder* and local governments, were first regulated by some local directives for the few schools affected by the virus³. From the 13th of March onwards, all *Länder* governments started to discuss and implement school closures for their entire territories⁴. The main argument put forward by experts and politicians was not so much the aim of protecting children and students, but to slow down the spread of the virus in order to gain time for adjusting the health infrastructure to the crisis and creating new capacities in hospitals. In contrast to the lockdown and shutdown rules, no formal joint agreement could be reached among the *Länder* regarding school closures. The joint guidelines passed by the “commission of the *Länder* ministers for education” (*Kultusministerkonferenz* – KMK; see the Resolution of the *Beschluss der 369. Kultusministerkonferenz* from 12/03/2020) left the decision about closing schools and kindergartens to the competent local health authority. Yet, after the 16th of March, the *Länder* gradually enacted ordinances regarding the closure of schools and kindergartens accompanied by specific regulations on emergency childcare. As a result, school closures, too, became regulated fairly uniformly across the country.

Economic Rescue Legislation

Starting from a quite comfortable economic and financial situation, the Federal Government put forward several packages of legislative proposals. A first economic rescue package was passed on 23rd of March meant to remedy the fatal impacts of the containment measures on businesses, freelancers, low-income earners and various groups of socially vulnerable people. To this end, the federation will run up new debts of up to 156.3 billion Euro which represents the most significant indebtedness ever seen in this country and which also clashes with the constitutionally enshrined “debt brake”. The new debts are to cover expected losses in tax revenues (33.5 billion Euro) and higher expenditures (122.8 billion Euro) necessary for rescue measures. These additional expenditures encompass among others a global coronabudget for any possible crisis-related contingencies (60 billion Euro), the financial support for small businesses and solo-entrepreneurs (50 billion

³ The city of Kehl in Baden-Württemberg was the first city in Germany stipulating a complete shutdown of schools on the 12th of March 2020. The government of the Saarland, which is situated on the borderline to the French region Grand-Est, one of the most affected regions in France, was the first government to close all schools on 16th of March 2020. All other *Länder* followed.

⁴ However, for the universities, no nationwide uniform regulations were agreed upon and the *Länder* decided quite differently on this issue with some of them stipulating a complete shutdown (NRW) while others initially only teaching and examinations were suspended without completely closing down the universities (Brandenburg).

Euro), support for the public health system to fight the Coronavirus (3.1 billion Euro) and social protection measures for job seekers (3 billion Euro). In this context, the government has also reshaped the bank-rescue fund created during the bank crises of 2008/09 into a new economy stabilization and rescue fund which permits granting additional money to firms. All things considered, the federal budget is expected to increase from 362 billion Euro to 484 billion Euro and the indebtedness to 350 billion Euro (10% of the GDP) - an unprecedented amount in the history of this country. Lacking reliable data, the supplementary budget passed on the 24th of March 2020 basically draws on the experiences made during the bank crisis of 2008/09, where the economy shrunk by 5.6%. Furthermore, the Ministry of Economic Affairs and Energy enacted a rescue package for small and medium sized enterprises and freelancers directed at granting immediate financial help to small enterprises (up to 50 billion Euro), also including subsidies which are not to be paid back. Furthermore, liquidity assistance, the possibility of tax deferrals and a more flexible handling of short-time allowance are provided as well as state guarantees for up to 600 billion Euro as part of the new economy stabilization and rescue fund. 100 billion Euro are made available for the state to nationalize (at least partially) strategically important big enterprises, such as Lufthansa, which were seriously affected by the crisis, in order to avoid the selling of these companies to foreign investors during the crisis (their re-privatization is intended however after the crisis). In addition, a whole package of social protection measures was put forward directed at absorbing situations of social hardship and existence threatening circumstances caused by the crisis (BMAS, 2020, p. 2). For one, the access to basic security benefits for job seekers (so called Hartz IV) was simplified, in order to offer quick and effective support to the 1.2 million new unemployed people expected during and in the aftermath of the crises, many of whom coming from small businesses, freelancers or so called "solo-entrepreneurs". Moreover, a moratorium for rents was enacted in aid of those tenants who were not able to pay their rents as a result of income losses caused by crisis-related shutdowns and lockdowns. The moratorium was to be valid from the 1st of April until the 30th of September 2020 and deferred the amount of rent to be paid back by the tenants later on. Finally, for parents of small children who face income losses because of the shutdowns of school and kindergartens an entitlement for compensation was introduced.

A second economic stimulus and crisis absorption package worth billions of Euro was decided by the government on 4th of June including additional components to kick-off the economy, strengthen local governments and to invest into digitalization, health capacities and sustainable technologies.

Health Capacities

Public health experts assess the capacity and resilience of the German hospital and care system as extraordinarily high compared to other countries, specifically in Southern and Eastern Europe, but also the UK and the US. Germany stands out for its high numbers of hospital beds available, particularly in intensive care units, measured per capita of the population and, in general, a dense network of health facilities throughout the country which guarantees for proximity and short distances. The local public health service of the countries and county-free cities which is among other tasks responsible for the registration of cases, the tracing of infection chains and the surveillances of quarantine rules, can be regarded as a strong backbone of the German health system in general – albeit some significant cutback measures of recent years. The health expenditures in Germany (4,300 per capita) and the number of hospitals beds per 1.000 inhabitants (8) are the highest in Europe (see European Commission, 2019). The management and financing of hospitals is assumed by the *Länder* and local governments with the latter being responsible for county and city hospitals, where roughly 30% of all German clinic doctors are employed (VKA 2020).

With the aim of avoiding a crash-down of the health system (as experienced in some Corona hotspots of Italy, Spain, and France), at all levels of government, efforts were taken to increase the – already comparatively fairly comfortable – hospital capacities. On the one hand, the Federal Government passed a legislative proposal aimed at financially supporting hospitals and medical practitioners and reducing red-tape for special-care homes. The new federal law on “COVID-19 hospital relief” stipulated inter alia financial support for hospitals facing problems due to the postponement of regular operations (2.8 billion Euro) and the purchase of protective equipment (financial supplement of 50 Euro per patient), furthermore measures to increase the liquidity of hospitals, compensations for medical practitioners with income losses resulting from decreasing numbers of patients, and the waiving of strict quality assessments and site visits for special-care homes. Furthermore, in an agreement of the federal and the *Länder* governments a strengthening of staff capacities in the local public health authorities was decided aimed at guaranteeing a minimum of 5 team members per 20,000 inhabitants to take care of testing, tracing chains of infection, and coaching patients. On the other hand, the *Länder* took various measures to enhance their hospital capacities in preparation of increasing numbers of cases. Their strategies were based on an agreement between the Prime Ministers of the *Länder* and the Federal Chancellery passed on the 17th of March stipulating an emergency plan for the German hospitals. One major element of the plan was the doubling of the 28,000 places in intensive care units (25,000 of which with respiratory equipment)

and the conversion of rehabilitation facilities, hotels and bigger halls into care centres for mild corona cases. The *Länder* were responsible to elaborate local plans with their clinics regarding the creation of provisional care capacities for expected corona patients, if necessary with the support of the German Red Cross (DRK) or the Technical Aid Organization (THW). Furthermore, local governments developed concepts together with their health authorities and corona task forces directed at converting local real estates into hospital-like structures or re-activating vacant or old clinic estates.

These comfortable starting conditions and the general good preparedness of the German health system notwithstanding, a severe problem lies with the staff situation in hospitals and nursing services, which has been seriously criticized by many experts and interest associations in the Germany. According to the German hospital association, about 17,000 positions are vacant in the nursing sector and about 3,500 for medical doctors and huge numbers of additional professionals are urgently needed in the health and care sectors. The situation has grown more and more acute over the years, because working conditions in the care sector have seriously worsened, employees have become overburdened and are badly paid (specifically regarding nursing services) and many have preferred part-time contracts, temporary work or have even resigned. From a comparative perspective, Germany is one of the countries with the lowest number of care personnel per capita in Europe. This so called "state of emergency in the care sector" (*Pflegenotstand*) has been increasingly acknowledged in the political debates, however, without effective solutions so far. In this context, the privatization and commercialization of hospitals in Germany since the 1990s (see Klenk & Reiter 2012, p. 410), which are still ongoing, merit attention (in 2017, 37% of German hospitals were in private ownership, 29% publicly owned and 34% managed by non-profit providers; Statista 2020). One consequence of this New Public Management-driven trend has been that efficiency and profitability concerns have become increasingly important in hospital management – partly at the expense of employees and patients, although, in total, the investment volume has increased as a result of more private investments. However, the personnel situation in the care sector is assessed as being dramatic and has been neglected too long. Another major shortcoming has to do with the government's disregard of its own risk analyses. As a consequence, German health institutions were rather ill prepared regarding necessary protection material and masks, which turned out to be a major problem in the course of the pandemic.

Although many German experts had forecasted a crash-down of the hospital system by end of March, a dramatic inrush of Corona patients (as experienced in some European hotspots) actually did not happen due to lower numbers of hospitalizations than prognosticated in combination with good resilience

of the health system. There were no capacity shortcomings regarding beds in hospitals, specifically in intensive care units (with ventilation) – quite on the contrary, an underutilization of bed capacities became the rule in many regions. In addition, there were some unintended side effect of this situation. On the one hand, up to 50% of planned and necessary surgeries, e.g. for cancer or diabetes patients, were postponed in order to keep hospital beds clear for the expected Corona patients which was more and more criticized by medical associations. On the other hand, in some clinic departments medical staff became under-loaded and even short-time work was introduced, whereas other departments suffered from intense activity to prepare for the (expected but not arriving) wave of Corona patients.

Concluding Remarks and Early Lessons

The German approach of pandemic management stands out for its bottom up logic and the decentralized-coordinated governance (see Bouckaert et al., 2020). Most of the containment measures were initiated at the city and *Länder* levels, and afterwards coordinated, horizontally between the *Länder*, as well as vertically between the federal and the *Länder* levels which mirrors the typical feature of “unitary federalism”. Although the enactment and implementation of the strict containment approach (limited lockdown, shutdown) which was pursued from mid-March to end of May falls to the executive competency of the *Länder* and local governments in their own discretion, in practice fairly uniform regulations were taken by the *Länder* governments in agreement with the federal level ensuring a quite harmonized handling of the containment policy across the country. The uniformity of regulations across *Länder* was highest in the middle of the crisis whereas at the beginning and towards the end of the pandemic more federal variety occurred, including some solo advances of individual heads of government (e.g. Bavaria, Thuringia). Legally and practically, the suspension of fundamental rights and civil liberties linked to the German containment policy could be enacted without any parliamentary approval because it was covered by the administrative competency of the *Länder* to execute the federal infection protection law.

Overall, decentralization, sub-national discretion and federal variance did not turn out to be hurdles or limitations of pandemic management, as sometimes assumed in crisis management literature. On the contrary, the decentralized responsibilities in pandemic management and the high agility, flexibility and reactivity of the local public health services in combination with a well-equipped hospital sector were supporting factors for pandemic governance in Germany. Another early lesson learned from the pandemic is that warnings and existing risk analysis should be taken into account by

policymakers more seriously to avoid shortcomings in staff, equipment and protection material. Furthermore, multiple unintended (second-round) consequences of the crisis management measures themselves, specifically those resulting from high-stakes emergency decisions, such as shutting down the economy, closing schools and sheltering people in place, must be considered in close connection to (first round) effects and permanently re-assessed in the course of the crisis. This facilitates early feedback mechanisms and in-time re-adjustments of (potentially disproportionate) mitigation strategies (see also Collins et al., 2020). For these assessments of “risk-risk trade-offs” (ibid.), besides virologists and epidemiologists, additional expertise is needed to guarantee for proportionate and sustainable pandemic management strategies. Shifting sufficient resources to the health sector and strengthening the pinpointed decentralized management of health emergencies in combination with a (more) pluralistic scientific debate and permanent multiple-effect risk assessments can be expected to contribute to a better preparedness and resilience of governments to cope with future crises in an efficient, effective and proportionate way.

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Governance and Policy Responses to the COVID-19 Pandemic in Hungary: Early Experiences and Lessons

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Abstract

The ambition of this chapter is to provide a brief overview of how the government responded to the COVID-19 pandemic in Hungary. This largely descriptive exercise is based on an indeed limited evidence available at the time of writing, mainly texts of legal measures, news media reports, and special reports produced by professional sources one deemed trustworthy. Given these limitations the focus is on process and institutional features of governance responses rather than on policy outcomes and their assessment. The time scope of the description ends mid-May 2020. The policy response of the government presented in this report shows a move away from decision making purely oriented by maximization of political benefits, and a step towards policy making based on evidence, expertise and collaboration – something in sharp contrast with the policy style of recent years.

Keywords

Government response, Hungary, COVID-19 (coronavirus), epidemic, policy instrument

Highlights

Central and Eastern European (CEE) countries, including Hungary have reacted to the COVID-19 pandemic relatively fast and confidentially in early March during the initial outbreak. Due to the relatively low numbers of confirmed cases and deaths Hungary seems to be a positive case in terms of international comparison. Although it is too early to assess the effectiveness of policy responses in the long term, but one might conclude that three key factors - early lockdown measures, social distancing and involving experts in decision making process- played an important role to combat the escalating COVID-19 pandemic.

Nevertheless, the Hungarian government success in tackling the epidemic was somewhat overshadowed by the recent attempts by the governments to extend its power and undermine some of the very institutions of democracy.

Institutional Context

In the last 10, years one of the most spectacular features of the Hungarian government institutional landscape is the intensified centralization of the organizational structure and the government authorities (see Hajnal & Kovács, 2007). Whereas this general trend appeared in all sectors of governance, of particular relevance to our overview is the sharp increase of centralization in public policy and service delivery areas such as public health or the education, and the centralization of most administrative and service functions earlier served by local governments but – since the early 2010s – taken over by the central, multi-purpose government agencies. (Kovács, 2018)

The Hungarian health care system - following a series of reforms initiated in 2011 - has become highly centralized. The national government is now responsible not only for setting strategic direction, controlling financing and issuing and enforcing regulations but also for delivering most outpatient specialist and inpatient care. In terms of health expenditure Hungary figures significantly below the EU average not only in absolute terms but also as a share of GDP, and it has been further decreasing over the recent years from 8.1% of GDP in 2013 to 6.9 %. This is fairly below the EU average (10.2% in 2013) but similar to other countries of the so-called Visegrad/V4 region (Czech Republic: 7,23%, Poland: 6,5% and Slovakia: 6,74%; OECD 2019).

Moreover, out-of-pocket payments are double the level of EU average (OECD, 2019). In terms of capacity, Hungary has fewer health professionals than the EU average. Overall, health care provision remains highly hospital-centric and primary care does not yet play a prominent role in Hungary (OECD, 2017). The number of Physicians (per 1,000 people) is 3.4 in Hungary (World Bank, 2018), which is within the range of other V4 countries too (World Bank, 2017). Nevertheless, the health care system practically covers the entire population. Routine vaccination programs are evaluated as successful due to “the robust policies to ensure good coverage” (OECD, 2019, p. 13.).

The agencies in charge of public health policy and administration were exposed to a series of restructurings in the early 2010's. As a result, the process of structural fragmentation – having already started in 2007 – intensified. In particular, the service became part of integrated multi-purpose county level territorial organization headed by explicitly political appointees of the Prime Minister. The number of service staff sunk further as did equipment and infrastructural capacity (Interview with a Head of Public Health Unit, 2014).

In line with overall administrative policy the agencies in charge of disaster management became increasingly integrated and centralized over the past years too. The unified, highly centralized disaster management organization works as a uniformed service under the direction of the Minister of the Interior. In emergency situations other actors such as local governments and the Defence Force are also involved.

These antecedents foreshadow the structural responses given to the pandemic, the most visible one of which the creation, on January 31, of a central coordination body, the so called Operational Group (hereinafter: Group) (In Hungarian the name has a military connotation.) The Group is staffed by two ministers, leaders of key central government agencies such as those in charge of public health, internal security, disaster management and immigration, as well as representatives of some large hospitals. The tasks of the Group include monitoring of the health and epidemiological situation, elaborating measures, and coordinating activities of state actors involved. Its most routine and visible activity was however the lengthy daily press conferences televised real time (see later section on communication).

On March 14, 2020, ten special sectoral working groups were created in addition. Their scope of tasks ranges from digital education, mobile hospitals, public finances, economic harm reduction and revitalization, medical research, communication, and border control. In addition, a working group in charge of identifying companies of strategic importance and preparing the take-over of their control by the Defence Forces, another one in charge of studying international policy responses to the pandemic, and yet another one in charge of preparing state-of-emergency legislation.

Policy Responses

On March 11, 2020, the Government declared the state of emergency. From this time on the government issued a series of emergency decrees, partly overruling existing laws. On March 30 the legislature adopted the so-called Authorization Act. This allows the Government to introduce significant restrictions without any functional or time limitation, without any debate in the Parliament, and without any guarantee for the immediate and effective constitutional review. According to some critics (Szente, 2020; Helsinki Committee, 2020) the absence of these guarantees leads to an irreversible and permanent damage in the democratic operation of the state. On the international level the Authorization Act triggered highly visible repercussions. MPs of the European Parliament called for “concrete actions to preserve the rule of law” (European Parliament, 2020). Recently however, the Prime Minister announced that “the government expects to be able to give up coronavirus-related special powers at end of May (Hungarian Government Official website [HG], 2020a).

Except for some very limited local variations in how lockdown measures are defined and implemented decision making and implementation of policy responses follow a tightly centralized pattern. Below we review the most significant areas of these policy responses are reviewed below.

The first, “wait and see” stage of the pandemic, when there were no known cases in the country, lasted from about mid-January to early March. In this period the government has already announced some preparatory and preventive measures, primarily information measures suggesting regular hand washing and cough hygiene. In this period, the most comprehensive set of measures was the 28-point action plan of the Group (HG, 2020b). “Soft” restrictions were enacted, primarily in relation to citizens and international students travelling to or from China, and to education institutions, asking them to limit international mobility.

A next stage of the pandemic was reached on March 4 when the first two cases were identified. The Group announced as key aims the early detection and isolation of cases, the rapid identification and close monitoring of persons in contacts with cases and ensuring separated clinical care. On March 11 arrivals from Italy, China, South Korea and Iran, as well as indoor events involving more than 100 and outdoor events involving more than 500 participants were banned.

The next stage of the pandemic, characterized by the emergence of clusters of COVID-19 cases, can be placed between mid-March and the end of March. Education institutions were closed down from March 16. While the lockdown of schools was ordered by government decree, the local governments could decide on the operation of kindergartens. In many cases, kindergartens remained on duty with limited capacity. Outpatient health care services were severely restricted, too. On the same day, the second package of restrictive measures was announced by the Prime Minister. In particular, the borders of Hungary were closed, so that only Hungarian citizens were allowed to enter the country. Apart from family gatherings, all public and social events were banned. All but non-essential commercial facilities were closed. From March 27 physical movement of citizens was limited too.

The fourth phase might be dated from the beginning of April to mid-May, when Hungary has been experiencing relatively larger outbreaks of local transmission. One of the most significant measures in this period was the ordering of public hospitals to free up 60% of their capacity, equalling 36 thousand beds. On April 7 there were around 800 known cases, so the capacity made available exceeded the foreseeable need by at least an order of magnitude (Ferenci, 2020).

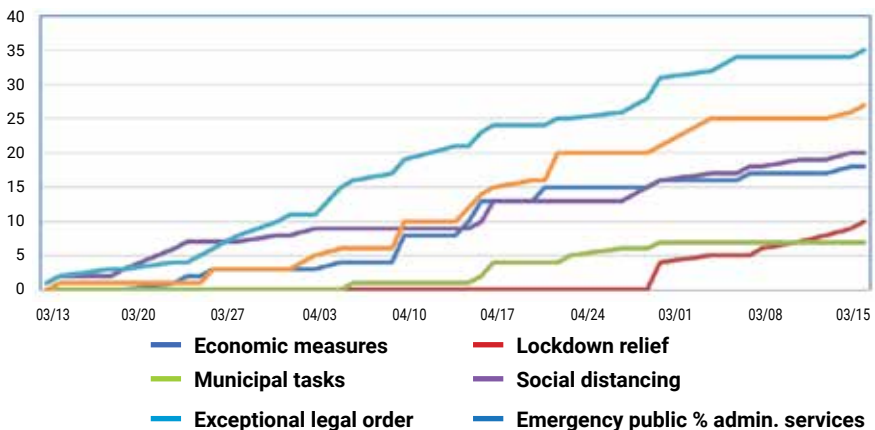
The current, fifth stage of the pandemic started on April 30 when the government started to selectively lift lockdown measures, first in the countryside and subsequently in the larger and the capital city Budapest too.

A particularly important subset of crisis measures was targeted at fighting the economic and employment consequences of lockdown. Various measures were put in place to fight such side effects. According to Anderson et al. (2020) the relative government spending on such measures was significantly lower than in most EU countries. Another interesting feature of this stimulus package is that it includes some measures – such as the reintroduction of 13th monthly pension from January 2021 “in order to enhance financial security of the elderly” (HG, 2020c) - which seems to be unrelated to healing the economic damages of the epidemic, but rather aims to increase the political popularity of the government.

Direct and indirect tax measures include a tax exemption for small businesses and individual entrepreneurs. In order to generate additional tax revenues new surtaxes on credit institutions and the retail sector were introduced (KPMG, 2020). VAT refunds were substantially accelerated to improve the solvency of small and medium size enterprises, and tax related deadlines were extended to lessen administrative burdens. Next, measures are those targeting employment included various measures for increasingly flexible employment regulations in terms of working hours and home office arrangements. Finally, relief regarding loans and introducing moratoriums included the suspension of loan repayments until December 2020 for all private individuals and businesses, and a price cap on consumer loans.

A summary overview of emergency government decrees is given in the Figure below.

Figure 1- Government decrees on pandemic emergency measures broken down by response type (March 13 to May 16, 2020 classified according to primary purpose)⁵



Source: Own compilation. Source of measures: Jogkövető (2020); Wolters Kluwe (2020).

⁵ Note that some government decrees became overruled by newer ones in the meantime

A spectacular feature of implementation is the strictly centralized command-and-control regime put in place. Moreover, implementation is characterized by a distinctly militarized style and a large role of the armed services in tackling the crisis. Illustrative of this is the fact that the daily news conference of the Operational Group, televised in prime-time public service news programs in real time, is led by a high ranking police officer, whereas members of other uniformed services feature high in the event too.

More importantly for the current purposes, responses of the armed services play a large substantive role, too. On March 31 military officers started their command of 51 hospitals out of 108 in Hungary⁶. As the government explanation said “Hospital commanders’ (...) job is to submit proposals and requests to the national commander, who forwards them to the Operational Group” (HG, 2020d). Another major build-up of military presence in managing the pandemic was that the action group in charge of the security decided that a total of 139 private companies operating in strategically important areas such as the food industry, oxygen supply, info-communications and energy and infrastructure were put under military oversight. Soon after, military teams started their work in 84 of them. The military coordinators have, according to applicable regulations, substantive decision and oversight roles. (Jogászvilág, 2020).

Communicating with the Public

In the early phase of the pandemic the government’s stance was to downplay the coronavirus issue. Instead, government communication insisted on continuing with its established political and rhetorical tropes such as the dangers created by, and measures taken to battle, international mass migration on the one hand, and the – allegedly closely related – conflicts with the EU, on the other. On February 16, the Prime Minister in his annual speech did not make a reference to the pandemic.

In the following weeks government communication emphasized that there were no COVID-19 cases registered in Hungary, and – amidst increasing media attention devoted to the issue – urged news media outlets to “avoid spreading fake news”, threatening with prosecuting those “triggering panic” (Balázs, 2020).

From January 31, government communication on the pandemic was taken over by the Operational Group’s lengthy daily live news conferences, apart from which only the Prime Minister’s regular talks broadcast on the public service radio program deserve special mentioning. The pattern of government communication was increasingly unidirectional. Whereas the established

⁶ Government Decree 72/2020. (III. 28.)

government policy of “filtering out” not-government-friendly media outlets continued to characterize the Operational Group’s press conferences another filtering mechanism was introduced in addition. Namely, journalists were requested to submit their questions in writing before the events, only a systematically selected subset of which were then taken up by the Operational Group. Facts, data or narratives perceived as questioning or undermining the government’s official narrative of the day were not allowed to feature.

Government communication was criticized because of holding back information seen as crucial for taking preventive measures by local governments, such as occurrence of cases broken down by regions and localities. This practice is in sharp contrast with those of many other countries such as Italy, Germany, France, Poland, the Czech Republic, and Slovakia.

The Prime Minister’s weekly media appearances on the government’s Radio Kossuth channel were, to the contrary, the primary locus of clarifying government stance on major policy issues and on the – sometimes drastic – changes thereof.

Content-wise, government communication initially insisted on embedding the pandemic issue into its received anti-migration theme. This was easy as the first known cases were Iranian students studying in Hungary. For the first two weeks the migrant background of the first known persons infected was constantly emphasized. The Prime Minister claimed a logical connection between the spread of coronavirus and migration: “we are fighting a two-front war: One front is called migration, and the other one belongs to the coronavirus. Hungary didn’t let anyone in before, we won’t start doing so now”. (HG, 2020e). Later, however, as the pandemic spread nationally as well as internationally, this narrative was impossible to maintain. The new narrative presented the pandemic as a war situation, requiring extraordinary measures and unquestioned, military style leadership.

Controlling the spread of information has been a major concern of the government from the outset. The possibly most remarkable measure in this regard was the modification of the Penal Code on March 31 whereby false statements or statements distorting true facts – if capable of “hindering or derailing the effectiveness of the response effort” – are punishable with up to five years in prison. According to its critics, the new provision disproportionately broadens the scope of criminal prosecution: not only those threatening public order directly, but any activities possibly limiting the effectiveness of a very broad range of government policies from health care to education, border control and economic measures. As the government and pro-government news media regularly called to fight “fake news” spread by opposition journalists, this modification was seen by some as seriously threatening media freedom (András, 2020).

Local Government and Civil Engagement

As most policy responses were introduced on the national level, local governments were empowered with some limited freedom regarding social distancing and other disease control measures only. It was at their discretion to decide to lockdown public parks and closing open spaces, distributing masks to elderly people, and locking the borders of municipalities.

More importantly, a number of central government decisions drew controversy among municipal leaders as many local governments lost important revenues. On April 6 a government decree made parking – an important source of local governmental revenues – free of charge. Moreover, the vehicle tax or in some towns the business tax – another important revenue source of local governments – was taken over by the central government's Epidemiological Fund or reallocated otherwise. Further, a number of local (including social) development projects were cancelled (Dmokos, 2020). Importantly, local governments of larger cities became strongholds of opposition political parties in the 2019 national elections; therefore, these measures could be seen as weapons of political fight between government and opposition forces. Such an interpretation is supported by the large imbalance between the local importance of the reallocated funds on the one hand, and their relative insignificance in comparison with central government revenues and expenses, on the other.

Whereas they had to contribute to central government efforts financially, local governments did not receive additional central government support for epidemic control and social care for the elderly. Some conflicts became highly visible such as the „blame game” between the (opposition party) mayor of Budapest and the central government on who bears responsibility for the mass infection in an elderly care centre in Budapest (24.hu, 2020).

As to the role of policy actors other than central or local government it is the role of scientific experts that has undergone a spectacular transformation in comparison with the policy style of the preceding years. Even prior to the H-UNCOVER survey the Prime Minister called into existence a high-level advisory group consisting of two cabinet members and five researchers of various disciplines such as medical sciences and mathematics (Portfolio, 2020a). These experts were not only symbolically present in the policy process, but their advice was relied on when making important decisions on lockdown (Portfolio, 2020b).

However, the relationship between the government and the professional and expert community is far from idyllic. The Hungarian Chamber of Medical Doctors (*Magyar Orvosi Kamara*) got into high profile conflicts with the government when raising issues of lacking or imperfect equipment,

infrastructure, financing or regulations encumbering the fight against the pandemic (The Hungarian Chamber of Medical Doctors, 2020).

Policy Effectiveness and Lessons Learned

On May 1, 2020 a large-scale government-sponsored testing program was launched, based on the organizational capacity of four medical universities. “The aim of the H-UNCOVER nationwide representative study is to get an accurate picture of the extent and dynamics of the epidemic and the number of people who are or have been infected by the coronavirus.” (Semmelweis University, 2020). The results of the survey surprised even the epidemiology experts as infection rates – both past and current – were by an order of magnitude smaller than it could have been expected. Apart from this success of the initial lockdown measures this screening program is a remarkably novel feature of Hungarian policy making. It constitutes a definite move away from decision making oriented by maximization of political benefits and opinion survey, and a step towards policy making based on evidence, expertise and collaboration – something in sharp contrast with the policy style of recent years.

The overall effectiveness of policies in terms of minimizing the health, social and economic losses caused by the pandemic cannot be judged at the time of writing.

The effectiveness of immediate responses such as social distancing measures seems to be significant nevertheless – note however that a similar pattern can be identified in most Central and Eastern European countries, which is hard to account for at the time of writing. The H-UNCOVER research project estimated on a large and representative sample of the 8.2 million Hungarian citizens (i.e. those excluding minors and people living in institutional setting) that in this population there may be 243 to 7230 active cases and between about 20 to 90 thousand people having been exposed to infection (Kovács, 2020). The success of the social distancing measures is supported by other information sources such as cell phone and traffic data nevertheless (Ferenci, 2020). Based on the number of deaths per 1 million among European countries, Hungary was close to the median in the EU scope (ECDC, 2020).

It should be noted however that the screening of both people having been exposed and people showing no symptoms was, during much of the pandemic, very low compared to other countries. The absence of serious damage done by the pandemic can therefore be attributed only to the effectiveness of the social distancing measures.

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Italy: Experiences of Multi-Level Governance with the COVID-19 Crisis

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Abstract

Italy has been the first European country to be dramatically affected by COVID-19. As of June 2020, the epidemic counts almost 240,000 cases and a staggering number of over 34,000 deaths. The central government established a progressive and harsh lockdown of all non-essential social and economic activities, prioritizing health issues. Given their established co-responsibility on health policy and the uneven spread of the virus throughout the country, regional authorities undertook further prevention actions independently and often in an uncoordinated way. Most of the policy decisions were shown to be informed by clinical experts, who assumed a great visibility with the public since the early phases of the crisis. Public healthcare managers were much less visible but took relevant decisions in very short timespans, filtering a multitude of policy inputs and communication noise. More particularly, they provided a space for action, coordinated multiple stakeholders and professionals of different backgrounds, and played a crucial role in service redesign, human resource management and logistics.

Keywords

Lockdown; national health service, multi-level governance, public managers, organizational and service innovation

Highlights

During the pandemic, the central government took the majority /most of the decisions concerning the lockdown based on the suggestions of clinical experts; for the most, regional authorities followed suit, but also acted independently based on the local epidemiological situation.

Public managers, despite their little visibility with the media, had great scope for autonomous decision and acted in very short timespans, filtering a multitude of policy inputs and communication noise.

Many challenges await public managers: some of the organizational and service innovations facilitated by the emergency need to be maintained; funds for health will need to be reallocated towards more long-term priorities such as prevention and community care, and massively invested in the support and strengthening of healthcare professionals' capacity and resilience.

Introduction

Italy is the fifth most populous country in Europe, with 60.3 million inhabitants (Istituto Nazionale di Statistica [ISTAT], 2020a). The Italian population is rapidly ageing: the quota of over 65 is 22% (+1.8 million compared to 2010), corresponding to the highest percentage in the EU-28. Density is also remarkable, with 204 inhabitants per square kilometre (EUROSTAT, 2020), well above the EU average value of 118 inhabitants/square km. Italy has been the first country in Europe to be affected by the COVID-19 health crisis. As of June 2020, the crisis counts almost 240,000 cases and a staggering number of over 34,000 deaths (World Health Organization [WHO], 2020), corresponding to the second hardest-hit European country after the UK. In such scenario, the central government established a 2-months long, complete lockdown of all non-essential social and economic activities, prioritizing health over any economic consideration. Partly because of the asymmetrical spread of the virus across the country, Regions undertook further actions independently, often in an uncoordinated way. Public managers had limited visibility with the media. However, they took relevant decisions in very short timespans, filtering a multitude of policy inputs and communication noise, and sometimes introducing remarkable innovations.

The COVID-19 Crisis: a Map of Actors Involved

The governance of the COVID-19 crisis

According to the Italian Constitution, health and healthcare are a “shared subject” between the national Government and Regions. As such, the experience of Italy with facing and managing the COVID-19 crisis cannot be fully understood outside of the governance arrangement that characterizes not only the Italian National Health Service (INHS), but also the system of emergency management in the country.

The INHS is a tax-funded, Beveridge-type public insurance scheme in which the government, notably the Ministry of Health, is in charge of defining general objectives and fundamental principles. The Ministry is supported by the Istituto

Superiore di Sanità (ISS, i.e., the National Institute of Health) performing research and monitoring in the public health field. Regions, instead, led by elected governors, are responsible for ensuring the delivery of healthcare services through a network of 120 local health authorities (LHA), coordinating a total of 446 public hospitals, 4,400 among public laboratories and outpatient facilities and approximately 44,000 general practitioners (CERGAS, 2019). LHAs and public hospitals can be labelled as “public healthcare organizations” (PHOs). Regions are responsible for guaranteeing essential standards of care and the financial equilibrium of their healthcare systems.

In Italy, extraordinary interventions during emergencies and catastrophic events are coordinated and executed by the Department of Civil Protection, that is, *de facto*, an operative branch of the Presidency of the Council of Ministers. The reputation of a highly efficient and effective Civil Protection has matured through a long experience with dealing with earthquakes. It is, therefore, not surprising that one of the first acts by the government has been that of declaring a state of emergency (January 31st) and entrusting the Department of Civil Protection with coordinating the emergency.

In the specific case of the COVID-19 crisis, additional committees and roles have been created to face the emergency. On February 3rd, the Civil Protection established a technical and scientific committee (hereafter, Scientific Committee) gathering 13 top-level public servants - selected by the Ministry of Health, the ISS, Regions, the same Civil Protection- and 7 clinical experts (mainly virologists, public health experts and prominent clinicians). The Scientific Committee was created to advice the government on epidemiological issues. Hardest-hit regions such as Lombardy, Veneto, Emilia-Romagna and Piedmont, all in the North of Italy, created also their own scientific advisory committees. In addition, on March 17th, the Prime Minister appointed a commissioner in charge of coordinating the centralized procurement of equipment of personal protection (PPEs) and ventilators.

Finally, on April 10th, the Prime Minister appointed a “committee of experts in economic and social subjects” in order to plan the transition phase from total lockdown to generalized reopening. Overall, the COVID-19 crisis has been a great exercise of multi-actor and multi-level governance.

The INHS and the context of the COVID-19 crisis

The experience of Italy with the COVID-19 crisis needs to be contextualized. Italy remains the fourth European economy, but public finances are constrained by long-lasting stagnation and high levels of government debt. Therefore, public expenditure for healthcare is scarce: 29% of welfare allocations compared to the EU average of 37% (EUROSTAT, 2019).

During the last decade, the Italian National Health Service (INHS) has experienced shrinking resources compared to the increasing needs of its ageing population: between 2010 and 2017, annual expenditure growth has been just 0.8% in nominal terms. Public coverage decreased from 76% to 74% of total healthcare expenditure, but healthcare services have remained largely free of charge at the point of service. For the most part, healthcare expenditure has been curbed through a discontinuation in hiring healthcare professionals. Between 2010 and 2018, INHS stable employees decreased from 694,000 to 647,000 (-6%), and the average age reached 51 years (ISTAT, 2020b). Alongside, hospital beds decreased by 14% to 3.2 per 1,000 inhabitant positioning Italy close to the UK, but far apart from France and Germany, registering 6.0 beds and 8.0 beds/1,000 inhabitants (CERGAS, 2019).

According to the German Institute of Statistics (DESTATIS 2020), at the beginning of the COVID-19 crisis, Italy could count on a capacity in intensive care of 8.6 beds per 100,000 inhabitants, limited if compared to France (16.3) or Germany (33.9). During the years, infectious diseases units in hospitals had seen a strong reduction and public health departments had lost most of their competence in contact tracing, an activity of great relevance during epidemics. In summary, the crisis occurred in the context of a healthcare system that has been heavily rationalized overall and for the competence and organizational capacity necessary to face such a pandemic.

Policies During the COVID-19 Crisis

Principles of government action

Two fundamental principles have marked the approach of the Italian Government to facing the COVID-19.

The first principle is that of graduality. The government issued, in the space of three weeks (see timeline in Table 1), a rapid series of restrictions to the social and economic lives of Italians but did so step by step. Being the legislative tool utilized that of “decrees of the Prime Minister”, i.e., without parliamentary approval and a legitimate tool only during a state of emergency, the government enacted the lockdown by progressive adjustments. In other words, it tried to balance the need to stop the fast spread of the infection with that of getting measures restricting liberties more easily accepted by the population. Most of the government’s decisions were shown to be informed by the Scientific Committee. In the case of the halt to non-essential economic activities, the government conducted a lengthy prior consultation with the union and firm representatives. Even with respect to controls and fines for

people disrespecting lockdown rules, the government was careful not to “militarize” the country and appealed more to the sense of responsibility of Italians than to the coercive and sanctioning capacity of the State.

The second principle permeating the action of the Italian government can be summarized with the motto: “Health first”. The prioritization of the health crisis over any other issue, even in the presence of profound negative consequences for the Italian economy, has been the leitmotiv of the government’s decisions, even amidst strong criticism from opposition parties and Regions. This approach has persisted even in the later phases of the crisis when deciding which non-essential economic activities could reopen and with which pace. The elaboration of strict sector-specific safety protocols for workplaces, despite requiring lengthy processes of negotiation with unions and businesses, has shown the attention of the Government for assuring safety first, even when it implied reducing overall production.

Starting from the initial phases of the crisis the Government created a strong alliance with the scientific and medical community represented by the group of experts in support of government action. Less evident, instead, has been the role of the Ministry of Health and its technocratic apparatus. The Minister, for instance, did not participate in the daily press conference about the data of the infection held by the Department of Civil Protection and the Scientific Committee. The limited involvement of the technocratic apparatus, e.g. in the planning department, of the Ministry of Health might partially explain some of the difficulties in having a coordinated action plan and a smooth implementation on the ground.

Multi-level governance: dynamics and critical issues

The COVID-19 crisis has allowed tensions across different institutional tiers (national, regional and local) to emerge. The devolution of healthcare to Regions has meant for the government the need to coordinate and negotiate regularly with this institutional tier. In this process, the government has attempted to design policies for the entire population, independently from the fact that the spread of the virus has been very asymmetrical across the country. This has not impeded Regions to undertake further actions independently. In some cases, Regions have introduced further restrictions with respect to national ones, at least in small areas of their territories. For instance, Lombardy, the hardest-hit region in Italy, introduced the obligation for the population to wear facemasks and gloves. In other cases, regions have decided to address issues, like that of screening, in a region-specific way. In Veneto, for instance, the regional government enacted a policy of widespread swab screening and contact tracing even in the presence of more conservative guidance from the national level (Pisano et al., 2020).

Tensions between the government and Regions have escalated in the later phases of the crisis when deciding how to reopen economic activities and newly grant mobility to the population.

In principle, the double layer of governance, i.e., national-regional, could represent a sophisticated mechanism to ensure that policies are adapted to local contexts and to the severity of the infection. In practice, though, it has resulted, first, in a certain degree of communication cacophony and a dangerous increase in confusion and uncertainty in the population. Second, tensions between government and regions about the respective scope of jurisdictional authority have been perceived by the public as ways of shifting the blame to the counterpart, rather than substantial controversies about the overall governance set up of the INHS. Third, the attempts of some regions to deviate from national directives have made evident the possibility for a system like the INHS based on equal access, to generate disparities, paradoxically when facing a public health issue of global impact like COVID-19. These dynamics have raised doubts in several quarters about the effectiveness of such a devolved system and about the capacity of Regions to manage at best the complexities of healthcare without a strong common direction. Overall, the positive aspects of a multi-governance system have been overshadowed by the incapacity of policymakers to foster a culture of concertation and cooperation across institutional tiers.

Finally, the COVID-19 crisis has witnessed a surge in the visibility and activism of local governments, especially of mayors. Closer to their original institutional role, mayors have worked, from the beginning, as advocates for their citizens, voicing to the regional and national governments their needs in terms of care, screening and, more recently, economic support. Some have been active in buying for their citizens PPEs or serological tests. Others have engaged the population in consultations on the strategy that the city should be following in the future steps of the crisis. Most have left their desks to be closer to their communities and showing their presence in a period of crisis.

Relevance of Public Managers and Management During the COVID-19 Crisis

As mentioned before, most of the national policy decisions were shown to be informed by clinical experts through the Scientific Committee. By collecting epidemiological data from all the regions, the ISS and the Scientific Committee monitored the evolution of the pandemic and reported directly to the population on a daily basis through the media. Therefore, members of the committee become key interlocutors not only for the national government, but also for

regions, business and union representatives and the media system. Besides the Scientific Committee, numerous clinicians, virologists and epidemiologists appeared daily in the media, with a proliferation of opinions and suggestions, sometimes confusing and contradictory. By comparison, public managers had much less visibility with the media. However, top managers in public healthcare organizations played a relevant and multifaceted role.

Management and policy of the COVID-19 crisis: what came first?

Traditionally, a policy cycle starts with some top-down rules or plans, guidelines for implementation and training for executive and middle management on the new policy. During the crisis, especially in the regions most affected by COVID-19, these steps could not be respected. There was no time either for comprehensive top-down planning, or for preparing in advance guidelines. Managers became, on the ground, policymakers and strategists, having to transform over night the capacity mix and the competence allocation within their organizations. Decisions that usually take months (or years) of analysis and discussion with internal and external stakeholders had to be taken in a very short span of time, and directly by managers, without the possibility to wait for guidance from policymakers. Managers played this role away from public and media attention that focused more on regional and national policies and regulations. This provided top management teams with a high degree of discretion and managerial autonomy to take decisions. Managers also operated in a situation of financial uncertainty without knowing the budget on which they could count. While normally this would have stopped them from acting, during the crisis it forced managers to take on themselves the full responsibility of resource allocation.

Managerial innovations

During the first two months of the COVID-19 crisis, healthcare managers took fundamental decisions in the following directions:

Capacity shift and competence reallocation

The entire healthcare capacity in hospitals was re-organized in order to serve two groups of patients: COVID-19 patients and urgent COVID-free patients. To do so most hospital wards abandoned their usual activities and contributed to cater for these patients. Physicians and nurses of these wards were also relocated to COVID areas, often with limited time for training. Since the mix of hospital activities and competence was different across PHOs, solutions were often local and context-based, with relevant room for managers' discretion. Due the speed of the infection, plans for capacity shifting had to be renewed on a weekly basis.

Logistic transformations and service innovation

To avoid the spread of the infection COVID patients needed to be separated from all the others. This required a complete redesign of patient flows within hospitals. For instance, two separated emergency rooms, paths, and teams had to be organized. The same happened for diagnostic services. At the same time, soon it became apparent that many COVID patients had only mild symptoms and could be treated at home. This required organizing specific services, including telemedicine, to monitor and care for these patients as well as identifying facilities (e.g., hotels) that could host patients not able to self-isolate at home.

Direct procurement of protection devices and other supplies

The early phases of the crisis were marked by a lack of personal protection devices, gowns for healthcare professionals, of diagnostic tests, and ventilators for intensive care units. PHOs did not have sufficient stocks of all these supplies so managers had to buy supplies directly in China, pay cash and work out ways to rationalize and control the supply chain, a practice considered simply impossible by normal public accountability rules.

Smart working

Most of the administrative staff started working from home, thanks to smart working technologies. Before the COVID-19 crisis, smart working was debated both in the public arena and during negotiations with unions, but never deemed feasible or acceptable. Suddenly, managers, to preserve safety, converted most of their staff to working from home.

The roles played by management in the early phases of the crisis

The top management during the crisis played the following roles:

- a. Project management and coordination became crucial functions in order to integrate different clinical knowledge groups, public health and curative philosophies, HR and technological approaches, internal and external communication. Management had to integrate all the actors involved in managing the emergency, provide a shared work framework, room for mutual adaptation, and mark the pace of action.
- b. National and regional guidelines, experts' suggestions, media debates flourished and generated a loud communication noise. Management prevented this noise from overwhelming their organizations and focused on interacting and communicating mainly with local stakeholders. Management teams filtered and processed the inputs coming from the public sphere, comparing them with the reality of their contexts and the knowledge of their organizational capacity and implementation potential.

- c. HR management became a critical task for top managers. Most clinicians and nurses had to care for COVID-19 patients feeling inadequate and unprepared. Many of them and part of the staff became infected and PPEs were sometimes lacking. A sense of duty and sacrifice among professionals were high, but this needed to be managed carefully in order to prevent burn out. Management had to play a crucial motivational role and provide leadership more than ever before.

Most of these roles played by managers were emergent and developed in the course of the emergency. Nevertheless, the quality and effectiveness of managerial action depended on extant capacity and competence. This partially explains the differences in outcomes across PHOs.

Concluding Remarks

What are the main lessons learnt from the experience of Italy with managing the COVID-19 crisis? First, in the Italian case health issues have been clearly prioritized. The lockdown was prompter, stricter and longer than in other European countries (Hale et al., 2020), and this has shown to be effective in curbing the spread of the infection, especially to Southern regions. However, the death toll by COVID-19 has been dramatic, especially among the elderly, and it has made evident a number of deficiencies and weaknesses of the healthcare system even in regions, such as Lombardy, considered able to deliver excellent standards of care. This should bring policy makers to reconsider priorities and investments in health and healthcare in the country.

Second, while in the first phase of the crisis the national government has been able, thanks to the strong support of the scientific and medical community, to coordinate interventions with the regions, in later phases this exercise of multi-level governance has shown its fragility. The relationship between central and regional governments has been increasingly uncoordinated and tense. While this might not be enough to lead to the dismantling of such institutional arrangements set in the Italian Constitution, it brought at least to the forefront the need to reflect on how multi-level governance should be practiced especially in the context of an emergency .

Third, as other scholars have noted (Bouckaert et al., 2020) public healthcare managers, although much less visible, have been the real drivers, on the ground, of the management of the crisis. Many challenges await them now: some of the organizational and service innovations facilitated by the emergency need to be maintained; funds for health will need to be reallocated towards more long-term priorities such as prevention and community care, and massively invested in the support and strengthening of healthcare professionals' capacity and resilience.

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Table 1 - Timeline of main events and of Italian government's actions

Date	Event and/or Policy Interventions
31-1-2020	After detection in Rome of two COVID-19 positive Chinese tourists, the Italian Council of Ministers declares a 6-month national emergency and entrusts the Department of Civil Protection for crisis coordination
21-2-2020	First Italian COVID-19 positive patient detected in Lombardy, followed by a number of cases in neighbouring areas in Emilia Romagna and Veneto
23-2-2020	The Government establishes in Lombardy and Veneto two "lockdown zones". In these areas, mobility from home must be justified by health, work or "necessity" reasons (e.g. grocery shopping)
04-03-2020	Closure of schools (all tiers) in the whole country
08-03-2020	Extension of the lockdown zone to all Lombardy and vast parts of Northern Italy
10-03-2020	Extension of the lockdown to whole Italy
17-03-2020	Decree (no. 18/20, "Cura Italia") to strengthen the INHS, maintain employment, suspend fiscal duties
22-03-2020	Interruption of all non-essential productive activities: complete lockdown
27-03-2020	Peak of daily deaths (969)
08-04-2020	Decree (n. 23/20, "Liquidità") to foster access to loans and business continuity; sustain liquidity across the economy, support internationalization, investments and export
04-05-2020	Reopening of most factories and some wholesale activities, with health safety measures; possibility to visit close relatives
13-05-2020	Decree ("Rilancio") to strengthen both hospitals and community-based healthcare services, hire nurses and reinforce medical education; support the liquidity of business activities and further postpone fiscal duties; sustain employment; prolong school closure; support families with disabled people; support municipalities' finances
18-05-2020	Reopening of bar, restaurants, shops and selected social activities (e.g., public worship)
04-06-2020	Restart of inter-regional free movement
15-06-2020	Reopening of many recreational activities (e.g., theatres, cinemas, summer camps)

Lithuanian COVID-19 Lessons for Public Governance

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Abstract

The chapter analyses the early lessons for public governance from Lithuanian COVID-19 response. The methodology of current research is based upon the data collected through media sources and logical classification and distribution. According to the research findings, it can be pointed out that the timely introduction of a quarantine is not sufficient. The maximum level of protective equipment needs to be in place to allow for several months of operation until the supply chain is restored as Lithuanian companies were highly dependant on the Chinese suppliers. Not all business restrictions work in practice, however the strict measures can be effective in case of small states in order to prevent the spread of the virus. The administrative capacity requires the development of new knowledge on electronic procurement, logistics and planning of the procurement in the new highly uncertain environment. The centralized approach for organizing testing is not working as more decentralized efforts increase the number of conducted tests.

Keywords

Business restrictions, COVID-19, head of operation, Lithuania, public procurement, tests

Introduction

Lithuania is the largest of the three Baltic states (the others being Estonia and Latvia), and borders Belarus, Russia, Latvia, and Poland. Lithuania covers slightly more than 25,000 square miles (65,300 square kilometres), and in 2019 it had an estimated population of 2.794 million. The official language is Lithuanian. In 2004, Lithuania became a member of the European Union (EU) and joined the North Atlantic Treaty Organization (NATO) (Dvorak, 2015).

Lithuania has a mixed health care system, financed by the compulsory health insurance fund. The main actor in regulating the health system is the Ministry of Health; it formulates health policy, defines standards, and applies requirements, licenses service providers and doctors, and justifies long-term investment. The National Health Insurance Fund, under the auspices of the Ministry of Health, implements compulsory health insurance and represents the interests of insured parties. Municipalities are responsible for the organization of primary health and social care as well as certain public health activities (60 municipalities in total) (Vaitiekūnas, 2019). In 2018, the share of current expenditure on health care in GDP was 6.48%; this has subsequently increased slightly to 6.57%. Lithuanian taxpayers maintain 127 hospitals. Lithuania has one of the highest ratios of hospital beds per population in the European Union and was highly criticized for that at the beginning of 2019. According to the OECD database for 2017, there are 608 inpatient beds per 100,000 people in Lithuania, and 4.6 physicians and 7.7 nurses per 1000 inhabitants.

Government Measures and Public Policies

A state-level emergency in Lithuania was declared on 26 February 2020 while other EU countries were still closely monitoring the situation in Italy and Spain. Many residents still travelled to the mountains of Italy or the sunny Canary Islands on holiday. The government's decision stated that the declaration of a state-level emergency would make it easier to coordinate preventive actions to prepare for the spread of COVID-19, organize the work of institutions, use the reserves of state medical resources, and perform other procedures faster and easier.

Organizational structure

On 20 October 2010, the Lithuanian government approved resolution No. 1503 "On the Approval of the State Emergency Management Plan". According to this resolution, the Ministry of Health is responsible for organizing the management of particularly dangerous communicable diseases (epidemics and / or pandemics). On 27 February 2020, by means of a Prime Ministerial Decree No. 27 "On the Appointment of the Head of Operations in a State Emergency",

the Minister of Health Mr. Aurelijus Veryga was appointed as head of operations. This meant that he also became the head of the National Emergency Situations Center (hereafter NESC) and his decisions began to affect the daily routine of all Lithuanians. At the same time, he had the important task of creating an effectively functioning emergency management system (Nakrošis, 2020). The NESC consists of six groups: (i) operational assessment and emergency prevention; (ii) information management; (iii) material and technical provision; (iv) public information; (v) administration; (vi) the organization and maintenance of electronic communications. The main groups are led by officials from the Fire and Rescue Department under the auspices of the Ministry of the Interior. Only the information management group is headed by a health ministry officer, while the public information group is led by an adviser of the Prime Minister (Davidonytė, 2020). According to V. Nakrošis (2020), such a structure of the NESC is departmental and not suitable for pandemic management, because the owners and managers responsible for specific projects are not widely known even at the end of the second month of quarantine.

Lack of resources or special tactics

The first case of COVID-19 was recorded on 28 February 2020. The media later speculated that this had been known earlier, because it appears to have been an attempt by the government to delay the reporting of the first case of infection until after the announcement of the appointment of the head of operations. The Prime Minister sent an optimistic message to the public the day before during a press conference with the Minister of Health that sufficient supplies were on hand and everyone was ready. Was the truth to be revealed later?

Although 10 days elapsed between the first recorded case of COVID-19 and the second case, the decision to quarantine was issued when there were only 12 infected people in Lithuania (all cases came from abroad), i.e. on 16 March 2020, but it had already become clear that there was a lasting shortage of individual protective equipment. This was already confirmed at the beginning of March by an adviser to the Prime Minister, who resigned as chair of the public information group. He openly criticized the head of operations for the lack of resources (masks, protective equipment etc.). The head of operations later recognized the lack of reserves: “The reserves have not run out, its potential is relative and it will all depend on how fast the number of cases grows. Under current growth, we have enough tools, but we are looking for new ones. If that number grows faster, there will be problems” (LRT Radijas, 2020). This could also mean that reserves had been exhausted. Therefore, the possibility is relative.

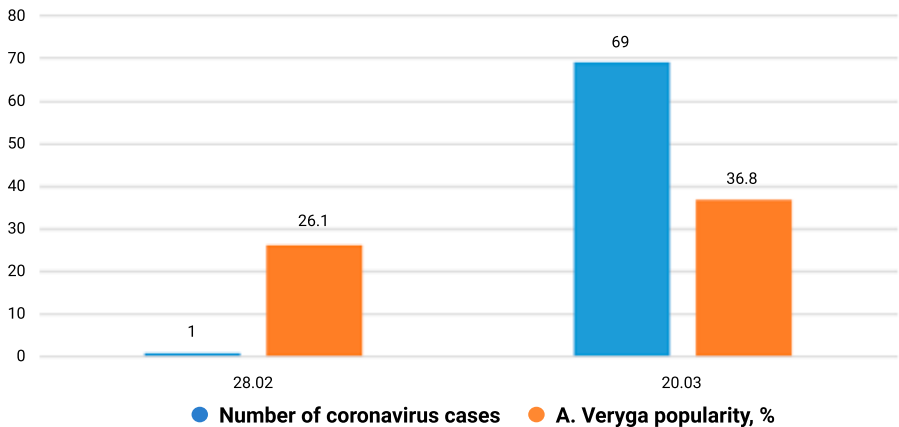
According to the discourse of the head of the department of infectious diseases of one of the hospitals, it can be concluded that the hospitals did not have the reserves for a specialized COVID-19 response and thought that everything would proceed as with other infectious diseases. As the head of

the department noted: “Maybe at the very beginning there weren’t enough of them (auth. protective equipment’s) that you could change 10 times and throw them away. Later, everything came up and those safeguards flooded into the hull, everything was enough” (Platūkytė, 2020). Indeed, the situation as regards the supply of individual protective equipment started to change at the end of March. According to the OECD (2020), between 28 March and 12 April, Lithuania received hundreds of tons of individual protective equipment purchased from Chinese suppliers. These included masks and respirators, suits, hats, gloves, etc. The equipment was distributed across major hospitals, ambulance centres, mobile testing points and fever clinics (OECD, 2020).

After starting to test the population and carrying out only 1220 tests on 20 March 2020, it became clear that there was a lack of reagents and that the entire COVID-19 test site could not function. The mayors of some of the largest cities reacted critically to this situation, especially in view of the fact that people from abroad had been allowed to enter the country by sea or air via these cities (ELTA, 2020). President G. Nausėda expressed his opinion on the lack of administrative capacity. According to the Presidential Institution, the NESC did not have the competence for electronic procurement, logistics: “we did not have a clear plan, neither of what we were buying nor how much” (Jakučionis, 2020). An even stricter assessment was made by the former president D. Grybauskaitė, who critically assessed the work of the head of operations and Lithuania’s administrative capacities, which she also criticized while working for the European Commission (Dvorak, 2013; 15min, 2020). The chairman of the largest opposition party in the Parliament (lit. Seimas) G. Landsbergis proposed replacing the head of operations with a military figure. According to him, the head of operations used the benefit of doubt, saying for three weeks that everything was fine in Lithuania (LRT, 2020). It is no coincidence that four soldiers with logistics, medical and process planning experience were later added to the NESC. However, despite criticism from the public, the approval rating of the head of operations increased when compared to the previous February and was the highest during the entire term of the current government (see Figure 1). At the beginning of his term, the Minister of Health managed to implement significant restrictions on the alcohol industry, so was not particularly popular in the XVII Government.

The lack of supply of disinfectant angered residents and businesses who were able to continue operations during the period of quarantine. The matter of supplying this solution was handled in a bureaucratic and inflexible way, although entrepreneurs say that they offered their services at the beginning of March 2020. However, according to OECD (2020) evidence, the ministry of health collaborated with private companies for the delivery of disinfectant solutions; although, according to the National Health Centre’s response to one

Figure 1 - Number of coronavirus cases and popularity of A. Veryga according to Vilnius



Source: Prepared according to Lietuvos rytas (2020).

company, “neither you nor any other company should expect any permission for a surface disinfectant” (Tvaskienė et al., 2020). The delay in issuing permits to businesses to start production only served to create a shortage on the market and raised the price of the disinfectant. According to representatives of business enterprises, not only business enterprises, but also municipal administrations, which are responsible for the provision of education, public transport and cleaning apartment staircases, are waiting in their queues (Tvaskienė et al., 2020).

Smart buyers

Despite the delays in purchasing protective equipment, it can be observed that public servants later became “*smart buyers*” and captured the attention of the Public Procurement Office (further PPO). This institution is responsible for the implementation of public procurement policy and compliance with public procurement law. The PPO (2020) has recognized that, in cases of extreme urgency, procurement can be carried out under a simplified procedure, i.e. faster, easier and unpublished. However, despite the high need for protective, preventive and diagnostic measures, it is necessary to start planning public procurement and assess to what extent it may be needed in the future and to use normal public procurement procedures (PPO, 2020).

Increased number of tests

Despite the repeated demands of the leading epidemiologists and virologists for greater testing, the same inflexibility and bureaucracy accompanied the opening of mobile COVID-19 checkpoints in all 10 Lithuanian counties, the

opening of which was delayed due to the certification of mobile testing points and the training of staff. Naturally, the operation of such mobile points had to be prepared in accordance with performance standards i.e. how the resident should register for testing, how to get to the testing point, what time to arrive, how to behave, and so on. Another reason was probably the lack of reagents as already mentioned above, which meant that the certifying officers tried to delay the opening of such testing points until more reagents were available. The installation of three mobile test points in Vilnius, two in Kaunas and one in each of the other county centres was planned (see Table 1).

Table 1 - Planned installation of mobile testing points in Lithuanian county centres

Date \ County	18.03	19.03	20.03	23.03	24.03	25.03
<i>Vilnius</i>	x	x	x			
<i>Kaunas</i>		x		x		
<i>Klaipėda</i>			x			
<i>Alytus</i>					x	
<i>Marijampolė</i>					x	
<i>Šiauliai</i>					x	
<i>Telšiai</i>						x
<i>Utena</i>						x
<i>Tauragė</i>						x
<i>Panėvėžys</i>						x

A centralized approach to the analysis of COVID-19 testing immediately proved ineffective, as hospitals had to send all collected tests to Vilnius. For example, the transportation of collected tests from Klaipėda alone took four hours, although Klaipėda University hospital also has a laboratory that could undertake analysis of the tests. However, the officials responsible also delayed the certification of the laboratories there. The decision on the decentralization of COVID-19 test analysis was taken by the Ministry of Health only on 18 March 2020, allowing four more laboratories to carry out the analysis of tests. The same laboratories were allowed to undertake the analysis of the tests done at the mobile testing points.

Staff

The problem of medical staff is not a new one in Lithuania. Due to low salaries, young physicians emigrate or moonlight in other jobs. This has created a challenge in managing the COVID-19 pandemic, as some facilities

have become focal points of the virus (both patients and staff became ill). The first health care professional fell ill on 13 March, but on 7 April as many as 154 health care professionals were infected. The managers of several hospitals were removed while internal investigations were conducted, but retained their posts despite outrage from the public and the medical community. “Thanks” to a misguided health professional, it became clear that some private health care facilities were providing services without licenses. Furthermore, the question of rising wages arises once again. On 7 April, Parliament approved a proposal to pay 60 to 100 percent higher salaries to employees of medical institutions who work with patients with particularly dangerous infectious diseases and health care professionals who help to prevent outbreaks of such diseases. Also, during the quarantine period, the administration of large municipalities organized the provision of pre-school education services to the children of health care professionals and officials (police officers, firefighters, and customs officers).

The problem of modelling

As already mentioned, quarantine began on 16 March 2020. Was it a model of the current government or did it learn from others? It is probably not possible to answer this question unambiguously and definitively. It is likely that parts of the knowledge and templates were taken from existing knowledge on how to fight a pandemic. Of course, during the thirty years of Lithuanian independence, knowledge pertaining to the spread of HIV infection has been accumulated, but experts with experience in combating this infection have not been involved in consultation on the NESG (Interview with an expert, 2020.05.05). J. Šiugždinienė (2020) noted that there was a lack of cooperation not only with experts in individual fields, but also between ministries. Innovative decisions were made taking into account the experience of other countries, as decisions on banning various activities and restricting travels were made reactively, i.e. depending on the country of arrival of incoming infected people, etc. Lithuania chose the strictest model of business restriction compared to other Baltic countries (see Table 2)

At the start of the quarantine period, flights were suspended at all airports. Only Vilnius Airport remained open for residents returning from abroad. Vilnius and Kaunas airports were also used to receive aircraft carrying individual protective equipment for hospitals. From mid-March to the end of March, 21 special flights were organized to facilitate the return of 3,253 residents (Verslo žinios, 2020). The flights were partly co-financed by the state and cost approximately 150,000 euros, which are expected to be covered by EU funds (Verslo žinios, 2020). The Ministries of Foreign Affairs and Transport participated in the coordination and organization of the flights. After closing the borders to the arrival of residents on 10 April, the only possibility of entering the country was via the seaport in Klaipėda by ferry from Germany.

Table 2 - Business restrictions in the Baltic States during the COVID-19 pandemic quarantine period

Countries \ Business	Shopping centres	Stations, roads	Drugstores	Bazaars	Grocery stores	Airports	Caterings, bars, pubs	Cases of infected (19 of May 2020)
Lithuania	Closed	Open	Open	Open	Open	Closed	Closed	1562
Latvia	Open	Open	Open	Open	Open	Closed	Closed	1102
Estonia	Open	Restricted	Open	Open	Open	Open	Open	1791

Source: Prepared according to Navakas, N. (2020) and John Hopkins University (2020).

Of course, these restrictive measures have had a significant impact on residents and businesses working in the catering, entertainment, sports and leisure segments. The Ministry of Economy and Innovation is responsible for the new business support package. The measures of the Ministry of Economy and Innovation are divided into COVID-19 support and measures to promote business. COVID-19 support measures include: (i) guarantees of up to 80% for investments and loans; (ii) loans from 25,000 EUR up to 1 million EUR; (iii) 100% reimbursement of interest paid. The guarantee institution JSC "Investiciju ir verslo garantijas" (INVEGA) is responsible for the implementation of these measures. The functions of the founder and supervisor of the company were assigned to the Ministry of Economy and Innovation. In April 2020, with the start of the easing of quarantine conditions and the announcement of the COVID-19 business support package there were immediate public complaints about the slow pace of support. Also, some entrepreneurs received negative responses regarding the granting of support, leading to significant criticism of the guarantee institution. According to UAB Invega data, they rejected about 18-19 percent of companies' applications for soft loans and rejected more than 50 percent of those applying for interest compensation (Šimelevičienė, 2020). It is important to note that one of the main criteria for support is related to the company's performance at the end of 2019. However, according to the implementing authority, this safeguard has been set by the European Commission (Šimelevičienė, 2020).

In fact, it can be stated that the pandemic control measures applied by all the Baltic countries have been effective, because the spread of the virus is not high and since 15 May 2020 the freedom of movement of people between the Baltic

States restored, i.e. one will not need to be quarantined for 14 days after going to Latvia or Estonia, nor after returning to Lithuania. On the other hand, the risk of infection is growing again, not only in cases from the Baltic States but also those coming from other countries. Therefore, ministers of the Baltic states have discussed how to classify foreign countries according to the level of risk. Finally, Lithuania has adopted COVID-19 management strategy. This strategy aims to control the short-term spread of COVID-19 and to prepare properly for possible new waves of the virus in the future in order to reduce their negative impact on public health, the national economy and social and cultural life. The proactive plan will be implemented during the next two years and can be reviewed if vaccine or antiviral drugs will be developed.

Early Lessons

1. The timely introduction of quarantine is not sufficient. The maximum level of stocks needs to be in place to allow for several months of operation until the supply chain is restored. The doctors and the wider population have sufficient individual protective equipment and reagents for carrying out testing.
2. A centralized approach for the analysis of tests is not effective, even in small countries, as the pandemic requires quick actions.
3. Not all business restrictions work in practice, and closing shopping centres is not necessary. It will have economic repercussions due to a rise in unemployment and a reduction in taxation revenue.
4. Moonlighting by healthcare specialists must be declared, as this information can prevent the spread of the virus in organizations providing healthcare services, both public and private.
5. Public procurement must be planned and future needs assessed in advance. Institutions have begun to use an emergency situation even for implementation of regular public procurement procedures.

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The Norwegian Government Response to the COVID-19 Pandemic

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Abstract

This chapter addresses how the Norwegian government handled the Corona pandemic. The main finding is that the government managed to control the pandemic rather quickly and effectively by adopting a suppression followed by a control strategy based on a collaborative and pragmatic decision-making style, successful communication with the public, a lot of resources, a high level of citizens' trust in government, professional hospital services and a low population density. The alleged success of the Norwegian case is about balancing crisis management capacity and democratic legitimacy. The Norwegian approach placed a heavy emphasis on the health aspect followed by stimulus packages to help support those affected and to restart the economy. The effect of this imbalance has yet to be seen and it is a growing debate on how to end the crisis regarding improving the economy again.

Keywords

Governance capacity, governance legitimacy, crisis communication, coordination, preparation

Highlights

An effective crisis management needs both governance capacity and governance legitimacy.

Effective crisis management is depending just as much on the citizens behaviour and voluntary cooperation based on trust in government as on government capacity.

A collaborative decision-making style with involvement and participation from stakeholders are crucial for a high performing crisis management.

Introduction

The Norwegian strategy to handle the COVID-19 pandemic was originally a wait-and-see approach which changed dramatically on 12 March 2020 when the government changed towards a suppression strategy and launched the most draconian regulations after World War II. A pragmatic controlling strategy followed resulting in gradual lifting the regulations from April 20. Overall, the Norwegian response was characterized by a collaborative approach and an effective crisis communication combining governance capacity and governance legitimacy resulting in a high performing crises management (Christensen & Læg Reid 2020).

Institutional Context

In Norway, the central crisis management authorities responsible for handling a pandemic are the Ministry of Health and Care Services (MH) and its subordinate agencies: the Norwegian Directorate of Health (NDH) and the Norwegian Institute of Public Health (NIPH). When the epidemic started, MH was the lead ministry but as the crisis expanded to other policy areas the Ministry of Justice and Public Security (MJ) was assigned that role. The prime minister and the cabinet are also central actors, in collaboration with parliament since the current government is a minority coalition government.

The quality of the Norwegian health care services is high compared with many other European countries. Almost all hospitals in Norway are public and are run by regional health enterprises with quite a large degree of autonomy. Nevertheless, the hospitals are owned by MH, which also has overall responsibility for the health enterprises. Norway has one of the youngest populations in Europe and the population density is also lower than in other countries, with a total population of only 5.37 million living in a vast territory.

Trust is also a key feature of Norwegian society. General trust among citizens as well as citizens' trust in government and trust between government authorities is higher than in many other countries (OECD, 2017). Norway has a strong economy, partly owing to its oil and gas revenues and a big pension fund to ensure responsible and long-term management of revenue from the oil and gas resources.

The Coronavirus Pandemic in Norway

On April 6 2020, three weeks after the government had launched draconian measures, the minister of health stated that the corona epidemic in Norway was under control. On average one infected person was infecting 0.7 other persons, while that number was about 2.5 when the epidemic started (this measure is

called secondary spreading or R) (NIPH, 2020). By May 6, this number was down to 0,49. The minister asserted that the government's measures to fight the spread of infection had worked. In spite of this good news, he warned against reducing the various social distancing measures too fast in order to avoid a resurgence of the virus.

The initial cases of COVID-19 in Norway were brought back by Norwegian vacationers who had been skiing in Northern Italy and Austria. The first case of the infection was registered on February 26. The geographical spread of the disease in Norway was very uneven, reflecting social status, vacation habits and population density. Oslo, the capital, has had by far the highest number of cases per capita. As of June 12, 8608 people were infected and 242 deaths had been registered; the average age of those who died was 82 and more than half of the deaths were in nursing homes for elderly people. A total of 272905 people have been tested for the corona virus, a very high percentage of the population compared with other countries; about 3-4 percent of them have tested positive. The number of infected and hospitalized patients increased rapidly until it peaked on April 1 with 324 in hospital and then gradually decreased, and on June 12 this number is only 15. The estimated total number of infected citizens over time was 14000, which is 1.51 pr. 1000 inhabitant. As of June 12, the death rate was 4.5 per 100,000 citizens, which is much lower than in UK (60,4), Spain (58,0), Italy (56,5), Sweden (47,4), France (43,1), the Netherlands (34,8) and USA (34,1), but also lower than Germany (10,1), Denmark (10,2), Austria (7,5) and Finland (5,9).

A Suppression Strategy Followed by Economic Measures

Up until March 12, the government adopted a wait-and-see approach to the pandemic but on that day draconian regulations were implemented. Three important regulatory measures were introduced the first two weeks of the virus process: First, a set of tough regulations and restrictions was announced, which on March 24 were extended to April 13. They were followed by four rounds of economic compensation packages and then by a proposal to pass a law granting the government more autonomy to act; the latter was modified by parliament.

The most important central regulations to fight the corona virus during the first month of the outbreak were (The Norwegian Government [NOGOV], 2020):

- Advice on washing hands, sneezing, social distancing and limiting gatherings to not more than five people. In addition, quarantining those infected, securing hospital capacity, forbidding health personnel to go abroad, and increasing authority to track contagion, etc.

- Advice on avoiding non-necessary journeys, avoiding using public transport and other highly frequented places. 2 weeks quarantine for all Norwegians returning from abroad.
- Stricter border controls. The border was closed to foreign nationals without a Norwegian residence permit.
- Closure of all kindergartens, schools, colleges and universities, but also all training and events in sports clubs, cultural events, etc.
- Closure of all hairdressers and other one-to-one businesses, gyms and hotels, but shops and shopping malls were allowed to stay open.
- People with second homes in another municipality were not allowed to stay overnight in their cottages.
- Regional and local governments also introduced rules regulating peoples' access to certain geographical areas – e.g., imposing a quarantine requirement for those entering certain cities in northern Norway.

Regarding the labour market. 291000 people, or 10.4 percent of the labour force, were registered as fully unemployed by March 24., while the figure two weeks earlier was 2.3 percent. The unemployment rate was reduced to 8.8 percent by May 5. To mitigate the negative economic effects of the strong restrictions, the Norwegian government introduced the following measures in several steps:

- On March 13, immediate measures were introduced to support jobs and to help companies avoiding unnecessary layoffs and bankruptcies.
- On March 16, NOK 100 billion worth of guarantees and loans in crisis support for businesses was made available, followed by a major compensation scheme for culture, the voluntary sector and sports.
- On March 27, the government approved additional financial measures to otherwise sustainable businesses that had been severely affected by measures to contain the pandemic.
- On April 3, additional measures were introduced directed at businesses that had been particularly hard hit during the pandemic, including cash support for enterprises. The fiscal measures so far added up to more NOK 241 billion taken from the petroleum fund, corresponding to an increase in the expenditures of 17 percent compared to the last year.
- On April 30, a package of measures to support oil and gas industry was launched.

The law of exceptions process, aimed at giving the government extraordinary powers in the crisis situation, was in some ways controversial. Initially, the government proposed it to last for half a year, but after being discussed in parliament, it was reduced to a month, the powers became more limited, and

certain parts of the law could be suspended if 1/3 of the representatives were against it. Even though the opposition made major changes in the government's original proposal, the debate was marked by an atmosphere of collaboration, trust and standing together in a crisis situation.

The gradual deregulation and opening up of the COVID-19 restrictions has had the following measures:

- The kindergartens were reopened from April 20 and primary school classes for years 1–4 from April 27. The ban on using holiday properties was lifted from April 20 and one-to-one contact businesses were allowed to resume operations. The social distancing was reduced to 1 meter from April 30.
- May 7, the government decided to reopen most closed-down activities by June 15. All schools reopened from May 11. The group size was increased from 5 to 20 persons for private gatherings and to 50 for public gatherings. Sports facilities and driving schools reopened, the ban on travelling abroad for health professionals was lifted, and the quarantine period was reduced from 14 to 10 days.
- From June 1, bars and amusement parks were reopened and from June 15 public arrangements of up to 200 people are allowed and universities, colleges, fitness centres, water parks, swimming pools and the top league in soccer reopened. But, the general infection control measures such as rules of social distances are maintained and home offices are preferred. Except for travelling to Finland, Denmark and Iceland international travels are still discouraged. People who have been outside Finland, Denmark and Iceland have to go into quarantine.

How Prepared were the Authorities?

The Norwegian authorities were in some ways not particularly well prepared to handle the crisis, because relatively little was done to build up specific capacity to deal with such an epidemic. National risk assessments had warned that the risk of a major pandemic was high but reserves of emergency medicine and infection control equipment were insufficient. The responsibility for such tasks was delegated to the individual regional health enterprises, which were mainly working according to the dominant management doctrine of 'just in time' and lean management, focusing on efficiency and not fit for building up robust emergency preparedness. The main bottleneck was lack of infection control equipment, respirators and testing kits. On the local level, 74 out of 356 municipalities did not have an operational plan for infection control, and training was lacking. But despite all this, as it turned out, it was more important that the Norwegian health care system is very good and overall resources are abundant, so in most important aspects it had enough capacity.

Regarding the economic measures, there were no major budget or finance issues. This was due to Norway's solid economy, partly based on oil and gas. Budgets were revised and resources ramped up as quickly as needed.

Decision-Making: Collaboration and Coordination

The COVID-19 decision-making process was characterized by a need to make major decisions under conditions of great uncertainty and urgency. The major decisions were taken by the cabinet in close collaboration with NDH and NIPH, and later on ad hoc expert groups, even though the political leadership deviated in some major decisions from their advice and opted for more radical measures such as closing schools and kindergartens and opening them at a slower pace. The government initially pursued a mitigation strategy, which was later changed to a suppression strategy, without changing the basic regulations. The rhetoric of the prime minister and central ministers was to stop the epidemic, while NIPH tended to talk about controlling it, so that the capacity of the hospitals was not overwhelmed.

The minority government also prepared its proposals for economic measures in a collegial way in close collaboration with employers' and employees' organizations, and via bipartisan collaboration in parliament, which resulted in stronger packages than suggested by the government. The decision-making process here was extremely fast.

In the last week of March, a conflict emerged regarding the tension between central and regional/local regulations. 134 municipalities, most of them in Northern Norway and with few COVID-19 cases, established local restrictions on movement into the municipalities or regions to avoid infections in areas with low health care capacity. The downside of these rules was that people coming from outside the municipality had to go into quarantine for fourteen days, which caused problems for local businesses. The executive political leadership struggled with this question. At first, they did not recommend these local rules, but few municipalities listened to them. Then national guidelines were established that were strongly supported by the employers' and employees' organizations, but the government stopped short of making them mandatory, because they feared negative political effects, which meant that some municipalities stuck to their local rules.

The national government responses and major decisions were initially guided by learning lessons from other governments, such as positive learning from some Asian countries like South Korea and China and negative learning from Italy and later Spain (Tian et al., 2020). Also, lessons from international public health organizations and institutes such as WHO and Imperial College London influenced the Norwegian strategy for fighting the pandemic.

Overall, the main decision-making style was consensual and based on a pragmatic collaborative approach combining argumentation and feedback, which reflected a common Norwegian style. Major decisions had to be taken under deep uncertainty. The executives balanced different decision premises, tried measures that they thought might work, the experts assessed the consequences and the course was adjusted if necessary. Such a pragmatic approach makes sense given that there was a lack of evidence-based knowledge and much uncertainty regarding the efficacy of measures to fight the pandemic (Ansell & Boin, 2019).

Meaning-Making: Appealing for Solidarity - United we Stand

The prime minister and the ministers involved played an important role in communicating with citizens and the media through daily media briefings together with NHD and NIPH and there was extensive media coverage. The executives early on defined the situation as dramatic and maintained that drastic measures would lead to a better long-term outcome. They alluded to the virus threatening Norwegians' way of life, completely overwhelming the health system, and to the existence of widespread and untraceable cases. The leaders communicated a joint strategy and appealed to people to follow the new regulations, show solidarity, put in extraordinary efforts to help, and to take care of and support their fellow citizens, especially vulnerable groups. They argued that 'life and health' and the 'precautionary principle' should be dominant. Overall, the political executives played relatively more on fear symbols, which was magnified by the scaremongering media coverage.

The health arguments from the top executives were the most important ones for justifying the draconian measures taken. The main message was that if the population followed these rules now, the epidemic could be stopped and life would more easily return to normal. They explained in some detail the reasons for certain specific control and quarantine measures but were rather vague about whether an overall precautionary strategy based on health criteria was the best one. Supported by epidemiologists, they also stressed that many people could be affected, that many were vulnerable and that the health system might experience capacity problems.

The main message was that the government really cared about these problems, but the reactions were somewhat mixed, depending on how satisfied different sectors and businesses were with the packages. The government seems to have succeeded rather well in connecting governance capacity and legitimacy using the argument that Norway had sufficient resources to deal with the crisis.

Implementation and Change Management Approach

The government measures were implemented through a combined strategy of advice, guidelines and mandatory directives, the latter followed up by potential penalties for non-compliance. The measures were pretty strong, but the most draconian measures such as a full shut-down of businesses, a curfew, full border closure and isolation of infected citizens in designated buildings, were not used. The authorities appealed to solidarity and citizens' trust in government, which was mainly loyally followed up by the population.

Overall, the approach was top-down, but based on collaboration between political, administrative and professional central authorities. National frameworks and policies dominated over local discretion. The biggest implementation challenges were related to the tension between central government, which wanted national standardized measures, and local government, which wanted local variations and protection.

When the various control measures were relaxed on April 7, the political leadership signalled that the pandemic would need to continue to be controlled for a longer period by using massive testing, data-assisted tracking, quarantine for those infected and special measures for vulnerable members of the population. On May 6, the infection situation was so good that the government launched a plan of gradual lifting the restrictions aiming at opening up to almost normal situation by June 15.

Governance Legitimacy and Trust

Overall citizens' trust in government increased significantly from an already high level during this crisis. Trust in government, in the health authorities, parliament and national and local politicians increased, as did trust in the prime minister (Medborgerpanelet, 2020). The citizens' satisfaction with the democracy had increased from 57% to 72% from January 2000 to April 2000, a very high rating internationally¹. On the other hand, interpersonal trust among citizens seems to have decreased somewhat, probably due to fear, to the focus on infections and isolation, and on how to enact the strict social distancing regulations. Confidence in the Norwegian economy decreased, reflecting the large increase in unemployment.

The government communication strategy appealed to solidarity, collective action and voluntary work, combined with penalties for breaching regulations.

¹ Information given by Elisabet Ivarsflaten at Webinar, April 3 2020. See Dahl (2020).

The main spokesmen of the government were the Minister of Health, the Prime Minister, administrative executives in the Directorate of Health and medical executives in the Institute of Public Health, mainly operating together in the media briefing. This seems to have been successful in terms of increasing citizens' trust in government. To some extent the authorities also managed to influence the levels of anxiety, stress, and fear among the public, even though the balance here was challenging.

Concluding Remarks: Main Lessons Learned

The main lesson learned from the Norwegian case is that, despite a lack of preparedness in some respects, the government managed to control the pandemic rather quickly and effectively by adopting a suppression strategy based on a collaborative and pragmatic decision-making style, successful communication with the public, a lot of resources, a high level of citizens' trust in government, professional hospital services and a low population density.

The alleged success of the Norwegian case is about balancing crisis management capacity and democratic legitimacy (Christensen et al., 2016; Lægneid & Rykkja 2019). Regarding democratic legitimacy, there were some challenging debates about how to balance political decisions and expert advices; the process related to the exception law; about the balance between national standardized measures and leeway for local adaption and flexibility; a growing debate on transparency; on the capacity at the nursing homes to fight the pandemic and on the tempo of lifting the regulations.

Another lesson is about the trade-off between protecting citizens from the pandemic and protecting the economy. Successful management of a pandemic needs to give priority to protecting citizens from becoming infected, but this also needs to be followed up by measures to reduce the negative economic side-effects of radical measures. The Norwegian approach placed a heavy emphasis on the health aspect but at the same time was able to earmark what it deemed sufficient government resources and stimulus packages to help support those affected and to restart the economy. The effect of this imbalance has yet to be seen and it is a growing debate on how to end the crisis regarding improving the economy again.

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When Politics Mixes with Fighting the Virus: Response to the COVID-19 Pandemic in Poland

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Abstract

The coronavirus pandemic caught Poland unprepared, and the authorities had made many mistakes long before news of the outbreak reached Europe. Fortunately, they responded swiftly and decisively, which absolved them from their previous transgressions. To their credit, they have successfully protected the health and lives of their citizens but have been negligent in their economic management and have not prepared a clear exit strategy from the restrictions imposed on business. The consequences of this negligence have yet to be fully played out.

The most conspicuous feature of the Polish experience is the unfortunate relenting in the fight against COVID-19 for political gain. The Polish authorities decided, for purely political reasons and at any cost, to hold the scheduled presidential election while the pandemic was in full swing. This shift in focus from the life and death of the citizenry to running a presidential campaign flew in the face of all rationality and should not have been countenanced in an OECD country.

Keywords

Poland, COVID-19, cooperation between central and local governments, proportionality in fighting pandemic

Highlights

If you are ill-prepared, swift and decisive decisions may nevertheless absolve you from your previous transgressions.

Great care should be taken to avoid throwing the baby out with the bathwater when fighting a pandemic.

Introduction

Poland started its fight with COVID-19 in early March 2020. Initially, the government focused on protecting the life and health of Polish citizens by introducing harsh lock-down measures, and little attention was paid to the proportionality of the restrictions, in particular their economic consequences. The presidential election, which took place in May, was a strong political factor shaping the government's strategy in combating the Coronavirus.

Institutional context and governance arrangements

The basic institutional context for the preparations to combat the pandemic was the then upcoming presidential election, scheduled for May 10, 2020. As a result, the Polish authorities were focused not only on fighting the pandemic between March and May 2020, but also on organizing the elections. This meant that not all the country's human, institutional and financial resources were totally committed to fighting the virus during that period. The government, the parliament, and even state enterprises such as the Postal Service, devoted an inordinate amount of time and resources on preparing for the election.

The Polish government had not joined the common EU purchasing platform before the outbreak, which proved highly unreasonable when the pandemic started (Gazeta Prawna, 2020). Had it done so, it would have been party to the joint public tenders for the purchase of necessary equipment. This omission should be treated as a grave planning error. In addition, experts have criticized the government for only having two certified laboratories in the country at the time of the outbreak (Szymczak, 2020). There are currently 86 (Jędrzyk, 2020).

Another grave error was the February 2020 decision of the Material Reserves Agency, the government body responsible for managing strategic reserves, to put up over 62,000 protective masks for sale. More than half of them were sold (Nizinkiewicz, 2020). This was clearly negligent planning.

At first, the government seemed to underestimate the gravity of the situation. The Minister of Health initially played down the COVID-19 threat, comparing it to an ordinary flu. It is hardly surprising, then, that the preparations for the pandemic were far from optimal.

Major decisions and measures

After the initial period of uncertainty about the nature of the threat, the Polish government reacted very swiftly and decisively. Poland's Patient Zero was diagnosed on March 4, 2020, and all mass events were cancelled on March 10. Two days later, the government ordered the closure of all schools and universities, and a sanitary cordon was placed on the country's borders on March 15.

The government formally announced a state of epidemic threat (March 14), then a state of epidemic (March 20), and then quarantined all Polish citizens returning from abroad. This was followed by a general lock-down (i.e. a ban on unnecessary movement), and the closure of public institutions such as courts. The government also decided to drastically restrict economic activity. Most shops were closed, apart from food stores and pharmacies, as were most service providers, including restaurants, hairdressers, and cosmeticians.

These measures were imposed by the government under the leadership of the Prime Minister. An important consultative and co-decision role was played by the Minister of Health, with the participation of the Chief Sanitary Inspector. The bans have been enforced by the national and the municipal police.

Learning from Others

The Polish government has been decidedly unforthcoming, so it is difficult to assess the extent to which Poland has followed other countries. The rapid and drastic measures taken to contain the pandemic were certainly influenced by the Italian experience and the fact that many Poles spend their winter holidays (between January and February) in the north of Italy. Having observed what was happening in Lombardy, the government was keen to avoid a belated response to the threat.

The authorities have frequently claimed that the Polish response is the model that other countries should follow (OKO. Press, 2020). However, there is no evidence for this. This position should therefore be treated as government propaganda rather than a factual diagnosis of the situation.

Crucial Implementation Challenges

The main implementation challenge for the government was that it was ill-prepared for the forecast pandemic. This resulted in having to import medical equipment quickly and urgently from abroad (especially from China). This was poorly planned and executed, leading to the import of poor quality, and even faulty, equipment (especially masks) (Rogacin , 2020).

Another problem is that the government has not been able to perform enough coronavirus tests. This has been compounded by delays in testing, due to laboratories not being able to cope with the sheer workload involved. In terms of the number of tests, Poland has been ranked fifth last in Europe, with 7,600 tests per million inhabitants (OKO.Press, 2020).

This has led to criticism of the government's actions, along with the accusation that the small number of tests was intended to convince the public

that the threat had been contained and that the presidential election, which the government had been strongly pushing for, could proceed as planned (Newsweek Polska, 2020).

Another serious implementation challenge was the aforementioned attempt to hold the presidential election on May 10, 2020, despite the ongoing pandemic. The election was ultimately not held, but a lot of time, energy, and resources, especially in April 2020, were devoted to preparing for it rather than fighting the virus.

Due to the friction between the national and regional governments, many of which are controlled by opposition politicians, the implementation chain has been short and centralized. The government's decisions have been made by a narrow circle consisting of the Prime Minister and several ministers, including the Minister of Health. Their implementation has been entrusted to centralized services, such as the Police, and to voivodes, who represent the government in individual voivodships, and who are responsible for e.g. designating which hospitals are to treat coronavirus patients.

The government did not coordinate testing between the provinces, by directing samples to those laboratories with the lightest workloads (OKO. Press, 2020), until six weeks after the diagnosis of Patient Zero. This shows that coordination between the central government and the voivodeships was not brilliant, even at the outset.

The crisis management in Poland has not been based on decentralizing decision-making or delegating responsibility, but on handing down administrative decisions to regional government authorities (i.e. definitely a top-down model.) This model has caused unnecessary friction between the national government and local governments, which has been further exacerbated by attempting to force local governments to organize the scheduled presidential election.

Communication Strategy and the Role of Experts

Unfortunately, communication between the government and the public has been entirely one-way, and official information has at times been unreliable and confusing (Zagórski, 2020). The frequent press conferences held by the Prime Minister and the Minister of Health to provide information about the measures being taken, explain the rationale behind them, and stress the need to follow them, have certainly been welcome. The announcements on ministerial websites, which have clearly informed the public about restrictions, have likewise been helpful, as has the daily information about the number of infected, dead and healed people, provided by the Ministry of Health.

However, the one-way nature of this communication has made the public suspicious as to the government's honesty and true intentions. As already said, the Polish government has conducted relatively few tests during the pandemic. At the same time, however, it was adamant that the presidential election would be held in May. This has made a large part of society suspect that the government has been understating the scale of the pandemic by controlling the number of tests to not reveal the real number of cases. This strategy, so this line of reasoning goes, was intended to convince the public that, as the epidemiological situation was not all that bad, it would be safe to hold the election. This only exacerbated public tension and increased the fear that the actual situation was much worse than were being told.

On top of all that, some of the government's decisions have been incomprehensible, e.g. the ban on individual physical activities (e.g. jogging), and the closure of public forests. These decisions were not sufficiently warranted and were soon amended or repealed. This raised doubts as to the rationality of the government's decisions.

Monitoring and Evaluation

Unfortunately, it is not clear whether the government actually *has* been monitoring the implementation of its measures - and least of all their economic impact. According to an Oko.Press report, government experts have been made to sign a confidentiality clause to prevent the mathematical model charting the course of the epidemic, along with other analyses, from being made public (Oko.Press, 2020). According to the unverifiable information released by the government, its quick and decisive lock-down decision has reduced the number of infections by as much as 90% (Jałochowski, 2020).

Since the public has not been presented with the analyses on which the restrictions of business activity and their relaxation have been based, these restrictions have sometimes appeared arbitrary. The only publicly available measure of the effectiveness of the government's actions is the number of confirmed cases, deaths and recoveries.

The effectiveness of the measures the government has put in place to shield the economy is particularly debatable. The public information available on business assistance has been selective, and sometimes signalled significant implementation difficulties. One example is that every one of the hundreds of applications for assistance submitted by Wrocław businesses has been rejected due to formal errors (Gazeta Wroclawska, 2020). This makes it difficult to assess the extent to which the implementation of key government decisions has been proceeding as planned.

The Co-operation between the Central and Local Governments

As already mentioned, cooperation between the national and regional governments has not been a strong point in managing this pandemic. The regional governments notified the national government that they were neither legally nor financially equipped to combat the pandemic (Portal Komunalny, 2020). This was clearly a matter for the national government. Regional governments have been appealing to the national government to implement the necessary legal regulations as a matter of urgency, so that they could fight the coronavirus more effectively (Portal Komunalny, 2020).

The presidents of Poland's 12 largest cities also appealed to the government, pointing to the increased financial burden on local governments, which was beginning to threaten their financial liquidity (Portal Komunalny, 2020). The presidents requested more cooperation from the national government in combating the pandemic. This further demonstrates that cooperation between the various levels of government has left much to be desired.

One contentious issue, which has further strained relations between local governments and the national government, has been the closure of schools and the corresponding requirement to switch to online education. Apart from the obvious headaches (e.g. not everyone has Internet access at home, and not all teachers are sufficiently computer-literate to conduct lessons online), this has driven up costs at a time when scarce government finances are being drained to fight the virus. Education expenditure has therefore been cut while the cost of providing it has increased (Infor, 2020). The cooperation between the national government, which is responsible for the curriculum and the organization of exams, and local governments, which maintain and finance schools, has been anything but optimal.

Effectiveness and Budgetary Issues

The most serious issue regarding the effectiveness of the government so far has been its negligence in preparation and prevention. Fortunately, their swift lock-down decision and the relatively slow development of the pandemic in Poland has spared the administration from being tested to breaking point. Nevertheless, the main lesson to be drawn from the Polish experience is that one always has to be prepared for the worst, no matter how remote the possibility might seem.

In the face of a pandemic, the national government and local governments have to work together efficiently and effectively. In Poland, this cooperation concerns two very sensitive areas, viz. health care and education. The

competences and responsibilities of the national and regional governments intersect in these areas. For political reasons, the national and local governments have been in conflict for a long time, and this has done nothing to facilitate cooperation in the face of the coronavirus threat.

The third issue concerns politics. Despite many appeals, the Polish government has still not declared a natural disaster which, in accordance with the Constitution, would have allowed the presidential election to be postponed and the president's term of office extended. The decision to press ahead with the election, however, was purely politically motivated. In particular, it was driven by the fear that the incumbent president's re-election prospects would plummet due to the profound economic recession that will inevitably follow in the wake of the pandemic. This fear pressured the government into holding the election, even though epidemiological organizations strongly warned against it (Dziennik, 2020).

In the end, the election was not held, but the government's focus on this issue throughout April and almost half of May reduced its effectiveness in fighting the pandemic. Suffice it to mention that, during this period, the parliament devoted a great deal of time to amending the electoral regulations, and the Postal Service was legally relieved of all other duties (including delivering parcels needed to fight the pandemic) so that it could concentrate its efforts on delivering and forwarding the postal votes for the election. This sort of callous disregard for the health and safety of the population is inexcusable.

The budgetary problem in Poland has so far mostly had to do with the National Health Fund's reimbursement of coronavirus tests. The original amount was about EUR 100 per test. This was reduced to about EUR 60 (Puls Medycyny, 2020). This led to protests by laboratory diagnosticians, who demonstrated that their tests were not cost-effective (Puls Medycyny, 2020). This may also indicate that the National Health Fund has been not been sufficiently resourced to fight the coronavirus (especially given the relatively small number of tests performed in Poland).

The availability of personal protective equipment (masks, protective suits, gloves) and coronavirus tests for medical personnel has been a major impediment from day one (Nizinkiewicz, 2020). Another serious problem has been the delays in testing, already discussed. This has prevented quick diagnoses, which would have prevented the spread of the disease.

Lessons to Be Learned and Concluding Remarks

Despite the government's numerous public declarations that the state of the economy is as important as public health, it has, by its actions, promoted the latter at the expense of the former. The restrictions to combat the pandemic

are stringent and were imposed without a thorough examination as to whether they were proportionate. By contrast, the business community deems the government's business support measures to be inadequate (Krzyżaniak, 2020). Surveys show that 56% of businesses consider the anti-crisis regulations too complicated, while 42% claim to have had no support from officialdom in applying these regulations. The businesses surveyed expected more government support for VAT payments, higher wage subsidies, and the suspension of social security contributions (Krzyżaniak, 2020).

The first lesson to be drawn from the Polish experience is that great care should be taken to avoid throwing the baby out with the bathwater when fighting a pandemic. The government's actions have to be assessed for their proportionality, not just their effectiveness, so that people's lives and health can be protected without depriving them of their livelihoods. It is politically difficult to explain the necessity of using common sense in an emergency, and many governments resort to extreme measures. This is not an exemplary solution.

The second lesson to be learned from the Polish experience is to plan an exit strategy before introducing restrictions. The Polish government was so focused on fighting the pandemic that it did not pay much attention to relaxing the restrictions imposed on businesses. Only after some time, and even then, only under the compulsion of social pressure, did it announce its strategy to "unfreeze" the economy (Rzeczpospolita, 2020). However, this strategy is not overly precise, and no analysis has been presented to the public to explain why some sectors of the economy should be unfrozen faster than others.

In addition, despite announcing the schedule for "unfreezing" the economy, the government has yet to fully implement it. Surveys show that almost 40% of businesses are concerned about the degree of uncertainty as to when the economy is actually going to get moving again, while the remaining 60% differ significantly as to the expected dates (Krzyżaniak, 2020). The second lesson is therefore to remember that planning is important to the business community, and that the exit strategy has to be clearly communicated and consistently implemented.

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The Romanian National Government Experiences in Dealing with the COVID-19 Crisis

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Abstract

The COVID-19 pandemic tested the government's capacity to deal effectively with uncertainty. As good practice cases before the start of the crisis were basically non-existent, governments across the world had to figure out the best way with dealing with the situation. The analysis highlights the specifics of the Romanian Governments reaction, pointing out the good and the bad of having a centralized emergency system and a top down approach in dealing with emergency situations. Although the public health challenge has been dealt with reasonably well, questions arise concerning the spillover effects in the social-economic dimension.

Keywords

Top-down approach, Covid-19, emergency response, public health, uncertainty.

Highlights

Relevance in understanding challenges faced in crisis situations with high complexity scenario. Impact of centralization/decentralization in dealing effectively with emergency & crisis situations.

Introduction

The COVID-19 crisis has been an incredible challenge for national and local governments alike due to the high uncertainty/high unknown characteristic of the crisis. The Romanian case highlights the strong and weak points of a centralized emergency management system. It also points to the importance of using information from other countries that can be used for rapid and evolving responses to a highly dynamic situation. Lessons learned in this case should be used to implement changes to make the system more flexible and transparent.

Institutional Context

Romania is a unitary state with a three-tier administration – local (Towns, municipalities and rural communes), county, and central. Management of emergency situations is not a responsibility decentralized at local or county level. It is carried out at central level and through deconcentrated branches of agencies located at the level of the central government.

Emergency situations in Romania are managed through the National Emergency Management System (hereafter NEMS) that consists of a network of institutional entities and structures competent in the area of emergency situations management. It also includes the necessary infrastructure and resources to fulfil their responsibilities in an emergency situation and was set up through a Government Emergency Ordinance (GEO no. 21/2004). NEMS is composed of: (1) committees for emergency situations - these are the main institutional structures in the system, inter-ministerial bodies made up of decision-makers, experts and specialists appointed by the ministries with attributions in the management of emergency situations; (2) General Inspectorate for Emergency Situations (responsible for implementation – can be described as operational structures); (3) professional emergency services and voluntary emergency services; (4) operative centres and centres for coordination and management of the intervention; (5) operative centres for emergency situations; and (5) the commander of the action.

The two main decisional structures (at national level) for emergency situations are:

The National Committee for Special Emergency Situations (hereafter CNSSU) - an inter-ministerial body composed of ministers and leaders of central public institutions (depending on the types of risk managed) and (2) The National Committee for Extreme Weather and Calamities (both set up in 2004¹). Along these two institutional bodies, each central ministry can set up its own Emergency Committee (depending on the nature of the emergency). CNSSU is led by the Deputy Prime Minister for National Security, oversight exercised directly by the Prime Minister of Romania.

The operational part is centrally led by the Department for Emergency Situations (DES) - which is an institutional structure without legal personality under the authority of the Minister of Interior. DES is headed by a secretary of state with the Ministry of Interior, appointed directly by the Prime Minister who is also the Vice President in the National Committee for Special Emergency Situations (CNSSU). The main responsibility of DES is to coordinate, on a permanent basis, the activities of prevention and management of emergencies,

¹ Main structure responsible in the case of COVID-19 crisis.

insurance and coordination of human, material, financial and other resources required for restoring normalcy.

In the case of COVID-19 pandemic, CNSSU is the main institutional body responsible for managing the situation while DES is responsible for implementation. The central structure (CNSSU)² takes decisions based on the recommendations of a technical scientific support group, which is set up to offer the support for such decisions and is composed of experts, specialists, academics or researchers in the relevant (emergency) field in question.

The central structures are replicated locally at each of the two administrative levels - county and municipality. The County Emergency Committee for Emergency Situations are set up under the coordination of the Prefect³ while local (municipal committees) are under the coordination of the Mayor. The last major emergency (before COVID-19) when the system came into action was the Ebola crisis (2014) when a series of measures for prevention of the spread of this virus were taken (establishment of a National Ebola Committee, acquisition of specific medical resources, establishment of an Ebola Case Management Center⁴). Oversight over DES is exercised by the CNSSU.

Overall, compared to other public services, which are mostly decentralized, the NEMS is a highly centralized system. Since its establishment in 2004 along with the Emergency Rescue Service (SMURD) very little has changed in terms of decentralizing the system. This is partly due to the effectiveness of the system in natural disaster situations (flooding, landslides, snow removal actions) and a positive image at national and international level of SMURD (both in terms of public perceptions and results) which created a strong belief that emergencies are best managed with a strong central command. Another factor is the high difference in administrative capacity between local communities - especially in small urban communities and rural ones, most public activity is dependent (at least financially) on the central government (Țiclău, et al., 2018). This leaves little flexibility and room for adaptation locally, all local institutional actors being in a position to execute the decisions taken centrally. If there are local initiatives these take alternative or complementary forms of action⁵. The unique nature of the current crisis highlighted the limits of a top-down, centralized approach.

² Main structure responsible in the case of COVID-19 crisis.

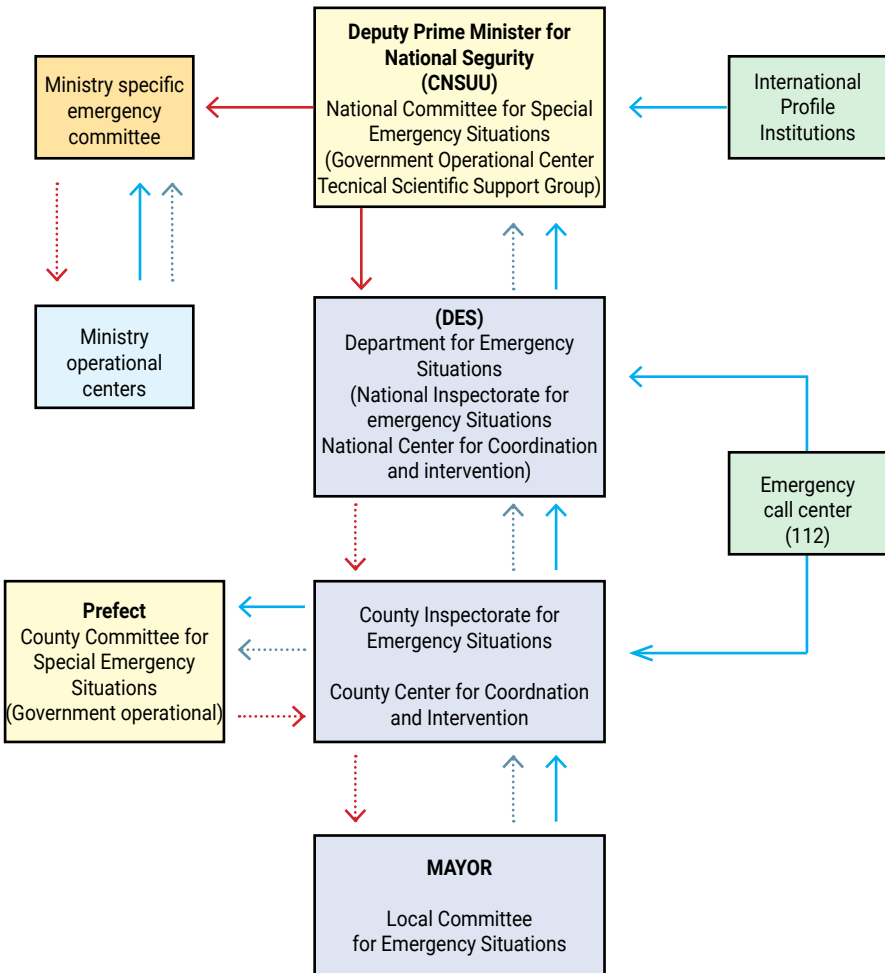
³ Central Government's representative at local level, appointed by the prime minister.

⁴ Decision no. 1/2014 of CNSSU.

⁵ Some local authorities implemented additional measures like ranging from daily public briefings on the evolution of the situation locally, specific public health measures (street cleaning, sanitizing apartment buildings regularly), specific policies for social distancing (adjusting public transportation procedures).

Figure 1 - Decision and operational coordination:

Operational Subordination	→
Coordination	⋯→
Reporting activities	⋯→
Informing on emergency/ generating risks situations	→



Source: Authors

Central Government Response

The first COVID-19 case in Romania was reported on 26th of February (2020)⁶. At that date several measures have already been taken through NEMS. On the 29th of January 2020, the Technical-Scientific Support Group on the Management of Highly Contagious Diseases in Romania⁷ (TSG) had an initial meeting as a reaction to the WHO declaring the international state of emergency concerning COVID-19. At this time TSG acknowledges “the lack of or insufficient availability of protective equipment for intervention, transportation and isolation of COVID-19 patients and decides to initiate (1) the acquisition of specific protective equipment through an emergency procedure and (2) the creation of a national, multi-annual inventory of resources for emergency situations with the development of a specific procedure for the management of such stocks (art. 1,2),⁸ that will be administered by the DES, which indicates that both a national inventory of resources⁹ or a procedure for the use of such resources was non-existent at that time. This was the first of a series of decisions taken for the management of COVID-19 crisis, presented below (Figure 1).

Table 1 - Central government efforts for managing the COVID crisis - January-April 2020

CNSSU Decisions during the COVID emergency ¹⁰		
Date	Decision	Content
02.02.2020	Decision no. 1	Acquisition of protective equipment and resources necessary for intervention, transportation, isolation of COVID-19 patients Creation of a national inventory for such equipment and resources under the management of DSU 14 days quarantine for people coming from China; public health officials present in all airports with international flights and borders
26.02.2020	Decision no. 2	14 days quarantine for people coming from Lombardy region Italy (11 communes with COVID cases), home isolation for anybody from Lombardy and Veneto Creation of a special COVID task-force ¹¹ and a Communication Unit

⁶ An asymptomatic patient which got infected after having contact with an Italian businessman (confirmed case).

⁷ This is the technical group which offers recommendations for the CNSSU decisions.

⁸ Articles 1, 2, decision 1/ 29th of January 2020, TSG.

⁹ These refer to the specific protective equipment necessary for handling COVID-19 cases.

¹⁰ TSG met on 29th of January and 1st of February, while the decision was adopted by CNSSU in 2nd of February 2020.

¹¹ Members are experts from Ministry of Health, Ministry of National Defence, National Public Health Institute, DES and General Inspectorate for Emergency Situations.

28.02.2020	Decision no. 3	Operational procedure for the management of COVID-19 cases
04.03.2020	Decision no. 4	Working scenarios for COVID-19 evolution TSG can take decisions without the approval of CNSSU (if no amendment is made in the first 8 hours) Humanitarian aid for Greece
09.03.2020	Decision no. 5	Procedure to suspend educational activities in cases of COVID confirmation Ban gatherings & events over 1,000 participants, below this number a special approval from local authorities was needed Redefinition of "suspect cases" based on other countries' experiences Modifying procedure for management of COVID cases for people coming from abroad Potential for SMS alert with hygiene instruction for incoming citizens from abroad Development of operational procedures and necessary equipment for medical personnel based on level of exposure Adoption of specific financing instruments and financial support for isolated/quarantined patients
09.03.2020	Decision no. 6	Temporary suspension of school for all pre-university levels (prolonged until the end of school year in June) Suspension of people travel services to and from Italy Disinfection measures for public authorities and economic operators Recommendation for working from home for all businesses and public organizations (as much as possible) Specific form to be used for people entering the country from abroad
11.03.2020	Decision no. 7	Suspending the distribution and sale of medical equipment and resources necessary for COVID-19 prevention, treatment Procedures for social distancing at work for private businesses Restriction of all activities with over 100 participants Closing of museums
12.03.2020	Decision no. 8	Closing of borders with limited traffic Regulations on EU funded projects to ensure safety in implementation
14.03.2020	Decision no. 9	Restriction of any kind of public activity (sports, religious, cultural, scientific) with over 50 members Introduction of specific operating procedures for key public companies (Postal Service, Electricity providers, Gas Providers)

14.03.2020	Decision no. 10	Proposal for establishing the state of emergency 14 days quarantine at home for all incoming citizens from countries with 500+ cases
16.03.2020 State of emergency at national level is adopted		
	Military Ordinance no. 1	Closing of all activities that imply multiple people in the same space (hotels, restaurants, cinemas, cultural events, religious gatherings and so on) Specific procedures for border crossing Suspension of all flights to or from Italy and Spain Communication of all COVID-19 information and content of decisions through mass media channels is mandatory
21.03.2020	Military Ordinance no. 2	Closure of dental offices Closing of commercial centers (malls) Recommendation people movement outside home limited and in max. group of 3 between 06-22 hours for specific purposes (medical, living supplies, individual physical activity, family emergency) Special certificate issued by the employer for continuing work from the office Personal signed statement for all other movement outside one's house with purpose and route used Enforced quarantine for cases that do not respect home isolation measures Restricted in and out of country movement of citizens
24.03.2020	Military Ordinance no. 3	Measures concerning people' movement outside their homes become mandatory People over the age of 65 can leave home between 11 am-13 pm only for same reasons Use of personal signed statement with purpose and route of movement All people coming from a foreign country will be set in home isolation or quarantine Update on countries to which or from which flights are banned (over 500 cases) Regulation of open air agri-food markets (remain open with special conditions)
29.03.2020	Military Ordinance 4	Small changes on business operations (disinfection measures) Local authorities' obligation to disinfect all apartment buildings and provide disinfectant solutions in each staircase
30.03.2020	Military Ordinance 5	Clarification of measures taken previously (sanctions, responsible personnel)

30.03.2020	Military Ordinance 6	City of Suceava and another 8 neighboring towns placed under quarantine with strict control over in/ out access County Emergency Operational Center becomes the main operational coordinator of local measures
15.04.2020 ¹²	State of emergency is lifted	

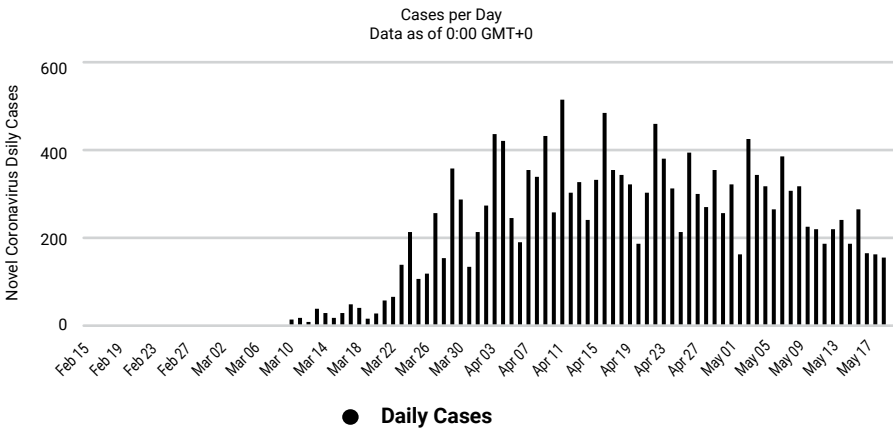
Government Effectiveness

From a public health perspective, Romania has not been so hardly hit compared to most western EU countries and sits below most EU countries in terms of no. of deaths, overall no. of cases and strain on the medical system. It seems that the fast measures concerning social distancing (especially closures of schools and universities along with leisure places) led to a less negative impact so far¹³:

Table 2.

Coronavirus cases	17.191
Deaths	1.141
Recovered	10.166

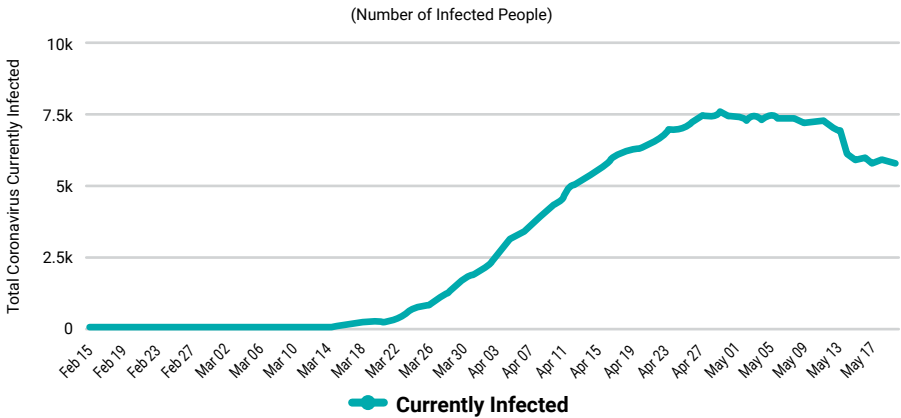
Figure 2 - Daily New Cases.



¹² An additional 5 Operational Commandment Orders were taken between 1st and 15th of April but these did not have national applicability and were focused on resolving specific problems in limited geographical areas (e.g. Transferring of property in order to offer quarantine space in a particular city) however these are proof of the centralized nature of the system.

¹³ Information on number of cases, deaths, active cases, recovered, retrieved from Worldometer (2020) on April 20th.

Figure 3 - Active Cases.



Source of data for above Figures 2 and 3 and Table 2: Worldometer (2020).

The institutional set up and the measures taken during the current COVID-19 crisis highlight the specifics of the National Emergency Management System (NEMS):

- Highly centralized with a top down approach, with decisions taken at the highest authority level (CNSSU) which are then implemented through the operational structures (DSU and its local operational centres for coordination).
- The Technical Scientific Committee (TSG) is indirectly the de facto decision-making authority based on its technical expertise - decisions highlighted in Figure 1 are decisions taken by TSG which have been then formally assumed by the CNSSU (no difference of content between the two documents). This is formally acknowledged through Decision no. 4 (04.03.2020) which enables TSG decisions to become official CNSSU ones if no amendment is made in the first 8hours.
- Although fully centralized, the NEMS displays a high level of responsiveness to the external environment (not surprising, given the nature of the current crisis). Thus, during the 71-day period, 21 decisions were taken as instruments for managing the crisis, an average of one new decision every 3.3 days. Another element highlighting responsiveness is the constant adaptation of regulations (decisions) based on the evolution of the situation outside of Romania. For example, the closing of all educational activities on the 9th of March was taken 3 days before WHO declared the COVID-19 crisis a Pandemic, mostly based on the evolution of the situation in Italy and Spain.

- Discretion of local authorities in reacting to the crisis is limited both legally (setup of the system and existing regulations) and effectively (due to limited administrative capacity and availability of resources).
- Evaluation of the effectiveness of measures followed the same top down approach with local bodies under the supervision of the DES feeding in information on a daily basis on a pre-established set of indicators (number of new cases, epidemiological investigation of cases, contact tracing, number of tests done and so on) (see Figure 1). The input of information had two major sources - reports coming in from the local level (Public Health Directions which were in charge to give daily updates on number of cases and the evolution of the situation internally) and information coming in from other countries and WHO. The influx of information was managed and evaluated by the TSG which then adjusted its decisions accordingly. These decisions were then assumed through the CNSU.
- Major challenges for the government were the acquisition of protective equipment and disinfectant especially in the first phase of the crisis (February - mid. March) for the medical personnel along with very different approaches in applying specific medical procedures in the first line care units. Part of this can be attributed to the high uncertainty level regarding the evolution of the virus and authorities being “caught off guard” by the exponential growth of cases. This led to “knee-jerk” reactions (in the first month of the crisis) for procuring protective gear and resources, in a highly competitive market, where each national government was battling for the same resources on the international market. The top down approach was maintained throughout the entire crisis and used as “appropriate method” in extreme situations - Suceava and Bucharest account for 30% of all cases - in both cases the epicentre of infection came from hospitals. CNSU placed Suceava under full quarantine and introduced military commandment of the County Hospital to get a grip on the situation. Discussions concerning the partial closure of Bucharest were held but never materialized. High differences between the numbers of infected medical personnel in different hospitals (several hospitals from Timișoara had no medical staff infected vs. County Hospital Suceava with 462 of medical staff infected) highlight discrepancies in the quality of management of the crisis at local level. The press accounts suggest that a combination of factors led to such high discrepancies in spite of the same regulations and procedures being applied everywhere through a highly centralized approach - best case practices involved the re-design of internal patient circuits (isolating COVID patients), multiple training of the medical staff concerning procedures of transportation, handling and treatment of patients and appropriate protection equipment and resources being available.

- Another element of discontent is related to Romania, together with other four countries, namely Latvia, Armenia, the Republic of Moldova and Estonia, denouncing the application of the ECHR Convention, based on article 15 which allows countries to do so during war or other similar situations. Those who criticized this decision invoked the fact that other Western European countries have also implemented limitations of citizens' freedom without however denouncing the Convention. Moreover, the most problematic aspect was that this decision was not communicated transparently to the public. Such a measure is highly problematic in a country where trust in public authorities has been traditionally low and where police have sometimes behaved abusively in fining citizens and economic operators for non-compliance with lockdown measures.
- The crisis has had positive effects in the realm of digitalization - faced with a series of major challenges in both the educational and public administration areas (ending of the school year, delivering public services, basic functions of the administration like tax collection) - a series of significant changes took place in order to adapt to the situation and keep the systems functioning - digital classes using different platforms, adoption of the digital signature, more services moved online, acquisition of digital devices for students, series of digitization programs for the Tax Collection Agency. This would be highly unlikely in a short term without the existing pressures raised by the crisis.
- Finally, a challenge for the Government was the recent decision made by the Constitutional Court to declare the GEO that imposed sanctions for those not respecting conditions of quarantine during the state of emergency as being unconstitutional. At the end of April, the Minister of Interior declared that, since the beginning of the state of emergency (16th of March), 290,000 contraventions have been applied in Romania in a total amount of 570 million RON (roughly 117 million Euros)¹³. Citizens can now contest these sanctions while the Government needs to change legislation in order to have the enforcing powers for the next phase of the crisis.

Communication

Communication throughout the entire crisis respected the highly centralized model - the Group of Strategic Communication was set up through Decision no. 2 of CNSSU (26.02.2020) and was in charge of all public communication concerning the government's handling of the crisis. The communication procedure was changed starting with 19.03.2020 (after the instalment of the

¹³ Full press briefing available at HotNews.ro (2020, April 30), online article.

national emergency state) limiting access to information for the general public and detailed information concerning active and new cases in each county. This prompted a concerted action of several NGO to accuse the government of lack of transparency and bad communication management¹⁴. A network of non-profit and civil stakeholders set up an open data portal (based on public data) (Geo-spatial.org, 2020) with the purpose of offering full and accurate data regarding the evolution of cases and also maintaining transparency and openness to public information throughout the crisis. The internal reporting system suffered from problems as well with official reports of significant errors in reporting made by Public Health Inspectorates (DSP) (responsible for centralizing data and sending it to central government) especially in hard hit counties¹⁵.

Communication with the general public during the pandemic was carried out at the central level by several important actors. On the one hand, the President, who is at least in theory non-political and non-partisan, acting in the behalf of all citizens, announced the establishment of the state of emergency and also the subsequent measures regarding the prevention of the spread of the virus. The President used his position in numerous occasions to send messages not only to the Romanians residing on the Romania's territory but also to the Romanians residing in other countries of the EU. The plea communicated publicly was for the Romanians in Italy and Spain to postpone their return to Romania in order not to overwhelm the hospitals and to increase the intra-community spread of the virus. The other three key actors involved in communicating with the public have been the Minister of health, Minister of the Interior, and the Chief of the Department for Emergency Situations. The latter individuals mentioned have been mostly involved in communicating to the public the legal provisions included in the military ordinances issued during the state of emergency. In some cases, communication can be described as mechanical, depersonalized and not very emphatic, with an emphasis on medical impact of the virus but less focus on explaining the purpose and impact of measures to the general public.

This impersonal style of communication lacks the empathetic, more personal ways needed to tackle other side effects of this situation, like emotional distress, feelings of loneliness and fear of death among different parts of the population, with the most vulnerable elements being hit the hardest. A recent study (Institutul Român pentru Evaluare și Strategie [IRES], 2020) highlighted that: 4 out of 10 Romanians had fears related to the impossibility of providing living resources amid the prolongation of the crisis generated by the pandemic,

¹⁴ Initiative for better communication and transparency signed by 13 NGOs and think tanks, available online at APADOR-CH, (2020, March 3).

¹⁵ Minister of Internal Affairs admits errors in reporting from DSP Suceava where number of tests done were reported as number of new cases. A criminal investigation is also under way at the Suceava County Hospital. See Nastaila (2020, May 16), online article.

more than a third had the feeling of fear of death due to the infection with the new Coronavirus. Elderly people have faced the isolation period either alone (25%) or with a life partner (45%) which made this period more stressful - 55% of the elderly (65+) live with the fear of infection that they associate with certain death, half of them felt a sense of loneliness these days, 47% of them live with the fear that there will be a food crisis, and a quarter of them felt that they were affected by a series of diseases they did not have before. Overall, Romanians experience, in quite high proportions, feelings and states of anxiety generated by the loss of living resources, the decisions of the authorities or loneliness, with young people feeling abandoned and reporting higher anxiety levels than usual, while adults (36-50) being mostly concerned with not being able to provide basic living resources for their families and being dissatisfied with authorities' decisions.

Economic Impact

The central government adopted a package consisting of economic measure meant to tackle the negative effects of the COVID-19 crisis (GEO no. 42/2020) which included: adoption of a multi-annual program to support SMEs by guaranteeing loans, subsidizing interest on these loans, specific financial facilities for companies experiencing financial difficulties, extending the deadlines for restructuring applications of the budgetary obligations and of the terms of payment of the local taxes by the population (until 2021), reductions of up to 15% for early tax payments, opening of specific credit lines for SMEs guaranteed by the Ministry of Finance (80% of the sum), providing guarantees for loans / lines of credit to finance working capital, excluding interest, commissions and bank charges related to the state-guaranteed credit up to 90%¹⁶, a loan of 1.15 billion lei to the National Company UNIFARM S.A.¹⁷, for a period of 6 months, assuring technical unemployment benefits (in specific conditions) for up to 75% of the salary, reductions of the tax on profit for certain types of activities. Regarding the civil service and the public administrative apparatus, the Government reduced the working week from 5 to 4 days and reduced payment to 75% of the base salary during the emergency crisis for non-essential public services, which would provide an additional revenue of 1.2-1.5 billion RON. Finally, the impact of the crisis has led the Government to make the first budgetary adjustment for 2020 - the economic impact of the COVID crisis has taken a significant toll on the economy - budget deficit is projected to reach 6.7% (up from 3.2%) at the end of the year, with a prognosis

¹⁶ The Ministry of Public Finance will subsidize 100% of the interest for the loans to be guaranteed, both for micro-enterprises and for small and medium enterprises. The interest will be subsidized from the moment of granting the loan until March 31, 2021.

¹⁷ State owned medicine producer.

for a GDP reduction of 1.9% for 2020. It is hard to make accurate predictions on the real impact of the crisis, current economic data, regarding the first two months (March, April, 2020) is mixed: after the first 3 months of the year, the consolidated general budget recorded a deficit of 18.06 billion lei (1.67% of GDP), with revenues decreasing by 3.3% compared to the registered level in the same period of 2019. The decrease in revenues in March was strong, 25% compared to March 2019, an evolution due also to the fiscal facilities granted by the government to support the economy. However, tax collection in April was more positive than expected, with revenues being higher compared to last year, according to the Minister of Finance.

The role of civil society in generating financial resources for managing the Corona-19 virus crisis, has been tremendous especially in the early days of the pandemic. When in early March it was obvious that medical supplies were missing, NGOs, grassroots initiatives and companies initiated useful campaigns to raise money and purchase medical supplies and equipment. Hundreds of smaller or larger initiatives have sprung up across the country in this context. From volunteers who offered to shop for the most vulnerable to restaurants that provide free lunches to doctors or to students who printed supplies for doctors and nurses with 3D printers. They were joined by people who donated money to campaigns started by NGOs and associations, but also by businessmen who teamed up with local authorities and bought equipment that the state did not have. Even more impressive, in some cities, civil society leadership managed to unite all these efforts under one big umbrella campaign and to coordinate small efforts in a way that nothing got wasted or misused. Such a program was initiated in the city of Cluj-Napoca under the name of One Single Cluj. Vlad Voiculescu, a former minister of health, estimated that at national level, by mid-April this effort amounted to 20 million Euros.

In terms of inefficient use of public resources during the pandemic, public procurement of medical supplies and equipment has been a special case. Given the severe lack of medical supplies in early March at the beginning of the crisis, the government decided, through the Ordinance setting up the state of emergency that regular norms regarding public procurement will not apply. Instead, special procedures including direct procurement (over the threshold from the national legislation) and negotiation without prior publication will be implemented. Also, it established a public company as a centralized purchasing body for medical supplies during the pandemic. All these provisions have resulted in purchases through intermediaries at higher prices than the ones paid by other EU countries. Right now, hospitals refuse to buy from the centralized entity due to the low quality of the goods purchased. Critics argue that the government should not have suspended EU rules on public procurement because the EU procedures put in place for procurement during the Corona crisis allowed for enough flexibility.

Moreover, as the critical supply of goods has been ensured, a return to normal procedures should have already taken place.

Lessons Learned so Far

The COVID-19 pandemic is probably the biggest challenge governments across the world have faced after WW2 mostly because of its novelty and high level of complexity, with spillover effects into the social and economic dimensions. Romania's reaction to the crisis although quite swift with above average results taking into consideration EU averages concerning deaths/1mil. Inhabitants and number of cases has brought into light a series of weaknesses of the NEMS. Some of them are detailed below.

1. The highly centralized nature of the system implies a difficult communication and coordination process - this is highlighted through a few "bad practice" cases where local authorities ignored/ did not respect in place regulation (cases like Suceava or Bucharest) and central authorities were quite slow to react. Additional negative factors are a low managerial capacity of different state institutions and a certain legalistic culture with a specific top down approach (Hințea & Țiclău, 2017), which led to significant errors in decision- making.
2. The main focus of decisions was medical or public health related, without a clear evaluation of the impact on other elements (economic, social, and educational). This has created a public debate concerning those involved in the decisional process (mainly the members of the TSG and CNSSU) where other points of view, besides a narrow epidemiological approach ("stopping the spread of the virus"), seem to be under represented. A crisis of such magnitude puts public decision-making systems to the test and highlights the importance of professional management in the public sector. In the absence of professional management systems, the weakest link in the chain leads to crises that affect the entire administrative apparatus.
3. A major challenge was maintaining a constant flow of information towards the public and respecting principles of transparency and accountability while still managing the public health hazard the crisis posed and using all legal instruments available (especially installing the state of emergency). The highly centralized nature of the system meant that any error made at local level would then escalate in national figures which in turn prompted the authorities to limit the amount of information offered to the public. An open system approach where data is available to all concerned parties would increase significantly the flexibility and learning capacity of the system - in a situation with such high levels of unpredictability this is an essential factor in making the system as adaptable as possible.

4. Although the outbreak hit Romania with about a 2 weeks delay compared to the EU initial epicentre (Italy and then Spain), authorities were caught off guard (as where most countries both in Europe and throughout the world) on what would be the proper measures to fight the pandemic but also concerning medical equipment and supplies for medical personnel. Coupled with the problems signalled above this led to major issues (high infection rates) in some areas.
5. Central authorities acted very early in limiting the spread and imposing social distancing measures (closure of schools even before an international pandemic was declared, limiting flights and immediate border control) which was key in limiting the number of cases and not overwhelming the medical system, avoiding a situation similar to Italy or Spain. This indicates a high level of responsiveness concerning processing information from outside and integrating this into the decisional process (with a 3.3-day average between decisions).
6. This crisis must be used as a catalyst in terms of lessons learned in public decision-making, public communication, economic and social effects, etc. to build an efficient crisis response system at the local and central government level that can deal with different types of disasters, with high levels of uncertainty - the case of the current crisis. It should also prompt authorities to revise the system as to offer more flexibility to the local level, as conditions and effects presented different types of challenges and responses, with a centralized system having major issues in integrating this.
7. Unfortunately, the first reaction at the international level seemed to be an approach in which each state tried to solve its own problems, without taking into account the bigger picture (systemic perspective). This lack of cooperation and partnership is the exact opposite of what should happen internationally or nationally and can have long lasting effects on trust levels towards the viability of the EU system.

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Slovak Strategies to Combat COVID-19 Pandemic

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Abstract

The goal of this chapter is to attempt to explain why Slovakia, at least from a short-term perspective, has been among the more successful countries in fighting COVID-19 and its consequences. The very specific issues for Slovakia are connected with the fact that the national elections were held on 29 February 2020; opposition parties won these elections and created new government exactly in the “middle” of the pandemic crisis. Based on facts, one can argue that the effectiveness of the Slovak government, as of mid-April, in limiting the spread of COVID-19 infections has been very high – from the point of COVID-19 mortality and morbidity, Slovakia is ranked as the most successful European country to date. However, the effectiveness of the Slovak government in protecting the economy has been rather limited.

Keywords

Slovakia, COVID-19, anti-epidemic measures, change of governments, economic crisis

Highlights

This chapter points out that effective government anti-epidemic action can limit the COVID-19 spread and that Slovak approaches may serve as important benchmark in this regard.

The text also shows potential critical trade-offs between strict anti-epidemic measures and the economic situation of the country and important challenge for future academic research in this area.

Introduction

With approximately 5.5 million inhabitants, Slovakia is one of the smaller members of the European Union. The territorial structure of the country is highly fragmented, with almost 3000 municipalities and only one city (the capital, Bratislava) with more than 100,000 inhabitants. The economy is fully open, dependent on import and export, especially with other EU countries (about 85% of its export is within the EU). With these characteristics, the potential socioeconomic impact of COVID-19 on Slovakia could be devastating. However, the situation is relatively positive at the moment. This text is an attempt to explain why Slovakia, at least from a short-term perspective, has been among the more successful countries in fighting COVID-19 and its consequences, and also to highlight some mid-term economic challenges. The preparation of this text was supported by the Czech Grant Agency project 19-06020S.

Core Implementation Challenges of COVID-19 Related to the Slovak Republic

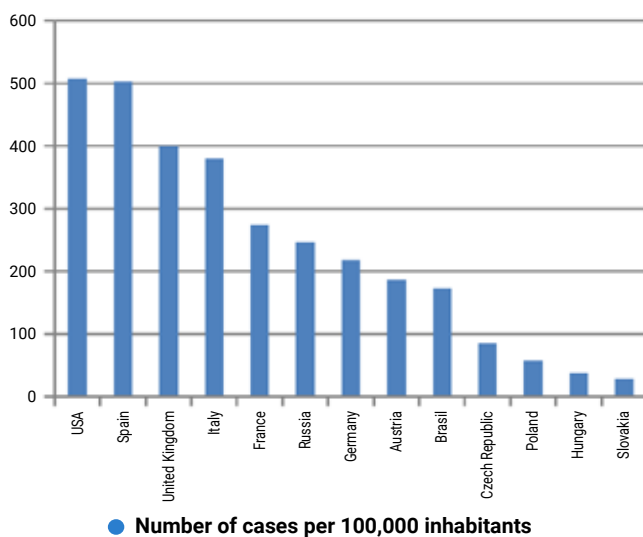
Slovak politicians, public servants, private managers, and citizens have had to cope with several core problems in developing an effective response to the COVID-19 pandemic. The very specific political situation for Slovakia is connected with the fact that the national elections were held on 29 February 2020; opposition parties won these elections. The change of the government overlapped with the initial outbreak days of the pandemic in the country. The first COVID-19 case in Slovakia was identified on 6 March 2020, and the new coalition government was appointed by the President on 21 March 2020.

In this situation, the first steps to fight the pandemic were taken by Prime Minister Pellegrini and his (dominantly left-wing) government, but the continuity was the responsibility of Prime Minister Matovic and his (mixed political orientation) government of four 'newcomer' political parties: OLaNO, Sme Rodina, SAS, and Za ľudí. The 'takeover' did work somewhat – during the last days of the Pellegrini government, the designated Prime Minister Matovic was invited to participate in all the meetings of the Security Council of the Slovak Republic (later for all the meetings of the Crisis Crew) – but it was not perfect, as could be expected. Even in the times of a real pandemic crisis, politics were not set aside, only slightly downsized. The newly designated Prime Minister tends to blame the previous government for late and ineffective actions, although in many cases they were not at fault. A very good example of this is the criticism that the Pellegrini government ordered only home quarantines, rather than centralised and state-controlled quarantines, for all people returning to Slovakia from other countries. A centralised quarantine system came into effect on 6 April 2020; this was two weeks after

the appointment of the new government and thus it is clearly not the fault of the previous government. Current opposition (especially the former leader Fico, who is still the chair of the main opposition party SMER) certainly tried to score political points by attacking some necessary contra-pandemic measures during parliamentary discussions.

For Slovakia, as for any other country, the two other core challenges connected with the pandemic are the health and economic impacts of COVID-19 on the nation. In terms of health, Slovakia is doing very well. By mid-April, Slovakia had registered only 977 cases (203 cases in hospitals) and only 8 deaths; the number of recovered patients is 167. These figures are comparatively very good (Figure 1 shows that this relative perfect position of Slovakia did not change one month later). It is impossible to predict future trends, as the most vulnerable population groups (especially about 0.5 million Roma) are still at great risk from the spread of COVID-19.

Figure 1 - Relative spread of COVID-19 infection, selected countries (25 May 2020)



Source: Author, based on Pravda (2020)

According to most experts, the positive health trends in Slovakia were achieved through very early and effective quarantine measures. However, the Council for Budgetary Responsibility (and many other experts) stated that the trade-off is the drastic impact of anti-epidemic measures on the national economy. 'Strict and country-wide quarantine measures serve as a drastic diet by hunger strike. The short-term effects are very visible, but this kind of cure cannot be used in a long-term perspective – it might lead to self-destruction' (Council for Budgetary Responsibility, 2020).

The Slovak economic ‘drop’ is enormous – most shops and service providers are closed, and many factories had to stop working – notably the core drivers of the Slovak economy, the car producers Volkswagen, Kia Motors, PSA, and Jaguar Land Rover. These four companies directly employ almost 200,000 people and indirectly employ hundreds of thousands more in satellite suppliers. By mid-April, the state had announced several measures to help the economy (see later text); however, only few EUR had yet been ‘pumped in’. There are different scenarios concerning GDP trends, but a minimum of a 10% drop in 2020 is expected.

The last challenge (and the particular catalyst of positive trends) is people. It is necessary to admit that Slovak citizens have behaved very responsibly. Except for a few specific cases, especially in marginalised groups, the public reaction to the very strict measures has been positive. The slogan ‘Stay at Home’ is promoted and accepted; face masks are used regularly. The high level of compliance with the adopted prevention measures may be the core factor in Slovakia’s success.

The National Government Experiences

No government in the world was fully prepared to cope with the COVID-19 pandemic. This is also the case in Slovakia, a country that has never had to cope with any major infection in its existence (since 1 January 1993). Like every other country, at least in Europe, Slovakia did not react immediately to the pandemic risks when the outbreaks started in China beyond having general emergency plans and resources. However, when the risks became evident, the Slovak government was one of the first to deliver swift and firm responses.

According to Law 387/2002 Z. z. on the management of the state in non-war crisis situations, the main body of crisis management in Slovakia is the government of the Slovak Republic. Another important crisis management body is the Security Council. The executive body during non-war crisis situations is the ‘Crisis Crew’, appointed by the government and following the statutes of this body (issued in 2002 and most recently amended in 2019).

The first activities connected with the possible risks of the COVID-19 pandemic, initiated in February 2020, were announced and managed by the Security Council. For example, on 14 February 2020, a system was organised at the Slovak border to identify people who were ill. On 27 February 2020, the Security Council announced the first concrete anti-pandemic measures – health status border control at all Slovak airports and selected border crossings, especially at the border with Austria. It also initiated purchases of necessary protective aids. The most important decision of this meeting was the activation of the Crisis Crew, located at the Ministry of Health.

The first meeting of the Crisis Crew during the COVID-19 pandemic was held on 6 March 2020, the same day that the first COVID-19 case was detected in Slovakia. The first comprehensive sets of anti-pandemic measures were announced by the Crisis Crew after its meetings on 9 March and 12 March 2020. These measures followed successful approaches from China and other Asian countries and were aimed at trying to limit the spread of the virus as much as possible. In late March and early April, the new Matovic government decided about stricter anti-pandemic measures and started to address the impact of the pandemic on the national economy. The list of the main restrictive measures according to sectors follows.

Emergency situation – a restricted emergency situation was announced on 11 March 2020; this was very early compared to most other European countries. The scale of the emergency was restricted to the healthcare sector and social care establishments for the elderly.

Regulations restricting the rights of citizens – from 25 March 2020, all citizens were required to wear protective face masks in all public spaces. The minimum distance between people was to be two meters. All citizens were advised to stay at home as much as possible and to limit any kind of mobility. Open shops were instructed to serve only people over 65 years of age between 9 am and 12 noon; age was verified using identification cards. The use of mass public transport was not recommended, and school holiday transport schedules were in force. High quality respirators were not available for sale to ordinary citizens. With the exception of listed specific groups, anyone arriving to Slovakia after 12 March 2020 from abroad was advised to stay in home quarantine for 14 days; after 6 April 2020, they were advised to stay in compulsory state-organised quarantine for testing and to stay in home quarantine for 14 days after negative testing. Travelling abroad was not recommended; in reality, travel abroad was impossible in the later phase, as all neighbouring countries also closed their borders, with the Austrian border closing last, in early April. A law making it possible to track the location of all mobile phones was passed. A curfew was put in place during the Easter holidays, with limited exemptions such as shopping, travelling to work, health purposes, and individual recreation in the surrounding forests and countryside.

Shops and services – from 16 March, almost all retail shops and services were closed, with exemptions especially for food stores and drugstores. In open shops, only one person was allowed for every 25 sqm of sales space. All shops were required to provide disinfection means or gloves at the entrance. A distance of a minimum of two meters was to be respected, including in the checkout area. Almost all shops and services, with very few exemptions, such as petrol pumps, were closed on Sunday.

Education, culture, and sports – all sport facilities were closed from 13 March 2020. The organisation of sports, social, and cultural events was prohibited from 9 March 2020. All schools and preschool facilities were closed from 12 March 2020 (leisure educational facilities were closed on 3 March).

Health care – all visits to hospitals were prohibited. Planned operations and other non-urgent treatments were postponed. Body temperature was to be measured upon entering health facilities. Selected hospitals were expected to construct drive-through points to test people for COVID-19 in cars. Specialised hospitals to treat COVID-19 were established in all regions.

Church – all public worship was prohibited (valid for all churches in Slovakia); internet or other means were to be put to use to make worship accessible to people.

Transport – all borders' crossing was closed from 12 March 2020. International public transport (trains, buses, boats) was restricted from 13 March 2020. Free railway transport for students was terminated. Domestic public transport was put on school holiday transport schedules. All public transport in operation was to be regularly disinfected.

From the beginning of April, the government began to express concern about the economic consequences of the crisis. From mid-April the set of first applications for help has been processed by the government (to cover part of the salary expenditures of employees for all closed shops and service providers and to support self-entrepreneurs with closed business and to deliver financial aid to self-entrepreneurs). Employees in quarantine and parents who must stay home with small children receive 55% of their gross salary. The deadline for tax declarations and payments is postponed. Healthcare establishments with decreased demand (like primary and specialised ambulances) are reimbursed at the level of 75% of average reimbursement. The 'kurzarbeit' system ('short-time working') should apply to larger firms. However, not much money has been "pumped-in", yet. For example, self-entrepreneurs receive in April maximum 270 EUR to compensate decreased revenues in March, however such sum just covers their minimum social contributions to the state.

Conclusions – Lessons Learned

Slovakia is performing very well during the COVID-19 pandemic in terms of health. These results have not been achieved as a result of the preparedness of the political and health care systems before the crisis started (Slovakia is ranked between the lowest performing European Union countries relative to the performance of its public administration and health care systems), and also more importantly, to the fast and comprehensive reaction of the old and new government, described above.

The positive results were achieved by a top-down approach, based on the decisions of responsible central bodies (especially the Crisis Team, consisting from of the best Slovak medical specialists on infectious diseases as core experts on health aspects of the pandemic, but also managers and other members, dealing with implementation issues) carried out via new laws and directives. Other stakeholders, especially employers, trade unions, the non-profit sector, and self-governments, have been periodically consulted on planned COVID-19 containment measures, but their voices are more or less marginal. Local and regional self-governments have been more followers than initiators; however, most of them did start to call meetings of regional and local security councils and carry out different preventive measures limiting the spread of the COVID-19 virus, including disinfections, free public transport to prevent any contact between passengers and drivers, food and drug delivery to the elderly using local capacities, etc.

On the other hand, by mid-April the Slovak government had not delivered enough in terms of protecting the economy from the impact of the crisis. As shown above, some measures to support suffering firms and employees were formally introduced in early April, but as of April 24 (when first transfers started) no actual EUR had been 'pumped in' to the economy. The fact that measures supporting and protecting the economy did not start to function is not due to a limited supply of resources. Thanks to decisions by the European Union, Slovakia should have approximately 5 billion EUR available to implement immediate measures. However, real actions were initiated too slowly because of a lack of consensus between the Prime Minister, who was focusing on the health aspects of crisis, and the ministers of finance and economy, who are expected to protect the national economy. Bureaucracy also plays a role – for example, during the first days of the support scheme for entrepreneurs, approximately 21,000 applications were submitted; almost all of them were returned for corrections of formal mistakes, as the online form was extremely complicated (Pravda, 2020). As of 25 April, there was no plan for restarting closed establishments and supporting several specific segments very significantly influenced by the crisis, such as the tourism industry (for example, travel agencies that had already purchased services from hotels and other suppliers and would not have the chance to deliver on public holidays – according to valid law, travel agencies are expected to return all pre-paid money to customers, but that is totally impossible in these circumstances).

The state has not yet started to address the inevitable financial crisis at the local self-government level. In May 2020, local and regional self-governments may go bankrupt due to significantly decreasing revenues and increased costs because of necessary anti-pandemic measures. Local self-governments are not able to collect local taxes (spring is the time when tax bills are issued to inhabitants, but because of limited postal services in the country, it is not

possible to send registered mail with the tax bills in larger cities) and their main revenue of shared taxes will fall significantly in May. The shared taxes for self-governments are usually allocated at the central level and the amount of money to transfer is calculated on the basis of the previous month's economic performance). Regional self-governments are almost entirely dependent on shared taxes, thus their situation will be very similar.

A few other issues need to be mentioned. First, the government is rather weak in communication, especially about communicating its decisions and measures. The Prime Minister or an appointed member of the Crisis Crew normally announces the daily decisions at the press conference held the day after a meeting, but the written communication is limited; this limit has been noted by the Slovak president – (Pravda, 2020). According to the Slovak legal order, any legal rule is valid only after its official publication; however, it is not easy to find what is valid online. The main message – ‘Stay at Home’ – is not sufficient to address the high levels of anxiety, stress, and fear among the public. No web page has yet reported any way to monitor and evaluate the implementation of major decisions relating to the pandemic and their impacts and results.

One may argue that the effectiveness of the Slovak government, as of mid-April, in limiting the spread of COVID-19 infections has been very high; however, the effectiveness of the Slovak government in protecting the economy has been rather limited. The unique situation in Slovakia is that the COVID-19 crisis started exactly when there was a major change in government. In reality, this political dimension did not impact on the anti-pandemic measures much. There has been significant continuity from this point of view. However, the situation allows, and possibly even motivates, the newly elected Prime Minister to try to find excuses for late or ineffective measures by blaming the previous government and its prime minister. This approach is not very positive in difficult times and is not helpful to anybody.

Only the future will show whether the eminent focus on anti-pandemic measures was a good choice for Slovakia or whether the economy should have been better protected. The fact that the ‘exit strategy’ from the pandemic had not yet been effectively discussed by mid-April should be considered a deficiency.

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Managing an Unexpected Crisis: Context, Actions, Stakeholders and Some Thoughts on the Response Against the Sanitary Crisis in Spain

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Abstract

In order to provide an overview of the response to the health crisis in Spain, the chapter describes the context in which the pandemic has occurred, the legal instruments related to the declaration of the state of alarm and the main public policy measures adopted, taking into account the significant degree of territorial decentralisation in the country. It reflects information on the agents involved, the systems of governance, the instruments to inform citizens, and the plans for progressive de-escalation to return to normal, as well as parliamentary work to design a social and economic reconstruction plan. Future reflections or early lessons learned focus on the challenges facing Spain, which will require, among others, strengthening the social protection networks, increasing resources and funding for science and research, and to improve national and international cooperation: more public resources and institutional capacities in order not to leave anyone behind.

Keywords

Cooperation, state of alarm, SARS-CoV-2 pandemic, public policies, open government

Highlights

The crisis has highlighted the need to take advantage of analysis of complex data to assist evidence-based decision-making, promoting an open dialogue between experts and the politicians.

Efforts to improve coordination between different public administrations within each country, intergovernmental cooperation and solidarity will be essential to overcome the crisis.

Introduction

The Congress of Deputies has authorised the Spanish Government to extend, for the sixth and last time, the “state of alarm” declared on March 14 for the management of the health crisis caused by SARS-CoV-2. The state of alarm will be in force until June 21.

During this emergency situation, many regulatory provisions and public policy measures have been adopted to manage the health situation and to alleviate its social, economic and cultural consequences. Likewise, institutional mechanisms for coordination between the different agents involved have been set up. Plans have also been launched for a gradual return to normality and for economic and social reconstruction after the crisis. Before addressing all those issues, a preliminary assessment of the context in which the pandemic has occurred will be made.

Institutional Context

On 10 November 2019, the general elections were held again in Spain. The new government appointed after the election was constituted at the beginning of January 2020. Therefore, a first fact is that the crisis arises less than two months after the constitution of a new government, in the middle of a process of changes in the ministerial structures and teams. A coalition government, an unprecedented formula in the recent history of Spanish democracy, and in an atmosphere of high tension and political polarisation, aggravated by the entry into parliament of the far right, and against the backdrop of territorial tension due to the situation in Catalonia.

The health crisis resulted in annual budgets waiting for approval, after several years of successively extended budgets. The economic situation is not favourable either, as the consequences of the 2008-2012 crisis are still being felt, with important impact in terms of institutional weakness and social inequality.

On the other hand, Spain has a system of distribution of competences and a highly decentralised administration at territorial level. The seventeen Autonomous Communities (regions) have broad political autonomy. Healthcare responsibilities (primary care and hospital management) are in the hands of the Autonomous Communities.

State of Alarm

The state of alarm is provided for in Article 116 of the Constitution and is regulated in all its details in Organic Law 4/1981 of 1 June. It shall be declared by the Government by means of a decree agreed upon in the Council of

Ministers for a maximum period of fifteen days, reporting to the Congress of Deputies, which shall meet immediately for this purpose and without whose authorisation this period cannot be extended. Under no circumstances may rights be suspended, but only measures that condition their exercise may be adopted (Piñar Mañas, 2020).

With the declaration of the current state of alarm, powers to combat the coronavirus have been centralized in the central government, especially in health and police matters, the freedom of movement of persons has been limited, and administrative deadlines have been suspended throughout the public sector (central, regional and local). It is important to note that in a vast majority of European countries emergency and derogation measures were adopted around the same dates (Barcelona Centre for International Affairs [CIDOB], 2020).

Following the declaration of the state of alarm, other “emergency measures” have been taken in Spain, such as the suspension of procedural deadlines; authorisation for agents of the authority to carry out checks on persons, goods, vehicles, premises and establishments, etc. (Álvarez García et al., 2020).

The exceptional nature of the state of alarm has been accompanied by a resurgence of legal analyses of its consequences by experts in the field. It will be interesting to follow the development of these debates and their future impact on constitutional law.

Throughout these weeks, debates have arisen about the right to data protection in the state of alarm. Even in these exceptional circumstances, those who process personal data must ensure that they are protected. Personal data protection regulations apply in full to the current situation because the same initiative contains safeguards to allow processing of personal data in health emergencies. In other words, data protection must not be used to hinder measures to combat the epidemic, a position that has been confirmed by the data protection authorities, confirming that security and privacy are not contradictory, but complementary (Piñar Mañas, 2020).

Crisis Management. Main Actors Involved

The first health and other preventive measures were adopted by the authorities of the Autonomous Communities. In the days prior to the declaration of the state of alarm, the Autonomous Communities and local entities, governed by political parties from across the ideological spectrum, carried the weight of the fight against the pandemic, using their own regulations and powers to combat the pandemic, approving in some cases the lockdown, closure of schools and university centres, or the closure of leisure spaces.

We have already mentioned that competences in health matters correspond mainly to the Autonomous Communities. Together with the Ministry of Health, they make up the National Health System. The maximum responsibility in the coordination and management of this system is held by the Interterritorial Health Council, which groups together the Ministry of Health and the Autonomous Communities.

This Ministry also plays an important role through the Health Alert and Emergency Coordination Centre (CCAES).

As of 14 March 2020, a single command was established for the management of the crisis with the Minister of Health at the helm, a single directorate in terms of general criteria and guidelines, compatible with the direct management of resources by the Autonomous Communities. Nevertheless, the Autonomous Communities have continued to exercise their functions and have never lost their health management competencies, playing a fundamental role in tackling the crisis.

The Ministry of Health has become the leading centre in the fight against the crisis. Throughout these months, coordination between the central government and the Autonomous Communities has been maintained and promoted, although points of improvement in governance have been detected. The Ministry has had to assume a special responsibility for leadership and centralization, after many years with scarce means and resources. Some are calling (Álvarez García et al., 2020) for this Ministry to be given more powers and means to deal with the public health crises in the future, or for a government department or agency to be created with the capacity to combat all kinds of major disasters, a body that could take the form of an independent administrative authority.

In addition, the Government has had a Technical Management Committee that has met on a daily basis and has also appeared daily before the media to report on the main developments and management of the crisis.

Besides, a Scientific Committee with specialists was set up on 21 March 2020 and has advised the Government during the crisis.

As far as the Public Administrations are concerned, following Ramió (2020), one can say that the health crisis is a demanding stress test on their institutional quality. The crisis has highlighted the importance of public institutions and public employees. For the management of the crisis, the administration has relied on its main asset: public employees. The people working in the front line, those most visible to the public, have stood out: health personnel, essential services, social services, civil protection and state security forces. But many other public employees have been fully committed and working in

this crisis management with little recognition and little visibility. With their administrative work they have made it possible to carry out all the contracts, procedures, management, and payment of services, aid and benefits. One can also mention the public employees in the education sector, who have guaranteed the continuity of the teaching programme.

But all these tasks have been carried out without prior planning, without adequate organisation and means. Nor has there been sufficient flexibility to quickly reassign troops from areas of public employment where it has not been possible to guarantee remote work or front-line work, and to refer them to other areas or emergency tasks, among several dysfunctions observed in the process, from which one must learn, not to mention the experience of teleworking, implemented abruptly.

Teleworking has proved to be an essential resource but it requires adequate regulation, resources and guarantees in order to be sustainable in the future and to support a more decisive advance in the process of digital transformation of Spanish Public Administrations.

Crisis Management. Main Measures Adopted

To compare with the measures taken in other countries, it is useful to consult the constantly updated repository created by the OECD, which includes a “Country Policy Tracker” (OECD, 2020), compiling the measures taken to contain the spread of the coronavirus, and how they are helping people, small businesses and the economy in general to overcome the crisis. However, a summary of the main measures adopted in Spain to tackle the current health crisis will now be attempted.

However, a summary of the main measures adopted in Spain to tackle the current health crisis will now be attempted.

Firstly, in addition to the closing borders, one should mention the general lockdown of the population to their homes and the cessation of non-essential economic activities. In spite of this, in the first phase, a large part of the construction industry and other factories continued their activity. In order to further reduce the mobility of the population and to stop the activity of these non-essential industries, the “recoverable paid leave” was approved on 29 March. In this way, companies were forced to maintain the salary of their employees while they were at home for two weeks. The lost days are to be made up later.

Secondly, in order to guarantee the provision of public services, organizational measures were approved: flexibility in working hours, priority for telephone and electronic assistance in public services, and the authorization of teleworking modalities for public employees. Likewise, the possibility of

collaboration by public employees in areas and activities other than those of their jobs has been regulated.

Thirdly, with the purpose of dealing with the crisis, the central government and the governments of the Autonomous Communities have had to acquire the health resources to provide hospitals, health centres and workers in essential services with the necessary materials to carry out their activities. The market situation and strong international competition have led to procurement problems, and there has been considerable expenditure and administrative overload in managing this exceptional situation. In fact, it has been necessary to authorise temporary staff recruitment to strengthen the provision of public services in essential areas.

A fourth block of measures relates to the economic sphere. In this area, several packages of measures have been approved to alleviate the negative consequences of the cessation of economic activity caused by the crisis, in particular to prevent the destruction of jobs and the factories: credit lines to guarantee the liquidity of small and medium-sized enterprises and self-employed workers, social protection measures such as the moratorium on mortgage payments by self-employed workers and workers affected by the crisis, etc. These measures also include speeding up and making more flexible temporary redundancy programmes or reducing the payment of social security contributions to companies that maintain their workforce.

Other measures or regulatory provisions have been designed to alleviate the consequences of the crisis for vulnerable sectors of the population or to cater for particularly affected economic sectors.

Informing the Public About the Measures Taken

General information is essential for monitoring the incidence data of the pandemic from a strictly health-related point of view. In this regard, the information provided by the Ministry of Health aimed at health professionals, citizens and the media, in relation to health and public health recommendations, is particularly noteworthy (Ministerio de Sanidad, 2020a).

In addition, many public bodies at all levels of government (central, regional and local) collect and disseminate up-to-date information, arranged chronologically or by subject, in order to provide a public service, informing citizens of the regulatory provisions and measures adopted.

Two sources of information that come from the central government: the Transparency Portal and the General Access Point are highlighted. In the Transparency Portal of the Central State Administration, which depends on the Ministry of Territorial Policy and Public Function, due to the current health crisis,

a page has been set up with information on the measures related to the pandemic published by the different ministries (Portal de la transparencia, 2020).

The Spanish General Access Point (PAG) is a single point of access for citizens to public administrations. The PAG has also set up a page dedicated to information on measures related to the health crisis (Punto de Acceso General, 2020).

This task in addition to the work carried out by the media and also by organized civil society entities, brings public information closer to citizens in an accessible format, in easy language or by means of simple infographics. For example, the work of the CIVIO Foundation (2020) should be highlighted, which also offers a guide to the aids available to citizens in this situation.

Plan for De-escalation of the Extraordinary Measures Taken to Deal with the Pandemic

Once of the most critical phases of the expansion of the pandemic has been overcome, in order to facilitate a gradual recovery of social and economic activity, the Government has defined a “Plan for the transition to a new normality”, approved on 28 April 2020, based on a report by the CCAES and on the proposals sent by the regional governments, and guided by the European Commission’s road map and the WHO’s guidelines. The Plan will be extended until the end of June (Ministerio de Sanidad, 2020b).

The opinions and proposals of experts in the health, scientific, social and business fields, as well as those responsible for administrations, social entities and social agents, have also been sought. The objective of the Plan is to achieve a gradual recovery of daily life and economic activity, minimizing the risk that the epidemic represents for the health of the population, and preventing the capacities of the National Health System from being overwhelmed.

The Minister of Health, the delegated competent authority, through a process in which the Autonomous Communities will participate, in accordance with the principles of cooperation and collaboration, will specify the measures to be applied in the de-escalation process. The measures will be determined according to the evolution of various health, epidemiological, social, economic and mobility indicators.

These measures may be implemented in specific territorial areas, either the province, the island or the territorial unit concerned in the process. It cannot be understood that a gradual return to normality must wait until the total elimination of the health risk, as this scenario will only come about when a vaccine, effective medical treatment or the necessary immunity of the population is available. It is therefore expected that, during the state of alert, a gradual lifting of containment measures will be initiated.

A case-by-case negotiation is carried out with the Autonomous Communities, based on the principle of prudence, and avoiding possible setbacks. This is a delicate balance between health safety, minimization of economic damage and equity, so as not to cause grievances between territories.

Parliamentary Commission for the Social and Economic Reconstruction of Spain after COVID-19

On May 6, 2020, a Commission for the Social and Economic Reconstruction of Spain after COVID-19 was established in the Congress of Deputies. The Commission will receive proposals, hold debates and draw up conclusions on four major aspects: strengthening health and public health; reviving the economy and modernising the production model; strengthening social protection and care systems and improving the tax system; and Spain's position vis-à-vis the European Union.

Their work will last for two months, which may be extended. At the end of its sessions, it will issue an opinion which will be submitted to the plenary session of Congress of Deputies for debate and approval, and which will contain resolutions and proposals on the subject of its work. The first meeting of the Commission took place on 13 May and its work plan was approved (Congreso de los Diputados, 2020).

Final comments

The observation of what has happened in Spain and in the rest of the world, to a greater or lesser extent and with a different emphasis according to each specific situation, allows one to state that sufficient temporal perspective to extract valid and safe lessons or conclusions is lacking. Nor does one have unequivocal answers as to how best to deal with this pandemic and its consequences, since not enough time has yet passed to assess the real effectiveness of the measures adopted.

No one has complete and accurate knowledge of what has happened or what is to come. Even the gradual "return to normal" or "de-escalation" processes that are being implemented are subject to a process of trial and error. More than lessons, there remain open some reflections and questions. It is urgent to promote debate on these reflections and questions in order to mitigate as much as possible the consequences of the crisis.

The crisis has highlighted the need to provide resources and funding for science and research, as well as to take advantage of the analysis of complex data to assist informed and evidence-based decision-making, promoting an open dialogue between experts and the politicians who take (and must take) the decisions.

Effective health information systems are needed as well as to improve the common definition of measurement indicators to ensure their validity, to allow reliable national and international comparisons, and to guarantee the correct design of public policy measures and decisions.

Well-funded health systems are needed, flexible and able to respond quickly to unforeseen sanitary crises.

Analyses on the differential impact of the disease and its consequences are needed on society according to different socio-demographic variables, in order to adopt measures accordingly.

Issues such as the fight against inequality and the strengthening of social protection networks and care for vulnerable people will be key issues in the coming years, with the aim of “leaving no one behind”.

So will efforts to improve coordination between different public administrations within each country, and mechanisms for cooperation and global governance. Intergovernmental cooperation and solidarity will be essential to overcome the crisis. Coordination with Europe is essential to minimise economic and social damages.

Public institutions are going to be affected if they are not able to adapt in times of crisis. In order to resituate them, politics must be strengthened in its leadership capacity at each and every level of government, and institutions must have professional managers.

There is also an opportunity to deepen public-private collaboration, and to promote open government, citizen and social organizations involvement in the design and co-creation of public services, thus strengthening confidence in the public and the quality of the country’s democracy.

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Turkey's COVID-19 Pandemic Response from a Public Administration Perspective

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Abstract

This chapter summarizes Turkey's COVID-19 Pandemic response from a public administration perspective. To this end, after the introduction of Turkey's demographic and institutional profile together with territorial organization, an overview of the status and preparedness of the health care system before the COVID-19 Pandemic Crisis is presented. Having presented the systematic review of central and local government responses to the Pandemic, the chapter concludes with the public administration lessons derived from the Turkish experience, such as the advantages of a centralized and thus fast decision-making system in a unitary structure, a health system with already high capacity, a well-established decision-making structure backed up by a scientific committee, a sound communication strategy, and competition between political parties at different spheres of the government which worked in favour of finding innovative ways in dealing with the Pandemic.

Keywords

Turkey, COVID-19 pandemic, scientific committee, health-care capacity, intergovernmental relations

Highlights

Turkey has been relatively successful in dealing with the first wave of the COVID-19 Pandemic due to its robust, relatively well-prepared health-care system that had a relatively stable intensive-care unit capacity, even before the Pandemic.

The advantages of competition between political parties at different spheres of the government outweighed its disadvantages and worked in favor of finding innovative ways to deal with the Pandemic.

Introduction

Turkey, which had a long tradition of a parliamentary system, has recently adopted a presidential system of government since 2018. The new system is based on a highly centralized presidential executive body with increased central authorities in nearly all subjects (Esen & Gumuscu, 2018). The country is divided into 81 provinces, 30 of which were declared metropolitan municipalities in 2012 with authorities spanning all provincial territories. Hence, Turkey is a country in transition concerning governmental structures at both national and local government levels (Çiner, 2018).

Although this transition makes it a sophisticated task to ascertain the level of urbanization fully, it is generally accepted now that approximately more than 75% of the whole population lives in urban areas today. Regarding local government units, there are 30 metropolitan municipalities, İstanbul (16 million), Ankara (6 million), and İzmir (4.5 million) being the most significant three. The 30 metropolitan municipalities in total account for most of the economic activity, 75% of the population, and almost 50% of the territory. İstanbul is the largest metropolitan region of the country, with nearly 20% of the population and 40% of the GDP, larger than some small countries (Celebioglu, 2019).

The Status and Preparedness of the Health Care System Before the COVID-19 Pandemic Crisis

Turkey already had a robust, relatively well-prepared health-care system that had a relatively stable intensive-care unit capacity before the Pandemic. Turkish Statistical Institute data show that as of 2018, there were 153,128 physicians, 190,499 nurses, and 177,409 health-care support workers in Turkey. There were 38 thousand intensive care beds, almost half of which are located in private hospitals. 63% of these were adult intensive care beds. These numbers emphasize a comparative advantage in favour of the Turkish Health Care System, which came as a result of two decades of restructuring and renovation. Although long-lasting health-care reform has always been a controversial issue in the Turkish case, increased capacity seemed to be holding well during the COVID-19 Pandemic.

Previously, Turkey's responses to former illnesses such as the avian flu and influenza outbreaks are also based on systematic precautions and found their reflection in the government's policy documents. Therefore, regarding preparedness, a comprehensive strategy document entitled "National Influenza Pandemic Plan" was prepared in 2019, before the Pandemic hit the world. It has been rapidly put into effect as it is used as a template, after some modifications.

Additionally, the construction of several new city hospitals has already been underway in many provinces for a few years before the Pandemic. Some were already in operation. This policy created some excess capacity in terms of hospital buildings because there was a chance to re-utilize some abandoned old hospitals as well as the new ones. Still, early in the process, on 20 March, all hospitals in Turkey were declared pandemic hospitals. Nevertheless, the government also decided to build two new pandemic hospitals, and constructions started.

The health-care system proved resilient against the crisis created by the spreading illness. Lockdown and home quarantine measures, together with contact tracing efforts, helped contain the number of patients to a level that has not overwhelmed the capacity of the hospitals. Besides, since the government covered all the necessary treatment costs as a result of a general free health-care plan, it was possible to assure public trust about the capacity of the hospitals and follow a different treatment plan than other countries such as applying experimental use of some medicine in earlier stages of the illness, thus reducing the number of casualties. The government also made clear that citizens will not be paying for all the COVID-19 testing and treatment, necessary and separate government funds are mobilized for these types of measures.

Demographically, Turkey is also relatively lucky, as one of the most critical factors affecting the outcome in the fight against the epidemic is the population structure of the country in question. Since 2019, persons over the age of 65 constitute only 9% of the total population of Turkey (United Nations, Department of Economic and Social Affairs, Population Division [UN], 2019). In contrast, this number is much higher in some other countries that suffered heavy losses in the outbreak, such as Italy (23%) Germany (21%), France (20%) and the UK (18%) (The Scientific and Technological Research Council of Turkey, 2020). Moreover, a significant portion of the +65 population still resides in low-density rural areas, and the majority of those living in urban areas do not reside in elderly care homes, which are also essential factors in controlling the number of casualties during the Pandemic.

Governmental Measures and Public Policies

At the national/central government level, the first COVID-19 case was identified on 10 March 2020. By that time, the authorities had the chance to observe and analyse the responses of countries affected by COVID-19 earlier, such as China, Italy, and Iran. The government, armed with the advice of a scientific committee, began to act fast and decisively on taking specific measures. Starting from 18 March, the Minister of Health began to deliver daily briefings on television and social media platforms.

On 12 March 2020, it has been announced that education at all levels is suspended for one week, starting from 16 March. Distance education systems were put in place via TV programs and online platforms. This suspension was then gradually extended until 31 May. Turkish Higher Education Council, the regulatory body for universities, also took measures to transfer higher education to distance-learning platforms, and university campuses were locked down. It was also announced on 16 March by the Ministry of Interior that the activities of many establishments, such as cafeterias, restaurants, cinemas, theatres, sports centres, coiffeurs (hairdressers), and barber shops, etc. will be temporarily halted. On 22 March, a flexible home-office working system was introduced for public sector employees. Moreover, the establishment of “provincial pandemic boards” were declared in 81 provinces of Turkey, with all the local decision-makers at the provincial level, including local representatives of relevant ministries and local government officials.

Beginning from 1 February, Turkish citizens in other countries, including thousands of pilgrims from Saudi Arabia, were flown back to the country and quarantined for 14 days. Older people and people with chronic diseases were subjected to lock-down (21 March). Later, people under the age of 20 were also subjected to curfew (3 April), as examples from other countries such as Italy and Spain clearly showed that children and teenagers spread the virus to their parents and grandparents without showing severe symptoms of the disease. There have been no lockdowns for the general population as yet. However, the majority of the populace living in 30 metropolitan municipalities were placed under lock-down beginning on 3 April, mostly just for the weekends and official holidays. On 3 April, wearing masks was made mandatory in crowded places and public transportation.

The land borders with the neighbouring countries were closed reasonably early. Borders with Iran were closed as early as 24 February. Other land borders were closed between March 15 and 18. The air travel was first incrementally restricted and then completely halted on 3 April. Entries to and departures from 30 metropolitan municipalities were limited again on 3 April, essential goods and services being exceptions. The municipalities and other government agencies provided daily logistical services and the needs of the citizens.

The administrators in Turkey have been working to achieve both mitigation and containment, in their plight to strike a balance between minimizing infection and deaths, as well as keeping the economic wheels turning. To reduce the adverse economic effects of the Pandemic on the economy and citizens, a financial support package of 100 Billion Turkish Liras (approximately 13.5 billion Euros), named “Economic Stability Shield Package” was announced on 18 March and enlarged to 240 billion Turkish Liras (32 billion Euros) in consecutive stages. It included economic support measures for many segments

of the society such as employers, employees, small and middle-sized firms, tradespeople, and retirees (Sakarya University Centre for Social and Economic Research, 2020). Yet, the size and scope of this package were criticized compared to the policies and support in other developed and developing countries facing the same crisis. Lastly, the Turkish Ministry of Interior provided systematic help o in terms of the daily routine and urgent needs of senior citizens (+65) and people with chronic diseases who were not allowed to go outside as part of the pandemic precautions. Based on a call centre, voluntary members of the police force, disaster intervention departments, and other civil servants were organized under the name of “*Vefa*¹ Social Support Groups,” and hundreds of thousands of citizens were served via this channel.

At the local government level, the COVID-19 Pandemic caught Turkey in the middle of turbulence in terms of local governments. First of all, the local government system in Turkey is separated into two types of municipal arrangements of the urban areas, including provinces with metropolitan municipalities and provinces without one. This separation was brought in 2012, and 30 metropolitan municipalities have already been transformed to provide the necessary institutional capacity to provide services to urban and rural areas alike within provincial boundaries. Amidst this alteration, the 2019 local government elections added another political dimension to this complicated situation. Opposition parties won elections in 11 of the prominent metropolitan regions, including the three largest ones, Istanbul, Ankara, and Izmir. As a result, together with the introduction of further centralization through the presidential system, there emerged a growing tension between opposition municipalities and the central government, which caused intriguing results in terms of local governments in Turkey.

At the beginning of the Pandemic in Turkey, The Ministry of Environment and Urbanism announced a circular for the local governments about details of measures of disinfection in public areas, transportation hubs and lines and providing for wide-spread dissemination of the necessary actions to be taken by the general public that has to be implemented by the municipalities (The Turkish Ministry of Environment and Urbanism, 2020). Later, further circulars were sent out about the infrastructure and services, postponement of the rents

¹ The Turkish term ‘vefa’ denotes a social bond between two human beings often surpassing the usual official social contracts such as marriage and kinship. Any two persons who shared something or spend some time together might be expected to honor this by showing behaviors of “vefa”, especially for the elderly and those in need of help. In that sense it is different from the words in English such as fidelity and loyalty and mostly seen as a virtue in the Turkish society. Just after the declaration of lockdown for elderly people, the precaution is misunderstood as if the old people are the source of the disease and some incidents of discrimination, mocking of and even insults against old people appeared in the social media. Therefore, the Ministry consciously selected the word ‘vefa’ to remind the public to behave in accordance with respect and indebtedness to the elderly.

and debts related to municipal enterprises. Since, there is a clear separation of responsibilities between central and local governments in Turkey related to health services, the general attitude of the government towards local governments was to advise them about sustaining services and providing general hygiene.

In general, at first, municipalities focused on general disinfection measures all over the country. There were scenes of municipal workers in the media, washing main boulevards and squares of the cities with liquid disinfectants, which was later interpreted as a futile and even dangerous effort to show that the issue is under control. Municipalities put hand disinfectants in nearly all public areas and transportation. Yet, after some time passed, especially the more the demands of the impoverished sections of the urban areas started to increase pressures on municipalities in terms of income loss, daily sustenance, and all other issues related to recessing economic activities. In terms of home lockdowns, the more the municipalities' actions started to change in the settlements where the ruling political party, i.e. AKP (Justice and Development Party) is in power, the municipalities tend to focus more on educating people about the disease and how to keep safe from it and distributing some necessary medical and daily consumables such as hand disinfectants, masks, and cologne, and some other material for the people locked down in their homes.

However, municipalities belonging to opposition parties followed a different and competitive path. Although municipalities had considerable losses in revenues because of postponed payments and decreasing transportation use, etc., some of the opposition municipalities declared to stop all other investments in infrastructure and road networks, focusing on supporting the poor residents of the urban areas. Since the Pandemic coincided with the holy month of Ramadan (23 April-23 May), these municipalities gave away food and income support to the poor. Moreover, they came together with NGOs and citizens' assemblies for fundraising campaigns and to find innovative ways to strengthen solidarity among residents including campaigns to widening the scope of "bread on the hanger" (volunteer citizens pay for loaves of bread that they leave at the grocery store for the needy to pick them up later) via online tools to bring together rich and the poor or paying the debts of the poor people in small grocery shops all around the city. Yet, some of these efforts were not welcomed by the central government; as such, the fundraising authority of the opposition metropolitan municipalities was halted based on an ambiguous wording in the municipal legislation. At the beginning of April 2020, this discussion turned into a political one, revolving around administrative tutelage on local governments.

Later, other than fundraising campaigns, local governments widened the scope of solidarity campaigns all over the country, and new rules in bazaars and public areas were set. They also tried to follow the central government's

procedures and experiences of other cities all around the world. For instance, the Turkish Union of Municipalities offered comprehensive online courses for municipal administrators to analyse and disseminate lessons learnt in other countries (Turkish Union of Municipalities, 2020). Also, some municipalities such as Ankara, the capital of Turkey, tried to get in contact with other capital cities for experience-sharing on online platforms (The Metropolitan Municipality of Ankara, 2020). To sum up, it can be said that the local government experience with the COVID-19 crisis in Turkey has been imbued with political tensions at the end, which somehow helped in the struggle with the Pandemic through creating competition among different tiers of the government.

Regarding the normalization process, beginning from 11 May, after almost two months of isolation and curfew measures which kept most of the country inside their houses, some limitations began to be relaxed. Some businesses, such as shopping malls, hairdressers, and open grocery markets, were reopened, but this time with strict health protection rules.

Turkey's normalization plan has four-steps. The first phase of which began on 11 May, the second stage will cover 27 May to 31 August. The third phase will be run from 1 September to 31 December. The fourth stage is expected to have the vaccine that has been described as planned from 1 January onwards.

The Role of Experts Advising Authorities

Under the Turkish Government's National Influenza Pandemic Plan, which was prepared and put into effect before the COVID-19 crisis, a science board of experts started to advise the Ministry of Health and the Presidency, as early as 10 January. Although the final decision-power stayed with the politicians, this expert panel not only provided strategic advice, they also answered people's questions on various media platforms (TV and social media), and thus mitigated the anxiety by providing scientific facts as well as psychological relief.

Later in the process, second and third science panels, including public health and social sciences experts, were added to the decision-making system, though with much less visibility than the first board. Although there is also existing Health Policies Board in the Presidential Office, it was not adequately visible in the planning and decision-making processes.

Early Lessons from COVID-19 Crisis

Turkey's COVID-19 response during the first wave of the COVID-19 Pandemic has been mostly successful from a public administration viewpoint, although there are areas for improvement. On the one hand, exemplifying moderate

success, COVID-19 fatalities per million (47) is much lower than countries such as the USA (257), Iran (81), Germany (94), France (415), Italy (514) and the UK (489). On the other hand, the number of tests per million (17.477) conducted in Turkey, however, need to be improved compared to countries such as Iceland (161.395), USA (30.971), Germany (37.570), France (21.213), Italy (45.246) and the UK (30.849) (Worldometers, 2020). The members of the scientific committee explained on numerous occasions the reason and algorithm behind the lower test numbers, yet the issue remained controversial. Another area that needs improvement is the central-local government cooperation in aid and PPE collection, production, and delivery. The central government and some local governments held by opposition parties competed rather than attempted to collaborate on these issues, mostly due to political reasons.

There has been no shortage of the production of personal protective pieces of equipment. Even some PPE were sent to the aid of other countries that desperately needed them, such as the US, UK, Italy, and Spain. However, some problems occurred during the distribution of especially face masks for the general population, which is partially solved by early May. The central government first declared that the face masks will be distributed free of charge through an e-government/internet application and pharmacies halted/banned selling and buying of masks in the market in the middle of April. Yet, this did not work as expected, and the government had to allow the selling of masks on the market with a price cap of 1 Turkish lira, from the beginning of May 2020.

The lessons derived from the Turkish experience can be highlighted (1) centralized decision making due to the presidential system, and the unitary structure is useful in making fast decisions, (2) high capacity of the health system creates a difference, (3) A well-established decision-making structure backed up by a scientific committee worked well via a sound communication strategy, (4) although competition between political parties at different spheres of the government worked in favor of finding innovations for especially strengthening solidarity among urban residents. A better collaboration would have produced better results for the distribution of basic needs and services.

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The United Kingdom Government's Response to COVID-19

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Abstract

This paper examines the United Kingdom's (UK) Government's response to COVID-19. It finds that the strategic response was set up by the Government's 2011 strategy for flu pandemic preparedness and reinforced by advice formulated by the Government's experts. It then looks at how events unfolded in 2020, including the decision to enter a lockdown in late March. The timing of this move into lockdown is considered in relation to the very high mortality rate evident at the end of May 2020.

The paper concludes with some possible explanations for the high mortality rate and offers a number of lessons in relation to government strategy, speed of decision making, and the organisation of expert advice for the Government.

Keywords

Governance, strategy, communications, scientific and medical advice

Introduction

As 2020 began, the UK Government appeared to be well prepared for an influenza pandemic virus. It had a strategy for preparedness dating from 2011 and it had run “Exercise Cygnus” in 2016, which was a rehearsal for a pandemic. The UK Prime Minister also believed that the country was well resourced and capable by virtue of leading international scientific experts and a well-resourced health system. Yet, by 3 June 2020, according to the Coronavirus Resource Centre at Johns Hopkins University & Medicine, the UK had suffered 59.3 deaths per thousand population, which was the second worst mortality rate in the world on this day.

In view of the UK’s extremely high incidence of deaths caused by COVID-19, the paper explores what went wrong in the governance of the pandemic. It briefly reviews some of the theory of government decision making based on evidence in order to provide a framework for an examination of some of the major decisions taken by the Government and how these decisions impacted on public opinion.

UK Governance of the COVID-19 Pandemic

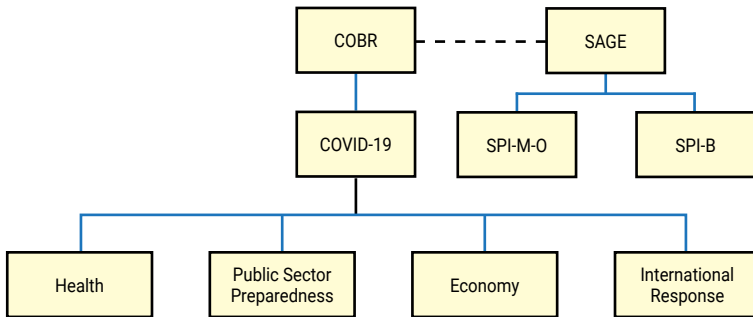
In the UK, if emergencies are serious or having widespread impacts, or are long-lasting, then central government coordination is provided by a body quaintly known as the Cabinet Office Briefing Rooms (COBR). Because the UK has devolved administrations, COBR is required to operate so as to recognise the importance of the devolved administrations as a level of government (UK Government 2013 191): “The devolved administrations in Scotland, Wales and Northern Ireland will, within their area of competence (area of responsibility as defined in the respective devolution settlements), play a full role in response to an emergency requiring government involvement” (UK Government, 2013, p. 191).

Another key body in the governance of a response to an emergency is the Scientific Advisory Group for Emergencies (SAGE). It consists of scientists and medical advisers but during the COVID-19 emergency it was attended by others including the Prime Minister’s top political adviser. SAGE has provided the politicians with scientific and technical advice relevant to the emergency. It has been supported in its work by a group called the Scientific Pandemic Influenza Group on Modelling (SPI-M-O).

During the course of the COVID-19 emergency, the basic governance structure for emergencies was further elaborated. In February SAGE added a second group to strengthen a behavioural science dimension to the advice it gave the UK Government; this was called the SPI-B group. In the middle of March, five new committees were created to sit underneath COBR. One was

the COVID-19 committee that was to meet daily and with a responsibility for refining measures determined by COBR and for monitoring the emergency. Beneath this, were four implementation committees chaired by senior government minister. See the Figure below showing the structure for executive decision making and advice.

Figure 1 - The UK's Governance Structure for COVID-19 (until end of May 2020)



The Prime Minister on Preparedness

The Government seems to have believed that the UK was well prepared for a pandemic. A statement made by the Prime Minister on the coronavirus action plan in early March is just one of a number of examples where ministers reported that the UK was well-prepared and also that the UK's healthcare system was fantastic, testing systems were good, and the UK had among the best scientific experts in the world (Johnson 2020):

The plan has four strands. Containing the virus, delaying its spread, researching its origins and cure, and finally mitigating the impact should the virus become more widespread. That is, contain, delay, research, mitigate.

(...) Keeping the country safe is the government's overriding priority. And our plan means we're committed to doing everything possible based on the advice of our world leading scientific experts to prepare for all eventualities.

Let's not forget – we already have a fantastic NHS, fantastic testing systems and fantastic surveillance of the spread of disease.

We will make sure the NHS gets all the support it needs to continue their brilliant response to the virus so far.

The plan does not set out what the government will do, it sets out the steps we could take at the right time along the basis of the scientific advice.

Our country remains extremely well prepared, as it has been since the outbreak began in Wuhan several months ago. (Johnson, 2020)

Mortality rate

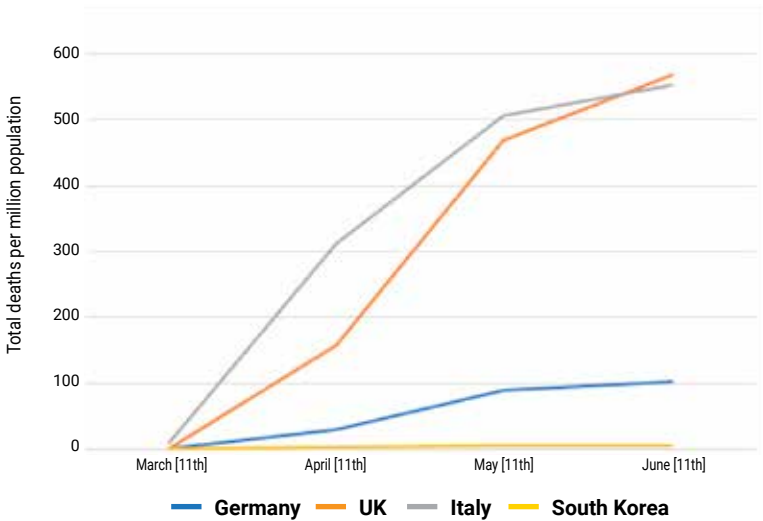
As the table and chart below show, the UK was initially trailing Italy in relation to the number of deaths per million, the UK's mortality rate overtook that of Italy before the end of May. It would probably be a mistake to suggest that the difference between the UK and Italy was significant on 1 June. It is possible to say that the UK did appreciably worse than Germany and South Korea.

Figure 2 - Mortality rates in four countries

Total deaths per million

Month	Germany	UK	Italy	South Korea
March [11th]	0.024	0.103	10.436	1.17
April [11th]	30.364	158.501	311.783	4.057
May [11th]	88.525	469.243	505.443	4.993
June [1st]	101.583	566.965	552.663	5.286

Source: www.OurWorldInData.org. [3 June 2020]



Given that the UK's Prime Minister considered the country to be well prepared for the pandemic, and since keeping the country safe was the top priority, what went wrong in the UK's response to COVID-19?

Making Decisions Scientifically

There is a risk of assuming that a public health policy is always determined by an evidence-based approach. In the UK it has been frequently claimed that the coronavirus pandemic of 2020 is "unprecedented" in its nature. Indeed, Sir Patrick Vallance (2020), the Government's Chief Scientific Officer stated that,

“we are learning as we go with Coronavirus”. This leads to a question: to what extent can a government utilise evidence when the situation is regarded as unprecedented?

It may be assumed that moving from the evidence to choosing a strategic option involves a one-way linear process and pure rationality. Yet public health and the decisions on how to approach a pandemic response sit within a democratic framework of politicians supported by technocrats, often from the government's SAGE. Public health decisions may not always be closely defined by an evidence base, as competing choices are often defined by politicians or by divisions on how competing evidence, if any, is translated into a final decision (Smith & Joyce, 2012).

One source of evidence that alarmed the UK government in mid-March, was the Imperial College London report by a team of epidemiologists led by Professor Neil Ferguson, which estimated that without any public health intervention, the UK could see up to 510,000 deaths (Imperial College COVID-19 Response Team, 2020). This was rapidly used to inform and justify the UK government's approach towards lock-down, yet the research has not been universally accepted by the scientific community who posited alternative scenarios (Financial Times, 2020). In very few cases were the models peer reviewed or scientifically tested which leads to question of whether governments are too ready to accept models. This can lead to mistakes and potential policy failure.

Whilst evidence for evaluating the strategic choices that defined the government's approach may currently be difficult, learning from mistakes should occur through the process of policy learning (Dunlop, 2017).

One issue in evaluating and learning arises in relation to defining the goals of government action, and this will, no doubt, be the case with evaluating the UK government's response to the pandemic. To provide a definitive answer, any future commission or inquiry will have to generate a whole range of complex analytical questions. Often the conclusions to such complexity will result in judgements on success versus failure sitting somewhere along a spectrum, or what a public failure theorist, Allan McConnell, called policy failure and the grey areas in between (McConnell, 2010).

Government's Strategy and the UK's Readiness

The difficulties of rational decision making in a democratic process and the challenges of political leaders drawing on scientific and medical advice were stark during the process of the UK Government responding to COVID-19. Analysis of these difficulties and challenges may provide some pointers as to

what went wrong in the UK Government response to the pandemic in the early months of 2020.

Twenty years ago, the World Health Organization [WHO] (1999, p. 5) had warned national authorities that a pandemic could have devastating effects and that preparation was needed to minimize these effects, even if national measures were not capable of halting a pandemic (WHO 1999 5).

In 2011, during a period in which there was a Coalition Government, the “UK influenza Pandemic Preparedness Strategy” was published. This agreed with the judgment made by the WHO in 1999 that it would be impossible to halt a new pandemic influenza virus. One of its goals was to minimize the potential health impact of a future influenza pandemic. The proposed means included promoting good hygiene practices among citizens and ensuring that the health care system and the social care system were ready to provide treatment and support.

A paper prepared by a SAGE group, the Scientific Pandemic Influenza Group on Modelling, in 2018, advised a planning assumption that screening international travellers would have insignificant benefit but would be costly and disruptive.

A reasonable conclusion about this background is that the UK Government was setting itself up to provide treatment to seriously ill victims of a pandemic but was not intending to prevent the pandemic from causing illness.

But was the UK ready? Public Health England carried out “Exercise Cygnus” in 2016 to check readiness to respond to a flu pandemic. Shortly afterwards, England’s chief medical officer spoke at a conference and she was reported to have said that hospitals were not ready for a major flu pandemic.

Another report placed doubt on the UK’s readiness. A newspaper report noted that in 2019 the National Security Risk Assessment had identified a flu pandemic as the top civil risk but quoted an unnamed source as making this comment about the UK’s actual readiness to respond to a pandemic (Hopkins 2020):

The really frustrating thing is that there were plans. But over the last few years emergency planning has been focused on political drivers, like Brexit and flooding.(...) There was a national plan for dealing with a pandemic that should have been implemented. We have been caught out. (Hopkins, 2020)

So, the UK’s selection of a treatment-based strategy, combined with, possibly, a state of unreadiness, probably meant it should not have been expected that there would be much action from the UK Government in the early stages of a pandemic. The strategy indicated action would be focused on seriously ill patients – and for this the key capability was the health system.

Making Decisions During the Pandemic

The earliest Coronavirus briefings of the public by government ministers seemed to indicate that decisions were being based on advice given by scientists and medical experts. Documents prepared by the Government's experts, and subsequently available on a Government website, suggested that, in early and mid-February, there was no great departure from past strategic thinking on the response to a pandemic. For example, the expert opinion on contact tracing stated it was useful in early cases as a means of understanding disease dynamics but that it would not be practical once there was a lot of cases and, in any case, such measures had a high opportunity cost (SPI-M-O, 2020).

The Government's expert opinion also thought a "reasonable worst case" for pandemic influenza would be appropriate as a planning scenario for COVID-19.

It took some while before scientists realised just how seriously they had underestimated the threat of COVID-19. The NERVTAG scientists, who were advising the Department of Health, decided to recommend the pandemic threat level was at "low" in January and then on 30 January they recommended it was a "moderate" threat and there it stayed until 12 March, when the chief medical officer moved it to "high".

It is important to note that the UK experts' judgements about the likely results of trying to halt the pandemic and about the role and significance of contract tracing meant that they were seriously at odds with the new thinking that now characterised the WHO. In contrast to the advice of the Director General of WHO, the UK Government decided it was no longer necessary for every person with COVID-19 to be identified. As well as deciding there should be no testing and tracing of individual cases in the community, it should also be noted that the UK Government had placed no controls on international travel and had not introduced screening or testing at ports of entry.

The Prime Minister announced the Government was now moving from a contain phase to a delay stage, with the aim of delaying the peak in the wave of infection. This was 12 March. The Government's chief scientific adviser, on the following day, also said the UK plan was to delay and reduce the peak of the wave of infection.

The Decision to Lockdown

Fairly or not, the period leading up to the lockdown on 23 March was seen by some commentators as one of dangerous delay by the Government. If the Government had implemented a lockdown on 12 March, when there were less

than 500 confirmed cases, and when the Prime Minister was making a speech about the need to delay and lower the peak, it is probable that the health of many more people would have been protected and many deaths would have been prevented.

The relationship between government leaders and their experts became more openly difficult in May when the Government was attempting to ease the lockdown. An “alternative SAGE” group was set independent of government, a group which was very critical of the lack of transparency about the advice given to the UK Government by the official SAGE. It also said it was unclear what the Government was trying to do – suppress or manage the pandemic.

At the end of May, as the Government began to ease the lockdown, the number of new cases occurring and the transmission of COVID-19 in the country were still relatively high. A number of SAGE experts advising the UK Government publicly voiced their concerns about the decisions to ease the lockdown: “A growing number of expert advisers to the government on the coronavirus crisis have expressed concern about plans to ease lockdown restrictions in England from Monday” (The Guardian, 2020).

Far from the lockdown being imposed on a reluctant public, opinion polling suggested that the public had strongly supported the lockdown and a majority of members of the public considered that the Government was not being sufficiently cautious in easing the lockdown. Presumably, it was public concern about the Government being too prepared to take risks with the easing of lockdown, in addition to a widespread view among members of the public that Government had performed badly in delivering personal protective equipment to the hospitals, that explain a substantial decline in approval ratings for the Prime Minister in late May. The controversy about one of his senior advisers breaking the Government’s rules on lockdown may have also damaged the ratings of the Prime Minister and reduced public support and compliance with the restrictions (Curtis, 2020).

Lessons

The narrative presented in this paper suggests two or three possible explanations for the high mortality rate. The first is that the UK had the wrong strategy, having decided that testing and tracing would not contain the spread of the virus in the early stages of the pandemic.

A second possible answer is that the lockdown should have been implemented sooner. For example, if the lockdown could have been brought in towards the beginning of March, when the number of cases was relatively low, the mortality rate at the end of May might have been very much lower.

By comparison Norway and Germany imposed a lockdown earlier, when the virus was less prevalent, and suffered few deaths as a result. If there was any reluctance on the part of the Prime Minister to move swiftly to carry out a lockdown it is possible that this was because the Government was worrying about the damage that might be inflicted by a lockdown on the economy and the difficulties of rebuilding the economy after a lockdown lasting several weeks.

A third possible answer is that the UK was not well prepared for the strategy and this may have been in part caused by other momentous events that were happening and were absorbing the attention that the risk of a pandemic required.

Arguably, the UK experience offers some important lessons for designing and managing Government responses to future pandemics.

The first lesson could be expressed as follows: the aggressiveness of the strategic response to a pandemic virus should at least match the aggressiveness of the pandemic virus. Judged in terms of its reproduction rate and its' mortality to infection rate, COVID-19 may have been more aggressive than expected. The UK Government strategy was not at all aggressive.

The second lesson is that an aggressive virus pandemic requires very speedy Government decision making during critical phases of the pandemic. This in turn requires equally speedy implementation by the agencies concerned at both local and national levels in accordance with civil contingency expectations.

The UK experience in the pandemic and the development of the "alternative SAGE" suggests a lesson in terms of government communications to the public: if government decisions are presented entirely as if they are based on scientific advice and nothing else, it may produce accusations that there is a lack of transparency about the scientific advice and a feeling that the intentions of the government are unclear.

What might be done to counter this? Governments could invite rival centres of expert advice to give advice and do so through public channels. This might attract the interest of the public and through rapid polling the government might access insights into public perceptions and preferences, which might, ideally, enrich the government response. It would have to be very rapid polling if the emergency was fast moving and aggressive.

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North America

The Canadian Response to the COVID-19 Pandemic

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Abstract

This brief paper examines the response of the federal and provincial governments in Canada in early 2020 to address the global COVID-19 pandemic. Relying on the flawed advice of the WHO, the Canadian response to the threat posed by the spread of the Coronavirus was rather tepid. However, by mid-March, provincial governments across the country had declared states of emergency and replaced the 14-day voluntary self-isolation policy with more coercive measures, such as shutting down day-cares, schools and universities, placing prohibitions on public gatherings and requiring the closure of non-essential businesses. It became clear early in the crisis that Canada, despite having lived through the 2003 SARS outbreak, was woefully unprepared for this pandemic. Although the number of cases (84,500) and deaths (6,400) in Canada are modest relative to many other countries, the country's efforts to contain COVID-19 have been undermined by a number of factors, including shortages of personal protective equipment and medical personnel, insufficient testing and tracing, a lack of clear communication and poor coordination and planning. Nonetheless, the COVID-19 pandemic has also demonstrated some important realities about the role of government and public administration.

Keywords

Canada, COVID-19, healthcare, public policy and administration, crisis response

Highlights

After the crisis has been averted, healthcare professionals need to work closely with the federal and provincial governments to ensure the country is better prepared for the next pandemic. This means ensuring the public health system is properly resourced on an ongoing basis and that stockpiles of personal protective equipment and medical supplies are maintained and properly managed. Both the 2008 global recession and the current health pandemic have demonstrated that governments continue to have relevance. Government can move quickly and implement policies when citizens and public servants accept that it is not “business as usual.”

Introduction

This paper examines the response of the Canadian governments to the COVID-19 pandemic. It begins by establishing some of the key features of the country's political and socio-economic context. The report then provides a brief overview of the status of the Canadian healthcare system prior to COVID-19. This will help to establish the country's preparedness and approach for addressing the crisis. The next section of the report examines the key measures that constitute the various governments' responses to COVID-19 followed by a brief outline of the evolution and current status of the pandemic in Canada and some early lessons learned. In the final analysis, while mistakes have been made and some glaring limitations in the country's preparedness for responding to a healthcare crisis of this scope and magnitude have been revealed, the COVID-19 pandemic has also demonstrated some important realities about the role of government and public administration.

Canada: The Political and Socio-Economic Context

Canada, widely recognized as a middle power with membership in both the G7 and G20 group of states, is one of the most affluent countries in the world with a 2018 GDP per capita of just over US\$51,000. Historically classified as a staple economy, because of its dependence on the extraction and sale of its abundant natural resources, the current industrial structure of the Canadian economy is quite typical of most advanced industrialized states. Nearly 80% of Canadians are employed in the service industries, while primary sector employment stands at just over 3%. The remainder of the Canadian workforce (about 17%) is employed in the various manufacturing and construction jobs that comprise the secondary sector.

While Canada is the second largest country in the world in terms of its geographic area, with an estimated 37.7 million people, it barely ranks in the top forty when considering the size of its population. Like much of the world today, Canada is highly urbanized; more than 80% of its residents live in cities, the vast majority of which are located within one hundred miles of the Canada-US border. Given the country's proximity to this global economic and cultural hegemon, its influence over Canada is enormous. The country's trade dependency on the US is particularly pronounced. North-south trade with the US represents approximately 50% of Canada's imports and three quarters of its exports, which means that the vitality of the Canadian economy is inextricably connected to that of its southern neighbour. This becomes a

major factor when discussions around the closure of borders arises as was the case with COVID-19.

In terms of its political system, Canada is a constitutional monarchy with the British sovereign serving as its head of state, although the powers of Queen Elizabeth are more symbolic than real. The country functions as a Westminster-style federal parliamentary democracy. According to its constitution, powers are divided and shared between the federal or national parliament and ten provincial legislatures. The country also comprises three territorial governments, but their authorities and responsibilities derive not from the constitution but rather are delegated to them by the federal parliament. Although the provincial and territorial legislatures are unicameral, the federal parliament is bicameral with a popularly elected lower chamber (House of Commons) and an unelected upper chamber (Senate). The 2019 general election produced a minority government for the Liberal Party of Canada, led by Justin Trudeau, so the executive is unable to govern without at least some support from members of the opposition parties. In addition, there are more than 3,500 municipal governments in Canada established and governed by provincial legislation.

Structure and Status of the Healthcare System in Canada

The structure of government in Canada noted above increases the complexity of responding to a global health pandemic like COVID-19. For example, while healthcare is a provincial responsibility under s.92(7) of the *Canada Constitution Act, 1982*, the federal government, by virtue of its spending power, has maintained a *de facto* national health insurance program. In essence, billions of dollars of federal revenues are transferred to the provincial governments each year to help pay their healthcare costs as long as they uphold the principles outlined in the *Canada Health Act*. Although differences in the provision of healthcare across the country are palpable, with world-class physicians and state-of-the-art medical equipment and facilities buttressed by significant healthcare spending, Canada has a universal healthcare system that is the envy of much of the world.

In terms of the machinery of government, federally, it is the Public Health Agency of Canada (PHAC), with regional offices throughout the country, that has responsibility for providing national leadership in response to public health emergencies and infectious disease outbreaks. It is but one agency in the broader health portfolio overseen by the Minister of Health. Both the minister and the president of the PSAC, its administrative head, receive advice and support regarding the management and leadership of the agency from the

chief medical officer of health (CMOH). This position has been filled since 2017 by Dr. Theresa Tam, a physician with expertise in immunization, infectious disease, emergency preparedness and global health security. Dr. Tam sits on a number of World Health Organization (WHO) advisory committees and serves as an official advisor to the WHO International Health Regulations Emergency Committee on 2019-nCoV. Her involvement as a member of this latter WHO committee undoubtedly provides insight regarding the way she has led and advised the Canadian government to deal with COVID-19.

Since health care is a provincial responsibility, each province and territory has its own ministry of health and associated agencies. For example, in Ontario, part of the Ontario Ministry of Health is an agency called Public Health Ontario, which is analogous to the PHAC at the federal level. The province has its own CMOH as do the province's various municipalities. Given this decentralized public health care system in Canada, it falls upon the federal CMOH to act as a unifying voice and to co-ordinate the responses of the various public health agencies.

According to the Canadian Institute of Health Information (2019), Canada spent 10.7% of its GDP on healthcare spending in 2018, which was slightly above the OECD average (8.8%). This translates into total health spending of CAN\$6,448 per capita versus an average of \$5,175 across the 36 OECD countries. Notably, while Canada spends more on health than the OECD average, its share of public funding (at 69.7%) is lower than the average of that comparator group (72.8%).

Although critics always accentuate the need for additional resources, especially for public health, the abovementioned statistics suggest that the Canadian healthcare system is reasonably well financed. However, a key question that needs to be raised is whether Canada was in a state of preparedness to deal with COVID-19. It should have been. After all, outside of East Asia, no country was as impacted by the 2003 SARS outbreak as Canada. That crisis, which was largely confined to Toronto and resulted in hundreds of cases, with 44 deaths and thousands more being quarantined, ostensibly demonstrated the shortcomings of the public health system that should have been rectified by the time of the onset of COVID-19. As the Honourable Justice Campbell noted in the final report for the SARS Commission:

SARS taught us that we must be ready for the unseen... we know now that new microbial threats like SARS have happened and can happen again. However, there is no longer any excuse for governments and hospitals to be caught off guard and no longer any excuse for health workers not to have available the maximum level of protection through appropriate equipment and training. (Campbell, 2006, p. 14).

Federally, the government responded by creating both the PHAC and the national CMOH. It also introduced, in conjunction with the provinces and

territories, the country's first pandemic preparedness plan, which has been revised and updated several times since 2004 (see Government of Canada, 2018). Unfortunately, however, many of the recommendations that were made to improve the public health system in Canada went unheeded. Most noticeably, after the urgency of a public health crisis passes, governments have a tendency to cut back on the resources necessary to be ready for the next pandemic. This has been aptly described as a cycle of “neglect, panic, repeat” (The Toronto Star, 2020). Therefore, some of the failings that compromised the public health response to SARS have re-emerged—with more significant and tragic consequences.

Canadian Government Response

Despite some glaring weaknesses with respect to Canada's management of this crisis, a late April IPSOS survey (Bricker, 2020) reveals that 81% of Canadian respondents believe that the government has done a good or very good job of containing the spread of COVID-19. This ranked Canada third (behind India and Australia) out of the 13 countries surveyed. Notably, however, this represents a 10 percentage point increase from the results of a similar survey conducted in late March, which is indicative of the seemingly lackadaisical approach that the federal government was taking towards the coronavirus until the WHO declared it a global pandemic on March 11.

From the outset, Canadian political leaders were concerned with balancing human health and loss of life considerations with keeping Canada's borders open and protecting the economy. A number of guiding principles have underpinned the Canadian response: 1) collaboration (between all levels of government and key stakeholders); 2) evidence-informed decision-making; 3) proportionality (the response should be proportionate to the threat); 4) flexibility (actions should evolve as new information becomes available); 5) a precautionary approach (timely and reasonable preventative action proportionate to the threat should be taken); 6) use of established practices and systems; and 7) ethical decision-making (ethical principles and societal values should be explicit and rooted in all decisions) (Government of Canada, 2020).

The reasonableness of these guiding principles is not being disputed; however, they have not prevented serious mistakes from being made. Making evidence-informed decisions has meant that federal and provincial political leaders have relied heavily on the advice and recommendations of both Canadian health care professionals and the expert advice of the WHO officials. The directives of the WHO have been particularly important in this case given the key role that the Canadian federal CMOH plays in that organization. This

proved to be problematic at times for two reasons. First, the WHO was initially being misinformed about the virus by the Chinese government; and second, little was known about this new novel coronavirus.

As a result of relying on tainted WHO advice, the CMOH was telling Canadians in late January that while the virus was serious, there was no reason to panic or be overly concerned. Moreover, the health minister, after a brief from departmental officials, stated that there was no clear evidence the virus was easily transmitted between people (Staples, 2020). Health screening was supposedly implemented for passengers arriving from Wuhan to major Canadian airports at that time, but these appear not to have been very rigorous. Those travellers exhibiting symptoms were advised to voluntarily self-isolate for 14 days; this was essentially the Canadian policy for two months.

Moreover, given the lack of understanding regarding this virus, official communications to the public have been confusing and contradictory. For instance, citizens were initially told that wearing masks was only useful for those who were symptomatic to help stop the spread of the virus; almost two months later, they were advised it would be useful for everyone to wear them when out in public. It is impossible to predict what impact this early muted government response has had on the spread of the virus, but as of late May there have been over 84,500 cases and 6,400 deaths from COVID-19 in Canada, the vast majority of which have been in the provinces of Quebec and Ontario.

A number of factors have challenged Canada's efforts to contain COVID-19, including shortages of personal protective equipment and medical personnel; an inability to conduct adequate testing, both because of a lack of laboratory capacity and insufficient supplies; inadequate contact tracing capacity; a lack of clear communication; and poor coordination and planning. While there were critical shortages of personal protective equipment and ventilators, the Canadian manufacturing sector stepped in to ramp up the country's capacity to produce these supplies and equipment. Several gin distilleries converted their operations to produce hand sanitizers, for example, and General Motors Canada started to manufacture face masks and ventilators. Other auto-parts manufacturers and Canadian companies also committed to producing ventilators; those not required in Canada would be shipped to other countries in dire need.

At the outset of this crisis, there were grave concerns about the capacity of Canadian hospitals to treat the thousands of COVID-19 patients that the predictive models were anticipating. Thus far, this has not been a problem. The country's social distancing efforts have been successful in containing the spread of the virus to manageable levels. Efforts to test and trace the spread of the virus in Canada, however, have been inadequate. Throughout the

crisis, Canada struggled to meet the daily testing targets that were considered necessary for properly tracking the spread of the virus and making decisions about re-opening the economy. Ontario was a notable laggard in that regard. Moreover, testing in Canada has been skewed by focusing on healthcare workers and nursing home residents. To date, fewer than 1.5 million Canadians have been tested for COVID-19.

Perhaps the biggest failing during this crisis has been the country's various long-term care facilities and nursing homes. The number of infections and deaths in long-term care homes has been catastrophic. More than 80% of the Canadian deaths have been individuals living in long-term-care homes. The number of support workers in these facilities that have fallen sick from COVID-19 (including several deaths) has been so great that the premiers of both Quebec and Ontario have asked assistance from the Canadian Forces. The federal government responded by deploying the military to various nursing homes across these two provinces as a stop-gap measure.

As the number of cases and deaths mounted, concerns about the need to protect the economy became secondary to containing the spread of the virus and mitigating the loss of life. In mid-to-late March, as cases of community transmission were confirmed, states of emergency were declared in all provinces and territories as well as many municipalities. Voluntary containment measures were replaced with coercive strategies as the provinces and territories, to varying degrees, shut down day-cares, schools and universities, placed prohibitions on public gatherings and required the closure of non-essential businesses. The federal government also adopted more stringent regulations to mitigate the spread of the virus. For example, the federal minister of health invoked the *Quarantine Act*, which made the 14-day self-isolation period for those returning to Canada from abroad mandatory. Moreover, the federal government eventually implemented a ban on all foreign nationals, from all countries except the United States, from entering into Canada. Ultimately, the Canada-US border was closed to all non-essential travel; it did, however, remain open for the purposes of trade and commerce.

In addition to border measures being implemented and a travel advisory, the federal government took a number of measures to protect the health and safety of Canadians. From a planning perspective, to mitigate the spread of the virus the prime minister created a new Cabinet Committee on the Federal Response to the Coronavirus Disease. This committee meets regularly to ensure that there is whole-of-government approach to limit the health, social and economic impacts of the virus. With respect to communication and education, the federal government established a dedicated coronavirus webpage on the main Government of Canada website (www.canada.ca) to keep Canadians informed, and Prime Minister Trudeau has been holding daily

press conferences to update the public regarding the spread of the virus and to make new announcements. Press conferences have also been a mainstay of the provincial premiers as well as the Canadian CMOH and her provincial counterparts.

To facilitate the co-ordination of public health policy across the country, a federal-provincial-territorial Special Advisory Committee on the Novel Coronavirus (SAC) was established; it comprises member of the Pan-Canadian Public Health Network Council and the Council of Chief Medical Officers of Health of Canada. A Technical Advisory Committee, Logistics Advisory Committee and Public Health Network Communications Group with public health experts and senior officials from the federal, provincial and territorial governments provide support to the SAC.

Quite naturally, as the various Canadian governments took more aggressive measures to prevent the spread of COVID-19, the impact on the economy was devastating. Unemployment soared and the loss of income was widespread. As a result, both the federal and provincial governments have announced several new measures to help attenuate the financial losses of Canadian citizens and businesses. In one of the first responses, the Bank of Canada reduced its key interest rate to 0.25%. Federal government expenditures to complement this fiscal stimulus have been mind-boggling with almost daily announcements by the prime minister of a new program to spend or lend money to individuals, businesses and/or social welfare organizations, like food banks and the Red Cross. These direct support expenditures exceed CAN\$145 billion, but the total figure tops \$817 billion when accounting for the cost of tax deferrals and various credit and loan programs (Roman, 2020). Billions more are being spent by the provincial governments. The Ontario government, for example, introduced CAN\$17 billion worth of new expenditures to fight the coronavirus, including tax deferrals, money to boost lab testing capacity, assistance for nursing homes and money to hire more medical professionals and support workers (Benzie et al., 2020).

It would not be feasible to document every COVID-19-related government program; therefore, only the main ones are highlighted. The largest of the programs is the Canada emergency wage subsidy (CEWS); Ottawa earmarked CAN\$73 billion to provide up to 75% of the wage cost (to a maximum of CAN\$847/week/employee) for businesses that have lost at least 30% of their revenues to avoid employee layoffs. Some 600,000 small businesses have received support through the Canada emergency business account (CEBA). In this instance, small businesses acquire a CAN\$40,000 loan through the banks of which only 75% is repayable. The federal government has also introduced myriad programs offering sector-specific support, such as agriculture and fisheries, energy, air transportation and tourism and hospitality among others.

In terms of support for individual Canadians, the federal government allocated CAN\$35 billion for the Canada emergency relief benefit (CERB). This was the first program unveiled and it provides CAN\$2,000 per month for four months for eligible workers who lost their incomes as a result of COVID-19. As of mid-May, the government has received more than 11 million applicants for this funding; unfortunately, it has been subject to abuse because any Canadian who applied for this benefit received it without qualification. In addition, in conjunction with the provincial governments, Ottawa will contribute up to CAN\$3 billion to share in the cost of a wage top-up for low-income essential workers, such as grocery store employees. The recently announced Canada student emergency benefit (CSEB) provides CAN\$1,250 from May to August for college and university students and recent graduates at a projected cost of CAN\$5.2 billion. Furthermore, there have been goods and services tax credits for low-income individuals, additional supports for seniors, Indigenous people and families eligible for the Canada Child Benefit.

Period Coverage

As noted earlier, Canada was a bit slow in taking definitive action to prevent and contain the spread of COVID-19. Canada's first case of COVID-19 was confirmed on January 27 and was related to an individual returning from Wuhan, China. It was February 20 when the first person who had not travelled to China was diagnosed with the illness. The country's first COVID-19 death was reported on March 9, 2020.

It was really after the WHO declared COVID-19 as a global pandemic on March 11, however, that the Canadian and provincial governments took the threat of the Coronavirus more seriously. In a span of just over a week and a half, all of the provinces had declared a state of emergency and, along with the federal government, began to close their borders (including internally in several provinces) and shutter economic activity. Canadians were advised to stay at home, although no province mandated them to do so.

Much of the Canadian economy remains closed. However, that is about to change as many provinces have initiated the early stages of their plans for re-opening their economies. Sit-down restaurants began to re-open in early May in Alberta, British Columbia and Manitoba, albeit with restrictions in place. Ontario just cancelled the remainder of the school year but is in the process of opening some public spaces, such as golf courses, marinas and parks, and allowing a variety of economic activities to resume. The strategy is to engage in a gradual opening of the economy. Businesses in Ontario must meet 80 safety guidelines if they are to re-open, including the provision of personal protective equipment for employees, handwashing protocols and physical distancing

requirements in the workplace. However, there are concerns that the lack of widespread COVID-19 testing means that the province does not have an accurate picture of the rate of infection, which could spell disaster as people begin to congregate more freely in public.

Early Lessons Learned

First, despite its experience with SARS, Canada was unprepared for this pandemic. Shockingly, N95 respirators were in short supply and this critical protective equipment was being rationed to healthcare professionals working on the frontlines. To exacerbate matters, tens of millions of dollars of medical supplies were being destroyed as the pandemic began because they had reached their expiry date. Clearly, stockpiling essential supplies is ineffective if there is no proper plan for managing and rotating them through the healthcare system in a timely and ongoing manner. The country also had an insufficient supply of ventilators and inadequate lab testing capacity.

Second, having a centralized, co-ordinated approach to managing a healthcare crisis is challenging if not impossible when each of the provincial governments is making its own autonomous decisions about everything from whether and when to declare a state of emergency, to determining when to loosen up the restrictions on social distancing to making decisions about re-opening their economies. For example, in early May, Quebec became the first province to open up some day-care centres and elementary schools, but British Columbia and Saskatchewan chose to let day-care facilities remain open the entire time even though they closed schools, bars and restaurants. Quebec also decided to move towards re-opening its economy earlier than any other province despite the fact that it has been most affected by COVID-19 and was recording hundreds of new cases daily when this decision was taken.

Third, failure to act promptly employing the precautionary principle can result in an unnecessary and tragic loss of life. Provincial governments made numerous mistakes with respect to their long-term care facilities. They waited too long (mid-March) to restrict visitors to these facilities, failed to prevent staff from working in multiple facilities until the middle of April, and were slow to undertake mass testing (late April) for the Coronavirus among this particularly vulnerable population. The consequences of these failures have been devastating for long-term care facilities, their residents and support staff.

Fourth, both the 2008 global recession and the current health pandemic have demonstrated that governments continue to have relevance. Unlike the era of new public management, where big government was seen as the problem and not a cure for that which ails society, Canadian citizens have looked to government to attenuate these crises. Related to this point is the role of public administration.

Contrary to the widely-held views of a sluggish and unresponsive bureaucracy, this crisis has demonstrated that government is able to move quickly and implement policies when public servants and citizens alike accept that it is not “business as usual” (see, for example, Taylor-Vaisey, 2020). Moreover, having massive numbers of public servants working remotely has not immobilized government.

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The COVID-19 Pandemic: Early Lessons for Public Governance The United States Experience

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Abstract

The COVID-19 pandemic may be unprecedented and its specific timing unpredictable. Yet it was not unexpected. It is premature to write the authoritative account of the U.S. response to COVID-19. However, the U.S. national response to date has been clouded by significant shortcomings in its administration, coordination, delivery, and national-state relations. Among these characteristics: Inadequate supplies and an ineffective distribution system. An ever-revolving cast of elected officials, policymakers and administrators whose responsibilities changed by the week, if not more frequently. The lack of a focal point of national-level responsibility and accountability, A hollowed out national government that has relied on private sector involvement, much to the surprise of the private sector itself. State governors who were told that they should rely on the national government only as a “backstop,” but found they were competing with national government to purchase the very same supplies.

Keywords

Federalism, devolution, accountability, partnership, capacity

Highlights

Unprecedented, Not Unexpected

¹Disclaimer: The perspectives expressed in this report are solely those of the author. They do not necessarily reflect the views or positions of the organizations by which he is employed or with which he is affiliated.

Introduction

The numbers crawl across the bottom of U.S. television screens airing 24-hour news channels: *101,196 deaths and 1,712,816 total cases in the United States*—28 percent of the global total—as of May 28, 2020. For most Americans, these are the numbers that tell the story of the COVID-19 pandemic. To be sure, they are the statistics that capture the ultimate impact of this unprecedented global health and economic crisis. For public administrators, other statistics are equally useful in helping to determine the presence and effectiveness—or ineffectiveness—of tools aimed at advancing the governmental response. Take these, also as of May 28:

- Nine of the 50 U.S. states have no “stay-at-home” orders or guidance. Eight have no limits on the number of individuals who may gather in public settings.
- Twenty-seven states do not have mandatory or recommended quarantine periods for those traveling from state to state.
- Seven states lack a formal plan for reopening their states or a specially created task force to guide their jurisdictions’ response to COVID-19 (National Governors Association, 2020).

These numbers demonstrate the inherent diversity within the U.S. federal system and the divergent, often conflicting ways, in which state leaders and administrators have guided mitigation and recovery efforts to date. Differences in approach add enormous complexity to the administration of public services, especially during periods of nationwide turmoil. They also make a coordinated, effective and efficient response at the national level all the more critical. Absent one, states are left to their own devices, relying on their own definitions of what is appropriate to protect their citizens’ interests—and lives—and their economies. The United States historically has prided itself on federalism and shared power between national and state governments. Yet it is during times of crisis when states look to the national government to identify the path forward, provide vital tools and lead.

It is premature to write the authoritative account of the U.S. response to COVID-19. As a leading U.S. epidemiologist recently remarked, “We’re just in the second inning of a nine-inning game” (Osterholm, 2020). The crisis continues to evolve, as attention turns to the prospect of a second wave later this year or sooner; uncertainties about a vaccine exacerbate an already high degree of societal anxiety; and economic necessity competes with—or takes precedence over—public health as the primary driver of determining “what’s next.”

What *are* the key characteristics of the U.S. national response thus far? Inadequate supplies and an ineffective distribution system. An ever-revolving cast of elected officials, policymakers and administrators whose responsibilities changed by the week, if not more frequently. The lack of a focal point of national-level responsibility and accountability, A hollowed out national government that has relied on private sector involvement, much to the surprise of the private sector itself. State governors who were told that they should rely on the national government only as a “backstop,” but found they were competing with national government to purchase the very same supplies.

Unprecedented, Not Unexpected

The COVID-19 pandemic may be unprecedented and its specific timing unpredictable. Yet it was not unexpected. For more than a decade, the U.S. government had anticipated a global health epidemic; even more, it had identified the steps necessary to combat it at a national and state level. “The U.S. government will use all powers at its disposal to prevent, slow or mitigate the spread of an emerging infectious disease threat... The American public will look to the U.S. government for action when multi-state or other significant events occur” (Diamond & Toosi, 2020). These are not the words recently spoken by an elected leader. They were included in a 69-page “Playbook for Early Response to High-Consequence Emerging Infectious Disease Threats and Biological Incidents”—better known as the Pandemic Playbook—that President Obama’s National Security Council (NSC) developed in 2016 to address a crisis the size and importance of COVID-19. Indeed, “novel coronaviruses” were among the pathogens highlighted as deserving heightened concern (Knight, 2020). The Trump administration was briefed on the playbook in 2017.

On January 13, 2017, one week before President Trump’s inauguration, incoming high-level officials joined their outgoing Obama administration counterparts for a “Presidential Transition Exercise,” one of several legally mandated sessions designed to orient the Trump team on a variety of scenarios that it might have to confront. This specific exercise focused on the rapid, global spread of a dangerous virus, one so serious that countries were imposing travel bans. With the role playing session came a real-life warning: Obama officials warned their successors of national shortages of ventilators, anti-viral drugs and other essentials, and that a unified national response was “paramount” (Toosi et al., 2020).

The NSC—the entity that developed the Pandemic Playbook—is the president’s principal arm to advise on and coordinate U.S. foreign and national security policy. Recognizing the potential risks of a pandemic, it established the Global Health Security and Biodefense unit within it in 2015. Its primary

aim? Pandemic preparedness. In addition, the Centres for Disease Control and Prevention (CDC)—the nation’s health protection agency—had long funded the resident adviser to the U.S. Field Epidemiology Training Program, a medical expert embedded within China’s disease control agency—effectively, on-the-ground “eyes and ears” monitoring emerging threats in a high risk area (Taylor, 2020).

Established in 1999, the Strategic National Stockpile sought to quell fears about potential disruptions to the medical supply chain from the impending Y2K. Those disruptions did not happen, but the stockpile since had been a valuable source of supplies during such national emergencies as 9/11, the nation’s anthrax attacks and major hurricanes. Its inventory is classified, but reports are that its contents include drugs, ventilators, N95 masks, face shields and surgical gowns, a total value of \$8 billion. (Estes, 2020).

These, among others, were the resources at the national government’s disposal in the period immediately preceding the onset of COVID-19: A step-by-step playbook. Knowledge that a pandemic threat was a matter of when—not if—and that medical supplies were limited. Expertise within the White House and in China, a high-risk transmission location. A large stockpile of equipment, if inadequate to fully address a crisis of this magnitude. Yet how these resources were used—or not—is a key element to the story of the U.S. response to COVID-19. If the nation’s leaders followed the Pandemic Playbook and answered the 21 questions and made the 34 key decisions required upon ascertaining a “credible threat,” it would have begun a national effort to procure personal protective equipment (PPEs) two months before it actually did (Diamond & Toosi, 2020). If there was a desire to apply the lessons of the January 2017 transition exercise to this real-life event, few would have been present to do it. Two-thirds of the exercise participants no longer serve in the administration (Toosi et al., 2020). The NSC’s security and biodefense unit? It was disbanded, with its components decentralized and merged into other units, in 2018; administration officials said a new directorate combining arms control and prevention, weapons of mass destruction terrorism and global health was more appropriate (Reuters, 2020). As for U.S. capacity within the China disease control agency, the government-funded position was eliminated in Fall 2018 amid the brewing U.S.-China trade battle (Taylor, 2020). Meanwhile, the national stockpile, underbudgeted at \$600 million annually, long has been the victim of partisan budget battles, shifting priorities from administration to administration and the general lack of investment in governmental infrastructure.

Would full utilization of these resources have stopped the trajectory of the pandemic and fully mitigated its impact? It is unlikely given the spread and unknowns associated with COVID 19. Yet they would have been critical pieces in

the government's arsenal, if they existed, were appropriately funded and were effectively deployed. The COVID-19 crisis lays bare the weaknesses created by a gradual, but considerable, hollowing out of the national government. As longtime *Washington Post* chief correspondent Dan Balz (2020) wrote, "The government's halting response to the pandemic represents the culmination of chronic structural weaknesses, years of underinvestment and political rhetoric that has undermined the public trust, conditions compounded by President Trump's open hostility to a federal bureaucracy that has been called upon to manage the crisis... The nation is reaping the effects of decades of denigration of government and also from a steady squeeze on the resources needed to shore up the domestic parts of the executive branch." The implications for those entities and individuals directing and administering the response are profound.

Responsibilities and Delivery

More numbers tell the story: 97 million respirators, 133.7 million surgical masks, 10.5 million face shields, 22.4 million surgical gowns, 989 million gloves, 10,600 ventilators, 8,450 medical station beds. These are the supplies and materials whose delivery to states, the national government, in partnership with the private sector, has coordinated as of May 14 (Federal Emergency Management Agency [FEMA], 2020). Another: an average 269,000 new tests conducted daily with 15.6 million Americans tested to date as of May 28 (The COVID Tracking Project, 2020). Whether the number of these supplies is adequate for the demand is an unresolved question as states reopen from different degrees of "lockdown."

Nonetheless, responsibility for administration of the supply chain and oversight of the overall U.S. response has continually shifted—formal and informal actors, inside and outside the government, have taken on undefined and often confusing roles—leading to inevitable concerns about who truly is in charge. Compounding the challenge are conflicting messages from elected leaders and administrators, sowing confusion at a time when Americans seek clarity.

A "whole of government approach"

Established on January 29, 2020, the President's Coronavirus Task Force had a straightforward but formidable mission: "Lead the Administration's efforts to monitor, contain, and mitigate the spread of the virus, while ensuring that the American people have the most accurate and up-to-date health and travel information" (White House, 2020). Its initial chair was a logical choice: Alex Azar, secretary of the U.S. Department of Health and Human Services (HHS), the department tasked with leading the coordination of the response; its components include the Centres for Disease Control and Prevention (CDC), U.S. Public Health Service and National Institutes of Health.

Within a month, the task force leadership changed, as Vice President Mike Pence took the helm and Ambassador Deborah Birx assumed the role of “response coordinator.” Yet Azar maintained that he had retained the title of chair, muddying the question of leadership on the coronavirus front and leading the nation’s former Ebola health czar to ask, “Ambassador Birx is great. But who, exactly, is in charge? Her? Pence? Azar?” (Santucci, 2020).

At near daily press briefings, Pence, surrounded by task force members, continually emphasized that the administration was mounting a “whole of government” approach, marshalling the full resources of government departments to get supplies and materials to where they were needed the most. Yet, just as leadership of the task force—which lacked formal or legal authority—changed, so, too, did the statutory entity charged with coordinating the overall response. On-March 18, Pence announced that the Federal Emergency Management Agency (FEMA)—a unit within the U.S. Department of Homeland Security, and until then playing a supporting role—would take charge overall, with HHS relegated to only manage the health and medical aspects. “This effort through FEMA will be locally executed, state managed and federally supported,” Pence said. (Bolen, 2020).

In theory, redesignating FEMA as the governmental lead made sense given its extensive experience with disaster response and state-level emergency operations centres. Yet it was hobbled from the outset, having entered the effort with no data from HHS, developing a plan two weeks after it assumed the lead and suffering from the lack of a clear streamlined distribution system for getting necessary equipment to the states. Said one former FEMA official, “(FEMA) can’t manage what they don’t have and you can’t expect them to do something on the fly that they’ve never done before, particularly when you keep changing the rules” (Alvarez et al., 2020). Illustrative of these challenges: FEMA Administrator Peter Gaynor informed Congress that he had not been invited to join the coronavirus task force until the week that his agency was charged with taking the lead. Then, merely a month and half after taking control, FEMA was looking to transfer its lead agency responsibility to another federal agency as the administration’s priorities shifted from increasing and distributing equipment to reopening the economy (Stein, 2020).

Broken supply chain?

As a practical matter, the U.S. government response generally has focused on two imperatives: (1) distribute equipment, especially ventilators and protective gear, to locations most in need; and (2) ensure and provide for an effective testing system. Within days of FEMA assuming the lead role, the administration deployed Navy Rear Admiral John Polowczyk to FEMA to direct the flow of supplies. Yet the complex U.S. medical supply chain—with seven

major distributors and 700 distribution points across the nation—was not designed for efficiency, especially as the pandemic spread and global demand for supplies skyrocketed. For FEMA, the response was not to do as much buying, distributing and allocating as it could, but to break down the supply chain barriers and get the product to the right places.

That objective cannot be understated. As the pandemic was unleashed, administration officials noted that the government made allocations to states based on population, hospital utilization rates and overall risk levels. Yet governors found a byzantine and chaotic supply chain and a national effort that was unclear and lacked guidance. The result? Inconsistent and conflicting administration and delivery as some states got more supplies that they wanted and others got little of what they needed. The state of Oklahoma received 120,000 face shields, although it only requested 16,000, while North Carolina asked for 500,000 medical overalls and got only 306 (Olorunnipa et al., 2020). Notwithstanding a highly charged political atmosphere in which the president attacked Democratic governors verbally and via Tweet, analysis shows that political favouritism did not dictate distribution of supplies. Rather, it indicates the extent to which distribution was limited in the first place, certainly an even more concerning reason (Bump, 2020).

Poloeczyk set out to manage supply administration and delivery along four objectives: (1) *preservation*, with hospitals needing to stretch existing supplies as much as possible; (2) *acceleration*, with FEMA clearing bottlenecks and speeding deliveries; (3) *expansion*, with new manufacturers stepping up to produce medical supplies; and (4) *reallocation*, with FEMA understanding what supplies are available, where they are located and where they need to go as new hot spots emerge (Muller & Swan, 2020).

Central to FEMA's approach, particularly with regard to expansion and reallocation, was "Project Airbridge," a public-private partnership in which nearly dozens of flights transported supplies—masks, ventilators, gloves, goggles and gowns—from Asia to American cities in early April. The vice president described FEMA's role as similar to an air traffic controller, directing supplies first to medical distributors, and then to hospitals and health care facilities. Using production act authority, the agency allowed half of the equipment to be sold to companies and local governments that previously placed orders, while the remainder would be sold to counties based on U.S. government prioritization (Kanno-Youngs & Nicas, 2020).

As for testing, public health experts diverge in their estimates on the number of tests needed to ascertain the true spread of COVID-19 and determine the manner and timing for states to reopen their economies and enable their residents to resume a sense of normalcy in their lives. More modest estimates

call for 500,000-one million daily tests (McDonald, 2020). Yet the lack of an infrastructure to produce this level of testing remains a significant challenge. Said one professor of emergency management, “I can’t emphasize enough how much there is no plan for how to manage this response, let alone the recovery... (the administration’s plan to reopen the economy) doesn’t tell you how to do any of those things. At best it tells you what your goals are, but it does not tell you how to achieve those goals” (Meyer, 2020).

Equally concerning in terms of test availability are unclear expectations and mixed messaging from national leaders and their administrators directing the response. “If somebody wants to be tested right now, they’ll be able to be tested,” President Trump proclaimed on May 11, during public statements in which he called for states to reopen their economies. Yet Admiral Brett Giroir, tasked with coordinating the government’s testing effort, said during the very same event that supplies can meet demand only for those who need a test (Dale et al., 2020).

States on the Front Lines: Cooperation...and Competition

What about the administration of the testing delivery system itself? On May 24, the Trump administration released a new testing strategy that laid responsibility almost completely on the states. The plan allowed for the national government to provide *some* supplies to states and defined 300,000 daily tests as sufficient, notwithstanding the levels that public health experts advocated. The “strategy” earned scorn among Democratic congressional leaders; their joint statement declared, “This disappointing report confirms that (the) national testing strategy is to deny the truth that there aren’t enough tests and supplies, reject responsibility and dump the burden onto the states...” (Mandavilli & Edmondson, 2020). Yet the devolution of responsibility to the states is perhaps one of the most predictable actions in what has been an otherwise completely unpredictable crisis. Two months earlier, the president said, “I don’t take responsibility at all” when asked about the lack of available tests.

More numbers tell the story, this time of state-level actions: Since the global outbreak, more than 170 bills introduced in 42 state legislatures on paid sick leave and worker protections. More than 300 executive actions issued in all 50 states, Puerto Rico, the District of Columbia, Guam and the Virgin Islands related to states of emergency, school closures, prohibition of mass gatherings, retail and business closures and restrictions, and stay at home orders. More than 1,170 executive actions were issued (Stateside Team, 2020).

Definitively assessing the U.S. response to COVID-19 will be as much about assessing the effectiveness of state efforts as it will be about measuring the national government's performance. To be sure, the nature of the U.S. federal system and the nation's diverse geography and demographic composition are factors. Yet there is a more practical, real-life dimension: To a significant extent, states have been left to their own devices to confront and overcome the pandemic's shattering health and economic impacts. The American experience of the national government leading in times of crisis has been redefined and minimized over the past several months. There is a real argument to be made that if state-level leaders and administrators will be judged effective, it will be in spite of—not thanks to—national government involvement.

The administration's May 24 plan is an intentional demonstration of this redefinition. So, too, were the instructions that states received from the administration during periods in which they diagnosed cases and deaths increased at an exponential rate. On March 19, President Trump stated that the responsibility of providing PPE to medical professionals lies with state governors: "Governors are supposed to be doing a lot of this work...The federal government is not supposed to be out there buying vast amounts of items and then shipping. You know, we're not a shipping clerk." Yet it is precisely a function which the national government historically was known to perform, one that the Pandemic Playbook called for. When asked about states' need for supplies from the National Strategic Stockpile, Jared Kushner—senior advisor to the president (and son-in-law)—declared that the supplies were "supposed to be *our* stockpile...it's not supposed to be the states' stockpiles that they can use," notwithstanding explicit recognition that this was one of the stockpile's purposes. A day later, the stockpile website was scrubbed to deemphasize its commitment to helping states and downplay the size of its inventory (Estes, 2020).

As the national government outbid states on the private market for supplies, states' governors collaborated on their own. The state of California banded with smaller states to procure millions of pieces of supplies, ensuring that smaller states did not lose out to larger ones (Olorunnipa, et al, 2020). Frustrated that the national government outbid his state on supplies already en route there, Massachusetts Governor Charlie Baker worked with the owner of the New England Patriots football team to fly the team jet to China to procure 1.2 million N95 protective masks for Massachusetts and New York (Holmes, et al, 2020). Maryland Governor Larry Hogan procured 500,000 COVID-19 testing kits from South Korea, secretly flying a stocked Korean Air jet to his state and keeping the tests under the watch of the Maryland State Police and National Guard to ensure the national government would not confiscate the goods for its own use (Siu, 2020).

As state economies reopen to varying degrees, the priority has shifted from the immediate demand for equipment and supplies to the longer-term critical need for testing. Given that the national government has left this responsibility to states, as well, it remains to be seen how well prepared they are to administer this responsibility. As Scott Gottlieb, former commissioner of the Food and Drug Administration, remarked on May 31, “I don’t think testing capacity is going to be the challenge heading into the fall. I think getting access to testing is going to be the challenge. There’ll be enough machines to run the tests. What there aren’t going to be are sites to go get tested very easily” (CBS News, 2020).

Conclusion

The COVID-19 pandemic has upended public health and economies around the globe. In the United States, it has shone a light—brighter than any other event in modern history—on the tensions with the federal system; the ramifications of politics colliding with policy; and the lack of investment in the public infrastructure, from hard supplies to the public servants tasked with making things work. For these public administrators—and for the public they serve—the issue remains: Who is—and should be—responsible for leading a response of this magnitude? That the answer is unresolved—and in a constant state of change—should be discomfiting to a public that is seeking reassurance as much as a test or face mask.

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Latin America

Public Policy Actions in Colombia in Response to COVID-19 Pandemic

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Abstract

This paper presents a description of the public policy actions adopted by Colombia in response to COVID-19 pandemic. The measures have been aimed at preserving people's lives and health, caring for the unprotected, preserving certain sectors of the economy from the point of view of income, and protecting the jobs and income of the population formally linked to the economy. Finally, the article addresses the issue of the gradual opening of the economy.

Keywords

Public policy, Colombia, institutions, COVID-19

Highlights

The pandemic exposed inequality in Latin America, faced with this, public policy measures must be structural to protect the vulnerable population. Likewise, the role of supranational organizations and the nexus of their policies with the governmental authorities of the countries must be determined.

There were limitations in having good quality current information and projections that allow, based on scientific evidence, to make a more rigorous analysis in order to make decisions.

Introduction

Public policy measures and government actions in Colombia were aimed at addressing four fundamental emergencies generated by the pandemic: first, to protect the lives and health of people through confinement, restriction of mobility and social interaction. The second was to strengthen the health system, the third was to guarantee essential services, and the fourth was to protect the jobs and income of the population formally linked to the economy. In this sense, public order measures were taken, of a political, social and economic nature, and the direction of the health and education systems.

Context and Data About the Evolution of COVID-19 in Colombia

According to figures from the National Administrative Department of Statistics (DANE), Colombia has a population of 48, 258,494 an unemployment rate of 12.6%, condition of informal employment of 50%, a fiscal deficit of 2.7%, the GDP in the first quarter of 2020 grew 1.1%. The population over 64 years of age represents 9.2% of the population; by 2019, the population over 70 represented the largest number of deaths with 55.3% total.

The first confirmed case of coronavirus in Colombia was on March 6, 2020. Since that date, according to the National Institute of Health (INS) (2020), until May 20 there were 16,935 confirmed cases, 613 of those patients have died; 4050 have recovered; 12,251 continue to be infected; of these, 90.70% are recovering at home; 7.86% are in hospitals and 1.44% are in an Intensive Care Unit (ICU). As for the age range, 50.5% of deaths occurred in people between 60 and 79 years of age; 22.6% in the population between 80 and 99 years of age; 20.7% in people between 40 and 59 years of age. 79.7% of the deaths had some comorbidity; 1 in 10 persons suffered from high blood pressure, 2 in 10 from diabetes and 2 in 10 from chronic obstructive pulmonary disease.

SARS-CoV-2 or “COVID-19” is the global enemy: it forced all countries and their governments to introduce unprecedented actions and public policies to contain its spread. According to the World Health Organization (WHO), it had its genesis in early December 2019, in the Chinese city of Wuhan, in a market for the illegal sale of wildlife, where several cases of viral pneumonia of unknown origin were detected. On January 9, 2020, Chinese authorities noted that this was a new type of coronavirus; since then, the outbreaks have spread rapidly and widely: first to Asian countries, then to Europe until it became a pandemic.

On January 30, 2020, the WHO Director-General Tedros Adhanom Ghebreyesus, following the recommendation of the Emergency Committee,

declared the outbreak of the new coronavirus (2019-nCoV) a public health emergency of international importance. The Director said, “it is expected that an increased international export of cases may occur in any country. Therefore, all countries should be prepared for containment, including active surveillance, early detection, isolation and case management, contact tracing and prevention of the spread of 2019-nCoV infection, and share comprehensive data with WHO” (ONU, 2020). Faced with this WHO statement, some governments did not act immediately. In the case of Colombia, although some immediate actions were taken, the main and forceful actions were taken on the spot.

Institutional Context and Initial Measures About COVID-19 Pandemic

To understand the situation in Colombia, it should be noted that the 1991 Constitution established the right of all Colombians to health care as a public service. In 1993, the General Social Security System (SGSSS) was created, in which public and private sectors share space. Higher-income citizens belong to the contributory regime; low-income persons benefit from a subsidized regime. The governing body for public health policy is the Ministry of Health and Social Protection; the agency responsible for ensuring the adequate flow of resources and respective controls is the Administrator of the Resources of the General Health Insurance System (ADRES). The Health Promotion Entities (EPS) are responsible for affiliation to the SGSSS, and the Service Provider Institutions (IPS), hospitals, clinics, and laboratories, among others, are responsible for providing health services.

Towards the end of January, one of the first actions taken by the government was to reallocate the budget of the Ministry of Health and Social Protection for 2020 to a value of approximately 350,000 USD. The resources would be allocated to strengthening the national reserve centre (medicines and supplies) and the national communications centre, the crisis room, and the office of territorial management, emergency and disasters. Finally, the transportation, emergency evacuation and institutional strengthening.

On March 2 the Risk Assessment Committee of the Ministry of Health and Social Protection made the decision to modify, from moderate to high risk, the entry of the coronavirus into the country. The first restrictions taken by Colombia were associated with the migratory flow. Bearing in mind that the COVID-19 was already in the region and that the migratory flow was extensive with some of the countries already reporting cases, Colombia made the decision to extend migratory screening to Ecuador, the United States, Spain and Germany; previously, screening had been extended to China, Italy, Korea,

Iran and Japan (Resolution 085, 2020). In addition, other regional actions in the country included how to implement the use of two formats when entering national territory: the first, a document or statement of health and travel history; and the second, a document with recommendations and symptoms. The country's capacity for hospital care such as ICU beds also started to be calculated. Biosecurity protocols such as hand washing, use of masks, and self-isolation measures began to be included.

On March 16, the government regulated the closure of sea, land, and river crossings with Panama, Ecuador, Peru, and Brazil from March 17 until May 30, 2020, and continued with the closure of the border with Venezuela allowing only the transport of cargo using biosecurity measures (Minsalud, 2020).

Public Policy Measures Taken by the Authorities in Colombia Regarding COVID-19 Pandemic

In Colombia, the first case of COVID-19 came from Milan, Italy, the epicentre of the epidemic in Europe, evidenced in a young Colombian woman who was infected and had entered the country on February 26 and was diagnosed as positive for Coronavirus on March 6. During the first fortnight of infection, 80% of the cases came from overseas, according to figures from the National Health Institute. Therefore, one of the main criticisms of the national government was its delay in closing the borders.

Faced with the appearance of the disease and the virus in Colombia, the government took measures based on the Constitution regarding emergencies and established a legal framework to deal with the pandemic. The body responsible for implementing all measures from the outset has been the executive branch, headed by the President and the Minister of Health. In this regard, it is appropriate to note the actions of governments, because Colombia is a unitary country, but with a decentralized structure of governments at the regional and municipal levels. Thus, despite the fact that the determinations, from the beginning until today, have been taken by the central government, it is clear that the regional and municipal governments must take their determinations in line with what the national authorities say; because of this, some occasional contradictions between the central and local levels of government have been observed.

The government made the decision to act under several measures, having an impact on solving the main emergencies. First, to preserve the life and health of the people; Second, to guarantee the essential goods and services by certain sectors of the economy; Third, to assist the people who are unprotected from the point of view of income and finally to protect the jobs and income of the

population formally linked to the economy. Already reduced the emergency, these last policies are related to the gradual opening of the economy.

To strengthen the General Health Insurance System (SGSSS), which is shared by public health (subsidized regime), and private providers (contributory regime), the government added resources for financial advantage and infrastructure improvement. The pandemic warned of the need for respirators and ICUs, but Colombia did not have the infrastructure required to deal with the pandemic. According to the Colombian Association of Scientific Societies (ACSC, 2020), there were 5,300 ICU beds available throughout the country, of which 750 beds had the appropriate level of isolation to deal with the health emergency; therefore, non-essential surgeries and general service appointments had to be postponed.

The second measure was to decree the health emergency. On March 12, the government took the measure of preventive isolation of the population and restricted mobility. Adults over 70 must be in isolation until May 30 (Resolution 385, 2020). Isolation began with academic settings, adopting the measure of temporary virtualization and prohibiting agglomerations of more than 50 people; these determinations were applied in the territories, regions and municipalities. Simulations of lockdown were carried out in the cities of Bogotá, Cali, and Medellín, between March 20 and 24. Subsequently, the national government decreed social isolation on March 25, which was set to end on April 13, but was postponed twice (May 11 and 25) and extended until May 31. In order to control the movement of people, the modality adopted was a quarantine policy to restrict people according to the odd or even-numbered ending or their gender. This restriction was aimed at controlling the use of financial services and the supply of essential goods. Non-compliance with confinement is subject to fines of up to \$241.

The government first preached the slogan of saving lives and protecting their risks. However, in order not to get into the dilemma between life and the economy, it decided to keep some essential sectors active: essential services (energy, communications, water, gas, etc.), health care and service provision, banking and financial services, cleaning, disinfecting and washing supplies and products, activities related to emergency services, and funeral services. The entire supply chain of basic goods remained active and subsidies were granted to the agricultural sector and the telecommunications sector for strata one, two and three. Operators were ordered to provide messenger services and access to State platforms that would enable Colombians to find out about pandemic measures. The government controlled and prohibited abuses in the increase of the cost of living.

The third measure related to social policy was aimed at assisting people who are unprotected from the point of view of income, because they are

independent, self-employed, people with limited resources, and in vulnerable conditions. These first aid measures, worth approximately US 4 million, were aimed at strengthening existing social programs such as: Families in Action, which provides an economic subsidy of around 40 US per month to 2.6 million families. For the Youth in Action program, an individual value of about US 100 per month was allocated to almost 300,000 young people; a monthly value of US 25 was also allocated for the Senior Program to almost 2 million beneficiaries. Another item of social spending included markets to families and kept the Student Food Program at home for 6.2 million children.

Another fiscal public policy measure adopted, under the auspices of the 2019 tax reform, was to anticipate the refund of IVA (VAT) to the poorest. Although it was ready to be implemented in June, the government had to put it into effect in April. To date, 2 million people have benefited from this aid, with an income of US \$20 per person. For individuals in situation of poverty and vulnerability that are not beneficiaries of social programs of the State, the government created a bonus of Solidarity Income in which a total monetary transfer of approximately 70 US. To date, according to government data, 1.7 million households have benefited.

The fourth public economic policy measure was to protect the jobs and incomes of the population, formally linked to the economy. Through the financial sector, financial relief was requested, the disbursement of credits from the *Banco Central (Banco de la República)* to the Commercial Banks. The capitalization of the National Guarantee Fund (FNG) with about US 18 million, seeking that companies and individuals can access credit. In addition, employees were able to dispose of their social security savings, the advancement of work vacations, and labour regulations were established prohibiting layoffs. Finally, the government sought to finance the salaries of SMEs, creating a three-month subsidy equivalent to 40% of the minimum wage, that is, about \$90 per month per employee, with the commitment that companies would not have layoffs..

A subsequent measure taken as the days of lockdown have passed is to aim at gradually opening up the economy. The government is taking steps towards this goal. For this reason, the government is gradually opening up some sectors of the national economy in a controlled manner in addition to the sectors that had already been functioning. The first sectors that opened on April 27 were construction and manufacturing. The second opening took place on May 11, to sectors such as maintenance, services and trade of furniture, vehicles and machinery and equipment. On the other hand, the municipalities declared as “non COVID-19” (which have no confirmed active cases) began their gradual opening by releasing their economy under strict biosecurity measures Resolution 734, 2020).

It should be pointed out that within the Colombian institutions there is an Emergency Mitigation Fund, which was created years ago with the purpose of attending to eventualities such as that related to the COVID-19. This emergency mitigation fund increased its resources through a self-loan from other funds such as: the Savings and Stabilization Fund “FAE” and the National Pension Fund of the Territorial Entities “FONPET”, which are resources of the territorial entities to attend to pensions and other expenses; This measure was initially questioned by the territorial entities.

In addition to the above measures, the monetary authorities acted on the corresponding policy, making reductions in interest rates: First, with a reduction by 0.5 points; Then another 0.50 to leave it at the current level of 3.25%. The monetary authorities decided to reduce bank reserves from 11% to 8 % to free up resources to allow banks to make forced investments in public solidarity bonds in order to have a source of financing to meet various expenses related to the pandemic. The *Banco Central* reinforces the supply of liquidity and supports the provision of credit, carrying out transitory expansion operations (Repos) with portfolio securities for up to 6.3 billion (Banco de la República, 2020). With the purpose of increasing international reserves and taking into account dollar monetization foreseen by the National Government, *Banco Central*, bought 2 billion USD.

The country’s fiscal deficit target was adjusted from 2.2% to 6.1%, which opens up more room for debt and mitigates the tailspin of the COVID-19. The IMF approved a new two-year Flexible Credit Line (FCL) arrangement for Colombia, designed for crisis prevention, the amount of US\$10.8 billion. The country also received a \$250 million development policy loan, better known as CAT DDO, from the World Bank. The first US\$1 billion will come from the Inter-American Development Bank (IDB) to work on COVID 19.

In terms of public trade policy, the Colombian government made decisions such as the following: the modification of the customs tariff for the import of products needed to deal with the health emergency caused by the coronavirus COVID-19; the relaxation of requirements for COVID-19 products, and the prohibition of the export and re-export of COVID-19 products.

A fundamental issue in the way this pandemic has been dealt with is public policy related to risk management and the protection of people’s lives. These determinations have been complemented by public order measures, in which regional and municipal governments have had a very important role. Thus, the public order provisions issued by regional and municipal governments have been previously coordinated and in accordance with the instructions given by the President of the Republic.

The government disseminates the actions through the television program “Prevention and Action” which is broadcast every day. Although it is not yet

known whether the measures adopted by the government have been adequate and correct, the country gave a quantitative rating to President Duque's actions in the survey published by the firm *Cifras & Conceptos*, according to which the president obtained a score of 61.7 out of 100 points. However, local governors had better ratings (El Tiempo, 2020).

Some Reflections About the Management of the COVID-19 Pandemic

The Colombian institutions to face this pandemic are: the Emergency Mitigation Fund, the Ministry of Health and Social Protection, the General Health and Social Security System, CONFIS, as a fiscal policy body, the Board of the *Banco Central*, as a monetary policy body, and the Superior Council of Foreign Trade. They have played a very important role and reflect the institutional strength that Colombia has to react quickly in public policy measures. However, there are some weaknesses in the health system, which has both a public and a private component, where there are problems with policy coordination and implementation. Other actors have been active participants in the adoption of public policy actions, such as civil society, business and financial associations, among others.

It is worth noting that the relations between the national, regional, territorial and municipal governments had roles in receiving the resources. However, there was friction between the central government of Colombia that sets policies, and the territorial and sub-national governments, the municipalities and local governments that execute them. In the case of the confinement rule, it has a generality, but the rulers are autonomous and have the capacity for a small-scale regime of exception, located in a department and a municipality.

Colombia has acted in a very similar way in some measures taken by other Latin American governments. Public policy actions in the region were oriented firstly towards making resources available to deal with the pandemic; secondly, closing borders; thirdly, confining the population and restricting its mobility; and finally, gradually opening up the economic sectors.

To maintain the lockdown, governments strengthened and created social programs focused on unemployment assistance, protection of vulnerable populations, loans to SMEs, subsidies to the education sector and food assistance. Likewise, governments leveraged the health sector financially and increased its capacity. In these countries, it is the executive branch at the head of the President and the Minister of Health, who conduct public policy actions; this creates a problem in the face of democracy, because power can be concentrated in the executive branch.

On the other hand, Latin American countries also face similar problems such as failures in relation to diagnostic tests, lack of traceability and tracking of cases, a measure that was adopted in Asian countries through mobile applications. The high rate of informality in the region also affects the containment of infection because people face the existential dilemma of “dying from the virus or from hunger”.

Lessons Learned and Challenges

Colombia faces great challenges: First, the alignment of local governments and society to the guidelines of the central government; Second, to provide the health sector in the most remote territories with a high concentration of poverty that do not have basic sanitation. Likewise, to improve the effectiveness and response of the financial sector for economic reactivation. Another challenge is to improve the structure of fiscal revenues because the state’s main income comes from oil. Together, the countries are not yet ready to take on virtual education and teleworking, due to the high rates of inequality in access to ICTs.

The economy needs to revive. Although there is relief for supply, the restriction of social contact can harm consumption and production. Moreover, long-term confinement is unsustainable; the state cannot and does not have the capacity to support the entire population indefinitely; this leads to economic collapse and social breakdown. The ideal is to implement partial lockdown. Faced with all these challenges, the latent risk in Colombia and in all countries is that, with the reactivation of the economy, the outbreak will come out again.

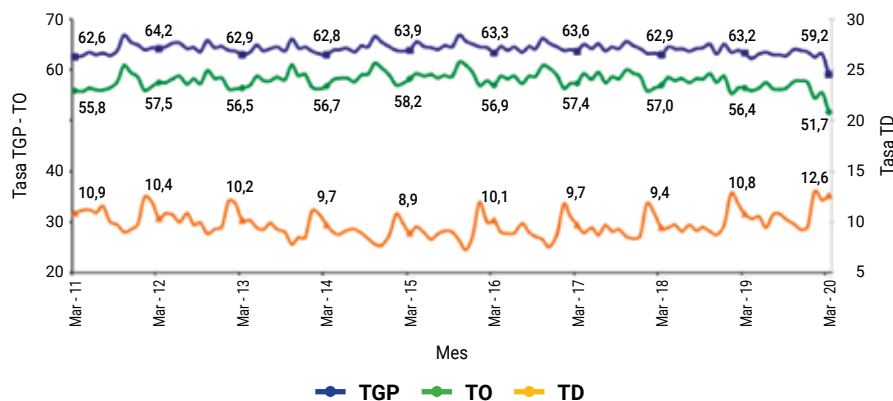
One of the main lessons of the pandemic is that Colombia, like other countries, was not prepared neither in its health system, nor in its institutional system, to face public health emergencies. It is imperative to have data based on scientific background to make public policy decisions. The role of supranational agencies such as WHO and the nexus of their policies with the government authorities of the countries must be determined. Finally, to decrease the market share related to society’s right to health care.

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Statistics

Figure 1 - Global participation rate, occupation and total national unemployment March (2011 - 2020)



Source: DANE, Large Integrated Household Survey (GEIH).

National Experience of Mexico on Coronavirus - COVID-19 Pandemic

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Abstract

This chapter analyses the aspects of how the Government of the United States of Mexico has been approaching COVID-19 from the perspective of public management and framed in the WHO guidelines. The text is developed in four parts. The first puts the country's federal public administration into perspective. Secondly, the public health institutions that are fundamental to combat COVID-19 are described. In the third part, the role that experts play in advising the government in the different phases of the pandemic are highlighted and finally, some data on resources for the public management of the health system are shown and finally various data on the cases and deaths caused by the coronavirus in the country are presented.

Keywords

COVID-19 pandemic, health institutions, health policy, public administration of Mexico, public management of the health system

Introduction

Mexico faces problems of regional inequalities, concentrated poverty in its southern states, and a relentless problem of public safety, accompanied by the grievance of widespread corruption. In 2018, the Bank of Mexico estimated – and the incoming government stated – that, by 2019, because of the country's great social needs, it would require considerable investments in health, infrastructure, and in an organized fight against crime, drug trafficking and corruption. This makes it essential to better target public spending and an increase in tax collection, which in Mexico is low. Expanding the tax base and changing the combination of tax rates could reduce informality and increase the government's revenues to meet the challenges of raising the standard of living, reducing poverty and inequality. Mexico advocates its hopes in the new Free Trade Agreement between Canada, the United States and Mexico, currently known as T-MEC. Mexico (with a territorial area of 1,964,375 km² and a population of 126 million) is a presidential (the period is 6 years) and federal (32 states) (INEGI, 2020).

At present, the private sector specialists consulted by the Bank of Mexico (Banxico, by its Spanish acronym) anticipated that the local economy will register a contraction of 7.27% for this year of 2020. The country's new expectation of GDP is a deeper decline than they anticipated a month ago, when they estimated that the downturn in the economy in 2020 would be 3.99%. In addition, 100% of the 38 specialists surveyed by the Mexican Central Bank warned that, currently, it is not a good time to make investments (El Financiero).

The context in which the Coronavirus epidemic broke in Mexico was shortly after the beginning of the government of Andrés Manuel López Obrador (who took office on December 1, 2018), of the National Regeneration Movement Party (MORENA by its Spanish acronym), whose election campaign was focused on attacking what he calls “the Mafia of Power”, corruption and neoliberalism, along with the promise that he would carry out the 4th Transformation of the country.

AMLO (as known by its acronym) came to the Presidency of the Republic with broad popular support. He won the election with 53% of the votes cast. His party, a member of coalition named “Together We Will Make History” (formed by the parties of Morena, the Labour Party and the Social Meeting Party) is often joined by the Green Ecologist Party of Mexico (PVEM, by its Spanish acronym) to form an absolute majority in the Chamber of Deputies (composed of 500 deputies). In the House of Senators (which has 128 senators), the “Together We'll Make History” coalition has a simple majority, but not a qualified majority. The important point is that amending the Constitution requires a qualified majority.

In order to better understand the concept of “The 4th Transformation”, one must mention that the history of Mexico is divided into three stages: 1) the Independence (1810-1821), whose emblematic figure is the priest Don Miguel Hidalgo y Costilla; 2) the Reform and the war against the French intervention (1854-1867), whose icon is Don Benito Juárez; and 3) the Mexican Revolution, initiated by Francisco I. Madero (1910). Such is the historical dimension that the government of López Obrador wishes to achieve.

Institutional arrangements

The Mexican federal public administration

The Office of the President of the Republic, the Ministries of State, the Legal Department of the Federal Executive and the Coordinated Regulatory Bodies form the Centralized Public Administration. Decentralized agencies, state-owned companies, national credit institutions, national auxiliary credit organizations, national insurance and surety institutions, and trusts make up the parastatal public administration (DOF 23-04-2020).

Within the framework of The 4th Transformation, the National Development Plan to which the units and entities of the Federal Public Administration will be subjected to is the basis for the development of the necessary programs to comply with its content. These programs must comply with the provisions of Articles 26, 26 Bis, 27, 29, 30 and 31 of the Planning Act. In order to comply with these provisions –and to help the achievement of the 2019-2024 National Development Plan’s provisions for eradicating corruption– the Ministry of Civil Service, the Ministry of Finance and Public Credit and the Coordination of the National Digital Strategy of the Office of the Presidency of the Republic will carry out the National Programme for Combating Corruption and Impunity –an improvement of the public management from 2019 to 2024, which complies with the aforementioned legal provisions and seeks to strengthen the actions of the Federal Public Administration in its fight against corruption and impunity in the administrative sphere, in strict compliance with the General Law on Administrative Responsibilities (DOF 19-11-2019), and the General Law of the National Anti-Corruption System (DOF 18-07-2016), as well.

The date of the Decree that establishes the austerity measures to be followed by the agencies and entities of the Federal Public Administration was March 23, 2020 was. It took, among other decisions, the reduction of salaries of senior officials by 25%, not receiving bonuses and the disappearance of ten undersecretaries of the Federal Public Administration.

Public health institutions and preparedness of the system

For the topic at hand (how the Mexican government has coped with the problem of the COVID-19 epidemic) one should point out that Mexico, in terms of public health, is organized according to the National Health System (SNS, by its Spanish acronym), which is formed up by a set of public entities —both federal and state —, as well as from the social and private sectors. The SNS was established thanks to the reform of the General Health Law (DOF 07-02-1984). This system is coordinated by the Ministry of Health. The largest institutions in the health sector in Mexico are: the Mexican Institute of Social Security (IMSS, by its Spanish acronym), which serves every 6 out of 10 Mexicans; the Institute of Security and Social Services for State Workers (ISSSTE, by its Spanish acronym) which, as its name implies, provides medical and social services to people that work for the federal government, while the Army and the Navy have their own health services.

Mexico also has the National Institutes of Health (INS by its Spanish acronym). These are specialized hospitals for certain sectors of the population or certain types of diseases, like the Children's Hospital of Mexico, the National Institute of Cardiology and many others. Recently, the Popular Insurance was changed by the Institute of Health for Welfare (INSABI by its Spanish acronym) which has the function of serving people with no social security. It will provide free public health services, medicines and other related supplies for whenever care is required. INSABI provides care through health centres, Health Centres with Extended Services (CESSA by its Spanish acronym), IMSS Wellness Medical Units, Medical Specialty Units (Unemes by its Spanish acronym), as well as general, rural, and community hospitals that offer world-class services (Gobierno de México, 2020a).

The role of experts in advising authorities on the COVID-19 pandemic

What one needs to highlight is the role that the National Institute of Respiratory Diseases (INER by its Spanish acronym) has played in the current pandemic. This is the hospital where the first Mexican infected by COVID-19 was treated: a 35-year-old man who was called “the index case”. The Undersecretary of Health, Hugo López Gatelle, reported this first case on February 28. The patient went into solitary confinement, as well as five of his relatives who had travelled with him to Italy between February the 14th and the 22nd.

On January 30, Tedros Adhanom Ghebreyesus, Director-General of the World Health Organization (WHO), declared the coronavirus epidemic to be an international emergency. Immediately, Mexico launched the Preparation

and Response Plan. This plan was unveiled by José Luis Alomía Zegarra, then the national spokesman for the Coronavirus crisis. This spokesman pointed out that, from the moment the WHO declared the seriousness of COVID-19, the National Committee for Health Safety held an extraordinary session with the aim of implementing prevention and action measures to be coordinated by the Ministry of Health.

The Director General of the National Centre for Preventive Programs and Disease Control (CENAPRECE by its Spanish acronym), Ruy López Ridaura, unveiled the agreements that were made in said extraordinary sessions, which included:

- The Ministry of Health (headed by Jorge Alcocer Varela), through the Undersecretariat for Health Prevention and Promotion (run by Hugo López Gatell) and its equivalents among the federal entities, would be responsible for the organization and coordination of preparation actions within the framework of the Health Safety committees.
- State health services would be instructed to hold an extraordinary session of the State Committee for Health Safety to report on the strategy and actions to be taken against the coronavirus.
- All members of the national committee would be requested to support the dissemination of disease-related advocacy and prevention materials issued by the Ministry of Health.
- It was confirmed that the sole voice for informing and communicating the risks of this emergency would be the Directorate-General for Epidemiology of the Ministry of Health.

In fact, this last point was not fulfilled: the one who has really played the role of spokesman for the federal government in reporting this health emergency is the Undersecretary of Public Health, Hugo López Gatell, who offers a daily press conference. This is a custom that AMLO has implemented since he was head of the government of Mexico City (2000-2005). Very early in the morning, he used to appear before the media and give information about Mexico's capital city, while also expressing his opinion on national politics and conducting a question-and-answer session. That is how he gained notoriety all over the country. Now that he is president, this practice has continued.

Resources for the Public Management of the Health System

What turned out to be surprising (this being a left-wing government) is that in the 2019 federal budget —when the XLIV party-dominated, the legislature was in office— the health sector received 123.2 billion pesos (about \$5 trillion

dollars): 3.2 percent less than the amount approved in 2018. By 2020, the health budget increased modestly by 0.18 percent. However, resources to combat the epidemics were cut.

On February 28, that is, when the coronavirus was on the rise, one of the country's business organizations, The Patronal Confederation of the Mexican Republic (COPARMEX by its Spanish acronym) issued the following statement: "With the budget cuts that the government of Andrés Manuel López Obrador has made, our health system is weak and less prepared. Cuts have been made in several units, including in the Directorate-General for Epidemiology, responsible for monitoring and issuing preventive measures against infectious outbreaks" (La Vanguardia).

Said statement declares that, at this time of global contingency, the Directorate-General for Epidemiology suffered a cut of almost 57 million pesos (about \$2 million dollars) to its budget. Such was the case of 18 National Health Institutions (INS by their Spanish acronyms) which suffered cuts of approximately 4 billion pesos (approximately \$173 million dollars).

This reduction in the health budget, cuts and layoffs of workers in this sector (doctors, nurses, paramedics, stretchers, ambulance drivers, quarterly staff, office workers, etc.) has resulted in protests from those affected since May 2019. From then on, there have been rallies in at least 13 states against the federal government's treatment of the health sector. Even before the coronavirus appeared, Andrés Manuel López Obrador downplayed the health sector: during the first six months of his government, hospitals began registering a lack of inputs. There were also unjustified layoffs. This began to make it difficult for these workers to care for patients.

The first to take their plea to the streets, were about 200 workers from the National Institute of Respiratory Diseases (INER) who, on February 13, 2019, demanded a higher budget, inputs and curb staff layoffs from the Ministry of Health. By April 15, resident physicians from 82 hospitals in 24 states of the country rallied in the republic's capital to demand payment of three fortnights in arrears and the 3,000 pesos (\$130 dollars) bond they receive every six months. The rallies of these health workers reflect the shortcomings that public hospitals in Mexico are working with against the Coronavirus pandemic.

The Mexican Social Security Institute's personnel (IMSS by its Spanish acronym) which, as pointed out, is the largest and most important health institution in Mexico, employees of clinics and hospital workers work "under protest" because they do not have the indispensable equipment to treat COVID-19 patients. That has led to COVID-19 contagion among doctors, nurses and the quartermaster's staff. By mid-April, 4,148 health employees with coronavirus symptoms had been tested. Of these, 535 tested positive and 9 of them died.

Carmen Alonso, of the *Médicos de México* Organization (“Medics of Mexico”), said that one of the main problems that health workers face in clinics and hospitals is that the international protocols to address a pandemic are not being properly applied. No one supervises that these protocols are met. Dr. Alonso added: “Hospital directors are over the board (...), we don’t properly use the experience of other countries; it was not planned as it should be done— institution by institution—and there are many improvisations. There is a very large gap between organizing and supervising” (Badillo, 2020, own translation).

To demonstrate the said precarious situation, lack of training and shortage of inputs that prevail in many Mexican hospitals, the following case study is presented: Monclova (380 thousand inhabitants), located in the state of Coahuila (bordering the United States) became the Mexican city with the highest per capita rate of the disease, and exposed the communication failures between the institutional authorities in Mexico City and its local dependencies. This case also highlights that the National Committee for Health Safety agreement of coordination between federal and state authorities was not met.

Measures Taken to Fight the COVID-19 Pandemic

The problem began when a trailer driver from Piedras Negras (in the state of Coahuila, 150 miles from Monclova), who had recently travelled to Chicago, entered the emergency room of the town’s hospital on March 15. He had an X-ray, and his diagnosis was pneumonia. An assessment from the Intensive Care Unit concluded that this was a likely case of COVID-19 that, as such, should be placed in isolation. But the hospital had not yet prepared any patient isolating measures. Thus, he was referred to the ER –an area through which many people transit. For a week, a COVID-19 patient was in contact with dozens of doctors and nurses who, in turn, were in contact with other colleagues and patients.

Two days later, patient zero had to be connected to a respirator. Tests were performed, the results of which came until March 22. Although the director of the Hospital, Dr. Ulysses Mendoza, learned on that very same day that the test was positive for COVID-19, he did not transfer the patient to another area until the next day.

By then, two doctors were already showing COVID-19 symptoms. Staff at IMSS Hospital No. 7 in Monclova work with a shortage of bottle caps, gloves and antibacterial gel. On March 24, workers at this hospital took to the streets to protest the lack of protective equipment for treating coronavirus patients.

In many of the country’s hospitals, supplies quickly ran out and were not replenished. Monclova Hospital No. 7 is an example of this. State and

municipal authorities had to intervene in order to implement measures against coronavirus within their state hospitals. On March 27, patient zero died. It was the first COVID-19 death in the state of Coahuila. More coronavirus patients began being reported in Monclova. Almost all of them (19 in total) worked at Hospital No. 7.

The problem that arose in Hospital No. 7 was made known nationally through the daily conference of Undersecretary Hugo López Gatell. However, he attributed the contagion to a clinic doctor who became infected with coronavirus in an “out-of-hospital consultation.” Outrage and protests from the people of Monclova were immediate and were covered by the national press. On March 31, Gatell had to apologize publicly. He admitted that the information he had given about what happened at Hospital 7 was erroneous. The result of the mistakes and tardiness of health authorities at the federal, state and municipal levels was that the contagions in Monclova got out of control. With 12 cases per each 100 thousand inhabitants, Monclova became the city with the highest rate in the country. In Mexico City, the rate is of 3.6 cases per each 100 inhabitants, almost four times higher. That is why the city of Monclova is known as “The Mexican Wuhan”.

Despite the tragedy of Monclova, which spread to other cities in Coahuila, this state has not received any help from the federation. For this reason, the governor of Coahuila, Miguel Riquelme Solís, together with the governors of Nuevo León, Jaime Rodríguez Calderón, and of Tamaulipas, Francisco García Cabeza de Vaca, decided to form a group to show their anger towards the federal government for the neglect they have suffered throughout the present administration. This group was joined by the governors of Durango, José Rosas Aispuro, and Michoacán, Silvano Aureoles Conejo, and has the sympathy of the governors of Jalisco, Guanajuato, Durango, Sonora, Chihuahua, Aguascalientes and Querétaro.

It is worth noting that Coahuila, Nuevo León and Tamaulipas are states bordering the United States (the border between Mexico and the United States measures 1,980 miles and includes, on the Mexican side, the states of Chihuahua, Sonora and Baja California; and on the American side, the states of California, Arizona, New Mexico and Texas).

During the press conference given by the governors of those three states, Francisco García Cabeza de Vaca said: “What I want to say to Undersecretary López Gatell is that for a long time we told them to filter and limit the flows of non-essential visitors from the United States, and to address the issue of [Central American] migrants that today have strong contagions and can infect the rest of the population. That’s what he’s omitting.” This pronouncement was made on April 29.

Earlier, on April 13, four governors (almost the same group), in the face of the coronavirus epidemic, demanded a revision of the fiscal pact. They were Enrique Alfaro, from Jalisco, Jaime Rodríguez, from Nuevo León, Miguel Riquelme Solís and, from Tamaulipas, Francisco García Cabeza de Vaca. This tax pact was established in 1980. It meant that all federal taxes went to a common bag from which they would be distributed according to the judgement of the president and the Secretary of the Treasury. The result has been that, for every peso that is charged, 80 cents are kept by the federation; 15 cents are distributed among the states; and 5 cents go to municipalities –of which there are 2,457 in Mexico (INEGI, 2020).

By the end of April 2020, a block of 21 governors began expressing their disagreements with the way in which the money is distributed. “The inconvenience of states in the absence of a fair distribution of resources is clear. The government does not give states their fair share; states contribute more money to the federation than they receive,” said the panel’s spokesman (Guzmán, 2020, own translation). This state reaction against the federation stems from the deficiencies that emerged from the coronavirus epidemic. Since IMSS hospitals (a federal institution) are under-supplied, state health services –although also suffering from deprivation – have had to take care of many coronavirus patients.

Internationally, the COVID-19 pandemic is known to demand very sophisticated medical equipment (particularly respirators). Thus, the Mexican government went on the search for suppliers and found them. On April 9, President Andrés Manuel López Obrador announced that an agreement had been signed with China for the purveyance of medical supplies for dealing with the COVID-19 pandemic. These negotiations were led by the Ministry of Foreign Affairs (SRE) and the Ministry of Health (SSA).

On the same occasion the chancellor, Marcelo Ebrard, noted that there would be up to four flights per week to bring the material that was purchased for \$56.5 million from China to Mexico.

On May 18, Mexico had recorded 5,332 dead and 51,633 infected due to COVID-19. One can see in Table No. 1 the variation between May 4 and May 18 in terms of the number of COVID-19 confirmed patients, suspected patients and dead in Mexico. As reported by Hugo López Gatell, the peak of the pandemic would arrive between May 4 and 6, before decreasing gradually –as long as Mexicans followed the established guidelines: shelter at home, wash their hands frequently and, if one had to go outside, use face masks and keep a safe distance from others. The problem is that many people have ignored these measures, especially at the most congested stations of the Mexico City’s subway system, whose metropolitan area has about 22 million inhabitants.

Table 1 - Mexico (2020) Variation of COVID-19 cases May 2020

Dates	Confirmed patients	Suspected patients	Dead
May 4*	26,025	16,079	2,507
May 6**	27,634	17,553	2,704
may-07	29,616	18,812	2,961
may-08	31,522	20,571	3,16
may-09	33,46	20,887	3,353
may-10	35,022	19,979	3,465
may-11	36,327	20,991	3,573
may-12	38,324	22,98	3,926
may-13	40,186	24,856	4,22
may-14	42,595	26.746	4,477
may-15	45,032	29,028	4,767
may-16	47,144	29,409	5,045
may-17	49,219	27507	5,177
may-18	51,633	26,933	5,332

* 236 deaths were recorded on May 5, the highest number in one day

** On May 7, 1,609 new cases are registered in one day.

Source: Own construction based on Secretaría de Salud Federal (2020), and John Hopkins University & Medicine (2020).

Defeating the coronavirus requires a collaboration between society and the government and this is an accepted fact. In Mexico, unfortunately, there is no civic education among the population and it is the only member country of the Organization for Economic Co-operation and Development (OECD) that has done the least for gathering evidence.

The example of countries like South Korea and New Zealand that have done a splendid job against the COVID-19 epidemic needs to be followed.

Concluding Remarks

Mexico's case is seen not as a success in treating this pandemic, but as a form of disdain since its inception, when it was declared worldwide by WHO. There were or have been many factors that have affected it. They are listed, namely: the institutional context of the country does not respond to the impact of the COVID-19 pandemic. The inadequacy of the Mexican health system has allowed public officials in the system to be unprepared for the coronavirus onslaught through guidelines and action programmes. Organizational and institutional incapacity

is shown. So far, there has not been a central base public decision at the federal level to respond to the pandemic. The actions taken have only been replicas of the World Health Organization's recommendations. There has been no clear public leadership. A key issue is that the Mexican government has not been transparent in what has been monitored and evaluated in terms of the implemented actions involving budgets and resources. There is no policy of accountability despite the proposals of the Accountability Network of the Centre for Research and Teaching in Economics (CIDE by its Spanish acronyms). As for state governments, few of them in the federation have pushed for clear and forceful actions like the governors of the states of Tamaulipas, Coahuila, Nuevo León, Jalisco and Baja California have. The municipal governments are characterized by their loneliness against this issue, with the exception of metropolitan ones.

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Peru – The Role of the National Government in Combatting the COVID-19 Pandemic

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Abstract

Since the fall of the Berlin Wall there have been major changes in the world. One is the conversion of Latin America into a highly strategic territory, due to its bio-oceanic position between the Atlantic and Pacific Oceans. Peru looks towards the Pacific Ocean. It is a complex country territorially, socially and politically. Despite major political crises during the current government, such as the resignation of the President in March 2018, the closure of Parliament in September 2019 and new elections for representatives to complete the term until 2021, and the seven Ministers of Health since July 2016, it has been able to develop a State of National Emergency with quarantine and curfew, which has been the cornerstone of its strategy. Thanks to its excellent macroeconomic strength, it has developed a program of economic support for families and businesses which, despite the difficulties, is producing the expected effects. Its main problems in facing the pandemic have been its disjointed health system and the high economic informality and its enormous number of micro and small businesses.

Keywords

Peru, COVID-19, health, pandemic, 5 T's

Highlights

“Despite the fact that the cumulative number of new cases and hospitalizations continues to increase, the percentage of people hospitalized tends to decline”.

“The difference in the evolution of the pandemic between one country and another lies in the speed of the reaction of the public apparatus and the articulation between the different measures taken”.

Introduction - Peru in Latin America

Since the fall of the Berlin Wall and the creation of the Asia-Pacific Forum in 1989, a new global configuration of power and, especially, of geostrategic spaces has been initiated. Since the first years of the 21st century there has been a great demand for exports from Latin America and an increase in direct foreign investment from all the centres of power. Not only because Latin America has become a geostrategically important “middle earth” between the Pacific and Atlantic Oceans, but also because of its less aged population, its natural resources, its great biodiversity and because in the last few years, five of its economies have been among the 21 most important emerging markets in the world. (Kondo & Teso, 2019). Also, after the global financial crisis, Latin America has become an attraction for migration from Europe (Córdova Alcaraz, 2015).

Latin American and Caribbean countries are among the best endowed with natural capital in the world: biodiversity and ecosystems. South America possesses more than 40% of the earth's biodiversity, more than a quarter of its forests and constitutes the area of greatest biological diversity in the world. (Bovarnick et al., 2010).

Peru has 84 of the 117 life zones of the planet and 28 of the 32 climates of the world (Vicente, 2011) and is located in South America, in the central South American space, looking at the Pacific Ocean and is one of the fifteen countries with the greatest biodiversity in the world (Batlle Cardona, 2020). In geographical extension, Peru is the third country after Brazil and Argentina. It has 1'285,215.6 Km² and its population is 31'237,385 inhabitants (Instituto Nacional de Estadística e Informática [INEI], 2018). It borders with Ecuador and Colombia to the North, Brazil to the East, Bolivia and Chile to the South and the Pacific Ocean to the West.

Peru has three major natural regions that divide the country longitudinally from North to South: Coast, Sierra and Jungle. Coast facing the sea, desert with valleys along its extension. In the centre of the Coast is the capital city, Lima. The Sierra, where the mountains are up to 6,768 meters above sea level. The Jungle, which is part of the Amazon forest (Servicio Nacional de Áreas Naturales Protegidas por el Estado [SERNANP], 2020).

Peru has 41 types of ecosystems grouped into five categories. Peru has 55 registered indigenous or native peoples (those who descend from populations that lived in our territory before the time of the Colony). These peoples have 48 original languages still in use (prior to the spread of the Spanish language). (Ministerio del Ambiente [MINAM], 2019).

With Chile, Colombia and Mexico, it forms the Pacific Alliance. This Alliance constitutes the eighth economic power and the eighth export power worldwide. In Latin America and the Caribbean, this bloc represents 37% of

the GDP, concentrates 52% of the total trade and attracts 45% of the foreign direct investment (The Pacific Alliance, 2020).

The Peruvian political division is in 25 territories: 24 Departments and 1 Constitutional Province, which is where the main airport and the most important port are located. These 25 territories have Regional Governments that are led by Governors elected every four years and are subdivided into Provinces (196 provinces) and these into Districts (1874 districts) (INEI, 2018). The Provinces and Districts are led by Mayors, also elected every four years in a simultaneous election with the Regional Governments.

The National Government is presidential in nature and the president and two vice-presidents are elected for a five-year term. During the current term, 2016-2021, the President had to resign at the beginning of 2018 because parliamentarians who supported him were recorded offering public projects in exchange for votes to avoid his impeachment. He was replaced by the First Vice President. The Second Vice President resigned in October 2019. The President of the Republic is the Head of Government.

The Council of Ministers is chaired by the President of the Council of Ministers or Prime Minister. Within its constitutional powers it has a political control function: the legal norms signed by the President of the Republic are not valid if they do not have the signature of the Prime Minister.

Although it is true that we have the National Civil Service Authority (SERVIR), Peru has not been able to fully reinstall the public career system that it had in the 1980s.

Parliament is elected on the same date as the President of the Republic. It is unicameral with 130 representatives who are called Congressmen of the Republic. On September 29, 2019, the President used a constitutional power, dissolved Parliament and called for new parliamentary elections. In January 2020, the new Congress was elected, which will complete the term of the dissolved parliament on July 28, 2021. The government does not have a majority in the current parliament.

Both presidential and parliamentary terms end on 28 July 2021, so there will be a general election in April 2021. Thus, the pandemic is advancing along with the first electoral polls.

The current government started on July 28, 2016. From that date until March 2020 when the pandemic started in Peru, there has been six Ministers of Health. A few days after declaring the state of national emergency and lockdown, the President replaced the sixth Minister. Now we have the seventh Minister of Health of the current presidential term.

Although it is true that since the global financial crisis of 2008 the regional economies have tended to cool down, Peru's macroeconomic performance has

allowed it to be the economy with the greatest strength to face COVID-19 in Latin America (The Economist, 2020).

Peru is a very complex country both territorially, politically and socially, as well as in the structure of its State. With a very solid macroeconomy, with high rurality, high economic informality and a large number of small productive units. It has a fragmented health system (state-subsidized, social security, armed forces and police and private), with total annual health expenditure below 6% of GDP (Pan-American Health Organization, 2017).

Peripheral health services are entrusted to Regional Governments, but the Steering Role for these services is held by the National Government through the Ministry of Health.

Since 2001 Peru has achieved a reduction in poverty by 34.3 percentage points, reaching a level of 20.5% in 2018 (INEL, 2019). In October 2001, as Minister of Health, I created the Seguro Integral de Salud (SIS), program with full coverage at no cost for the poor. The majority of those registered and attended were constantly rural and marginal urban dwellers. This has been a determining factor in the drastic reduction of total infant mortality and, particularly, of infant mortality in the poverty quintiles. It has also been instrumental in reducing maternal mortality.

The Beginning

On January 31, 2020, the Ministry of Health approved the technical document “National Plan of Preparation and Response to the Risk of Introduction of Coronavirus 2019-nCoV”. It had not yet been named SARS-CoV2. A 29 pages document, which presented the plan in only 8 of them. The plan showed that the magnitude of COVID-19 was not yet predicted.

On March 6, 2020, the first case of COVID-19 was detected in Peru. This was an imported case. A 25-year-old male (index case), working for a Latin American-based airline, who had travelled to Europe on holiday on a European-based airline and visited Spain, France and the Czech Republic and returned to Peru on February 26. His isolation and treatment were at home.

The National Center for Epidemiology, Prevention and Disease Control of the Ministry of Health detected that the traveler infected two social contacts and six family contacts (first generation cases). One of the later was a seven-year-old schoolboy. The Ministry of Health did not close the school, but the school itself decided to “close doors”.

Of the two infected relatives (67 and 74 years old) each one infected one social contact, in total two, both aged 69 (second generation cases). One of these infected two other social contacts (third generation cases), persons aged 39 and

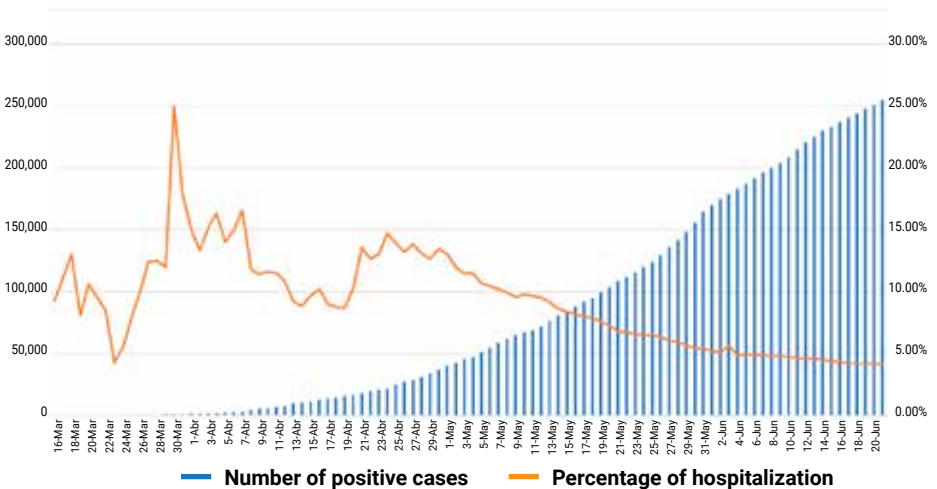
74. The latter, a male (74) was the first to die. He died at home (Centro Nacional de Epidemiología, Prevención y Control de Enfermedades [CDC-MINSA], 2020).

With Peru having only one major international airport, one would think that it would be relatively easy to minimize the possibility of virus entry through this airport. The measures adopted were essentially temperature control upon arrival of the passengers and after a few days an affidavit of health form was added. This was distant from the rigid methodologies applied by Thailand and Taiwan.

On March 11, a Health Emergency was declared. On March 15, a State of National Emergency was declared with quarantine, border closures and an overnight curfew from 8 pm to 5 am. On May 23, the legal regulation providing for the extension of the State of National Emergency and quarantine until 30 June was published.

On March 16 we had 86 positive cases, 8 hospitalized and 4 in the Intensive Care Unit (ICU). Seven days later Peru had 395 infected, 17 hospitalized and 7 in the ICU. Thirty days later the country had 12,491 infected, 1,277 hospitalized and 169 in the ICU. On June 21, Peru has reached 254,936 infected, 10,566 hospitalized and 1,137 in the ICU. Peru started out doing 3,075 tests per day. By the month were done 12,000 tests per day, accumulating 121,468 tests. The country has reached a maximum of 49,101 tests in a single day. By the time this article was submitted, Peru has collectively conducted 1,504,209 tests (Instituto Nacional de Salud & Centro Nacional de Epidemiología, Prevención y Control de Enfermedades-MINSA [INS & CDC-MINSA], 2020).

Figure 1- Peru - Number of positive cases and percentage of hospitalization by COVID-19 (March 16 – June 21)



Source: Own Elaboration. INS & MINSA (2020).

Despite the fact that the cumulative number of new cases and hospitalizations continues to increase, the percentage of people hospitalized tends to decline (Figure 1). We had 25% of hospitalized people in one day; at the time this article was submitted Peru has 4.14%. This means that when we had 25% hospitalized, 75% were mild or asymptomatic cases. Meanwhile, now that the percentage is 4.14% it means that 95.86% of cases are mild or asymptomatic and are treated at home (INS & CDC-MINSA, 2020).

Over time, mild cases have increased and those requiring hospitalization have decreased. This could mean that over time cases tend to become more and more benign. Apparently, this could be a process that does not depend on the actions taken but rather on the nature of the virus.

The trend observed has remained unchanged since April 30 (55th day since the first case). If this trend continues, it could be a predictive variable of the successive drop initially in the number of hospitalized people and subsequently in the total number of infected people. As this is a new disease, we do not yet know the so-called “natural history of the disease”. We are learning about it.

Five T's Strategy

Once the pandemic is installed in a country, we now know what needs to be done and that it works not only for containment but also for suppression of the infection. The difference in the evolution of the pandemic between one country and another lies in the speed of the reaction of the public apparatus and the articulation between the different measures taken. If actions are not well articulated or if some are imperfect, other actions may be affected.

The essential measures for the control of the pandemic have been organized in what I have called the 5 T's strategy: 1. **Testing** (to detect infected symptomatic or asymptomatic); 2. **Tracking** (symptomatic and asymptomatic and their contacts); 3. **To your home** (quarantine to avoid social contact); 4. **Treatment** for hospitalized patients (save lives, reduce hospital stay and free up health resources); and, 5. **Take care** of your health workers.

Of course, this is linked to personal, family and work behavioural measures: hygiene, no touching and social distancing (Michie et al., 2020). Also particularly important are border closures and airport controls, as well as measures to support the productive apparatus and its workers and direct support to vulnerable families.

The point of testing and further testing is not only to detect infected cases, but essentially to establish adequate surveillance of positives and their contacts. The best tracking and surveillance have been through cell phones. It

has been tremendously successful in the countries that have implemented it. Testing and surveillance are closely related.

The sense of total quarantine does not only appear when a country cannot do electronic surveillance, but in the phase of rapid community contagion it can be an indispensable measure.

At the end of April, the State of New York could not clearly establish why it had 600 new hospitalizations every day. They conducted a three-day survey of 113 hospitals with 1269 responses. Big surprise! 66% of the new hospitalized had never left their homes. They were infected by contacts at home, who went out and did not quarantine (CNBC Television, 2020).

Those of us who have received the pandemic subsequently have learned all about the complications and stages of the disease: asymptomatic, mild, moderate, severe, critical. Thus, treatments have been standardized worldwide. In Peru, the effect of such knowledge has been, according to the Peruvian Society of Intensive Care Medicine, that at present the duration of time in ventilatory support in patients who need it has been reduced.

Finally, the protection of health workers, who assume the greatest risk of illness and death. We have seen in the news, images from many countries with doctors, nurses and other workers protesting against shortages in supply.

On Friday, May 15, I participated in a webinar with four doctors from Taiwan. In my opinion this country was the most prepared and the fastest to respond to the pandemic, with its already famous 124 actions (Wang et al., 2020). I asked one of them: which of the five actions mentioned above had been the most important to their success in controlling the pandemic? The answer was immediate: tracking patients and their contacts (Taiwan External Trade Development Council, 2020).

The Government Experiences: Some Lessons Learned ?

In Peru, although we perform many tests, not all are molecular tests capable of detecting viral particles; most are serological tests that detect defences or antibodies. In our case, while molecular tests detected about 28% of the tests performed as positive, serological tests detect about 15%. The main reason for the difference is that the greatest effectiveness of the serological test is in the second week. The difference is indicative that not all those infected who are tested serologically would be detected, and when reported as negative they would continue to transit, not complying with the quarantine and infecting others. Therefore, it is difficult to reduce the infected and hospitalized curves.

If we add that in anticipation of a partial and progressive economic reopening, companies have been authorized to hire or test their workers directly, but reporting the results to the health authority, it is likely that this will also push up the number of infected cases.

In our country there is no electronic tracking through cell phones. Therefore, tracking is essentially administrative. The free telephone numbers of the Ministry of Health and ESSALUD (social security) for reporting cases and requesting tests were quickly overwhelmed.

Just as there are people who do not comply with traffic regulations, for which the traffic police exists, when there is a legal regulation that orders quarantine, the public authority has a duty to protect everyone by enforcing it.

In our quarantine, which began on Monday March 16, people were allowed to leave to buy food in markets and supermarkets, as well as to go to banks and insurance companies. Mobilization of health, transportation and press workers has also been allowed since the beginning of the quarantine.

In the week following the beginning of the State of National Emergency (March 15), I did several radio or television interviews, warning that once mass attendance sports and religious services were suspended, the crowds to be controlled were the markets and transport. Markets in the populated districts began to fill up with people: outside, informal vendors and people; inside, formal vendors and consumers. The consequences were twofold: 1. the distribution of infected people changed from the initial districts to the populated and lower-income districts; and, 2. markets became focal points of infection, as the State would show when it began to test the markets only at the end of April. It was not until 11 May that public forces began to control order in the markets.

A second mechanism of non-compliance with the quarantine has been that the productive lockdown has caused hundreds of entire families to leave the city and move to their home territories, creating a movement of the virus toward to the interior of the country. Some sub-national governments have been very effective in blocking the entry of the virus and have contained the multiplication of cases, but there have also been others at the other extreme. In the latter territories there has been a virtual collapse of health services and infection and death of many health workers.

The third mechanism producing crowds has been produced in the banks when the State announced that the first of two economic support bonuses for vulnerable families was available. People turned to the banks without any personal distance.

The permanent discourse from the State has been to attribute to the citizenry all the responsibility for the failure to comply with the quarantine,

when it is obvious that the markets did not have enough police or armed forces to support the necessary order. Also, that territorial displacement (usual in epidemics) was not foreseen, and neither was foreseen that the distribution system for the first economic bonus will create crowds.

Many times, health workers have gone out to the media protesting the lack of logistics in the delivery of personal protection equipment(s) (PPEs). There has also been a serious problem with the supply of oxygen in the main city at the Jungle. As well as the same problem in other countries, not enough beds, insufficient ICU beds and ventilators for the most severe cases.

The State has set up a new hospital in the capital city, dedicated exclusively to COVID-19 patients, and adapted buildings to house the 2019 Pan-American Games athletes, as a place for quarantine and less complex cases.

Deficiencies in the logistical support for the supply of PPE's have contributed to the fact that to date there are 1713 infected doctors, 41 in ICU and 60 dead doctors (Rivas, 2020).

Additionally, Peru defined a spending program of 17% of GDP to face the pandemic. It created economic bonus for vulnerable families, created a support program for micro and small enterprises (Fondo de Apoyo Empresarial - FAEMYPE) and another (REACTIVA PERU) for medium and large enterprises. It successfully issued bonds internationally, which had eight times the demand (USD 25 billion) over the amount offered (USD 3 billion), as an expression of the confidence of the international financial system in Peru.

Since the beginning of May, phase 1 of the economic reopening began with the progressive resumption of 27 activities. Phase 2 began on May 25, during which six economic activities will be progressively resumed. The activities in phase 1 and 2 are of low intensity of interpersonal contact. Phases 2 and 4 will depend on the evolution of the pandemic.

The countries that have been most successful in defeating the pandemic, in addition to the Five T's Strategy, have taken the following actions: 1. were prepared in advance; 2. quickly activated their systems; 3. had leadership in driving at the highest level; 4. had a competent health system; 5. made strict travel restrictions.

The epidemic curves in various Departments of the country indicate that there is a territorial reduction. Despite all the political, social and economic efforts, the economic opening since May has generated a growing number of positive cases, with a minimal downward trend. The significant reduction in the percentage of hospitalized patients has meant that the most severe cases are those that arrive at the hospitals, which has had an impact on the increase in lethality.

A main conclusion from the previous paragraph is that the absence of electronic tracking of patients and their contacts, as in other Latin American countries, is an essential factor for a slow exit from the pandemic.

It is very difficult to deal with what is not known, especially if it is a pandemic with an unknown virus. If we remember all I have explained, we see that the cornerstone of effectiveness is in the actions of the public authority. That is, in the people with name and surname who take charge of the actions and make decisions and decide what actions should be carried out. In the present case, putting data and truthful information before emotions and politics. Truth, prudence and patience are safer than opening up the lockdown before a country is ready for it.

*“In moments of crisis, only the imagination
is more important than knowledge.”*

Albert Einstein

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Middle East / North Africa

Egypt and the Response to the COVID-19 Pandemic

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Abstract

At the time of the COVID-19 outbreak, Egypt had just been entering a period of economic and political stability and witnessing improvements at the macroeconomic level. The Egyptian response to the crisis was rapid and effective in putting together interventions that managed to ease the economic and social repercussions of the pandemic, and expand the capacities of the health sector to detect and report infected cases, and implement policies to contain the spread of the disease. On the other hand, preparedness was behind in terms of public spending on health and education as well as the availability of sufficient data to inform policymaking. Economic interventions focused on countering inflation, supporting affected economic sectors, easing consumption, and supporting the economically vulnerable. The crisis should influence government spending as well as administrative reforms to improve the ability to predict the next crisis and coordinate the work of various agencies and non-state partners.

Keywords

Egypt, COVID-19, preparedness, health, economy

Highlights

The state apparatus has to take the lead in crisis response.

In order to respond to the next crisis, there is a need to increase spending and invest in public sector reform.

Introduction

Located in the north eastern corner of Africa, Egypt is the most populous country in the Middle East. Its population has surpassed 100 million for the first time in 2019. Egypt has witnessed a period of political turmoil and economic decline following the global financial crisis and the outbreak of the January 25th uprising in 2011. Growth fell to 1.8% per annum which is lower than the average rate of population growth in 2006-2017 period (2.5% per annum) (Central Agency for Public Mobilization and Statistics [CAPMAS], 2019).

When the WHO announced COVID-19 as a global pandemic, Egypt was entering a period of political and macroeconomic stability following years of turbulence and bitter economic reforms that included currency devaluation and rationalizing subsidies. Economic growth witnessed improvement in recent years, reaching 5.6% in FY2018/2019 (Ministry of Planning and Economic Development [MPED], 2019). This is due to a series of economic reforms and relative political stability (Krafft et al., 2019). Among the sectors that contribute to this growth are wholesale and retail, manufacturing and agriculture (World Bank Group, 2020). Due to decline in imports, the Balance of Payment achieved a surplus of 0.1% of GDP in 2019. Despite these reforms which started in 2016, economic vulnerability persisted, where the poverty rate is 29.1% (IMF, 2019) and the employment rate remained low at 39% of the labour force (CAPMAS, 2019).

Building and improving the information infrastructure, and digitizing public services, which have been among the pillars of public administration reform, were the responsibility of the Ministry of State for Administrative Development (MSAD) then the Ministry of Planning, Monitoring, and Administrative Reform (MoPMAR). This responsibility had to be shared with the Ministry of Communications and Information Technology (MCIIT), which was responsible for establishing the digital infrastructure. MoPMAR's Vice Minister for Administrative Reform was responsible for completing and integrating national databases as well as various issues related to capacity building, public sector reform, reforming the legal framework for managing public employees, etc. However, MoPMAR had to share some of these responsibilities with the Central Agency for Administration and Organization (CAOA) especially those related to public sector employees and the legal framework for structuring/restructuring the civil service.

The cabinet reshuffle on December 22, 2019 moved the public administration portfolio away from the Ministry of Planning and made it the responsibility of three key entities: Prime Minister, CAO, and MCIT. The Prime Minister appointed an advisor for public administration reform and delegated broad responsibilities over public sector reform to the President of CAO. The

information build up and digitization portfolio became the sole responsibility of MCIT. These changes facilitated information sharing which proved critical in applying many of the economic interventions necessitated by the pandemic, especially those related to supporting the irregular workforce.

The Health Sector

Egypt has a pluralistic healthcare system with public, private, and non-profit providers. Like many other low and middle-income countries, Egypt has an integrated healthcare system, where public providers receiving budgetary support from the public budget are subject to the rules and regulations set by CAO to govern other civil service organizations.

As of May 17, there are 11,228 confirmed cases and 592 deaths due to COVID-19 (World Health Organization [WHO], 2020). The country nowadays is in the community transmission stage – where infections spread to the society and cannot be traced to contact with a specific person. However, Egypt is still facing a low spreading rate from one person to another (MRC Centre for Global Infectious Disease Analysis, 2020). Government procedures to slow the spreading rate started in mid-March when schools and worship places closed. Furthermore, the government suspended international flights (March 19) and instituted a night curfew starting at 6 pm (March 25) and on April 2nd, university hospitals and public university dormitories (dorms) began transforming into quarantine stations.

Regarding the preparedness of the health sector for the pandemic, Egypt's scores for health system capacity (15.7, where the average is 26.4) (Global Health Security Index, 2019) indicate deficiencies in health capacity in clinics, medical countermeasures and infection control practices. Spending on health as a percentage of GDP remained declining and low since 2000 and then from 2011 started to increase and just surpassed 5% (still low) (WHO, 2017). This growth, however, is attributed to growth in the private health expenditure. Public health spending remains low (1.7% of GDP), which left many public hospitals underfunded (Ayadi, 2020). Of the total health spending in 2017, public health spending accounted for 33% and 67% for private health spending (WHO, 2017). The number of physicians and nursing staff (per 10,000) are 13.5 and 22.3 (CAPMAS, 2017) which is the lowest in the MENA region (Ayadi, 2020). There are 132,092 beds, of which 96,111 are public, in 1,770 hospitals (CAPMAS, 2017).

On the other hand, Egypt scores above average for its rapid response to COVID-19 (45, average 38.4) and in line with global average in its level of detection and reporting (41.5). As an evidence of Egypt's prompt response

to the outbreak, 2000 beds, half of which are intensive care and 600 with ventilators and 400,000 test kits have been prepared (Ismail & Lewis, 2020). Additionally, there are 50 testing centres and 8 quarantine and treatment hospitals for COVID-19. Furthermore, the government banned all exports of medical and protective equipment. It also banned the export of any medicine unless there is at least six months of supply available. All purchases of medicine and medical utilities had to be conducted by the Egyptian Authority for Unified Procurement, Medical Supply and Technology Management (AUPP) to avoid price speculations.

In order to deal with the shortages in the numbers of doctors and nurses, the Ministry of Health (MOH) closed all out-patient clinics affiliated with public hospitals to direct all medical staff toward healthcare units. The purpose is to reduce the possibility of overwhelming public hospitals by allowing healthcare units to be the first point of contact, as they would deal with a limited number of individuals at the locality level. The health centre would send high-risk cases to a Fever or Chest Disease Hospital to do the COVID-19 PCR test. Positive cases are transferred to an isolation hospital.

The fiscal push to support the healthcare system is part of the government effort to mitigate the effects of the pandemic. The GOE announced EGP200 million as a supplemental fund for health sector budget FY2019/2020 and promised to increase the upcoming budget FY2020/2021 by 100% compared to the previous year. Additionally, GOE announced EGP3.8 billion to provide urgent medical supplies in public hospitals, disburse bonuses to medical staff working in quarantine hospitals, and increase the allowances of the professional medical staff by 75% over their basic wage (Ministry of Health and Population [MOHP], 2020).

Overall, the MOH applied a centralized approach. The private sector did not play any central role. Private labs were not allowed to perform testing for Coronavirus, and private sector hospitals cannot test or receive Coronavirus cases for treatment. When private hospitals were later allowed to receive Coronavirus cases, the unwarranted expenses drew popular criticism. The MOH put caps on the amount of money hospitals can charge Coronavirus patients, which led hospitals to stop receiving cases.

Unlike the situation in other countries such as Italy, no private sector companies have directed their production line to producing medical equipment. However, a number of businesspersons dedicated their hotels to serve as quarantine stations. Others donated financial resources or medical equipment (purchased mainly from China). Similarly, charity organizations and individuals provided financial donations, as well as donations of medical supplies and equipment.

This could be attributed to the government's attempt to avoid commercialization of the pandemic by denying private labs and hospitals the opportunity to make financial gains out of testing and/or treatment. It could also be a function of the government's attempt to make sure that the hospitals receiving COVID-19 positive cases are well equipped for this purpose, avoid spreading panic, and to control the official numbers released about the spread of the virus.

The GOE looked toward China for support. The Minister of Health travelled to China on March 3rd. The official purpose of the visit was to send aid and a message of solidarity to the Chinese people as they fight the spread of the pandemic. Since this visit, the news media reported technical support and several shipments of medical equipment to help with efforts to fight the pandemic in Egypt.

Key Policy Interventions

Egypt succeeded in implementing decisive measures to mitigate the spread of the virus and reduce its impact on the economy, either by protecting individuals in the workplace, stimulating the economy, stimulating demand and fully supporting the vulnerable, and through income generation.

Monetary policy

The Central Bank of Egypt (CBE) slashed policy rates by 300 basis points for the overnight and lending deposits to stimulate the economy and prop up inflation rate. CBE allocated EGP20 billion towards stock purchases to protect stock market from its trough. It reduced discount rate from 10% to 8% for financing sectors such as tourism, manufacturing and mortgages. Additionally, it increased the limit for both credit and debit cards to rationalize access to capital and credit. Finally, it suspended credit score black lists for irregular clients.

Fiscal policy

GOE announced a stimulus package of EGP100 billion to support economic sectors and vulnerable individuals. At the same time, the Ministry of Finance (MOF) postponed payment of property tax for tourism and manufacturing sectors for three months, and reduced dividend tax and stamp duty on the stock market. The tax authority extended the deadline for paying taxes to 31 March and removed the online fees to encourage submission online.

Social policies

GOE announced that pensions increased by 14 percent. The targeted cash transfer social programs, Takaful and Karama, are also being extended to reach

more families. A targeted support initiative for irregular workers in most severely hit sectors has been announced, which entails EGP500 in monthly grants for 3 months. Income tax law amendments; include increasing the exemption limit from EGP8000 to EGP15,000 and decreasing the burden on lower income groups by changing income brackets and the corresponding tax rates. Regarding the most affected economic sectors such as manufacturing, electricity price has been lowered by 10 piasters per KWh for medium, high, and ultra-high voltages while keeping tariffs unchanged for the next 3 – 5 years.

The price of natural gas was lowered for all industries to stand at a unified rate of USD 4.5/mmBtu. Real estate tax relief was provided for industrial and tourism sectors; and a discount on fuel price has been announced for the aviation sector. As part of the EGP100 billion stimulus, The government announced EGP50 billion to provide support for the tourism sector, which contributes close to 12 percent of Egypt's GDP, 10 percent of employment, and almost 4 percent of GDP in terms of receipts, as of 2019. The moratorium on the tax law on agricultural land was extended for 2 years. Loans with a two-year grace period will be made available to aviation sector firms.

Regarding exports and imports the GOE allocated a payment of 1EGP billion worth of export subsidy arrears in March and April and 10% cash payments to exporters during June; and suspended the authentication requirement of certificates of origin, a previous condition for customs clearance. The GOE excluded basic food commodity imports from the 100% cash cover requirement for one year.

The education sector:

K-12 education

On March 14, the MOE announced the cancellation of all final exams for grades 3 to 9, replacing them with a research paper for each class. Grades 10 and 11 students will have an online experimental test in April to test the system's preparedness for holding the final online exams in May. Kindergarten, and Grades 1 and 2 students will not have exams. Instead, teachers will assess their students and send the reports to parents, who should ensure that the children finish the curriculum available on the e-library.

The MOE stressed the utility of its investments in building the information infrastructure since 2017 as part of its reform strategy. These investments include launching the Egypt Knowledge Bank (www.ekb.com) in 2016 – a digital library for researchers, educators, students, as well as the public. The Ministry utilized this platform for posting educational material and resources for final research papers. The Minister recorded a video, posted on the MOE

website, to explain how to utilize the Edmodo platform to connect students, parents, and teachers virtually. The ministry is also making lessons available through TV channels.

Given the importance of Grade 12 (*Thanaweyya 'amma*) exam grades for determining the potential of students to join tertiary education, the Ministry decided to hold the exams, only deferring them for two weeks to allow time for taking extra precautions. These precautions include limiting the number of students per examination class to 14, increasing the number of schools for holding the exams, and reserving two classrooms in each school for emergency cases.

It is too early to evaluate the effectiveness and potential of the MOE reforms based on expanding reliance on IT. It is not clear whether teachers are ready to utilize the available platforms, and socioeconomic variations among students can lead to inequities in educational opportunities. Furthermore, there have been reports of students and parents buying the final research papers that each student has to submit in lieu of a final exam.

Tertiary Education

The Ministry of Higher Education cancelled mid-term exams for all public and private universities. The Supreme Council of Universities, an independent body chaired by the Minister of Higher Education and includes the Presidents of all Public Universities, stipulated that, for non-senior students, universities had the option to require a research paper in each class, with a Pass/Fail grade, or a final online exam. Final exams for graduating students were postponed until July 1st. These exams had to take place on campus.

All universities moved to online teaching. However, different capacities within and among universities created the necessity for allowing space for each University, and the schools within each university, to make their own decisions about how to move to online teaching. The majority of schools in public universities relied mainly on audio recording the sessions by individual faculty members at home through zoom or PowerPoint. The IT department in each school then posts the recordings through an online resource, such as the school website or YouTube channel, Google Classroom, or Webex. Other universities, especially smaller private universities, stipulated that their faculty members hold live zoom discussion sessions after posting their recordings.

A number of private universities supported virtual online teaching and online exams, with varying degrees of success based mainly on their infrastructural preparedness. Individual schools that had more resources were better able to help their students. For example, the Faculty of Economics and Political Science (FEPS) at Cairo University distributed tablets with the recorded classes to students who did not have access to high-speed internet.

The main test for the success of online teaching is its ability to contribute to student learning. This issue requires in-depth evaluation that is yet to be conducted. Looking forward, there should be more efforts at the individual universities' level to build the infrastructure necessary for online teaching, including e-learning platforms.

Early Lessons from COVID-19 Crisis

When the WHO announced COVID-19 as a global pandemic, Egypt was just recovering from a protracted period of economic hardship and political instability that extended at least since 2011. The partial lockdown hit hard some important economic sectors such as retail as well as the large irregular workforce.

The economic responses of the Egyptian government focused on rapidly designing economic interventions to counter inflation, support affected economic sectors, ease consumption, and support the economically vulnerable. The availability of national databases and digitized public services, managed mainly through the MCIT, facilitated these interventions, especially those targeting the economically vulnerable segments of the population, such as the irregular workforce.

The crisis revealed the limitations of the health sector, including poor funding, which directly affected the sector's preparedness for the pandemic. The government adopted a centralized approach, possibly in order to avoid commercializing the pandemic, and guarantee that the dedicated hospitals and health units are equipped to deal with the situation.

The crisis also put education sector reforms to the test. While K-12 and tertiary education were able to wither the crisis, at least for the time being, evaluations, as well as more investments, are needed in order to make sure that the education system is ready for this and future crises

Looking forward, there are a number of key lessons. First, dissemination of accurate, timely and transparent data is very useful not only for combating the COVID-19 pandemic, but also for boosting confidence at all levels of the economy and society. Secondly, there should be constructive and persistent interagency coordination between different ministries in developing effective responses at the macroeconomic level. Finally, government agencies have to be forward looking. Egyptian government officials and public administrators in fields such as health and education often have to respond to day-to-day problems and act within limited budgets. The next crisis can come in the form of an environmental disaster, food shortages, etc. Therefore, the government has to act now in order to invest in the sectors that matter, such as health and

education, involve societal partners from the business and non-profit sectors, create the capacity to predict crises, enhance its information infrastructure, and rethink the nature of the economy in ways that support economic diversification and human capital development.

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Measures Taken by the Kingdom of Morocco to Deal with COVID-19

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Abstract

Morocco has enforced a proactive policy and taken a set of measures to face the COVID-19 crisis effects and consequences at the health, economic and social levels. While the radical nature of the public authorities' decisions was the result of the unprecedented seriousness of the present crisis, it has, however, given evidence of the resilience of Morocco and its institutions.

The approach that was adopted stood out for its efficiency and pragmatism. The "Moroccan Marshall Plan" with its cross-cutting aspects embodies, indeed, the diverse and multiple measures taken to stop the virus propagation and alleviate the economic and social impact of the pandemic.

Thus, the Moroccan model was often cited as an example in the world. While the country has started a large review of renovating its economic development, this experience will, no doubt, open a door to integrate the complex dynamics of crisis-management and develop, in light of this, its future options in terms of content and steering and implementation mechanisms of development policies.

Keywords

COVID-19, Morocco, development model, resilience

Introduction

The Kingdom of Morocco is going through an unprecedented pandemic crisis like all the other countries on the planet. To deal with it, the State mobilized, under the enlightened leadership of HM King Mohammed VI, all the nation's living forces which showed a high level of patriotism and commitment, solidarity and mutual aid to defeat this virus and face its repercussions, which are likely to affect a large segment of citizens and businesses following the sudden cessation of economic activities.

Faced with this, and in accordance with the high instructions of HM King Mohammed VI, the Moroccan state has placed at the top of its priorities the health and safety of citizens while taking into account the urgent need to support the fragile categories affected by the pandemic and focusing on limiting its impact on the economic situation of the country. In this context, the Moroccan government has taken urgent and proactive measures to contain the spread of the virus. It was among the first countries to proclaim a state of health emergency nationwide.

National cohesion and integrated governance

These circumstances were an opportunity to demonstrate the values of solidarity and mutual aid often shown by Moroccans in difficult times. Two major measures should be highlighted in this context: the repatriation of Moroccans from the Chinese city of Wuhan and the creation of a special fund to deal with the repercussions of the pandemic which was financed by various institutions and forces of the country.

In the wake of the solidarity measures taken, Morocco proposed, following the initiative of King Mohammed VI, to support African countries in the various phases of their management of the pandemic and to share experiences and good practices. This initiative was welcomed by many African leaders and gained their support.

In this context of health crisis, all Moroccans showed a high level of solidarity, maturity, discipline, respect of the provisions of the state of health emergency, trust in institutions and cooperation with public authorities.

All health executives from the public and private sector as well as the civil and military security forces were mobilized, and each of them, from its position, contributed with professionalism and competence to apply the provisions of the state of health emergency. Furthermore, agents and civil servants from all administrative structures, both central and local (Ministry, public institutions, local authorities, etc.) contributed, in accordance with the powers assigned to them, to combating the spread of COVID 19 in an exemplary manner to ensure

the continuity of public service. Educational and administrative staff working for the Ministry of Education, Higher Education and Scientific Research also made enormous efforts in remote education.

Integrated crisis management system

In order to guarantee effective management of the crisis, the government has adopted a governance system aiming at the convergence and coherence of all stakeholders' action, as well as the complementarity of the interventions of the various competent authorities and departments, through the following mechanisms:

- **A steering committee** to monitor the epidemiological situation and take the necessary measures. It includes in particular the Departments of Health and the Interior, the Royal Gendarmerie, the military health services and Civil Protection.
- **A national scientific and technical committee**, stemming from the Ministry of Health, responsible for monitoring the medical and scientific aspects relating to this pandemic, providing specialized medical and scientific support for government decisions and supporting rapid changes in the epidemiologic situation.
- **An economic watch committee** which includes several ministerial departments, alongside representatives of the banking and financial sector and economic operators. This committee is responsible for reviewing the economic and social repercussions of the pandemic and proposing solutions.

Monitoring units were also set up at the level of the various ministerial departments, to monitor and address the repercussions of this pandemic at various levels.

After the proclamation of the state of emergency, on March 23, the authorities took the following measures: The closure of Moroccan air and maritime spaces to travellers, the cancellation of sports, cultural and artistic meetings and events, the suspension of in-class courses in schools and universities, the temporary closure of mosques and the suspension of the hearings in the various courts of the Kingdom.

This mobilization resulted in the establishment of monitoring cells at the level of the various ministerial departments and permanent meetings of the Council of Government to take stock of the evolution of the epidemiological situation, take the needed decisions and support the implementation of the various measures.

An overview of the various measures taken by the public authorities to deal with the health, social and economic impact of this pandemic will be made

in the rest of this document, starting with an update of the epidemiological situation in our country.

Health Measures

In terms of health, a series of surveillance and monitoring measures were taken in addition to capacity development of the national health system and the treatment of persons affected by the virus.

Epidemiological surveillance and monitoring

Since September 2019, the country has had an epidemiological monitoring system set up as part of the implementation of the “national health plan 2025”, through a national centre and regional emergency operations centres in the public health system.

This system manages epidemics and other public health emergencies, in particular those linked to infectious diseases when they occur, and prepares the response to public health threats caused by emergency situations and disasters.

Capacity building of the national health system

Efforts have been made to increase the capacity of hospital structures, by equipping public hospitals and establishing military field hospitals to back up hospitals. Indeed as many as 47 hospital units were dedicated to people with coronavirus, with a capacity of 1,826 beds at first, that could be reinforced depending on the extent of the epidemic spread in each region and mobilizing 1,214 intensive care beds in public hospitals.

The private clinics with a capacity of 504 additional beds as well as 177 hotels and tourist centres in 38 cities in Morocco contributed to the operation of accommodating and monitoring the state of health of the patients.

Support system for infected cases and health sector

Since the outbreak of the pandemic in Morocco, the health sector also tried to ensure the intervention operations of medical staff at the various stages of infection (adoption of a therapeutic protocol, organizational plan for the management of infected cases or suspected infected cases, laboratories involved, accommodation conditions, etc.) and also guarantee that medical treatments are free of charge.

The permanent support to the health sector by the government, constitutes a national priority besides the creation of hospitals and the strengthening of their capacity.

Accompanying Measures of the State of Health Emergency

Among the other major actions taken to mitigate the effects of the pandemic, we need to mention the following:

Development of digital education

The government has taken several measures to ensure distance education, by means of electronic platforms and a strong involvement of education staff and technicians.

These efforts gave a strong impulse to the integration of new technologies in the pedagogical process as a support and lever of in-class courses. It should be noted that during this short period, the pedagogic teams succeeded in developing more digital contents than in the past 10 years.

Thus, digital platforms were quickly created to ensure the continuity of remote courses for all levels (from primary to baccalaureate) allowing teachers to communicate with their students locked down in their homes. This was also the case for professional training where the sessions were provided through virtual classes created for this purpose.

Continuity of public services

A pack of measures and decisions was taken to ensure this continuity, while preserving the safety and health of the personnel of public administrations, local authorities and public enterprises.

To this end, executive officials were encouraged to use new communication technologies instead of paper, telework, the electronic counter for administrative mail. Administrations are called, in this sense, to respect preventive measures and to set up a rotation system between employees. Other decisions have been taken regarding inter alia, the suspension of hearings in the various courts starting from March 17 and the postponement of recruitment examinations.

Masks, cleaning and sterilization products

In order to avert speculation in medical and paramedical products, in particular cleaning and sterilization products and protective masks, the government intervened to fix their prices and encourage local production. At the same time, medical masks and export authorization was required for sanitization solutions, in order to give priority to domestic needs.

Adaptation of public transport to the epidemiological situation

In order to ensure the protection of public transport users, the State took action to reduce by half the transport capacity of taxis, urban transport buses, trains and trams which are cleaned and sterilized on a regular basis in cooperation with local authorities.

Social Measures

The country has taken a series of measures for the benefit of employees and businesses, in particular SMEs and very small businesses, as well as the liberal professions who are facing difficulties due to this pandemic. The government has also taken a series of decisions to support families whose provider works in the informal sector and affected by this situation.

Measures for employees

The economic watch committee has proposed exceptional measures in favour of employers affiliated to the CNSS (National Social Security Fund) in difficulty in order to preserve jobs (Bill 25.20). However, concerning employees recruited under the integration contract that went out of activity and working for companies affiliated to the CNSS which are in difficulty, it was decided to allocate them a flat monthly allowance of 2,000 dirhams. These employees also benefitted from family allowances and Compulsory Health Insurance benefits.

Support for precarious categories in the informal sector

Concerning these precarious categories of population (women in difficult situations, people with disabilities, the chronically ill, children in a precarious situation), many efforts were deployed in order to alleviate their burden by providing them with assistance such as inter alia, communication cells and psychological support in host establishments .

Due to this collective effort, executives and employees of the National Mutual Aid (Entraide Nationale), the Moroccan Red Crescent, local authorities, local authorities, civil society and recipients, in addition to some 6,230 homeless people were taken care of, including 1,699 people who were brought back to their families on April 19.

Furthermore, the government decided to provide support to people working in the informal sector who are without financial resources because of the lock-down. The number of recipients exceeded 200,000 people. The endowment varies between 800 and 1200 dirhams, according to defined criteria.

Protecting the health of prisoners in correctional institutions

In this regard, preventive measures have been taken to protect the prison population against the risks of the spread of the coronavirus. Among these measures, it is necessary to mention the royal grace which reduced the density of prisons by releasing 5,654 prisoners selected on the basis of humanitarian criteria.

Economic Measures

The government set a fundamental objective during this critical period, which is to give priority to preserving the health and safety of citizens, and to limit the number of victims of the pandemic, through preventive measures taken as part of the state of health emergency.

Severe repercussions on the national economy

As a result of the pandemic, several companies ceased activities and many sectors have been impacted, such as tourism, export-oriented sectors and the automobile industry, which shut down on March 19, 2020, and the consequences of this cessation on other affiliated sectors. The textile sector is also suffering from this situation due to disruptions in its supply markets in Asia in general and particularly in China, alongside a decline in external demand, especially in Spain and France.

There will be negative repercussions on the life of companies, the performance of the national economy, macroeconomic balances, as well as on trade and the balance of payments. However, in addition to these temporary measures, the effort also focused on developing scenarios for revitalizing the national economy through the gradual resumption of various economic activities.

Solidarity and hope

It should be noted that the funds allocated by the special fund for the management of the coronavirus pandemic, to support the national economy and the most affected sectors and alleviate the social repercussions of this crisis, will also benefit the most affected companies and industries.

To this end, the government's efforts will be concentrated on the development of a global approach to save the economic situation and its imperatives to the national economy support, on one side, in terms of alleviating the repercussions on public finances and major balances, and on other side at the level of supporting companies by giving priority to vital sectors to guarantee the maintenance of their employment and production capacity.

Support for public finances and maintenance of major balances

To cope with this exceptional situation of public finances, a set of measures was taken to control public spending:

- Rationalization of public spending: this measure is based on the principle of maintaining only the necessary expenses (salaries of civil servants, investment expenses, expenses dedicated to managing the pandemic, the effects of drought, etc.) and reducing or cancelling unnecessary expenses.
- Use of external financing: This measure consists in increasing the ceiling of external financing on an urgent and exceptional basis and use international financial institutions and markets to increase funds and, therefore, have access to the needed foreign currencies for the purchase of goods and services, particularly basic commodities, medical devices and equipment, medicines, food, energy and other products. In this context, Morocco decided, on April 7, to use the entire precautionary line and the International Monetary Fund liquidity, amounting to 3 billion dollars repayable over 5 years, with a three-year grace period.
- Adaptation of the banking system: Bank Al Maghrib has adopted a series of monetary and prudential policy measures to support access to bank credit for both households and businesses. These include, for example the drop in the main key rate from 2.25% to 2% and the possibility for the banks to use all the refinancing instruments available in dirham and foreign currency.

Measures for the benefit of businesses

Concerning businesses, particularly the small one and liberal professions, whose activities have been greatly impeded, or even stopped in certain cases, the government has taken measures divided into three parts concerning the reduction of charges, support for the treasury of business and investment support and market access facilitation.

Conclusion

The Kingdom of Morocco has so far been able to act with anticipation and insight, rely on its own means, and develop national responses, in particular for medicines and medical equipment, by setting the ambition to go further on the measures already taken.

In this regard, the solidarity and cohesion shown by the officials, government, political parties and trade unions, economic operators and civil society, media and the civil society, and their mobilization to contribute to the coronavirus pandemic fund, which continues to receive donations, should be welcomed.

It should also be noted that all the measures taken by the government in this exceptional situation target mainly the precarious social categories and the most-heavily affected companies in the context of a solidarity approach, which deserves to be supported by civil society, particularly for awareness-promotion of citizens.

Role of Public Administration in the State of Palestine in Facing the COVID-19 Pandemic

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Abstract

The Government of Palestine leadership acted swiftly to contain and suppress the spread of coronavirus in March 2020. It took many proactive measures, addressing the need to protect health and save lives, provide support and relief to citizens and promote the recovery of the economy. These measures had a clear and strong impact on slowing the spread of the virus, praised by the World Health Organization and different countries in the world. The developmental work of the General Personnel Council (GPC), the responsible organization for promoting Public Administration in Palestine, and the Palestinian National School of Administration (PNSA) and the enhancement of infrastructure and digitization of operations also had a major impact that enabled them to present their work with high efficiency and transparency without interruption in the light of the declaration of the ongoing state of emergency.

Keywords

Leadership, digitalization, proactive, balance, solidarity

Highlights

The extent of countries' intelligence in building, managing and running governments, infrastructures and other functions during a pandemic is based on wise leadership and digitization, which are considered important factors for improving the well-being of people in the future.

Introduction

On 5 March 2020 the World Health Organization (WHO) reported that the occupied Palestinian territory had four cases of COVID-19. These were people who had become infected outside of Palestine. The Government of Palestine moved swiftly. On the same day, 5 March 2020, the Palestinian President H.E. Mahmoud Abbas declared a state of emergency and the Prime Minister Dr. Mohammad Shtayyeh set up an Emergency Command in Centre. Early measures to contain the outbreak in the West Bank included isolating governorates from each other, stopping public gatherings, closing of educational institutions, and measures relating to working in Jerusalem area. In the Gaza Strip the measures taken included ones for travellers to the Gaza Strip, stopping public gatherings, and closing of educational institutions. On 22 March the Palestinian Authority imposed a two-week curfew in the West Bank. Quarantine centres were established, and many people quarantined. Later in March, travel restrictions were implemented regarding Palestinians travel to Jordan with the closure of all borders and crossings, in addition to restricting the movement of Palestinian workers into Jerusalem. On 26 March 2020 the Government of Palestine's COVID-19 Response Plan headlined an approach based on containment and strictness.

The swift and clear response by the Government seemed to work well. Although the number of total cases had risen fast in late March, the number then increased much more slowly until June.

The picture from June to the beginning of September was less positive. In June the number of confirmed cases surged. By the end of June 2020, the State of Palestine had over 1,500 confirmed cases of COVID-19. Those infected were mainly under 50 years of age and, possibly as a result of this, the number of confirmed deaths involving COVID-19 was very small. Many of the total confirmed cases were people living in Hebron and Jerusalem. The impact of COVID-19 continued to worsen and by the beginning of September the number of confirmed cases had risen to over 37,000 and there had been 224 deaths.

Early in 2020, the country's leadership had to decide on a response to the Coronavirus pandemic taking into account government capabilities, the availability of advanced medical equipment, and the state of the infrastructure. At the time the WHO was calling for a comprehensive response by national authorities, including education of the public, surveillance, and caring for those who were ill with COVID-19.

A big issue for the success of the State of Palestine in responding to COVID-19 was the extent of national resources and the capacity of its health system. Gerald Rockenschaub, Head of the World Health Organization Office

for the occupied Palestinian territory, reported a Health Cluster meeting on 15 April at which there was, it seems, a consensus on “full alignment of health partners to support the government COVID-19 response plan through coordinated support from UN, NGOs and civil society” (Rockenschaub, 2020).

National Context

The State of Palestine has a population estimated at 5.039 million people, with an average population density of 836 people per km² (Palestinian Central Bureau of Statistics [PCBS], 2020). Palestine shares borders with Jordan, Egypt, Lebanon, and Syria. The capital city is Jerusalem, with government administration being temporarily based in Ramallah. The political system is a mixed presidential and parliamentary system. In 2018, the Gross Domestic Product (GDP) of Palestine was US\$15.62 billion and the GDP Per Capita was \$3,562 (PCBS, 2020). The Palestinian economy is currently contracting due to the COVID-19 pandemic (World Bank, 2020).

Challenges and Openness

The Government clearly stated its concerns about its constraints in its response plan (Government of Palestine 2020 5-6):

We do not have the necessary sovereignty (control over borders, etc) and national resources (medical, financial, etc) to cope with a significant outbreak, particularly when our population has many high-risk characteristics (crowded cities and refugee camps, poverty, food insecurity, non-communicable diseases, etc.). ... The GoP budget deficit is expected to increase significantly due to loss in government revenue. ... Additionally, we expect that the economic loss from COVID-19 will be at least \$2.8 billion. [...] An increased budget deficit will restrict our ability to cover operating expenses, pay salaries and pensions, and maintain the social safety network. In the context of COVID-19, this means that we will not be able to cover the full salaries of our health workers in the months leading to restrictions in GoP's ability to manage the pandemic. Additionally, we will also have insufficient funds to cover the scheduled government transfers to the most vulnerable population, with greater numbers of Palestinians expected to need government support due to the economic impact of COVID-19. (State of Palestine, 2020, pp. 5-6).

The Government of Palestine, however, was willing to learn from other countries' experiences of COVID-19, including China's experiences in containing and preventing its spread. Specialized units were formed to follow up on and monitor what was happening internationally. Important parts of the Cabinet's sessions were devoted to discussing the steps and procedures for responding to the pandemic.

Early Stages

Early on in 2020 the Government of Palestine monitored everything related to the epidemic and studied the available information, news and statistics about the virus. It started monitoring the movement of tourists entering and leaving the State of Palestine, to make informed decisions and take appropriate measures to prevent the spread of the virus in Palestine. It began its efforts to contain and suppress the spread of the virus by cancelling tourism, hotel reservations for foreign tourists and expediting their safe exit from Palestine.

On the 5th of March, four foreign tourists were identified as COVID-19 cases. His Excellency President Mahmoud Abbas made a presidential decree declaring a state of emergency in Palestinian Territories for a thirty-day period. The Palestinian government took further measures restricting movement, while giving priority to the health of citizens. Among these measures was the closure of Bethlehem Governorate, Palestinian schools, universities, cafes and halls, weddings and places for public gatherings. At the end of March, tougher decisions were taken to close all border crossings, preventing movement between and within governorates, between cities and villages, and compelling domestic citizens in homes to prevent the spread of the virus. Pharmacies, bakeries and stores were allowed to continue working to provide for the basic needs of citizens. Governmental decisions were always followed by executive procedures on the ground, so that ministries, heads of government departments, authorities, and security agencies were empowered to implement the issued procedures and decisions.

The Government of Palestine was clear that communication was an important part of its approach. Government communications were important inside and outside government. So, there were communications and networking between, ministries, government departments, security agencies, the private sector and civil society. There were also communications with international partners and with citizens. The importance of transparency was also appreciated; twice daily briefings though the national media were planned as part of the COVID-19 Response Plan in order to update on cases and on government guidelines. Information was provided to citizens about the virus and its spread. Statistics were reported on infected cases at the two conferences a day to provide correct and official information about the state of this epidemic.

Preparations, Containment and Suppression, and Treatment

The COVID-19 Response Plan reported that the Government had worked with local and international partners to “mobilize health professionals and

facilities across the West Bank and equip them with training and the necessary protective gear, medical supplies, and medicine” (State of Palestine, 2020, p. 4).

The Palestinian government also gave preference to local anti-virus products, such as medicines, masks, sterilizers, and protective clothing. It also gave them full preference in governmental procurement, to encourage and support small and medium enterprises. Palestinian local factories started producing medical materials, supplies, protective clothing and special insulation in an accelerated manner in accordance with the highest local and international quality standards and specifications.

Testing was important for containing and suppressing the virus. The Government worked on building its capacity to conduct to conduct testing. Initially it was able to conduct three hundred tests daily, but this was increased to five thousand daily.

In addition to allocating places for isolation and treatment for infected people, the government also converted several hotels to hospitals and isolation centres.

Health, Relief, the Economy

The Government’s measures were initially focused on health. Its endeavours early on succeeded very significantly in limiting the spread of the virus and slowing the rise in infected cases. The number of infections was slowed that in mid-May there were 554 cases in Jerusalem, the West Bank and the Gaza Strip. The number of governorates free of coronavirus was increased to 9 governorates.

The Palestinian Government’s plan included a relief plan. It supported 125,000 families, by providing 98,000 food parcels, and by providing financial assistance to nearly 40,000 workers affected by the Corona pandemic. Banks were asked to postpone and reschedule loan payments for four months for those people affected by the crisis. In addition the government has established “Waqfet Izz” fund to focus the national efforts to contribute in facing the repercussions of the virus spread in Palestine and its economic, social and health dimensions through promoting solidarity among the Palestinian community and direct support to needy families, and to support the health sector.

The next phase included coexistence with what happens by committing to complete health measures, reviving the economy and moving the wheels of production and economic installations. Soft loans worth \$300 million were also to be given by banks and other financial institutions at a fixed interest rate not exceeding 1.5% to support small and medium enterprises and entrepreneurial projects. In addition, the Government provided tax

incentives to employers, enterprises and projects that were affected by the Coronavirus pandemic, and gave preference in government procurement to the purchases of local products.

The Functioning of Government Departments

In view of all the preventive measures, government departments were obligated to put in place innovative mechanisms and work methods to ensure business continuity and non-disruption during the Corona pandemic that was expected to be prolonged.

The General Personnel Council (GPC) is responsible for promoting Public Administration and the civil service sector in Palestine by raising the efficiency of human resources and administrative systems. With support and guidance of the senior management of GPC represented by its Chairman Minister Mousa Abu Zaid, GPC's staff has worked at an accelerated and proactive pace during the previous years to improve the work environment, raising its efficiency and enhance its employees' capabilities. This led to the continuity of the GPC work with high quality and high readiness even in the light of emergency cases and manage the crisis in an efficient and transparent manner. Here, the role that the high leadership plays becomes clear, and the importance of an inspiring, motivating and supportive leader who supports change, creativity and excellence clearly looks to the future and plans for it in every step. This was done through:

1. Continuous support and motivation from the top management represented by the Chairman of the General Personnel Council, which pushes the employees to creativity, achievement, and work continuity and dedication with all sincerity and efficiency under the most difficult conditions.
2. Promoting the use of information technology and digitization in implementing all administrative procedures, with the investment in the infrastructure, servers, and information security.
3. Connecting governmental departments with the General Personnel council (GPC) electronically through electronic systems.
4. Promoting communication between different administrative levels and removing barriers that prevent innovation and creativity.
5. Improving the work environment for employees, which supports ethics and positive behaviours, such as job affiliation, and the creation of development ideas.

These steps contributed to the rapid response of the GPC to the changes that occurred due to the Corona pandemic, so that the tasks were distributed

and all requirements were done with high quality and efficiency. The senior management of GPC developed an integrated emergency plan that included a set of steps as follows:

1. Emphasizing the continuation of GPC's work and fulfilling its administrative obligations in the interest of civil servants' rights.
2. Daily and continuous follow-up of the work progress by the Chairman of the General Personnel Council and overcoming any obstacles faced by employees in carrying out their work.
3. Authorizing departments' directors to set a flexible time schedule that ensures continuity in the implementation of procedures and the absence of more than two employees in each room for work cases from within GPC.
4. Providing the means of protection in General Personnel Council by installing hand sterilizers at the building entrances, elevators and employees' offices.
5. Obliging employees to wear face mask and gloves during the work period.
6. Adopting remote work and virtual office.
7. Providing the required logistics for employees to support their work remotely, such as providing them with laptops to use during the emergency period, and downloading programs related to their work on their personal devices.
8. Reliance on electronic transactions and documents in implementing administrative procedures for government departments.
9. Forming a technical support team who provided government departments with their contact information to help implement measures remotely throughout the emergency period.
10. Holding regular meetings through virtual meeting applications.
11. Emphasizing that through the Coronavirus crisis it is possible to generate a set of new ideas and mechanisms that contribute to developing new forms of work.
12. Documenting the work during the emergency period to benefit from that experience, evaluate it and build on its outputs in the future.
13. Submitting periodic completion reports for the work of the various departments.

The General Personnel Council managed during the emergency period to hold remote employment interviews for more than 500 applicants for the Ministries of Health, Justice, Education, and Transportation, through which

citizens were able to hold employment interviews with the relevant committees while they were in their homes and avoid the dangers of gathering in one place to hold these interviews. Educational jobs have also been announced for the Ministry of Education and citizens were able to apply for jobs electronically through the electronic portal of the General Personnel Council; the number of requests reached 49,061 applications.

Administrative transactions were also received from government departments across the Electronic Systems accredited by the General Personnel Council without the need for any paperwork. The work of the specialized committees continued to develop the incentives system, the contract system, the development of the civil service law, the completion of job classification tables, the discussion and approval of job description cards for ministries and governmental departments, and the completion of contracting procedures, confirmation and update of employees and contract data via Information Systems.

The Palestinian National School of Administration

The Palestinian National School of Administration (PNSA) also continued, under the direction of the head of its Board of Management, His Excellency Minister Mousa Abu Zaid, to advance its work since the beginning of the emergency declaration and worked within a crisis group on several strategic issues. The development of training programs and the preparation of three full electronic training programs on issues of effective leadership, human resource development and the action plans were continued. The PNSA also began providing its remote training programs using Zoom and Moodle techniques as a training platform, and developed detailed procedures manuals and protocols for remote training for all roles. In addition to that, administrative work resulted in the completion of annual reports, the completion of the strategic plan for the next three years, the holding of periodic Board of Management meetings, and following up the new PNSA headquarter preparations. The development of training evaluation processes in PNSA were continued, as was the work of developing a new organizational.

Conclusion and Lessons Learnt

The work of the General Personnel Council over a period of time proved useful in the government services adapting to the special conditions occurring in a pandemic. For example, remote working was enabled because of investment in digitizing procedures and strengthening electronic communication channels between service providers and service recipients. Ultimately, the Government of Palestine experience in the pandemic showed the benefits to be gained

from the existence of outstanding leadership and a forward-looking view of civil service development. The lesson is the benefit arising from having a wise, inspirational leadership that supports the employees and motivates them towards creativity and excellence, supports managerial flexibility, looks to the future and plans for it and works proactively and with high responsibility.

It is also important for each country to prepare procedure manuals for crisis management and development actions in the future, so that it lists the most important challenges it faces and how to address them during the crisis.

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Coping with COVID-19 in Tunisia: Unfreezing the Mammoth!

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Abstract

The Coronavirus epidemic hit the country at the worst possible time amidst a political, economic and security crisis. Yet the new government, which was formed barely a week before the first COVID-19 case was detected, embarked on a fully engaged strategy to cope with the pandemic. On the health front and less than 3 months down the road, Tunisia is on the verge of overcoming the spread of the disease. The strict lockdown has been eased as a result and the country will fully reopen its borders by the end of June. On other fronts, the Government has been able to enact a myriad of economic and social measures to cope with the crisis, and further achieve major breakthroughs in administrative digitization and key reforms that saw the light of day through unfreezing the “mammoth”, i.e. public administration, and setting the stage for fixing other ills of the country such as poverty, corruption and other forms of ill governance.

Keywords

Corruption, economy, government, healthcare, reform

Highlights

Major crises like the Coronavirus unfreeze existing inertia and make possible changes that are not easy to do otherwise. This is especially true for public administration.

Post-COVID-19 plans have to be thought of and planned during the crisis. The two key decrees of the Tunisian Head of Government related to important changes (unique identifier and reallocation of staff from central to local government) that will strengthen the country’s resilience to future cataclysms of this kind.

Country Context

COVID-19 hit Tunisia at a time when the country was going through difficult times, characterized by grave political, economic and national security challenges. A new Government was not formed until mid-February following interminable political wrangling resulting from Presidential and legislative elections held in September and October 2019. The elections yielded a divided national assembly, hence requiring a coalition government made up of several parties that stood on opposing ends of the ideological divide. A first Government formation nominated by the relative majority party was voted down by the people's assembly prompting the President of the Republic to nominate another candidate who succeeded in forming a coalition Government. However, the new coalition did not seem to muster the necessary goodwill to manage the imminent menace of COVID-19 that was about to befall the country. The new Government was finally approved on February 26th just-in-time for the country to diagnose its first case of COVID-19 contamination on March 2nd, 2020.

On the economic front, the country has been undergoing a severe economic crisis that seemed to worsen following the revolution of December 2010/January 2011¹. Despite the many reforms and measures adopted during the last decade, Tunisia has struggled to revive its sluggish economy marked by a slowdown in economic growth, a persistent high rate of unemployment and a relatively high inflation.

On the security front, and though the State seemed to be in control since the massive and deadly attacks on the Bardo Museum, a summer resort in the town of Sousse and the Presidential Guard all in 2015, a new attack near the US embassy took place just four days before reporting the first case of COVID-19, killing a security officer and injuring few others. Otherwise, terrorism was restricted to the mountainous regions on the borders with neighbouring Algeria.

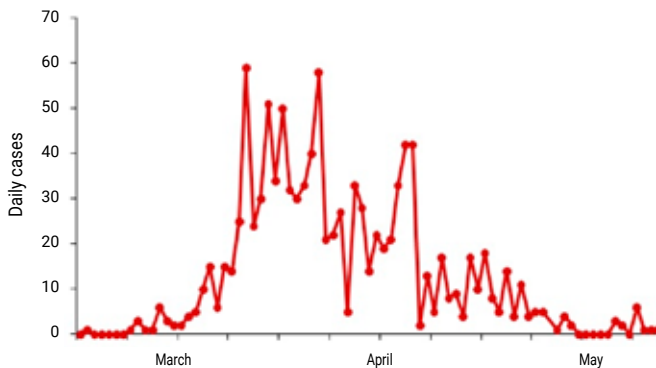
The COVID-19 crisis came against the backdrop of this difficult context to further increase the country's economic woes by undermining key economic sectors like tourism and exports, severely restricting the informal economy, small businesses and trades which ensured the livelihood of a large portion of the active population. Many small and medium enterprises forced to close during the period of the lockdown did not have the necessary liquidities to sustain the sudden drop in operations and in many cases defaulted on salary payments or simply let go of its personnel, further aggravating the social crisis.

¹ Former President, Zine El Abidine Ben Ali was ousted from power on January 14th, 2011 following country-wide unrest that started on December 17th.

The Healthcare Strategy for Fighting COVID-19

The difficult context of the country did not stop the government from fully engaging in a strategy centred on saving human lives and flattening the curve to avoid a collapse of the healthcare system. Economic considerations became a priority when the health situation improved drastically and seemed to become sustainable. The Government shifted then complete focus to mitigating the economic fallouts of the crisis. The President of the Republic and the Head of Government, in various communications, sent clear messages that the State would stand with the most vulnerable and committed not to leave anybody behind. Beyond political rhetoric, this proved to be largely true as the Ministry of Health, under the leadership of its “superstar” minister² and few of his close aids, mounted a massive public healthcare operation to rid the country of the pandemic. Almost three months after the first elements of the strategy were put in place, the strategy looks like an astounding success, based on objectives outcomes. Figure 1 below shows the curve of the spread of COVID-19 until May 20th, 2020. Not only was the curve flattened but the disease was almost eradicated with no daily new cases for 5 consecutive days May 9-13 and very few cases ever since, mostly of repatriated citizens. Many regions of the country have been already declared COVID-19 free and it is expected that little trace of the epidemic will be left by the time the country reopens its international national borders at the end of June. In what follows, key elements of the health strategy are presented:

Figure 1- COVID-19 Spread curve in Tunisia



² Opinion polls undertaken during the crisis placed the health minister at an all-time high both in his own party and as a national political figure. The polls have been consistent placing him second only to the President of the Republic and before the Head of Government in terms of popularity.

Broadly speaking, the Tunisian approach to fighting COVID-19 has been characterized by transparency, proactiveness and realism. In his daily briefings, the Minister of Public Health was noticeably clear about the spread of the disease, and the state of the public health infrastructure and its readiness. He used primetime TV programs and daily briefings to raise people's awareness about the imperative of flattening the curve of the disease spread and how an exponential growth in COVID-19 contaminations could lead to the disastrous situation of overwhelming the 300 Intensive care unit beds available in public hospitals³. The ministry's daily communication was very instrumental in mustering a strict compliance with the measures, in a population that is not easily amenable to lockdowns and is otherwise reluctant to follow government orders⁴. The Government also communicated transparently about the economic and social situation in the country. This helped restore a base level trust in Government actions in tackling the disease and its fallouts despite a deeply engrained mistrust in Government as a result of the endemic corruption that is gripping it, and which we will examine later.

On a proactive level, health authorities did not wait for the first infections to occur to start tackling the virus. Thermal cameras for fever screening were installed in airports and at border crossings with neighbouring countries as early as January 20th, almost a month and half before the first case was detected. Moreover, a general lockdown was decreed within three weeks from reporting the first case of COVID-19. The lockdown was accompanied with a curfew from 6:00 pm to 6:00 am, to be progressively relaxed as the situation improved. The army was deployed in the streets alongside the police to enforce the curfew. Many other proactive decisions were taken, as plotted in the timeline of Figure 2 below and further described in Annex A.

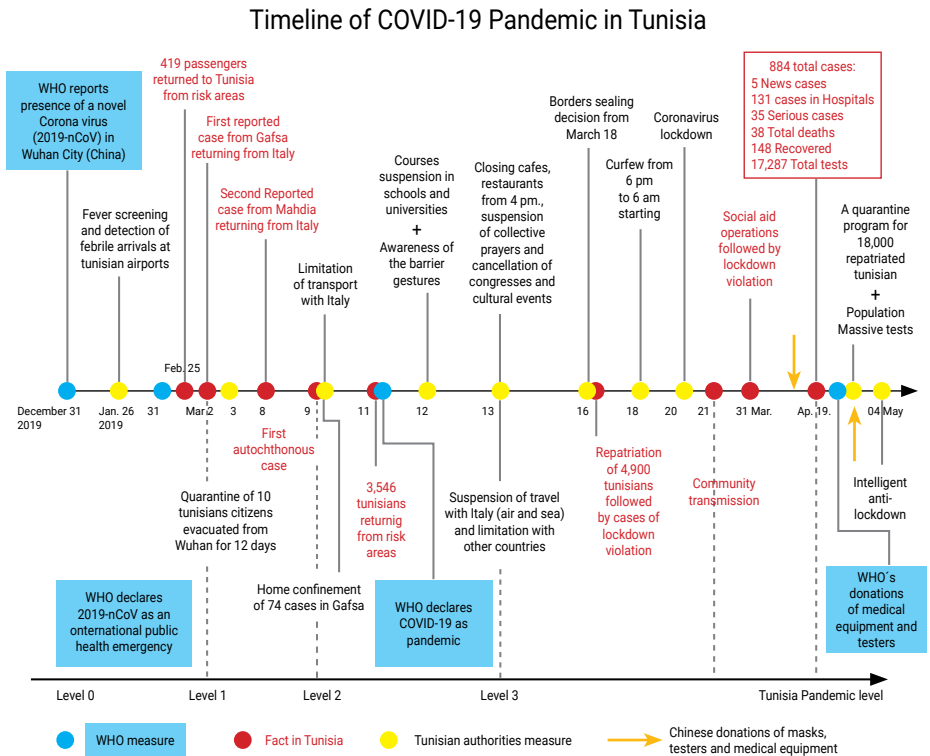
The realism of the strategy is mostly seen in the testing approach adopted. First, it is worth mentioning that in the beginning some people argued for a "herd immunity" strategy given the limited resources of the country⁵. However, it was never considered; the tragedy unfolding full scale in Italy at that time and videos showing people in China collapsing in the streets, along with social norms rejecting the exposure of the weak and frail to the risk of disease, were enough of a deterrent for any related option to be considered. The government

³ The total number of ICU beds in the country is estimated at 500 including units available in private clinics.

⁴ In one such press conference, the Minister burst in tears when the number of cases seemed to go out of control after the lockdown appeared to leak. Some accused him of manipulative tactics, but it seemed to work and alert the population to the seriousness of the situation.

⁵ A presidential candidate and head of a political party which has 3 deputies in the parliament advocated this strategy. Ironically, he caught Covid-19 along with some of his family members and recovered since.

Figure 2 - Milestones of the COVID-19 crisis in Tunisia (Adapted from Boubaker, 2020)



rather opted for a selective testing strategy. Only people with symptoms were tested and if they turned out to be positive, their immediate trail was tested as well. Whenever there were more than 5 cases in a single location at once, it was declared a contamination cluster and isolated thereof. As the lockdown is gradually eased, the same strategy is further expanded to ensure that any new propagation is stopped quickly. After a more than a month since the lockdown was first partially eased, hence beyond the virus incubation period for people who might have been infected after lifting of the lockdown, there does not seem to be any new spike, again recomforting the Ministry's testing strategy. On the medical front, the scientific committee advising the Government⁶ opted for a conservative approach regarding controversial issues like the

⁶ Despite the overall transparency of the Government in dealing with the crisis, some die-hard reflexes of lingering non-transparency were there. For instance, we could not locate the list of members of the scientific committee, which is symptomatic of the lack of a consistent communication strategy of the Government prior to the COVID-19 crisis.

hydroxychloroquine despite pressure being put by many influential people including medical doctors and other prominent public figures.⁷

Beyond healthcare, many measures were taken by the Government to respond to the crisis, including security measures, economic measures, and social solidarity measures. The measures are too many to discuss in this paper and some of the most salient ones will be discussed, further below, as part of the role of public administration in their implementation.

The Crisis Effect on Public Administration Reforms

“Unfreezing” the mammoth

The Head of Government and other senior government officials have repeatedly pointed out that they were facing a major bureaucratic hurdle in trying to implement emergency measures to cope with the COVID-19 crisis. In his May 20 address to the nation, he outlined an overall post-COVID-19 plan of reforms, which included seven priorities⁸. The Minister of Public Service, Administrative Reform and Fighting Corruption stated in a TV program that the coronavirus crisis spearheaded changes that would have taken 10 years to do otherwise. Indeed, and in light of the bureaucratic tradition of the Tunisian public administration, changes are very difficult to enact because of the mammoth size of the administrative apparatus and the deep entrenchment of the administration in serving a rentier economy that does not look very positively at changes that imply transparency, equal access, efficiency and effectiveness. Changes were made possible now because of the imperative to deliver quickly and well, given the dramatic social conditions unveiled and further aggravated by the crisis. The distribution of financial help to the “weakest slice of society⁹” uncovered a situation of deprivation that many seemed to be shocked to discover. Indeed, and in planning financial disbursements to the needy, the Ministry of Social Affairs collated its different initiatives of previous poverty programs¹⁰ and further made a call for people

⁷ A petition of 68 highly influential figures sent to the Head of Government requested that Hydroxychloroquine be adopted, in combination with an antibiotic, as a compulsory medical protocol for the early treatment of the disease.

⁸ (1) the resolution of outstanding problems hampering major projects and the return to normal activity in the mining and oil industries, (2) salvaging jobs, (3) the fight against precarious employment, (4) the revival of the economic sectors most affected by the COVID-19 pandemic, (5) the preservation of the economic fabric, particularly SMEs, (6) the fight against corruption and impunity, and (7) the consolidation of national sovereignty and security

⁹ Official reference of the Government to people below the threshold of poverty.

¹⁰ Popularly referred to as the “white and yellow books” which refer to books that needy family and individuals must carry to claim government help.

to come forward to register for financial help. The final tally of people that qualified for help came up to almost 900,000 families. With an average of 2.23 children per family (CIA, 2020), the number of people concerned with this measure represents roughly third of the Tunisian population. This came as a shock to many including the Head of Government himself who stated that he was flabbergasted by the pervasive poverty in the country. These numbers stood at double what was released by the National Institute of Statistics, which puts the poverty rate at 15.20%¹¹. What was further shocking is that the Ministry of Social Affairs did not have reliable numbers and databases about poverty in the country beyond the formal programs it was running. It was another clear indication of how public administration fell short in its mission despite overstaffing and a massive presence all over the country. This failing was mostly visible in the way the disbursements were done in the first wave, through postal offices, causing major crowding that threatened a spike in COVID-19 contaminations. While the blame was put on the Government for ill planning the disbursements, it is clear that the failing predated the disbursements and is the result of the absence of a reliable payment mechanism to reach out to a large number of people in a restricted period of time. To its credit, the Government, through the Ministry of Finance, took immediate measures to avoid the same scenario in the second wave of payments and disbursements were done smoothly through a digital wallet that was set-up quickly enabling beneficiaries to retrieve their allowance through ATMs and postal offices alike, hence multiplying points of payment 4 fold (African Manager, 2020). This was probably the biggest breakthrough digital application ever that was targeted at citizens. Most of the developments thus far have been limited to Government back-office operations and to “high-value” clients like corporate taxpayers beyond a certain threshold income and other compliance matters like the “corporate register.” The digital wallet spearheaded a series of government reforms that were accelerated by the devolvement of legislative powers to the Head of Government giving him the necessary flexibility to enact legislation to fight COVID-19. Many digital innovations were indeed developed locally including a nurse robot, a policy robot, an on-line platform to deliver emergency economic aid to SMEs, another one to deliver permits for people to move around in motorized vehicles during the lockdown, and a contact tracing application among many others.

Aside from digital innovations, two major decrees brought into effect long standing proposals about public administration reform that were delayed for various reasons:

¹¹ The national statistics institute computes poverty levels on a different basis however. See Statistiques Tunisie (2020).

- The national unique identifier, which the Ministry of Interior and other Government quarters objected to in the past for fear of losing control over proprietary information, a reflex reminiscent of the security apparatus culture that was built into the post-independence State and heavily reinforced by the pre-revolution governments. By creating a single instance of every citizen in government databases and allowing cross-referencing, the unique identifier will allow the integration of citizen-focused services across all government departments and avoid the multiple requests of documents from people who seek public services;
- The reallocation of personnel from central government to local collectivities will provide human capital necessary to deliver more and better services to citizens locally. Indeed, of the total 800,000 public servants in the country, merely 36,000 work in 350 municipalities scattered all over the country. This is a first step that needs to be complemented with the reallocation of competencies from the central to the local level. An organic law to this effect has yet to be promulgated as it is heavily resisted by central government departments that are reluctant to let go of any of their duties, even those that can be better delivered locally.

Though the above two reforms should not normally come within the preview of emergency measures and decrees to fight the coronavirus crisis, as stipulated in the agreement of delegation of legislative powers from the People's Assembly to the Government, their promulgation is amply justified to put in place a robust governance system to fight similar pandemics in the future.

Missing the call

Though some quarters of public administration showed some agility and resiliency in coping with changes, failings were also visible, chief amongst these the cancellation of teaching at all levels without an alternative provision for on-line learning. Yet, the technology is there and accessible at little cost. Tunisia has even a virtual university whose remit since its inception was to support the university system to deliver teaching on-line. The problem for higher education was not the technology, but the production of learning content ready to be delivered on-line. The Ministry and higher education institutions are probably not able to enforce the delivery of e-learning on their teaching staff as a result of the pervasive influence of blue-collar like unionism which would not consider any such initiative outside of the rigid framework of labor negotiations¹². Irrespective, many continued to deliver on-line lectures

¹² In a move that came very late on May 14th, the Ministry of Higher Education announced that it was allowing free access to the Virtual University digital platform as well as the national university network and further mediated free Internet access for one month to 80,000 students who benefitted from government scholarships. But this was not expected to make any difference 2 months after classes had been suspended.

and facilitate student learning. Engineering schools were very active trying to design equipment and supply for the healthcare system.

For secondary and primary education, the school year was brought to an abrupt finish except for the terminal classes due to take national exams, namely 6, 9 and baccalaureate (Business News, 2020) levels. A TV channel was started by the Ministry of Education to offer students support with preparing for the national exams. e-Learning was dismissed since the beginning allegedly because of the unequal access to Internet and remote learning. While that can be partially true, it could have been remedied with emergency measures put in place, like the ones adopted by the Ministry of Higher Education albeit very late. The real reasons are probably the unwillingness of the worker union for its members to shift their mode of delivery and second the inability of a highly centralized system and ministry to manage a distributed learning process.

Other than the front-line ministries which were facing the crisis, the remainder of the State apparatus literally disappeared from the scene and came to provide minimal services with a limited number of personnel. This is partially due to the lockdown of government personnel at home¹³ as only essential staff were asked to continue reporting to work. Though the Government proclamation provided for working from home, the heavily paper-based, security-minded and hierarchical Tunisian public administration did not give much room to perform any duty from home¹⁴. No statistics exist in this respect and it is hoped that the Ministry of Public Service collects such data to better harness telework and put in place reforms to make it possible in the future. There was hardly any previous research in this respect.

Endemic corruption

While it can be said that the coronavirus triggered the “reform” antibodies of the Government, fast-tracking reforms like never before, it has also brought to the fore one of the most serious problems of the country, namely corruption which has amplified during the crisis. Corruption is considered as one of the most endemic problems of the country along with terrorism, tax evasion, an ineffective and inefficient public administration that has inflated beyond any reasonable limit, public corporations that are accumulating massive losses, an unruly workers union that has become more akin to organized crime¹⁵,

¹³ Only one third of the total personnel stayed on the job.

¹⁴ Fax machines remain a key communication channel within public administration.

¹⁵ One of the deputy secretary generals of the national workers union (UGTT) gave an ultimatum to the justice system to release some of its activists before the Eid break (end of Ramadan on May 24th) or face the wrath of the organization. The activists were arrested and are being tried for beating a parliamentary deputy (medical doctor) who belongs to a party known for its anti-UGTT stands. The anti-corruption observatory RAQABA has published many reports about the union's sponsorship of criminal practices in many public corporations.

and foremost a rentier system that bogs down the State to serving a privileged oligarchy¹⁶.

Prior to the COVID-19 crisis, corruption had been estimated to be extremely high (OCDE, 2019). Statistics provided by the National Anti-Corruption Authority (Instance Nationale de Lutte contre la Corruption - INLUCC) have shown a further rise in corruption and other illegal practices during the short period of the lockdown. From March 20 to April 26, 2020, the INLUCC received 8852 reports on suspected corruption practices (INLUCC, 2020) of which more than 50% pertaining to price hikes and illegal trade practices. Speculation is rampant in the Tunisian economy and has put the low-income class in a situation of severe precarity, further exacerbated by the crisis because of the disruption in the supply of basic goods. Speculation in food commodities has thus become a normalized business in Tunisia and is run by another powerful cartel of the economy, the barons of the informal economy, mainly the speculators and the *Knatria*¹⁷. Despite claims of wanting to reign on the problem, the Government has failed to curtail this phenomenon raising suspicions of complicity within its own departments especially its ministry of commerce. Political rhetoric of fighting corruption and illicit wealth has rather been used to soothe public anger against the proliferation of the corruption pandemic. The Government seems incapable of articulating a clear anti-corruption strategy and in some cases even to be chaperoning corruption itself¹⁸. During the crisis, a public procurement of safety masks was diverted to a deputy by the Minister of Industry, who was anyways barred to do business with the Government being a member of parliament. The affair was taken up by the justice system, the INLUCC, and an internal control body dependent on the Minister of Public Service, Administration Reform and Fighting Corruption¹⁹. While the three bodies were looking into the affair, the Head of Government came on live TV to defend his Minister and supported the deal, which did not go through. There could not be a worse dent than this episode in the alleged government effort to uphold the rule of law and fight corruption.

¹⁶ The EU representative in Tunisia gave an interview to the French newspaper *Le Monde* where he stated that family oligarchies resisted the emergence of new economic agents. Many even ascribe the emergence of a large informal system to the access barriers set up by the country's rentiers. https://www.lemonde.fr/afrique/article/2019/07/09/face-aux-turbulences-regionales-l-europe-ne-veut-pas-perdre-le-soldat-tunisie_5487381_3212.html

¹⁷ *Knatria* is a plural for *Contra*, itself a diminutive of *contrabbando* an Italian expression for the illicit trade.

¹⁸ On May 14th, the Government announced the forceful retirement of 21 senior officers at the Customs Directorate for suspicion of corruption. Ironically two of these were members of a parallel anti-corruption Board that was set up by the previous Head of Government.

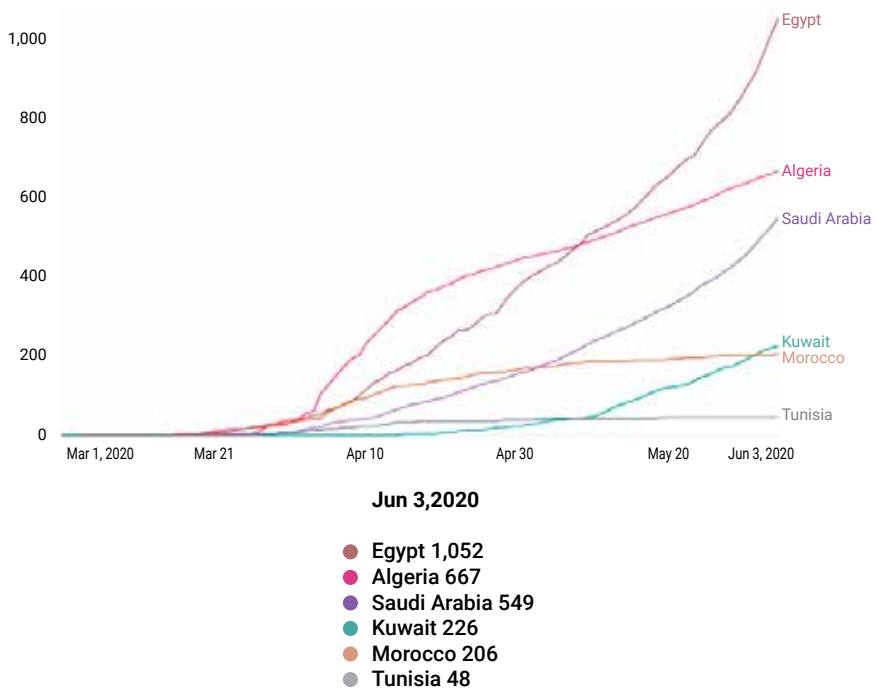
¹⁹ The State Minister for public service, administrative reform and fighting corruption is the head of one of the government coalition parties and focused his party's campaign on the rule of law and fighting corruption.

Notwithstanding, the digitization of public administration, if it goes through, could prove to be turning point in the war against corruption. Moreover, an NGO (Raqaba Observatory) led by a past parliamentarian and advisor to the first post-revolution President has been investigating corruption cases and publishing its findings online, prompting the Government to remove officers holding senior positions in public corporations. But the strategy remains very reactive and limited to removing those who are irretrievably compromised.

Tunisia's Response to COVID-19: a Success Story

Success or failure in managing the coronavirus health crisis is easy to establish. On the healthcare front, and if one looks at the numbers of Tunisia, they are all in the green and compare well with neighbouring countries as well as worldwide. Figure 3 draws a comparative evolution of the number of deaths with select Arab countries. Tough these numbers have to be reported to size of the population, the trend is very significant and shows a more positive evolution for Tunisia than all other countries.

Figure 3 - Evolution of number of confirmed deaths in select Arab countries



The country has already started easing its lockdown since May 4th and will completely unlock by late June, unless there is a relapse in the epidemic situation, which is not expected. By then, activity would resume almost normally except for new behavioural norms that will have to stay in place until a vaccine is found, namely social distancing, wearing a mask, and sanitizing hands. However, and despite the success of its healthcare strategy in controlling the disease, there is still no clear evidence as to what the real reasons behind the positive outcome are. The measures taken by the Government were also taken elsewhere by other governments and did not yield similar positive results. Research is already being conducted to see the immunity level of the Tunisian population, a possible explanation for the low numbers of symptomatic cases. Further studies about other possible determinants of success would have to be conducted, however. These would have to include both objective factors like the population immunity level and measures taken but also subjective factors like competency and engagement levels of health and other personnel involved in fighting the crisis, compliance level of the population, lifestyles, etc.

On the economic front, the country stands a good chance of salvaging parts of its tourist season which is about to start. Special protocols have been developed to ensure the safety of tourists²⁰ and returning expatriates alike²¹, while visiting the country this summer. The other economic sectors that have suffered from the lockdown should be able to partially recoup their losses by the end of the year. But this does not mean that the country comes out unscathed from the crisis. In his TV address on May 20th, the Head of Government, announced that the economic growth rate for the year was projected to decrease by 7 points compared to 2019, which puts it at -5%.

Despite limitations in its resources and capacity to manage a large-scale crisis like the coronavirus one, the State, Government and public administration overall were viewed in a positive light. Many stories were reported internationally to laud some of the initiatives developed locally. Example of these include the street patrolling robot (Business Insider, 2020), the workers locking themselves in a factory for 30 days to manufacture masks and other personal protective equipment for the medical staff (France 24, 2020), the national airline carrier as well as military flights repatriating citizens stranded abroad and in some cases foreigners stranded in Tunisia (Tunis Afrique Presse, 2020), the Government fully-paid quarantine in hotels for repatriated citizens,

²⁰ The German minister for development expressed his hope that Germans could still go on vacation to North Africa (Morocco, Tunisia and Egypt) pending strict health standards being enforced

²¹ So far, repatriated citizens were forced to quarantine in hotels for 2 weeks and were fully taken in charge by the Government.

a military medical mission sent to Italy for two weeks during the peak of the pandemic and many other good practices. More importantly, the country came together in this difficult time and solidarity was all visible to support the weaker members of society. The coronavirus has surely created damage, like everywhere else, but seems to have reignited hope in a better future for the country.

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Part IV
Comparative Studies
and Perspectives

Mild Hit, Flexible Response: How Local Administrations in Austria and Germany Confronted (First Wave) of the COVID-19 Pandemic

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Abstract

The COVID-19 pandemic constitutes a veritable capacity test for local administrations in Germany and Austria. Based on a survey among systematically sampled Austrian (n=130) and German (n=517) employees of local public administrations, the article taps into the perceptions of how the bureaucracies in the two federal states coped with the challenges emerging at the early stage of the crisis. As it turns out, in the administratively well-equipped and—in comparison to disastrous situations elsewhere—mildly hit countries, local administrations did fine—even growing beyond themselves. Key to a higher probability of coping well with COVID-19 appears to be an intelligent administrative networking strategy. Five tentative lessons are drawn on what—at this early stage—can only constitute an incomplete picture taken from a fluid context.

Keywords

COVID-19, crisis reaction, local administration, coping strategies, learning, networks, resilience

Introduction

The COVID-19 pandemic challenges not just health sectors, but public administration systems in general. The comprehensiveness of the pandemic impact—direct by the disease, and indirect by the consequences of the lockdown—are unheard of. If the metaphor of entering uncharted waters ever applied, it is to what is currently faced. And if organizational resilience ever was needed, it is the case now in view of the state's bureaucratic capacities. Moreover, at the time of writing (May 2020) it looks likely that the lockdown of whole countries including their economies, was the easier task compared to the unfreezing ahead. The term “unfreezing” might still prove to be terrifyingly accurate and full of potentially tragic surprises. Consider that a mammoth unfrozen after 10.000 years can still be eaten (though it remains dead!), but grapes do not come out of the freezer in an appealing state. In other words, from a public administrative perspective, flexibility, clear communication with the public and the encouraging of the involvement of the organized society are the instruments of choice in order to keep agile in a situation of lasting uncertainty.

Against this backdrop, this chapter attempts to take stock of how Austria and Germany's early reactions to (what is likely to be the first wave of) the COVID-19 outbreak. The focus lies on the local administrations of these countries. The local level perspective is of crucial importance if the implementation of the state's reaction is to be studied. It is there where the state faces its citizens directly, and where emergency actions to assure public health must be implemented. The bulk of those actions which directly impinge on the lives of citizens have to be entertained by local authorities—aid for the local economy has to be allocated, new instruments need to be developed to serve people at risk, the compliance of stakeholders with new rules and restrictions has to be monitored, and last but not least the internal organization has to be restructured, many services have to turn digital, personnel has to be reallocated. Germany and Austria, in addition, are examples of federal states, run by coalition governments, with a long tradition of autonomous regions and local self-determination. In other words, both are states with political systems characterized by a veto player culture, regional diversity, and loosely coupled administrative levels making up a multileveled executive order. And yet, geographically close to Italy, the first European epicentre of pandemic, Germany and Austria were hit early, reacted both swiftly and comprehensively, and appear to have been able to manage the first wave of the COVID-19 disease relatively successfully—if compared with other states like France, Spain, or the United Kingdom. Based on employee surveys the remainder of this article reports how public administrations at local level in Germany and Austria managed to stand up against the wicked problem posed by the current pandemic. How did public administrations cope

with the challenge, and what, if anything, can one learn from their responses so far? One can argue that the lockdown constituted a veritable capacity test of local administrations in Germany and Austria—which they apparently passed. So, although it is still early and the jury is still out regarding a systematic performance assessment, by describing the reactions of local administrations to COVID-19, one provides some tentative lessons in view to which factors have helped public bureaucracies to cope with the crisis so far.

Surveying Local Authorities' Crisis Perceptions in Austria and Germany

To capture the current challenges for local administrations, between April 6th, and May 4th, 2020, an online survey was conducted in Austria and Germany. The questionnaire contained modules on the work environment, intra-organizational structural change due to the COVID-19 pandemic, related networking activities with other public agencies and external actors, knowledge management, as well as questions on socio-economic and demographic characteristics of the municipality. All German and Austrian health authorities, district administrators and mayors were contacted as well as all municipalities that begin with the initial letter “M” in all federal states in Germany, the letters “B”, “H”, and “R” in Austria. Overall, 130 respondents from the local level in Austria, and 517 in Germany, respectively, took part in this survey (for details on the single countries see Bauer et al., (2020); Schomaker et al., (2020).

The survey aimed to understand how local public administrations reacted to the COVID-19 shock, what the major concerns of administrators in this situation were, and which measures got adopted to ensure appropriate administrative performance, in particular with a view on agility of reaction, and adaptations in structures and processes. Patterns of network activities constituted a particular focus in this context. Furthermore, the interest was in how far lessons from previous crises—notably the increased refugee immigration in 2015 and 2016—mattered in the terms of boosting administrative “preparedness”, and in how far adjustments made in the current pandemic could potentially pave the way for innovation and permanent change beyond the COVID-19 pandemic.

Both countries analysed are federations with a similar administrative culture, also the legal and institutional framework is comparable, even if the public sector in Austria is remarkably smaller compared to Germany. The initial preparedness of the national levels in terms of legal and governance framework is also comparable. As for Germany, a National Pandemic Plan (NPP) existed before the crisis started (published in 2005, updated in 2017), it comprises a collection of instructions for the occurrence of a pandemic in Germany. In Austria, the so-called “Influenza Pandemic Plan”, created 2006,

covers similar topics, but is not as comprehensive, in particular in terms of governance structures. Austria as well as Germany are characterized by a welfare system with a highly developed public health care system, ranking amongst the best-performing countries worldwide (World Health Organization [WHO], 2019).

Both countries exhibit an administrative culture that is rooted in the “Rechtsstaat” tradition, with fairly high levels of politicization but a merit based professional civil service. Usually, they have the reputation of sticking to a Weberian organizational culture that is not known for its flexibility or swift reaction capacity, but rather for principled thoroughness combined with risk aversion that leads to incrementalism and decelerating legalism. Despite such clichés both countries’ public administrations reacted on the pandemic offhand with swift adjustments of legal instruments and governance structures to fight the immediate effects of the pandemic in its public health and social dimension. Recommendations coming from the national level were swiftly and unbureaucratically applied. Nonetheless, due to the federal nature, some differences in the reactions concerning intensity and the sequencing of specific measures to fight the immediate effects can be detected—if one compares individual federal states in Austria and Germany, respectively. Such differences however have a higher variance in Germany than in Austria. After two months of virtual complete lockdown, a trend away from uniform responses is currently emerging. The prior voluntary obedience seems about to dissolve into variegated patterns of rulemaking as states now enter the phase of organizing the unfreeze. This probably marks the end of the extraordinarily homogeneity which the loosely coupled actors from all governmental levels had managed to sustain so far when faced with the uncertainty at the beginning of the outbreak. Comparing the social measures and economic rescue plans to smoothen the negative effects for the overall economy and society applied in both countries, extent, quality and substance of the responses have been remarkably similar. The measures comprise immediate emergency aid for social infrastructure and short-term financial support for enterprises, start-up entrepreneurs, and employees (e.g. short-time compensation, direct financial transfers, and tax deferrals) as well as long-term measures as fiscal rescue packages, and the investment in crucial social infrastructures, and plans for strengthening the national investment in public health, including the production of protective equipment, or vaccines and medicine. Interestingly, even if the governmental action to fight the health effects of the COVID-19 pandemic started earlier in Austria, with a time-lag of about two weeks, and also the lockdown-measures undertaken were stricter (e.g. in Austria an official exit restriction for individuals was given, while Germany only posed a so-called “contact ban” on the population), the crisis responses of the government and also the PA do not differ significantly, which is also reflected by the results.

Survey Results

All in all, the respondents consider their own authorities to be efficient as well as innovative in their immediate crisis reaction and assume that their municipalities can master the challenges posed by the pandemic “well” to “very well”. About 85% of the respondents agree that their local authority can “effectively or very effectively” tackle the challenges posed by the current pandemic, this number applies to Austria as well as Germany. Only 15% (Austria) and 18% (Germany) of respondents are concerned that the local public administration in general may be overburdened.

Furthermore, 74% of respondents in Austria, and 77% in Germany, respectively, agree or rather agree that innovative solutions beyond the existing routines are tested in response to the challenges, while around 60% (Austria) and 67% (Germany) expect that the adjustments made will also lead to additional medium-term innovation.

Two factors appear to explain this perceived resilience in the eyes of the respondents: First, the use of networks with other administrative units or bodies, as well as with actors from the civil society (and on a lower level, with private enterprises) is seen as relevant for a majority of respondents. About 70% of the respondents in both countries claimed that the interaction with other administrations worked well, while such a positive assessment is stated for cooperating and networking with the civil society by 60% of respondents, respectively. Second, learning experiences from the past, notably regarding, again, cooperation within networks, matters for the evaluation of the respective administration’s efficiency and effectiveness. While a learning effect from the refugee crisis can be observed, specific preparations for the current situation did not seem to be very relevant, and such preparation and specific training for the current challenges are hardly being used: Special training for employees as preparation for measures and adjustments due to the pandemic only took place in about one third of the administrations surveyed in both countries.

Nonetheless, even if drawing to already existing structures is important for the local bureaucracies in Austria as well as in Germany, the strength of the effect differs amongst the countries. Relevant differences exist in the revitalization of networks that were created in the “refugee crisis”, the high level of refugee migration to Europe in 2015 and 2016. While more than 75% of respondents in Germany relied on these networks with other administrative units, or the civil society, in Austria only about 51% (for intra-administrative cooperation) and 57% (for cooperation with the civil society) of the respondents indicate that they revitalized such networks.

Structural changes mentioned in the answers indicate innovative solutions being reached in the context of the current crisis. Almost all the respondents (around 98% in both countries) made customer contact more digital, and extended home office and digital work (83% in Austria, and 92% in Germany). Previous efforts by administrations at all levels to digitalize more are further consolidated and even accelerated. Many measures stated by survey respondents are related to personnel. Overall, more flexibility can be observed. The surveys confirm that in 87% of the cases in Germany (and in 72% in Austria) personnel in the general administration is redistributed more flexibly, with the percentages being even higher for employees working in the respective health authorities. Moreover, the personnel structure was changed in more than 53% of the cases in Austria (58% in Germany). In around 56% of the cases in Germany, but only 32% in Austria, these adjustments were done by reactivating structures of the refugee crisis.

Despite the fact that the overall adjustment to the crisis worked well, the local administrations express needs for more assistance to cope with additional duties as well as for continuing to provide general services properly during the pandemic. More support is requested in the areas “social issues” (comprising e.g. childcare and nursery homes; ranked first in both countries with about 70% of respondents indicating urgent need), “health issues”, “digital infrastructure” and “financial support”, while additional resources in areas like “personnel”, “better information” and “external communication” are less frequently demanded. These results are valid for both countries, only minor differences in the percentages exist—in particular in organizing healthcare, in Austria only about 55% of respondents require support, while in Germany 65% indicate that this is necessary.

Finally, striking differences exist with view to whom the local bureaucrats turn to for additional help. The questionnaire offered the choices “EU Level”, “Federal Level”, and “State Level”. Among those three choices, the EU comes out last. In no category is the EU level the first choice with respect to expecting help. That the regional level is the first addressee—except for direct financial aid which is requested from the respective federal levels—mirrors the constitutional reality of the local administrations. It sadly reflects however the marginalization of the EU in the pandemic context—despite the fact that as regards border control, purchasing and fairly distributing needed medical equipment and channelling financial support made available from what will be biggest supranational budget ever, the EU is objectively an important player in the design of the mid- to long-term reaction towards the COVID-19 crisis.

Emerging Lessons

Understanding what can be learned from the early crisis reactions at local levels in Austria and Germany, the concept of “intra-crisis learning” and “inter-crisis learning” developed by Donald Moynihan (2008; 2009) are instructive. While “intra-crisis learning” implies the direct reflection and adoption of new processes or adjustments regarding structures and actors whenever traditional schemes cannot usefully be applied any longer, “inter-crisis learning” comprises drawing lessons from the past, in particular former crises, and the adaptation of selected measures to the needs of specific units or departments.

Applying econometric models to the collected survey data, high levels of correlation as well as causal links between specific adjustments made and a high efficiency and effectiveness of the respective public administration are found. This is also reflected by non-parametric Mann-Whitney U tests to detect group differences in the data set. The data indicates that municipalities that declare themselves as being well-prepared due to experience from the “refugee crisis”—because they can revitalize established networks and prior cooperation—on average perform significantly better in the current pandemic.

The same applies to the quality of the network cooperation between the bureaucracies and the civil society: administrations that indicate an intensified use of networks with other actors from the administrative system or with the civil society and economic actors, perform on average significantly better; the more sore the higher they rank the quality of this network exchange (see appendix).

Tentative Observations

To be sure, it is too early to draw conclusions or even to resume comprehensively what the lessons from the COVID-19 crisis for public governance in Austria and Germany will be. This contribution attempted a briefing based on documentary analysis and two employee surveys with local administrators from the two countries. Instead of solid insights one thus ends with a couple of tentative observations. We are only at the beginning of the pandemic, and we can thus only interpret on what necessarily is an incomplete picture taken from a fluid situation. Bearing this caveat in mind, our reading of the early Austrian and Germany experiences at the level of local authorities supports the following observations.

Despite their reputation for inflexible legalism, i.e. for putting procedural thoroughness over swift and flexible reactions, the pragmatism and elasticity of the bureaucratic reaction towards the COVID-19 pandemic of the local administrations in Austria and Germany is to be positively acknowledged. The local public administrations seem at no point in danger to succumb to the

challenges of the emergency situation. To the contrary: a surprising flexibility, especially in terms of swift redistribution of internal personnel and facilitation of the usage of digital instruments, stands out as characteristic of the early crisis response.

Moreover, the local administrative action was quite uniform—to a degree not to be expected in federal systems. This voluntary homogeneousness—that boosted general trust in the state's capacity to cope with the crisis—was probably the effect of the uncertainty of the situation during the first weeks of the outbreak. The eagerness to obey and follow central level recommendations is currently declining. Managing the unfreeze will be a matter of much greater differentiation and diversity—with all the potential positive (experimentation) and negative (regional failures) consequences inherent to such variation.

Another lesson to be drawn from our data is that the ability of administrations to manoeuvre and orchestrate networks be it among public agencies or between the bureaucracy and the civil society are of fundamental importance. Where such networks in good shape existed local administrations apparently had a head start to successfully cope with the COVID-19 crisis. Furthermore, where the local administrations were able to rely on lessons learned during the previous crisis, also had a greater capacity to handle the COVID-19 outbreak. In other words, network-related inter-crisis learning is key as it boosted the preparedness of local administrations, and it usually goes along with high levels of intra-crisis learning capacity in terms of adaptability towards changing external needs and organizational requirements. In our story, investments in the proliferation and maintenance of external and peers' networks constituted the best hedge for the COVID-19 outbreak. Networking capacity appears to be the crucial element of administrative resilience—and thus merits further and systematic attention in the current crisis.

In sum, Austrian and German local administrations managed well the first wave of the COVID-19 pandemic. They showed unexpectedly high levels of intra-crisis learning (in terms of swift adaptation and orchestrated regulation) as well as inter-crisis learning (especially if previous crisis networks were still operational or easily reactivated). Although it should not be forgotten that the Austrian and German local administrations—coined by a tradition of self-determination—have been entering the crisis well-equipped (compared to their peers in the European South or East) and were also fortunate to have to cope with relatively mild courses of the disease in their countries—have demonstrated so far a reassuring resilience in the face of the unfolding pandemic drama.

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Appendix 1

Table 4 - Group Differences Covid-19 Pandemic

Significance Level *** 1%, ** 5%, * 10%

	Effectiveness	Performance of PA	Performance of PA high
Grouping Variable: Preparedness			
Mann-Whitney U	11576,000	11218,500	11695,500
Wilcoxon W	34154,000	36194,500	36671,500
Z	-3,449	-4,513	-3,635
Asymp. Sig. (2-tailed)	,001***	,000***	,000***
Grouping Variable: Quality Coordination with Administration			
Mann-Whitney U	7606,500	6885,000	8629,500
Wilcoxon W	13601,500	12880,000	14624,500
Z	-8,300	-8,914	-5,698
Asymp. Sig. (2-tailed)	,000***	,000***	,000***
Grouping Variable: Quality Coordination with Civil Society			
Mann-Whitney U	10464,500	10898,000	11682,500
Wilcoxon W	21639,500	22073,000	22857,500
Z	-5,995	-5,016	-3,548
Asymp. Sig. (2-tailed)	,000***	,000***	,000***

Source: Authors' estimations

An Integrated Approach to the Fight for the COVID-19 Pandemic: Italy and Switzerland

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Abstract

The COVID-19 pandemic displays all features characterizing a wicked problem. It is not only an intensive units crisis but also a more complex social and humanitarian crisis. Moreover, its risks will continue until a mass vaccination is carried out, with control of contagiousness relying on citizens' responsible behavior. Strategies fighting COVID-19 in different regions of Italy and in Ticino, Switzerland, have shown that a more balanced approach relying on territorial medicine as well as hospitals pays off. Benefits of a more balanced approach are clinical, social and economic and include a better readiness for future emergencies.

Keywords

COVID-19, territorial medicine, health

Introduction

This chapter starting from an analysis on how the COVID-19 pandemic is managed in Italy, aims at engaging scholars and practitioners in a conversation on an alternative approach. The central thesis is that the focus of public policies was – and still is – on hospitals, leaving the territory exposed. By raising awareness that the COVID-19 is not only an intensive units crisis but also a complex social and humanitarian crisis, we propose an inclusive approach able to engage different professionalities (epidemiologists, social psychologists, hygienists, immunologists, health psychologists, crises and communication experts, social scientists, experts in logistics, and social workers beside virologists) and to integrate hospital care with territorial medicine, also activating citizens and their communities.

A more balanced approach has been solicited by several petitions from Italian doctors operating in the most hit zones. It has been used by some Italian regions with satisfactory results and is not dissimilar from those effectively used in low-income countries to deal with global health problems. Such a proposal has several clinical, social and economic benefits including capillarity, early detection and greater ownership. Several conditions that enable it are identified including the existence of a well-functioning territorial medicine, trust and social capital. It is applicable to other high-income countries with healthcare systems operating beyond maximum capacity and struggling to control the circulation of the virus over a longer term. It could also improve society preparedness in future health emergencies.

The COVID-19 Pandemic as a Wicked Problem

A pneumonia of unknown cause was detected in Wuhan, China on 31 December 2019. On 11 February 2020, the World Health Organization [WHO] announced a name for the new coronavirus disease: COVID-19. It is a highly transmittable and potentially fatal coronavirus. Labelled the Ebola of the rich, it has been noticed that the more medicalized and centralized the society, the more widespread the virus (Nacoti et al., 2020).

As of March 30, 2020, it has been officially declared a global pandemic. At the time of writing, there are 4,589,526 confirmed cases and 310,391 deaths spread in 203 countries (WHO, 2020. Date accessed: 18 May 2020).

The COVID-19 pandemic displays all the features of a wicked problem (Head 2008; Weber & Khademian, 2008). Its evolution is *unstructured* as precise causes and effects are difficult to identify and continuously evolving, making unanticipated consequences of policy actions very likely (Agranoff, 2003, p. 9). It *crosses* multiple policy domains, levels of government and jurisdictions and, consequently, several, interdependent, stakeholders, each bringing in different

views, priorities, values, cultural and political backgrounds and championing alternative solutions. Among scientists, politicians and in the public opinion, there is *broad disagreement* on what ‘the problem’ is, making the search for solutions open ended. Health, social and economic issues are intertwined and create several *trade-offs*. The government at different levels, trade unions, and private firms’ associations champion alternative solutions and compete with one another to frame ‘the problem’ in a way that directly connects their preferred solution and their preferred problem definition. If not managed, this *multiplicity* easily translates in high conflict degrees.

Meanwhile, as our knowledge of COVID-19 increases, its understanding and the feasibility of solutions are put *in constant change*. Constraints are generated by numerous interested parties who “come and go, change their minds, fail to communicate, or otherwise change the rules by which the problem must be solved” (Conklin & Weil, 2007, p. 4. See Roberts, 2000). Finally, the problem is *relentless*, there is no finish line in view.

Additional characteristics make the COVID-19 particularly apt for an integrated approach: its widespread nature is a first, logistical, driver. The high number of people affected, several of them asymptomatic or paucisymptomatic makes it a problem spread in the territory rather than concentrated in hospitals. This characteristic goes hand in hand with the urgency to address it: scientists have highlighted that it is important to intervene in the first 7 days for the cures to be effective; however, a delayed intervention is noted, with patients arriving at the hospital when they enter the final stage with serious respiratory problems.

The decreasing trust of citizens in government is a second, governance, driver. For the aims of our article, it is interesting to notice that the decreasing confidence of people in their national governments is going hand in hand with a rising solidarity of local communities and businesses and the strong commitment of health workers to their communities. The growing understanding about the importance of the collective and community is the fertile ground on which our proposal is embedded.

Strategies Against the COVID-19 in Italy

Italy was one of the most hardly hit countries after the outbreak of the COVID-19 in Wuhan. The national emergency status was declared by end of January, after two coronavirus positive Chinese tourists were found in Rome. Three local sites emerged afterwards: on February 22nd in Lombardy, followed by the adjacent regions of Emilia Romagna and Veneto, soon followed by the spread of the virus through all the country. The closure of schools and universities was decided in early March, followed by a partial lockdown. A complete lockdown in all the country was adopted on March 22nd. At the time

of writing, Italy accounts for 224,760 cases and 31,763 deaths, although these figures underestimate the reality.

Italy has a national health service created in 1978, based on principles of uniformity and solidarity. It was reformed several times in 1992-1993 and 1999 promoting market-type mechanisms, managerialism, and regionalism. As a consequence, Italy has 21 regional healthcare systems that are the result of national and regional policies. It is also worthy to note that this pandemic has hit the country after a decade of strict spending reviews and severe cost containment measures.

The national government's response to the outbreak of the COVID-19 was developed along the following lines:

- Enhancement of hospital capacity by creating new COVID-19 facilities, increasing ICU beds of 50% and pneumology and infectious diseases beds by 100%, through fast-track hiring of both medical and nursing students, and by allowing retired healthcare professionals to go back to practice, by developing an inter-regional collaboration mechanism called CROSS and simplifying procurement regulations;
- Lockdown of all non-essential activities imposed partially and gradually;
- Financial aid and support to businesses and families;
- Last, and unfortunately least, delegation to the 21 regions to organize the territorial assistance to citizens and to COVID-19 asymptomatic, mild or recovered patients.

The first anomalous cases were reported by GPs in early January but were not able to reach regional decision makers in the communication system, highlighting the weakness of epidemiological surveillance.

The main feature of the national policies is their focus on the hospital response to the emergency, while being slow in organizing an effective response at the primary/community level. In the first phase of the emergency, the response to the pandemic completely neglected territorial assistance. Even in terms of communication, everything was focused on emergency services and hospital care”.

Unfortunately, this continued after the initial shock and despite the call of several medical associations. Italy did not make the most of its GPs. At the beginning of the crisis, they were assigned a very limited role of stopping the overflow of suspect patients to hospitals without a care protocol. Not only, but they were left without personal protection instruments in dealing with both COVID-19 and other patients. 51 out of 150 doctors victims of COVID-19 were general practitioners.

When the negative effects of the negligence of territorial and home assistance started to become evident also to the public opinion, the government accepted

a proposal from the National Federation of Doctors and General Practitioners. On March 9th, the regions were asked to create special units of care continuity (USCA) by March 20th. These “represent the possibility to reach patients at home in a time when GPs are unable to do so because of shortage of personal protection equipment (PPE)”, according to the Marche regional secretary of the National Federation of Doctors and General Practitioners. Some regions have so far adopted guidelines mainly recommending the use of telemedicine, providing few incentives (40€ per working hour) and insufficient personal protection. As emerged also from the interviews, they also rely on newly graduated medicine students but many of them are waiting organizational and logistical indications from staff that is already working close to maximum capacity.

As already mentioned, the Italian healthcare system is regionalized (i.e. regions retain some political, legislative and managerial autonomy even during an emergency status) and the regional responses varied according to the different pre-COVID-regional healthcare models. For the purpose of our article, it is interesting to compare Lombardy and Veneto, two regions close to each other that were both hardly hit, but which pursued very different strategies and achieved different outcomes (Bosa, 2020; Zanini, 2020).

The Lombardy case study is effectively summarized in a letter from the Regional Federation of Doctors and General Practitioners to the regional government highlighting seven mistakes in managing the COVID-19 crisis including: no testing of people outside of hospitals, which also mines data reliability; mismanagement of nursing homes for the elderly; no personal protection devices to doctors working in the territory (general practitioners, pediatricians, emergency doctors), which has brought the contagion and death of many of them as well as made them the involuntary vehicle of diffusion; the lack of public health actions (isolation of contacts, testing in the territory to positive patients and their contacts); failure to govern the territory has determined a saturation of hospital beds, thus keeping people that would have been otherwise hospitalized at home. “The disaster that was created in our region (ed. Lombardy) is in large part to be attributed to the interpretation of the situation as an intensive care emergency, when in fact it is a public health emergency. Public health and territorial assistance have for a long time been neglected and depleted in our region”. (see Redazione FNOMCeO, 2020).

Another issue is that of elderly people who, due to the lockdown, have been abandoned by their usual in-home caregivers and family. Despite the greater reach of telemedicine, their GPs are unable to keep up with their health and social needs, which are unloaded on the emergency service.

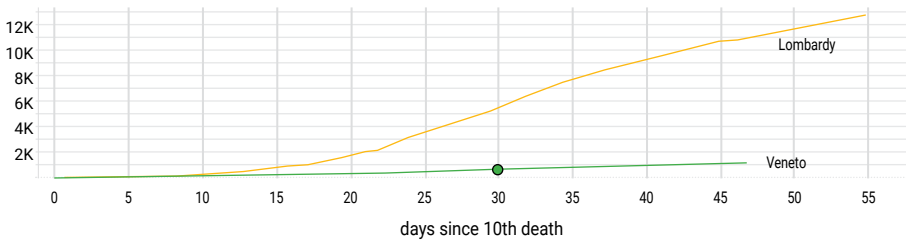
Veneto implemented a different strategy: health professionals and academicians were extensively involved in political decisions against COVID-19.

Three key characteristics make Veneto's response distinctive (Zanini, 2020; Zingales, 2020):

- Focus on home diagnosis and care, handled by a dedicated group of over 720 disease prevention specialists, divided into fifteen teams across the region (who also perform regular check-ins with patients). This has reduced the burden on hospitals and minimized the risk of COVID-19 spread in medical facilities.
- Extensive testing and active surveillance (tracing and isolation at home and in medical facilities). Such efforts relied on collaboration among hospitals, labs, and medical professionals deployed across the territory. The human and relational capital compensated the fact that testing and tracing were not as high tech as in Singapore and South Korea.
- A hub and spoke network of dedicated hospitals for COVID-19 patients was established, which streamlined the process for intake and treatment, and reduced the risk of COVID-19 infections among medical staff and patients.

Veneto (which experienced its first death the same day as Lombardy) seems to have a growth of infected people much slower than the other main Northern regions (Figure 1). Its approach has the merit of blocking contagion in the territory and not in hospitals (Sadun et al., 2020).

Figure 1 - Total COVID-19 fatalities, days after 10° death: Lombardy and Veneto regions



Source: Zanini (2020).

Italian differentiated regional experiences as well as those of other countries have shown that a more balanced and systemic approach covering the territory and home assistance is more effective than an approach exclusively focused on hospitals. We can also make a step further and aim for communities to be more actively engaged, aware that currently territorial medicine is unable to address the capillarity and entity of COVID-19 and that its risks will continue for at least a year, until a mass vaccination is carried out. Moreover, lockdown measures will inevitably loosen over time and control of contagiousness will rely on the social responsible behavior and self-control of citizens. Finally, Italy has one of the oldest populations in the World and has in time developed a high number of public and non-profit actors focusing on homecare.

Therefore, we propose an approach focused on the territory and based on a strong collaboration between professionals of territorial medicine from different disciplines and local communities. This approach is also mentioned in a letter to national health authorities signed by 100.000 Italian doctors (Redazione FNOMCeO, 2020). The main weakness of the national healthcare system in the fight of COVID-19 is the territory, they say. Also doctors operating in Bergamo, one of the hot zones in Lombardy, have called for a different approach: “In a pandemic, patient-centred care is inadequate and must be replaced by community-centred care. Early oxygen therapy, pulse oximeters, and nutrition can be delivered to the homes of mildly ill and convalescent patients, setting up a broad surveillance system with adequate isolation and leveraging innovative telemedicine instruments” (Nacoti et al., 2020, p. 1; Heymann & Shindo 2020; Grasselli et al., 2020).

Alongside a loss of citizens’ confidence in their political leadership, images of solidarity have emerged. Neighbors have organized to support vulnerable people; businesses and national governments have stepped up to provide support for those who need it and strengthen social security and health services (The Lancet Editorial, 2020).

While it is clear that citizens are highly motivated to help each other in addressing their social and health needs, community contribution is also feasible and collaboration with doctors and nurses would be the best way to make the most of it (Cepiku & Giordano, 2014). Community engagement has also the benefits of strengthening social control and promoting compliance in citizens’ behaviors.

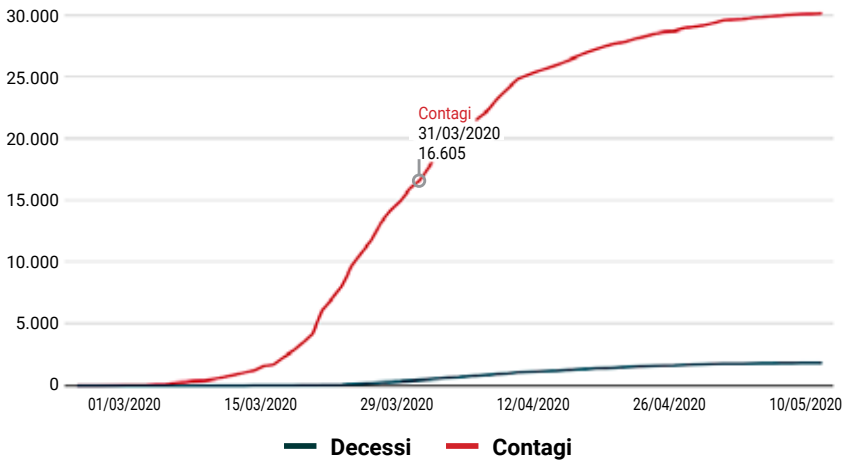
Strategies Against the COVID-19 in Italian Switzerland

The Canton of Ticino, canton bordering with the Region of Lombardy (Italy), represents an interesting case study to compare two experiences happened in two different countries, but distant only 70 km from each other and with many social, linguistic, and traditional aspects of homogeneity, not to mention a strong hybridization represented by about 60.000 cross-border workers who come every day from Lombardy (and partly also Piedmont) to Switzerland.

On 12 May 2020, the Canton of Ticino reported zero new infections and zero deaths despite a strong impact of the virus started with a sudden acceleration after February 25, Martedì Grasso (Shrove Tuesday) and the closing day of the Carnival. In the last 40 days there were 3.268 cases (out of a population of about 330.000 inhabitants) and 340 deaths.

Ticino, together with the Canton of Geneva, has become an area requiring particular attention in the Swiss Confederation regarding strategies to respond to the pandemic (Figure 2).

Figure 2 - Evolution of COVID-19 in Switzerland



Source: Probest (2020).

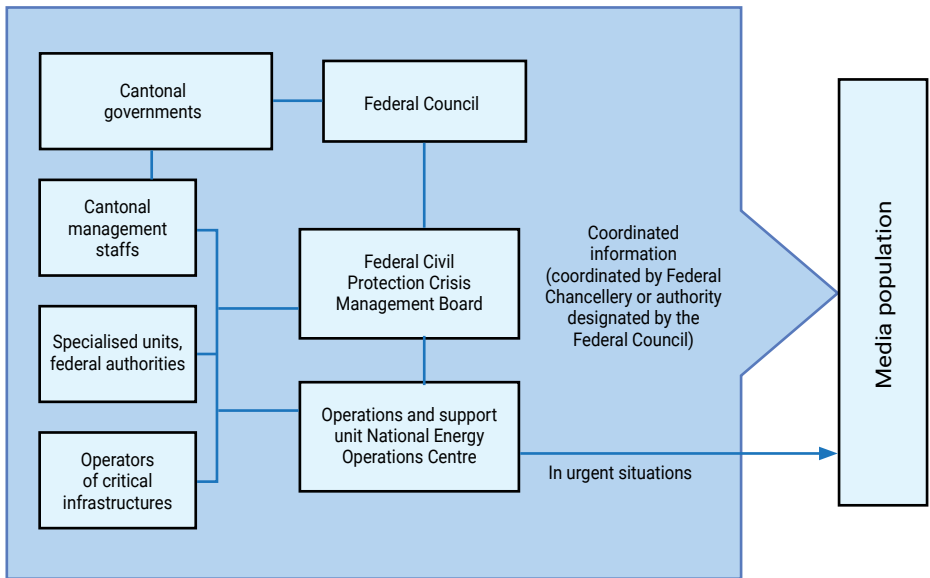
There are four possible elements explaining the different response capacity and the results recorded in the fight against COVID-19: a sound model of governance and inter-institutional cooperation, the development of public-private partnerships in the hospital system and, mainly, between the two COVID-19 hospitals (Hospital 'La Carità' in Locarno and Moncucco Clinic in Lugano).

In addition, two further elements consist of a system of emergency health services, acute care, long-term care, palliative care, and rehabilitation based on a multi-site model (Meneguzzo Pellanda, 2018) and on a networked system (Rossi et al., 2019). Last but not least, the citizens' and patients' level of trust towards the hospitals and health system played an important role.

The center of governance and strategic coordination of the response to the pandemic was the 'Stato Maggiore di Condotta', activated by the Government of the Canton Ticino, coherently with the model adopted by the Federal Office for Population Protection. The Federal Civil Protection Crisis Management Board (FCPCM) is responsible for ensuring both the flow of information and the coordination with other federal and cantonal staffs and offices, and for coordinating expert knowledge and the deployment of national and international resources.

As the figure shows, the Population Protection is an integrated system of management, protection and intervention that involves five main partner organizations (police, firefighters, public health, technical companies and civil protection).

Figure 3 - Task force organization in the event of national emergencies related to civil protection



Source: Federal Office for Civil Protection [FOCP] (2020).

Public-private collaboration has proven to be fundamental in two main areas: integrated offer of intensive care beds, and procurement of drugs and medical supplies (Crivelli, 2020), confirming the strong and multi-annual experience of public private partnership characterizing the Swiss health system (Meneguzzo & Rossi, 2020).

The public health delivery system entrusted to the Cantonal Hospital (EOC), based on a multi-site logic, reacted rapidly by designating a COVID-19 hospital (Hospital 'La Carità' in Locarno) in which professional resources were concentrated (medical and nursing resources throughout the EOC). The personnel involved in the fight against COVID-19 increased from about 900 FTE to 1400 FTE. The internal logistics and space distribution were reorganized (Merlini, 2020).

Most importantly, the initially six intensive care beds were increased to 45 beds, to which were added 25 beds dedicated to support patients after being disconnected from respirators ("weaning" beds).

The response capacity was enhanced thanks to the 32 intensive care beds activated within the Moncucco Clinic (a non-profit hospital that collaborated closely through a permanent discussion 24 hours 7 days) and the coordinated management of internal task forces (crisis cells).

Collaboration with the local pharmaceutical industry, with the regulatory authority (SWISSMEDIC authorized the EOC to run drug trials) and with equipment manufacturers were important. Thanks to the Army, 30 latest generation respirators were acquired to increase places in intensive care.

Concluding Remarks

For a collaborative approach between hospitals, territorial medicine and communities to be effective in the prevention and fight of COVID-19, both sides – territorial medicine and communities – need to be well developed and equipped with the necessary resources, they need to trust each other and the government and collaboration needs to be managed. The two case studies – Italy, with its two regions Veneto and Lombardy, and Ticino in Switzerland – show how the lack or the presence of an integrated approach can make a change.

It is worthy of note that Switzerland has the highest level of trust toward public services according to the ‘Government at a glance report’ by the OECD.

Also, it is not a case that Italian regions that had a stronger territorial medicine before the crisis were more effective in containing its spread. It seems that managerial reforms of healthcare systems have weakened prevention and public health at the scape of hospital care.

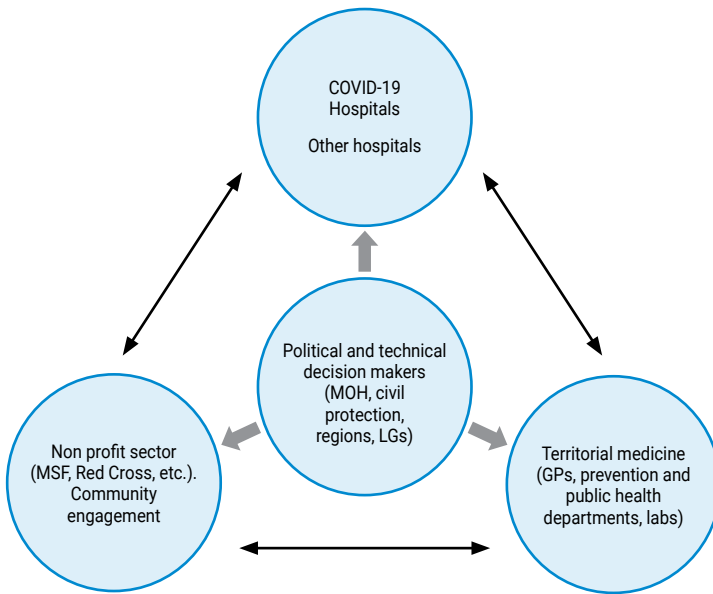
We propose an integrated approach to wicked problems, including the fight of COVID-19, that is illustrated in Figure 4.

Key aspects include (Lehmann & Sanders, 2007; Liu et al., 2011; Cepiku & Giordano, 2014):

- The selection of lay actors that serve as a bridge between health professionals and the community and need to be responsive to both groups.
- Good program management: unrealistic expectations, poor planning, and an underestimation of the effort and input required to make integration work are the main reasons of failure.
- Supervision by professionals and logistic/infrastructure support: early mistakes such as shortage of PPE for health workers should not be repeated (Remuzzi & Remuzzi, 2020). They are vital to provide logistical support to lay actors and to ensure that they can effectively refer patients to other parts of the health system.
- Political stewardship and adequate resourcing mean that lay actors are recognized by legislation and policies.

Other key levers include effectiveness of communication to generate common consensus about what the two parties can do with and for each other, management of lay actors and health professionals such as training, motivation-building (also aimed at enhancing self-efficacy), socialization and group identity building.

Figure 4 - An integrated approach to the fight of COVID-19



Expected advantages coming from a widespread and prompt response, making use of community informational and relational capital and other resources include clinical, social and economic benefits.

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Understanding the Context, Organizational Form, and Partnership Capabilities of the UK Public Governance Response to the COVID-19 Virus

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Introduction

Governments are expected to play a central role in how nations respond to pandemics. Their decisions and actions should effectively mobilise the state and public services to protect the public. They should also be leading a whole-of-society effort to defeat the pandemic. This contribution is a case study to understand the patterns of action and the efficacy of action by the UK¹ Government that together constituted the nature of its response to Coronavirus. It looks at three critically important factors in the UK's public governance response to COVID-19. These are the political and ideological context, the degree of centralisation of the machinery of government in England, and the capabilities for partnership working with the private sector.

There is little or no dispute over the basic facts regarding events in the UK from the beginning of the year until the end of May. Officially the UK had its first COVID-19 case on 31 January 2020 and its first death was reported to

¹ This paper concerns itself with England. The UK now has a strong domestic policy and practice devolution to Scotland, Wales and Northern Ireland. The legal nature of these devolutions is different in every case. However in all cases public health is a devolved matter, the culture of the three nations that have been devolved too are different. Up until May 10 the actions of the 4 nations were similar but after then they differed. The politics of all four nations are very different from each other. Whilst much is similar I would not like to talk with as much authority about Scotland Wales and Northern Ireland and, even though the UK government has a set of overall responsibilities for all 4 nations, I will therefore restrict this to England.

the World Health Organization on 5 March. There was a minimal response by the UK Government in February and much of March: very little testing and contact tracing was carried out (National Audit Office [NAO], 2020), the borders were kept completely open, and there was no screening of incoming international travellers at ports of entry. In the context of fears that the growth of cases might overwhelm the capacity of the National Health Service to treat the victims of COVID-19, the UK Prime Minister, Boris Johnson, announced a lock down on 23 March 2020 and instructed people to stay at home (Sinclair & Read, 2020). During the lockdown the UK Government began to increase the numbers of tests for COVID-19. Less than two weeks into the lockdown the Secretary of State for Health announced five “pillars” for building testing capacity. During April the Government struggled to supply sufficient personal protection equipment to staff in the National Health Service and care homes. On 10 May Boris Johnson announced the beginning of the end of lockdown. By that date, according to figures reported to the World Health Organization, the UK’s total number of confirmed cases was over 200,000 and the UK’s total deaths was 31,587. (The UK’s Office of National Statistics using different data and including deaths in hospitals, care homes and elsewhere reported much higher mortality figures.)

Given that the basic facts are clear, this contribution explores how events were shaped by critically important factors, and how these factors affected decisions, their implementation, and their consequences for protecting the public in the UK. The analysis is used to generate a set of lessons based on generalising about what happened in this case.

Politics, Ideology, and the Practice of Running an Enlarged State

The British Government that was elected in December 2019 was like no other in recent history. After over 30 years of the Conservative Party being torn apart by a war over whether the UK should leave the European Union, the Conservative Government formed after the 2019 election was no longer at war with itself. The party was now owned by passionate Brexiteers.

In fact, the Prime Minister, Boris Johnson, purged the upper echelons of the party of those people who did not passionately support Brexit. The purges ensured that the Government had total agreement on Brexit, but it also had an important side effect on the capability of Government Ministers. Those that had been purged by the Brexiteers included senior individuals in the Conservative Party who had previous experience of how Government decisions were made and implemented. Ministers in the new government were appointed because

they were passionate about building an economy and a society outside the European Union. This was what the Government was elected to do. It was not elected to competently run the state as normal. It seemed not to matter that the ministers had little experience of running departments.

When the first UK case of COVID-19 was reported by the chief medical officer on 31 January, this did not receive a lot of attention. The main event that day was a speech by the Prime Minister in which he talked about the withdrawal from the European Union (Calvert et al., 2020). On 31 January, it was the politics of the Government leaving the European Union that mattered. Then, in February, the main Government activity was announcing the stance for the next set of negotiations with the European Union about the UK's withdrawal. February also saw the announcement of new immigration rules for January 2021 which would severely limit the number of nurses and care workers that could enter the country to work in health and social care. Just to underline a point made above: the government was doing what it was elected to do: "Get Brexit done".

Lesson 1. This is, then, the first explanation of why the Government found the COVID-19 Virus difficult to govern. The Government was not elected nor were ministers selected to run the state but to transform it away from 40 years of working within the EU. Whatever one thought about Brexit, this was to be a very big task. Given it had won a majority of the Parliamentary seats, it was legitimate for the Government to dedicate the next 5 years of work to this task. Organising the delivery of millions of bits of Personal Protective Equipment (PPE) to hundreds of thousands of staff was not in any Ministers desired competencies or their job description.

It was not just that the Government was concentrating very hard in another direction when COVID-19 hit. There were other impacts of Brexit politics that were important for the Government reaction to COVID-19. All nations think they are different but "British Exceptionalism" was at the core of the Brexit policy. The Government genuinely believed Britain was very different, and better, and that it was developing a radical future for Britain. This was based upon the idea of "Britannia Unchained". There have been constant references to the indomitable spirit of the British People. World War 2 was a powerful metaphor in which the myth was 'Britain stood alone.'

This image of the nation was wrapped up in a strong belief in British freedom. It was believed that the full use of that freedom would transform UK society, the UK economy, and the UK's place in the world. Leaving the European Union was leaving an organisation that had detracted from British Exceptionalism and limited the nation and its population's freedom. This belief in freedom was not a by-product of the ideology of the Government but was at its core.

For the last week before the start of lockdown there was the peculiar situation of the Government advising people not to go down the pub or get their hair cut, but not using the law to stop the public from doing those things. To most policy makers this hesitation by the state to use law to limit behaviour that it wanted to stop might look odd. But within the ideology of the Government that passionately believed in ‘ancient *inalienable right to go down the pub*’ (the words of the Prime Minister, Boris Johnson) asking people not to exercise that right was very different from using the law to stop them. Ideologically and culturally this Government did not want to do use the law to lock the population down. The distinction between people choosing to act and being told to act was not one that public health doctors could understand. However, it was central to the Government’s ideology of freedom

And even after the Government decided to use the law, this debate with the libertarian right continued vociferously. When the state lockdown was eventually announced on 23 March, the banner front page headline on the 24 May in the Daily Telegraph was “*The end of Freedom* “. This strong right-wing libertarian ideology had been a central part of the Johnson Government.

For the next 10 weeks the Daily Telegraph attacked the Government nearly every day, not for mistakes in implementation, but for ‘*ending freedom*’. International readers may feel this is simply a robust media debate, but the Telegraph is always seen as the house journal of the Conservative Party. More importantly it had been a cheer leader for Boris Johnson to become leader of the Party²

One of the main criticisms of the British Government’s response to Coronavirus is that Britain went into lockdown too slowly and some suggested the decision to lockdown should have been taken one or two weeks before (Stewart & Sample, 2020). There was also a concern among members of the public that after May 10 the Government was ending the lockdown too quickly. Commentators thought the Government easing of lockdown was shambolic.

As in the USA. from near the beginning of lockdown there were statistics that demonstrated that a prolonged economic depression would kill more people than the virus. In the USA the President wondered whether the “cure would be worse than the disease’. Whilst these ideas may not have been widely popular, within the current Conservative Party, they had a big impact.

When the Government started to end the lockdown (which was 11 May 2020) there was intense pressure from within the governing party to do so more quickly and on a deeper and broader basis. The fact it did so in a very confused way was caused by the debate between the pragmatic safety that the lockdown had created and the ideology of freedom which disagreed with that lockdown.

² And Boris Johnson wrote a weekly column for the paper for most of the previous decade.

Lesson 2. The current UK government was profoundly ideological both in the manner it won power at an election and in the way it has governed. Its ideology defines for government leaders who they are. It has influenced their response to COVID-19 in terms of action and timing. (And given their election democratically correct for them respond so.) The easing of the lockdown occurred chaotically. Ideologically the Government wanted to get back to freedom quickly but practically it recognised the dangers of doing this. The tension created the hesitant approach to ending the lockdown. These points are worth making because public management theory frequently underestimates the importance of a strong Government ideology in dominating what Governments actually do. In the UK, the impact of ideology on Government action in response to the pandemic has been clear.

If government leaders end up doing something that they don't agree with – such as, imposing a locking down of society and the economy – they are likely to implement this poorly compared to doing something that they do ideologically agree with. Years of saying and believing that a major policy is very morally wrong are a bad preparation for implementing such a policy.

Communicating with the Public

Boris Johnson became Prime Minister in July 2019. From that moment on he ran a powerful and effective political populist campaign against those parts of British society that disagreed with him. The Prime Minister's office attacked not just the political opposition, but sections of the Conservative Party, the institution of Parliament, the civil service, the BBC, and the judicial system. One of the ways this Government defined itself was to see itself and its Brexit passion in powerful opposition to traditional institutions of UK society. In its first four months this is what the Government did. It was not concerned about the day to day business of government. Aggressive communications with the public was its output and it was very good at it using simple slogans in opposition to others.

When the election came in December 2019, the Conservative Party campaigned under the slogan of 'Get Brexit Done' and won a large majority of Parliamentary seats on that slogan. This campaigning continued into the New Year, with the Government designing its messaging to batter and threaten any power base of opposition to its agenda.

Once the lockdown started on March 23, the Governments communication strategy for the next seven weeks was organised around the three-part slogan: "Stay at Home; Protect the NHS; Save Lives". British people wanted a reason to stay at home (because they were afraid). They were given two motivations by the Government slogan. First, to protect the National Health Service, a totemic

organisation very loved by the UK population, and, second, save lives. People could understand that this was an infection crisis and therefore staying at home was doing their bit.

However, there was a problem for the Government since the success of its strategic communications for the last six months had been based on making its case by battering a section of UK society, and then getting that section to publicly defend itself, before it carried out another battering of that section, and so on in a circular pattern. Since one of the Government's main messages about the virus was that the whole society was in this together, its main form of communication – to find an enemy in society and go to war with it - could not work.

Of course, the virus was a clear enemy to the nation and could be attacked, but unlike Parliament, it could not defend itself publicly to keep the cycle of campaigning going. This meant that what was successful strategic communications became to feel empty. Not doing something – staying at home - works for a while but not for ever.

It is also the case that a small but powerful section of British society felt that the lockdown was the end of freedom. Within the Government there was a very heated debate going on about lifting the lockdown. None of this ever reverberated with the public, but, regularly, sections of the Conservative party would argue for the lockdown to end and there were constant reports of some Ministers arguing for it too.

On Wednesday 6 May the UK Government said it would make an announcement four days later on Sunday 10 May. However, on the same day (Wednesday 6 May), the Prime Minister's Office leaked that it would create a wide range of freedoms in their Sunday announcement, which meant that most newspapers splashed their Thursday front pages with the story that Monday would be freedom day. On Friday 8 May, the Government spent all day saying that their leak of the previous day wasn't true and diminishing the relaxation story to be announced on Sunday. On Saturday this confusion itself was the story.

Therefore, once the communications had to be more nuanced about coming out from the lockdown, the Governments communications became confused. Given there was no enemy to attack, and it needed a row to make its case, in an odd way the Government had created its own leaks as its own enemy.

Lesson 3. During the prolonged Brexit debate and in the 2019 General Election the Government had excelled at a highly combative communications regime. In particular it created evocative three-word slogans to win over public opinion. Once the Government had decided to tell the public to stay at home (March 23) the slogan of

“Stay at Home; Protect the NHS; Save Lives” was highly effective in helping to shape behaviour. After the Government decided on a more nuanced ending of lockdown this approach was less efficacious and failed to communicate as well.

Following the Science

Passionate Brexiteers had won the 2016 Leave referendum in part by denying the arguments posed by most economists against leaving the EU. Famously, during that campaign, Michael Gove, Secretary of State for the Cabinet Office in Boris Johnson’s Government, argued against expertise by arguing that the British people have had enough of experts. Given the political link between expertise and the ‘liberal establishment’ the politics of this slogan is very much part of the right-wing libertarian play book.

However, in the context of the COVID-19 crisis, the Government wanted to speak ‘for the whole country’ rather than an insurgent sectional interest. It had, therefore, to step away from partisan politics. Its solution was to justify decisions by claiming government leaders were ‘*following the science.*’ It reinforced this justification by frequently holding Downing Street press conferences led by Cabinet Ministers flanked by two scientists, with the scientists present to provide cover and backing for what the Government said. (Strictly speaking, these press conferences focused on COVID-19 measures being taken in England but this was not always clear – and sometimes led to complaints from the devolved administration in Scotland that it should be made clearer that measures were for England alone and did not apply in Scotland).

Many of the decisions the Government took were ‘life and death’ decisions. They wanted to spread the load of making those decisions away from the simple politics of Government. Including ‘the science’ as an explanation for an action became THE major way in which Government Ministers explained what they were doing. They did not want to say: ‘*We think this is the right thing to do.*’ Instead they denied the agency of politics and Government and said that all activity was instructed by “the” science.

But real scientists publicly disagreed with each other about what “the” science said. The scientists said this virus was very new and there was not a simple agreement about what it was, how it would work, and what should be done about it. This ‘natural’ disagreement between scientists when exploring something very new was combined with a very public social media that was used by scientists as a platform for passionately and publicly disagreeing. As the COVID-19 crisis progressed the singularity of one agreed science that the Government claimed to be following became more and more difficult for the Government to use. Its own agency for decisions that it was taking became more apparent.

The Government's belief in British exceptionalism continually stressed the role of British "Science". Against this, since Galileo in the 17th century, real science has been very international. When most of the British scientists were interviewed, they stressed the importance of international science.

Lessons 4. A Government might try to argue that the decisions it is making are not its 'fault' but spring from the nature of science itself. Over time it is demonstrated that science cannot be interpreted as a set of agreed instructions, but its essence is a set of sharp disagreements about new phenomenon. These public disagreements undermine the efficacy of the Government depending upon a single agreed science.

Centralised Governance

The long-term nature of the state in England³ had an impact on the way in which the crisis was dealt with. It is also the case that a decade of cuts in public expenditure had a profound impact upon the capacity and form of the state.

Compared to most other states and national organisations of public services, the state organisation inherited by the new Johnson Government in late 2019 had become very centralised politically in Westminster and organisationally across the road in Whitehall (which is the home of the civil service). This was definitely true in the case of England. The situation of the other three parts of the UK is more complex by virtue of the devolved administrations of Northern Ireland, Scotland and Wales, set up over twenty years ago. Within England, however, there has never been a strong regional tier of government to act as a counterbalance to Whitehall.

And over the last 50 years English local government had powers and resources taken away from them. By 2020 English local government provided fewer services than at any time for 120 years. Local government at best commissioned services (such as social care) and at worst they provided a framework for services delivered mainly by others (e.g. primary and secondary education). During a decade of cuts, central Government grants to local government fell by nearly 60%. Local government in England met the COVID-19 crisis stripped of both powers and money. As a form of state power, it had been hollowed out.

The state form that the Government had in its hands to confront the virus was primarily the central state. This partly explains why the vast majority of the activity that the Government mobilised was through the central state.

³ One reaction to this UK centralisation of power has been the devolution of some power to Wales, Scotland and Northern Ireland against the idea that the Whitehall as the centre of England is the same as the UK. It isn't. Once more this section is about England.

In March, April and May there was constant discussion in the media about how central government policy announced in by the Government had not often succeeded in reaching all of the different parts of our society. British society went through an intense tutorial about how the management of public service delivery works (and doesn't work).

As will be analysed below, the centralisation of power seemed to be successful in the action to increase the number of intensive care unit beds. In contrast, the supply of personal protection equipment (PPE) and the testing of people with viruses were both organised centrally but were troubled by enormous problems of distribution. Once you develop capacity only from the centre, you automatically create the problem of how to distribute, say, masks to the millions of staff and patients that need them. The centralised nature of the machinery of government was an important issue in delivery of certain policies. Having capacity in Whitehall, or in a depot in the middle of the country, doesn't help when they need them in that street and in that street.

There was also an issue in relation to the deployment of volunteers. In England the National Health Service hospitals have volunteers. They are organised locally. The friends of hospitals are there to greet patients at the door. And the charity of a hospital will be present asking for donations for a new piece of kit. In the National Health Service, voluntary endeavour is offered and accepted locally.

Very soon on in the COVID-19 crisis the National Health Service asked for volunteers. Within a few days 750,000 people asked to become volunteers. This demonstrated the public wish to give to the National Health Service and its patients. However, six weeks later most of the volunteers had not heard anything from Government. The need for volunteers is local and specific. If that request for volunteers had taken place locally, the matching with local people in need would have been much better organised.

The same is true for health care services in residential care homes. As National Health Service hospitals organised the National Health Service response to COVID-19, for several weeks the local reality of vulnerable people in care homes was left out of much of the service. Over the weeks of the lockdown this local problem was broadcast to the nation as a national problem. As the crisis developed this started to get airtime in regional and local news programmes and then the national news picked up on it. Care homes then became a national problem for the Government. If the local relationships between the National Health Service and care homes had been better, the solution of integrated services between the National Health Service and care homes would have been developed locally.

The UK is physically a small country. But power is very centralised. It has been learnt that much more power needs to be decentralised. That won't be easy for the National Health Service, but future health depends upon it.

From 2013 Public Health in England was organised at a national and at a local level. There is a national body called Public Health England (PHE) and there are Directors of Public Health in the 152 major local authorities across England. However, for most of the COVID-19 crisis public health was organised at a national and not a local level. Care homes, staff and patients are all physically located in localities. This has defeated the Government on most occasions and led to policies not actually being implemented.

It was not until 9 May, six weeks into the lockdown, that central government for the first time recognised that public health was a service delivered through 152 local authorities. It was then that central government recognised that local authorities were better placed to take up the responsibility for testing 400,000 care home residents and 300,000 care home staff. Up until that date the Government had believed that this could be organised from Whitehall.

In summary, the state form – in this case a centralised state form - has been a factor in how UK Government policies on the COVID-19 crisis have or have not been delivered.

Lesson 5. The centralisation of the UK Government hampered the delivery of COVID-19 virus policies. The ministers were working in a very centralised state and it was nearly two months into the crisis before they realised that they needed a much more decentralised state form to deliver the policies. It is puzzling that a Government that was full of Ministers who disagree with the central power of the state, had seen central state power as the way in which they could deal with issues. Why, again and again, did a set of Ministers who do not believe in state power end up trying to pull leavers from Whitehall that were not connected to distribution systems that had any capacity to deliver?

Policy Execution and the Civil Service

Governments depend upon the civil service to help develop and carry out its policy. The civil service tradition is mainly one of an impartial and independent civil service. Only a very few people (less than 200) are political appointments made by a new Government to help them run the civil service.

For the prior ten years, Conservative Governments had diminished the size and the capacity of the civil service. The civil service at the start of 2020 was a smaller civil service than it had been for decades. Between 2010 and 2016 the size of the civil service was reduced by a fifth. By 2020 civil service numbers at the Department of Health and Social Care had been cut by a third.

In addition, between the general election in December 2019 and the lock down in March, the Government was in conflict with some of its senior civil servants. There were discussions about a radical change in the number of political appointments to be made at the expense of the traditional civil service. The highest civil servant in the Home Office resigned amidst claims he was harassed by his political boss, the Home Secretary. He took the Home Secretary to an employment tribunal.

Lesson 6. The Government chose its own central government administration as the main vehicle for implementation of policy. It therefore depended upon a civil service that was diminished in numbers and was also being reformed by the Government. There are many opinions about how the civil service might be reformed or left alone, but no Government would have chosen this moment – of diminished numbers and authority - to have to rely upon the civil service to administer some very important and complex policies

The NHS health treatment of people who were very sick with the COVID-19 virus was a success. In contrast, the ability of the central state to create distributed systems to find out where the virus was (primarily through testing) and then to deal with it outside of the national hospitals was poor. The issue of testing is the best exemplar of a failure by the Government in delivering something that all nations would agree is key to combatting the virus. On March 3, the UK Prime Minister said that ‘we have a fantastic testing system’ (Johnson, 2020). But, the UK didn’t. First, there was a production issue. There was a need to increase the numbers of tests. Second, there was a distribution problem to get the tests (and more crucially the results) to those people that needed them across the country.

Testing to see whether someone had the virus or not is the key to most tactics and all strategies for restricting the power of the pandemic virus.

- At the initial stages of containing the virus the Government needed to know how many people had been infected, and where they are, and who they have been in contact with to work out how to stop the spread. In Britain this period was truncated by the lack of capacity to test. In South Korea it continued throughout the outbreak.
- Since infected people without symptoms (i.e. asymptomatic cases) can infect other people, it is no good self-isolating only those with symptoms. You need to test others at risk as well and arrange for those who are asymptomatic to self-isolate.
- The National Health Service needs to discharge people from hospital as soon as they are well enough. Many discharges were taking place when there were insufficient tests to know whether discharged patients were infected, so patients who were still infected were discharged often into care

homes. These homes are full of very vulnerable people. Releasing infected people into these homes will have cost hundreds of lives.

- In the first 6 weeks of the virus if a health worker had any symptoms of the virus (high temperature or persistent dry cough) they were recommended to stay at home. Given they were not tested many of these people did not have the virus but would not go to work in the health service. The lack of testing diminished the health and care workforce at the time they were needed most.
- It would have been wise to test and quarantine all international travellers into the country as other nations did. The Government decided Britain will start this at the end of May when there will be enough tests. The Secretary of State for Transport when announcing this said that this could only be carried out then 'because we had the capacity' to test.

The fact that the Government failed in delivering testing for several months meant that on many occasions policy was created, not because it was the right thing to do, but simply because their options were reduced by a low level of capacity to carry out testing.

Lesson 7. The low level of testing capacity constrained the Government's policy options. In fact, for the whole period between the beginning of the crisis and 20 May having little capacity to give and to distribute the tests to where they are needed determined a lot of Government policy. For each of the policies it did make, restricted as they were by a lack of testing capacity, the Government had to find another explanation as to why they supported them.

Partnership Policy

Britain is a technologically advanced society with an advanced bio medical and chemical industry. It has had one of the best University research sectors in the world. For the first two months of the crisis the Government failed to mobilise these resources. Instead, it chose to look inwards and expand its own state resources.

It was not until 2 April that the Secretary of State for Health announced a change in approach. He had decided to expand production through a policy of mobilising partners. This involved addressing already existing laboratory capacity in Universities, industrial production and research institutes. Over the next month capacity to test increased from 20,000 to 100,000. If this partnership policy had been carried out from 31 January, when the first COVID-19 case was reported by the chief medical officer, the country would have had the capacity to test 100,000 people two months earlier (i.e. from the beginning of March).

But capacity was only a part of the problem. Distribution of that capacity to where the people who need to be tested actually are was as important. Failure

to successfully tackle this issue meant that over month from mid-April to mid-May several hundreds of thousands of tests were not applied to the individuals that needed them. Testing centres were set up in large car parks in regions around the country and it was expected that people who needed testing would drive there. For many people this would involve a round trip of 100 miles.

If someone was feeling ill – or also if they did not have a car- they did not make this drive and therefore could not get tested. The Government clearly thought that regional testing centres was a distributed system. To organise this, they looked to assistance from the Army who, after all, deal successfully with logistics every day. General Carver, in charge of the Army assistance to this process, described this as ‘the most difficult logistics process the Army had been involved in’. The logistics of Army distribution does not have the experience of delivering ammunition and rations at the convenience of its troops. Command and Control is more important than convenience. Whilst a partnership with the army is a partnership, it does not extend beyond the state. It does not recognise the capabilities and resources for distribution present in the private sector.

The distribution of groceries, thousands of different lines of goods to thousands of different shops – every day – is a normal part of the lives of British citizens. Most people have shops within a short distance- and the clue is in the name- they are called convenience stores. People don’t have to go to regional centres to buy their groceries. That is done for them by the industry.

At work, most supply chains for most production lines, involve the successful distribution of goods from several very different industries and from very many different locations. Until the COVID-19 crisis much of this was international. Car manufacturers don’t have to go to a regional depot to pick up the tyres to put on the car they are making. The tyres come to the factory through a distributed logistics network.

These examples make the point that highly distributed systems are a very normal part of British society. Whilst the supermarkets were busy during the crisis, there were thousands of experienced staff in industry that planned and implemented distributed supply chains as a normal part of their lives.

Lesson 8. The failure to create nationwide partnerships to develop the capacity to create and distribute the tests had a severe impact upon the way in which policies were implemented. Over the previous 10 years Britain has had a polarised political debate and there have been very few examples of politics arguing for a partnership between the public and private sectors. Therefore, the culture and skills of developing partnering that are essential for any joint work were not developed and could not be simply used as a part of the state form available to the Government. Therefore, for the first few weeks of the COVID-19 crisis the Government thought the state could provide, for example, all

the tests through state organisations. Once Government realised partnership with other sectors was essential for increasing capacity for both testing and distribution, then they had the problem that in both the public sector and the private sector needed new skills and a new culture. In the absence of recent partnerships it is difficult to create these skills and this culture with speed in the middle of a crisis.

The National Health Service

In 1948 the National Health Service was set up as if it was a nationalised service. It has always had a powerful centralising authority. The N in the title matters a great deal to the public. But in 1948 only one part of the National Health Service, the hospital service, was nationalised. The part that provides the most health care – primary care- was locally organised around a series of small local businesses called General Practices. From the start, for the NHS to work, practical authority needed to be both national and local. But, for most of the 70 years of the NHS there has been two very different and barely interconnected systems of primary care and hospital care. One local; one national.

In Britain the public love the National Health Service as an institution and not just the staff who work in it. British people love the National Health Service because they can depend upon their right to use it without any recourse to their own finances at the point of use. They feel their parents created it and they sustain it with both money and support. Because the public know that they all pay for the National Health Service out of national taxation the N (National) in the National Health Service has come to define the nation. There have been, and continue to be, real problems with how it delivers health care and how modern it is in that delivery, but the experience of those problems has not lessened public support for it.

The health care part of the pandemic crisis (treating sickness rather than maintaining health⁴) was therefore met in England by a national institution that has massive support. Crucially in February 2020, given the lag between Italy being hit by the virus and the UK, the NHS could see the Italian health service (known as a very good health service) being overrun by an excess of demand. This gave the NHS a few weeks to increase the specific capacity needed to tackle the increase in COVID-19 numbers. Without doubt the National Health Service reacted well to the challenge of treating COVID-19 patients and showed its ability to organise over 200 hospital trusts to develop a powerful emergency

⁴ The National Health Service treats ill health and is supported strongly as a sickness service. That is how it worked with the COVID-19 crisis. Public Health England (PHE) is a separate national organisation and has been the main organisation to mobilise to stop the infection spreading. The National Health Service is very popular. PHE is unknown.

purpose. And thousands of lives have been saved by having an N in the NHS. It was also clear that the National Health Service continued to enjoy public support during the lockdown. On a number of successive Thursday evenings in the lockdown the public came out of their homes and applauded the National Health Service and its staff.

Lesson 9. The National Health Service is the most popular institution in England. It is therefore very important to demonstrate how it is a core part of confronting any crisis. For the Government to suggest to the public that staying at home would protect the National Health Service mobilised the people to stay at home.

Historically because the National Health Service is a very efficient health service, it has many fewer Intensive Care Beds (ICU) per head of the population than other countries. The UK also had fewer ventilators per head of the population than others. Over those early few weeks the centrally organised National Health Service increased the numbers of ICU beds and ventilators. Much of the normal work of National Health Service hospitals was stopped. This was achieved mainly by repurposing existing resources. For example, mental health trusts, that would have beds but not acute care staff, were repurposed and a call was made for recently retired doctors and nurses to come back to work in the National Health Service.

Alongside this repurposing, every part of the country built a new 'hospital' aimed at playing a part in treating COVID-19 patients - either a location where existing hospitals could move patients on to whilst they were sick, or a place where patients could rest after their treatment before going back home (step down beds).

And for parts of the National Health Service, the response to the crisis was a great success. Tens of thousands of staff quickly learnt and applied new skills. ICU resources in the hospital sector were very successfully ramped up. Across England, sub region by sub region, the National Health Service increased ventilators and ICU beds at a faster rate than anyone could imagine.

All of this increase in capacity was successful. Apart from one or two anxious days towards the beginning of the crisis in London, where the virus first hit, the National Health Service always had spare hospital capacity to take in more sick COVID-19 patients. Over the whole period of the crisis the daily news reports of the work of hospitals in the National Health Service were a story of success. Our major institution - a hospital led National Health Service - worked.

Lesson 10. A nationalised system of hospital provision proved to be very capable in ramping up the number of hospital beds and ventilators. In doing this a great deal of innovation in buildings, kit, staff, and systems took place.

Lesson 11. The very important success of this centralised control of a nationalised industry misled the Government and the public sector to believe (wrongly) that this national control would work in all settings. This meant that when a decentralised distribution system was needed, central direction was still attempted - and failed.

Looking to the Next Steps

This paper was delivered on May 20th. This was ten days before that the UK Government started the process of removing the lockdown. For any nation this is a difficult and uncertain process. It was made harder because of the ideological beliefs about freedom that were outlined above.

Because the Government so wanted to go back to a world of free social and economic relationships and didn't like the idea of lockdown, it gave the impression that it was releasing the public much more from lockdown than it was. In his 10 May broadcast the Prime Minister seemed to be signalling that people should go back to work the next day. This led to great uncertainty.

The next day the Prime Minister said that there may never be a vaccine (having earlier in the crisis promised one). Government is therefore preparing for a long and hesitant process of undoing the lockdown. Getting through this long period of time will depend in a large part on the capacity and capabilities of the nation to go 'back to normal' whilst physical distancing. For some parts of our economy and society this will be very hard and sometimes impossible.

Easing the lockdown would be better if there was an increased capacity and capability to find and isolate those who have been infected with the virus and stop them infecting others. In the UK this is called test, track and trace. Between the end of April and 20 May the Government are employing some 18,000 new staff to help in this process. It is developing an app for use on mobile phones. This app is similar to ones that are used elsewhere in the world - but as of May 20 - has not been finalised.

There will be two different ways of getting test track and trace to work. Either continuing with the centralised approach that the Government have tried so far or recognising the decentralised capacity of local government to implement this. This is an important choice. Most public health doctors would argue for the local implementation of this policy. This is because the issues of tracking and tracing take place in real localities - knowing where people actually go in real streets and real localities. Existing local government provides local accountability for this, but the Government would have to let go of its control for this to happen.

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Part V
Conclusions

Managing Global Pandemics: Public Governance Matters

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Introduction

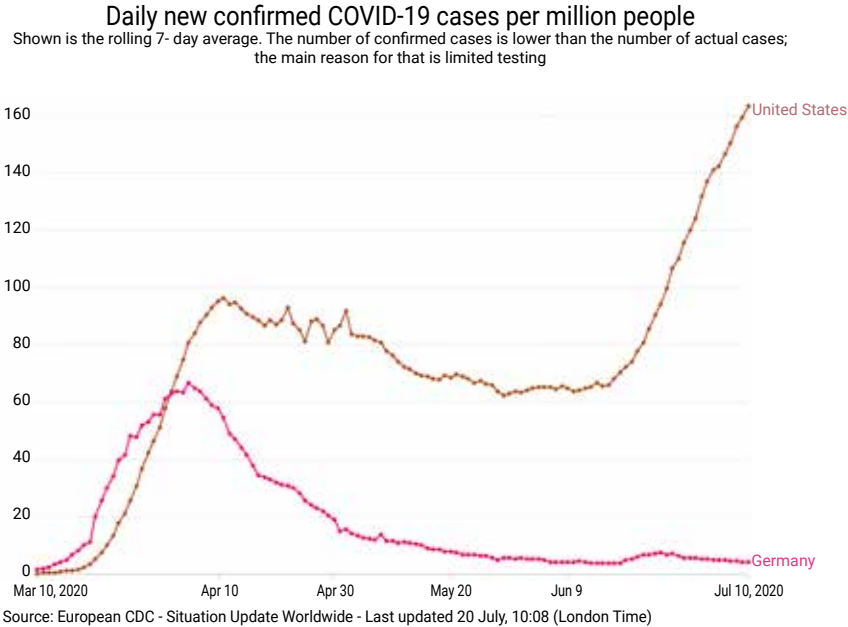
The main tasks of this final chapter are the analysis and assessment of the public governance of country responses to COVID-19 during its early phases from the start of 2020 to May and June. This is a period of five to six months. As this period finished there was much discussion of outbreaks, spikes and second waves, as well as soaring infection and mortality rates in a number of countries as COVID-19 spread. The dynamics and contexts of COVID-19 transmission in the next five to six months may present further and new complexities and difficulties to the governments of the world. This last possibility should be kept in mind when reading this final chapter, based as it was on experiences of governance until June.

The starting point for this chapter is the idea that “good governance” requires learning from mistakes and learning from the successful practices of other governments. In order to be good at learning government need to put into practice the principles of open government – this includes being transparent, being accountable, and being responsive to the public. It also means being good at experimenting, being good at evaluating, and having the ability to adapt to changing feedback and changing contexts. The hope is

that governments will learn from each other and will learn rapidly from the experiences of the first waves of COVID-19 so that they are better prepared for subsequent waves.

Governments around the world made protecting the lives and health of citizens, if not the top priority, then, one of their top priorities. It seems a reasonable first step in understanding the role of public governance in handling the emergency created by COVID-19 to assume that governments that are normally among the most effective ones will have managed the emergency better. It is a short step from this to the assumption that we can “read off” from the trajectory of COVID-19 in a particular country just how effective is the government of that country. So, we might hypothesise the existence of a negative correlation between government effectiveness and the statistics for the number of COVID-19 cases and deaths. This type of working hypothesis can be illustrated using a tweet showing a statistical comparison of COVID-19 cases in the US and Germany between March 10 and July 10 2020 which prompted a British physicist and professor of particle physics at the University of Manchester to comment: “It’s very rare to see the relative competence of political administrations plotted on a graph” (Cox, 2020). See Figure 1.

Figure 1 - Using COVID-19 cases to measure competence of governance

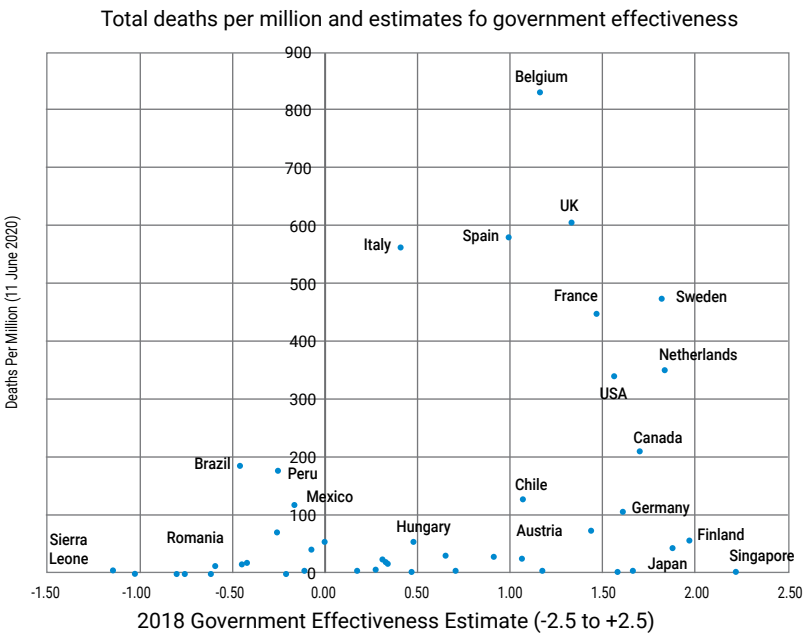


Source: Our World in Data (2020a).

The implication is, of course, that Germany had more effective government that brought COVID-19 under control and kept the rate of cases lower than the government of the United States.

In fact, as the scatterplot in Figure 2 shows, while it does seem plausible that effective governance of a pandemic is made easier when there is effective government, by early June the evidence seemed to point to the opposite conclusion. In other words, there was a slight correlation between countries that had governments rated as more effective and countries with higher COVID-19 mortality rates. The sample used for Figure 2 consists of 45 countries selected to include G20 countries and a variety of other countries from all continents.

Figure 2 - Scatterplot of mortality rates and government effectiveness estimates



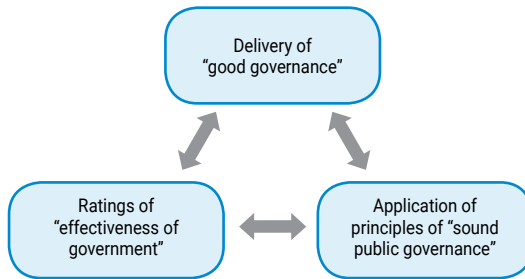
Source: Data on government effectiveness in 2018, World Bank (2020); data for 11 June 2020 on COVID-19 mortality rates, Our World in Data (2020b).

Looking at the scatterplot, it is surprising not only that high values of government effectiveness did not correlate with a low COVID-19 mortality, but also that countries with governments rated as very ineffective were also, very often, countries with low mortality rates. So, why was the relationship between government effectiveness and COVID-19 mortality rates not as expected? It seems necessary to look for a more complex account of how government effectiveness relates to variations in COVID-19 mortality rates.

One of the possible complicating factors is that governments may have needed to mobilize citizens and stakeholders beyond government in order to get a grip on the pandemic in their country. From the start of 2020, the World Health Organization maintained a steady focus on advising and helping governments to suppress the transmission of COVID-19 and to save lives - and it did this month after month. It told governments that they could not defeat the pandemic all by themselves; they needed to facilitate a whole-of-society approach. To bring this about, it seems likely that effective and credible governments would be at an advantage compared to less effective and less credible governments, but, still, it might have been a big challenge even for an effective government to deploy a whole-of-society approach. And, of course, there may have been other factors too.

In both the opening chapter and this chapter one of the standout facts about the first five months of 2020 is that some countries with the worst COVID-19 infection and mortality rates are countries that have for many years been thought to have “effective” governments – as reflected in the estimates for a worldwide governance indicator published by the World Bank. An important implication of this fact is that the relationships between the delivery of “good governance”, the application of principles of “sound” public governance, and the judgment of the “effectiveness of government” need to be examined deeply and critically (see Figure 3).

Figure 3 - Public Governance



In an ideal world, it might be expected that governments should aim to deliver good governance and that they would be helped to do this by applying the principles of sound public governance when taking action. The consequence of aiming for good governance and applying the principle of sound public governance should be subjective estimations that the governments are effective – that is, they would be rated as effective because they are doing the right things and doing them in the right way.

The early months of the COVID-19 pandemic have provided many tests of both good governance and of the ability of governments to apply the principles of sound public governance. Some did not pass the tests. As already stated,

some countries formerly seen as having effective governments, governments that were officially saying that they wanted to protect the health of citizens and save lives, showed they were ineffective in responding to the pandemic.

In this chapter the governance of COVID-19 is taken as the “problem”. It is not assumed that governments can be arranged in some permanent hierarchy of governments ranked by their effectiveness, and that the degree of effectiveness of their response was determined by this hierarchy. It is assumed that all governments are fallible and make mistakes. It is also assumed that one reason that any hierarchy of effectiveness cannot be permanent is that times and circumstances change and the evolution of public governance proceeds as an experimental process. In other words, good governance and the principles of sound governance do not stand still but are changed in response to experiences.

The following matters are reviewed below to explore and elaborate the links between effective government and effective responses to COVID-19: global and sub-national patterns of economic activity and social interaction, the nature of good and sound public governance, the importance of political commitments, and value of governance agility and adaptability for protecting the health of citizens and saving lives. The chapter concludes with a presentation of some of the lessons of the COVID-19 experience suggested by practitioners.

Global and Sub-National Patterns of Economic Activity and Social Interaction

Two things that have been changing in the circumstances of government are, firstly, the amount and speed of international travel, and, secondly, the importance of urban living in cities. At least as far back as 1999, the World Health Organization (WHO) was writing about the effects of the increasing volume and speed of international travel and the effects of population growth and urbanisation. These were seen as two effects that would have implications for control measures in relation to pandemics.

International travellers include tourists, business travellers, and migrants visiting their family in their country of origin. A very crude demonstration of the possible role of international tourism in the transmission of COVID-19 is a simple analysis of the countries in our sample of 45 countries. A comparison of countries with a high COVID-19 mortality rate and a large volume of international travellers arriving in the country in 2018 suggests there is a substantial correlation between the two phenomena. (The data for tourism in 2018 was used as a proxy for tourism numbers in early 2020). Countries with a high mortality rate and high volumes of international tourists visiting the country included: France, Spain, the United States, Italy and the UK. However, both China and Japan also had many tourists (in 2018) but a low mortality

rate on 11 June 2020. It is very clear from the country report for China (see the chapter by Manchuan Wang) that China's response to the outbreak of COVID-19 was very determined and very ambitious – the country's leaders were resolved to suppress the virus and gain control of it. Therefore, it can be conjectured that international tourism makes it more likely that popular tourist destinations will be vulnerable to high mortality rates in aggressive pandemics – but it is not inevitable. It depends on how the country's leaders and government respond. This could be one explanation for why the United Kingdom and Germany had similar volumes of international tourists, but the mortality rate was so different. No assumption is made here that flows of international tourists will determine the final cumulative total of deaths, but it might be expected that the tourist flows will affect which countries are likely to form the earlier and later epicentres of an aggressive pandemic. Thus, Brazil, Peru, and Chile, which had relatively small volumes of international tourists, were all countries in the Latin America region that began to develop into a new epicentre after the European countries managed to stem the rapid rise in mortality. The correlation observed between international tourism numbers and the mortality rate on 11 June for this sample of countries might not persist through later phases of a pandemic.

Table 1 - International tourism and total deaths (11 June 2020)

	Country	Total deaths per million population (11 June 2020)	International tourism, millions of arrivals (2018)
1	Belgium	830.8	9.1
2	United Kingdom	605.8	36.3
3	Spain	580.4	82.8
4	Italy	564.2	61.6
5	Sweden	474.8	7.4
6	France	449.2	89.3
7	Netherlands	352.6	18.8
8	United States	341.2	79.7
9	Canada	210.9	21.1
10	Brazil	186.7	6.6
11	Peru	179.0	4.4
12	Chile	129.5	5.7
13	Mexico	119.1	41.3
14	Germany	104.5	38.9
15	Austria	74.7	30.8

Source: Data on international tourism in 2018, World Bank (2020); data for 11 June 2020 on COVID-19 mortality rates, Our World in Data (2020b).

The WHO also referred to population growth and urbanisation as important conditioning factors. It is, in fact, obvious in the cases of some countries that very big cities (e.g. New York and New Jersey in the US; London in the UK) were the first places in these countries to experience a rapid take-off of the virus. The cities are places where there are concentrations of people living and working in close proximity, and places that have a lot of people commuting to work using mass transit systems. Presumably these characteristics of cities cause a high intensity of interactions between people and reduced physical distancing (e.g. in crowded mass transit systems in the rush hours).

Within countries the specifics of economic activity and social interaction may be hypothesised to explain the specifics of the spread and extent of COVID-19 mortality. In Singapore a lockdown was ordered when the virus spread quickly specifically in foreign workers' dormitories and construction sites. In South Korea a large religious gathering of people spurred a rise of infections. It is suspected in the UK that places where there are more families living in three-generation households are especially more favourable to the spread of COVID-19. In a County in South Texas (US) that includes within the city of Corpus Christi, COVID-19 cases grew rapidly in June 2020. Local officials expressed concerns about summer tourists visiting the beaches in the area and people gathering in restaurants.

In summary, based on the early months of the COVID-19 emergency, it seems the intensity and dynamics of pandemics are conditioned by the activities and human interactions of people and families living, working, socializing, gathering, travelling, holidaying, etc. In this sense, pandemics are deeply intertwined in social relationships and integrated into the activities of local communities and civil society. Public governance, therefore, can be seen as an intervention on behalf of people into a pandemic that is given its specific shape and dynamics by human interactions.

Defining a Concept and Principles of Governance

In a bid to reduce as much confusion as possible about conceptual matters in the analysis and discussion that follows, specific working definitions are offered here:

Governance is defined as being about communities and societies deciding on laws and rules and deciding on the means and ends that will be used collectively to meet the needs of the public and solve the problems of concern to the public.

Good governance is defined as governance that creates good outcomes - such as high levels of subjective wellbeing, economic prosperity for all, and the delivery of the Sustainable Development Goals that form the 2030 Agenda -

and solves the public's problems. This definition has been specially formulated for the purposes of this chapter's analysis but was partially inspired by ideas in a recent report on sound public governance (OECD, 2019).

A possible conceptual framework for the principles of good governance is based on six key concepts drawn selectively from the "Policy Framework on Sound Public Governance," which was approved by two OECD Committees in November 2019 (OECD, 2019). The key concepts are:

1. A long-term strategic vision that is based on political commitments and ambitions, that is published in a government strategic vision document, or strategic plan or government programme, and that can help to steer government, civil society, the private sector and citizens toward a common goal (OECD, 2011).
2. Whole-of-government co-ordination that delivers the strategic vision and which, as a result, produces more focus on a small number of policy priorities and delivers more policy coherence.
3. A forward-looking state that delivers a high rate of public-sector innovation based on experimental approaches to implementation, evaluation and learning processes (including learning from failures), and budgeting systems that support innovation.
4. Centres-of-Government that have sufficient capacity to deliver whole-of-government co-ordination and policy coherence across administrative units (ministries, agencies) within a government and between levels of government.
5. Cooperation with the private sector (e.g. through public-private and public-civil society partnerships) in implementation and service delivery.
6. Public participation in government decision making (above and beyond participation through elections) that delivers an opening-up of government decision making processes (including policy making) and that results in transparent, responsive, and inclusive government.

This conceptual framework could be seen as compatible with both ideas of "whole-of-government" and "whole-of-society" thinking on government.

Governance of COVID-19

a. Political commitments and ambitions

The formation of a credible political commitment to underpin leadership of a government response to a pandemic is unlikely to be just a matter of organisational structures and roles. Arguably, the country leadership of a pandemic cannot be a purely technical or professional affair. It also has

to contain a believable political commitment, that is, political will and determination to respond. New Zealand's Prime Minister has received plaudits from commentators on her provision of leadership in the face of the emergency situation created by COVID-19. Her speed in closing the country's borders is often cited as an example of her leadership. She was quoted as saying "I expect that we will see further border restrictions in New Zealand because that is what we've been doing to date. We keep moving to try and make sure that we're keeping that number one priority - New Zealanders - safe" (RNZ 2020).

Similarly, China's leadership seems to have displayed political commitment to the national priorities. Manchuan Wang highlighted the leadership of the Chinese President in his account of the Chinese Government's response to COVID-19:

...President XI Jinping gave important instructions to various levels of government. He made it clear that life safety and health of the people should be put as top priority. He urged that full efforts be made to curb the spread of the pandemic, cure infected patients, identify routes of infection and transmission, monitor infected cases, release information on the pandemic to the public, and strengthen international cooperation.

The political commitment may have to be maintained despite the existence of political criticism and rivalry. The report on the response of the South Korean Government to the COVID-19 threat by Tobin Im mentions how an opposition party criticised the President's optimistic assessment of the situation that it would soon end. It appears from this account that the Government's credibility survived this criticism because the government was judged to have done well – as could be seen when people compared the scale of the impact of COVID-19 in South Korea compared to that in the USA and in European countries.

Political commitment does not have to be totally ideological in nature. In some of the country accounts in this report there is approval for a pragmatic style of national leadership. The importance of pragmatism was made by Tom Christensen and Per Laegreid when discussing Norway's success in suppressing COVID-19. In the case of Australia, John Halligan contrasts pragmatic decision making with ideological decisions when he discusses an issue in public governance:

There was...the need for government to move beyond long-standing ideological and partisan divisions that had rended politics and governance and to demonstrate adaptability to fit the circumstances. The prime minister and other ministers adopted a pragmatic approach to devising health and economic solutions and the use of the federal public service.

One of the biggest lessons of the COVID-19 pandemic so far is that good governance depends on doing the right things as well as having a highly

professional civil service. In other words, the political commitments had to be correctly focused.

The Chinese response strategy to the epidemic was, essentially, simple to summarise: the country's leadership and its Government set out first to contain and then secondly to suppress COVID-19. As Manchuan Wang reported in his contribution to this report, China's country leadership emphasised prevention right from the beginning: "The Chinese government developed a clear national strategy of prevention and control from the very beginning of its response".

The Chinese political commitment to getting control of the virus and saving lives and determined response to cases of COVID-19 in January proved an important influence on the WHO assessment of what worked best at national level. In early March, still before the spread of COVID-19 had been classified as a pandemic, Dr Michael Ryan of the WHO was, like the Director-General, conveying a message that there was hope and encouraging governments and people to be proactive:

We've seen the comprehensive [public health] measures that China has taken, and ... we believe that that has had an impact on changing the natural trajectory of the outbreak in China.

...We believe that this is possible in other countries. With following these fundamental measures of looking for cases, looking for contacts, social distancing, hand-washing, respiratory etiquette, readying your systems, having an aggressive approach to this, we believe that a reduction in cases in other countries, including Korea, including Italy, including Iran, everywhere, that this is possible. (WHO, 2020).

The WHO warned against immediately resorting to the blunt instrument of a "lock-down" when the number of cases in a country was still low. Singapore's early responses to COVID-19 seemed to be broadly consistent with the WHO view of the importance of Government being proactive and making aggressive containment efforts.

The UK provides an example of a government that entered the COVID-19 emergency not politically committed to aggressive containment. To fully understand this involves appreciating the history of UK government thinking since early 2010 when its political commitment became very focused on austerity to reduce public spending.

The UK in early 2020 was not prepared or equipped for a containment strategy as recommended by the WHO. It did not have the testing capacity or the infrastructure for contact-tracing to deliver an adequate programme of testing, contact-tracing and isolation to contain the outbreak. The Chief Medical Officer (advisor to the Prime Minister) confirmed the first COVID-19

case in England on 31 January. Even in early March the UK was testing less than 2,000 people per day. Testing was subsequently ramped up – beginning in the last week in April. But when it mattered, in February and March, the lack of testing capacity and infrastructure for contact-tracing and isolation meant that it had little choice but to consider a mitigation strategy to protect the NHS in March and April. Presumably the desire to protect the NHS was borne of the horrific scenes of the hospital system in northern Italy being overwhelmed.

b. Delivering a response to COVID-19

A key factor in determining the potential for agility and ability to adapt quickly in a pandemic emergency surely must be the preparations that a government makes for a pandemic in the years before it strikes. It is evident that Singapore had prepared. As Celia Lee mentioned in her contribution to this report, Singapore's approach included pandemic preparedness and rapid large-scale social orchestration using ICT. The alertness present in Singapore's response is evidenced by a number of facts, including the speed with which Singapore put in place screening of people travelling from Wuhan, the implementation of pandemic response plans (which had been refined through regular simulation exercises in public hospitals), and the launching of a mobile phone app to support contact tracing.

According to Celia Lee: "Singapore did things right at the onset of the pandemic without closing schools and shutting down businesses, through rigorous screening, contact tracing, isolation orders, social distancing, safe measurements". Its government at first implemented measures to control the entry of international travellers and to carry out exhaustive contact-tracing to bring the epidemic under control. For example, in early January it screened travellers from Wuhan; later, it introduced bans of travellers from affected countries (Iran, South Korea and Italy) and isolation measures for travellers who had been in a range of countries. Then, on 23 March 2020, Singapore closed its borders to travellers from all at-risk countries. Other measures were added. Large-scale events were deferred or cancelled. Another example of a measure was restricting gatherings of people to 10 persons. It was only in early April that Singapore began a partial lock-down. In other words, the lock-down was only deployed after international travel controls, strenuous contact-tracing, and other measures such as banning public events had been used and it was used only because it proved necessary to get an outbreak in April back under control.

The Singapore case also highlights the need for any pandemic response strategy to be tailored to the specific circumstances and to the specific events of an individual country. This need involves adjusting measures when matters take a surprising turn. Having quickly brought COVID-19

under control, the outbreak of COVID-19 that Singapore faced in early April was among foreign workers' dormitories and construction sites. Celia Lee argued that COVID-19 had exposed a specific inequality problem in Singapore society - the position of the low-wage migrant workers living in overcrowded conditions. The implication of this experience is that the Government pandemic response strategy had to be adjusted to compensate for the limited impact of social distancing measures in this social group where overcrowding was an issue.

Not every country followed WHO advice. The UK is a clear example of a country that was slow to respond to the threat of COVID-19 and then responded with a mitigation strategy and lacked the capacity to do the testing, contact tracing and isolating on a large scale throughout the months January to the end of May (Public Accounts Committee, 2020). Sridhar (2020), writing a week before the UK went suddenly into a lockdown towards the end of March, reflected on both the effectiveness of the Government of China's response and the exceptional nature of the UK response to COVID-19 and implied the Government had selected a high-risk option in terms of the possible consequences:

The [effective] Chinese response also had the consequence of buying other countries time. The UK has now had eight weeks to track the outbreak, and to learn about the virus. What we can now say for certain is that the UK has decided to chart its own course. Unfortunately, no certainty can attach to the wisdom of this – indeed, one needs to ask whether the UK approach is akin to gambling with the health of the population.

The Singapore example suggests that preparation for a pandemic involves investing in future agility and adaptability. This investment may feel like a cost since it may involve spending public money on, say, personal protective equipment stocks that go out of date and costly exercises and training of people that may need to be redone and redone. The investment buys governments the scope for more choices about how they respond further down the line when a pandemic happens. Failure to spend money in earlier years may seem like greater efficiency but it could mean severely constrained options in the onset of an emergency situation.

The UK in early June 2020 had the second worst COVID-19 mortality rate in the world. A recently published report by the National Audit Office of the UK identified at least two major issues in the delivery of the UK government pandemic response. Both can be linked to the preparations made by the UK Government in the preceding 10 years.

The first was an issue of inadequate Personal Protective Equipment in the government's central stockpile when the COVID-19 epidemic arrived in the UK:

It lacked items such as gowns and visors, which an independent committee advising the Department on stockpile contents had recommended in 2019. ... The lowest level of distribution to health settings was for gowns (where central stocks distributed were 20% of the modelled requirement), eye protectors (33%) and aprons (50%). Central stocks distributed to social care accounted for 15% or less of the modelled requirement for any item of PPE, apart from face masks. ... A range of bodies across health and social care have expressed concerns about PPE supply ... (National Audit Office, 2020, p. 12)

The second issue probably occurred because the mitigation strategy of the UK Government was so strongly focused on protecting the hospital system from being overwhelmed by the numbers of seriously ill people needing treatment in intensive care units and needing hospital beds with ventilators. The government's hospital system, a big part of the National Health Service, took a variety of measures through internal reorganisation to increase its capacity for responding to COVID-19. There was also a decision by NHS leaders to advise hospitals to increase available capacity by discharging people from hospital into care homes:

Between 9 March and 17 May, around 5,900 (38%) care homes across England reported an outbreak. This peaked at just over 1,000 homes in the first week of April. ...

Between 17 March and 15 April, around 25,000 people were discharged from hospitals into care homes. ... Due to government policy at the time, not all patients were tested for COVID-19 before discharge, with priority given to patients with respiratory illness or flu-like symptoms. (National Audit Office, 2020, p. 11)

The implication of this National Audit Office observation is that many people might have been discharged to care homes who were ill with COVID-19 and this may have triggered deadly outbreaks in the care homes leading to a massive loss of life.

The UK case suggests that agility and adaptability depend, in part, on advance preparation and investment. This conclusion can be balanced against the Norwegian experience described in this special report by Tom Christensen and Per Laegreid. They argue that there was a lack of preparedness. They refer to issues such as inadequate stocks of emergency medicine and infection control equipment, reliance on 'just in time' and lean management, and an emphasis on efficiency and not emergency preparedness.

But despite a lack of preparedness, the Government of Norway went for a suppression strategy and managed to raise the citizen's satisfaction with democracy in this difficult time of COVID-19. How did they do this? Tom Christensen and Per Laegreid refer to the Government relying on pragmatic decision making and a collaborative approach. They also pointed out, however, that there were a lot of resources available. As is well known, Norway's economy

was good, and budgets and resources were adjusted by the Government to respond to the pandemic.

c. Evaluation and learning

In the case of Norway, the Government responded to the pandemic in a manner that was receptive to learning, that was collaborative and pragmatic. It may also be especially significant in explaining the government's choice of a suppression strategy that the Norwegian Government was receptive to learning from others. They learnt from Asian countries (e.g. South Korea and China), from what had happened in Italy, and from bodies such as WHO and Imperial College London. So, receptivity to learning, combined with strong public finances, pragmatic decision making (rather than ideological decision making?) and a collaborative decision-making style may create the best possibilities for agility and adaptability.

At various times during the UK Government's Downing Street briefings of the public during the lockdown period, it seemed that there might be a reluctance to evaluate and learn lessons from experiences in real time – either the UK's experiences or those of other countries. One recurring theme in the remarks of ministers and advisers was the idea that evaluation should be left to much later when the data would be more reliable. It was often said that making international comparisons of infection rates and deaths was problematic. There may have been some defensiveness about the mortality rate or there may have been some imperviousness to learning because of an attitude of British "exceptionalism". There seemed to be some perception of exceptionalism implicit in a pride in the UK's capabilities for modelling the future course of the pandemic. In one Downing Street briefing, on 8 April 2020, for example, a British television journalist referred to the Chief Medical Officer having said that Germany's lower COVID-19 death toll was down to it testing more people more quickly. The journalist went on to ask if the government should admit that its failure to test more people for COVID-19 and its slowness had caused thousands of UK people to die from the virus. This question came at a time when many in the UK were suggesting the UK government could learn from the successes of the German government about how to respond to the pandemic. The National Medical Director at the National Health Service England answered that linking a lower death rate to more testing in Germany was difficult. He said that there were a range of factors to be taken into account in explaining mortality rates. He went on to suggest that other countries might want to learn from the UK:

I think the Chief Medical Officer was also making clear that it is important that all countries learn from each other. And I've no doubt that other countries will

want to learn from our experience and some of the things that we have done in the United Kingdom. For instance, the work on modelling and predicting what the epidemic might do". (UK Government, 2020)

But, based on public communications by the UK government, there continued to be a public reticence about learning lessons until much later. It was often said in briefings that the UK government had taken the right decisions at the right time, which did not suggest much openness to evaluation and learning.

A UK Parliamentary Committee, the House of Commons Public Accounts Committee, also criticised the UK Government's apparent lack of learning:

We are concerned that lessons have not been learned ahead of a potential second spike of infections. It is not clear that the government is undertaking the necessary preparatory work for a second peak of infections. The Department for Business, Energy and Industrial Strategy still has nothing convincing to say about what lessons it might have learned from the implementation of its business support schemes. These issues are compounded by a lack of transparency by government on critical issues relating to its decision making in responding to the pandemic, such as delays in publishing the 12 ministerial directions received on COVID-19 spending, including the government's business support schemes. (Public Accounts Committee 2020, p. 5)

d. Whole of government co-ordination

Countries have to decide how to create a co-ordinated response to a pandemic. They may make use of an existing body or create a new body to provide national executive leadership of the pandemic. According to Manchuan Wang's report on China, the creation of leadership for the response to the pandemic was done in two steps and leadership was ensured at every level of government. First, on 20 January, the State Council Joint Prevention and Control Mechanism was formed. This comprised the National Health Commission and Ministries and Commissions. Its mission was to coordinate nationally the prevention and control of the pandemic. Second, 5 days later, the decision was taken to form the Central Leading Group for Responses to the COVID-19 Pandemic. It was to provide "unified leadership and command of prevention and control of the pandemic." This group was then replicated at each level of local government.

In Singapore, the Multi-Ministry Task Force on COVID-19 was set up on the 22nd January 2020 and had responsibility for both policies and issues. Its early success in co-ordinating containing and controlling the threat were described in Celia Lee's account of what has happened in Singapore and what the consequences have been.

The creation of alignment up and down all levels of government in a country can come about in different ways. Some of the main possibilities include a very centralised government running and managing every aspect of national response to a pandemic and a centralised government steering local action but with implementation decisions being decided and delivered by local government.

A predictable tension in any system of governance that has a degree of centralisation in decision making is the inevitable feeling at the local level that decisions made at a central level are flawed because they assume “one size fits all”. Despite the Norway Government’s achievements in suppressing COVID-19, there were still central-local tensions. Tom Christensen and Per Laegreid report that the biggest implementation challenges were rooted in the clash between national standardized measures and local government’s awareness of and concern for local variations. The scope for such tensions to become more pronounced are probably much greater when the national government has not had an effective response to COVID-19 and the sub-national level may have heightened concerns about the risks to local populations of national measures designed and implemented without any local flexibility. For example, lock-down measures might be eased nationally even through levels of infection vary throughout a country and a second wave of infection seems possible.

It also possible to have very decentralised systems of governance in which sub-regional levels have a wide scope of competence and relatively little is decided at the national level. Spain has a system of governance that normally works on the basis of sub-national autonomy. This has not proved to be a major difficulty during the response to COVID-19. According to Fátima Mínguez Llorente, the lead was provided nationally in the health sector:

The Ministry of Health has become the leading centre in the fight against the crisis. Throughout these months, coordination between the central government and the Autonomous Communities has been maintained and promoted, although points of improvement in governance have been detected.

But decentralisation can bring advantages as well. In the case of Finland, for example, the municipal level of government really matters, and the municipal authorities have been quite innovative during the COVID-19 emergency in finding new ways of delivering public services in relation to, for example, schooling and care services.

The situation in China’s multi-level governance response to COVID-19 had two particular features worth highlighting here. First, the national level was not simply active in decision making, it was, according to Mancuan Wang, also prominent in concentrating resources where they were most needed:

In Wuhan and some other cities in Hubei Province where infected cases were first identified and reported in China, the pandemic was so serious at the initial stage that medical resources of these cities were in severe shortage. To have all suspected cases checked and all infected cases treated in time, the central government mobilized and organized resources from all over China to race against the clock to assist those cities. More than 30,000 medical workers from 29 provinces, autonomous regions, or municipalities directly under the State Council were sent to assist Wuhan. A “one province for one city” pairing assistance mechanism was adopted to organize medical workers from 16 provinces to assist 16 other cities in Hubei Province.

Secondly, the political system played an important role in co-ordinating the governmental system so as to bring about alignment with national policies. Manchuan Wang indicated this in his contribution to the report on China: “As the ruling party, the CPC has a system of party organizations from the central level down to neighbourhood level. These party organizations have played an active role in supporting the implementation of the central policies.”

UK examples of deficiencies in government co-ordination of the COVID-19 response can be found in the UK Parliament’s Public Accounts Committee’s recent report on the whole-of-government response to COVID-19. Its recent report highlights slow decision making, slowness in developing a testing and contact tracing programme, and poor provision of information to local authorities (Public Accounts Committee 2020 6):

Effective coordination and command structures are critical for good decision making in any ongoing emergency. ... However, decision making on important issues, such as introducing the Test and Trace programme, has been slow. The government’s response in some areas has been poorly coordinated and has not adequately taken into account long-term impacts on people and communities. ... At the time of our hearing in June local authorities were developing their local outbreak plans, but did not have the detailed information they need on individuals identified through the government’s Test and Trace scheme. (Public Accounts Committee, 2020, p. 6)

e. Public-private co-operation

Many different issues and lessons might be discussed in respect of COVID-19 and the use by governments of the resources and capabilities of the private sector. The single point to be made here is that while there is much discussion of a whole-of-society approach, meaning mobilising all stakeholders to pursue important societal priorities, it seems that governments generally have a lot to learn about catalysing private sector partners to work effectively to deliver government strategic goals.

Even governments that espouse the use of the private sector to deliver public purposes are not always adept at mobilising the private sector productively. This was a point made recently about how the UK Government had failed to mobilise others to help deliver the expanded scale of testing for COVID-19 that it wanted. According to one assessment of the situation (Corrigan 2020):

Today the question that needs to be answered is why – even allowing for the possibility that they [the UK Government] may have acted late – did the strategy they followed to increase testing capacity up until April 2nd not work? On that date the Secretary of State had to change the strategy to resting on his five pillar plan. The pillars in the plan were all partnerships with a range of different bodies outside of Government: – Universities, research institutes and the private sector. They were each asked to mobilise their resources in the overall struggle to expand testing capacity. Given the scale of the crisis, it looks like a very sensible idea to work in partnership with every organisation in society to expand that capacity. (Corrigan, 2020)

It seems possible that one explanation for the continuing challenges government have in mobilising others in a whole-of-society effort is the continuing hold the idea of a self-sufficient state has on the thinking of ministers and civil servants.

f. Public participation

In general, it is accepted that governments ideally should be transparent, responsive to the public, and open and inclusive in decision making. However, one of the features of the early months of a pandemic is the responsiveness of government to scientific and medical advice, which may have the effect of downplaying the scope for public participation in deciding on a national response to the confirmation of cases.

The Australian situation, as reported by John Halligan, was much as might be expected during the COVID-19 emergency. The Prime Minister and the Minister for Health were advised by a chief medical officer, who in turn was supported by experts. John Halligan (2020) writes:

The Communicable Diseases Network, an advisory sub-committee of the AHPPC has regularly reported to the chief medical officer. The Australian Health Protection Principal Committee (AHPPC, 2020), the key decision-making committee for health emergencies, is composed of state/territory chief health officers and chaired by the Australian chief medical officer. It advises the Australian Health Ministers' Advisory Council and National Cabinet.

In the event that the Government struggles to contain and control a pandemic such as COVID-19, and in the event that the illness and mortality rates become very high, there may well be a stage in the development of an

emergency that politicians blame the experts for giving the wrong advice and the experts may counter with claims that politicians were also making decisions on the basis of their political thinking rather than advice or had not followed the expert advice given.

Where does this elevation of scientific and medical advice as an input into government decision making leave the relationship between government and public? The focus is placed on government communicating to the public and doing this throughout the time that the pandemic is happening. The Government, moreover, has to be alert and sensitive to the fears and concerns of citizens, so that it is ready to respond with communications as needed. Celia Lee made this point in her contribution to this report when she discussed the DORSCON risk management framework for Singapore:

The raising of the DORSCON level led to panic buying island wide which prompted the Minister of Trade and Industry to assure the public of sufficient stockpiling and supplies of essential items via Facebook and prompted the PM to address the nation. This incident pointed to the importance of providing the public with access to reliable, clear and timely information. Therefore, a WhatsApp subscription platform was used to provide citizens with daily and trusted updates in four official languages to help control panic by countering fake news promptly...

Public support may get undermined if there are unresolved social problems. Clear examples of this occurred in both the USA, and the UK, where the greater mortality rate among black citizens had caused questions and concerns to surface. In fact, the death of a black citizen in the USA, in an incident involving the police, triggered protests not only in the USA but elsewhere. It seems likely that the protests are best understood as taking place in the context of the higher mortality rates in the black community and was not a simple effect of the incident. In the UK the Government responded to mass protests in London and elsewhere by calling for people to remember that social distancing was still needed because the country was still in the midst of the COVID-19 epidemic.

Are Effective Governments Better at Emergency Management?

In the introductory chapter to this special report a provisional grouping of countries was suggested. The groups and some tentative definitions are shown in Table 2.

The ratings of government effectiveness for these countries is shown in Table 3, which divides governments into those with higher coefficients and lower coefficients for estimates of government effectiveness. These effectiveness estimates are based on surveys of perceptions and form part

Table 2 - Groups of Countries During the Early Phases of COVID-19

Groups	Tentative Definition	Countries
1	Countries that have largely succeeded in containing and controlling COVID-19.	China, South Korea, Japan, Singapore, Australia, New Zealand, Germany, Norway and Finland.
2	Countries that appeared to lose control of the spread of COVID-19 but then had subsequently managed to halt or slow its further spread. Many lives were lost in the process.	Belgium, the UK, Spain, Italy, Sweden, France, The Netherlands and the USA.
3	Countries that did not have a high total mortality rate in June 2020 but between the middle of April and 11 June, a period of about two months, there was a relatively high percentage increase in their mortality rate.	Brazil, Chile, India, Mexico, Nigeria., Peru, Russia, and South Africa.
4	Countries that had a relatively low mortality rate in June 2020 but were in a sense the "other" countries.	Canada, Ethiopia, Saudi Arabia, Slovakia, and Ukraine.

Table 3 - Government Effectiveness and COVID-19 During the Early Phases

	Groups			
	1	2	3	4
Government Effectiveness (Estimate -2.5 to +2.5) <i>Higher estimate</i> (1.00 or more)	Australia Finland Germany Japan New Zealand Norway Singapore South Korea	Belgium France Netherlands Spain Sweden UK USA	Chile	Austria Canada Lithuania
<i>Lower estimate</i> (less than 1)	China	Italy	Brazil India Mexico Nigeria Peru Poland Russia South Africa	Algeria Czech Republic Egypt Ethiopia Ghana Hungary Indonesia Palestine Romania Saudi Arabia Sierra Leone Slovakia Tanzania Tunisia Turkey Ukraine

Note: The estimates of government effectiveness are published by the World Bank and related to the year 2018.

Source: <https://databank.org/home.aspx> (12 June 2020)

of a set of Worldwide Governance Indicators that can be found in the World Bank's online databank. The data on which the coefficients are based has to be appreciated for what it is – perceptual data. These coefficients do not change much year by year and it is possible that governments may continue for a time to have a good reputation for effectiveness even when their ability to deliver outcomes that matter to their citizens has reduced substantially.

In this tabular analysis it should be recalled that the countries in group 1 had done well in saving lives and controlling the outbreak of COVID-19, while those in group 2 had a high mortality rate but had succeeded in bringing their out of control epidemics back under control.

Governance Agility and Adaptability

It is noticeable that the first and second groups of countries typically have governments that have good reputations for their effectiveness. For example, Singapore has a reputation for being one of the best governments in the world. Maybe, therefore, we should have expected all the governments in these two groups to have succeeded in suppressing the transmission of the virus quickly and prevented a high mortality rate. But this was not the case.

If we take the view that reputational judgments are slightly problematic, but we also assume that there may be some kind of very approximate relationship between a reputation for effectiveness and actual effectiveness, then the interesting implication is that one group of governments acted very effectively to protect the lives of their citizens in the course of the period January to June, and another group used their effectiveness to recover control of an epidemic.

The conjecture here is that the first group of countries were agile and able to quickly adapt to the COVID-19 situation, whereas the second group of countries either had political commitments and ambitions that did not focus on aggressive containment or had a government that had limited amounts of agility and adaptability.

The hypothesis for four of the countries – the Netherlands, Sweden, UK, and USA – could be that political commitment to an aggressive containment strategy was absent at the outset or in the early months of the pandemic. This seems confirmed by media speeches and interviews at the time. For example, Mark Rutte, the Netherlands's Prime Minister, made a televised speech to Dutch people on 16 March and he made remarks that do shine a light on the issue of political commitment - indicating a commitment to mitigation rather than containment. He told the people of the Netherlands (Rutte 2020):

The reality is also that in the coming period a large proportion of the Dutch population will become infected with this virus.

That's what the experts are telling us now.

They are also telling us that – as we wait for a vaccine or treatment to be developed – we can delay the spread of the virus and at the same time build up population immunity in a controlled manner. (Rutte, 2020)

Something similar was being said by the Chief Scientific Adviser in the UK at about the same time. He was talking on a radio news programme when he said (Stewart and Busby 2020):

What we don't want is everybody to end up getting it in a short period of time so we swamp and overwhelm NHS services [...] Our aim is to try and reduce the peak, broaden the peak, not suppress it completely; also, because the vast majority of people get a mild illness, to build up some kind of herd immunity so more people are immune to this disease and we reduce the transmission, at the same time we protect those who are most vulnerable to it. Those are the key things we need to do. (Stewart & Busby, 2020)

Sweden was very similar to both the Netherlands and the UK in its pandemic strategy objective. In early April it described the objective as follows: “The overall objective of the Government’s efforts is to reduce the pace of the COVID-19 virus’s spread: to ‘flatten the curve’ so that large numbers of people do not become ill at the same time” (Government of Sweden, 2020). It attempted to deliver this mitigation objective in a way that has attracted much attention. Its approach has been described as having a light-touch to implementing its strategy: it relied on voluntary recommendations to bring about social distancing and working at home.

The US is probably best seen as a little different from the other three countries in this group. While it also lacked a political commitment to containment at the federal level, it also did little to pursue a mitigation strategy. One reflection on political leadership of the pandemic in the US was provided by James Fallows and was based on his talking to a selection of key informants comprising, “some 30 scientists, health experts, and past and current government officials—all of them people with first-hand knowledge of what our response to the coronavirus pandemic should have been, could have been, and actually was” (Fallows, 2020). Fallows acknowledged that responding to pandemics poses complex challenges but emphasised the delaying of action at the federal level in seeking to explain the high number of COVID-19 infections and the high mortality toll in the US. He quoted James Giordano, an expert at Georgetown University Medical Centre, as saying: “In the midst of this emergency, we should have been able to act, swiftly and soundly—and we didn’t.” He concludes at one point in the reflection: “This president was saying that the disease didn’t matter, or would solve itself. No one was capable of attracting his attention, or changing his mind, or even using his indifference as a shield for behind-the-scenes preparation for a response”.

In summary, the political direction of the Netherlands, Sweden, UK, and the US meant that the agility and adaptability that might have been used to pursue an aggressive containment strategy as recommended by WHO officials proved irrelevant because the political direction ruled out this strategy. Agility and adaptability might still be displayed by civil servants, as, for example, in the case of the UK when civil servants designed an economic and financial infrastructure to deal with COVID-19 and when the National Health Service created Nightingale hospitals to boost hospital capacity to cope with a surge in COVID-19 patients needing treatment. But these were appointed officials rather than political leaders working within a strategic framework defined by political decisions.

For the second group of four countries – Belgium, France, Italy and Spain – it might be hypothesised that the governance of these countries was initially lacking in the strategic capabilities specifically needed for agility and adaptability to mount an aggressive containment strategy as soon as confirmed cases were reported and the numbers of them began to rise. Evidence is needed to test this hypothesis.

Conclusion

All in all, one lesson of the first five months of the COVID-19 pandemic can be summed up as the recognition of the importance of both good governance and sound governance for protecting the health of people and saving lives in a pandemic emergency. The experiences of the first five months of COVID-19 can teach governments much about the critical importance of choosing and making the right political commitments and the critical importance of possessing and using key governance capabilities. It can also be said that COVID-19 tested how good governments really are in an emergency and the evidence showed quite clearly that some governments that have a reputation for effective government floundered and failed to protect the health of the public as much as other governments.

This chapter has been framed by the need for better understanding of “good governance” and its causes. Good governance and the principles of sound governance are of relevance to countries everywhere and there was evidence of them in a number of countries in both the East and in Europe. Good governance and sound governance are compatible with a range of constitutional designs and institutional arrangements and practices. There may be new examples of countries showing good governance and sound governance to add from elsewhere in the world as COVID-19 continues to be transmitted causing more infections and deaths.

Not everything of importance has been covered in this special report. First, more evidence and analysis were needed on the parts played during the earliest

phases of the pandemic by not-for-profit organisations, city governments, and regional and local authorities. A whole-of-society approach is not just about public-private partnerships and public participation – it is also about the efforts of regional and local government and not-for-profit organisations. There was some attention in this special report to the important role played by regional and local government, but more attention is needed to the work of sub-national levels of government in this period. Second, despite brief references to the World Health Organisation, it is also acknowledged here that the important role of supra-national governance in countering the pandemic was considered to be beyond the scope of this special report. Third, in the transition away from the earlier phases of the pandemic in a number of countries, it is clear that governments were trying to address the issue of supporting and boosting economic activity for the next year or so. How governments prepare for this and manage it is a vital topic of public governance. Governments that used drastic measures to implement a national lockdown, including workplace and school closures, public transport system closures, restrictions on movement and travel within a county, closure of borders and restrictions on international travel, also reduced economic activity drastically. The governments then faced challenges about how to “get back to a new normal”; meaning how to restart or expand economic activity while keeping people safe. This challenge could be seen as created by a tension between government meeting the need to protect “lives” and meeting the need to protect “livelihoods”. In the case of countries that have long relied on international tourism for a substantial chunk of their GDP, how soon could they restart their tourism industries without triggering a new wave of COVID-19 infections and deaths? The challenge was also a dilemma for governments where closing the national borders had worked well and protected the public’s lives; now the question was, how could they continue to protect lives but make some exceptions for purposes of trade?

The COVID-19 experiences, both those that occurred in the early months of 2020 and those that are yet to come, have a lot to teach us about the governance capabilities that will be needed when future emergency situations occur, emergencies that might be created by pandemics or climate change, or various other global risks. It is hypothesised here that governments will need to be agile, able to learn in real time, good at evaluating evidence in fast changing and complex situations, and good at facilitating coordination across the whole-of-government and in partnership with citizens and the private sector.

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Jean-Michel Eymeri-Douzans

Jean-Michel **Eymeri-Douzans** (PhD) is the President of the European Group for Public Administration (EGPA). An Exceptional Class Professor and former Vice-Rector at Sciences Po Toulouse, school of government of Toulouse University, he has worked extensively, since his early secondment at the European Institute of Public Administration (EIPA), Maastricht (1999-2001), for the European Commission as an expert and trainer, in Brussels and in Candidate Countries within many Twinning Projects. In France, he served as Chairman of the scientific council of DGAFP, Ministry for Civil Service, Paris, and works regularly for the ENA. His books and research publications investigate comparative public administration in Europe, with special foci on the relations between political power, political advisors, higher bureaucracy, and expertise; on HRM in the Civil Service; on post-NPM and neo-bureaucracy.

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Ala'a Hammad

Ala'a **Hammad** works in Palestinian National School of Administration (PNSA) as head division of training department, he holds a Master's degree in Business Administration from Birzeit University, and a Bachelor's degree in Business Administration and Information Technology from Al-Quds University. Ala'a also a youth activist and a community volunteer in various organizations that are concerned with the development of local community through the integration of youth, positive change and the effective role of the media in raising community awareness. In addition, he participated in many national and international conferences, seminars, trainings and youth exchange programs.

Guoqing Hao

Guoqing **Hao**, Professor, Director of the Department of Public Administration, Hubei Institute of Administration, China. From February 1 to April 22, 2020, when Wuhan was suffering from COVID-19, Guoqing Hao was appointed by the Provincial Committee of Hubei of the Chinese Communist

Party and Hubei Provincial Government as a voluntary public administrator to serve the people in local communities.

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Youngmee Jee

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Branko Kolarić

Branko **Kolarić** MD, PhD, a specialist in epidemiology, employed at Medical Faculty University of Rijeka – Department for Social Medicine and Epidemiology and as a head of Department for Public Health Gerontology at Andrija Štampar Teaching Institute of Public Health. He is also a head of Referral Centre of Ministry of Health for Elderly Health Protection. He is experienced in conducting scientific and professional international projects. He is an external evaluator for European projects in health and works as a supervisor at ECDC program for public health training and field epidemiology - EPIET. His scientific interests are design of epidemiological research, outbreaks control and healthy ageing. He is an author or coauthor of 80 scientific articles and was a mentor of five PhD thesis. During the current pandemic he was a project leader in developing digital assistant Andrija on WhatsApp and chief epidemiologist for homes for elderly.

Ivan Koprić

Ivan **Koprić** (PhD) is tenured professor and head of the Administrative Science Department, University of Zagreb, Croatia. He is president of the Institute of Public Administration in Zagreb. His publications include more than 30 authored and edited books and numerous papers. He is editor-in-chief of the international scholarly journal “Croatian and Comparative Public Administration”. Recent books: “Migrations, Diversity, Integration, and Public

Governance in Europe and Beyond“, Institute of Public Administration, 2019 (with G. Lalić Novak & T. Vukojičić Tomić), “Evaluating Reforms of Local Public and Social Services in Europe”, Palgrave Macmillan, 2018 (with H. Wollmann & G. Marcou).

Éva Margit Kovács

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Asma Sehiri Laabidi

Asma Sehiri **Laabidi** was appointed on February 19, 2020, as Minister for Women, Family, Children and the Elderly in the new government of Elyes Fakhfakh and subsequently as the spokesperson for the newly formed government. She had been, since 2018, the first woman to hold the position of director general of the National School of Administration (ENA). Sehiri Laabidi is a lawyer by training and a counselor of public services (CSP), a graduate diploma from the ENA in Tunis. She began her professional career in 1997 in the Prime Ministry. In 2012, she was promoted, as the first woman, to the position of Government Legal and Legislative Counsel. Asma Sehiri Laabidi teaches in several establishments (ENA, National School of Finance, Maghreb Development Finance Institute and National Defense Institute).

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Per **Lægreid** is Professor Emeritus at Department of Administration and Organization Theory, University of Bergen, Norway. He has published extensively on public sector reform, public management policy, institutional change and crisis management from a comparative perspective. His latest

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Freddy **Mariñez** Navarro - Ph.D. in Political Sociology from the Université Laval, Canada with master's degrees in Economics and Sociology of Cooperation. Professor Researcher of El Colegio de Jalisco, México. National Researcher of the National Research System (SNI), Conacyt. Member of the Management Board of the International Association of Schools and Institutes of Administration (IASIA) (2010-2013). He is also an active member of the Latin American Group for Public Administration (LAGPA-GLAP) where he was a member of the Board of Directors. Visiting Scholars at the Woodrow Wilson Center and Georgetown University (Washington), as well as at the Kennedy School of Government of Harvard University.

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corruption, French-English relations in business interest associations, and nationalist mobilization in Quebec and Scotland. His latest book is a co-edited volume (with Melchior Powell and Dina Wafa), *Corruption in a Global Context: Restoring Public Trust, Integrity and Accountability*. Routledge Corruption and Anti-Corruption Series. (London: Routledge, January 2020).

Rachid Melliani

Rachid **Melliani** is the General manager of Moroccan National School of Administration (ENSA), former member of the cabinet of the head of government, former director of the cabinet minister of industry and trade, former central director at the ministry of economy and finance. Graduated from three schools: ENA France, ENA Morocco, Ecole des Mines.

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Marco **Meneguzzo** is Full Professor of Public Administration and Management, Department of Business Administration, Faculty of Economics, University of Rome Tor Vergata, Rome, Italy (since 2002). He is also the Research Group Coordinator: “Government and Civil Society”. He is Professor of Public and Non-profit management and in Management of Health Organizations at the Faculty of Economics, Università della Svizzera Italiana (USI), Lugano, Switzerland He is a member and scientific coordinator of projects with the Dipartimento della Funzione Pubblica - Ministry of Public Administration and Services - Italy (Cantieri - Task force on Innovation, —Outsourcing, Innovations and Financial Management, Public Governance, Spending Review, 2014—, Management and Performance assessment & Risk management, 2018). Visiting professor in several French institutions: CNFPT - INSEAD Paris, ENTPE Lyon, Aix Marseille Université- IMPGT (France).

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Zwelini Mkhize

Zwelini **Mkhize** (MBChB) is the Minister of Health of the Republic of South Africa. He qualified as a medical doctor at the University of KwaZulu-Natal and currently plays a key role in leading the country's response to the Covid19 pandemic. Under his leadership of the health sector, South Africa has received positive acknowledgement by the World Health Organisation and the United Nations Secretary General. He has served as Minister of Cooperative Governance and Traditional Affairs in 2018/19 and has held various positions in the Province of KwaZulu-Natal, namely MEC for Health and then Finance and Economic Development from 1994 to 2004 and Premier from 2009 to 2013. He has been a member of the ANC National Executive Committee since 1997 and served as ANC Treasurer-General from 2012-2017.

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James L. **Nkata** is a scholar of Higher Education Management and Administration and the Director General of Uganda Management Institute. Prior to this he was an Assoc. Prof. of Management and Administrative Studies at Makerere University and Director of the East African Institute of Higher Education Studies and Research. He is involved in national and international financial support negotiations and has won a number of research grants. He is credited for successfully supervising 17 PhD candidates. He has extensively published in the area of management and Administration of organizations. He is currently a Vice President of International Association of Schools and Institutes of Administration (IASIA), in charge of Africa region. He also serves on several editorial boards of International Journals.

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