European Coronationalism? A Hot Spot Governing a Pandemic Crisis

Abstract: The COVID-19 crisis has shown that European countries remain poorly prepared for dealing and coping with health crises and for responding in a coordinated way to a severe influenza pandemic. Within the European Union, the response to the COVID-19 pandemic has a striking diversity in its approach. By focusing on Belgium, France, Germany, and Italy—countries that represent different models of administrative systems in Europe—the analysis shows that major similarities and convergences have become apparent from a cross-country perspective. Moreover, coping with the crisis has been first and foremost an issue of the national states, whereas the European voice has been weak. Hence, the countries’ immediate responses appear to be corona-nationalistic, which we label "coronationalism." This essay shows the extent to which the four countries adopted different crisis management strategies and which factors explain this variance, with a special focus on their institutional settings and administrative systems.

During the last two decades, the globalized world has been exposed to a series of pandemics (SARS-CoV in 2002–03, global influenza in 2004–05, swine flu in 2009–10, and global influenza again in 2017–18 and 2019–20). In light of these events, national governments around the world, including those in the European Union (EU), have often had opportunities to prepare for health crises, their management, and the development of governance mechanisms to deal with them. The COVID-19 crisis has shown that European countries remain poorly prepared for dealing and coping with health crises and for responding in a coordinated way to a severe influenza pandemic or to any similar global, sustained, and threatening public health emergency (WHO 2019, 2–3). Even if many countries’ risk analyses and pandemic plans were available and the specialized agency of the EU—the European Centre for Disease Prevention and Control (ECDC)—periodically stressed the importance of planning, these plans have rarely been exercised in preparation for expected events. As a consequence, the knowledge gained from previous pandemics and risk scenarios has been barely, if at all, used and shared by decision makers. Most striking from an EU perspective, coping with the crisis was first and foremost an issue of the national states, whereas the collective European voice was rather weak, if not sometimes entirely absent. Hence, the countries’ immediate responses appear to be corona-nationalistic, which we label “coronationalism.”

Public administration has several theories and models that try to capture different realities of governments handling major crises or failures in general, such as crisis management (Boin et al. 2016; Boin and Lodge 2016; Christensen et al. 2016), policy failures (Peters 2015), and blame avoidance (Hood 2010; Mortensen 2013). There are also several theories and models about dramatic changes in realities, such as change management (Fernandez and Rainey 2006) with “burning platforms” (Skinner 2016), disruptive and sustainable innovations (Osborne and Brown 2005), or transformation governance (Grin, Rotmans, and Schot 2010).

This contribution compares the struggles of national governments in the first four months of 2020 to develop, establish, and use mechanisms for crisis governance as a response to cope with the COVID-19 pandemic within the diverse scenery of the EU. The focus of this article is thus on what the national crisis response mechanisms (in the coronavirus crisis) look like and which factors influence their design and use. However, at this early stage, we do not discuss the implications of the measures taken on the basis of these crisis management mechanisms.

The analysis focuses on Belgium, France, Germany, and Italy, countries that represent different models of administrative systems in Europe (see Kuhlmann and Wollmann 2019). Whereas France and Italy stand for the Continental European Napoleonic model with a traditionally highly centralized administrative...
Two main points result from our comparison:

- To fight global crises, national responses are necessary but not sufficient.
- To the extent that national responses are different and divergent, more coordination is required. These differences and divergences can be explained mainly by institutional variance.

This essay shows the extent to which the four countries adopted different crisis management strategies and the factors that explain this variance, with a special focus on institutional settings and administrative systems. Drawing on this cross-country comparative perspective, we show that managing the COVID-19 crisis in Europe has been predominantly shaped by distinct country-specific approaches instead of (convergent) Europeanized action.

“Early warning” detection systems are crucial for speedy and effective responses. This needs to be combined with reliable and comparable monitoring systems and mechanisms to translate and interpret data into information, which is made available and useful for risk analysis and decision-making and for feeding adjusted policy measures and service delivery. The different attention paid by countries to the updating of their pandemic preparedness plans (see table 1) has probably been reflected in different attitudes toward and awareness of the threat. The different governance structures for epidemiological risk analyses and pandemic plans were also influential.

### Table 1 Regulatory Design for Management of Health Crises (Pandemics)

| Epidemiological risk analyses; pandemic plans | Federal government: Sciensano: Scientific Institute of Public Health (federal government agency) | National Ministry of Solidarity and Health (Ministère des Solidarités et de la Santé) with General Direction of Health (Direction générale de la santé, DGS) and CORRUSS (Centre opérationnel de régulation et de réponse aux urgences sanitaires et sociales) | Federal Ministry of Health (Robert-Koch-Institute): National Pandemic Plan; Länder and local pandemic plans | Ministry of Health + National Institute for Health + Regional Health Care Systems |
|---------------------------------------------|-----------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| Last influenza pandemic preparedness plan   | 2009 No specific procedures for health-related crises except for general emergency procedures and structures | 2011 Activation of “standard operating procedures,” including CORRUSS (1) and National Defense and Security Committee, beginning of January | 2016 No centralized procedures available; establishment of national/regional/local task forces; amendment of the federal infection protection law to declare an epidemic emergency of national concern (March 25, 2020) | 2010 Activation of Civil Protection Operational Committee, end of January |

Source: Authors’ compilation of information based on online references on the country cases at the end of the article.
In all countries, the most important initiatives were taken only when the number of reported cases—and deaths—began to increase, and public awareness grew accordingly. During this delay, the national institutions began to prepare, although there was no common practice of testing that allowed the identification of the exact number of contaminations. Notwithstanding these similarities, there are also important differences to be observed among the four countries with respect to the activation of formal risk management procedures. Although they all declared a pandemic emergency of national concern, this was the case at an early stage in France and Italy (January) (INSEE, Ministère des Solidarités et de Santé and Santé Publique France 2020, 2). In Belgium, the COVID-19 outbreak was officially called a pandemic in early February. In Germany, because of initially lacking legal provisions in this regard, the declaration was only made by the federal parliament by end of March (when the peak of the crisis was already over).

In France and Italy, centralized risk management procedures and structures were activated only after numbers became “visible,” whereas in Germany, no such centralized structures were available and the establishment of crisis task forces had to go from the bottom up (table 1). In Belgium, a three-step containment plan was introduced before the first contamination reached the country, but it largely failed as it was very quickly overtaken by the numbers.

Monitoring systems have been set up and evolved very differently, depending on the policy and intensity of testing, organizational coverage (hospitals, centers of care, private homes), the geographic perimeter (regional versus national), and the procedures for data collection (centralized versus decentralized). Overall, coordination of monitoring systems at the EU level was clearly lacking. From this comparative observation, we can conclude that the multilevel administrative setting in the four countries has had an important influence on the activation and functioning of risk management procedures.

**Learning from Whom? How to Put Effective Practices and Operations in Place**

Since the first cases emerged, European countries have learned from past crises by implementing crisis management systems and processes that have been adopted from other countries, but also by adapting these systems and processes for each local context.

Almost all European countries have gone through a number of health and other crises and developed readiness plans. In Germany, there is a history of managing floods (2003) and influenza (2009 and 2017–18), and operational emergency plans and risk analyses have been available since 2013 for pandemics and floods. However, in reality, these plans were not practiced and were not linked to risk management. In France, during periods of major crises, such as the terror attacks in 2015 (Charlie Hebdo) or sanitary crises (such as several heat waves in 2003, 2006, and 2019), the central government takes over and starts running the system. In Italy, the Civil Protection Department has a long history of crisis intervention in earthquakes (1976 in Friuli, 1980 in Irpinia, 1997 in Umbria, 2009 in L’Aquila, 2012 in Emilia Romagna, and 2016 in Lazio) and floods (1994 in Piemonte, 1998 in Campania, 2000 in Piemonte), but not in health crises. In Belgium, the dioxine crisis (1999), influenza crises (2007, 2009–10), and a terrorist attack (March 2016) positioned action and response plans. All these experiences have resulted in different approaches to disaster management (table 2). For instance, the Italian Civil Protection Department consolidated experiences in crisis management, but at the same time, it has never directly managed a big pandemic. Neither have the corresponding actors in other European countries.

Even if this was a helpful starting position, the rapid global spread of this type of crisis, the lack of practice, the missing link to risk management, and the need to mobilize specific capacity made this learning necessary but not sufficient.

There was learning from other countries, but this was mostly at the level of health experts, exchanging data, models, and health measures, even if expert discussion (e.g., on how useful which masks are) has also limited learning from others. Contingencies made that learning at the level of running the political, administrative, and managerial machine has been limited.

**Decision-Making: What Sustainable Logics to Follow?**

Within this pandemic crisis, two logics have been followed, and some countries probably changed logics. As a result of scientific debates about how to effectively stop the virus, the “herd” logic of building collective immunity through spreading the virus in the “herd” was opposed to the “containment” logic, which required drastic and immediate “quarantine” measures to let the virus expire.

Italy, France, Germany, and Belgium (but also other countries, such as Spain, Switzerland, and Austria) followed the containment logic, whereas the United Kingdom and the Netherlands initially followed the herd logic. Sweden took a different approach by, on the one hand, pursuing the containment logic (stopping the virus from spreading), in particular by the government issuing official recommendations of conduct, notably to high-risk groups, but, on the other hand, abstaining from restrictive measures, such as lockdowns, and contenting itself with voluntary citizen compliance regarding social distancing and other hygiene precautions.

What explains these differences? In the four Napoleonic and classical Continental European countries examined here, the
Table 2  Institutional Design for Governing Health Crises in Four European Countries

| Legal-institutional foundation of sanitary and public health policies and their implementation | Belgium | France | Germany | Italy |
|---|---|---|---|---|
| Legislation on sanitary and public health issues | Federal legislation for hospitals; regional legislation for homes for care (elderly, disabled etc.) | National code of public health; “white plan” (plan blanc + plan) | Federal Infection Protection + Law (IfSG); Länder legislation on regional hospitals and public health institutions | National legislation on essential levels of assistance and financial resources reallocation; regional policy making and legislation |
| Execution of sanitary and public health issues; hospital management | Federal Public Service (ministry) for Health, Food Chain Safety, and Environment + regional ministries and agencies | Regional Health Agencies (Agences régionales de santé, ARS); managements of public (state: regional, local + universities) hospitals and private clinics | Länder and local execution of federal IfSG; Länder-level hospital plans’ financing; Länder and local management of hospitals | Regional government, local health authorities, and local (private) hospitals steered by regional government; National Institutes for Healthcare |
| Risk and disaster management; pandemic mitigation/containment measures | Federal minister for interior (national disaster plans + civil protection); provincial governors: provincial disaster plans; local government: mayors (local disaster plans) | Ministry of the Interior: National crisis center for civil protection in peace times; in coronavirus times, prime minister and ministerial cabinet + national restricted defense and security council headed by the state president | Länder competency for civil protection in peace times; local management of disasters; in coronavirus crisis, predominantly local health authorities | National Civil Protection Agency—independent organization inside the presidency of Ministers’ Council |
| Disaster management | Federal minister for interior (national disaster plans + civil protection); provincial governors: provincial disaster plans; local government: mayors (local disaster plans) | Ministry of the Interior: National crisis center for civil protection in peace times; in coronavirus times, prime minister and ministerial cabinet + national restricted defense and security council headed by the state president | Länder competency for civil protection in peace times; local management of disasters; in coronavirus crisis, predominantly local health authorities | National Civil Protection Agency—indepedent organization inside the presidency of Ministers’ Council |
| Declaration of pandemic emergency of national concern | Federal and local police | Local policy supported by national gendarmerie | Länder police; local authorities for public order and safety | National police, armies, local police |
| Shutdowns/lockdowns/contact bans/canceling of events | National Security Council (federal PM, and relevant ministers, regional PMs, top civil servants); National Crisis Centre (NCCN) | Amendment of sanitary code by new part on sanitary emergency (sanitary emergency can be declared by the ministerial cabinet for two months and can be prolonged with approval of parliament) | So far no legal provision; newly introduced during the Corona crisis by the Federal government (with parliamentary approval) | Ministers’ Council resolution adopted according to the existing legislation without Parliamentary approval (January 31, first two cases of Chinese tourist in Rome). Activation of Civil Protection Operational Committee |
| Controlling of measures and punishment for noncompliance | Federal and local police | Federal and local police | Länder police; local authorities for public order and safety | National police, armies, local police |
| General mode of crisis management | Centralized + negotiated with regions; decentralized implementation (regions and local government) | Centralized; very strong position of central state/central level | Decentralized/coordinated; weak position of the federal level | Centralized/top-down with ad hoc coordination mechanisms (Civil Protection Department Network); strong Regional involvement |

Source: Authors’ compilation of information based on online references on the country cases at the end of the article.

clear separation of state and society and the perceived supremacy of the state vis-à-vis society, which are essential elements of the administrative culture of each country (Kuhlmann and Wollmann 2019, 16 et seq.), are central to the explanation of the immediate, restrictive, and fairly undisputed approaches to containment. Here, the state quickly took the lead and made tough decisions that restricted citizens’ freedoms in order to stop the spread of the virus. In the cases of Italy and France, where the virus spread more rapidly, a determined shift toward containment logic can also be explained by the sheer pressure to act as the number of deaths increased. In Belgium and Germany, on the other hand, dramatic news and images from Italy and, to some extent, France supported the strong reactions, first and foremost, of governments at the central level. They were supported by the regional or Länder governments in a coordinated and united way. The more “liberal” coping with the pandemic that was adopted, at least initially, in the United Kingdom, the Netherlands, and Sweden, can presumably be related (inter alia) to their administrative cultures marked by a less interventionist and hierarchical logic of governmental activities. However, the United Kingdom and the Netherlands, after a while, shifted to the containment logic, which can be interpreted as a convergence of pandemic management paradigms. A range of reasons (“collateral damage” getting too high, expert discussions being controversial) may explain this shift, although all governments based their decisions on what scientists claimed what was best to do (Van Dooren and Noordegraaf 2020).

The common containment logic has resulted in a similar mix of shutdowns, lockdowns, contact bans, and event cancellations. Security forces have been responsible for monitoring these measures and punishing noncompliance. The substantial equivalence of the choices made appears to be of particular interest in consideration of the different general modes of crisis management that distinguished the four countries (table 2). Whereas the restrictive containment
approach represents a convergent trend of coping with the crisis in European countries (with Sweden as a remarkable exception), there are major differences in the institutional drivers. A clear distinction can be made between a more regional or decentralized and a more national or centralized logic.

In some countries, such as France and Belgium, there was a national strategy from the beginning. In other countries, such as Germany and Italy, there was initially a regional logic, defined in some regions, which then resulted in national political coordination, which then became a national or coordinated strategy of resource allocation and what regions should do at an operational level. Whereas in Germany, the crisis-related agenda setting and problem-solving started at the local level with functionally strong local public health services and the Länder being responsible for pandemic crisis management, in France and Italy, the central state was the key actor, while local and regional governments played a more or less subordinate role. Belgium took a middle position: on the one hand, the regions assumed major functions in crisis management; on the other hand, the position of the federation became increasingly pronounced over the course of the crisis.

**Coordinating: How to Make Complex Things Happen through Standardized Solutions or Exceptional Solutions?**

Implementing logics in an effective way requires coherent operational and managerial standardized practices, such as top-down versus bottom-up decision-making, coordination of measures, linking of experts and administrators, or linking of administrators and politicians.

To streamline multiple actors at multiple levels, a combination of top-down and bottom-up dynamics is indispensable. The combinations of modes of crisis management vary among the European countries, from enforced top-down (France), to predominantly top-down with operational bottom-up (Italy), to delegated/negotiated/coordinate top-down with significant bottom-up (Belgium and Germany) (tables 1 and 2). This has allowed the avoidance of a joint decision trap of nondecision, and it has allowed sub-central pilot practices to spread to other parts of the country.

Most countries have secured coordination through a central ministry (health, interior, or prime minister) or a department of an agency (civil protection). However, the classic coordination problem of silos remains a point of attention to avoid disconnects. This has been particularly evident with regard to sanitary and public health policies as the number of subjects involved in the legislation and execution is very high, especially in Germany and Italy (table 2). In Germany, most of the competencies to respond are at the Länder and local levels. The federal minister of health pledges for the Länder for compliance, and the chancellor pushes for coordinated measures but is not in the position to impose them on the Länder. To achieve nationwide solutions and uniform standards, in Germany, the horizontal self-coordination of all 16 Länder plus the vertical involvement of the federal level is necessary. The same, more or less, applies to Belgium, a federal state that lacks hierarchy between the national and the regional levels and in which health is a shared competence. As a consequence, coordination between governments at different levels is key.

However, standard operating procedures and practices were not sufficient. Special task forces have been established in all countries, based on expert knowledge, risk assessment, operations, or general crises. At the EU level, the Crisis Coordination Committee has been established under the leadership of the commissioner, who is the emergency response coordinator. The EU Civil Protection Mechanism is another recently established disaster management instrument to strengthen cooperation between member states but designed for “classical” natural disasters. Also, the European Commission coordinates regular contacts between European ministers for health and interior.

Coordination by expertise has also been evident. Health experts are at the crossroads of politicians, administrators, and the population at large. Legal burdens, limitations, or restrictions on electronic transfers of data, teleworking, fast-track processing seem to accelerate and create precedents for future ways of delivering services, implement policies, and taking decisions.

However, all European countries wrestle with remaining issues, which cannot be entirely solved by experts or technical committees for coordination, at the national or at EU level, about tensions between policies or allocation of resources and capacity. There are tensions about how to allocate capacity (masks, ventilators, personal protective equipment) between regions, between hospitals and centers of care (homes for senior citizens, handicapped, psychiatric patients, prisons), and between delivery chain or security forces. There are tensions between values and priorities: monitoring mobility through mobile technology versus privacy; keeping public transport mobility versus restricting mobility.

Finally, extraordinary measures such as “plenary powers” or “national emergency powers” allow for tackling these very complex, even wicked problems.

**Communicating: Whom to Convince and How?**

Framing and effective communication require a simple and straightforward logic. To move from monitoring and risk management to grounded decisions that are “owned” by those who need to implement these measures requires a “framing” in an official and a general communication strategy. This “ownership” of the message around a shared objective, “contain and stop the spread of the virus,” is needed to unite and to mobilize goodwill and resources, supported by traditional “old” media as well as “new” social media and to collaborate politically (all or most political parties, but also executive with legislative and judicial powers) across the public sector—that is, vertically (all levels of government)—and across society—that is horizontally (private sector, nongovernmental organizations, and citizens).

In all cases, the key official communication was centralized and monopolized by the highest political leadership communicating directly with the population. All speeches by heads of state or government include three components: first, enhancing awareness by emphasizing the gravity of the pandemic, the difference from past diseases, and the need for urgent and drastic measures; second, providing reassurance of being hands-on and having the capacity to solve but requesting discipline and support from everybody; and third, gratefulness to frontline workers, with a message of hope and...
Courage to conquer and remedy. Next to these speeches, official press conferences regularly lined up key politicians (such as the national ministers of health) with scientists, particularly medical doctors specializing in virology. In Germany, it was even stated that “the virologists have taken over government” (see FAZ, 23.3.2020).

Key societal players contributed to solidarity and support. In Belgium, for instance, the federal minister of health engaged well-known “influencers” such as TV celebrities and sports personalities to get the message through all layers and age cohorts of society. In Italy (but also in all other countries), with the approval of the Vatican, this resulted in all churches being closed for the period of Lent and Easter, something that did not even occur during the Second World War. In general, the repeated general communication strategy was rather convincing for some weeks.

Despite the constraints imposed on the lives of citizens, communication has generally resulted in approval and higher levels of trust. Trust figures in Italy have reached 71 percent, the highest in five years (De Feo 2020). Government support for contact bans in Germany peaked at 87 percent immediately after the decision was taken (but shrunk to 64 percent by the beginning of May; see infratest dimap 2020). Public support for the French president also increased when considering his popularity in the polls had previously suffered greatly against the background of the comprehensive reforms of the pensions, the social security system, and the yellow vest protests. In Belgium, the minority government already suffered from a lack of trust before the crisis started. The popularity rates of individual politicians, often those with clear crisis management responsibilities and regular media performances, have gone up and down.

Within this common framework, there are major differences within the European scenery. In Italy, for about a month, many politicians from all political backgrounds issued mixed signals regarding the opportunity to take drastic measures, behaving in accordance with the so-called confirmation bias (a cognitive phenomenon for which we are predisposed to absorb and consider only the information that confirms our starting beliefs). The political conflict with the national opposition parties (Lega Nord), which control the governments in the northern regions, resulted in controversies about statistics, unavailable equipment, and aid. It also resulted in the president of the republic calling several times for unity. In France, the prime minister and the cabinet of ministers together with the president of the republic—in accordance with the centralist state tradition—took over the political leadership of crisis management, and also crisis communication from the very beginning. In order to make the seriousness of the situation clear, President Emmanuel Macron used strong rhetoric in his addresses to the nation and spoke of a “war” against the virus. In the implementation of measures, Jacobin culture led to the central government exercising its authority at the level of departments and regions (special agencies, préfets) and municipalities (mayors). In Belgium, at the verge of the outbreak, there was still a caretaker federal government after almost a year of polarized political discussions between Flemish nationalists and other political families, and between the Flemish and Francophone regions. The crisis eventually resulted in an effective and functional minority government for six (three plus three) months, the first in Belgian political history, which also obtained special powers to master the COVID-19 crisis for that limited period of time.

However, there are also dissonances. Even if at the beginning of the crisis, there was no real opposition to the increasingly tight measures taken, there were explicit concerns expressed. In Italy, trade unions protested and threatened with strikes to ensure that sufficient health protection measures should be taken, such as masks. Also, police trade unions in Belgium threatened to strike for the same reason. In Italy, the prison population revolted. In Belgium, but also in Germany, there were concerns about “establishing” a “police state.” In Tirol (Italy), a class-action lawsuit started against the regional government for having hid information on the virus.

From a generational point of view, it took longer to convince young people to respect the lockdown measures. In Belgium, during the Easter weekend, 27,000 penalties were issued by the police for not following the containment measures, half of which were for people younger than 30 (HLN 2020). There were also concerns that measures were not reaching closed communities and minority groups. Lifestyles in Southern Europe, too, encourage an affectionate kind of social behavior. Also, to anticipate and avoid lockdowns in small apartments, or away from “home,” the announcement, or leaking, of lockdown measures resulted in significant moves of populations. In Italy, after the adoption of first measures, there was a massive move from the northern provinces to the southern ones. In France, about 1.2 million people moved out of Paris to their country houses or to stay with relatives. In response to “national emergency legislation” and the violation of constitutionally enshrined “basic rights” (Grundrechte), in Germany, there were growing concerns about respecting the Constitution and a number of lawsuits submitted to the constitutional courts (see, e.g., Bundesverfassungsgericht 2020). People also increasingly organized in (new) social movements (such as Widerstand 2020) and mobilized against the coronavirus directives for getting back their constitutional rights of liberty (about 5,000 people on May 2, 2020, in the city of Stuttgart; see SWR aktuell 2020).

The Question of Leadership: Who Is in Charge, Ultimately?

Leadership is another key component in controlling a crisis. From an institutional point of view, whereas the public sector increasingly was pushed into the role of an equal partner of private and not-for-profit actors in a governance logic, this situation is being reversed. Again, just like during the major financial crisis of 2008, the state and its public sector became the “lender of last resort,” above all actors, and ultimately in charge of the consolidated system. Public sector organizations, as “hierarchies,” are (re)taking the lead from “markets” and “networks,” even if both are still needed. Since executive powers are taking over control, legislative powers decide to transfer powers, at least for a defined period of time, to their governments. However, in the Hungarian case of the “illiberal” politics of its prime minister, the “Bill on Protection Against Coronavirus,” which has no sunset clause, postponed indefinitely elections and referendums and allowed the government to rule by decree for as long as considered necessary, including measures of up to five years of imprisonment for anyone who undermines “successful protection.”
In most countries, leadership is also visible through existing, standing, or ad hoc entities such as the Italian premier or the Belgian National Security Council with its Risk Assessment Group, Risk Management Group, Economic Risk Management Group, and Group of Experts responsible for an exit strategy, among other advisory bodies.

Crisis are also part of leadership competition in a political arena. In Germany, it has become an opportunity for possible future chancellor candidates to take over leadership and make a mark as managers of the crisis. In Belgium, it has been an opportunity for the federal level to demonstrate its functionality and its necessity in a constitutional debate about the role of the regions. In France, the rapid assumption of the central crisis management function by the government and the president is historically consistent; in times of crisis, the nation gathers behind the president. Subnational leadership is also important to be visible and move to a national level.

Even if medical scientists demonstrated intellectual leadership, politicians remained in power, certainly in France, and keep the decision-making capacity by controlling trade-offs (e.g., controlling mobility and privacy) or by safeguarding proportionality of measures and expected effects.

However, for (con)federal countries much more than for centralized unitary countries, there is a risk of disconnected decision-making systems when a multilevel government needs important vertical coordination and even integration with a top-down guidance. Countries with hybrid and overlapping or concurrent legal competencies may have suffered from competitive federalism, or may have benefit from its ambiguity and allow for effective leadership (see also table 2).

These leadership questions certainly apply to the EU. Action was limited because health is not an EU legal competence. Primary responsibility lies with the member states. The EU’s main role is to coordinate, especially in a crisis situation, complementing national policies. COVID-19 is the EU’s first major health crisis, although the Union has a lot of experience with crisis management, in particular cases that are linked to health issues (of animals), such as the bovine spongiform encephalopathy, commonly known as mad cow disease in the 1990s, as well as during the euro crisis (2009–14) and the refugee crisis (2015). With regard to health, and next to its specialized agency ECDC, the Early Warning and Response System and the Health Security Committee should, in principle (as they are particularly designed for this purpose), enable a rapid response. However, there is no evidence that they were able to play a leading role. Next to the usual turf wars between the European Commission president and the European Council president, there is clearly a lack of single command when member states disagree about issues that are not linked to a clear EU competence. Traditional political competition is then moved to a lower level, such as which commissioners are part of the coronavirus response team.

Recovering: Capacity, Capacity, Capacity
Starting positions are crucial to understand how “path dependency” affects the current situation and the possibility to handle the future (Peters, Pierre, and King 2005). There are major differences between countries concerning hospital capacity and coverage by social security systems (table 3). In France, also, budget cuts and the reduction of capacities, notably in the hospital sector, were core elements in recent “strategy of choices” of the national health administration. Other countries, such as Germany, or Belgium followed different patterns to reduce budgets. In some countries, such as Italy or Spain, there are major regional differences in hospital capacity, for instance.

It could be expected that countries that have cut their “unnecessary” capacity in the past, reducing their health spending as a percentage of gross domestic product (GDP) and/or the number of hospital beds per 1,000 inhabitants, will have to mobilize more resources to

| Table 3 National Health Capacity (to Manage the Coronavirus Pandemic Crisis) in Four European Countries |
|-----------------------------------------------|
| **Health spending as % of GDP**               |
| Belgium **8.8% (2019)**                       |
| France **9%**                                 |
| Germany **11.2%**                            |
| Italy **6%**                                  |
| **Euro/capita/year in U.S. dollars** (2018)   |
| Belgium **4,944**                            |
| France **4,965**                             |
| Germany **5,986**                            |
| Italy **3,428**                              |
| **Hospital beds per 1,000 inhabitants (2017)** |
| Belgium **5.7**                              |
| France **6**                                 |
| Germany **8**                                |
| Italy **3.2**                                |
| **Total intensive care unit beds (ICU)** (2019); number of short-term increase in ICU during COVID-19 crisis** |
| Belgium **1,900 (16.5 per 100,000 population)** |
| France **5,832 (2018) (11.4 per 100,000 population)** |
| Germany **28,031 (33.7 per 100,000 population)** |
| Italy **5,090 (8.4 per 100,000 population)** |
| **Social security and health system** |
| Belgium SHI-based health system; financing flowing from global SHI-contributions; centralized health government in coordination with SHI |
| France SHI-based health system; financing based partly on contributions and partly on tax-like duties; centralized health government in coordination with SHI |
| Germany SHI-based health system; financing based on social contributions; health self-government (health corporatism) |
| Italy Regionalized public health service; tax-based financing; regional health planning, organization and governance |

Sources: https://www.covid19healthsystem.org/countries; http://www.oecd.org/coronavirus/en/#country-profile; https://www.oecd.org/health/health-systems/health-at-a-glance-19991312.htm.
*Health spending as a percentage of GDP in EU average: 7.4%.
*Hospital beds per 1,000 inhabitants in EU average: 5.
recover the capacity needed to handle the crisis, especially if a herd logic was (initially) taken.

The effort put in place by the administrations of the four countries considered shows that in a few weeks, it was possible to increase the number of intensive care beds, especially in the most affected areas. The cost of this capacity is unclear for now. And while this recovery seems to have benefited widely from bilateral donations and aid between states, the EU level has proved to be of little relevance. Creating capacity, or support, through solidarity among European countries has been limited, even disappointing, and sometimes even absent. The sharing of staff, masks, and other instruments has been limited, although the EU managed after initial decisions to confine the use of medical supplies to national markets to guarantee the free movement of essential goods such as medical protective equipment. From a bilateral point of view, there have been patient transfers between Germany, the Netherlands, Luxembourg, Switzerland, France, and Italy (but not Belgium).

Lessons and Conclusions

Within the EU, the response to the COVID-19 pandemic has a striking diversity in its approach, even if many dynamics have been similar, and the initial objective has been the same everywhere: to have as quickly as possible an efficient, effective, and proportional response.

Our analysis shows that, on the one hand, major similarities and convergences have become apparent from a cross-country perspective. They all followed the containment logic, activated their risk management procedures, and increased hospital capacity. On the other hand, each country pursued its own coronalionalistic path shaped by different starting conditions, historically inherited administrative cultures and state traditions. Whereas France, with its conspicuously centralist approach, represents one governance extreme, Germany stands for the opposite model of a predominantly decentralized crisis governance. Italy and Belgium are to be positioned between these two extremes as they are characterized by intermediate degrees of centralization/decentralization in crisis governance.

Monitoring systems have been different, too, and numbers have initially been difficult to compare but have also been converging to higher levels of comparison. Therefore, practice will benefit from solid, transparent, and auditable monitoring systems, especially since policies have been based on these numbers.

Learning has occurred but has been limited. Learning from past experiences was limited by the lack of practicing procedures, lack of related risk assessments, and insufficient coordination of experiences. Therefore, practice will benefit from exercising agreed upon procedures, from developing risk assessments, and from creating networks for sharing experiences across levels and policy fields.

Decision-making was defined by institutional variation. Dynamics could be more top-down or bottom-up, depending on more central or decentral arrangements. Therefore, practice will benefit from taking these contingencies into account, rather than using decision-making models from systems that are differently designed.

Coordination takes different shapes. There is institutional coordination that is enforced top-down (France), predominantly top-down with operational bottom-up (Italy), and delegated/negotiated/coordinated top-down with significant bottom-up (Belgium and Germany). There is organizational coordination, which may be based on standard competencies or on exceptional and ad hoc platforms. Finally, there is expert coordination with administration and politics. Practice will benefit from flexible arrangements.

Official communication became clear and direct in its messages, supported by experts. However, combined social media communications was needed for specific target groups, especially those that were behaving in ways opposing the decisions taken. Practice will benefit from complementary channels of communication.

Leadership was crucial and varied. In some countries, the central government and executive branch were leading in a hierarchical way. However, in other countries, a more shared and networked way matched the institutional setting. Practice will benefit from exploring the legal frames and developing cultures of cooperation.

Capacity was existing or had to be created by reallocating resources. Practice will benefit from guaranteeing levels of flexibility to activate and re-allocate resources.

At this (early) stage of assessment, we cannot provide a final answer to the question “does it make a difference,” based on a systematic analysis of the empirical evidence and an academic understanding of the COVID-19 crisis management in Europe. Therefore, it remains an important task for future comparative research to continue to reveal the impact of various approaches of pandemic crisis management in a given administrative context and its effect on the ways of coping with such a crisis as well as the sustainability of its successes, if any.

Resilience, trust, and support are essential to impose drastic measures. The Continental European culture of supporting and trusting the state seems to be functional and “working” for realizing this fight against the coronavirus, but it can also result in a lesser propensity to collaborate across borders toward a common goal, by favoring the option of maintaining a coronanalional approach. Coronationalism, rather than European interaction and coordination, is therefore for the time being characteristic of the political-administrative management of the COVID-19 crisis.

Within the context of the EU, it is clear that to fight global crises, national responses are necessary but not sufficient. It is also obvious that to the extent that national responses are different and divergent, more coordination is required.

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