Full Title:

European Coronationalism? A Hot Spot Governing a Pandemic Crisis

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Biography

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Abstract:
###150 words###
The COVID-19 crisis has shown that European countries still remain poorly prepared for dealing and coping with health crises and for responding in a coordinated way to a severe influenza pandemic. Within the EU, the response to the COVID-19 virus has a striking diversity in its approach. By focusing on Belgium, France, Germany and Italy, four countries which represent different models of administrative systems in Europe, the analysis shows that major similarities and convergences have become apparent from a cross-countries perspective. Moreover, coping with the crises has been first and foremost an issue of the national states whereas the European voice has been weak. Hence, the countries’ immediate responses has appeared to be Corona-nationalistic, which we label as Coronationalism.
The paper shows to what extent 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.

Evidence for Practice:

- The COVID-19 pandemic crisis has shown that to fight global crises, national responses are necessary but not sufficient.
- As crises imply contingencies, national administrative standard operating procedures in preparation of crisis situations are partially helpful at best.
- Dynamic learning by doing seems to be relevant, but needs fast feedback and accountability mechanisms, quick matching responses, and corrective decisions and actions to play out.
- Irrespective of the public administrative system, (inter-level and inter-sectional) coordination is a central feature of effective crisis management.
- In the four countries compared – Belgium, France, Germany, Italy – the multilevel administrative setting has had an important influence on the activation and functioning of risk management procedures.

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European Coronationalism? A Hot Spot Governing a Pandemic Crisis

During the last two decades, the globalized world has been exposed to a series of pandemics (SARS-CoV 2002/03, global influenza 2004/05, swine flu 2009/10, global influenza 2017/18, global influenza 2019/20). In the light of these events, national governments around the world, also 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 still 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 similarly global, sustained and threatening public health emergency (WHO 2019, 2–3). Even if in 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 have rarely been exercised in preparation to 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 strikingly from an EU perspective, coping with the crises 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 as 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 e.g. crisis management (Boin et al. 2016; Boin and Lodge 2016; Christensen et al. 2016), policy failures (Peters 2015), or blame avoidance (Mortensen 2013; Hood 2010). There are also several theories and models about dramatic changes of realities, such as change management (Fernandez and Rainey, 2006) with 'burning platforms' (Skinner 2016), disruptive and sustainable innovations (Osborne et al, 2005), or transformation governance (Grin et al, 2010).

This contribution compares struggles of national governments in the first four months of 2020 to develop, establish and/or use mechanisms for crisis governance as a response to cope with the COVID-19 virus within the diverse scenery of the EU. The focus of this article is thus on the question of how national crisis response mechanisms (in the Corona crisis) look like and by which factors their design and use are influenced. On the other hand, we – at this early stage – do not discuss implications of the measures taken on the basis of these crisis management mechanisms.

The analysis focuses on Belgium, France, Germany and Italy, four countries which 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 setting (although with recent tendencies of decentralization), Germany is a federal state with strong Länder governments. Belgium has moved from a centralized (Napoleonic) country to a federal state where the subnational level, called 'regions', enjoy significant powers. We assume that these differences in the administrative settings will play a role when it comes to explain specific modes of crisis management, regarding a. monitoring, b. learning, c. decision making, d. coordinating, e. communicating, e. leading, and g. recovering capacity.

Two main points result from our comparison:

- to fight global crises national responses are necessary but not sufficient; and

- to the extent that national responses are different and divergent, more co-ordination is required. These differences and divergences can be explained mainly by institutional variance.

The paper shows to what extent 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. Drawing on this cross-countries comparative perspective, we will show that managing the COVID-19 crisis in Europe was predominantly shaped by distinct country-specific approaches instead of (convergent) Europeanized action.

a. Monitoring: When and how to start defining and solving which problem?

The scope of the problem hit many countries by surprise, as almost nobody expected Europe to be the next epicenter of the virus outbreak, after China. The EU's agency that was established to avoid and contain such a crisis, the Stockholm-based ECDC, failed to alert its EU member states. Within the EU, Italy became the first hot spot, with a second wave hitting France, Spain and Austria, and a third wave in Belgium, the Netherlands and Germany. Central and Eastern European countries showed less registered cases. Highly affected non-EU countries were the UK, Norway and Switzerland. In general, dynamics differed and reasons for different impacts also differed from country to country.

The importance of 'early warning' detection systems is 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 deliveries. The different attention paid by countries to the updating of their pandemic preparedness plans (Box 1), has probably been reflected in a different attitude and awareness towards the threat. The different governance structure for epidemiological risk analyses and pandemic plans was also influential.

< Insert Box 1 here >

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. In this delay the national institutions began to prepare, although there was no common practice of testing that allowed to identify the exact number of contaminations. Notwithstanding these similarities, there are also important differences to be observed between 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 in 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, due to 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 bottom up. (Box 1). In Belgium, a three steps 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 very differently, and evolved, depending on the policy and intensity of testing, on the organizational coverage (hospitals, centers of care, private homes), the

geographical perimeter (regional vs national), and on the procedure of data collection (centralized vs decentralized). Overall, coordination of monitoring systems at 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.

b. Learning from whom? How to put effective practices and operations in place

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

Almost all European countries went through a number of health and other crises, and developed readiness plans. In Germany, there was a history of managing floods (2003), and influenza (2009 and 2017/18), and there are operational emergency plans and risk analyses available since 2013 for pandemics and floods. However, in reality these plans were not practiced, and where not linked to risk management. In France, in periods of major crises, such as the terror attacks in 2015 (Charlie Hebdo), or sanitary crises (such as several heat waves; 2003, 2006, 2019), central government takes over and starts running the system. In Italy, the Civil Protection Department has a long experience for crises intervention in e.g. earthquakes (1976 Friuli, 1980 Irpinia, 1997 Umbria, 2009 L'Aquila, 2012 Emilia Romagna, 2016 Lazio), and floods (1994 Piemonte, 1998 Campania, 2000 Piemonte), however, not in health crises. In Belgium, the dioxine crisis (1999), influenza crises (2007, 2009-2010), and a terrorist attack (March 2016) positioned action and response plans. All these experiences have resulted in different approaches in disaster management (Box 2). For instance, the Italian Civil Protection Department consolidated experiences in crisis management, but at the same time has never directly managed a big pandemic. Neither have the corresponding actors in other European countries.

< Insert Box 2 here >

Even if this was a helpful starting position, the rapid global spread of this type of crisis, a lack of practicing, a 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.

Dynamic learning *by doing* seems to be relevant, but needs functioning and fast feedback and accountability mechanisms, quick matching responses, and corrective decisions and actions. One of the so-called 'solutions', i.e. 'closing borders', resulted in many problems and was also implemented inconsistently (with exceptions for commuters). The issue was which borders to close for what, and by whom? The European Economic Area (EEA) is one space with open borders and free movement for persons, goods, services, and capital. These free movements are limited across the EU for persons (non-Schengen countries), or when there is a national emergency. Member States are still responsible for external EU borders which are a complex set of international airports and harbours, and physical outer country borders. The European Border and Coast Guard Agency (Frontex) assists EU member states and Schengen associated countries

(e.g. Switzerland) to manage these external borders and to harmonize EU border control. Overall, in some cases the 'closing border' solution was part of symbolic policies by national politicians under pressure to take visible measures for their domestic audiences. In other words, these policies provide another prime example of "Coronationalism".

c. 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 up collective immunity through spreading the virus in the 'herd', was opposed to the 'contain' logic which needs 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) following the 'contain' logic, whereas the UK, and the Netherlands initially followed the 'herd' logic. Sweden took a different approach by, on the one hand, pursuing the contain-logic (stopping the virus from spread) in particular by the government issuing official recommendations of conduct notably to risk groups, but, on the other hand, abstaining from restrictive measures, such as lockdowns, and contenting itself with voluntary citizens' compliance regarding social distancing and other hygiene precautions. What explains these differences? In the four Napoleonic and Classical Continental European countries examined, the clear separation of state and society and the perceived supremacy of the state vis-à-vis the society, which are essential elements of the administrative culture of each country (Kuhlmann and Wollmann 2019, p. 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 towards 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 which was, at least initially, adopted in the UK, 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 UK and the Netherlands, after a while, shifted to the 'contain' logic which can be interpreted as a convergence in pandemic management paradigms. A range of reasons ('collateral damages' getting too high; experts 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 'contain logic' has resulted in a similar mix of shutdowns, lockdowns, contact-bans and events cancellation. Security forces have been responsible for monitoring these measures and punishing non-compliance. The substantial equivalence of the choices made, appears to be of particular interest also in consideration of the different general mode of crisis management which has distinguished the four countries (Box 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, e.g. France and Belgium, there was a national strategy from the beginning. In other countries, e.g. Germany and Italy, there was initially a regional logic, defined in some

regions, which then resulted in a national political co-ordination, 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 takes a middle position because 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.

d. 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, e.g. top-down versus bottom-up decision-making, co-ordination of measures, linking experts and administrators, or linking administrators and politicians.

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

Most countries have secured co-ordination through a central ministry (health, or interiors, or prime minister), or a department of agency (civil protection). However, the classical co-ordination problem of silo's remains a point of attention to avoid disconnects. This has been particularly evident as regards sanitary and public health policies as the number of subjects involved in the legislation and execution is very high, especially in Germany and Italy (Box 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 to the Länder. To achieve nation-wide solutions and uniform standards, in Germany, the horizontal self-coordination of all 16 Länder plus the vertical involvement of the federal level are 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 Commission coordinates regular contacts between European Ministers for Health, and for Interiors.

Co-ordination by expertise has also been evident. Health experts are at the crossroad of politicians, administrators, and the population at large. Legal burdens, limitations, or restrictions for electronic transfers of data, tele-working, 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 co-ordination, at the national or at EU level, are 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), 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, extra-ordinary measures such as 'plenary powers', or 'national emergency powers' allow to tackle these very complex, even wicked problems.

e. Communicating: Whom to convince and how?

Framing and effective communication requires a simple and straight forward logic.
To move from monitoring and risk management to grounded decisions which 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, i.e. vertically (all levels of government), and across society, i.e. horizontally (private sector, NGOs, and the citizens).
In all cases the key official communication was centralized and monopolized by the highest political leadership communicating directly to the population. All speeches by heads of state or government include three components: first, enhancing awareness by emphasizing gravity, difference from past diseases, and with the need for urgent and drastic measures, but also, second, providing re-assurance 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 (like national ministers of health) with scientists, particularly medical doctors specialized 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 sport 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 to be closed in the period of Lent and Easter, something which 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 %, the highest in five year's (De Feo 2020). Government support for contact-bans in Germany peaked at 87% immediately after the decision was taken (to shrink however to 64% by 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 protest. In Belgium the minority government already suffered from a lack of trust before the crisis started.

The popularity rate 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 issue mixed signals regarding the opportunity to take drastic measures, behaving accordingly 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, results in controversies about statistics, unavailable equipment, and aid. It also results in the President of the Republic to call 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 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 one 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 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 lock-down 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 persons younger than thirty (HLN 2020). There were also concerns that measures did not reach closed communities and minority groups. Life styles in Southern Europe, too, encourage an affectionate kind of social behavior. Also, to anticipate and avoid lock-downs in small apartments, or away from 'home', the announcement, or leaking, of lock-down 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 for instance: Bundesverfassungsgericht 2020). People also increasingly organized in (new) social movements (such as Widerstand 2020) and mobilized against the Corona directives for getting back their constitutional rights of liberty (about 5,000 people on 2nd of May 2020 in the City of Stuttgart; see SWR aktuell 2020).

f. 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 allows 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 e.g. 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.

Crises 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 for disconnected decision making systems when a multi-level government needs important vertical co-ordination 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 Box 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 it 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 (BSE), commonly known as the mad cow disease in the 1990s, as well as in the euro crisis (2009-2014) 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 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, like e.g. which Commissioners are part of the Corona virus response team.

g. 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 et al, 2005). There are major differences between countries concerning hospital capacity and coverage by social security systems (Box 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 of e.g. hospital capacity.

< Insert Box 3 here >

It could be expected that countries that have cut in the past their 'unnecessary' capacity, reducing their health spending as % of GDP and/or the number of hospital beds per 1.000 inhabitants, will have to mobilize more resources to 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 has been 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 between 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 virus 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-countries perspective. They all followed the contain logics, activated their risk management procedures, and increased hospital capacities. On the other hand, each country pursued its own Coronationalistic 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 or mixed 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 due to lack of practicing procedures, lack of related risk assessments, and insufficient co-ordination 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 to take these contingencies into account, rather than using decision making models from systems that are differently designed.

Co-ordination takes different shapes. There is institutional co-ordination which is enforced top-down (France), to predominantly top-down with operational bottom-up (Italy), to delegated/negotiated/coordinated top-down with significant bottom-up (Belgium and Germany). There is organizational co-ordination, which may be based on standard competencies or on exceptional and ad hoc platforms. Finally, there is expert co-ordination 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 decisions taken. Practice will benefit from complementary channels of communication.

Leadership was crucial and varied. In some countries, the central government and executive branch was leading in a hierarchical way. However, in other countries, a more shared and networked way was matching the institutional settings. Practice will benefit to explore the legal frames, and also to develop cultures of co-operation.

Capacity was existing or had to be created through re-allocating resources. Practice will benefit to guarantee levels of flexibility to activate and re-allocate resources.

At this (early) stage of assessment, our paper 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 Corona but it can also result in a lesser propensity to collaborate across borders towards a common goal, by thus favoring the option of maintaining a Corona-national 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 became clear that to fight global crises national responses are necessary but not sufficient. It also was obvious that to the extent that national responses are different and divergent, more co-ordination is required.

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Box 1: Regulatory design for management of health crises (pandemics)

	Belgium	France	Germany	Italy
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 plans	2009	2011	2016	2010
Formal risk management procedures and structures	No specific procedures for health related crises except for general emergency procedures and structures	Activation of "standard operating procedures", including CORRUSS[1] and National Defense and Security Committee, beginning of January	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 (25th of March 2020)	Activation of Civil Protection Operational Committee, end of January

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

[1] Operational Centre for the Regulation and Response to Sanitary and Social crisis.

Box 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 re-allocation. 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 ministeries and agencies	Regional Health Agencies (Agences regionals 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				
Disaster Management	Federal Minister for Interiors (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 Corona 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 Corona crisis predominantly local health authorities	National Civil Protection Agency – Independent organization inside the Presidency of Ministers' Council
Declaration of pandemic emergency of national concern	Federal competency: National/federal coordination when two or more provinces are involved, or provincial competence is	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	So far no legal provision; newly introduced during the Corona crisis by the Federal government (with parliamentary	Ministers' Council resolution adopted according to the existing legislation without Parliamentary approval (January, the 31st, first two cases of Chinese

	insufficient	with approval of parliament	approval)	tourist in Rome). Activation of Civil Protection Operational Committee
Shutdowns/ lockdowns/ contact-bans/ cancelling of events	National Security Council (Federal PM, and relevant ministers, regional PMs, top civil servants); National Crisis Centre (NCCN):	First half of March: first voluntary; As of 17 March: President announces shut-down of nurseries and schools As of 23 March: President declares sanitary emergency: general lockdown	Initially, separate statutory orders by 16 Länder; later: coordinated federal-Länder-agreements; implementation of Länder orders by cities/counties;	National Government decision, initially limited to some red zone (21 February), then extended to the country (9 March).
Controlling of measures and punishment for non-compliance	Federal and local police	Local policy supported by national gendarmerie	Länder police; local authorities for public order and safety	National Police, Armies, Local Police
General Mode of Crisis Management	Centralised + negotiated with regions; decentralised 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: Own compilation of information based on online references on the country-cases at the end of the article.

Box 3: National health capacity (to manage the Corona pandemic crisis) in four European countries

	Belgium	France	Germany	Italy
Health spending as % of GDP (2019)*	8,8 %	9 %	11.2 %	6 %
Euro/capita/year in US dollar (2018)	4.944	4.965	5.986	3.428
Hospital beds per 1.000 inhabitants (2017)**	5.7	6	8	3.2
Total of intensive care beds (ICU) (2019); number of short-term increase in ICU during COVID-19 crisis	1.900 (=16.5 per 100.000 population); increase to about 24 ICU / 100.000 population (beginning of April 2020)	5.832 (2018) (=11.4 per 100.000 population); +3.000 (end of March 2020)	28.031 (=33.7 per 100.000 population) of which 25.000 with ventilation capacity; +12.000 (end of March 2020)	5.090 (=8.4 per 100.000 population); +3.700 (end of March 2020).
Social security and health system	SHI-based health system; financing flowing from global SHI-contributions; centralized health government in coordination with SHI	SHI-based health system; financing based partly on contributions and partly on tax-like duties; centralized health government in coordination with SHI	SHI-based health system; financing based on social contributions; health self-government (health corporatism)	Regionalized public health service; tax-based financing; regional health planning, organization and governance

* Health spending as % of GDP in EU average: 7,4 %.
** Hospital beds per 1.000 inhabitants in EU average: 5.

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