WHO'S IN CHARGE AND WHY?
CENTRALISATION WITHIN AND BETWEEN GOVERNMENTS

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Summary: Successful response to the COVID-19 pandemic requires coordination within and across governments. Within governments, heads of governments gathered together power and authority early in the response, concentrating power and energy at the centre of government. Across governments, different governments adopted differing approaches to coordinating pandemic response between central governments, regions, and local government. In many cases, policy was temporarily centralised in federations, with the central government making more policies than usual. In the second wave, there seems to be less centralisation, particularly in federations, and regional or local governments are more prominent.

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Public health planners have long argued for a "command and control" approach to pandemics.[1] Governments almost universally adopted that approach early in the pandemic. The result was that for a few months in 2020, politics looked very different in many countries. Policymaking became far more centralised and hierarchical than usual, with less regional and ministerial autonomy and more empowered heads of government. Normal politics is slowly returning, even as the pandemic continues. The challenge is to learn lessons about ways to coordinate during and after a health crisis that are sensitive to the complexities of politics.

There are two different kinds of centralisation visible in the pandemic so far. One is *within governments*. In this case, the head of a government – any government, from a town hall to a country – gathers together the power normally dispersed across different ministries, politicians, and agencies. The other is *between governments*. In this case, power that is normally in the hands of one government, such as a local government, or regional governments such as Italian or Spanish regions or the states of Austria or Germany, shifts to the central government.

Both kinds of centralisation were at work across Europe in spring and summer 2020. Within government, heads of government centralised power at the expense of ministerial and agency autonomy, whether by running policy directly, by empowering ministers, or by working closely with existing agencies. Hands-off approaches were seemingly not politically viable for heads of government. In

intergovernmental relations, the response in many countries was a degree of centralisation as well as an unusual degree of coordination, but basic constitutional mechanisms and political incentives are hard to override for long, and countries with problems of intergovernmental conflict, blame shifting, and poor coordination started to see them re-emerge quickly.

Centralising within governments: taking control of the COVID response at the top

In early March 2020, COVID-19 moved from being a public health or health ministry problem to being, in every sense, a whole of society problem requiring (at least) a whole of government response. Furthermore, it was clear that citizens were looking to their governments, and that the political stakes of success and failure were enormous.

In country after country, heads of government reacted by taking control of responses, on their own or with the health minister. *De facto* power moved from ministries to the head of government, often working through a special task force or sub-cabinet. In some countries, this meant the health ministry was highly visible and important; in others, the head of government clearly dominated. At least 21 European region countries passed emergency legislation.

As the first wave of COVID-19 spread across Europe, the day to day response was frequently centralised through different tools. As reported in our previous policy snapshot,[2] in Canada, Estonia, Finland, France, Israel, Serbia and Ukraine, the pandemic response was led by the Prime Minister's Office. In other countries, such as the Czech Republic, Greece, Lithuania and Slovenia, the Minister of Health was at the forefront of the governmental response to COVID-19. Finally, heads of government work in tandem and share equal responsibility with Ministers of health in a subset of countries, including Estonia, Lithuania, Latvia and Malta. A second tool, often found in special COVID-19 legislation or existing law, is the creation of a coordinating committee that enhances intersectoral governance by centralising authority in a body that represents the key sectors involved in response. Most countries have established or activated such a body, led by top politicians or their delegates. The Russian Federation government established a Coordination Council led by the Prime Minister and the Mayor of Moscow to coordinate all actions at the federal, regional, and municipal levels. Non-federal countries created different types of institutional designs to coordinate the response, such as special government emergency committees (Lithuania, North Macedonia, Ukraine, Finland), an Operational Intersectoral Headquarter (Serbia) or an interagency working group led by the Minister of Social Affairs (Estonia). A subset of countries empowered pre-existing entities, such as the Croatian National Civil Protection Authority or the Dutch National Institute for Public Health and the Environment, which became the main coordinating actors in the national response to COVID-19.

Specialist and generalist government have had their objectives aligned

We can take away a general point. Most of government, including health ministries, is what Daniel Fox calls "specialist government." People in it specialise in particular issues and advocate for attention to those issues. A smaller and more powerful segment of government, typically around the head of government and the finance ministry, is "generalist government." Generalist government's key job is to make the trade-offs between goals and sectors – between health and education spending, between taxation and spending levels, or between legislative priorities. As Fox writes, "Most practitioners of public health in government are, by definition, specialists. To succeed in the politics of making and implementing policy they must earn and maintain reciprocal loyalty with generalists."[3]

In the case of COVID-19, a public health issue had the undivided attention of generalist government for a very long time. Unsurprisingly, generalist government did not simply delegate management of a worldwide pandemic to health ministries or public health agencies. The interesting variation is in how much attention and respect generalist government gave them. What kind of status, organisation, and strategies led to a prominent place for established public health agencies and actors in these newly centralised governance approaches? In some cases, the public health agency was firmly in the lead, as in South Korea. In others, it was side-lined, firmly subordinated to political leaders, as in France, or even – as in England – eliminated and folded into a new agency with little warning.

The most globally visible case to diverge from this pattern was Sweden. Sweden has an unusually high level of legal autonomy for its government agencies. Legally and politically, the Swedish prime minister or health minister have relatively limited power over its public health agency, and only at a high political price could they instigate conflict by publicly contradicting it. This enabled the Swedish public health agency, led by its high-profile state epidemiologist, to pursue a strategy unusual in Europe of limited constraint on mobility. What is interesting here is whether a country with a less autonomous public health agency would have chosen a different route. It is intriguing that in the one high-profile European country where the public health agency was autonomous and led the response, the chosen response was so polemical.

Centralising between governments

There are many merits to federalism and decentralisation. For example, one virtue is that it means a layer of governments that can take action to compensate for unconstructive behaviour by the central government (as we have seen in a number of the world's big federations).[4] But policymaking in a decentralised country is harder, with more need for coordination and less unity because governments can be of different political colours. In some cases, as with the current Scottish and Catalan governments, they do not even agree with the central state on its legitimacy. Formally unitary states are not exempt from the need to coordinate. Local governments are often politically important and legitimate and possess resources that are necessary for public health and social policy responses.

Coordinating with them involves a certain amount of inevitable friction and there can be political incentives to create conflict or try to shift blame.

As reported in our policy snapshot on federal countries,[5] coordination challenges appear in all the major areas of the COVID-19 response. **Table 1** identifies key areas. *Governance* to decision-making: the general procedures that governments within a country use to make and implement decisions. In many cases, regional autonomy has been somewhat curtailed, though many of the measures curtailing regional autonomy are temporary.

In terms of *preventing transmission,* which means mechanisms such as physical distancing and surveillance, regional autonomy has mostly remained. This might reflect the fact that regional governments often are the ones with resources such as contact tracing staff or police. Notably, some countries such as Spain and Belgium, which have complex territorial politics, have at least temporarily centralised the acquisition of personal protective equipment (PPE). In *ensuring sufficient physical infrastructure and workforce capacity,* insofar as there is a pattern it is one of persisting regional autonomy or of central governments acting unilaterally (e.g. by easing restrictions on professional mobility). In *efficient health care service provision,* likewise, there is a mixture of centralisation and regional diversity. In both of these areas, there is a strong case for regional autonomy and regional governments empirically have resources on the ground, but they might lack the ability to coordinate for efficient patient flows without central direction or might not command elements of the legal infrastructure (such as professional regulation) necessary to optimise responses. Finally, and very strikingly, we did not find change in health financing outside a fairly limited change in Belgium. This might make sense in social insurance systems, where there is often some distance between social insurance funds and regional governments, but it is an area to watch. Broadly, there is more political responsiveness in Berveridgean national health service (NHS) model systems such as Spain, the United Kingdom, Italy, and Canada, where substantial health expenditures come out of general government budgets and where unexpected health challenges can create unexpected problems.

In general, as with much of health politics in federations beneath the confusion there is a basic rationality at work, with central governments handling issues that require large risk pools and regional ones issues that handle local knowledge and resources. Strikingly, we found no case of change in the basic territorial politics of entitlements, which is important. If regional governments did not take the opportunity of the crisis to restrict benefits, and instead expanded them, that will have good effects on public health, including avoiding avoidable new outbreaks.

Given that federations do have clear coordination problems, how do they deal with them? One way is *voluntary cooperation* in which regional governments identify and solve shared problems among themselves or with the central state guidance or control. In Italy, each region adopted its own approach to testing based on national and international recommendations but as testing capacity greatly varied by regions, national guidelines were issued by the central government to outline the basic criteria for testing. With respect to protective equipment, the German federal government delivered stocks of PPE to the Länder, which were responsible for allocating and distributing the material to regional health care providers. Though there is in those countries regional budgetary autonomy, investment in public health infrastructure and new public health workers positions was coming from the federal government as it is the case in Germany. As for Spain, the transition strategy was released in late April and was meant to be coordinated with the Spanish regional authorities. Finally, regarding inner border closure, the Austrian state governments were in charge of executing decisions taken at the federal level, but were also free to apply stricter measures, such as quarantine for smaller regions severely hit by the crisis.

The second way is *centralisation* of powers and functions[6] in the hands of the central state. This can be for immediate functional reasons, e.g. to acquire supplies at a better price and coordinate logistics, or to reduce popular confusion about closure and reopening measures. In Germany, the "Act for protecting the public health in an epidemic situation of national importance" granted the Ministry of Health (MoH) expanded but temporary power. The federal MoH was consequently authorised to take measures regarding the provision of pharmaceutical and medical devices and to strengthen the medical workforce. These new powers will, however, expire on 1st April 2021. In countries with particularly difficult central-regional politics, the question of whether centralising measures will be temporary or permanent is obviously charged and has not been entirely resolved. In Spain, a Royal Decree declared a state of emergency on 14 March and put all publicly funded health authorities under the direct order of the Ministry of Health. The Spanish MoH was therefore temporarily entitled to implement COVID-19 related measures across the whole country. In Italy, a country whose health care system is highly decentralised, the MoH issued a series of regulations increasing the availability of health professionals and requiring all regions to increase health care capacity. In most cases our data does not show any change to the formal role of local government. Few clearly permanent changes have been made to federal arrangements; this might be a data limitation but, if true, it is an interesting contrast to the centralisation seen in some federations[7] due to the global financial crisis of 2008–2012.

The third way is *continuing regional diversity and autonomy* when there is a case for local implementation and decision-making or when the political situation makes coordination or centralisation unrealistic, resulting in a variety of responses. Despite the increased role of the central government, Italian regions still retain decision-making autonomy regarding the delivery and organisation of health services, such as whether to conduct COVID-19 tests in the entire regional population or whether to suspend or maintain medical services, such as surgical procedures. In Spain, although all publicly funded

Table 1: Level of coordination of policy responses

POLICY RESPONSES	ACTIVITIES	VOLUNTARY COORDINATION	POWER CENTRALIZATION	REGIONS RETAINING AUTONOMY
Governance	–	Belgium Spain	Austria Belgium Germany Italy Spain Switzerland United Kingdom	Italy Spain Switzerland
Preventing transmission	**Health communication**	Canada	–	Canada
	Physical distancing	–	Italy Switzerland	Belgium Canada Germany (during the transition phase)
	Isolation and Quarantine	–	Canada	Austria Canada Italy
	Monitoring and Surveillance	Canada	–	Austria Canada Spain
	Testing & Contact Tracing	Canada Germany Italy	Austria	Belgium Canada Italy Switzerland
	Protective equipment (purchasing and distribution)	Germany	Austria Belgium (before the transition phase) Germany (for the acquisition of PPE) Italy Spain	Belgium (during the transition phase) Germany (for the distribution of PPE)
Ensuring sufficient physical infrastructure and workforce capacity	**Physical infrastructure**	Belgium	Austria Canada	Canada Italy
	Workforce	–	Italy Spain	Belgium Canada Germany Italy
Providing health services effectively	**Planning services**	Canada Germany	Italy Spain	Switzerland
	Managing cases	–	Austria Italy	Canada Italy
	Maintaining essential services	–	Switzerland	Italy
Paying for services	**Health financing**	–	Belgium (for hospitals)	Belgium (for nursing homes and facilities for people with disabilities)

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authorities are temporarily supervised by the central government, regional and local public health administrations still retain operational management of health services. Swiss cantons are free to organise the cantonal response to COVID-19, which has led to great variation in the organisation of testing and treatment across regions. In Germany, measures to expand the workforce involved in treating COVID-19 patients were instigated by individual hospitals, cities or regions, with limited overall coordination and planning at the federal level.

As we might expect, *decentralising between governments* is also a tactic that is becoming increasingly prominent. Central governments that centralised in the first wave might choose to share more responsibility – and blame – with their local and regional governments in the second wave. There is a case for local and regional pre-eminence in many areas since local and regional governments have resources and knowledge on the ground that central governments often lack, but there is also a risk that responsibility and blame are being shifted without resources, money, or power.

Lessons learned: Centralisation is not enough, diversity can be an asset

We should not be surprised to have seen a high degree of centralisation around heads of government. The magnitude of the COVID-19 crisis, and the way it affected every dimension of life, meant that it had to be the focus of the entire government. Whole-of-government responses to health problems are famously hard to achieve, but the pandemic caused them nearly everywhere.

We learned that centralisation is not enough. Concentrating power has undeniable advantages if we assume that the concentrated power is used effectively. As we have seen, that is not always the case. Adopting the wrong decisions, a lack of political leadership or a lack of trust on the side of the population may render centralisation of power ineffective. Decentralisation produces coordination problems but diversity can be an asset if it reduces the effect of any one mistaken, delayed, or ineffective policy.

In addition, not all kinds of centralisation are the same. In some cases, individual regional or local governments were more or less rigorous than their state governments would have chosen. Simply taking away their powers might be unwise as well as unconstitutional, but conditional support for them in managing their problems (e.g. construction or improvement of state-wide surveillance systems) might shape their behaviour.

The return of normal politics

A dramatic centralisation of power within governments was always going to be largely temporary, outside cases of democratic backsliding. As the literature on Health in All Policies shows, there are powerful fissiparous forces within government that mean agencies as different as the police, health care providers, and schools, for example, will have distinct interests and be hard to coordinate.[8,9] Controlling them takes not just impressive energy and focus at the centre of government, but also a shared sense of crisis and mission that inevitably abates. As soon as the perceived importance and consensus on the challenge crumbles, centralisation is likely to fall apart. Generalist government will move on – if nothing else, to shaping and responding to the enormous effects of COVID-19 on everything from small business to gender equity to housing markets.

Centralisation and coordination problems, in particular within federal countries, are a different kind of issue. COVID-19 did not lead to widespread constitutional change. The regional governments of Austria, Belgium, Germany, Italy, Spain, Switzerland, and the UK all remain powerful and autonomous actors with their own politics, resources, and legitimacy. That they were willing to tolerate, or unable to prevent, centralisation in many cases does not mean that authority and power have actually shifted for good. Indeed, pandemic response, and the politics of blame, might actually make intergovernmental relations more difficult in the near future. We already see public arguments between major regions and their central governments in cases as different as Scotland and the Madrid region of Spain. This trend may be reinforced by the dwindling financial base of public health and health care, due to falling tax revenues and falling social insurance contributions. Very quickly, conflicts around the sustainability of health finance may arise, replacing the investment policies of today with by austerity like measures.

Conclusion

Policymakers should not be too impressed by some of the short-term centralisation we saw in federations. Normal politics is coming back, and will assert itself in COVID-19 response and recovery as well as all the other issues. It would probably be wise to draw lessons about better coordination and alignment that can work outside the kind of rush we saw in early 2020, since many countries are showing far less unity as they enter the second wave of COVID-19. More robust coordination mechanisms, grounded in clear law and political agreements, are hard to build but the pandemic might offer an opportunity to build them since nobody can rely forever on the ability of elected central, regional, and local governments to get along.

Most crises come and go and the after-action report and learning risk being forgotten. COVID-19 is not such a crisis. Until there is a safe and widely distributed vaccine, the need for public health response will continue. Political consensus and societal patience might not. As a result, it is an opportunity to learn from the governance experiments so far and build stronger mechanisms that can serve in this pandemic and inevitable future ones.

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