CENTRALISATION AND DECENTRALISATION IN A CRISIS: HOW CREDIT AND BLAME SHAPE GOVERNANCE

By: Scott L. Greer, Michelle Falkenbach, Holly Jarman, Olga Lőblová, Sarah Rozenblum, Noah Williams and Matthias Wismar

Summary: The COVID-19 pandemic led to unprecedented challenges and political creativity worldwide. In governance, this often led to unexpected centralisation and decentralisation in response to case surges. Changes in the distribution of power and responsibility throughout governments changed quickly as the pandemic progressed. Centralisation and decentralisation occurred within governments and between governments, as power shifted. The main explanation for the patterns of centralisation and decentralisation is the politics of credit and blame. Politicians at all levels seek to centralise when there is credit to be had from forceful action and decentralise when there are unpopular policies or bad news coming.

Keywords: Governance, Centralisation, Decentralisation, COVID-19, Politics

Centralisation and decentralisation occurred between and within governments

The COVID-19 pandemic was far from business as usual, and governments responded with dramatic measures in governance as well as in policy. Governance is how societies make and implement decisions. In an analysis of the key components of governance, participation in decision-making, transparency of decisions, policy capacity, integrity and accountability were key dimensions, and changes in centralisation in a pandemic affect them all. In the tumult of 2020, governments and citizens alike learned a great deal about what is possible, helpful, and sustainable in governance.

There has long been a public health argument for “command and control” in emergencies, which critics would argue could overestimate the expertise and good intentions of central commanders. COVID-19 thus did not just give us an opportunity to evaluate that argument; it allowed us to understand the political logic of command and control and decentralisation. If public health scholars, practitioners, and researchers recommend approaches that are not politically
sustainable and do not respond to the changing politics of a health issue, they will be giving bad advice that might discredit them, undermine the people who listen to them, and limit the effectiveness of public health policies. This fact has long frustrated advocates of coordination, including intersectoral coordination such as Health in All Policies.

The first wave of the pandemic saw a wave of centralisation within governments almost everywhere. (see Table 1). Heads of government in different countries took control of both the agenda and the public administration, taking prominent roles in communications and often setting up their own advisory groups.

Centralisation between governments

Centralisation and decentralisation between governments is perhaps more recognised. It demonstrably shapes health systems and is a constant theme in the politics of some countries such as Spain and Belgium. Local and regional governments are often important actors in health and health care policy, specifically in pandemic-related policy. In a crisis it is not surprising that central governments choose to commandeer their resources or at least give them more direction than in normal times. This can mean a substantial shift from transactional to hierarchical relationships, as when the initial “state of alert” decrees in Spain gave the central government extensive powers, temporarily changing the normally transactional nature of Spanish politics and health policies. It can also mean political challenges to hierarchy, as posed by the Madrid regional government, and substantial shifts back to transaction later. Even in countries with relatively unitary public administration, such as Czechia, the role of regional public health agencies and governors varied over the pandemic.

A third way? Coordination among regional governments can be challenging

Making health policy through hierarchy and transaction is not appealing to many. So, is it possible for regional governments to coordinate amongst themselves effectively, without a key role for the central government? To a limited extent, yes. In countries with a long tradition of such coordination, established mechanisms for doing so, and party politics conducive to it, notably Germany, this seems to work. However, as the pandemic wore on, it turned out that voluntary horizontal coordination among regional governments was challenging to sustain over time, even in Germany. Voluntary horizontal coordination among governments depends on their leaders’ shared sense that they are on a team together and that there is an agreed-upon set of policy goals, neither of which is the normal state of politics.

Explaining centralisation and decentralisation: The politics of credit and blame

What explains these patterns? One of the key concepts of political science: the politics of credit and blame. Politicians who wish to be effective and elected seek credit and avoid blame. That is also how they get re-elected. Politicians’ focus on getting and staying in high office might not seem as statesmanlike as we could ask for, but a politician in office can almost always do more than a politician out of office. Therefore, it is quite effective to understand politics in terms of credit and blame as understood by particular politicians.

short-term malleability and long-term durability of governance structures

In the context of the first wave, in spring 2020, this meant that heads of government had enormous incentive to centralise power, creating hierarchies and emphasising their position at the top. Heads of government had all the reason to do so: they would be blamed if they declined the opportunity to be heroes, and they stood to reap credit for decisive action. It was time to be a hero. Other politicians such as regional health ministers were often initially happy to cede leadership since they would escape blame if things went badly. Thus, federal and regional governments in countries...
as different as Austria and Spain largely agreed to implement central direction and not raise questions about the unusual degree of centralisation.

In summer 2020, in Europe, centralisation continued, with heads of government taking credit for low case counts and the end of public health restrictions. But over the summer, in more and more countries the head of government began to quietly decentralise again, whether by letting emergency measures lapse or just holding fewer press conferences. Some leaders announced reopenings timed to facilitate public holidays, declaring (premature) victory. Decentralisation put other parts of government and other governments, such as regional governments, to the fore when the inevitable second wave hit.

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Box 1: “COVID-19: The end of new public management?”

Not everybody saw decentralisation within government as a bad thing. New Public Management (NPM) had often advocated for decentralisation within government in the decades prior to COVID-19. Independent agencies, purchaser–provider splits, strategic purchasing, and the addition of corporate structures such as boards to government departments were all efforts to create decentralisation within government. The idea was to tap expertise while creating agencies that could pursue set goals without interference. Thus, for example, the UK government deliberately attempted to divest much of its power over the National Health Service (NHS) to various agencies over previous decades, while an autonomous public health agency became something of an international model for communicable disease control. Unsurprisingly, governments took back a great deal of control at the expense of such agencies in the context of the 2020 crisis and gave orders where they might previously have tried to steer systems through contracts, competition, or regulations. In some cases, such as England, that recentralisation may last.

The efficiency that NPM was supposed to promote is also less clearly attractive now that COVID-19 has shown the extent to which there is a trade-off between efficiency (e.g. limited bed numbers) and resilience (ability to adapt to unexpected challenges such as COVID-19 posed). One major open question is whether governments will conclude that resilient and effective response to emergencies such as COVID-19 requires more hierarchy and resources and less of the elaborate and putatively efficiency-enhancing policies associated with NPM.

It is no accident that autumn 2020 in Europe was such a confusing time. Heads of government had mostly withdrawn from their highly exposed centralising positions, leaving the blame for rising cases and deaths, and renewed public health measures, to ministers, agency heads, and regional or local governments. This was a rational strategy for them, since by autumn 2020, the initial enthusiasm for leaders and health policy – symbolised by clapping for health care workers and surges in the popularity of almost all leaders – was long gone. Even if public opinion often remained positive about public health measures, political conversations shifted, with energised opponents of lockdown increasingly visible, the media looking for new stories of political conflict, and opposition parties seeking a basis on which to critique governments. In the countries where social policy measures were insufficient to support public health restrictions on the economy, the politics of public health were even more complicated since there was more blame and less credit to be had.

In short, in spring of 2020, when there was credit to be had in forceful action, heads of government centralised, accentuating hierarchy at the expense of their fellow ministers, agencies, and regional or local governments. In summer, when there was credit to be had in relaxing public health measures, heads of government did that and decentralised so that the expected next waves and lockdowns would be shared with others. Regional politicians often went along with this strategy, only using their positions to challenge the government and articulate different stances on issues such as restarting nightlife after the initial centralising, solidaristic dynamics of spring and summer 2020 had worn off. In autumn 2020 and onwards, when the next waves hit, there was less credit and more blame to be had, and a wide variety of voices with views on who merited blame and credit. Unfortunately for many heads of government in Europe, their inherited political institutions and cultures meant voters still attributed credit and blame to heads of government. This implied that the heads of government still often ended up imposing new public health measures and being the face of those measures.

Likewise, it was heads of government who received credit and blame during the varied experiences of vaccine acquisition and rolling out vaccination programmes in Europe.

Centralisation and decentralisation, credit and blame

COVID-19 made two things clear about governance. The first is the short-term malleability and long-term durability of governance structures. In the short term, such as spring-summer 2020, a crisis enables dramatic changes in governance and politics. But over time, the logic that led to federalism, independent agencies, or powerful ministers, reasserts itself. The lasting institutional effects of COVID-19 might be less than the politics of 2020, or even the voluminous emergency legislation of that year, might suggest. If there is a change, it might be in the loss of enthusiasm for new public management (NPM) reforms that deliberately fragment decision-making in efforts to replace hierarchical public sector organisations with various forms of internal markets. Centralisation within government of health care and health care services might be a lasting legacy after policymakers saw the needless complexity and limited resilience of many NPM ideas in a crisis (see Box 1).

The second is the extent that the politics of credit and blame are fundamental to pandemic governance. In country after country, from Czechia to the UK and from the US to Austria, the head of government proved able to briefly change governance, centralising and decentralising in order to make creditworthy decisions and then
gently decentralise more blame-attracting ones to agency heads, scientists, less powerful ministers or other governments.

**Conclusion**

It is a truism that good public health means “knowing your pandemic,” but that cannot be understood to mean that good public health allows us to ignore history and politics. Politics explains governance in many cases, and governance explains the effectiveness and the nature of governments’ response to COVID-19. Governance responses were a mixture of centralisation and decentralisation, and they reflected the particular ways that politicians understood credit and blame to work at different stages of the pandemic and in different political systems.

There is extensive debate about when and whether centralisation might be a good or bad idea. There is extensive debate about whether technical experts or heads of government should lead and communicate responses. But in addition to those excellent questions, there is a third question: what is the political viability and sustainability of the advice they produce? Recommending politically nonviable ideas can discredit public health experts, while recommending politically unsustainable ideas can discredit their allies in government as well.

**References**


**What are the key priority areas where European health systems can learn from each other?**

By: J Hansen, A Haarrmann, P Groenewegen, N Azzopardi Muscat, G Tomaselli, M Poldrugovac

**Copenhagen:** World Health Organization 2021

(acting as the host organization for, and secretariat of, the European Observatory on Health Systems and Policies)

**Observatory Policy Brief 41**

**Number of pages:** 33; **ISSN:** 1997-8073

**Freely available for download:** [https://eurohealthobservatory.who.int/publications/i/what-are-the-key-priority-areas-where-european-health-systems-can-learn-from-each-other](https://eurohealthobservatory.who.int/publications/i/what-are-the-key-priority-areas-where-european-health-systems-can-learn-from-each-other)

Health systems in Europe face numerous challenges which will only intensify following the shock of the COVID-19 pandemic. There is therefore an urgent need for innovative solutions to ensure that health systems provide accessible, high quality, responsive, affordable and financially sustainable health services. Cross-country comparisons are a valuable tool for capturing the range of innovative approaches countries have harnessed to address common challenges. However, in order to learn from each other, countries need to better understand what their common topics of interest are.

In this new policy brief, the authors draw on key documents and inputs from stakeholders within European health systems in order to propose a set of priorities for cross-country learning. These priorities focus on innovation areas that are likely to dominate the policy agendas of today and the years to come. This is the second of two briefs that set out key findings from the TO-REACH project, funded by the European Union’s Horizon 2020 programme.

The authors show that priorities for cross-country learning and innovation can be clustered in four domains: person- and population-centredness; integration of services across all health sectors and traditional health system boundaries; four key sectors of care requiring reform including, long-term care, hospital care, primary care and mental health care; and preconditions for improved functionality of the priority areas above. Certain supporting mechanisms are also needed across all sectors to improve the functionality of the identified priorities. In concluding, it is argued that the scale and nature of challenges faced by European health systems mean they cannot be met by Member States acting alone and a partnership is needed that brings together stakeholders from across European health systems.