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EUROPEAN NATIONAL HEALTH SYSTEMS IN FIGHTING AGAINST THE COVID-19 PANDEMIC

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European National Health Systems in Fighting against the COVID-19 Pandemic

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Preface

Health systems are responsible for delivering healthcare services that are supposed to improve, maintain and restore the health of individuals and their communities. Nevertheless, the COVID-19 pandemic has brought unprecedented pressure on the National Health Systems across Europe and great impact on national healthcare policies. Therefore, it is of great importance to have a better understanding of how individual European countries and their national health systems react to the pandemic as the systems differ from one to another.

This book provides a brief analysis on the European countries' National Health Systems against the backdrop of the coronavirus pandemic and the attendant uncertainties. The papers in this collection were written during the second season of the year, which was the critical and challenging moment for (mainly Western) European countries and their national health systems to contain the coronavirus outbreak, and then published as working papers of China-CEE Institute. Considering the time sensitivity, some of the ideas and data covered in the papers may need to be updated, but still the papers are able to present a general overview of National Health Systems of some European countries. The views in the book are represented by the individual authors instead of the China-CEE Institute.

The China-CEE Institute, registered as a non-profit limited company in Budapest, Hungary, was established by the Chinese Academy of Social Sciences (CASS) in April 2017. The China-CEE Institute builds ties and strengthens partnerships with academic institutions and think tanks in Hungary, Central and Eastern European countries, as well as other parts of

Europe. The China-CEE Institute aims to encourage scholars and researchers to carry out joint research and field studies, to organize seminars and lecture series, to hold some training programs for younger students, and to publish academic results, etc.

I hope this collection will be helpful for enriching the knowledge of the national health systems of European countries and promoting the mutual understanding between China and Europe.

Prof. Dr. CHEN Xin
Executive President and Managing Director, China-CEE Institute
Deputy Director General, Institute of European Studies, CASS

Why the Italian NHS Has Rapidly Reached Its Maximum Capacity in COVID-19 Pandemic?

LI Kaixuan[1]

Abstract

It seems paradoxical that in Italy, a European country with a world-class health care system, the fatality rate of COVID-19 patients has exceeded 10% on 25 March, 2020. Obviously, the Italian National Health Service (NHS) has already reached its maximum capability. In addition to the issue of aging population, the Italian NHS is facing the shortage of hospital beds and crucial medical equipment. The widening regional gap under the decentralized governance structure, constant public health cost containment, as well as the relatively low integration of General practitioners (GPs) practices have caused further concerns. Italian NHS can hardly beat the Coronavirus alone. As the COVID-19 disease has already become a global pandemic, only by deepening international cooperation can the world win the battle and contain its consequences.

***Key words**: Italian NHS; COVID-19; Regional Gap; Cost Containment; International Cooperation*

1. Introduction

Since the first local case has been found in Lombardy in mid-February 2020, Italy has become Europe's hardest-hit in the COVID-19 pandemic. On 25 March, 2020, the infected cases have reached 74,386 and the death toll is 7,503. The fatality rate reported between March 1 and March 25, 2020, has increased from 5% to 10.08% of actively infected patients. Currently, this percentage is too much higher than any countries in the world. It seems that

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1 Li Kaixuan, Associate Research Fellow, Academy of Marxism of the Chinese Academy of Social Sciences.

there is a paradox between the high fatality rate and the world-class health care system of Italy.

In fact, seven days at the initial phase of the pandemic, the health system has rapidly reached the limit in northern Italy. The shortage of ICU beds, medical staff and protective supplies has exposed from the beginning. In addition to the exponential growth of severe cases among aging people, it is another important cause that has dragged the Italian NHS in dilemma.

According to the assessment published by Lancet online in November 2019, aging population and gradual decrease of public health financing are two main concerning issues for the Italian NHS. These issues will pose challenges to the future of Italy’s health status. Unfortunately, huge challenges are coming too soon.

Furthermore, the decentralization of NHS and the low integration of primary care in Italy might also have limited the capability of Italian NHS to deal with the new risk.

Both the national government and the regional authorities have announced a series of countermeasures to slow down the fast growth of newly infected patients and intensive care cases. Local Health Authorities have implemented several measures to expand their capability to save lives. However, as the situation is becoming more emergent, the Italian NHS system has been at its maximum capacity. Hence, international assistance and cooperation are crucial to prepare Italian NHS to meet this unprecedented challenge.

2. Paradox and dilemma of Italian NHS in the COVID-19 Pandemic

In 1978, Italy’s tax-funded National Health Service (NHS; *Servizio Sanitario Nazionale*, SSN) was established. At the same time, health insurance funds were abolished by the reform. The main aims of NHS are to guarantee uniform levels of care throughout Italy, equitable access to services for all Italian citizens and legal residence in Italy, as well as health spending control. Furthermore, the Italian NHS claims that it also has three

guiding principles. The first one is universality—— all citizens have an equal right to access services provided. The second one is solidarity—— every citizen contributes to funding the NHS based on their means, through progressive taxation. The last one is uniformity——the quality of the services provided by the NHS in all regions must be uniform.

After reforms in 1990s, the Italian NHS was reshaped and became more efficient. In 2000, Italian health system ranked second in the world by the World Health Organization. Although Italy has introduced stringent cost cutting in health-related reforms, its NHS has maintained its world-class level of performance. In 2015, OECD and the European Observatory on Health Systems and Policies, affirmed Italian NHS's performance, given its effectiveness, access and resilience.

In November 2019, Lancet published the assessment on personal health-care access and quality with the Health-care Access and Quality (HAQ) Index for 195 countries and territories online. According the assessment on Italy, Italian NHS provides world's leading services. In 2017, life expectancy ranks Italy eighth globally for females and sixth for males, and an HAQ Index score of 94.9 in 2016 compared with 81.54 in 1990, keeps Italy ranked as ninth globally.[1] The assessment, presented several critical data from 1990 to 2017, including causes of death, years of life lost, years lived with disability, disability-adjusted life-years (DALYs), life expectancy at birth and at age 65 years, healthy life expectancy, and Healthcare Access and Quality (HAQ) Index.[2] The comparison between the estimates of Italy and other 15 European countries, shows that Italian NHS generally provides an excellent health care service, combining with Italian people's healthy behaviours, contributes to favourable overall health.

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1 GBD 2017 Italy Collaborators, "Italy's health performance, 1990–2017: findings from the Global Burden of Disease Study 2017", https://www.thelancet.com/action/showPdf?pii=S2468-2667%2819%2930189-6.

2 GBD 2017 Italy Collaborators, "Italy's health performance, 1990–2017: findings from the Global Burden of Disease Study 2017", https://www.thelancet.com/action/showPdf?pii=S2468-2667%2819%2930189-6.

However, under the attack of COVID-19, the Italian NHS's performance is not as good as expected. It seems that the growing fatality rate really contrasts with the praise that received in the past years.

When the COVID-19 suddenly become pandemic in northern Italy, the Italian NHS obviously has not been prepared. When the number of severe cases surged dramatically in a short time in the most prosperous Region——Lombardy, its heath care system is destined to deal with more complicated situations. Because the majority of those severe cases were elderly and had underlying health conditions, and more than two-thirds of them had diabetes, cardiovascular diseases, or cancer, or had been former smokers. They are even harder to be cured.

In addition, Italian elderly died patients had acute respiratory distress syndrome, needed intensive care and would not have died otherwise.[1] Hence, combining with the issue of elderly patients, the shortage of ICU beds and ventilators has rapidly dragged the health care system to the verge of collapse. Meanwhile, the health care workers have fallen into an ethical dilemma, for the decision to be made about whom should be treated firstly. The physicians themselves, for the shortage of medical protective equipment, also have fallen in a health security dilemma.

3. Main Features of Italian NHS

As noted above, mostly for the number of elderly patients with COVID-19 increasing dramatically and the shortage of crucial medical materials, the NHS in Lombardy has fallen rapidly into dilemma. Then, the further question should be why the NHS in the most prosperous Region in Italy lacks ICU beds and medical materials so much, and why its southern counterparts cannot support it strongly? We might be able to get enlightenment by analyzing the main features of Italian NHS, including the

1 Amdrea Remuzzi, Giuseppe Remuzzi, "COVID-19 and Italy: what next?", https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30627-9/fulltext.

issues of organization, public financing trend and general practitioners practice model in primary care.

3.1 Decentralization and Heterogeneity of Italian NHS

In 1992-1993, the second reform of NHS introduced the essential benefit of package (*Livelli Essenziali di Assistenza*, LEA). In addition, the second reform also included four main elements: (1) regionalization; (2) managerialism;(3) quasi-market system;(4) opting-out of the NHS (Ferrè et al., 2014). The 1999 reform restated that health is one of citizens' basic rights and is a collective responsibility. After the reforms in 1990s, the configuration of Italian NHS has been complemented. It has elements of an internal market in several regions. Local health authorities and public hospitals enjoy managerial autonomy in each Region. Especially after the reform of the Constitutional Law in 2001, Italy's regions gained more autonomy and power from national government. Therefore, Italy' s health care system is essentially a decentralized and regionally organized NHS, and there is a health care gap between poor southern regions and richer northern regions.

At national level, the central government sets the legislative framework for health care. Being supported by several specialized agencies, such as the National Health Council (*Consiglio Superiore di Sanità*, CSS), the National Institute of Health (*Istituto Superiore di Sanità*, ISS) ,the Italian Medicines Agency (*Agenzia italiana del farmaco*, AIFA) etc., the Ministry of Health defines the fundamental principles and goals of the NHS, as well as the essential benefit package and standard of health services in regions. Ministry of Health also has the function to allocate available funds to the regional health systems, to monitor the operation of NHS and to manage the National Institutes for Scientific Research (IRCCS).

The Regions and Autonomous Provinces are exclusively in charge of organizing and managing health services, and of the implementation of LEA. Through its elected Regional Council, each Region conducts

legislative activities by defining its general rules about the roles of the regional authority, Local Health Authorities (*Aziende Sanitarie Locali*, ASLs) and Public Hospital Enterprises (Aziende Ospedaliere, AOs) and private providers, criteria for financing and technical and management guidelines. The regional Department of Health plays the main executive role on regional level. It is in charge of drafting Regional Health Plan, defining the criteria for accrediting public and private health-care providers and monitoring their service quality, as well as defining the geographical boundaries of ASLs and AOs, appointing their directors and allocating resources to them (Ferrè et al., 2014).

Within each Region, ASLs are responsible for organization and delivery of health care service on local level. ASLs are population-based local authorities with geographical boundaries. The territory of ASLs are divided into smaller Districts. Each District with a coverage of about 60000 inhabitants, directly manage public health and primary care services on institutional level. The Department of Prevention in ASL provides preventive medicine and public health services. General practitioners (GPs) delivering family medicine services, play a role as gatekeeper to higher levels of care. But these GPs are not salaried employees of ASLs, they sign contracts with NHS and Agreed Inter-regional Sanitary Structure (Struttura Interregionale Sanitari Convenzionati, SISAC). Secondary care providers can be hospitals owned by the ASLs or be public hospital enterprises, i.e. the AOs. In the latter case, the ASLs perform as buyers of services. It depends on individual regions to choose whether to opt for buyer-provider separation (Ferrè et al., 2014).

In different Region, the relationships between providers of health and social care services and the ASLs are different. For instance, in Tuscany and Emilia-Romagna, the system is strongly centralized. Most hospitals remain under ASL control, and only a handful become AOs. In Lombardy, it is exactly on the opposite side. Since 1998, all hospital and specialist services have been provided by AOs or private providers. ASLs negotiate financing terms with AOs, and control the quality of services provided.

There is an internal market in Lombardy health care system. Although there have been some changes in subsequent years, the basic mode of operation is still the same. Currently, in Lazio, Molise and Campania, there is a relatively high level of private care.

Another main regional variation of the Italian health-care system is in the distribution of health-care expenditure. Since the fiscal federalism process initiated in 2000s, the differences between public health funding are substantial. The public health care system is financed by an earmarked corporate tax (IRAP) on the value added of enterprises and on the salaries paid to public sector employees; a regional surcharge on the national income tax (addizionale IRPEF); a fixed proportion of national value-added tax (VAT) revenue collected by the central government for the national equalization fund (Ferrè et al., 2014). Hence, per capita public health expenditures in central and northern regions are above the national average, and in southern regions are below.

Generally speaking, the NHS in the northern Italy has higher capacity, more advanced technology than southern regions. It conducts the mobility of patients from southern Italy to north-central regions to obtain better perceived quality of care. Data from the Ministry of Health show the southern regions of Campania, Calabria and Sicily lose at least 30 000 patients a year in search of health care and attract far fewer.1 As a result, when there is a massive outbreak of COVID-19 in northern regions of Italy, it would be difficult to procure powerful help from their southern counterparts.

3.2 Gradual decrease of public financing

As noted above, Italian NHS is funded mainly through national and regional taxes, complemented by Out-of-Pocket (OOP) payments for

1 "Italy: Country Health Profile 2019", https://read.oecd-ilibrary.org/social-issues-migration-health/italy-country-health-profile-2019_cef1e5cb-en#page7.

outpatient care and pharmaceuticals. Since 1990s, public spending containment has been one of the main issues in health-related reforms. Especially after the fiscal federalism introduced in 2000s, responsibility of expenditure control has been strongly decentralized too. If Regions with large health-care expenditure deficits failed to comply with the financial recovery, would face strict sanctions, including suspension of staff turnover, mandated tax increase, appointment of a national government-appointed commissioner to temporarily oversee the management. In the sense of budget control, the Italian health system has been ongoing a centralization. However, the power is shifting from Ministry of Health to Ministry of Economics and Finance.

Since 2008, to response the financial crisis and public budget constraints imposed by European Commission and European Central Bank, the Italian central government had increased its efforts to reduce health care costs. In 2009, the maximum level for the health care budget deficit in Region was originally set at 7% but was reduced to 5%. Stricter cost-reduction measures have been introduced by central government. For instance, from 2010 to 2013, Italian NHS reduced significantly the expenditure caps on purchasing medical equipment and services. Central government also has directly cut health care expenditure on several items, such as the payment of personnel, recruitment, standards for hospital care (e.g. minimum size of hospitals), as well as the requirement to reduce the number of hospital beds to 3.7 per 1000 inhabitants from 4 previously. In fact, in 2017, the number of hospital beds is only 3.07 per 1000 inhabitants in Italy. In Lombardy, the "red zone" of the COVID-19 crisis in 2020, the number is 2.97, and it is 3.34 in the South of Italy. In 2017, the number of doctors per 1000 inhabitants is reduced to 3.99 nationally. The number of public hospitals has been decreased dramatically from 613 in 2014 to 576 in 2017,

and the number of accredited private facilities has been reduced from 506 in 2014 to 479 in 2017.1

In Italy, total health expenditure is composed by three parts. The major one is public sources, which is decreasing gradually in recent years, accounted for about 75%-78%. The second share of health spending is OOP payments. It has increased constantly from 21% in 2009 to 23.5% in 2017.[2] The last tiny share (about 2%) is funded by private health care insurance and mutual funds.

Data from OECD show that in 2017, total Italian health expenditure accounted for 8.8% of GDP, lower than the EU average of 9.8%. 3 Public spending share decreased from 7% of GDP in 2010 to 6.5% in 2017, below the EU average too.4

That is why medical workers in Lombardy have already fallen into a double-dilemma at the initial stages of transmission. On one side, it is in the ethical sense that the physicians even have to choose whom to be treated firstly for the shortage of ICU beds etc. On the other side, it is about occupational safety, that the doctors themselves have been at the high risk of infection, for shortage of protective suits and trained medical peers like them.

3.3 Low Integration in Primary Care

Theoretically, the Italian NHS was designed to be a very integrated system. The national level has exclusive authority in defining the essential benefit package, i.e. LEA as mentioned above, that must be guaranteed uniformly

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1 All the data are avalible on Istat website, http://dati.istat.it/?lang=en&SubSessionId=ef8c6eee-9946-4d40-9500-98afa9062069#.
2 “Italy : Country Health Profile 2019” ttps://read.oecd-ilibrary.org/social-issues-migration-health/italy-country-health-profile-2019_cef1e5cb-en#page16
3 “Italy : Country Health Profile 2019”, https://read.oecd-ilibrary.org/social-issues-migration-health/italy-country-health-profile-2019_cef1e5cb-en#page8.
4 “Health expenditure and financing”, https://stats.oecd.org/Index.aspx?DataSetCode=SHA.

across the country. ASLs are the institutions that virtually organize, control and deliver health-related services, and the delivery of essential benefit package is organized by ASLs in every Region three health-care categories: public health services; community health care, including primary care; hospital health care, i.e. secondary care.

As noted above, given the reforms which introduced quasi-market mechanism, separated health service purchasers and provider, put focus on expenditure containment since 1990s, the variation and heterogeneity of the NHS are not avoidable across the country. Meanwhile, the reforms have barely improved the integration level of primary care.

Primary care is responsible to provide continuous health services by appropriate coordination. However, primary care is still mainly based on solo-practice general practitioners (GPs) in Italy. GPs and pediatricians who are delivering family medicine services, play a role as gatekeeper to higher levels of care. GPs are not salaried employees of ASLs, but self-employed and independent doctors. They sign contracts with NHS and Agreed Inter-regional Sanitary Structure, i.e. SISAC as mentioned above, paid mainly based on the capitation fee on the number of registered patients. For many years, primary care delivered by GPs are in a less inter-professional and collaborative way, especially in southern regions. There is a gap between front-line staff and patients. Even though patients increasingly need health professionals working in a coordinated way to ensure quality of care. Since 2005, national government and regional authorities have made efforts to promote GPs voluntarily formed group practice for increasing degrees of integration. Currently, a summary of various types of integrated practice models are available. But, primary care is still dominated by the traditional model of GPs, i.e. working in single practices.

To compensate the insufficient primary care, especially the poor home care and long-term care, a disproportional amount of their expenditure has been devoted to secondary care for establishing small size of hospitals. The repetition establishment of small size hospitals, hasn’t significantly

promoted group practice and other organizational models based on a variety of health professionals. As a result, it crowded out resources that should be allocated to median size of hospitals. The median size hospitals in Italy is one-third less than that in Germany, France and Austria, and around half of that in the UK.

Therefore, the less integrated model of GPs practice in primary care, limits its capability to identify and handle new epidemic, such as COVID-19. And the small hospitals accounting for a large proportion, which are designed to make up the long-term care and home care, do not have adequate resources and medical staff to deal with COVID-19 emergency.

4. Countermeasures Adopted by Italian Authorities

The Italian central government responded quickly in this COVID-19 crisis. Firstly, on 31 January, 2020, the national government suspended all flights to and from China and declared a state of National Public Health Emergency after first cases of coronavirus were confirmed in Italy. Secondly, the central government announced decrees to contain infected population at national level. On March 8, 2020, the Italian Government announced a series of lockdown measures to expand the quarantine, including travel restrictions and a ban on public gatherings. But obviously, it is not enough. The situation is getting more critical. The number of newly infected patients hasn't started to decrease within 3-4 days from March 11 as optimistically predicted by Italian experts.[1] Therefore, Italian Prime Minister Giuseppe Conte signed another decree to stop unnecessary production activities across the country since 23 March, 2020. However, the most effective way to decrease the peak of the tsunami of cases, is to make sure all the measures be carried out strictly.

Given the governance structure of Italian NHS system, the central government is in charge of promoting the three fundamental principles of

1 https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30627-9/fulltext

NHS, i.e. university, solidarity and uniformity to be implemented on executive-level in each Region. Meanwhile, the central government releases the cost-containment by increasing temporarily public funding devoted in health system to expand hospital capability. The other essential option adopted by the Italian government is to recall retired medical doctors and nurses, and to hire graduated doctors who have not received the enabling license yet.

At regional level, the governments and Local Health Authorities, which in charge of NHS at executive-level, have adopted measures to increase beds for patients with COVID-19. Hence, the number public and private ICU beds increased from 640 in Lombardy at initial phase to more than 900 on 20 March, 2020. In addition, the regions in central and Southern Italy are currently estimated to be about 11-14 days behind the situation in Lombardy, and these regions are scrambling to expand their capacity, for example by converting other wards to intensive care use.

However, the number of infections increases exponentially every day in Italy. Italian NHS's capacity in Lombardy and Emilia-Romagna to effectively meet the needs of COVID-19 patients who require admission to an ICU for ARDS, has already reached the limit. It will be a matter of grave concern in Italian southern regions. Only the "lockdown and stop" decrees announced by Italian government implemented effectively, the pressure on the health care workers will be released in future.

A general consensus is forming that the COVID-19 crisis is a global challenge, and it requires cooperation across different countries. As countermeasures are adopting, Italy has received international assistance for several days. Due to 25 March, 2020, China, emerging from the hardest moment in its own battle, has sent several groups of experienced doctors to aid, as well as more than one hundred tons of medical material to Italy. The medical material includes ventilators, monitors, protective suits, N95 masks, medical masks, quarantine masks and traditional Chinese patent medicines. A flood of aid from China has enabled Italy to save lives. The investment in the Italy-China friendship has been paid off and the return

from China has improved significantly the capability of Italy to heal the sick. The People who scoffed at the idea of Italy joining the Belt and Road Initiative, it is time for them to acknowledge the fact, as Italian Foreign Minister Luigi Di Maio confessed in an interview with Italian National Radio and Television (Radio televisione italiana, RAI) on 24 March, 2020. As reported, Russia and Cuba also have expressed the solidarity with Italian people, by sending expert teams and medical resources. Germany announced to receive patients from Italy too.

5. Conclusion

It is really a paradox for the fatality rate in the country like Italy with a world-class health care system. Certainly, aging population is one of the main causes. Elderly patient with COVID-19 concentrated in a short time, makes the situation more complicated in Italy. Meanwhile, the shortage of hospital beds, specially of ICU beds, medical resources and trained medical staff become the other apparent cause, that has worsened the situation initially. When the NHS in the most prosperous northern Region in Italy hit the ceiling rapidly at short notice, the number of elderly deaths with COVID-19 started to rise substantially day by day.

In addition to the issue of aging population, the regional gap for the decentralization governance structure, downward trend in public health-related spending, as well as the relatively low integration of GPs practices have caused further concerns. As Italian NHS is an essentially decentralized and regionally organized health care system, the medical performance gap between poor southern regions and richer northern regions has widened gradually in recent years. For the NHS in northern "red-zone", it is hard to get powerful support from their southern counterparts to significantly improve the situation. Moreover, since 1990s, cost containment has been the focus in health-related reforms. Expenditure cutting, inevitably caused shortage of trained medical staff and medical materials.

The integration and coordination between general practitioners and district services is relatively low, and it is not conductive to improving the capability of primary care in Italy. To compensate this problem, small size hospitals have been established at a large proportion, and the number of medium-size hospitals in Italy is far fewer than that in Germany and France. It may contain the Italian NHS overall capability in front of the unprecedented public health challenge.

Italian authorities have adopted several extraordinary countermeasures to respond the COVID-19 crisis. However, Italy can hardly beat the Coronavirus alone. As the COVID-19 disease has already become a global pandemic, only by deepening international cooperation can the world win the battle and contain its consequences.

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NHS System Under the Shocking Coronavirus: Overview, Response and Evaluation

Xiaoyu Zhu[1] Yujie Gan[2]

Abstract

The Covid-19 is impacting Europe's public health system. This article focuses on the British public medical system's response to the Covid-19 epidemic. We systematically reviewed the UK's National Health System (NHS), such as its historical origins, organizational structure, financing channels, carrying capacity and performance. On this basis, we focus on the response measures of the UK NHS system under the impact of the Covid-19, and we especially summarize the changes in the response strategies adopted by the NHS as the epidemic develops. Finally, we analyze the reasons and logic behind the policy changes. Through international comparative analysis, we summarize the policy logic under different national conditions and resource constraints. At the end of the article, we conducted a final summary assessment of the NHS, such as its advantages and challenges, and gave our policy recommendations based on the full context.

Keywords: *UK NHS; Covid-19; Healthcare System*

1. NHS System in the UK

The National Health Service (NHS) is major provider of healthcare service in the UK. It is a publicly funded healthcare system that aims to provide 'health and high-quality care for all, now and for future generations'.

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1 Xiaoyu Zhu, Post-Doctoral Research Fellow, the Chinese Academy of Fiscal Science.
2 Yujie Gan, Assistant Professor, School of Government, Peking University.

1.1 History

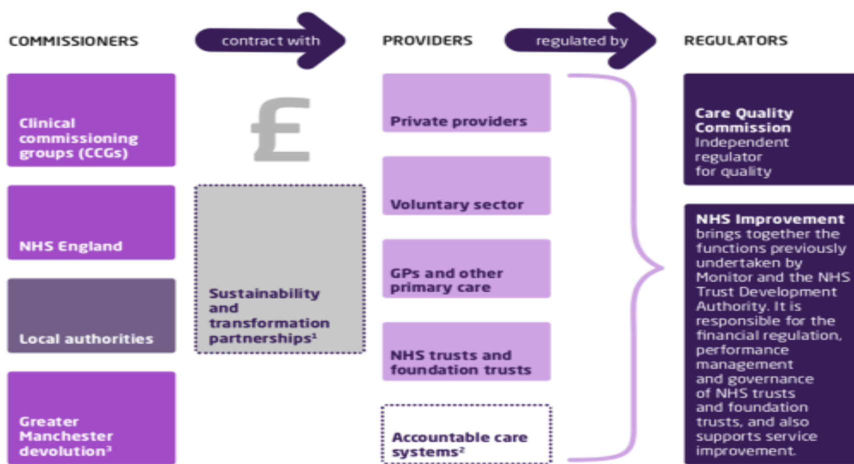
In 1948, Labour overcomes opposition from doctors' leaders to establish the NHS, which was financed by central taxation, effectively nationalizing healthcare and providing treatment free at the point of use. Since 1974, a large-scale administrative reorganization of the NHS in England planned by the Tories is implemented by an incoming Labour government, placing all health services into regional and area health authorities. In 1987, Conservative prime minister Margaret Thatcher commissions a review of the NHS, amid concerns over growing financial pressures. This leads to the creation of the "internal market" in 1991 under the auspices of the then health secretary Ken Clarke. The market splits health authorities (which commission care for their local population) from hospital trusts (which compete to provide care). GP fundholding, which gives some family doctors budgets to buy care on their patients' behalf, is introduced.

In 2000, after the NHS staggered under the pressures of a winter hospital crisis, Labour responded with an ambitious "NHS plan" and massively increases investment. It re-adopted the principles of competition and markets, expanded the PFI, or private finance initiative, to build scores of hospitals through private enterprise, and hired firms to provide some clinical services, while drawing up a vast array of performance targets and national guidelines in an attempt to create uniform standards of care. Primary care trusts were created to purchase healthcare on behalf of GPs. Prior to the election in 2010, the Conservatives promised to avoid "massive structural reorganization", but the health secretary Andrew Lansley had drawn up radical plans which would give spending power back to GPs, sideline primary care trusts, give the private sector a bigger role, and dismantle much of the architecture of regulation and targets introduced by Labour. Commentators called the proposed changes the biggest reorganization of the NHS for decades.

1.2 Structure

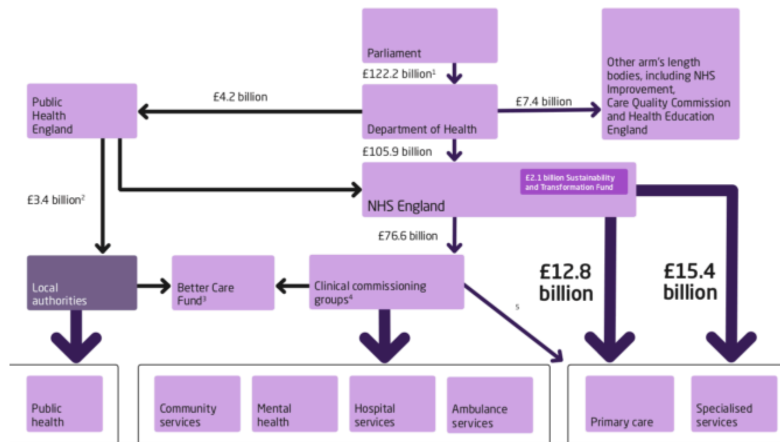
The NHS is mainly responsible for Nationally commissioned services, and CCG (Clinical Commissioning Groups) oversees Locally commissioned services. Figure 1 and figure 2 show how providers are regulated and commissioned, and how the money flows.

Figure 1: How providers are regulated and commissioned



Source: Department of Health (2017). Annual report and accounts 2016-17. London: Department of Health. Available at: www.gov.uk/government/publications/department-of-health-annual-report-and-accounts-2016-to-2017

Figure 2: How the money flows



Source: National Audit Office (2017). A short guide to the Department of Health and NHS England. London: The Stationery Office. Available at: www.nao.org.uk/report/short-guide-for-health/

Primary care, as the core of Nationally commissioned services, is essentially the system of health care available outside of the hospital setting, often in close physical proximity to the people it serves. It may take many forms and is provided by a range of health care professionals. It has two essential characteristics: in most cases, it provides the first point of contact for a person seeking advice on, or treatment of, a health concern and it provides continuous access to general medical care for common conditions and injuries, often with a designated health care professional taking primary responsibility for that person. The system also tends to play a gatekeeping role in determining access to more specialized, often hospital-based, acute health care services.

The focal point for primary care is the GP (General Practice) or the GP practice consisting of a group of GPs working together. GPs provide a range of preventative, diagnostic and curative primary care services. They are usually the first point of contact for a person and also act as gatekeepers to secondary care, although people can attend the A&E department in an

acute hospital if they believe their condition is sufficiently urgent. The primary health care team based around general practice may include doctors, nurses, physiotherapists, counsellors, speech therapists and administrative staff.

Secondary and tertiary care, commissioned by CCGs, are provided mainly in hospital settings by specialist doctors working with a range of other health professionals (e.g. nurses, therapists, diagnostic professionals). Patients may stay overnight in the hospital or, as is increasingly the case, are treated as day cases. Most of this care is provided and paid by the public sector although there is also a sizeable private sector. The NHS also provides some private care (i.e. care not paid for by the state). In addition, some care is provided for the NHS by private- sector hospitals.

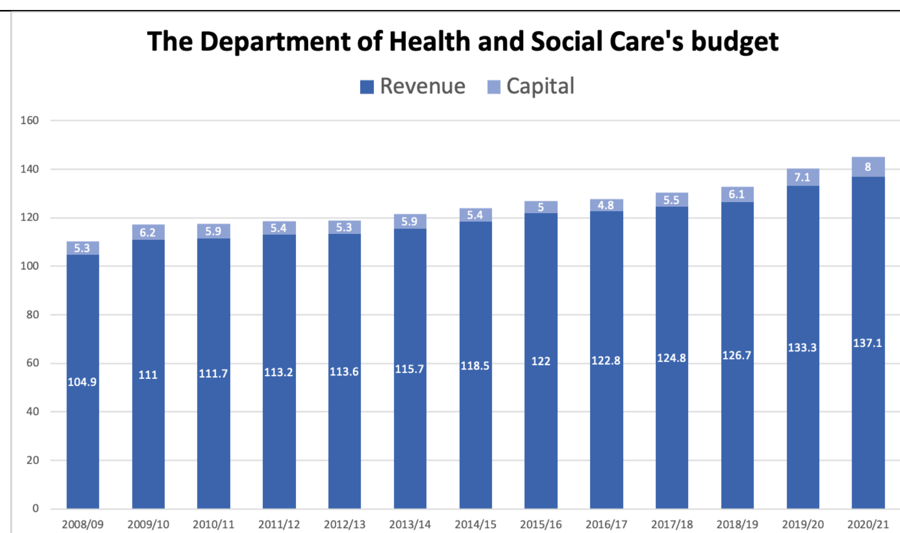
To access NHS specialist care, patients require a referral for a consultation from a GP, though they may also be admitted as an emergency. Patients can also pay out of pocket for a private consultation or be referred through a PMI scheme if they are members of such a scheme.

1.3 Finance

1.3.1 Budget

Planned spending for the Department of Health and Social Care in England is £140.4 billion in 2019/20. The majority (£133.3 billion) of this is revenue funding for spending on day-to-day items such as staff salaries and medicines. The remainder (£7.1 billion) is for capital spending on buildings and equipment, which are longer term investments.

Figure 3: The NHS budgets and how it has changed



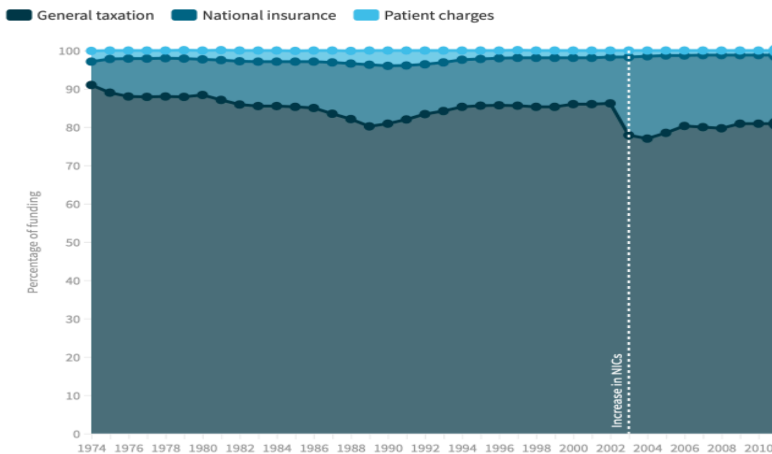
Source: Health at a glance (OECD, 2017).

Though funding for the Department of Health and Social Care continues to grow, the rate of growth slowed during the period of austerity that followed the 2008 economic crash. Budgets rose by 1.4 per cent each year on average (adjusting for inflation) in the 10 years between 2009/10 to 2018/19, compared to the 3.7 per cent average growth rate since the NHS was established.

1.3.2 Funding

The general taxation accounts for the vast majority (about 80%) of NHS funding. From April 2003, National Insurance Contributions were increased to boost NHS funding. This increased the share of NHS funding (about 18%) that comes from National Insurance Contributions. In addition, a small proportion (about 2%) of NHS funding comes from patient charges.

Figure 4: Sources of funding for the NHS



Source: Hawe and Cockcroft (2013). Available at: https://www.kingsfund.org.uk/projects/nhs-in-a-nutshell/how-nhs-funded

Around 10% of GDP is spent on health care in 2016. Some 60% of the NHS budget is used to pay staff. A further 20% pays for drugs and other supplies, with the remaining 20% split between buildings, equipment, training costs, medical equipment, catering and cleaning. Nearly 80% of the total budget is distributed by local trusts in line with the particular health priorities in their areas.

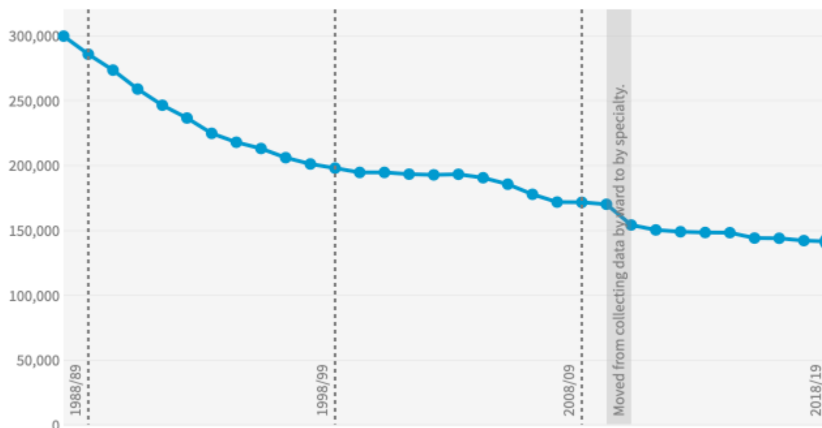
Health spending has experienced significant growth since 1949/50, at an average annual real rate of 3.7% up to 2014/15. After uneven growth between the 1970s and the late 1990s, the last Labour government oversaw an acceleration of the increases in spending on the National Health Service, pushing up health spending to around 7% of national income prior to the recession. While other departments have experienced budget cuts as part of the coalition government's program of austerity, spending on health has been increased in real terms. This 'protection' nonetheless represents a tight funding environment for the NHS, not least as demographic pressure pushes up demand.

1.4 Capacity

1.4.1 Hospital beds

Over the past 30 years, the number of hospital beds in England has halved. Medical advances mean that patients don't have to stay in hospital for long, and a shift in policy towards providing treatment and care outside hospital has both contributed to the reduction.

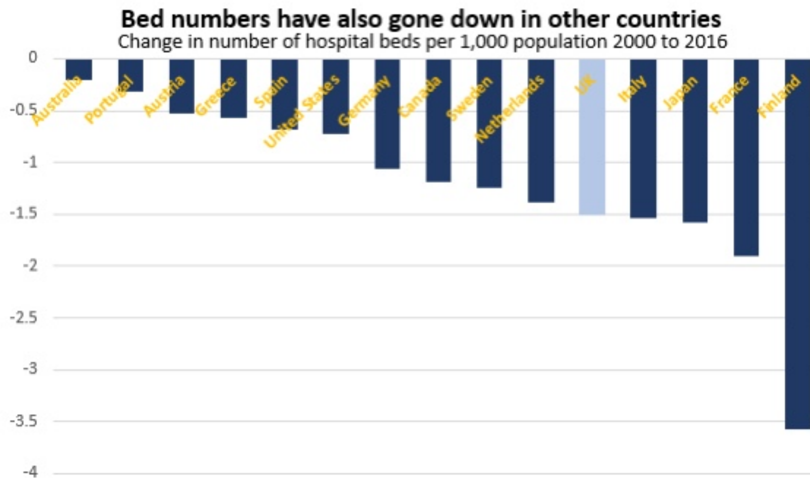
Figure 5: The number of hospital beds in England has halved over the past 30 years



Source: NHS England. Available at: https://www.kingsfund.org.uk/projects/nhs-in-a-nutshell/hospital-beds

Bed numbers have also gone down in other countries. However, the UK already has a low number of hospital beds: 2.6 per 1,000 population versus 6.1 in France and 8.1 in Germany. Low bed numbers can indicate good patient care – with patients being treated and able to return home more quickly – and can demonstrate resources are being used efficiently. However, the scarcity of beds can lead to high bed occupancy rates, increasing waiting times for patients.

Figure 6: Bed numbers have also gone down in other countries



Source: Glance at a health (OECD, 2018)

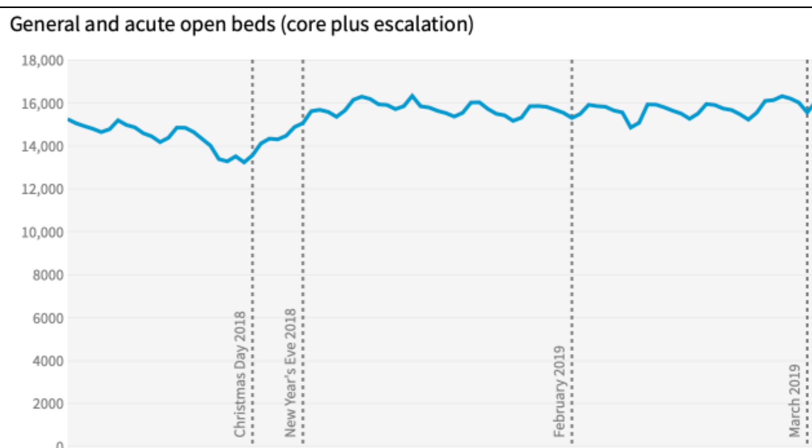
Hospitals often open more general and acute beds in winter when demand for services is very high. However, opening additional beds is costly and not as simple as it sounds. The NHS is in the middle of a workforce crisis, and hospitals are already struggling to staff existing beds. There is also limited space in existing buildings to house additional beds.

The medical resources such as ECMO and infectious disease" beds needed by severe patients are very limited in the UK, and most of them are currently occupied.

According to the government and NHS documents, there are 15 available beds for adult extracorporeal membrane oxygenation (ECMO) treatment at five centers across England. There were 30 such beds in total available during the 2018-19 winter flu season. ECMO has been used to treat Covid-19 cases in China, and UK is ordering more machines from Germany, according to media. Since the beginning of February there have been eight "high-consequence infectious disease" beds and around 500 "infectious

disease" beds. For most of last week, there were roughly 3,700 adult critical care beds in England, of which about 80% were occupied. This left 670 such beds free at the peak of occupancy.

Figure 7: General and acute beds in winter



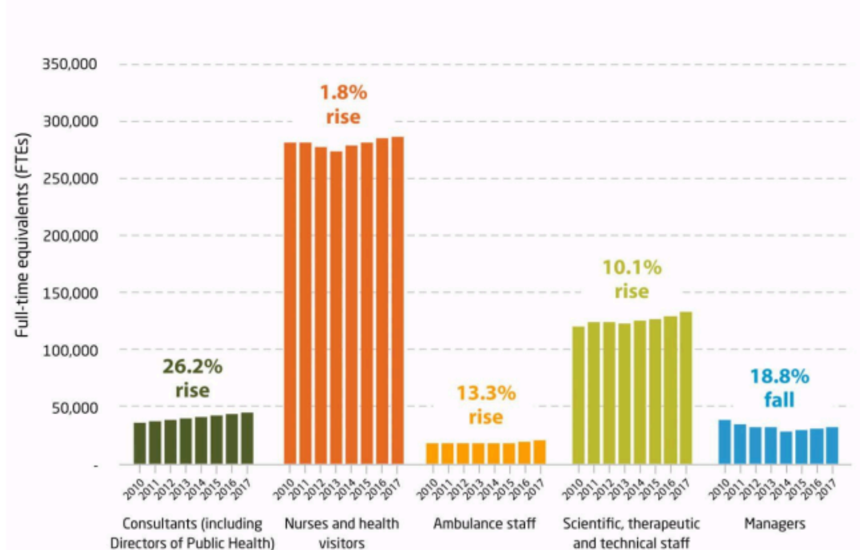
Source: NHS England. Available at:
https://www.kingsfund.org.uk/projects/nhs-in-a-nutshell/hospital-beds

1.4.2 Staffing

Staff are the backbone of a skilled service industry like health care and spending on staff is the single biggest cost for the NHS. The NHS in England employs just over 1 million full-time equivalent (FTE) staff (not including those working in general practice). This number has been increasing at about 0.5 per cent on average per year over the past seven years. Since 2010 there has been an increase in the number of staffs in all groups except managers and backroom support staff. The number of nursing staff has increased by 1.8 per cent from 281,064 FTEs in 2010 to 286,020 FTEs in 2017. The increase in nursing numbers reflects the NHS response to various reports on the quality of patient care. Despite this increase, there is a shortage of nurses in the NHS. Health Education

England has estimated a shortfall in nursing staff of approximately 8.9 per cent as of March 2015, and has projected that this could rise to 11.4 per cent by 2020.

Figure 8: NHS FTE staffing number outside general practice,2010-2017



Source: NHS workforce statistics-January 2017, National Health Service Pay Review Body 30th report 2017 (NHS, 2017).

1.5 Performance

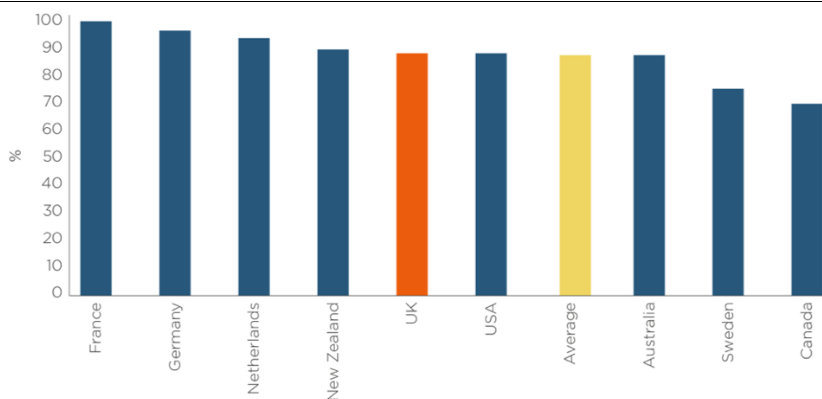
1.5.1 Waiting times

While the NHS largely provides care to everybody on the spot without high costs, how quickly it did so have long been a contentious issue. The British public name waiting times as one of the top reasons for dissatisfaction with the service.

A Commonwealth Fund survey recently asked people in several countries about how long they had waited to be treated the last time they visited an A&E department. They found that 88% of people in the UK reported

having been treated within four hours, a roughly average performance, as shown in Figure 9.

Figure 9: Proportion of people seen within four hours at emergency departments (2016)



Source: The Health Foundation (2017).

1.5.2 Performance on the 12 most lethal diseases

The table below summarizes how well the NHS appears to be doing, first on each of the 12 most lethal diseases, and then on the other three fields. As well as the NHS's performance in the latest year, it also looks at whether the UK has closed the gap over the last decade. This is relevant for outcome measures since most tend to improve over time as technology improves: a good health service should not just be performing well, but also getting better more quickly.

Table 1. Performance on the diseases

	Relative performance	Relative change over time
Breast cancer	Poor	Improving
Colorectal cancer	Poor	Improving
Lung cancer	Poor	Improving
Pancreatic cancer	Poor	Improving
Diabetes	Good	Unclear
Kidney disease*	Good	Unclear
Chronic obstructive pulmonary disease	Poor	Unclear
Lower respiratory tract infection*	Poor	Improving
Suicide*	Good	Unclear
Dementia*	Unclear	Unclear
Stroke	Poor	Improving
Heart attack	Poor	Unclear
Amenable mortality	Poor	Unclear
Patient experience	Good	Unclear
Birth	Poor	Unclear

* Data on performance is particularly limited for lower respiratory tract infection, the mental health conditions associated with suicide, and kidney disease, and is lacking altogether for dementia.

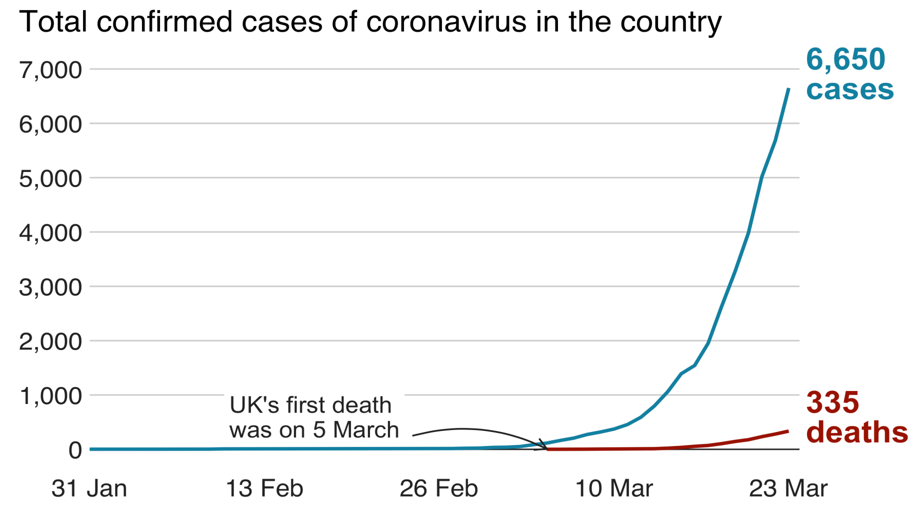
Source: Dayan M (2018).

2. Response

2.1 Coronavirus in UK (up to 25th Mar)

As of 9 a.m. on 25 March 2020, a total of 97,019 people has been tested, of which 87,490 were confirmed negative and 9,529 were confirmed positive. 463 patients in the UK who tested positive for coronavirus (COVID-19) have died. The figure below shows the increase in the number of confirmed cases in the UK.

Figure 10: Total confirmed cases of coronavirus in the country



Source: Public Health England, Updated:23 Mar. See https://www.gov.uk/government/organisations/public-health-england.

2.2 Timeline

The UK prevention policy can be divided into three stages, with March 3 and March 16 as the lines of demarcation.

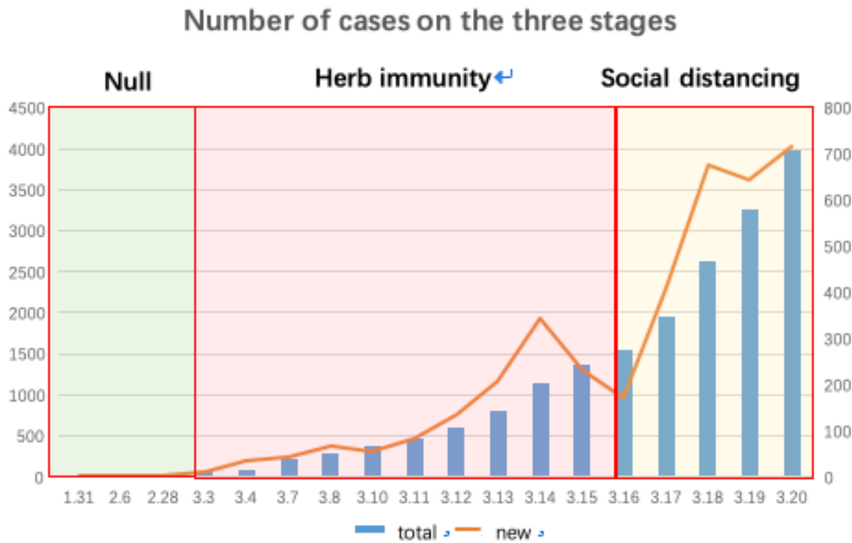
Before March 3, the number of cases in the UK was very small, and the vast majority were imported cases. The UK government was always concerned about the epidemic, but the measures taken were limited to the inside of the health system, and the focus of epidemic prevention was to prevent the external import of cases. Social life in the UK was as usual, and major events continue.

On March 3, the British government issued the coronavirus action plan, marking the second stage of the UK's epidemic prevention measures. In this stage, the British government adopted the group immunization strategy, which lasted until March 16. The coronavirus action plan is the UK's overall response to the epidemic, including the UK government's awareness of the virus, actions taken so far and actions to be taken. The

program divides the response to the epidemic into four stages: Containment-delay-research-mitigate. During this period, the number of cases in the UK increased rapidly, and the organizers of some large-scale events cancelled the event out of concern. At this stage, the British government adopted the group immunization strategy, trying to make most people gradually infected with the disease so as to obtain immunity. Sir Patrick Vallance said “our aim is to try and reduce the peak, broaden the peak, not suppress it completely. At this stage, the British government's epidemic prevention strategy is very negative: only issued some suggestions, almost no compulsory measures. They required people with mild symptoms stay home instead of hospital and NHS no longer detects mild symptoms. Social life remained normal, schools and entertainment venues were open as usual, and large-scale activities were carried out normally.

After March 16, great changes took place in British policy, and the British government began to take drastic action. The strategy of this period is social distance and self -solation, aiming to block the spread of the epidemic to the greatest extent. The UK passed the emergency bill quickly, giving the government more emergency powers and enabling the government to take compulsory measures. The British government asked everyone to avoid going out, closed all schools, forced the closure of restaurants and bars, and began to recall retired medical staff on a large scale. The British Prime Minister said the country had entered a state of war and would not rule out tougher measures.

Figure 11: Number of cases on the three stages



Source: Author self -made.

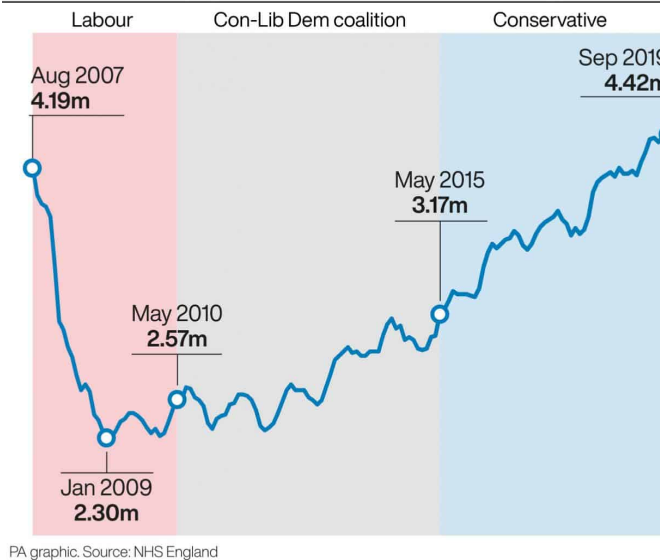
2.3 Criticism

As soon as the herd immunity policy was introduced, it aroused strong criticism. The World Health Organization (WHO) criticized this negative practice, hundreds of scientists wrote to UK government in protest. Some commentators denounced this policy as" Social Darwinism" or even "Nazi". All in all, it's a really controversial policy. So why does the British government dare to open this policy? It seems that there is no evidence to prove the policy is related to social Darwinism. This is just the political strategy of the Conservative Party headed by Johnson, which is forced by the reality.

The fact is that Britain's NHS has long been facing difficulties, and UK is one of the countries with the serious shortage of medical resources in developed countries, even worse than some developing countries. Numbers of UK's hospital beds per people is one of the lowest in the world and patients have to wait longer and longer in recent 10 years. The number of

doctors per thousand people in the UK is also far lower than that in EU countries.

Figure 12: Patients waiting for NHS treatment



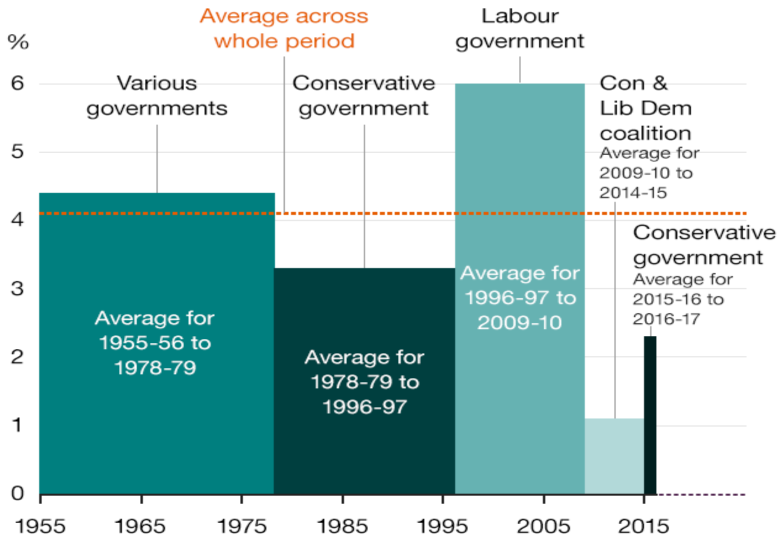
Source: NHS England. https://www.thelondoneconomic.com/politics/a-decade-of-tory-austerity-in-numbers/31/12/.

3. Evaluation

3.1 The reason behind the policies

The conservative party, as a neoliberal party, has always been ambivalent about the NHS. They should be responsible for its tensions. The growth rate of the NHS appropriation during conservative government is far less than that of the labor government.

Figure 13: Spending on health slowed down



Source: IFS. See https://www.bbc.co.uk/news/health-42572110

The Conservatives had tried to privatize the NHS for many times since the Thatcher era. They achieved their goal in secret. In fact, many services in the NHS system had already been outsourced up to now. For example, Virgin has been awarded almost £2bn worth of NHS contracts from 2013 to 2018. The company and its subsidiaries now hold at least 400 contracts across the public sector – ranging from healthcare in prisons to school immunization programs and dementia care for the elderly. In one year alone, the company's health arm, Virgin Care, won deals potentially worth £1bn to provide services around England.

The Conservative Party pursues **Neo liberalism** and **the concept of small government**. In recent decade, conservative government strictly control fiscal deficit and cut government spending by more than 100 billion pounds. A decade of austerity since 2010 has led to the reduction of public services

and social welfare, which is the root cause of the dilemma facing the NHS. The NHS appropriation growth rate has slowed significantly since 2010, while the UK is accelerating its ageing.

In this case, sudden and forceful measures will make the NHS under great pressure in the short term, expose the accumulated problems, and then turn into a crisis of public trust in the conservative party. The Conservatives are trying to avoid this for political reasons, and the herd immunization policy is believed to reduce and broaden the peak, which is naturally become a prior choice for conservative government.

Another potential reason is that the conservative government tried to use the theory of behavioral economics to guide the residents' action, deliberately exaggerating the danger so that they could not go out. There is a behavioral economics advisory team in the British Conservative cabinet, and Johnson's core staff publicized that he used behavioral economics in the Brexit propaganda. The British government openly admitted that the worry of people might have "behavioral fatigue" is the key reason that they refused the large-scale blockade at the beginning and “behavioral fatigue" is a key concept from behavioral economics.

3.2 Comparison of medical resources

The table below compares medical resources and financial investment in China, the UK and France. It can be seen that China's financial investment in medical care and per capita medical resources are obviously insufficient.

Table 2. Comparison of medical resources			
	China	UK	France
population	1.4billion (Wuhan 11milion)	66.5million	67million
Total number of hospital beds	6-6.5million (Wuhan 82,000)	150,000	34,5000
Number of available hospital beds per 1000 inhabitants	4.2 (Wuhan 7.4)	2.6	5.15
Number of doctors per 1000 inhabitants	2.6 (Wuhan3.6)	2.8	3.4
Number of nurses per 1000 inhabitants	2.9 (Wuhan4.9)	7.8	10.8
Total number of nurses and doctors per 1000 inhabitants	5.5 (Wuhan8.5)	10.6	14.2
Government(compulsory) health spending（US dollars／capita）	399	3138	4141
Voluntary health spending（US dollars／capita）	277	931	824
Total health spending (US dollars／capita)	688	4070	4965
Health spending ／GDP（%）	5.0	9.8	11.2

Source: OECD data, organized by author.

Although the per capita medical resources are not dominant, the blocked policy started in early time and effectively controlled the spread of the virus. Meanwhile, China has mobilized 344 national medical teams and 42322 medical workers from other regions of the country to support Hubei. The medical team of aiding Hubei directly took over the disease area and played

an important role in the process of the epidemic treatment. stopping movement in and out of Wuhan.

3.3 Assessment of NHS

3.3.1 Strengths

Improve public health: The universal health system allows every legal people in the country to get the basic health care. This health care also helps improving the general population health since people have equal access to free medical care.

Widespread accessibility: In Britain, the universal health care system is accessible throughout the breadth and length of the country. Whether it is in a rural area, countryside, or urban centers; almost all health services available.

Full coverage: This full coverage means every native and immigrant who has to obtain British citizenship can have health insurance which is provided and funded by the government.

Good financial protection: It provides unusually good financial protection to the public from the consequences of ill health. For example, it has the lowest proportion of people who skipped medicine due to cost (2.3% in 2016 compared to an average of 7.2% across the comparator countries).

Good performance in managing patients: It performs well in managing patients with some long-term conditions like diabetes and kidney diseases: fewer than one in a thousand people are admitted to hospital for diabetes in a given year, compared to over two in a thousand admitted in Austria or Germany.

3.3.2 Challenges

Aging population: When the NHS was created, life expectancy was 13 years shorter than it is now (2013). It is predicted that the proportion of the UK's aging population (aged 65 and over) would increase to nearly 25% in 2044.The NHS has to adapt to the fact that the workforce is reducing while the population in need of healthcare is growing.

Low wages for nurses and doctors: From the point of view of nurses and doctors as the government employees, the universal health care system is considered as not very fair. They do not receive the rewarding financial packages. For the sensitive and significant professions of doctors and nurses, they are often complaining about low wages under the universal health care system.

Lack of staff: EU will affect physicians from EU countries, about 11% of the physician workforce. A survey suggests 60% would be considering leaving the UK if Brexit happened, as they had doubts that they and their families can live in the country. Record numbers of EU nationals (17,197 EU staff working in the NHS which include nurses and doctors) left in 2016.

Lack of funding: even though in 2017 in excess of £140bn was spent on health across the UK - more than 10 times the figure that was ploughed in 60 years ago, it is still not enough. The level of financial pressure on the NHS is severe and shows no signs of easing. This is primarily due to a significant slowdown in funding growth: between 2010/11 and 2014/15, health spending increased by an average of 1.2 per cent a year in real terms and increases are set to continue at a similar rate until the end of this parliament. This is far below the historic annual growth rate of 3.7 per cent. The current rate of funding growth is not sufficient to cover growing demand, which is estimated to cost NHS providers an extra 4 per cent each year.

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Coronavirus in Poland:
Domestic Solutions and International Impact
Preliminary Report

Bogdan J. Góralczyk1

Abstract
Due to the unexpected outbreak of coronavirus, known as COVID-19, Europe and the whole world has probably been going through the darkest days since World War II. Almost for sure the initial attack of lethal virus and disease, which created a medical crisis and brought about a real lockdown of countries concerned, will be followed by another one – an economic recession, maybe even bigger than after 2008 (how big, depends from the scale of the current pandemic). Poland, being a case study here, was surprised like everyone else. In this preliminary assessment ("preliminary", as we do not know, what will be a final result of the COVID-19 outbreak, as well as when and how it will finish), the author is trying to show the tendencies, weak or strong points in the country strategies in those extraordinary circumstances, and finally drawing some (also preliminary) conclusions concerning the international position and role of the country in near future.
Key words: *Coronavirus-COVID-19, pandemic, health safety, disease prevention, crisis management, economic recession*

Coronavirus, known as COVID-19, like everywhere, came to Poland suddenly and unexpectedly, even if the outbreak in Chinese city of Wuhan and the first measures were attentively observed by the media and public

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in the country already since the end of January 2020. The first case of the disease, so called patient zero, has appeared in Poland on March 4, 2019 in the town of Zielona Góra, in western part of the country. It was a 66 years old person who came to Poland by bus from Germany (fortunately now cured and out of hospital). The first death case from coronavirus disease in Poland was that of a 56-year-old woman confirmed on March 12.1

Since then the situation is incredibly dynamic, both in the sense of epidemic situations and widespread disease, being in focus of attention of the public, media and all authorities. The latter, first of all Ministry of Health, the head of the National Institute of Hygiene and the Government, almost immediately after detecting the first case of disease in the country and in reaction to the situation on the globe and European continent, took some drastic measures, in large extent following the footsteps taken in China or Hubei Province, more or less like many other countries, also in Europe. They included, among others, the announcement on March 14 the state of epidemic danger, from March 15 imposed a kind of *cordon sanitaire* on Polish external borders, diminishing all kinds of foreign travels, communication and exchange (by car, by train or plane). Finally, an official epidemic was declared in Poland on 20 March 2020 by the prime minister, Mateusz Morawiecki (with unspecified final date, but "at least" until mid of April). According to him: This extraordinary situation means "more prerogatives for the government but also more responsibility (from the public)". 2

Morawiecki also stated it to the international audience in a special interview given the same day to CNN network. He mentioned there that Poland was the first country in the EU to introduce sanitary border controls where travelers were screened for symptoms of coronavirus and stressed

1 Basic valuable up-to date and valuable data on the epidemic situation in Poland see: https://en.wikipedia.org/wiki/2020_coronavirus_pandemic_in_Poland Official recommendations on coronavirus in the country see a special government website: https://www.gov.pl/web/coronavirus (2020.03.30.)
2 https://polandin.com/47209441/pm-declares-state-of-epidemic-in-poland (2020.03.30.)

simultaneously that the country is intending to introduce “special measures and procedures” to re-introduce border checks also with its EU neighbors, abolishing this way open border policy of the Schengen agreement. 1

Since then the country has had a state of epidemic (a kind of state of emergency but not a curfew or martial law). As a result, many institutions and most working places were closed, with the exception of shops, public communication and constant production (e.g. energy, telecommunication, transport, etc.), and all the citizens were asked to stay home. Those unprecedented, drastic measures notwithstanding, in the time of writing this essay (see the date below) the situation is extremely dynamic, and the number of both - those under obligatory quarantine, those who are infected and those who passed away unfortunately is constantly growing. At the moment (of submitting this text) the numbers are the following: in Poland 2946 infected and 57 fatalities, with high tide in recent two-three days. While worldwide the number of those infected is approaching a million, and number of fatalities is on the verge of 50 thousand.2 As is obvious and well known, they will grow yet – and nobody knows for how long.

1. Prevention, containment and countermeasures

The numbers in Poland are smaller than in some other European countries, with disastrous data coming from Italy and Spain, partially due to drastic measures taken by the authorities. Since the very beginning when the virus came to the country a central role is played by the government and prime minister Mateusz Morawiecki, but first of all minister of health Łukasz Szumowski, who happened to be a professor of medicine in his professional

1 https://polandin.com/47201457/anticoronavirus-actions-taken-by-poland-effective-pm-for-cnn (2020.03.30.)

2 Good source, constantly adjusting the data:
https://en.wikipedia.org/wiki/2020_coronavirus_pandemic_ in_Poland It can be compared with the most valuable global data provided by the Johns Hopkins University: https://www.esri.com/arcgis-blog/products/product/public-safety/coronavirus-covid-19-data-available-by-county-from-johns-hopkins-university/

life (specialization: cardiology and electrophysiology) and took the most decision-making process as well as media coverage on himself, suddenly becoming the most visible Polish politician as well. It is him who explains to the public in the media the menace it is confronted with, suggesting necessary solutions and also explaining the obligatory lockdown measures. As for now he seems to convince the public how lethal the virus is (confirmed by daily data coming from outside) and giving some convincing explanations or details how to react to this unprecedented ordeal.

Thus, it is obvious that the role of the central government and all authorities in the fight against COVID-19 is absolutely crucial and decisive. It is a factor which already has and probably will have important long-term political consequences as well. It is visible and obvious for the public that after the former domination of the market the state, its institutions and authority is coming back. Of course, under condition that the state will remain effective and successful in its efforts and solutions in this new kind of war - against an invisible but so dangerous and lethal enemy in a form of hyper infectious disease.

Polish prevention measures, as taken until now, are focused on containment (closing the border, cities, institutions, etc.). At the end of March practically all the country is locked down, even if the cities are not totally closed and the communication between them is open. However, all citizens are advised, by the Ministry of Health, the government and the media, to stay at home (even if not under quarantine, that is obligatory to all those who had a confirmed contact with a person infected).

Polish authorities, like all the others, were taken by surprise by the scale and speed of the virus. Initially, it was just a media story, coming from Hubei Province in China, or spectacular case of "Diamond Princess" at the harbor of Yokohama. 1 Initially we were just passive watchers on

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1 https://www.nytimes.com/2020/03/08/world/asia/coronavirus-cruise-ship.html (2020 .03.28.)

observers, not realizing - for too long - how dangerous is the situation and how quick is this virus.

The first active steps were taken on January 25, when the central Frederic Chopin Airport in Warsaw imposed special procedures and surveys for passengers arriving from China. Since January 31, due to the seriousness of the disease and its widespread, the first laboratory tests were taken from those coming from abroad who were suspected of having some previous contact with the infected.

It was all the time that the first announcements and advice were given to the citizens, to maintain overall good personal hygiene, washing hands, avoiding touching the eyes, nose, or mouth with unwashed hands, and coughing or sneezing into a tissue and putting the tissue directly into a waste container.

First active measures were taken only at the end of February, when following the Chinese case, Polish flagship LOT Airlines diminished the numbers of flights to Italy and South Korea, which at the time emerged as the new epicenter of the virus.

On 6 of March Polish Parliament Chairman Elżbieta Witek announced the first steps to contain Poland from external exchange, cancelling 21 coming visits to Poland. At the same day the Ministry of Health declared as forbidden to export from Poland any hygienic or medical items necessary to fight COVID-19. And exactly at those days, and especially after the first case of disease and the first fatal case, as described at the beginning of this text, the first containment measures were introduced, starting from home quarantine and monitoring suspects. It was also the time of the inauguration of a large-scale testing on coronavirus, as advised by the WHO, and following the footsteps of others (South Korea, China, recently also Germany, etc.).

Only when the number of those infected has started to increase, and the containment measures were taken, another idea emerged as an urgent one: a necessity of introduction of special legal regulations due to the large scale

stop of production and public activities. Thus a new law (nicknamed: *specustawa,* that is *special law*) has come to the fore, as the source to manage a possible epidemic of COVID-19 or other infectious diseases in Poland via administrative, budgetary and epidemiological measures, and nicknamed as an "Anti-Crisis Shield".1

It was another important step in the crisis management situation in the country. The law was confirmed by the Polish Sejm (lower chamber of the parliament) twice (during the night of March 26/27 and again on March 31). When voting for the second time the Sejm rejected some adjustments made in express way by the Senate, which is dominated by the opposition and was trying to remove some political (and electoral) solutions given additional to anti-crisis measures by the lower diet chamber dominated by the ruling PiS. This second version was immediately signed by President Andrzej Duda,2 just to allow the Shield to come into force on April 1, as originally scheduled by the government.

The most important part of it is a large-scale fiscal package (220 bln Polish zloty).3 As it is obvious to everyone now, the Coronavirus crisis will be followed by another, economic one, or- very probably - recession. Thus, saving the workplace, resume of production and return to normal life are the next important challenges. And all of them require not only coordinated resolution but first of all some extra money - in the form of a special stimulus package as this (an open question is: is this enough, which of course depends on further developments with the virus).

However, during a public and parliamentary debate it was strongly criticized and even described in opposition media as a solution compared

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1 More details, in Polish, on official Government site:
https://www.gov.pl/web/tarczaantykryzysowa (2020.03.31.)

2 "Rusza pomoc dla firm. Tarcza antykryzysowa z podpisem prezydenta" (Help for business and enterprises Has started. Anti-Crisis Shield Signed by the President):
https://biznes.radiozet.pl/News/Covid-19.-Tarcza-antykryzysowa-od-1-kwietnia.-Co-przewiduje (2020.04.01)

3 One USD amounts currently 4,3 Polish zloty. 220 bln Polish zloty amounts to 46,6 bln euro.

to “an umbrella during a bombardment”, that is a worthless solution to combat an breakdown and expected economic slowdown or even recession. 1 Also Polish business community is reacting for the Shield cautiously, expecting some further measures to support endangered production (“Anti-Crisis Shield 2.0) and describing current solution as only another “medical drop-bag”.2

What is more, the controversy is not only economic, but also a political one, as during that debate another important political issue has emerged, that is the presidential election scheduled for May 10 (its first round, eventually second should take place two weeks later). The ruling Law and Justice Party (PiS in Polish) and its charismatic leader Jarosław Kaczyński is constantly claiming that it should go as normal, according to the constitutional requirements.

However, the opposition - divided and of different ideological and political orientation, but not so weak - is absolutely against it, voting for an introduction of special laws or state of emergency (and not "sanitary-epidemiological" emergency, as it is now). The major reason for this political clash is more than obvious: extraordinary measures due to the coronavirus outbreak have effectively abrogated the election campaign, while the current President, Andrzej Duda, due to the situation is performing his duties, is visible and playing a media role almost day by day. In result, as the recent public opinion polls are showing, he has a chance to win in the first round of the elections, which was a scenario not so sure prior to the coronavirus outbreak.

Also, in this respect the situation in the country is extremely dynamic, and unclear, even if all major international events, including the Olympic Games or European Soccer Cup are already rescheduled. Only time will tell what comes out of this political domestic controversy. However, what

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1 https://wyborcza.pl/7,173236,25830564,polish-anti-crisis-shield-is-worth-as-much-as-an-umbrella.html
2 https://businessinsider.com.pl/firmy/tarcza-antykryzysowa-20-potrzebna-mowia-przedsiebiorcy-sa-propozycje/rj1j68c (2020.04.01.)

is significant and worth to be mentioned, even Polish representative in the European Court of Justice, law professor Marek Safjan has declared openly that eventual result of elections to be carried out on May "could be legally undermined".1 In this respect, we have in Poland not only medical, but also political and legal effects of the COVID-19 crisis, which emerged even before economic ones. As for the moment, it is too early to judge or evaluate yet what will be a final result of those deep controversies, having so many open questions in front of us. Obviously, it is also too early to estimate any costs of pandemic, both on local/country or global scale.

Wide opposition notwithstanding the ruling party (and Kaczynski himself) prevailed, adding some controversial stipulation to the Shield, those of political meaning, and especially some amendments to the Electoral Code, for instance enabling voting by correspondence to persons in quarantine and persons who have reached the age of 60 at the latest on the day of the election.2 The same day the Anti-Crisis Shield was implemented, on April 1, a package of new austerity measures for the public were taken, including VAT payments delay, further restrictions on public life and movement were enforced. According to them: only two persons can walk alongside each other; only small, detailed number of people can stay in the shops; shops for the elders, above age 65 to be opened for them only between 10 am and noon; all hotels, barbed shops, cosmetic salons, even parks or beaches were closed (indefinitely).3

Those extraordinary measures notwithstanding, the ruling party and its leader seem to be determined anyhow to go to the elections as scheduled, that is on May 10, whatever the costs and with some controversies inside

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1 "Prof. Safjan: PiS is changing electoral law": https://wiadomosci.onet.pl/tylko-w-onecie/koronawirus-pis-zmienia-kodeks-wyborczy-prof-safjan-komentuje/394ehvf (2020.03.28)

2 https://wyborcza.pl/7,173236,25833461,the-anti-crisis-shield-has-been-approved-by-senat.html

3 https://www.forbes.pl/gospodarka/koronawirus-w-polsce-nowe-ograniczenia-od-1-kwietnia-i-2-kwietnia-2020-r/cd0w5f7 (2020.04.02.)

of the ruling coalition (as PiS is supported by two smaller parties).1 In effect, recently another idea has emerged: to arrange all the voting online or – even better – just by correspondence, what many experts openly declare as an ”unconstitutional measure”, foremost due to the fact that according to the Polish Constitution it is forbidden to change the Electoral Code in the period of six months prior to the election day. At the moment of writing this text it is a “hot potato” of domestic political (and legal) scenes, with final conclusions open.

2. Disadvantages, weak and strong points

The pandemic came to us as a surprise. And almost immediately has shown some weak points of the country, especially in ill prepared health systems, not having enough space in hospitals (mainly on intensive care – ICU), shortage of beds, or medical resources, especially on infectious diseases compartments. Immediately the capabilities of the health system have been put into a strain. The public opinion and political decision makers realized how weak is the health system to fight an unexpected menace and virus, and ill-disposed it is in surgical masks, clothing, respirators, goggles, face protectors, etc. And of course, lie everywhere, there is no vaccine, while when there is no vaccine, there is no cure. While the public safety was in the focus from the very beginning.

Government initiated lockdown-type control measures started on March 10–12, with closing schools and university classes and cancelling mass events. They were strengthened on 25 March, limiting non-family gatherings to two people and religious gatherings to six and forbidding non-essential travel. All of them put into a stress both local and central administration, and has shown rather a solidarity of citizens than effectiveness of authorities involved. Not everywhere epidemic controls

1 “Przyszłośc rządu wisiała na włosku” (The Future of the Government was hanging on a thin line): https://wiadomosci.gazeta.pl/wiaomosci/7,114884,25834834,przyszlosc-rzadu-wisiala-na-cienkiej-nitce-kulisy-wojny-o.html#s=BoxMMt3

were observed. Some bottlenecks were soon discovered, like work without disinfection, lack of specialized (nursing) personnel in a whole health system, or detailed rules how to carry-out a necessary two-week long quarantine. Some public controversies emerged also concerning religious gatherings or difficulty to oppose the false information misleading public opinion. Once again it was obvious that nobody was prepared for this kind of crisis.

Fortunately, there was no initiative like that in Great Britain, with the idea of "herd immunity", but strict, even drastic measures to fight this invisible, but lethal enemy. It was extremely important in a country with an ageing society, while – as available data confirm – the most vulnerable strata of those infected and passing away are the people of age 65 and above. How to care for the elder was a constant topic from the very beginning of this crisis management situation – with some mixed results.

More effective was another initiative, the one from LOT Polish Airlines, known as "Return Home" (Powrót do domu), declared immediately after another government measure to stop all international flights as of March 15. Already the next day the first special flight from London, came to Poland, and the interest was enormous, as so many people were totally surprised by the events. Popularity of the idea was confirmed immediately, as there were charter flights not only from Europe or the US, but also Peru, Mexico, Australia or Singapore. Initially some 18 thousand of Polish citizens locked down or living abroad expressed their intent to come back to their homeland,[1] while later their number was constantly growing. As of March 26, some 35 thousand Poles came back to the country, while another 15 was still waiting for this opportunity. The whole idea was openly declared as "excellent".[2]

1 https://wiadomosci.wp.pl/akcja-lot-do-domu-juz-18-tys-polakow-zadeklarowalo-powrot-do-kraju-6489188882241665a (2020.03.30)
2 https://wgospodarce.pl/informacje/77167-za-kilka-dni-koniec-lot-u-do-domu (2020.03.30)

In those circumstances Poland has started to search for new supplies of medical equipment, first in the EU and its member states, and later, after a crucial telephone talk of President A. Duda with his Chinese counterpart Xi Jinping on March 24. Polish President applauded China's prompt, decisive and forceful response measures that have proven effective in stemming the spread of the virus. He also stressed the serious challenge confronting his country and its urgent need for medical supplies.[1] In effect of this talk, the first echelon of the Chinese medical supply, partially purchased, partially given by the Chinese side as a gift, in response to initial Polish positive response to the Wuhan outbreak, has arrived already three days later, on March 27.[2]

3. The EU and the international framework

Polish authorities did not participate in the 28 February 2020 European Union (EU) tender procedure for purchasing COVID-19 pandemic related medical equipment, in which 20 member states participated. Poland applied on 6 March for the 17 March tender for the purchase of gloves, goggles, face protectors, surgical masks and clothing; the European Commission stated that all requests in the tender were satisfied by offers.

Finally, the EU has organized a very specific "virtual" summit on March 26, but unfortunately failed to agree on common financial support for the member states, and leaving the Eurogroupe "to present the proposal within two weeks". According to experts, it should be like an "innovative financial

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1 "President Xi Jinping speaks by phone with President Andrzej Duda", https://www.fmprc.gov.cn/mfa_eng/zxxx_662805/t1761096.shtml (2020,03.28); "Rozmowa prezydenta z Xi Jinpingiem, Do Pekinu poleci specjalny samolot" (President talk with Xi Jinping. A special plane will fly to Beijing): https://wiadomosci.dziennik.pl/polityka/artykuly/6467235,andrzej-duda-pekin-xi-jinping-koronawirus-covid-19.html (2020.03.28).

2"Koronawirus: Pierwszy transport z pomocą Chin już w Polsce" (Coronavirus: First transport of Chinese help already in Poland), https://www.euractiv.pl/section/bezpieczenstwo-i-obrona/news/koronawirus-pierwszy-transport-z-pomoca-z-chin-juz-w-polsce/ (2020.03.29).

instruments truly adapted to a war".[1] The most probable "right instrument" to do so is the European Stability Mechanism (ESM), a special solution was set up in 2012 for a euro-area bailout fund and has a lending capacity of €700 billion. The first problem is that not all the EU member states, including Poland, are not a member of ten Eurozone. What to do with them?

The second, not less important issue is the timing. According to media reports Prime Minister of Italy Giuseppe Conte, was asking for some extra funds on amount of 500 billion euro ($ 539) already in mid-of-March, when he said: "The route to follow is to open ESM (European Stability Mechanism) credit lines to all member states to help them fight the consequences of the COVID-19 epidemic, under the condition of full accountability by each member state on the way resources are spent".[2] While after the summit of March 26 he was furious about adamant opposition to the idea of coronavirus bonds, led by the Netherlands and Germany. "We need to react with innovative financial tools," Conte told his counterparts. According to some reports, Conte issued an ultimatum giving officials in Brussels 10 days to come back with "an adequate solution."[3]

A real push from Italy and Spain, two countries most affected by crisis, for new financial solutions in those extraordinary times has met resistance from Germany and the Netherlands, which is a pity and could emerge as another division line within the EU, while at the moment it is former Prime Minister of Belgium and liberal Member of European Parliament Guy Verhofstadt, who is right, claiming that "only European solidarity can avert economic disaster". As for now "the jobs and livelihoods of millions of Europeans are at stake".[4]

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1 https://www.euronews.com/2020/03/27/covid-19-eu-leaders-fail-to-agree-on-common-financial-response-during-virtual-summit (2020.03.30.)
2 https://www.cnbc.com/2020/03/20/italy-conte-calls-for-eu-crisis-fund-as-coronavirus-death-toll-rises.html (2020.03.31.)
3 https://www.politico.eu/article/virtual-summit-real-acrimony-eu-leaders-clash-over-corona-bonds/ (2020,03.30.)
4 https://www.politico.eu/article/economy-guy-verhofstadt-coronavirus/ (2020.03.30.)

Finally, on April 1, in reaction to the growing opposition and critic the president of the European Commission Ursula von der Leyen has issued a groveling apology for Italy, a kind of self-criticism, with promise of more coronavirus help. As she stated and wrote: "It must be recognized that in the early days of the crisis, in the face of the need for a common European response, too many have thought only of their own home problems".1 Thus it seems to be more than certain that the EU institutions will arrange some extra financial sources for those who were mostly victimized during the COVID-19 crisis.

As far as Poland is concerned. the EU is important in the same aspect: originally it promised financial support for Poland of EURO 7,4 bln, and the funds will come from the pool foreseen for Poland in the 2014-2020 Cohesion Policy rules. Recently the amount was raised, as some expert say, to an amount of 50 bln euro. While initially it was not exactly a new money provided to fight coronavirus outbreak, but only the sources not used yet during the current budgetary framework,2 so at the beginning of April it seems that the situation has changed and Poland, like other member states, can expect some extra financial resources from the EU.

Another important angle is NATO's reaction to the COVID-19 outbreak. As a military alliance it has many stipulations on deterrence and defense. In this respect a visible lack of reaction of NATO in the first weeks of this crisis management situation is leading one Polish expert Wojciech Lorenz (not only him, obviously) to the conclusion that this "lack of visible reaction on current crisis can diminish the public support, create a drop in its significance and thus lead to the weakening of joint missions or drills".3

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1 https://www.express.co.uk/news/world/1264130/Italy-coronavirus-eu-update-Ursula-von-der-Leyen-apology-economy-COVID-19-latest-europe (2020.04.02.)

2 https://www.thefirstnews.com/article/poland-to-receive-eur-74-billion-in-eu-funds-to-fight-coronavirus-11230 (2020.03.31.)

3 W. Lorenz, "Pandemia COVID-19 – konsekwencje dla NATO (COVID-19 Pandemic – Consequences for NATO), *PISM (Polish Institute of International Affairs) Bulletin,* Warsaw, March 31, 2020:
https://www.pism.pl/publikacje/Pandemia_COVID19__konsekwencje_dla_NATO

Finally, on March 31 secretary general of NATO Jens Stoltenberg has announced a gathering of special ministerial meeting on April 2 and promised the alliance engagement in the fight “against an invisible enemy”. He also asked for some more solidarity and mutual understanding in this challenging time, saying: “We are in this crisis together and when we respond together, our response is more effective.”1 So at last we can expect that NATO will follow the EU footsteps as an active participant in the fight against coronavirus pandemic.

As a surprise to many, another active player in the EU and Central and Eastern European region, which emerged during the coronavirus crisis is the People’s Republic of China. In one of this series of Working Papers, Ma Junchi from CASS collected and edited the reactions of Chinese and European ambassadors on the outbreak of the virus crisis in China.2 From this collection of statements and especially the media coverage of the crisis management situation China is emerging as an extremely important and active, but controversial to many in Europe, player on the continent, submitting not only medical supplies (test-kits, gloves, ventilators, masks, etc.) but official aid and prevention materials against the virus. These new Chinese activities led to an open debate in Brussels and many capitals of the EU member states where the question was raised: Is China winning the coronavirus response narrative in the EU?3

According to historians, Poland is “the Heart of Europe”,4 while Polish geostrategic position, “between Russia and Germany” (being a kind of

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1 https://www.euronews.com/2020/04/01/coronavirus-we-are-helping-fight-invisible-enemy-says-nato-chief-jens-stoltenberg (2020.04.02.)

2 Ma Junchi, „The Chinese and European Ambassadors on the COVID-19 Virus Situation in China”, *Working Paper* 2020 No.1, China-CEE Institute, Budapest, 2 March 2020

3 See the opinions of experts of the Atlantic Council: https://atlanticcouncil.org/blogs/new-atlanticist/is-china-winning-the-coronavirus-response-narrative-in-the-eu/ (2020.03.31.)

4 Once famous volume by a historian Norman Davies: *Heart of Europe. The Past in Poland’s Present,* Oxford University Press 2019 (it is already 21 – sic! – edition of this book).

historical proverb on the country and its historical fate) is also locating the state in the center. All that makes the situation of Poland a specific one. In this respect it is probably not so surprising that the unique, but significant, exchange of letters between US and Chinese ambassadors in Warsaw on the issue of coronavirus and the Chinese engagement in it took place in one of the most important Polish internet sources.

On March 23 the US ambassador Georgette Mosbacher published an open letter, only in Polish, not available on the US Embassy site, in which she has put the whole responsibility of the COVID-19 outbreak on China and asked for “free circulation of honest information” concerning the widespread of the virus. She also was blaming the Chinese authorities for “a delay with alarm on the disease” and “selective information” on it.1

Already next day the Chinese ambassador in Poland, Liu Guangyuan, on the same website has answered: “It is America which is spreading a political virus”. He rejected all American allegations and wrote that “to widespread a <political virus> is more dangerous as the virus itself, and not only doesn’t help to fight a virus in any country, but could also endanger the global defense of the security of public health”. According to him, by action like the letter of his US counterpart in Warsaw and by blaming China, USA “is trying to remove attention from initially not very strong reaction of American authorities”.2

This meaningful exchange of letters has shown the Polish public how important the virus situation is, and that it has not only local, or even continental, but definitely a global impact. Two major economic powers

1 G. Mosbacher, „Tuszując prawdę, Chiny doprowadziły do globalnej pandemii” (Hushing the truth China bring the global pandemic): https://wiadomosci.onet.pl/opinie/koronawirus-ambasador-usa-w-polsce-komentuje-dla-onetu/zlktyzb (2020,03.30.)

2 Liu Guangyun, “To Ameryka rozsiewa polityczny wirus” (It is America which spread political virus): https://wiadomosci.onet.pl/opinie/koronawirus-ambasador-chin-w-polsce-to-ameryka-rozsiewa-polityczny-wirus/qdbl7rj (2020.03.30.)

clashed on Polish territory. Fortunately, there was no follow-up to this exchange, even if it had created a wave of immediate comments.

What is more, the Chinese supply of medicaments and aid deliveries has not initiated a public debate or discourse on the subject, as in some other EU member states, starting from Spain and Italy. Unlike there, in Poland those emergency shipments are treated in a positive way and not stigmatized as "masks diplomacy".[1]

Poland is not the only recipient of the Chinese deliveries. We have many examples of it both in the EU and 17+1 framework, with the most famous case of Serbia, describing Chinese leader Xi Jinping as "brother and friend", according to its Prime Minister Aleksandar Vucic, but also Hungary or Czechia. What is more, it is combined in many commentaries with the slowness of the EU reaction and lack of common action in this particular respect also of Visegrad Group (V4) member states. Really, solidarity and mutual support seems to be a European deficiency now, which contrasts with the new Chinese activity.

In the particular case of Poland one individual partner is absolutely crucial in the economic field: Germany (like the US in security), as some 30 percent of Polish trade volume is with this country alone (around 80 percent with the EU prior to Brexit). Unfortunately, Polish-German border was also closed and put under strict scrutiny and crossing it from Germany to Poland (or any country, by the way) automatically means: two-week long quarantine. For how long – nobody knows. As nobody knows at the moment, what can be expected as the economic cost of the coronavirus crisis.

However, what is known already, in the era of geostrategic competition or confrontation between USA and China (first trade war, since coronavirus outbreak followed by information and propaganda and new narrative war) chancellor Angela Merkel is exploring deeper cooperation with China and

1 https://time.com/5807710/china-sends-medical-supplies-coronavirus/ (2020.03.30.)

its leader Xi Jinping. According to some experts, also in the USA[1], economic – expected and now obvious – upheaval from the coronavirus could reinforce the temptation in Berlin to keep Beijing close. While Poland, being on the main course of the overland route of the Belt and Road Initiative (BRI) should take into account those dynamic processes on the international arena, when new trading networks are under creation. When Germany is reluctant to antagonize Beijing, Poland should also take it into account.

4. Preliminary Conclusions

Coronavirus disease is definitely not only an unexpected Black Swan on the global markets, but also a major threshold or fault line on the international arena. The crisis effects (not only in economic sense) almost for sure will be even greater than those after 2008. Maybe even as important as those after the collapse of the USSR or in December 1991 or more – after the II World War, as a new global order could emerge from it.

Probably once again it will be a multipolar order and an open question is: how many new power centers we will have, outside of the USA and China. From a Polish or Central European point of view another question is crucial: is Europe, the EU or Germany alone (after Brexit a reasonable question mark) to be counted among them? To avoid the worst, Europe has to learn from its past mistakes and act quickly, decisively and with a sense of solidarity. The repercussions of bungling the EU response to the virus outbreak, as observed in its initial stage, could be dire. As in the title of the of the book published in Warsaw already in 2015 and edited by the author

1 N. Barkin „Germany's Strategic Grey Zone with China", The Carnegie Endowment of Peace, March 25, 2020: https://carnegieendowment.org/2020/03/25/germany-s-strategic-gray-zone-with-china-pub-81360 (2020.04.01)

of this text: “The European Union on the Global Scene. United or Irrelevant?” [1]

The time has come when everyone needs to think hard about how to position themselves in new circumstances. In this respect, as far as Polish position is concerned, it is worth to note conclusions of leading Polish China experts, Łukasz Sarek, who in recent study on our future relations with China after the coronavirus is specifying following problems:

- Value chains disruption
- Delay with supplies
- Diminishing of export (in all directions)
- Possibilities of bankruptcy (everywhere).2

In other words, first of all we will have many new problems in front of us to be resolved in the first instance, practically in all our bilateral relations.

First two months in Europe and three months on the globe (i.e. including China) of the coronavirus crisis leads to another important conclusion: We can witness a destructive re-nationalization and petty competition which already emerged on the horizon. Instead of engagement in constructive cooperation, even within the EU or NATO alliance, we can observe a clash of interests and power games (with some recent signals of waking-up).

Simultaneously the State, its power and role re-emerged once again (like after 2008) on our agenda, which can – on the one side – lead to the solution like in Hungary, that is the situation when not only liberal order but democracy is at stake.3 or at least will lead us in the Western hemisphere

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1 B. Góralczyk (Ed.), *European Union on the Global Scene: United or Irrelevant?* Centre for Europe, University of Warsaw, Warsaw 2015

2 L. Sarek, “Wpływ spowolnienia gospodarczego w Chinach na polską gospodarkę w krótkim okresie” (An Impact of Economic Slowdown in China on Polish Economy in a Short Term), In: „Pandemia SARS-COV-2. Doświadczenia Azji Wschodniej” (SARS-COV-2 Pandemic. Experiences of East Asia), *The Bulletin of Asia Research Centre,* Centre for Security Studies, War Studies University, Warsaw, March 2020

3 Emblematic study and Western perspective: D. Hegedüs, “Orban Uses Coronaviruse to put Hungary’s Democracy in a State of Danger”, the General Marshall Fund, March 26, 2020 http://www.gmfus.org/blog/2020/03/26/orban-uses-coronavirus-put-hungarys-

to necessary re-definition of the role of the State in the political, economic and social systems.

The role of the State is one dimension of the new narrative. The other one, not so new already, is the new emerging global order. Already prior to the coronavirus outbreak we saw the trade war (between the US and China, but also the US and the EU or Germany for that matter). COVID-19 has brought about another dimension of these competition – a media competition and a new war: on arguments and narratives, as was seen in an extraordinary exchange of letters between the US and Chinese ambassadors in Warsaw ("for domestic consumption only", as both were published only in Polish). While it is necessary to keep in mind, that after pandemic followed by economic recession (for sure now) and propaganda war another two Black Swans are looming on the horizon: those of climate change and environmental pollution worldwide. Time to think about the world different way.

The COVID-19 will bring about, almost for sure, a new Great Re-Definition of our lives, institutions, mechanisms and solutions, as well as projections of the future. What will be the final result, is of course too early to say, as we are still in the game with the lethal virus. That is why this study, like all others at the moment on this subject, is only a preliminary one. We are still in the position of the persons rather guessing than real pundits giving us a proper solution, so necessary, but not ready yet.

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The Coronavirus Outbreak and Its Containment Measures in Benelux Countries

Zeren Langjia[1]

Abstract

Europe, along with the rest part of the world, is undergoing what people now call the coronavirus crisis, but there is no idea about when this crisis will end. To date, as countries have weak knowledge of the coronavirus and its potential impact, it's far too early to make any firm conclusions on this entire situation. Nevertheless, it is of great importance to observe the situation in Europe from national and regional perspectives as European countries do have variations in their coronavirus containment policies and measures. Benelux countries are small EU Member States, but they have a relatively high number of coronavirus confirmed cases and deaths. In particular, as of 5 April 2020, Belgium and the Netherlands are ranked the fifth and sixth worst-affected EU countries behind Spain, Italy, Germany and France. In this paper, the author tries to chronologically follow the evolution of the coronavirus outbreak in Benelux countries, explores and interprets their containment measures taken, and gives some thoughts about the coronavirus crisis and its potential impact.

Key words: *Coronavirus outbreak; Containment measures; Benelux; Further thoughts*

1. Introduction

As of 4 April, according to the data of the worldometer.info[2], the coronavirus outbreak, known as COVID-19, is affecting 205 countries and territories around the world, of which many European countries are seeing

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1 Zeren Langjia, Ph.D. in EU Studies, Assistant Research Fellow, Institute of European Studies, Chinese Academy of Social Sciences. Dr. Langjia is currently based in Budapest and in charge of research coordination at the China-CEE Institute.

2 "COVID-19 CORONAVIRUS PANDEMIC", worldometer.info, 5 April 2020. Retrieved 5 April 2020.

steep rises in infections and deaths. The website, based upon the total confirmed coronavirus cases of each country, ranks the three Benelux countries (Belgium, the Netherlands and Luxembourg) 11th, 12th and 35th out of all these affected countries respectively. Considering the relatively small population (17, 11 and 0.6 million respectively), the Benelux is witnessing a fast growing and high number of coronavirus infections, which is exerting great impact on many aspects of people's daily life and their behaviours.

In this paper, the author tries to follow the developmental evolution of coronavirus infections in Benelux and explore the reasons behind the steep rises in the coronavirus cases, analyses the coronavirus containment measures taken by Benelux countries, and gives some thoughts on the coronavirus outbreak, its impact and its challenges to the Benelux and the world in a wider sense.

2. Evolution of the COVID-19 Outbreak in Benelux Countries

2.1 Belgium

Phase one: 29 January to 29 February

Belgium had its first confirmed Coronavirus case on 4 February, which is actually the only confirmed case in January and February, but the then situation was not serious and seemed under control. Belgian Minister of Health Maggie De Block said, the country works in three phases according to the development of the outbreak[1]:

> Phase 1: That means that the virus is kept out and that people with complaints are checked.
> Phase 2: That means that the virus is already passed on in our country. If the virus is there, the main focus is on isolation. Possible patients are tested, and the people around him or her

[1] Hanne Decré, "Minister De Block: 'Kans is reëel dat coronavirus naar ons land komt, maar er is een plan'" (in Dutch), 25 February 2020. Retrieved 1 April 2020.

are also tested. There is also a European system for notifying each other.

Stage 3: That means there really is an outbreak, and many people are getting infected. Italy is currently in phase 3. Then the focus is on medical care.

As of 25 February, De Block said that Belgium was still in phase 1 and "it is now mainly a matter of waiting, adjusting and seeing that the hospitals are ready"[1]. The country did not have the plan to extra check Belgian tourists who visited Italy. Health Minister further added2, it makes no sense to extra check these tourists and close the border. Of course, quarantine is not supposed to be a measure at all for this stage. According to De Block, Belgium was prepared for the possible outbreak of the Coronavirus in the country. However, the fact that Belgium did not extra check Belgians returning from Italy has hints of what's going to come later.

Phase two: from 1 March

After Belgium found the second Coronavirus case on 1 March, the country entered the phase 2 of its health risk containment strategy, which means that official measures would focus on containing the virus from spreading further inside the country, every person whom the infected patients had close contact with is identified, but those who showed no symptoms were allowed to resume their routine activities without requirements for quarantine.3 Although the number of infected cases was slowly increasing, it seems the patients' whereouts were traceable and the whole situation was under control. However, some experts criticized the government for lack of measures and called for wider testing.4 According to research, patients

[1]Ibid., Hanne Decré, "Minister De Block…".

[2] Ibid., Hanne Decré, "Minister De Block…".

[3] Gabriela Galindo, "Belgium enters Phase 2 for coronavirus: what does it mean?", 2 March 2020, *The Brussels Time*. Retrieved 1 April 2020.

[4] Pieter Huyberechts, Pieter Lesaffer, Veerle Beel, Sam Reyntjens, Andreas Rotty, "Experts disagree about coronavirus approach: 'Patient would not have been found if we had followed government guidelines'", 2 March 2020, GVA. Retrieved 1 April 2020.

without symptoms may also infect other people. Thus, symptom-free patients, who were not in quarantine, probably expanded the infections before they showed symptoms at later time.

Of the ten new cases on 4 March, nine patients recently returned from Italy. On the same say, the European Defence Aganecy confirmed that one of its senior staff tested positive, who had a trip to Italy and thus became the first case in the EU agencies.1 It is said that this senior official had meeting with around thirty other European officials after he came back to Belgium. On 6 March, the Ministry of Health confirmed for the first time that infections occurred on Belgium territory.2 Of course, the confirmed cases are the minimal number of infections because the confirmed number depends upon how many samples are taken for test. One of the top limitations for testing is the lack of reagents.

On 10 March, the Federal Government advised against indoor events with more than 1000 people to curb the outbreak, but Prime Minister Sophie Wilmès said that it is not a ban but a recommendation.3 This measure probably did not do any tangible contribution to containing the spread the virus as Coronavirus spread does not need one thousand people. Instead, the virus can spread very fast through human contact in small groups. On the other hand, the government did encourage companies to let employees telework, but had no objection to outdoor activities.4 For the time being, schools remained open but were advised not to travel abroad, and companies were encouraged to set flexible work time, which may reduce the possibility of be contracted in public transports. This was regarded as the reinforced phase 2, and social distance was the main measure

[1] Gerardo Fortuna, "First confirmed case of COVID-19 in the EU institutions", 4 March 2020, Euractiv.com. Retrieved 1 April 2020.
[2] “2020 coronavirus pandemic in Belgium”, Wikipedia. Retrieved 1 April 2020.
[3] "Zeg alles af, of we stevenen op Italiaanse toestanden af" (in Dutch), 11 March 2020, *De Standaard*. Retrieved 1 April 2020.
[4] Ibid., "Zeg alles af…".

advocated.[1] Besides, Belgium had its first three death cases on 10 March, which possibly urged the relevant authorities to take stricter measures to control the situation. On 12 March, the National Security Council met at the request of the Prime Minister and in consultation with the Minister-Presidents and decided to "strengthen the existing measures with additional social distancing measures, with the same objective of stemming the spread of the epidemic"[2]. "From an operational point of view, we are moving into the federal phase of crisis management, which means that all decisions will be taken by a management cell composed of, among others, the Prime Minister, the competent ministers and the Ministers-Presidents."[3] From Friday 13 March, schools, discos, cafes and restaurants closed, and all public gatherings for sporting, cultural or festive purposes were cancelled according to the government's order made one day before.[4] However, it's not a lockdown because people were still allowed to go out of their houses.

In the evening of 16 March, in view of the increasingly serious situation, the Belgium's Head of State King Philippe, who normally addresses only on Christmas Eve and on the Eve of Belgian National Day, addressed the nation due to the exceptional health hazard of the coronavirus as he did in the aftermath of the 2016 terrorist attacks in Brussels and Zaventem. King Philippe described the Coronavirus outbreak as "an unprecedented health crisis on the global level" and called on Belgian people to adapt their behaviours at this critical moment based upon the containment measures of authorities, strongly believing that "The current situation reminds us of our vulnerability, but at the same time also brings our strength to the fore. We will come out of this ever stronger".[5] Unsurprisingly, his address was

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1 "New corona control measures", 18 March 2020, zorg-en-gezondheid.be. Retrieved 1 April 2020.
2 "Coronavirus : Phase 2 maintained, transition to the federal phase and additional measures", 12 March 2020, info-coronavirus.be. Retrieved 1 April 2020.
3 Ibid., "Coronavirus : Phase 2 maintained, transition to the federal phase and additional measures".
4 "2020 coronavirus pandemic in Belgium", Wikipedia. Retrieved 1 April 2020.
5 "King Filip calls on Belgians to respect the COVID-19 measures 'for ourselves and for the most vulnerable among us'", VRT nws, 17 March 2020. Retrieved 4 April 2020.

supposed to conform citizens and encourage them pay attention to the ongoing situation. On 17 March, the Belgian government announced “new, far-reaching measures to stem the spread of the coronavirus”, which only allowed essential movements, banned public gatherings, closed non-essential shops and imposed penalty for companies and individuals breaching the rules from 18 March onwards, and the measure will be valid until 5 April,[1] which was already extended.

On 20 March onwards, the Interior and Security Minister Pieter De Crem (Flemish Christian democrat) announced that “our country’s borders with the Netherlands, France, Luxembourg and Germany were now closed to all that don’t need to cross them without good reason” and that “the local and federal police services will be responsible for carrying out checks on those entering and leaving the country.”[2]. On 27 March, the National Security Council decided that the measures currently in force to curb the spread of the COVID-19 “will remain in force until midnight on Sunday 19 April”, which is two weeks longer than the originally planned date on 5 April, and that the measures include “a ban on groups of more than two persons that don’t live under the same roof assembling in public and the closure of all non-essential shops”.[3] According to the VRT news[4], if necessary, the measures could be extended either in part or in full for a further fortnight until 3 May. Nevertheless, “The good news is that we have slowed down the growth of the epidemic, but we still haven’t reached the peak”[5],

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1 Floor Bruggeman, Michaël Torfs, Ellen Maerevoet, Denny Baert, Freek Willems, “LIVEBLOG: Belgium takes ‘far-reaching measures’ against corona: only ‘essential movements’ are allowed” 17 March 2020, VRT nws. Retrieved 1 April 2020.
2 “Borders closed to non-essential travel”, 20 March 2020, VRT nws. Retrieved 1 April 2020.
3 “Measures to curb the spread of the novel coronavirus to remain in force until at least 19 April”, 27 March 2020, VRT nws. Retrieved 1 April 2020.
4 “Measures to curb the spread of the novel coronavirus to remain in force until at least 19 April”, 27 March 2020, VRT nws. Retrieved 1 April 2020.
5 Michaël Torfs, “Covid-19: almost 800 in intensive care now, 64 deaths in the past 24 hours”, 28 March 2020, VRT nws. Retrieved 1 April 2020.

virologist Steven Van Gucht told reporters at the press conference on 28 March.

From 21 March onwards, several brewers, a pharmaceutical company and the sugar refinery of Tienen, started to produce alcohol for hand sanitiser in an effort to alleviate its shortage in Belgium.[1] Meanwhile, research on the Coronavirus is going on in several universities and companies. For instance, at the request of the Bill & Melinda Gates Foundation, KU Leuven screens 15,000 medicinal molecules for their action against the coronavirus.[2] University of Namur developed a new procedure to diagnose coronavirus.[3] “It is a process of manually extracting the genetic code of the virus using a chemical compound, a fume hood and a centrifuge,” said Benoït Muylkens, a virologist and director of the Integrated Veterinary Research Unit at the University of Namur, and partly the technique will increase the number of tests in the country.[4] Moreover, according to the RTBF news[5], the company Coris BioConcept, located in Gembloux, developed a brand new and “antigenic” test of the Covid-19 in 15 minutes, which will react to Coronavirus antigens (viral proteins) and detect them from the patient’s nasopharyngeal respiratory sample, with the University Hospital Laboratory of Brussels, the LHUB-ULB, and other partners, including the Laboratory of the University of Liège and the National Center of Reference of respiratory pathogens. The RTBF news further said, the new test is “obviously less precise than the molecular biology tests carried out in the laboratory”, but it “gave a positive diagnosis” according to a trial basis and “saves time on the front line and initiates treatment more quickly”. Considering the positive result (7 out of 10 patients with high viral loads of COVID-19), the Federal Agency for Medicines and Health Products

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[1] “2020 coronavirus pandemic in Belgium”, Wikipedia. Retrieved 1 April 2020.
[2] “Bill Gates orders large corona study in Leuven”, 4 March 2020, *De Standaard*. Retrieved 1 April 2020.
[3] “New test to diagnose coronavirus developed by University of Namur”, 17 March 2020, The Brussels Times. Retrieved 1 April 2020.
[4] Ibid.
[5] Johanne Montay, “Coronavirus: Belgian test in 15 minutes receives certification”, 24 March 2020, RTBF. Retrieved 1 April 2020.

(FAMHP) decided to give certification to Coris BioConcept to sell and distribute the tests.[1]

Phase 3 of the risk containment plan will be activated at the moment when authorities can no longer accurately follow how and where the virus is spreading within the country. So far, the country remains at the enhanced phase 2 of containment strategy. According to the data of worldometer.info, as of Monday morning, 6 April, the total confirmed cases have reached 19,691 in Belgium and the death toll is 1447.

2.2 The Netherlands

At the time when Wuhan (the epicentre of the pandemic in China) was put on lockdown on 23 January, the Netherlands did not take measures against the outbreak. More than one month later, on 26 February, the Dutch foreign ministry advised its citizens not to travel to a number of places affected by the Coronavirus outbreak, which is mainly due to the outbreak in the northern Italy rather than the situation in China. Besides, the virus spread to the Canary Islands in Spain and at least 13 Dutch people were among the estimated 1,000 holidaymakers who were quarantined at a hotel on the holiday island of Tenerife. [2]

At that time, everyone who visited their doctor with a cough or sneezing and had visited a risk area was being tested at that time.[3] The first confirmed Coronavirus case was reported on 27 February. The patient visited the Lombardy region in Italy[4] and then was isolated at the Elisabeth-TweeSteden Hospital in Tilburg.[5] Meanwhile, the Municipal

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1 Johanne Montay, "Coronavirus: Belgian test in 15 minutes receives certification", 24 March 2020, RTBF. Retrieved 1 April 2020.
2 "Dutch update Italy travel advice as coronavirus takes hold", 25 February 2020, DutchNews.nl. Retrieved 2 April 2020.
3 Ibid.
4 "Patient with novel coronavirus COVID-19 in the Netherlands." *RIVM.nl*. 27 February 2020. Retrieved 2 April 2020.
5 "RIVM: first corona case in the Netherlands". *Telegraaf.nl*. 27 February 2020. Retrieved 2 April 2020.

Health Service (GGD) carried out a contact investigation as a part of the isolation action: isolate, contact investigation and monitoring of the patient.1 It was found that the second confirmed patient from Amsterdam also visited Lombardy and thus was quarantined at home.2 According to the RIVM news, four family members of these two first patients were found positive on 29 February. Likewise, the seventh patient also had her trip to Lombardy days before and resided in home isolation when her test was found positive.3 The NOS news said4, she had no contact with other infected patients. However, such a statement may not be correct. Two explanations are possible. First, when visiting Lombardy, how could she know whether she had a contact with infected people? Simply speaking, it could be contaminated by a stranger. Second, she was possibly infected by another patient who showed no symptoms. Otherwise, it's impossible to be infected from nowhere. On 1 March, a 49-year-old woman, who was hospitalized at the Beatrix Hospital in Gorinchem on 21 February due to respiratory problems, was eventually found positive and then transferred to Erasmus MC in Rotterdam due to her deteriorating condition. Unfortunately, the Beatrix hospital did not conduct a test for the patient and thus failed to take any measures against the virus.5 In the following days, the number of infected people increased quickly, and the first death case, who admitted to the Ikazia Hospital in Rotterdam, was an 86-year-old man and died on 6 March6.

Of course, the number of confirmed cases depends very much on test policy, which may result in an increase or decrease in counting the infected patients.

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[1] "Patient with novel coronavirus COVID-19 in the Netherlands." *RIVM.nl*. 27 February 2020. Retrieved 2 April 2020.

[2] "Tweede patient in Nederland met COVID-19". *RIVM.nl*. 28 February 2020. Retrieved 2 April 2020.

[3] "Woman in Delft also has corona, seventh case in the Netherlands",NOS news, 29 February 2020. Retrieved 2 April 2020.

[4] Ibid.

[5] "Beatrix hospital Gorinchem closed for coronavirus, ten patients in NL", NOS news, 1 March 2020. Retrieved 2 April 2020.

[6] Janene Pieters, "First coronavirus fatality in Netherlands: Rotterdam patient dead at 86". *nltimes.nl*. 6 March 2020. Retrieved 2 April 2020.

According to the RIVM1, “People with mild complaints have not been tested since March 12 because there is a national measure to stay at home with the first complaints. In addition, more tests are being carried out among risk groups.” By limiting the scope of testing people, authorities could make test material sufficiently available for risky cases.2 In this case, many patients with mild complaints were in quarantine at home and could not be tested timely. As they were not in full quarantine, there was a high risk in contaminating other people.

In the evening on 16 March, Prime Minister Mark Rutte addressed the nation “on the corona crisis”, which was the first time a prime minister had addressed the nation since the 1973 oil crisis, on which former Prime Minister Joop den Uyl addressed the nation3. As an ‘address to the nation” is “an absolute rarity in the Netherlands”4, much attention was paid to Rutte’s speech. One major focus of PM Rutte’s address is the importance of protecting the elderly and other vulnerable people, who may face higher risks and thus are more concerned. He introduced three scenarios in terms of controlling the spread of the virus and explained the Dutch choice, which actually takes into serious consideration the situation of the elderly people. The three scenarios are to ‘maximally’ control the virus, to ‘let the virus run unchecked’ and to ‘endlessly try to stop the virus’.5 According to PM Rutte, ‘maximally controlling the virus” is the Dutch scenario of choice based upon a consideration to group immunity, and it means that Dutch authorities and people “try to use measures to level off and smooth the peak in the number of infections and spread it over a longer period” 6. By this approach, the spread of the virus can be slowed down and people will only

[1] “Two new corona deaths in the Netherlands, 155 registered patients”, NOS news, 14 March 2020. Retrieved 2 April 2020.
[2] Ibid.
[3] Dylan van Bekkum, “Rutte's live speech is an absolute rarity”, de Volkskrant, 16 March 2020. Retrieved 2 April 2020.
[4] Ibid.
[5] Janene Pieters, “Coronavirus: Full Text of Prime Minister Rutte's National Address in English”, nltimes.nl, 16 March 2020. Retrieved 2 April 2020.
[6] Ibid.

get minor complaints. Consequentially, the healthcare system will face less pressure and group immunity can be built over the time. By doing so, "nursing homes, in-home care, hospitals, and especially intensive care units are not overloaded", and "there is always sufficient capacity to help the people who are most vulnerable" 1 . However, the second and third scenarios will "completely overload our healthcare system at the peak of contamination" and "have to shut down our country for a year or even longer" respectively2. Meanwhile, Ruttes called on people for respecting scientific recommendations and for solidarity to overcome "the difficult period". Essentially, Prime Minister tried to send "a reassuring message" 3, as expected by Carla van Baalen of the Center for Parliamentary History, that the country and the rest part of the world are confronted with a virus crisis and a difficult time that takes the efforts of 17 million Dutch people and more. Meanwhile, the government decided to close all schools and childcare centres from Monday 16 March to Monday 6 April,4 which was later extended until 28 April (inclusive).

Mr Bruno Bruins, the Minister for Medical Care, who collapsed from exhaustion during a parliamentary debate on the epidemic, quitted his position because "it was unclear how long it would take for him to recover"5. On Thursday 19 March 2020, the King's Office has announced that His Majesty has honourably discharged Mr Bruno Bruins, upon his own request for resignation and the recommendation of the Prime Minister and thanked him for his many important services rendered to the monarch and the Kingdom.6 On the following day, the King's Office announced that

1 Janene Pieters, "Coronavirus: Full Text of Prime Minister Rutte's National Address in English", nltimes.nl, 16 March 2020. Retrieved 2 April 2020.
2 Ibid.
3 Dylan van Bekkum, "Rutte's live speech is an absolute rarity", de Volkskrant, 16 March 2020. Retrieved 2 April 2020.
4 Government of the Netherlands "Temporary closure of schools and childcare centres in strategy to fight coronavirus", 15 March 2020. Retrieved 2 April 2020.
5 "Exhausted Dutch minister leading coronavirus fight quits", *Reuters*, 19 March 2020. Retrieved 4 April 2020.
6 Government of the Netherlands, "Minister for Medical Care resigns", 19 March 2020. Retrieved 2 April 2020.

His Majesty would appoint Martin van Rijn as acting Minister for Medical Care on Friday 20 March 2020 upon the recommendation of the Prime Minister and that the new Minister would be received at Huis ten Bosch and sworn in on Monday 23 March 2020 in the presence of His Majesty the King.[1] Meanwhile, the Minister for Health, Welfare and Sport, Hugo de Jonge, would assume responsibility for the tasks of the Minister for Medical Care until a new minister is appointed.[2]

In the evening of 20 March, King of the Netherlands Willem-Alexander addressed the nation on the situation surrounding the COVID-19. He emphasized "the need for people to find it in their hearts to be as compassionate and assertive as possible during the coronavirus pandemic" and expressed "his gratitude and praise for many of the hardest working people in the country"[3]. Meanwhile, the King strongly believes that corona has unleashed "an incredible amount of positive energy, creativity and public-spiritedness"[4], with which the country will be able to tackle the crisis together. Essentially, King Willem-Alexander's address defines the Coronavirus outbreak as a challenging crisis on the one hand and calls on people for being united on the other hand.

According to the website of worldometer.info, as of as of Monday morning, 6 April, the total confirmed coronavirus cases have reached 17,851 and the death toll is 1,766 in the Netherlands, but it has only 250 recovered cases in total and its morality rate is close to 10%.

2.3 Luxemburg

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1 Government of the Netherlands, "Acting Minister for Medical Care appointed", 20 March 2020. Retrieved 2 April 2020.
2 Government of the Netherlands, "Minister for Medical Care resigns", 19 March 2020. Retrieved 2 April 2020.
3 Zack Newmark, "Full Text in English of Dutch King's Speech on the Coronavirus Pandemic", nltimes.nl, 20 March 2020. Retrieved 2 April 2020.
4 Ibid.

On Saturday, 29 February, the Ministry of Health of Luxembourg confirmed the country's patient zero, a man who had returned from Italy to Luxembourg "at the beginning of the week" and showed Coronavirus symptoms "more recently"[1]. Besides, according to Today.rtl.lu news, all the following six confirmed patients are imported cases, with two patients having "epidemiological link" with northern Italy, two patients returning from the Alsace region in France, and the other two returning from the US and Switzerland respectively. Additionally, the Ministry of Health informed that one of the confirmed cases is a cross-border worker, whose infection took place in France.2 From 11 March, the first cases of local transmission began to occur in Luxembourg, which also resulted in "a significant increase" in confirmed Coronavirus cases and urged the government to adopt new measures against the outbreak.3 According to the Ministry of Health, of the 12 new cases on 12 March, two of them were found to have contracted the coronavirus in the country.4 Shortly after finding the local cases, the government decided to adapt its control strategy by focusing "more on the treatment of severe cases and the protection of fragile populations"5.

On 13 March, Minister of Health Paulette Lenert, Minister for Mobility François Bausch, and Minister for Family Affairs Corinne Cahen held a press briefing about the coronavirus situation, with a focus on the question of "how Luxembourg is shielding its elderly citizens and other vulnerable members of society from the virus"6. Meanwhile, during the press, Paulette

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1 "Luxembourg reports first coronavirus case, linked to Italy", ThaiPBSWorld.com, 1 March 2020. Retrieved 3 April 2020.
2 The Luxembourg Government, "COVID-19 in Luxembourg: First infection diagnosed with a cross-border worker", 9 March 2020. Retrieved 3 April 2020.
3 The Lexembourg Government, "Measures taken by the Government Council of March 12, 2020 against the Coronavirus", 12 March 2020. Retrieved 3 April 2020.
4 "12 new confirmed cases in Luxembourg - among them first local infections", Today.rtl.lu, 12 March 2020. Retrieved 4 April 2020.
5 The Lexembourg Government, "Measures taken by the Government Council of March 12, 2020 against the Coronavirus", 12 March 2020. Retrieved 3 April 2020.
6 Gerry Erang, "Press conference summary - Luxembourg records first coronavirus death", today.rtl.lu, 14 March 2020. Retrieved 5 April 2020.

Lenert also announced that Luxembourg has recorded its first coronavirus death of a 94-year-old man. When 17 new cases occurred on 13 March alone, which brought the confirmed cases up to 51, Paulette Lenert stresses that "the virus has arrived," saying that the situation is starting to be "critical" and "unprecedented".1 Since then, the confirmed cases rise very fast in Luxembourg. When the total confirmed cases rose to 335 with 4 deaths in total on 19 March, Prime Minister of Luxembourg Xavier Bettel declared a state of emergency.

According to the data of the official website coronavirus of worldometer.info, as of Monday morning, 6 April, there are 2804 positive cases of 23,687 tests carried out since the beginning of the corona crisis and with 36 deaths.

3. Coronavirus Containment Measures in Benelux Countries

3.1 Belgium

Since the outbreak of the coronavirus, Belgium has already taken various measures to stem the spread of the virus. On 30 January, the Belgian government's information website name "info-coronavirus.be" was registered by authorities.2 This action could be regarded as a sign that authorities began to concern about the outbreak and recognized the necessity of sharing information for the public through a transparent approach.

3.1.1 Repatriation of Belgian Nationals

Together with other European nationals, 12 Belgian nationals, voluntarily repatriated from the Chinese province of Hubei, arrived at the Melsbroek military airport on 2 February by a joint evacuation flight, which landed in Marseille, from where non-French nationals were boarded into different flights depending on their destinations, with the Belgians and the Dutch

1 "51 confirmed cases of coronavirus in Luxembourg on Saturday (figure now revised to 81)", today.rtl.lu, 16 March 2020. Retrieved 5 April 2020.

2 "'info-coronavirus.be' était enregistré le 30 janvier: mais à part ça, la Belgique était-elle 'vraiment préparée' à la crise sanitaire?" (in French). RTBF. 30 March 2020.

boarding one plane together with some Slovakian, Danish and Czech evacuees.[1] In order to exclude any public health risk, the repatriated Belgians were kept in isolation from others throughout the entire process, and only a professional medical team had contact with them.[2] After medical checks at Neder-Over-Hembeek where the evacuees were put in quarantine, according to the public service (FPS Santé), one of the Belgian evacuees from China tested positive on 4 February and stayed at Saint Peter's Hospital in Brussels, which became the first confirmed Coronavirus case in Belgium[3], but he "had no signal, no fever, not even a snot"[4]. In addition to the repatriated Belgians, the Danish person, who was not able to travel on to Denmark on Sunday evening and tested negative, also stayed in Neder-Over-Hembeek for two nights and was transferred to the good care of the Danish government on 4 February.[5] On 9 February, two more people (one Belgian and one European national living in Belgium), who informed the FPS Foreign Affairs of their desire to leave China, flew back to Belgium from Wuhan on a British flight, which made a stopover in the UK, then flew to Berlin and finally landed in the Netherlands, and were placed in strict quarantine in the military hospital in Neder-Over-Hembeek but in a separate section from the first group.[6] During their quarantine, all the evacuees were tested several times so as to avoid any health risks. As of 16 February, all the nine Belgian evacuees were allowed to go home as

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1 Gabriela Galindo, "Belgians evacuated from China amid coronavirus outbreak arrived in Brussels", *The Brussels Times,* 3 February 2020. Retrieved 1 April 2020. According to the Belgian official website about the Coronavirus, nine Belgians were repatriated from China. Some news pointed out that the other three people are the relatives of these evacuated Belgians.
2 "Nine Belgians safely repatriated from Wuhan in China", 2 February 2020, info-coronavirus.be. Retrieved 1 April 2020.
3 Gabriela Galindo, "Belgians evacuated from China amid coronavirus outbreak arrived in Brussels", *The Brussels Times,* 3 February 2020. Retrieved 1 April 2020.
4 Hanne Decré, "Minister De Block: 'Kans is reëel dat coronavirus naar ons land komt, maar er is een plan'" (in Dutch), 25 February 2020. Retrieved 1 April 2020.
5 "One repatriated Belgian has tested positive for the novel coronavirus", 4 February 2020, info-coronavirus.be. Retrieved 1 April 2020.
6 "Two more people flown back to Belgium from China", 9 February 2020, info-coronavirus.be. Retrieved 1 April 2020.

they did not pose any risks to those around them1 and the other two who finished their fortnight quarantine on 23 March returned home.2 As of 21 February, all the ten Belgian nationals on the cruise ship Westerdam returned to their country and stayed isolated at home as a precaution as the risk of contamination was believed to be very small for the passengers of the Westerdam[3].

3.1.2 Cooperation with Social Media

On the one hand, as rumours and gossip are spreading rapidly across the online platforms we use, it's very important to cooperate with social media to share authentic information. On the other hand, as many people are currently searching for information through social media, it becomes quite necessary to make users have access to authentic information. To this end, on 7 February, info-coronavirus.be launched a partnership with Twitter, which will highlight the official website in searches, to contain false information and to guarantee readers reliable information for Belgium[4]. On 24 February, the Belgian official website info-coronavirus.be developed cooperation with Facebook, which is supposed to represent an official source of information and promote this website in the results on their timeline when users search for information about the new virus.[5]

3.1.3 Banning public activities

On 29 January, having consulted with other European countries and with China, the Belgian Ministry of Foreign Affairs tightened its travel advice

1 "End of quarantine for eight Belgian nationals who returned from Wuhan on 2 February",16 February 2020, info-coronavirus.be. Retrieved 1 April 2020.
2 "End of quarantine for two persons in the Military Hospital of Neder-over-Heembeek", 23 February 2020, info-coronavirus.be. Retrieved 1 April 2020.
3 "All Belgian nationals on cruise ship Westerdam back home", 21 February 2020, info-coronavirus.be. Retrieved 1 April 2020.
4 "Know the facts! #UnitedAgainstFakeNews", 7 February 2020, info-coronavirus.be. Retrieved 1 April 2020.
5 "Facebook helps us to promote reliable information about the new coronavirus covid-19", 24 February 2020, info-coronavirus.be. Retrieved 1 April 2020.

to China, with the exception of Hong Kong, and some travel agencies started to cancel trips to China due to the advice.[1]

The student association for Chinese students in Leuven decided not to celebrate the Chinese New Year, given that there was a potential risk of infection on the one hand and the association found the celebration inappropriate while dozens of people died from the Coronavirus on the other hand.2 Besides, VIVES University of Applied Sciences announced that the China trip for students of Commercial Sciences and Business in Bruges and Kortrijk has been postponed.[3]

3.1.4 Setting up GPs post

Anyone who feels ill is encouraged to call their General Practitioners (GPs) straight away, and the GPs will tell them what to do and prescribe the right medication for infected people to reduce their symptoms.4 It is said that, along with the hospitals, Belgian GPs have put in an enormous effort in recent weeks to make sure that everyone can get the right care. In general, the GPs are able to offer professional suggestions to the Coronavirus (potential) patients in four aspects5: First, when the potential patients have different symptoms, the GPs will listen carefully and decide on the best course of action; If you have mild Covid-19 symptoms, the GPs will follow up on you by telephone and ask you to stay strictly isolated at home until the symptoms disappear; if you need to be examined, the GPs will refer you to the nearest Triage Centre; and If the symptoms are causing much concern, the GPs may decide to send you to hospital, where you can be admitted.

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1 Jos De Greef, "Buitenlandse Zaken raadt alle niet-essentiële reizen naar China af wegens het coronavirus" (in Dutch), VRT nws, 29 January 2020.
2 Michael Torfs, "Douaniers op onze luchthavens dragen voortaan mondmaskers: 'Maar hier masker dragen tegen coronavirus heeft geen zin'" (in Dutch), VRT nws, 29 January 2020.
3 Ibid.
4 "Help our hospitals and GPs to beat the Covid-19 virus", 31 March 2020, info-coronavirus.be. Retrieved 1 April 2020.
5 Ibid.

3.1.5 Closing borders

Since 18 March, Belgium has banned non-essential travel abroad, but the circulation of goods and services remains authorized.[1] From 20 March, Belgium has forbidden all entry to the country without an essential reason while border checks are put in place and it is a must to have justification for crossing the border.[2] According to Interior Minister Pieter De Crem[3], Belgium closes its borders for "non-essential inbound and outbound travel" to make the spread of the coronavirus slower", cross-border trips, which is a "particularly large burden" on Belgian efforts to counter the spread of the virus, are banned, border checks are restored and strict sanctions up up to €4,000 and three months in prison are also ready for rule breaches. It is said that the new rules on travel restrictions also prevent Belgian residents from moving to a second residence on Belgian territory[4]. Basically, the restrictions target tourist or leisure border crossings but also applies anyone who has a secondary residence in Belgium[5]. Apparently, it is also in line with the general call for staying at home.

All in all, Belgian containment measures are in line with the main aim of slowing the spread of the virus and delaying the peak of contamination in a longer time. At the beginning stage, all the patients are imported cases, of which most patients had been to northern Italy. As the containment policy was to delay the peak of the infections, people with mild complaints were not put in strict quarantine, which probably contributed to the rapid increase in the confirmed number at later time. Meanwhile, people seriously underestimated the outbreak and its impact on many aspects of

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1 "Questions about crossing our borders?", centredecrise.be, 29 March 2020. Retrieved 4 April 2020. For detailed information about the essential and non-essential activities, see the website of Centre de Crise.
2 Embassy of Estonia in Brussels, "COVID-19 – situation in Belgium and Luxembourg and crossing borders", 30 March 2020. Retrieved 4 April 2020.
3 Hanne Cokelaere, "Belgium closes borders for 'non-essential' travel", *Politico*, 20 March 2020. Retrieved 4 April 2020.
4 Ibid.
5 Gabriela Galindo, "Coronavirus: Belgium shuts borders to all 'non-essential' travel", *The Brussels Times*, 20 March 2020. Retrieved 4 April 2020.

social life (definitely not limited to economy). Thus, they neither took into serious consideration the whole situation, nor did they fully recognize the necessity of protecting themselves and others too.

3.1.6 Mask-wearing is not a top option

At the beginning, people were discouraged to wear mask. Virologist Marc Van Ranst (KU Leuven) said, “The virus is not here. And even if there is an initial case here, it will be an isolated case, and there is no risk yet. So in Belgium wearing masks makes no sense at all.”1 Virologist Steven Van Gucht of the Institute of Health Scienasano expressed the same idea that surgical masks are of little use in Belgium, but they can “protect others a bit of you are infected yourself”, saying that the really efficient masks are completely different and more expensive types and “very uncomfortable” to wear.2 When asked questions about wearing masks, Van Gucht said3:

“Indeed, wearing a surgical mask is necessary for persons who are already infected by the coronavirus. In this case, the masks protect the people around the patient from the germs transmitted when coughing, sneezing or talking. The healthcare staff working in an environment where a patient infected by the coronavirus is under treatment should also benefit from this kind of mask. So, wearing a mask in the street is not very useful for someone in good health.”

He further explained, “The best way to protect oneself against the coronavirus is just to apply the same protection measures as for the season flu:

-Wash your hands regularly with soap and water,

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1 Michael Torfs, "Douaniers op onze luchthavens dragen voortaan mondmaskers: ‘Maar hier masker dragen tegen coronavirus heeft geen zin’" (in Dutch), VRT nws, 29 January 2020.

2 "China zuigt alle mondmaskers aan in België" (in Dutch). De Standaard. 29 January 2020.

3 “Virologist Steven Van Gucht answers 3 questions about wearing a face mask”, 26 February 2020, info-coronavirus.be. Retrieved 1 April 2020.

-Cover your mouth with a tissue handkerchief when coughing or sneezing and throw it away after use, then wash your hands,

-If you don't have a handkerchief, cough or sneeze in your elbow, not in your hands

-If you are ill, stay a home." [1]

However, on 15 March, in a debate in the news program the Seventh day, Virologist Marc Van Ranst pointed out that stocks in Belgium are running out and it is "a very big problem"2. Belgium ordered 5 million masks from a Turkish producer, but it became clear on 15 March that the masks cannot be delivered on time as the masks might have involved fraud3. Belgium had placed the order of 5 million masks with various protective equipment for an amount of five million euros, as a part of a group purchase for Member States organized by the EU by late February, and products were intended for general practitioners and hospitals.4 The group purchase made it possible for Member States to gain time "by avoiding them to carry on separate negotiations with producers and suppliers"5. These protective equipment and masks were supposed to support hospitals in case of a shortage, general practitioners and healthcare staff who are responsible for providing care to their patients, the Coronavirus-infected people6. It is said that another large order (of more than 1 million mask pieces) by the Flemish government was also jeopardized by the problems at the same producer.7 Soon, the Belgian federal prosecutor's office opened a fraud investigation while "other avenues" were being pursued according to Health minister

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1 "Virologist Steven Van Gucht answers 3 questions about wearing a face mask", 26 February 2020, info-coronavirus.be. Retrieved 1 April 2020.

2 *"Mogelijk fraude: kans dat mondmaskers tijdig geleverd worden aan ons land, 'is miniem'" (in Dutch). De Standaard. 16 March 2020.*

3 Ibid.

4 "Belgium suspects Turkey firm of fraud: 5 million masks missing!" ANF News, 17 March 2020.

5 "Face masks and other protective equipment: Belgium participates in the joint procurement at European level", 27 February 2020, info-coronavirus.be. Retrieved 2 April 2020.

6 Ibid.

7 *"Mogelijk fraude: kans dat mondmaskers tijdig geleverd worden aan ons land, 'is miniem'" (in Dutch). De Standaard. 16 March 2020.*

Maggie De Block.[1] Over the time, people find protective and medical equipment more important and urgent, especially for medical staff. Otherwise, many medical practitioners are basically exposed to the virus. On 22 March, two surgeons at Saint-Pierre hospital (ULB) in Brussels wrote an open entitled "La double peine du personnel hospitalier (The double punishment of hospital staff)" to Prime Minister Sophie Wilmès, demanding "a systematic detection test for the coronavirus from patients and caregivers"[2] and calling for "the mobilisation of Belgian industries and laboratories to provide Belgium with sufficient production capacity"[3]. On 24 March, in her response letter, Wilmès "referred to the decision to appoint a task force, set up by Health Minister Maggie De Block and led by Minister Philippe De Backer, the 'minister of masks', on the management and restocking of equipment" and also confirmed that "in total, over the past ten days, 11.5 million surgical masks and 459,000 FFP2 masks have been received in Belgium, while several companies are developing domestic mask production projects".[4] As of the date, 16,500,000 surgical masks already arrived in Belgium and were distributed or were being distributed, along with 544,000 FFP2-type masks, and in total, 30,500,000 surgical masks had been ordered, together with 5,359,000 FFP2 masks.[5] To dispatch the masks efficiently, the authorities, who are also building a strategic stock of masks, have designated its priority groups: hospitals, ambulances, sorting centres, health professionals in general, laboratory staff and suspicious/confirmed cases in residential communities.[6]

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1 "Belgium launches fraud investigation over missing coronavirus masks", The Bulletin, 15 March 2020.
2 "'The double punishment of hospital staff': the open letter from two surgeons who demand systematic tests from the Prime Minister!", Sudinfo.be, 22 March 2020.
3 Alexandra Brzozowski, "Belgian surgeons sound alarm over scarcity of masks, reagents and drugs", EURACTIV.com, 25 March 2020.
4 Ibid.
5 "Delivery and distribution of masks: situation and stocks", 25 March 2020, info-coronavirus.be. Retrieved 2 April 2020.
6 Ibid.

All these issues have demonstrated the necessity of masks and other protective equipment, revealed the failure in renewing the strategic reserves of the masks, and more importantly exposed the relevant authorities' ability of assessing and predicting the situation of the Coronavirus outbreak, which is seriously underestimated.

3.2 The Netherlands

The paramount purpose of Dutch approach to tackling the Coronavirus outbreak is to control the spread at the maximum.1 To this end, the main guiding principle is to "lead to a controlled spread among the groups least at risk", "stop nursing homes, home care services, hospitals and, above all, intensive care units becoming overwhelmed" and "make sure they always have enough capacity to help the people who need it most" 2. Basically, the authorities have been facing two major types of pressure. On the one hand, the authorities feel pressured due to the shortage of medical and protective gear, which consequentially shrinks the scope of people to be tested and certainly increases the risk of infection among wider population. On the other hand, the authorities have to take into account the capacity of hospitals so that patients could get proper care. Therefore, all the measures taken need to take these two factors into consideration. On 31 March, as the risk was still high, the Dutch government decided that all measures taken to fight the coronavirus outbreak will be extended until Tuesday 28 April inclusive[3].

3.2.1 Help from GP Post

The potential patients are encouraged to call the doctor or the GP post if the symptoms get worse, which specifically include two situations according to the official website information of the RIVM. That is, when

1 Government of the Netherlands, "The approach to tackling coronavirus in the Netherlands". Retrieved 2 April 2020.
2 Ibid.
3 Government of the Netherlands, "Measures to combat coronavirus extended until Tuesday 28 April inclusive", 31 March 2020. Retrieved 2 April 2020.

the potential patients (1) "have a fever (over 38 degrees Celsius)" and "cough or breathe hard" and (2) "are over 70, have a chronic illness or less resistance AND you get a fever", they are hoped to take the initiative to contact the doctors.1

3.2.2 Home Isolation and Social Distance

Two main measures at the general level are to stay at home and to keep social distance. In the case of home isolation2, people are allowed to leave the house but hopefully and only to go for work when it's not available from home, to buy essential goods, to take care of other people, and to a less extent to get some fresh air without being in groups. Nevertheless, this measure is not applicable to key workers in crucial sectors and critical processes 3 , unless they themselves get sick. Besides, social distance measure encourages people to always keep a good distance from others (at least 1.5 metres), to avoid all social events and groups of people, to limit the number of family visitors (up to 3).4 For those who have a cough and other mild complaints, they are encouraged first to quarantine at home as a precaution.

3.2.3 Reducing public gatherings and cancelling social events

The Dutch government tried to minimize public gatherings as an effort to contain the Coronavirus outbreak. On 12 March, the government decided that gatherings of more than 100 people would be cancelled throughout the Netherlands5. To achieve this objective more efficiently, on the one hand, Dutch public events and gatherings, for which organisers would normally

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1 "Current information about the new coronavirus (COVID-19)", 1 April 2020, DutchNews.nl. Retrieved 2 April 2020.
2 Government of the Netherlands, "The approach to tackling coronavirus in the Netherlands". Retrieved 2 April 2020.
3 For more information about crucial sectors and other, see "Childcare for children of people working in crucial sectors", Government of the Netherlands.
4 Government of the Netherlands, "The approach to tackling coronavirus in the Netherlands". Retrieved 2 April 2020.
5 Government of the Netherlands, "New measures to stop spread of coronavirus in the Netherlands", 12 March 2020. Retrieved 2 April 2020.

be required to apply for a permit or notify the authorities, are banned until 1 June 2020. On the other hand, all other gatherings are banned until 28 April (inclusive), with a small number of exceptions: funerals and marriage ceremonies (no more than 30 people), religious or ideological gatherings (no more than 30 people), gatherings that are required by law, such as municipal council meetings and meetings of the States-General (no more than 100 people), gatherings that are necessary to ensure the continued daily operations of institutions, businesses and other organisations (no more than 100 people). The government emphasized that all these gatherings listed above "can only take place if all recommended hygiene measures to combat the spread of coronavirus are taken and participants stay 1.5 metres away from one another" [1].

Apart from the aforementioned measures, various public places (such as museums, concert venues, theatres, sports clubs, casinos, bars, cafés, restaurants with an exception of take-away services) stay closed, and jobs with contact-based roles stop performing (unless the required social distance and hygiene can be guaranteed) until 28 April (inclusive)[2].

3.2.4 Online education

Regarding education issue, the Dutch government advocates to launch online education and cancels all national exams for this school year[3]. Firstly, Distance learning is organized for students from primary and second schools, secondary vocational education schools and childcare centres will stay closed until 28 April (inclusive), but all these institutions will remain open for the children whose parents working in crucial sectors like healthcare, the police, public transport and the fire service with no extra charge. Secondly, all national exams for this school year are cancelled, but pupils can obtain their school-leaving certificates based on their results on

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1 Government of the Netherlands, "The approach to tackling coronavirus in the Netherlands". Retrieved 2 April 2020.
2 Ibid.
3 Ibid.

the school exams. Furthermore, higher education institutions are requested to give online lectures.

3.2.5 Welcoming back former nurses and doctors

According to former Minister of Medical Care, Bruno Bruins, he received many messages every day from former nurses and doctors that they want to help former healthcare colleagues, which encouraged him to made the decision that nurses and doctors whose registration in the Dutch Healthcare Professionals (BIG) Register expired after 1 January 2018 may take up their former profession without the requirement for registration process again.[1] Bruno's rationales for the decision are that: the healthcare sector urgently needs more staff to deal effectively with the coronavirus outbreak on the one hand and this measure will enable healthcare institutions to benefit from the experience and expertise of former nurses and doctors on the other hand.

3.2.6 Closing its borders to persons from third countries

To combat the spread of the virus, the Ministry of Security and Justice of the Netherlands, based on the approach proposed by the European Commission, imposed a restriction concerning all non-essential travels by persons from third countries to Europe (i.e. all EU member states, all Schengen countries and the United Kingdom) from 18:00 on 19 March,[2] which in principle will remain in force for 30 days.[3] According to the official information, the restriction does not apply to the several categories of persons, including EU (and UK) citizens and their families, nationals of Norway, Iceland, Switzerland and Liechtenstein and their families, third country nationals with a residence permit, persons who perform a crucial

1 Government of the Netherlands "Former nurses and doctors welcome back in profession", 18 March 2020. Retrieved 2 April 2020.
2 Janene Pieters, "Dutch stranded abroad by closing borders, canceled flights", nltimes.nl, 19 March 2020. Retrieved 2 April 2020.
3 Government of the Netherlands, "The Netherlands closes its borders to persons from outside Europe" 18 March 2020. Retrieved 2 April 2020.

function or have imperative needs and so forth.[1] Basically, this restriction does not exert much impact on European nationals but on non-European nationals with non-essential journeys. The global COVID-19 virus has far-reaching consequences for the services provided by Dutch embassies worldwide, including external service providers such as visa agencies, and until at least 28 April 2020 no passport applications, visa applications for short and long stays will be collected via embassies and visa agencies.[2]

3.2.7 Others at various social levels

Except all the aforementioned measures, many other measures have been taken to curb the outbreak. For instance, considering the closed nature of DJI institutions and the safety of personnel and prisoners, the Custodial Institutions Agency (DJI) decided that all visits to prisoners in custodial institutions were suspended from 14 March.[3] Likewise, to better protect vulnerable elderly against coronavirus (COVID-19), Health minister Hugo de Jonge announced that nursing homes and small-scale residential accommodation for the elderly would be closed to visitors and anyone not involved in the provision of basic care from 20 March[4], which will apply nationwide until at least 6 April inclusive according to original plan and now is further extended until 28 April. One more instance is that the disability care and psychiatric care sectors adopted new visitors regulations with an intention of better protecting staff and residents in care homes (youth care homes included) against the Coronavirus,[5] which will also apply at least until 28 April.

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1 Government of the Netherlands, "The Netherlands closes its borders to persons from outside Europe" 18 March 2020. Retrieved 2 April 2020. For detailed information about people who are allowed to enter the border, see the website.
2 Government of the Netherlands, "Coronavirus: visas for the Netherlands". Retrieved 2 April 2020.
3 Government of the Netherlands, "DJI takes preventive action against coronavirus", 13 March 2020. Retrieved 2 April 2020.
4 Government of the Netherlands, "Coronavirus puts stop to visits to nursing homes", 19 March 2020. Retrieved 2April 2020.
5 Government of the Netherlands, "New visitors regulations for the disability care and psychiatric care sectors", 23 March 2020. Retrieved 2 April 2020.

3.2.8 Special Cases

According to the Dutch government website information, some essential places such as markets are playing special roles in people's daily life, different regulations are applied that municipalities and markets superintendents will examine and ensure the social distance among the public. In addition, mayors are empowered to introduce local emergency legislation with an aim of improving the enforcement of the containment measures, to close specific locations and impose fines.

3.3 Luxemburg

Luxembourg follows containment measures taken by other European countries, in particular Switzerland and Belgium.

3.3.1 Prioritizing protection of vulnerable people

As the coronavirus cases are increasing quickly and as it comes to be clear that it is impossible to keep the virus from spreading throughout the general population"[1], Luxembourg's policy shifted from fully controlling the spread of the virus to choosing to focus on vulnerable people and abate the pressure of healthcare system. More importantly, since its adaptation of coronavirus prevention and control measures on 12 March, the country's "accent lies on the protection of fragile populations at risk of severe complications"[2]. People over the age of 65 or those who already have one of the conditions (diabetes, cardiovascular illnesses, chronic respiratory diseases, cancer, immune weakness due to illness or therapy) are believed to be at increased risk of developing severe complications, and thus they are recommended, if necessary, to run errands outside of rush hour and to avoid unnecessary trips, mass events and crowded place where social distance (1-2 metres) cannot be guaranteed, public transport, etc.[3] The

1 The Government of the Grand Duchy Luxembourg, "WEBSITE CORONAVIRUS (COVID-19)". Retrieved 3 April 2020.
2 Ibid.
3 The Luxembourg Government, "Measures taken by the Government Council of March 12, 2020 against the Coronavirus", 12 March 2020. Retrieved 3 April 2020.

rationale behind this decision is that patients with mild complaints are likely to develop immunity against the coronavirus and eventually herd immunity could be build up. On the other hand, the limited medical resources could be concentrated on patients with critical conditions. In doing so, the healthcare system is less pressured, and the outbreak situation will not be out of control. However, such an assumption can only be valid when the virus is not a big threat to the life of most population. Even though the majority of the death toll in Luxembourg and the rest part of the world are the elderly people, there is a considerable number of young people suffering from the virus. Thus, further appraisal of the Coronavirus and its lethality is needed, and group immunity as a measure remains to be seen. To better protect, Luxembourg approved nursing homes and accommodation facilities for the elderly people, who are also required to follow the government's recommendations (avoiding visitors and outings, respecting hygiene rules) until further notice.[1]

3.3.2 Activating online education

From 16 march, all activities in basic, secondary and higher education structures were suspended, but a remote supervision system is put in place to ensure continuity of learning during the period of suspension.[2] Meanwhile, parents are allowed to exercise their right to leave for family reasons.

3.3.3 Suspending public events and gatherings and keep social distance

As early as 9 March, the Health Department recommended that public events, which bring together more than 1,000 people in a confined environment and thus make the traceability of contacts more difficult, should not be organized or even postponed, because large public gatherings

1 The Luxembourg Government, "Measures taken by the Government Council of March 12, 2020 against the Coronavirus", 12 March 2020. Retrieved 3 April 2020.
2 Ibid.

encourage the transmission of the virus.1 This recommendation is based upon concerns to "protect the public health of our population by preventing the spread of the coronavirus and reducing the potential multiplication of transmission chains in the presence of events where participants are often very close to each other"2.

From 13 March until further notice, protected demonstrations of more than 100 people are prohibited, and demonstrations in an unconfined environment gathering more than 500 people are prohibited. In addition, news rules were made so as to reduce the risk in the public transport. For instance, in order to avoid prolonged close contact with the driver, the first two rows in the buses are omitted for passengers, and the frequency of public transport are also adjusted.3 As of 17 March, the Government of Luxembourg has issued a State of Emergency and implemented several new measures and suggestions to prevent the spread of COVID-19, including social distance measure.4 Citizens are advised to only leave their homes for the essential purposes, and Grand Ducal Police patrols may impose penalty fines for those rule-breakers.

3.3.4 Diagnostic tests reduced, self-isolation and auto-quarantine measures

Luxembourg's anti-pandemic strategy "does not rely on formal preventive quarantine measures anymore, but instead focuses on isolation, auto-isolation and auto-quarantine" 5 . The Government Council has also clarified when and how the diagnostic tests, self-isolation and auto-

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1 The Luxembourg Government, "COVID-19: Recommendation from the Department of Health concerning events involving more than 1000 people", 9 March 2020. Retrieved 3 April 2020.
2 Ibid.
3 The Luxembourg Government, "Measures taken by the Government Council of March 12, 2020 against the Coronavirus", 12 March 2020. Retrieved 3 April 2020.
4 U.S. Embassy in Luxembourg, "COVID-19 Information", 3 April 2020. Retrieved 4 April 2020.
5 The Government of the Grand Duchy Luxembourg, "WEBSITE CORONAVIRUS (COVID-19)". Retrieved 3 April 2020.

quarantine measures should be carried out[1]. Firstly, the government does no longer recommend systematic diagnostic test for any suspected infection, as the test is supposed to be reserved for severe cases or with complications. Thus, a test indication is no longer an indication of defining the risk zone. Secondly, any patient who presents symptoms compatible with an acute respiratory infection goes into self-isolation at home for the duration of the symptoms followed by a period of 24 hours after the end symptoms, and a test is no longer necessary if the symptoms remain mild. However, people, in particular family members, are facing a relatively high risk of be infected during the incubation period if a family member gets the disease, which may result in transmission in clusters. Thirdly, anyone who has been in direct or close contact (<2m, more than 15 minutes) with a confirmed case of infection goes into auto-quarantine at home for 7 days, followed by a period of 7 days self-monitoring (resumption of normal activities, but monitoring of body temperature twice a day, or cough, breathing difficulties).

3.3.5 Hospital structures and others

Health personnel are required to take all the necessary protective measures to ensure the protection of patients, and it is recommended to cancel the leave of health personnel, if such a measure becomes necessary in the light of the evolution of the situation.[2] This measure is of great importance considering the shortage of human resources in the field of healthcare system. At the same time, since March 18, general medical centres are accepting patients with symptoms of acute respiratory infection in order to minimize the number of patients seeking emergency services and care in general medical practices, which is considered an effort to curb the spread of the pandemic and to allow on-site access to diagnosis by personnel

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1 The Luxembourg Government, “Measures taken by the Government Council of March 12, 2020 against the Coronavirus”, 12 March 2020. Retrieved 3 April 2020.
2 Ibid.

provided with the required protections.[1] Besides, regarding the importance of essential social services, companies and public administrations are encouraged to continue their activities as far as possible on the basis of their business continuity plan, and telework is to be promoted as far as possible, not least preferably among the vulnerable population.[2] As there is no certain information about the possible duration of the coronavirus outbreak on the one hand and the impact of the crisis is apparently quite obvious, to guarantee the continuity of normal social services comes to be essential in many aspects, such as maintenance of social order, social stability, social security, economic development, employment, etc.

3.3.6 Introduction of leave for family support

On 3 April, the Luxembourg government introduced paid family support leave, which is limited to assisting workers in the private sector and the self-employed who are forced to stop working for the closure of an approved structure for people with disabilities or for the elderly, in order to make the beneficiaries take care of a disabled adult or a dependent elderly person living in their household.[3] The measure is applicable retroactively to March 18, 2020, but of course those who want to benefit from this policy have to meet three conditions.

3.3.7 Closing its borders?

Luxembourg has not announced to shut down its borders, but most of its neighbour countries closed their borders. France, the Netherlands, Austria and Germany closed their borders with Luxembourg.[4] As the European Commission have not made a decision on suspending the Schengen Area temporarily and closing its both internal and external borders, most

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1 U.S. Embassy in Luxembourg, "COVID-19 Information", 3 April 2020. Retrieved 4 April 2020.

2 The Luxembourg Government, "Measures taken by the Government Council of March 12, 2020 against the Coronavirus", 12 March 2020. Retrieved 3 April 2020.

3 The Luxembourg Government, "Covid-19: Introduction of leave for family support", 3 April 2020. Retrieved 3 April 2020.

4 "21/26 Schengen Countries Have Already Closed Borders While EC Still Mulls Schengen Suspension Idea", 17 March 2020. Retrieved 4 April 2020.

Member States did so unilaterally.[1] So far, Belgium, France and Germany have restricted their borders crossing with Luxembourg to those only with valid reasons, such as healthcare workers, vehicles carrying cargo, commuters or cross-border workers and diplomats.[2]

4. Some thoughts on the coronavirus containment measures, its impact and its challenge

4.1 Containment measures: a perspective of wearing-mask

The coronavirus containment measures differ from one country to another. This is because countries are differently affected by the coronavirus outbreak on the one hand and thus hold divergent views on how to respond the crisis on the other hand. For instance, whether ordinary people should wear a mask or not has been a hotly debated subject.

As the World Health Organisation (WHO) does not recommend to wear a mask “in a preventive manner” as a means to avoid contamination with the COVID-19 virus, Luxembourg, along with many other European countries, respects this recommendation and does not encourage ordinary people to wear it. Instead, it is a common sense in the country and the rest part of the world that health personnel, who themselves have respiratory symptoms, should wear a surgical mask to avoid contaminating others. The use of special masks (FFP2) to prevent infection with coronavirus only makes sense in hospitals where patients infected with Coronavirus are treated and for the analysis of the body material of these patients.[3] Particularly, there is a necessity for healthcare personnel to wear a FFP2 mask when a test (nasal swab) is performed on a patient and similarly for the laboratory technicians to wear a surgical mask when they are handling respiratory samples.

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1 “21/26 Schengen Countries Have Already Closed Borders While EC Still Mulls Schengen Suspension Idea”, 17 March 2020. Retrieved 4 April 2020.
2 U.S. Embassy in Luxembourg, “COVID-19 Information”, 3 April 2020. Retrieved 4 April 2020.
3 The Government of the Grand Duchy Luxembourg, “WEBSITE CORONAVIRUS (COVID-19)”. Retrieved 3 April 2020.

There are also some reasons explaining the discouragement of wearing a mask. **Above all**, for sure the shortage of medical and protective gears including different types of masks is one of main concerns behind the discouragement of ordinary people from wearing a mask. Even though there had some time to prepare for the storage of medical equipment for Europe and the rest part of the world when the outbreak was mainly confined within the Chinese border, probably most countries including European ones, dating back to that time, probably did not expect what they are going through currently.

In addition, for ordinary people (non-healthcare professionals), wearing a mask may not make much sense if people avoid all gatherings and social distance is guaranteed. In this way, wearing a mask is a way of wasting the limited medical resources. Sometimes, culture is considered as a factor explaining why people do or do not wear a mask, which, however, is not so well-grounded. No culture is coming from nowhere. For instance, Japanese people have a habit of wearing a mask because many people are allergic to pollen, which is a social phenomenon instead of a 'culture'. One more instance is that almost every Chinese in cities and sometimes small places has been encouraged to wear a mask, which is mandatory if they leave their houses. However, it cannot say that wearing a mask is a part of Chinese culture. Instead, the fact that Chinese people may have good awareness of protecting themselves is a more convincing explanation. European people do not wear a mask partly because they are following the professional instructions of the WTO and national authorities, who uphold that masks are more helpful for healthcare professionals, and partly because they do not think that the Coronavirus is as dangerous and lethal as people say. Partly, both in the Chinese and European cases, people are following the instructions of their authorities. According to experts, the biggest benefit of mask-wearing is "protecting others from you in the event that

you are sick or asymptomatic" but masks "aren't as effective" if you try to protect yourself from getting infected from others.[1]

Moreover, whether people should wear a mask also depends upon what type of Coronavirus containment strategies different countries adopt. While Chinese strategy is to fully control the spread of the virus, European strategy (though there is no unified strategy) in general is to maximally stem the outbreak with a major concern of reducing the pressure of healthcare system simultaneously and with a ray of hope to build up group immunity. Due to the variations in Coronavirus containment measures, there is a huge difference in the number of confirmed cases (see the table below).

Last but not the least, wearing a mask may also produce some psychological impact both in positive and negative ways. For some people, mask-wearing is a sign of self-protection and sense of social responsibility; for others, mask-wearing is a sign of causing social panic. One explanation for the nuanced perceptions on mask-wearing is that people interpret mask-wearing. For those who do not have the disease, mask-wearing is a way of protecting themselves from being infected; for those who have the disease, mask-wearing is a way of protecting others from being infected. Thus, if people misunderstand the situation, conflicts may occur. To a large extent, the dispute is unavoidable.

4.2 Containing the coronavirus needs international cooperation

Without any doubt, the coronavirus outbreak is a global issue. No one single country can curb the spread of the virus alone. When the crisis broke out in Wuhan in January, the country faced the problem of scarcity of medical and protective gear. Many European countries and other international partners came to aid China to face the challenge together. Later on, when other countries were confronted with the sudden outbreak of coronavirus by the end of February, they had the same problem of

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1 Sumathi Reddy, "What Are the Benefits of Wearing a Face Mask?", 3 April 2020. Retrieved 4 April 2020.

shortage in medical materials. At that time, as China gradually brought the outbreak under control, the country began to restart its production and some major industrial companies returned to work.[1] This made it possible for China to restart its production of medical supplies and help other countries.

Apart from medical and protective supplies, sharing coronavirus experience and knowledge becomes an important and urgent issue at the global level. As the coronavirus crisis broke out first in China, who is also one of the first countries to bring the outbreak under good control, the country had much experience and knowledge regarding how to prevent and control the spread of the virus. China began to share coronavirus experience and knowledge with various other countries and even send medical teams to help them fight the pandemic.[2]

Certainly, international cooperation is not just limited to the bilateral cooperation between China and European countries. It's taking place both at the regional level and globally. The EU institutions have been trying to coordinate its Member States and fight the pandemic together. Putting aside some undesirable aspects exploded at the beginning stage of the outbreak, the EU did not retreat from assisting its Member States to overcome the difficult time. The pandemic is not just a health crisis or an economic crisis. It's essentially the representation of multiple crises. Admittedly, economic losses are obvious and unavoidable. To help its Member States to overcome the difficulties, the European Commission has launched "a Coronavirus Response Investment Initiative (CRII) to mobilise cohesion policy to flexibly respond to the rapidly emerging needs in the most exposed sectors, such as healthcare, SMEs and labour markets, and help the most affected territories in Member States and their citizens"[3]. The Initiative can help Member States immediately address three key priorities in the fight against

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1 "China's main manufacturing hubs reboot after virus shutdown", Reuters, 25 February 2020. Retrieved 6 April 2020.
2 "Exporting coronavirus knowledge, China sends medical teams to countries to help fight pandemic", *South China Morning Post*, 12 March 2020. Retrieved 6 April 2020.
3 European Commission, "Coronavirus Response Investment Initiative". Retrieved 6 April 2020.

the current emergency and its economic consequences: spending on healthcare, support to short time work schemes, and support to the SMEs working capital.[1] On 18 March 2020, Commissioners Elisa Ferreira responsible for Cohesion and Reforms and Nicolas Schmit responsible for Jobs and Social Rights have sent letters to all the EU countries to inform them on the individual support they can receive under the CRII.

Undoubtedly, international cooperation goes far beyond this, and at the global level more cooperation and coordination are needed to fight the pandemic. So far, there is no sign showing the possible end of the coronavirus outbreak soon.

4.3 The corona crisis: a health hazard or a democratic crisis?

Above all, the coronavirus outbreak is for sure a health crisis as many countries have claimed. According to the website of worldometer.info, as of 5 April, there are over 1.2 million confirmed cases and over 67,232 deaths globally.

As the epicenter of the pandemic shifted from Wuhan of China to Europe, European countries are seeing fast rises in the number of confirmed coronavirus cases. The sudden outbreak in Europe has made people doubt about the efficiency of containment measures taken by democratic countries and about their capacity of crisis management. Some people have even claimed that democratic principles are endangered. It will be very interesting and worth to debate on the capacity of crisis management of different political systems. Nevertheless, in the Chinese and European cases, it is the containment strategies that have made the huge differences in the number of the confirmed coronavirus cases. While China tries to fully control the spread of the virus, the aim of European counterparts is to delay the peak of contamination, which actually allows the slow infection

1 European Commission, "Coronavirus Response Investment Initiative". Retrieved 6 April 2020.

among the general people so that group immunity, also known as herd immunity, could be build up.

While the author does not have much belief in the collapse discourse of democratic system, the corona crisis does pose a huge challenge to the efficiency of democratic systems and particularly to the EU project. Even though various European countries claimed before the sudden outbreak in Europe that they were well prepared for how to respond the crisis, the reality did show that they were not so ready for the whole situation. For instance, various countries are facing the shortage of strategic stock of medical and protective gear, and mutual trust and assistance between Member states (and EU institutions) is another issue. This is partly because the real situation goes far beyond what they expected. The capacity of hospital admissions is a typical instance.

When asked whether democratic principles are endangered, Wolfgang Merkel, head of the Department of Democracy and Democratization at the Berlin Social Science Center, said that "It depends a lot on how long this crisis and the restriction of fundamental freedoms last".[1] He sees the freedom of movement, assembly and religion being "massively limited" at the moment. However, his interpretation on democratic principles seems to be quite stubborn. Free movement does not mean that people can move freely even when they are facing crises like coronavirus outbreak. If free movement is threatening the safety of other people, it's supposed to be "massively limited". Essentially, free movement is not free but conditional.

Merkel is particularly concerned about two possible scenarios: first, if governments fail to contain the crisis and the number of victims rises, citizens' trust in the system erodes; second, if the elites rule "with almost authoritarian means" prove successful, people may doubt about the roles of the parliaments.[2] As a consequence, some governments may use the threat

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1 Grzegorz Szymanowski, "How coronavirus challenges open democracies", dw.com, 25 March 2020. Retrieved 5 April 2020.
2 Ibid.

of the pandemic as an excuse to expand their own power. There is such a possibility, but so far the discourse that denies the value of democratic principles due to the outbreak is not well grounded either. It's not just about what much the authorities do, but also about how they communicate their containment strategies with their citizens. Apparently, there is a communicative deficit regarding the coronavirus outbreak. Many citizens have no idea about the measures taken by the relevant authorities.

5. Conclusion

The coronavirus is still going on, and its peak does not occur yet in Benelux countries and other European countries. Therefore, there are many uncertainties in assessing the situation in Europe and in the rest part of the world in a wider sense.

Above all, like most other European countries, the Benelux countries did not expect that the coronavirus broke out in such a sudden. Both the relevant authorities and the public underestimated the severity of the coronavirus infection. To a large extent, the undesirable situation can be ascribed to the insufficient preparedness of the authorities, and symptom-free patients might have infected others and speeded up the spread of the virus. The underestimation has also been shown by the fact that the original deadlines for containment measures were frequently extended by the relevant Benelux authorities.

Besides, the Benelux countries' coronavirus containment strategies, which are basically based upon the theory of herd immunity either as a by-product or a main goal, are the main and safe explanations for the high number of the confirmed coronavirus cases. Essentially, the containment strategies mainly aim at slowing the spread of the virus instead of cutting off the pandemic's transmission routes. In a wider sense, different prevention and control measures are the major factors explaining the variations in the confirmed numbers of different countries. Without denying, the confirmed number also depends upon the number of conducted tests.

Moreover, the impact of the coronavirus is all-around. Economy is just one dimension. Unfortunately, at the beginning stage of the corona crisis, its impact was underrated not merely in the Benelux countries but also in the rest part of the world. Over the time, countries and people began to realize that the coronavirus's impact will be far-reaching. Experts are considering the coronavirus outbreak a watershed in international situation, that is, a world before Corona and a world after Corona.

Finally, the coronavirus crisis is definitely a global health hazard but goes far beyond. It is a new type of challenge for every country and international organizations. The EU has taken a series of actions since the beginning of the outbreak. On the one hand, it is playing a positive role, and its proactive coordination on repatriation is an exemplary case. However, on the other hand, due to various reasons, including its bureaucratic complex, the EU just cannot act as fast as nation states do, which have resulted in some complaints from its Member States. But it has to be acknowledged that this is a very complicated issue the EU is facing.

As the number of the confirmed coronavirus cases still keeps growing very fast, it's too early to draw any firm conclusions on how the corona is going to change the world. However, it is certain that the world is facing an unprecedented challenge. Even though the coronavirus challenge is overwhelming and mankind has to pay a price, human society can move forward in the crises if seen from a more sanguine perspective.

COVID-19 Situation in Spain:

Overview, Response and Evaluation

Yun Li[1]; Hong Shen[2]

Abstract

With a universal healthcare system, Spain provides free basic medical services. By 13 April 2020, the totally cases have surpassed it neighbor, Italy and ranked second right after the United States. As one of the countries deeply hit by COVID-19, Spain faces the overwhelming burden of hospitals and beds. There is a huge gap between what is happening and what the Spanish government has expected. The authorities seem to be too optimistic about the current situation. This paper aims at investigating the Spanish National Health Service, and summarizing the country's fight against coronavirus pandemic, so as to make an analysis of how the country response to the disease. As the virus is spreading across the country, only by strengthening internal and external cooperation can Spain finally win the battle against the COVID-19 disease.

Keywords: *coronavirus, Spain, National Health System.*

1. Status quo of Coronavirus in Spain (updated to April 13, 2020)

The first case of novel coronavirus on the Spanish mainland was confirmed on 31 January, 2020 by health authorities. On 25 March, Spanish Prime Minister Pedro Sanchez started the first meeting of an inter-ministerial committee which his government has set up to deal with the crisis. Spanish

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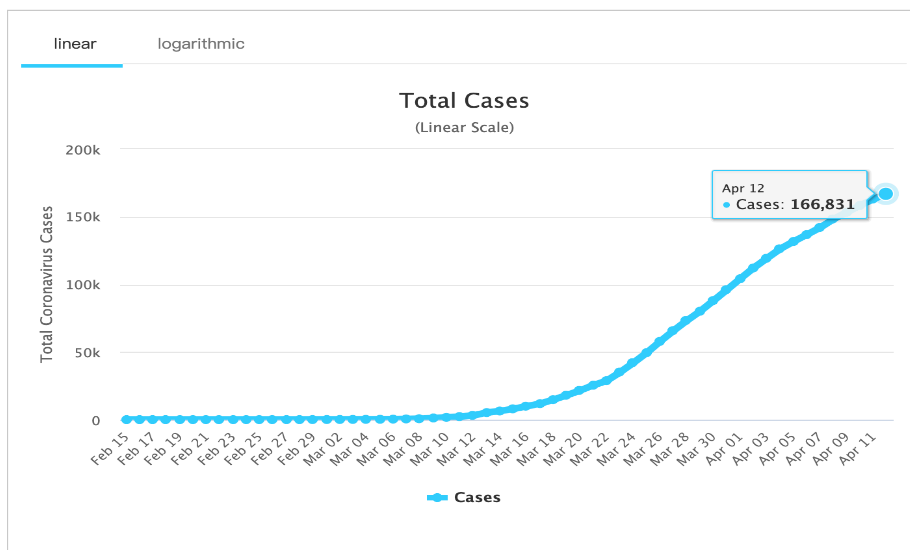
2 Hong Shen, MA in linguistics from China University of Political Science and Law. E-mail adress: hsdfy@163.com.

government has pledged to act with "measure, transparency and proportionality" in the face of the coronavirus.

By April 13, 2020, the total cases have reached 169, 496, with 17,489 deaths and 64, 727 recovered.1

Total Coronavirus Cases in Spain



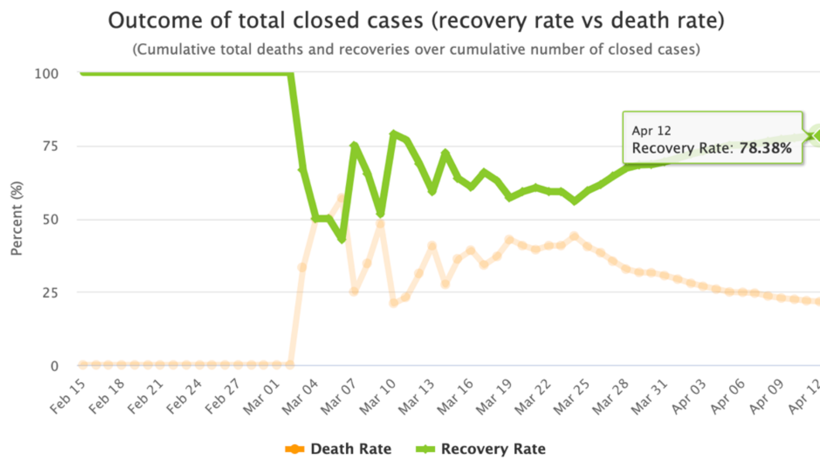
Graph 1 Total Coronavirus Cases in Spain
Source: Worldmeter's COVID-19 data

Country, Other	Total Cases	New Cases	Total Deaths	New Deaths	Total Recovered	Active Cases	Serious, Critical	Tot Cases/ 1M pop	Deaths/ 1M pop	Total Tests	Tests/ 1M pop
World	1,873,125	+20,868	116,043	+1,849	434,876	1,322,206	50,798	240	14.9		
USA	561,159	+859	22,133	+28	33,122	505,904	11,770	1,695	67	2,845,135	8,596
Spain	169,496	+2,665	17,489	+280	64,727	87,280	7,371	3,625	374	600,000	12,833
Italy	156,363		19,899		34,211	102,253	3,343	2,586	329	1,010,193	16,708
France	132,591		14,393		27,186	91,012	6,845	2,031	221	333,807	5,114
Germany	127,854		3,022		64,300	60,532	4,895	1,526	36	1,317,887	15,730
UK	88,621	+4,342	11,329	+717	N/A	76,948	1,559	1,305	167	367,667	5,416
China	82,160	+108	3,341	+2	77,663	1,156	121	57	2		

Table1: World COVID-19 infected cases
Source: Worldmeter's COVID-19 data

1 Statistics released by Spanish Minister of Health, https://covid19.isciii.es/

On April 13, 2020, total cases in Spain (169,496) have surpassed the number in Italy (156,363), ranking the second in the globe, which is more than twice the number in China (82,160). This country has suffered the second-highest number of casualties from the virus after the United States.



Graph 2: Outcome of total closed cases
Source: Worldmeter's COVID-19 data

Based on the data in Graph 2, the spread of the coronavirus outbreak in Spain sees a turn for the better. The recovery rate curve climbs steadily over the past half a month. The slowdown is an encouraging sign for the country. As the rate of new infections and deaths slows, Spanish government starts to consider a gradual unwinding of lockdown policies.

2. NHS System in Spain

2.1 History

Spain has a high-quality system of hospitals and medical centers all over the country. Not only do Spaniards enjoy one of the world's longest life expectancies and healthiest lifestyles, they also benefit from a sound healthcare system.

The Spanish National Healthcare System ("Instituto Nacional de la Salud"), founded on Spain's General Healthcare Act of 1986, guarantees universal coverage and free healthcare access to all Spanish nationals, regardless of economic situation or participation in the social security network.

Public intervention in community health has always been an issue of concern, mainly in the control of epidemics, or at least in the minimum control capacity allowed by Navy quarantine personnel. After the vigorous development of Al Andalus' medicine and the outstanding contribution of Jews in the middle ages, the city walls were closed, communication with cities affected by the plague was prohibited, and other health or mitigation measures were taken. In the age of Carlos V, the primary medical school was institutionalized, but the medical majors in the medical schools of medieval universities were very scattered, including medical schools and other organizations. Surgery and pharmacy are the distinct medical disciplines, rather than popular ones, in the Welsh sub democratic model that dominated the former Spanish regime.

Novices in the late 17th century had a major area of activity in the medical community, limited to individual and local initiatives. The Enlightenment of Spain in the second half of the 18th century was more continuous in the early 19th century (San Carlos College of surgery, etc.). The real charity vaccine project (1803) is the most ambitious public health project in the world.

As early as in modern times, they discussed the health law of 1822 in the three-year period of freedom. However, due to the lack of scientific and technical consensus on the means of the law, the law was not adopted. During the so-called progress two-year period, the law of 28 November 18552 established the General Directorate of health, which will maintain long-term organizational continuity shortly after its establishment. The Royal Decree of 12 January 1904 approved the general health regulations, but did not change the organizational structure of 1855 (the name of the general health department was changed from time to time to the general health inspection bureau).

On July 11, 1934, the health coordination law was promulgated, the main purpose of which is to strengthen the initial intervention of the state to the local health service organizations.

According to the law of December 14, 1942, compulsory SOE health insurance was implemented under the state reserve institution, and health risks were covered by quotas related to work. The general social security law of May 1974 adjusted this system. The objective of the program is to be within its benefits and to cover more individuals and groups. However, a 1967 who report noted that the system was seriously flawed.

According to the provisions of articles 43 and 49 of the Spanish Constitution of 1978 on public health, the general health law (25 April 1986) 7 and the establishment of health advisers and the Ministry of Health stipulate the right of all citizens to health protection. It defines the responsibility of the autonomous regions for health care.

The year 1986 sees the adoption of General Health Law No. 14 / 1986. There are two reasons for the enactment of the general health law. The first is that it derives from the authorization of the Spanish Constitution, because articles 43 and 49 of the basic law stipulate the right of all citizens to health protection. The law recognizes the right of all citizens and foreigners residing in Spain to the benefits of the health system. The second reason is organizational, because Chapter VIII of the Constitution gives the autonomous region wide health power. Autonomous regions play an important role in who. The law allows the implementation of service transfer procedures, which is a health facility sufficient to meet the health needs of residents within its jurisdiction. Article 149.1.16 of the constitution, on which this law is based, sets forth substantive principles and standards, making the new health care system universal and common, and the foundation of national health services.

Royal Decree No. 1 / 1994 of 20 June 1994 adopted a consolidated text of the general social security law, Chapter IV of which deals with protection measures. The act includes:

1. Provide health care in the event of childbirth, illness (general or occupational) and accidents (whether working or not).

2. In any of the above cases, confirm the occupational recovery of the source

3. Economic benefits in the case of temporary incapacity, pregnancy, paternity, pregnancy risk, breast-feeding risk, care for minors suffering from cancer or other serious diseases, incapacity to work by way of payment or nonpayment, retirement, etc, In its contributory and noncontributory forms; unemployment at the level of contributions and assistance; death and survival; and death and survival provided in emergency and special circumstances under management.

In 2003, all autonomous regions gradually assumed the responsibility of health care, and established a stable financing model for all functions undertaken, thus promoting the implementation of the law.

A few years after the entry into force of the general health law, profound changes have taken place in the culture, technology and socio-economic aspects of society, as well as in the way people live and get sick. Organizations of the national health system also face new challenges.

Therefore, the law stipulates the coordination and cooperation actions of public health management departments, as a means to protect citizens' right to health protection, with the common goal of ensuring equity, quality and social participation in the national health system.

The act identifies common core actions for the health services of the national health system and its components. Without interfering with the various ways of organizing, managing and providing basic services in decentralized countries, the services provided by public health services to citizens are aimed at providing basic and common guarantees.

The areas of cooperation between public health administrations under the act are: welfare of the national health system; pharmacies; health professionals; research; health information systems; and quality of health systems.

As a result, the Act establishes or strengthens specialized agencies, which are open to autonomous regions, such as the technical assessment agency, the Spanish agency for drugs and health products, the Human Resources Commission, the Advisory Committee on health research, etc. Carlos III Institute of health, Institute of health information, National Institutes of health system quality 10 and national health system observatory.

2.2 Structure

All Spanish citizens can enjoy the country's universal healthcare system, known as National Health System (seguridad social). Spain also provides private medical insurance. 72% of the income of the private centers comes from the insurance companies.

The current system consists of three organizational levels:

1 Central (Organizacion de la Administracion Central)

The Ministry of Health, the state's central administration agency, is in charge of issuing health proposals, planning and implementing government health guidelines, and coordinating activities aimed at reducing the consumption of illegal drugs.

2 Autonomous Community (Organizacion Autonomica)

Each of Spain's 17 Autonomous Communities (Comunidades Autonomas) is responsible for offering integrated health services to the regional population through the centers, services and establishments of that community.

3 Local (Areas de Salud)

The "areas de salud" are responsible for the unitary management of the health services offered at the level of the Autonomous Community and are defined by taking into account factors of demography, geography, climate, socioeconomics, employment, epidemiology and culture. To increase

operability and efficiency, the "areas de salud" are subdivided into smaller units called "zonas basicas de salud".

Primary Healthcare services are available within a 15-minute radius from any place of residence. The main facilities are the healthcare centers, staffed by multidisciplinary teams comprising of general practitioners, paediatricians, nurses and administrative staff, as well as, in some cases, social workers, midwives and physiotherapists. The principles of maximum accessibility and equity mean that community primary healthcare also provides home care, whenever necessary and also deal with health promotion and disease prevention.

Specialist care is provided in specialist care centers and hospitals in the form of outpatient and inpatient care. Patients having received specialist care and treatment are referred back to their primary healthcare doctor, who assumes responsibility for any necessary follow-up treatment and care, ensuring the provision of continuous care under equitable conditions, irrespective of the patient's place of residence and individual circumstances.

Private healthcare insurance for treatment at private hospitals and clinics is not widespread and mainly used to avoid the occasional long waiting lists to see specialist doctors in the public healthcare system. Only 10 percent of the population has voluntary private insurance although some private services are contracted by the public sector. Only in Catalonia, due to historical reasons, there are a large number of non-profit, semi-public entities. Private healthcare companies often offer quicker service to patients but also value-added services such as private rooms, express mailing of test results and keeping patients informed via email and SMS messages.

2.3 Budget and Funding

As is settled in the Spanish constitution that the state has to provide medical care, its public healthcare is robust. Article 10 of the National Health System Coordination and Quality Act provides that Spanish public health funding is the responsibility of the autonomous region under the transfer agreement and the current autonomous financing system. Without

prejudice to the third party's obligation to pay. According to the autonomous Financing Act, whether there is sufficient funds to pay the allowance depends on the resources allocated to the autonomous region. The premium for occupational accidents and diseases is to fund health care related to occupational accidents. Public health services are provided by management entities (INSS or ISM) or joint or cooperative enterprises (in this case, direct), and for self-employed persons who choose occupational risk insurance, enterprises or workers cooperate with them. They have arranged occupational emergency insurance. Along with the inclusion of a new benefit in the NHS benefits catalogue, an economic report will be prepared to assess the possible positive or negative effects of the benefit. The report will be submitted to the Committee on fiscal and financial policy for its consideration and approval, as appropriate.

According to Spain's National Health System Information System, the health expenditure for the public healthcare sector is 74 billion euros per year, taking up of 6.4% GDP. That for the private sector is 31 billion euros per year, taking up 2.6% GDP.

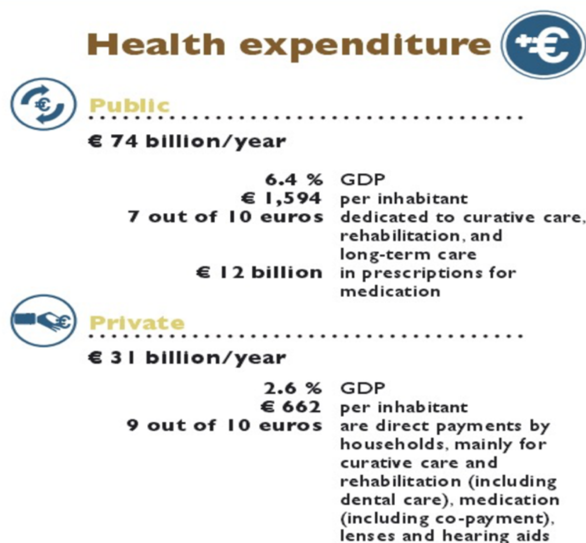


Table 1: Health Expenditure of Public and Private Sectors

Source：Spain's National Health System Information System

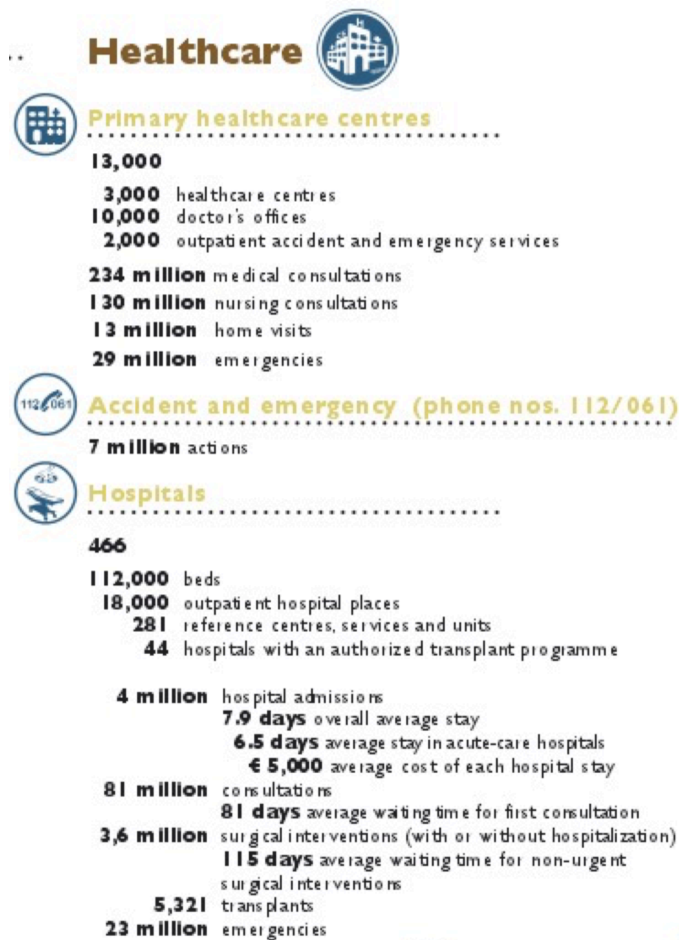


Table 2: Healthcare centers and hospitals

Source：Spain's National Health System Information System

UNESPA (the Spanish Association of Insurers and Reinsurers) confirms that the insurance provides health coverage in Spain to 10.3 million people. With this amount, 8.4 million policyholders contract their protection as a complement to public health care. The remaining 1.8 million insured come from the mutual funds of officials of the Central State Administration, who have the option of covering their health care through concerts with private insurers in conditions analogous to those provided by public health services.

ASPE sources have confirmed that 72% of the average billing of the hospitals in its network comes from health insurance. This insurance industry billed last year more than 6,700 million euros, 4.12% of the total invoiced by insurance in Spain (48,327 million euros) in the first three quarters of 2019.

3. Responses

3.1 Timetable

Since its first registered case on 31 January 2020 when a tourist from Germany tested positive, coronavirus pandemic has spread in Spain for over the past three months. And when it comes to the case toll, there is a sharp increase and recently a flat curve.

On 19 February, there was an explosion of the virus in Lombardy as 2,500 Valencia soccer fans gathered together with 40,000 Atalanta supporters gathered together for a Champion League game in Milan. Valencia players, fans and sports journalists were the first cases. By the end of February, there were merely 59 cases in total. Unfortunately, by then, Spanish authorities had not seen the danger of such big-scale activities.

Then 8 March saw sports events, political party conferences and massive demonstrations of International Women's Day happen in one day. While many other countries cancelled massive activities, Spaniards seemed to be too optimistic.

From 26 February to 12 March, community transmission cases started to show up in different parts of the country. By 13 March, all the 50 provinces of the country reported cases. And on 14 March a state of alarm and national lockdown was imposed. However, not until 28 March did the Spanish government banned all non-essential activities.

The lockdown of Spain began on 14 March has been efficiently enforced with police fines and popular pressure. Under this lockdown, people are

told to stay at home for the next 14 days. As a result, Spain's curve of deaths began to flatten.

And in a press conference on 2 April, Health Minister Salvador Illa said: "The data shows us that the curve has stabilized, and we have achieved the primary objective of reaching the peak of the curve and that now we are starting the phase of deceleration."1 However, on the same day, Spain reported 950 coronavirus death within 24 hours, which is the a single-day toll higher than any country.

From 3 April to 11 April, the number of new cases and deaths in general had a decreasing trend. Although there is a sign of slowdown, many experts are still warning that it is not the time to relax the alarm. And given the high death toll (17,489), the country has to consider reasoning behind such a high fatality rate.

3.2 Public-private cooperation

The COVID-19 is believed to remove the barrier between the public healthcare system and the private healthcare system. The pandemic proves the unique healthcare system in Spain. The collaboration between public and private sectors in Spain puts into practice in practice a unique health model that mobilizing technical, material and human resources to tackle the mortality cause by coronavirus.

There are 806 hospitals of the National Health System and 468 private hospital centers and more than 143,300 beds set by the Ministry of Health to fight against the pandemic in response to the great onslaught of the disease. Like public centers, private establishments have released their data showing that private healthcare is accepting about 19% of patients infected by coronavirus.

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1 "Spain coronavirus cases surpass Italy". US News and World Report. Retrieved 2020-04-13. https://www.usnews.com/news/world-report/articles/2020-04-03/spain-coronavirus-cases-surpass-italy-deaths-near-11-000

ASPE (Alianza de la Sanidad Privada Española), Spanish private health union has confirmed that it is caring for 80 patients in intensive care units (ICU) out of a group of 970 hospitalized in private centers. This network has so far registered a total of 1,800 positive cases among the global number of patients attended. These records show that, unfortunately, there have been 30 deaths.

ASPE President Carlos Rus noted that "since the beginning of the crisis, there has been collaboration with the public sector to combat the pandemic and we have always been at the disposal of the health authorities." "The important thing and what concern us," he adds, "is caring for patients under the sole command of public health in each of the autonomous communities, who have asked us for resources and coordination."

This collaboration, as stated by La Vanguardia Boi Ruiz, professor at the UIC (Universidad Internacional de Catalunya), indicates “the importance of taking health care as a public service to citizens independent of whoever pays, be it a mutual insurance company or the administrations”.

Ruiz insists on excellence in results of both public and private assistance, which “denies social opinion not based on reality” from those who try to separate the capacities of both sectors.

From the IDIS Foundation (Institute for the Development and Integration of Health), made up of the majority of privately owned health companies in Spain, many of them linked to the main insurance companies, it is highlighted that the coronavirus pandemic is showing “ today, more than ever, that there is only one healthcare "and that" today there are no public and private hospitals: there are simply hospitals that ensure the health and well-being of all ".

For Boi Ruiz, this de facto collaboration that already exists in Spain between the public and private health sectors could be advanced and become much more effective “if coordination and control by the same Health Authority for both sectors were unified and it was structured a common information system on the medical records of all patients”.

In fact, Professor Ruiz points out, “many professionals already work in public and private healthcare to compensate salaries below the European average, and there are around two and a half million officials served by the private sector through mutual societies such as Muface and similar public financing”.

3.3 Hospitals and beds.

The spokesman for the Association for the Defense of Public Health in Madrid, warns that, although there are 102 hospitals in the region, many of them are "tiny" and have "no capacity to deal with health problems of this caliber".

When Esperanza Aguirre announced the creation of eight new hospitals in the region, she promised that they would be modular and their capacity would be increased in the future, "something that never happened," insists Sánchez, who also points out that "while the new infrastructures were opened, beds were closed in the large reference complexes in Madrid”.

"We have the Guinness record of having more hospitals, having less total number of beds, something very difficult to understand outside of here," he summarizes.

3.4 Professionals

There are 266,728 professionals from private centers under the unified arrangement of the Ministry of Health to fight against coronavirus. As reported by Vivo Seguro, the private sector has mobilized at the disposal of the Ministry of Health, by Royal Decree 463/202 of March 14 declaring the State of Alarm, a total of 266,728 professionals who are joined by hospital pharmacists and community, psychologists, social workers and other health professions.

For its part, the insurance company UNESPA has confirmed that the insurance maintains assistance for coronavirus to all its policyholders and has reiterated "its firm and unequivocal collaboration with the measures to

control the spread of the coronavirus in Spain established by the health authorities."

From Catalonia, the Association of Health and Social Entities, which brings together more than a hundred public and private health and social entities with more than 460 centers and 60,000 professionals, has indicated its collaboration with the Generalitat de Catalunya and the country's health authorities before “unity of action” against Covid-19.

3.4 Dilemma of Spanish NHS

The coronavirus tests a health system featured on years of cuts. The spokesman for the Association in Defense of Public Health in Madrid asks Díaz Ayuso for "real solutions" and not promises that cannot be kept. Spain faces the challenge of facing the Covid-19. The number of cases continues to increase, and the Community of Madrid continues to be the most affected by the epidemic.

The health system in this region is being tested after years of hard cuts, which have destroyed thousands of jobs." She has been the leader in this regard," recalls ELPLURAL.COM Marciano Sánchez Bayle, spokesperson for the Association for the Defense of Public Health in Madrid.

The Government of Isabel Díaz Ayuso has already announced that 1,300 professionals will be hired, but "according to the latest data, 3,000 have been lost," recalls this retired doctor.

This means that, even adding these new additions, the number of health personnel of yesteryear was not reached, when there was no special situation like this. Therefore, "it is still insufficient," says this retired doctor.

"Our primary care has the dubious honor of being the first region in number of people assigned by nursing and family doctor," emphasizes Sánchez. To this he adds that "the new hires that are going to be made will not be good at all", as far as working conditions are concerned. "They will be contracts of 15 days or a month," he says, and "they will not have it so easy," he

warns, because "they will opt for those places where they are offered better conditions."

Like Italy, the aging population. adds difficulties to the fight against the disease. It’s fairly odd for the rest of the nearly 50 million people in Spain, where one-fifth of the population is over 65 and thus at increased risk of “getting very sick” from Covid-19.

Another headache is that Spain’s long-standing political, economic, and historical problems are making a coherent response difficult. Prime Minister Pedro Sánchez, after forming a minority government, likely didn’t want to risk his fragile hold on power by banning large gathering. Instead, he allowed thousands to attend soccer games, as well as permitted a 120,000-strong feminist rally in Madrid to proceed.

“The [health care] system was not prepared for the seriousness of what was coming,” a doctor in a southern Spanish hospital told *El País* newspaper this week. “Up until at least a week ago, we weren’t able to do a PCR [a diagnostic test] for coronavirus without asking for authorization. I could order a PCR for the flu, but not for the coronavirus.”

“We would like to test everyone but with the diagnostic capability and number of kits we have, that is not possible,” Rafael Cantón, the microbiology chief in the city’s Ramón y Cajal hospital, also told El País.

Cinta Moro, a doctor in the southern city of Seville, believes the lack of foresight and planning doomed Spain from the start. “With tests, we would’ve stopped a lot of the problems we have now,” she said. But it wasn’t just a testing failure, it was a cultural and political failure, too.1

4. Evaluation

4.1 Countermeasures Adopted by Spanish Authorities

1 Ward, Alex (2020-03-20). "How Spain's coronavirus outbreak got so bad so fast". Vox. Retrieved 2020-04-01, https://www.vox.com/2020/3/20/21183315/coronavirus-spain-outbreak-cases-tests.

Although Spain responses clumsily compared to many other countries in the world, which leads to the current mortalities, the Spanish government has adopted different policies to stop the explosion of coronavirus since the early March.

The first strategy is travel restriction. From 10 March to 16 March, the government of Spain gradually cancelled traffic from other countries to Spain. It started from the cancellation of all direct flights from Italy to Spain on 10 March. And then on 12 March, it suspended the traffic between Morocco and Spain. And on 16 March, Spain only authorize the entry of Spanish citizens and merchandise to guarantee the supply.

The second strategy is closure of public places so as to prevent people from gathering together. On 10 March, the Ministry of Culture closed its museums and libraries in Madrid. Then on 14 March, Madrid mayor closed parks and public gardens.

The third method is quarantines and lockdown. On 12 March, the Catalan central government announced the quarantines for four towns-- Igualada, Vilanova del Cami, Santa Margarida de Montbui and Odena. During the state of alarm, the central government in Madrid has all powers. All security forces are under direct orders of Interior Minister Fernando Grande-Marlaska. The government forbad many nonessential public activities, including large gatherings, restaurants, museums, sport events, etc. However, citizens are still permitted to go to work and purchase necessities.[1] On 25 March, the request of extending the state of alarm until 11 April was approved by Spanish parliament. On April 13, non-essential worker, who had been asked to stay at home, are allowed to return to work, which is criticized for the risk of causing additional spread of the virus.

Also, another measure is enforcement. Military personnel and health installations will be used to strengthen the national health system across

1 "Spain's state of alarm: the key measures that are now in place". EL PAÍS. 2020-03-15. Retrieved 2020-04-13 from https://english.elpais.com/society/2020-03-15/spains-state-of-alarm-the-key-measures-that-are-now-in-place.html.

Spain. The Health Ministry will ensure that production centers for health supplies continue to operate, including the temporary intervention of companies, private health establishments and pharmaceutical sector centers. As mentioned above, during the state of alarm, police powers were under control of the Interior Ministry. On 23 March 2020, 240,245 police officers and more than 2,500 military were arranged all over Spain. In Madrid, hospitals refused transfers from nursing homes, and a skating rink was used to store dead bodies as the city morgue overflowed.1 By 10 April, 3,000 drivers had been sanctioned for violating quarantine while thousands were being stopped each day.2

4.2 Criticism

On 9 February, Fernando Simón, who is in charge of medical emergencies in Madrid, stated that "Spain will only have a handful of cases". One and a half months later, the number of dead per capita is already three times that of Iran, and 40 times higher than China. The unexpected spread of the pandemic is an inevitable results of the country's late response. 3As Spain has Italy nearby, its government should have done better after seeing what happened in Italy.

By the time of 8 March, the country had wasted one month and a half since its first case in the end of January. "… We had weeks to prepare after watching what's happened in Italy," said Angela Hernandez Puente, a top official at a health labor union in Madrid. 4

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1 "Grim find: Bodies of virus victims in Spanish nursing homes". AP NEWS. 2020-03-24. Retrieved 2020-04

2 Dolz, Patricia Ortega (2020-04-10). "Más de 3.000 conductores sancionados por no respetar los límites de movilidad del estado de alarma". EL PAÍS (in Spanish). Retrieved 2020-04-13, https://elpais.com/espana/2020-04-10/mas-de-3000-conductores-sancionados-por-no-respetar-los-limites-de-movilidad-del-estado-el-alarma.html..

3 Tremlett, Giles (2020-03-26). "How did Spain get its coronavirus response so wrong?". The Guardian. Retrieved 2020-04-13, https://www.theguardian.com/world/2020/mar/26/spain-coronavirus-response-analysis.

4 Ward, Alex (2020-03-20). "How Spain's coronavirus outbreak got so bad so fast". Vox. Retrieved 2020-04-01, https://www.vox.com/2020/3/20/21183315/coronavirus-spain-outbreak-cases-tests.

Thus, the Government is already considering approving a second extension of the state of emergency in Spain, which could extend the exceptional situation decreed to face the coronavirus pandemic for another fifteen days, until next April 25.

The spokesman for the Association in Defense of Public Health in Madrid points out that the WHO already warned three or four years ago that one of the effects of globalization and climate change was going to be the greatest risk of pandemics and stressed the need to have powerful sanitary systems to face them. In his opinion, what is happening "should make us reflect on what the deterioration and decapitalization of the system entails, which makes it lose its ability to face emergency situations."

According to *The Guardian*, Spain's initially slow response to the coronavirus caused the epidemic to become severe even though it did not share a land border with Italy or other severely affected countries. An analysis in *Vox* hypothesized that the minority government did not want to risk its hold on power by banning large gatherings early; the prime minister initially defended his decision to allow large gatherings to continue.

5. Conclusion

For countries like Spain where there is the most developed healthcare system in the world, it seems to be ironic that they have to struggle in the high fatality rate. Given the deadly nature of coronavirus, the aging population in Spain makes a fifth of its people are susceptible individuals.

And the Spanish government's slow response, and late cancellation of public gathers make another cause for the fast development of the pandemic. While its neighbor, Italy, has long set an example as the first European country badly hit by COVID-19, Spain fails to realize the grim situation. It is a pity that despite its medical resources and scientific healthcare system, Spain surpasses Italy and becomes the worst infected country in EU.

At the domestic level, private sectors and public sectors of Spain's healthcare system have cooperated effectively so as to fight against the pandemic. At the international level, foreign assistance such as donation of tests from China, has helped to smooth the medical pressure of the country.

By the time of mid-March 2020, the government starts to take a series of measures to slow down the increase of infected and deaths. The policies did flatten its curves and the Spanish government sees a sign of hope. But basically, countries other than Spain still seem worried about its situation while Spain itself has found back its optimism again. When it enters April, the Ministry of Health has expressed their confidence in winning the battle for many times.

Hopefully, in the coming days, deepened internal and external cooperation can help Spain as well as the whole world to contain COVID-19.

An Analysis of the COVID-19 Outbreaks in Germany: Why the Death Rate in Germany Is Relatively Low?

Yang Xiepu[1]; Hua Rongxin[2]

Abstract

In the context of the global outbreak of COVID-19, the death rate of COVID-19 in Germany is much lower than some of the European neighbors such as Italy, France and Spain. However, due to the time difference of outbreak in each country, it is only sensible to select data from the same stage of the outbreak for comparison. This article first defines the selected data and compares the number of confirmed cases and mortality in the same stage of the epidemic in four European countries. It is concluded that the mortality rate of Germany under the COVID-19 epidemic is indeed relatively low. On this basis, we analyzed the reasons for Germany's relatively low death rate in terms of emergency mechanisms for preventing and controlling infectious diseases, medical and health resources, medical insurance systems, social and family structures, civil society and political consensus. Although Germany has achieved "fragile interim success" in the prevention and control of COVID-19, But there is still uncertainty in the future development of the pandemic. However, compared to some of European neighbors, Germany's prevention and control situation is relatively optimistic.

Keywords: *Germany; Death rate; COVID-19; Healthcare system*

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1. Introduction

The COVID-19 pandemic has raged around the world, causing millions of infections worldwide and hundreds of thousands of deaths. Among European countries, the situation in Italy, Spain and France has not been alleviated, but is relatively optimistic in Germany. The current confirmed cases in Germany are 145,742 and the death toll is 4,642. Although the death rate in Germany rose from 0.2% on March 11 to 3.19% on April 20.1 But compared with 13.22% in Italy, 10.29% in Spain and 12.9% in France, Germany clearly has a considerable advantage in responding to the COVID-19 epidemic. On April 15, Chancellor Merkel and the Heads of Government of the Federal State have reached agreement that Germany has reached a "fragile interim success" in the fight against the COVID-19. The contact restrictions are to be extended until 3 May, schools will gradually reopen since May 3 and shops (up to 800 square meters) may reopen.2

Compared with other European countries, the death rate in Germany was relatively low in the outbreak. The striking disparity attracted our attention and caused us to think about the following questions: Can these data reflect outbreaks in different countries? If so, to what extent? And why German performance in COVID-19 crisis is so outstanding? What lessons and experience could be learned by other countries?

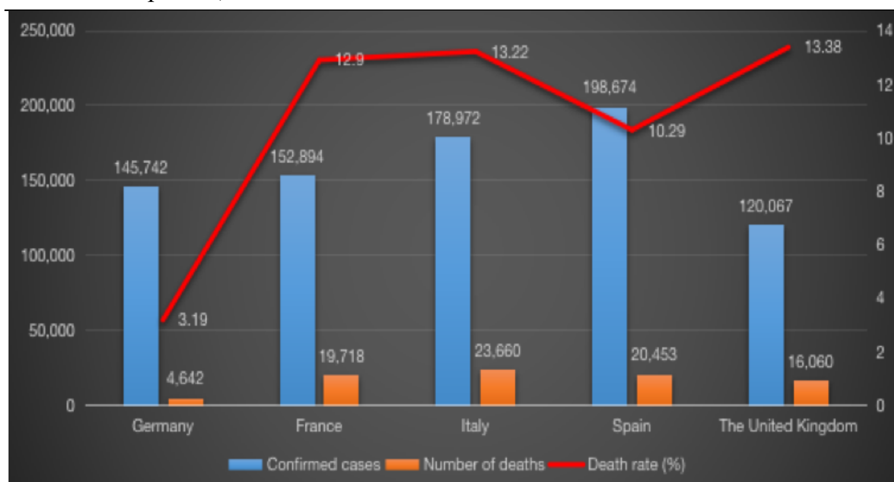
According to WHO (World Health Organization), the formula used to calculate the death rate of COVID-19 is: cumulative current total deaths / current confirmed cases. The number describes the probability of dying if infected by the virus. While the death rate is more than 4% worldwide, many European countries have figures higher than the world average. First of all, it has to be made clear that the statistics of the individual countries can only be compared to a limited extent. The current death rates are based

1 "Coronavirus (COVID-20) death rate in countries with confirmed deaths and over 1,000 reported cases as of April 20, 2020", https://www.statista.com/statistics/1105914/coronavirus-death-rates-worldwide/.

2 „Wir müssen ganz konzentriert weiter machen", https://www.bundeskanzlerin.de/bkin-de/aktuelles/bund-laender-corona-1744306.

on the proportion of deaths in the officially reported numbers, however, these often lag behind due to technical delays and different data sources. In addition, the number of tested and the resulting number of confirmed cases also have an enormous impact on the death rate: if a country conducts a large number of tests, the number of confirmed patients with mild complaints will increase accordingly, which indirectly results in a lower death rate. One explanation for the low death rate is that there are far more people tested in Germany than in other European countries. This means testing more people with no / mild symptoms trends to increases the number of known cases but not the number of deaths. Secondly, since each country does not have an outbreak at the same time, so they are at different stages of COVID-19. If we compare data from the same date in different countries, can we fully reflect the situation in each country? Taking Germany as an example, the outbreak of COVID-19 in Germany was relatively later than in Italy, and the death rate has gradually risen since the outbreak, from 0.2% at the beginning to the current 3.19%. And with the spread of the epidemic, this number is likely to rise further.

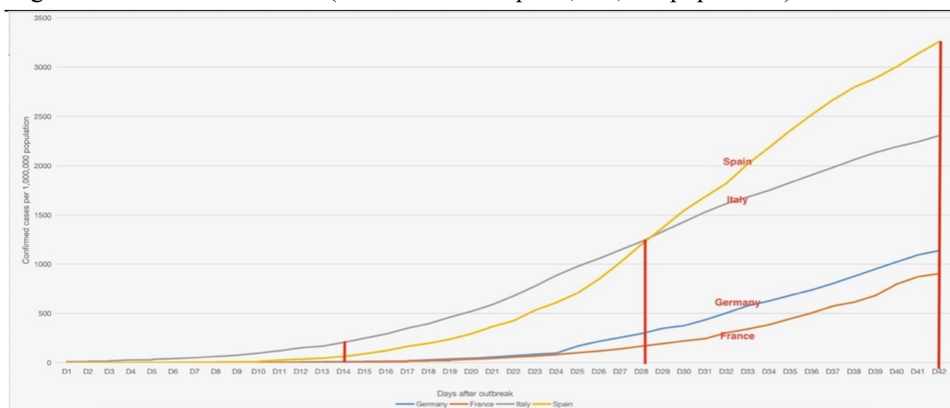
Figure 1: Coronavirus (COVID-19) death rate in countries with confirmed deaths as of April 20, 2020



Source: Statista: Coronavirus (COVID-19) death rate in countries with confirmed deaths and over 1,000 reported cases as of April 20, 2020, by country. Available at: https://www.statista.com/statistics/1105914/coronavirus-death-rates-worldwide/

After the carnival, the German COVID-19 outbreak began in North Rhine-Westphalia (Nordrhein-Westfalen) at the end of February and then spread to the whole country. Let us compare the curve of infection (confirmed cases per 1,000,000 population) and mortality (deaths per 1,000,000 population) within 42 days after the outbreak in Germany, France, Italy and Spain. (According to the WHO, China's National Health Commission and The United States' CDC, the incubation period of COVID-19 is estimated to be between 2 and 14 days, therefore, we take the statistics of the 14th day; 28th day and 42th day after the outbreak as observation points). Figure 2 shows the infection curve (confirmed cases per 1,000,000 population), the starting point of the abscissa in this figure is the date of the outbreak (given the incubation period, we take the 29th day after the date of the first confirmed case appears as the date of the outbreak) in each country (the date is different) rather than the same date. This facilitates a horizontal comparison of the same stage of the epidemic. The ordinate is the average number of confirmed cases per million people, which makes it more scientific to combine countries with different population bases. It can be seen from the figure that the speed and scale of virus outbreaks in Germany (blue curve) are very close to Italy (grey curve), and the average upward trend curve of confirmed cases per million people is very similar.

Figure 2: The infection curve (confirmed cases per 1,000,000 population)



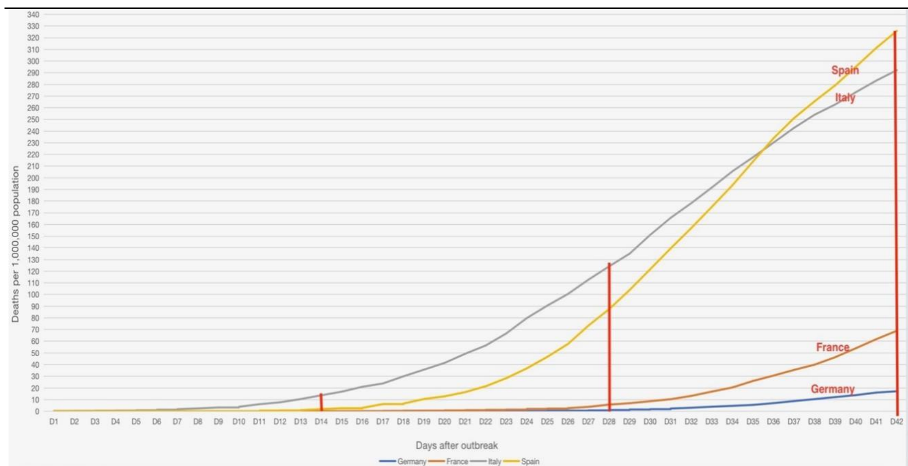
Source: Author self -made.
Data sources: European Centre for Disease Prevention and Control, https://www.ecdc.europa.eu/en/publications-data/download-todays-data-geographic-distribution-covid-19-cases-worldwide

From the mortality curve (deaths per 1,000,000 population) in Figure 3, we can see that the average number of deaths per million population in Germany is very low. For example, on the 28th day after the outbreak of COVID-19, 1.122 out of every million people in Germany died of this disease, which is far lower than the average number of deaths in France (5.699), Italy (124.128) and Spain (87.456) during the same period.

Therefore, according to these comparisons, the death rate in Germany is indeed much lower than in several other countries. Although the death rate of the various countries will gradually increase with the development of the disease course, based on the overall data flow, the death rate in Germany continuously at a relatively low level, with a relatively slow climbing rate.

In the following, we will analyze the reasons for Germany's relatively low death rate in the fight against COVID-19.

Figure 3: The mortality curve (deaths per 1,000,000 population)



Source: Author self -made.
Data sources: European Centre for Disease Prevention and Control,
https://www.ecdc.europa.eu/en/publications-data/download-todays-data-geographic-distribution-covid-19-cases-worldwide

2. Main Reasons for the low Death rate in Germany

There are many reasons for the difference in mortality between Germany and some of European neighbors. It is not only related to the national emergency mechanism for the prevention and control of infectious diseases, but also related to various factors such as the country's medical and health resources, medical insurance system, economic and financial strength, and social and cultural environment. Combining information from different channels such as the World Health Organization, the German RKI (Das Robert Koch-Institut), the German Federal Ministry of Health (BGM: Bundesministerium fuer Gesundheit), and the German media, we have summarized five main reasons for the low death rate in Germany.

2.1 Younger patients and smaller household size in Germany

It is suspected that the number of deaths in Italy is so high because there are comparatively many elderly people living there, since among other things, the risk of a severe COVID-19 disease increases with age. The average age of those infected in Germany is lower than in countries such as Italy or Spain. According to the Robert Koch Institute, the majority of COVID-19 cases (70%) in Germany are between 15 and 59 years old.1 In Italy, on the other hand, according to a national daily report, 36 percent of those infected are over 70 years old. In many cases, younger also means healthier. According to Hans-Georg Kräusslich, Head of Virology at Heidelberg University Hospital, many - young people in particular - were infected in the Austrian and Italian ski areas. "It started as an epidemic of skiers", Kräusslich told The New York Times.2

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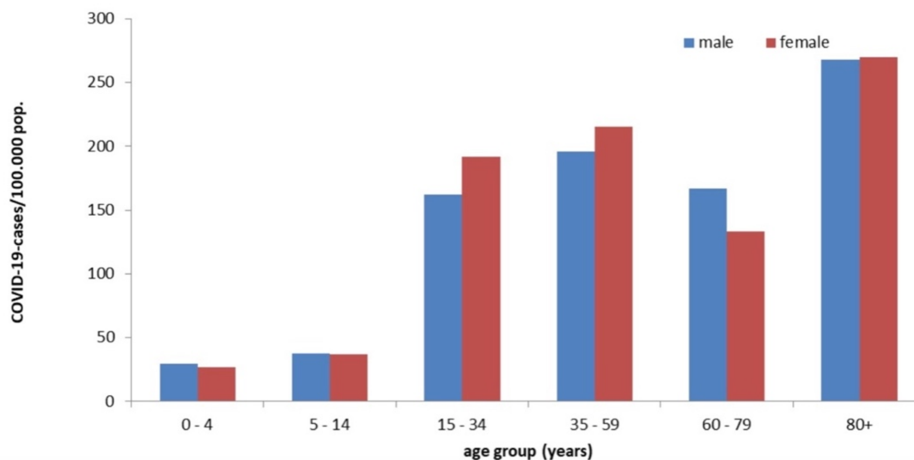
1 „Täglicher Lagebericht des RKI zur Coronavirus-Krankheit-2019(COVID-19)09.04.2020 –AKTUALISIERTER STAND FÜR DEUTSCHLAND",
https://www.rki.de/DE/Content/InfAZ/N/Neuartiges_Coronavirus/Situationsberichte/2020-04-09-de.pdf?__blob=publicationFile.

2 „Warum die Zahl der Toten in Deutschland vergleichsweise niedrig ist",

Figure 4: Electronically reported COVID-19 cases/100,000 population in Germany by age group and sex (n=139,248) for cases with information available (19/04/2020, 12:00 AM)



Source: Coronavirus Disease 2019 (COVID-19) Daily Situation Report of the Robert Koch Institute 19/04/2020 - UPDATED STATUS FOR GERMANY.

According to the experience of China, the death rate of novel coronavirus accounted for 0.2% in the population under 39 years old, and the death rate of 60-70 years old was 3.6%, that of 70-79 years old was 8%, and that of over 80 years old was 14.8%. Therefore, the lower the age of the infected people, the lower the death rate, and from this perspective, it's easy to understand the low death rate in Germany. However, we need to pay attention to the fact that the initial group of people infected in Germany is indeed young people, but given that Germany is an aging country, almost a quarter of the German population is older than 60 years. Both the infection rate and death rate of the COVID-19 among the elderly are high. So why aren't older people in Germany immediately infected by the younger ones? The median age of Germany's population known to be

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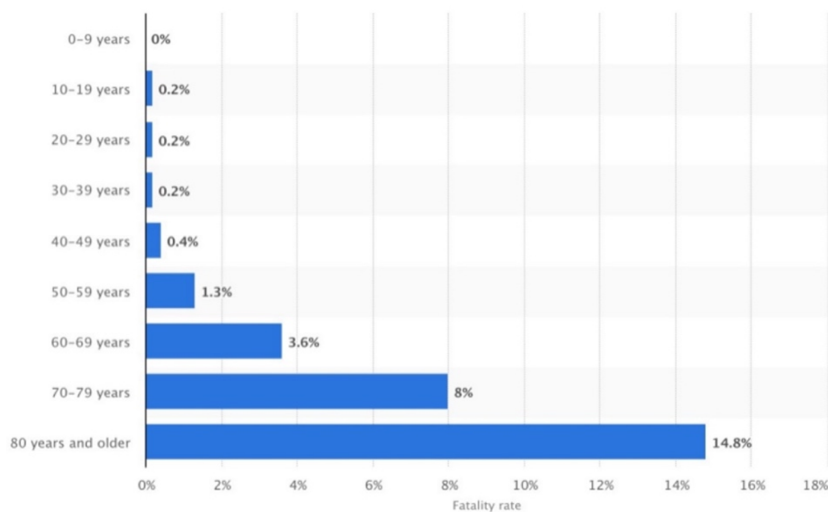
https://www.tagesspiegel.de/wissen/drei-erklaerungsversuche-fuer-erstaunliche-corona-zahlen-warum-die-zahl-der-toten-in-deutschland-vergleichsweise-niedrig-ist/25726578.html.

infected by COVID -19 is lower: 46 as opposed to Italy's 63. This should be attributed to the German family structure. According to the data from the Federal Statistical Office (Statistisches Bundesamt) in 2018, 41.9% of German households consist of one person, and 33.8% of households consist of two persons. Fewer than 25% of German households are made up of 3 or more people. Compared with Germany, more than 20% of Italians between the ages of 30 and 49 live with their parents.1 That's more than double the rate for Germans in that age bracket. In addition, at the beginning of the outbreak, Germany took non-medical interventions on the elderly, and advised young people not to visit the elderly, to reduce the spread of infection, and to focus on protecting the elderly and other high-risk groups. It is because of the low average age of infected people in Germany, and its smaller family size compared with Italy, that the death rate in Germany has been kept at a very low level.

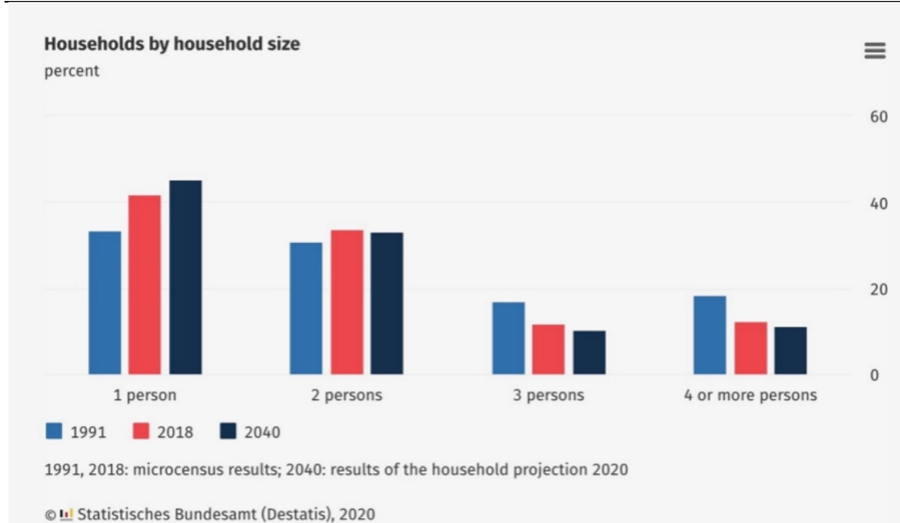
Figure 5: Fatality rate of novel coronavirus COVID-19 in China as of February 11, 2020, by age group



Source:http://weekly.chinacdc.cn/en/article/id/e53946e2-c6c4-41e9-9a9b-fea8db1a8f51

1 "Coronavirus Less Deadly in Germany Because of Youthful Patients", https://www.bloomberg.com/news/articles/2020-03-24/coronavirus-less-deadly-in-germany-because-of-youthful-patients.

Figure 6: Households by household size in Germany



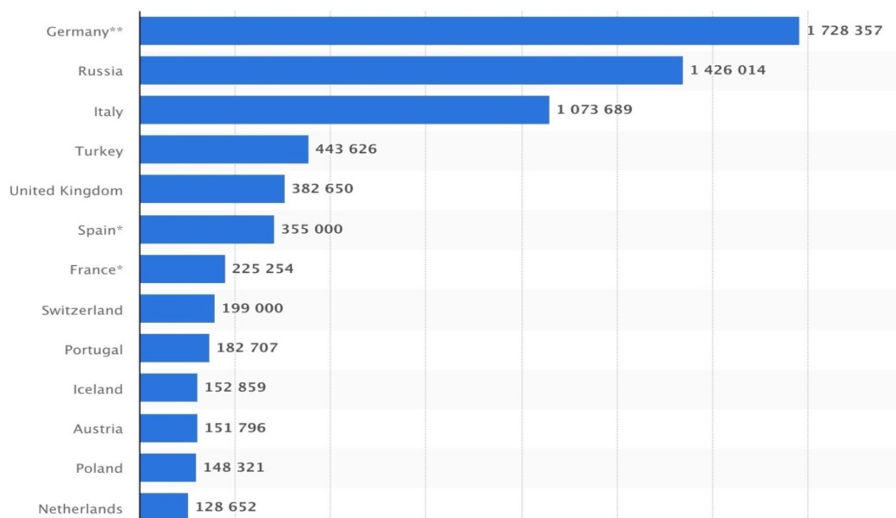
Source:https://www.destatis.de/EN/Themes/Society-Environment/Population/_Graphic/_Interactive/households-size.html;jsessionid=6D172456DF968EEAF2FD6722C6C15E0F.internet8721

2.2 Early mass tests and prompt action

The second reason for the low death rate may be the prompt action by the German authorities. Germany was very early in recognizing the virus and thus securing an advance in the detection of the epidemic. Scientists of the Institute for Virology at the Berlin Charité developed one of the first tests for the COVID-19 in January, and Germany also has a decentralization diagnostic system, laboratories across the country carry out independent testing. Many laboratories started testing in January when the number of cases was still very low. The high laboratory density makes it easier to test in Germany than in other countries. According to Robert Koch-Institut (RKI), as of April 12, private labs in Germany have helped the country test 1,317,887 people for COVID-19. In the first week of March, Germany tested 160,000 people. In the third week of March, it reached 250,000 people, and in the fourth week it reached 400,000 people, after March

Germany insists on testing 500,000 people a week.1 Compared with Italy, where the epidemic is most serious, only 150,000 people have been tested in Italy as of March 20. Germany's detection capabilities are much higher than some of European neighbors. On the one hand, the mass tests lead to a statistical anomaly: in Italy, Spain or the United States, patients with a much higher risk of death are primarily tested. In Germany, on the other hand, people who have no symptoms at all, but who have had contact with the person who has tested positive are also tested. Thus, many more people fall into the statistics. In Germany, early testing also brings decisive advantages: first, treatment can be started early if necessary, which increases the patient's chance of survival. Second, the infected person can be isolated as early as possible to avoid more infections.

Figure 7: Number of coronavirus (COVID-19) tests carried out in Europe as of April 15, 2020



Source:https://www.statista.com/statistics/1109066/coronavirus-testing-in-europe-by-country/

1 "Germany 'increases its COVID-19 tests to 500,000 per week'", https://www.euronews.com/2020/03/27/germany-increases-its-covid-19-tests-to-500-000-per-week.

With the development of economy and society and the improvement of public health, Germany has regarded epidemic prevention and control as one of the country's important tasks. The German Federal Ministry of Health has developed a national pandemic plan (Nationaler Pandemieplan) and each state has its own epidemic plan. Germany first released a national epidemic plan in 2005, which is updated every two years, the last update was in 2017. Its main contents are as follows: providing the public with the latest information; implementing compulsory report; closing public places such as kindergartens, schools; prohibiting assembly and large-scale activities; quarantine measures; disinfecting public places, adding hospital wards; setting up crisis groups; observing and timely evaluating the current situation; adjusting epidemic plans according to the actual situation etc.. These measures were also largely highlighted in the Merkel TV speech on March 18. In addition to the early large-scale and decentralized testing, Germany noticed the development of the COVID-19 earlier and adopted active measures, such as issuing a ban on nursing homes, tracking close contacts, etc., which made the German epidemic under better control at the beginning and kept the death rate at a lower level. In March 2020, the RKI has released the "Supplement to the National Pandemic Plan - COVID-19 - Novel Corona Virus Disease" (Ergänzung zum Nationalen Pandemieplan-COVID-19-neuartige Cornaviruserkrankung), its contents include relevant infection control measures, continuous risk assessment of the outbreak (disease transmission capacity, severity, medical system burden, etc.); disease surveillance; medical treatment; personal protection; vaccine development; antibody testing; and disclosure of information to the public etc..[1]

Because Germany attached importance to the prevention and control of the COVID-19 epidemic earlier, and adopted strong and rapid response

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1 Ergänzung zum Nationalen Pandemieplan-COVID-19-neuartige Cornaviruserkrankung, https://www.rki.de/DE/Content/InfAZ/N/Neuartiges_Coronavirus/Ergaenzung_Pandemieplan_Covid.pdf?__blob=publicationFile.

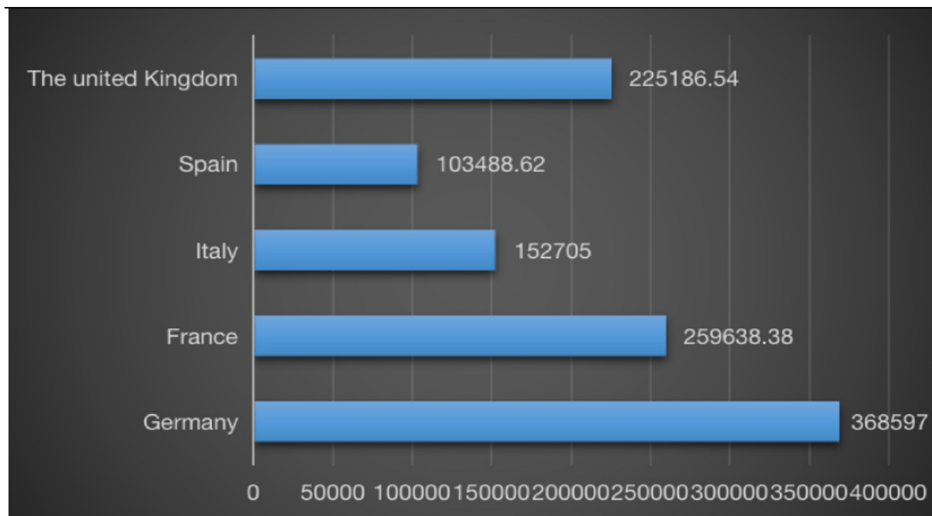
measures, such as large-scale, decentralized testing, and isolation of high-risk groups, the COVID-19 epidemic did not cause a large number of deaths. In the early stages of the outbreak, large-scale decentralized detection found many no / mild symptoms cases, which made the base of confirmed cases larger and lead to a low death rate.

2.3 Sufficient and high quality medical resources in Germany

Whether a country has sufficient and high-quality medical resources is one of the important factors for the country to overcome the epidemic. Germany is more capable of responding to the epidemic than most of other European countries. According to OECD and European statistics (Eurostat) data, compared with France, Italy, Spain and the United Kingdom, Germany has a great advantage in terms of Total Health Care Expenditure, Number of hospitals, Number of total hospital beds, Total numbers of critical care beds per 100,000 inhabitants and the Number of ventilators.

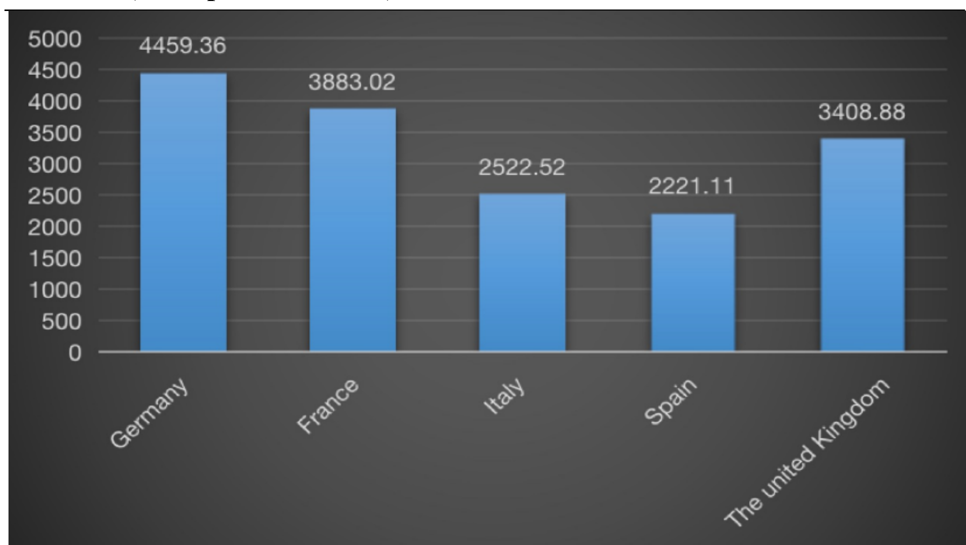
Health care expenditure quantifies the economic resources dedicated to health functions, and is an important indicator of a country 's medical resources. Take Eurostat data in 2017 (the last date) as an example (see Figure 8 and Figure 9): Germany's Total Health Care Expenditure is 368,597 Million Euro, and Total Health Care Expenditure per inhabitant is 4,459.36 Euro. However, the Total Health Care Expenditure in Italy and Spain are 152,705 Million Euro and 103,488.62 Million Euro respectively, which is only about one third of Germany. Total Health Care Expenditure per inhabitant are 2,252.52 Euro and 2,221.11 Euro, which is only about half of that in Germany.

Figure 8: Total Health Care Expenditure in select countries in 2017 (Million Euro)



Source:Total Health Care Expenditure, Available at https://ec.europa.eu/eurostat/databrowser/view/tps00207/default/table?lang=en

Figure9: Total Health Care Expenditure in select countries in 2017 (Euro per inhabitant)

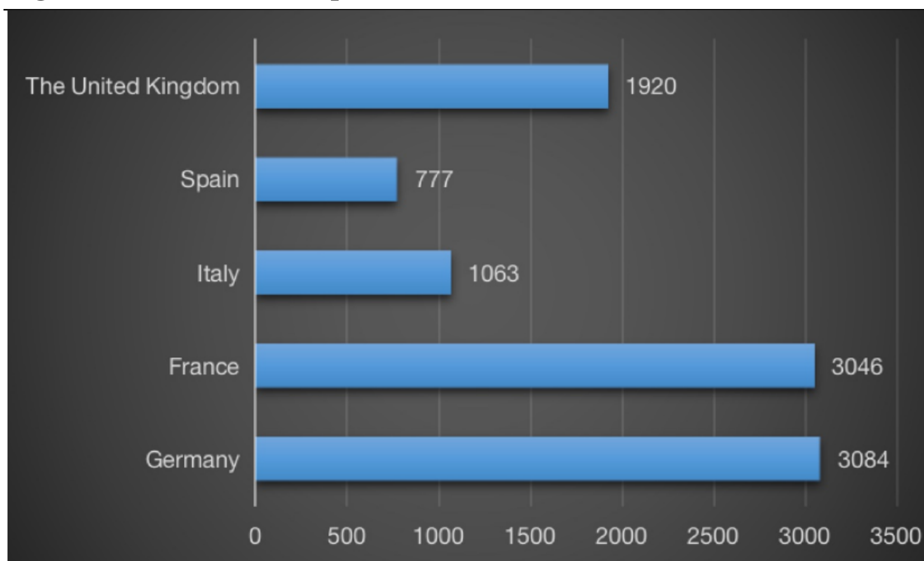


Source: Total Health Care Expenditure, Available at: https://ec.europa.eu/eurostat/databrowser/view/tps00207/default/table?lang=en

Faced with a large number of infected people, the number of hospitals; hospital beds, the density of hospital beds and the number of ventilators played significant roles in the rescue of severe patients and reducing the overall death rate. According to OECD data in 2017, Germany's number of hospitals, total hospital beds, hospital bed density (per 1,000 population), total numbers of critical care beds per 100,000 inhabitants and the number of ventilators are far higher than some of European neighbors. There are 3,084 hospitals (see Figure 10) in Germany with different sizes. The distribution of medical resources across Germany is relatively even, and the gap between hospitals is not too huge. Compared to Germany (around 80million inhabitants), Italy (60 million inhabitants), the worst-hit country in the epidemic, has 1,063 hospitals, while Spain (47million inhabitants) has only 777 hospitals, which is only a quarter of the number in Germany.

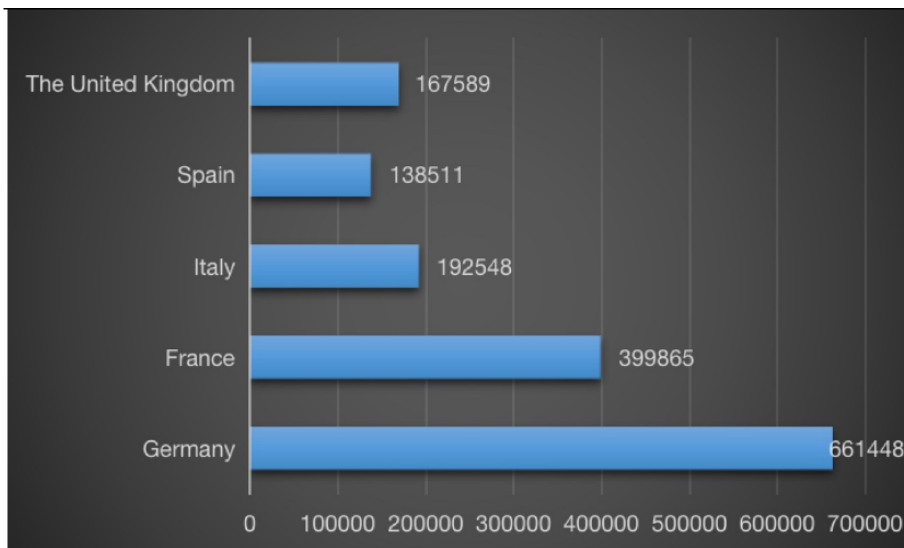
The number of total hospital beds also differs significantly. According to the OECD (see Figure 11 and Figure 12), Italy with around 60 million inhabitants has 192,548 hospital beds, hospital bed density (per 1000 population) is 3.2. Spain, with 47 million inhabitants, has 138,511 hospital beds, hospital bed density is 3. Germany, with around 80 million inhabitants, there are 661,448 hospital beds, is more than 3 times of Italy, is nearly five times (4.77) of Spain. The hospital bed density in Germany is 8, which is nearly three times of numbers in Italy and Spain. The most critically medical resources in the crisis: critical care beds, Italy had 5,000 critical care beds before the crisis, and more beds are being made. In Germany, there are about 28,000 before the crisis, now there are around 40,000. Italy critical care beds per 100,000 inhabitants are 12.5 (see Figure 13), Spain are 9.7 and Germany are 29.2. It is worth mentioning that Germany is not only provided better beds overall, clinics have also made emergency plans ahead of time, increased staff, postponed operations and cleaned wards for the COVID-19 patients.

Figure 10: Number of hospitals in select countries as of 2017



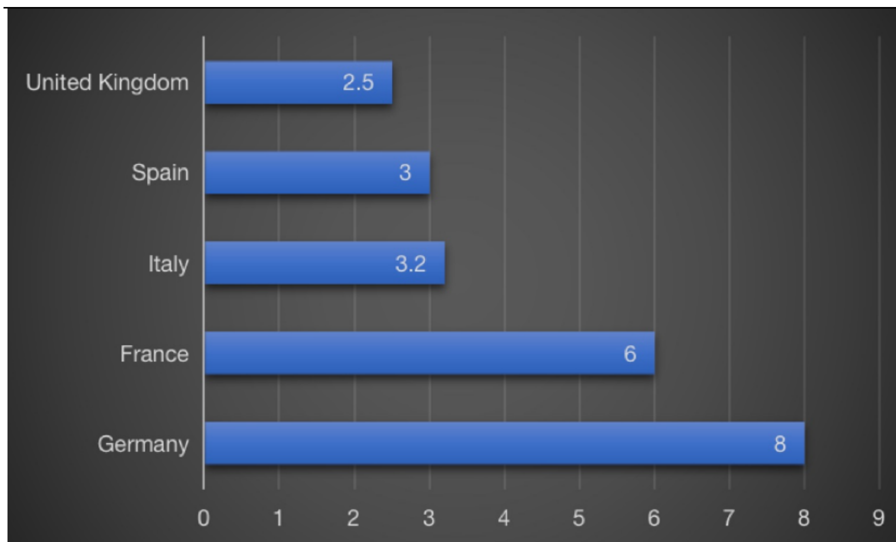
Source: Health Care Resources, Available at:
https://stats.oecd.org/viewhtml.aspx?datasetcode=HEALTH_REAC&lang=en#

Figure 11: Number of total hospital beds in select countries as of 2017



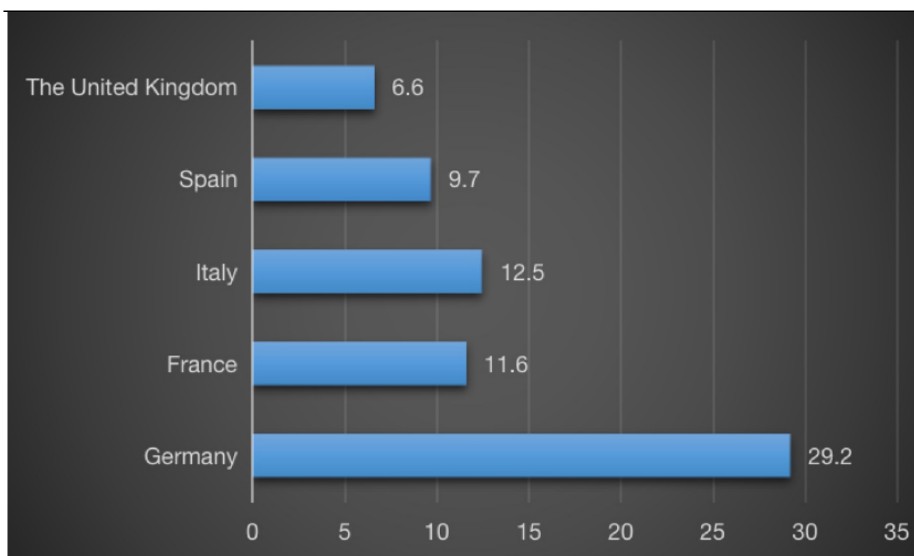
Source:Health Care Resources, Available at:
https://stats.oecd.org/viewhtml.aspx?datasetcode=HEALTH_REAC&lang=en#

Figure 12: Hospital bed density in select countries as of 2017 (per 1,000 population)



Source:Health Care Resources, Available at:
https://stats.oecd.org/viewhtml.aspx?datasetcode=HEALTH_REAC&lang=en#

Figure 13: Total numbers of critical care beds per 100,000 inhabitants in selected countries



Source:https://www.researchgate.net/figure/Numbers-of-critical-care-beds-corrected-for-size-of-population-per-100-000-inhabitants_fig1_229013572

Before the Corona crisis, there were 28,000 critical care beds nationwide in Germany, of which 20,000 with ventilators. According to the German Hospital Federation (DKG: Deutsche Krankenhaus Gesellschaft), these beds are only 70-80% occupied. The number of critical care beds has recently been increased to 40,000 and the ventilators to 30,000.[1] Compared with Germany, France has only around 5,000 ventilators available.[2] Germany has enough ventilators and can produce more by ordering from domestic healthcare companies. For example, German government ordered for 10,000 ventilators and other medical equipment from the Drägerwerk AG & Co. KGaA in mid-March and the batch are ready now, according to Draeger CEO Stefan Draeger.[3]

During the epidemic, lack of medical resources is the main reason for the surge in mortality. With the spread of COVID-19 in Germany, the number of confirmed cases is indeed increasing, but medical resources have not yet been exhausted. This is partly because the confirmed cases in Germany are relatively evenly distributed. The population of Germany mostly lives in small and medium-sized cities, and only four cities have a population of more than one million (Berlin, Hamburg, Munich, Cologne). Therefore, the epidemic in Germany is not as concentrated as Wuhan, New York and Lombardy, resulting in a shortage of local medical resources and a high death rate. On the other hand, the distribution of medical resources across Germany is relatively even, and the gap between hospitals is not too large. For example, if calculated according to the total population of each state, the proportion of ventilators in hospitals in different German states will not be much different.

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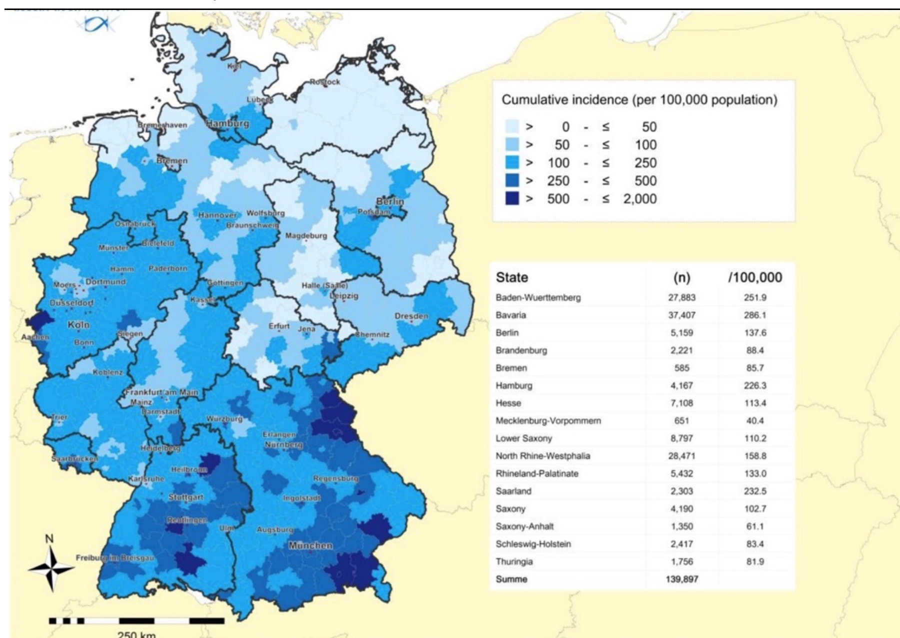
1 „Coronavirus: Fakten und Infos“, https://www.dkgev.de/dkg/coronavirus-fakten-und-infos/.

2 “Germany Has More Than Enough Ventilators. It Should Share Them,” https://www.nytimes.com/2020/03/17/opinion/coronavirus-europe-germany.html.

3 “Shares of a German Ventilator Manufacturer Are Soaring”, https://www.bloomberg.com/news/articles/2020-03-30/a-ventilator-maker-is-germany-s-best-performing-stock-this-year.

Although Germany's medical resources are indeed sufficient and have great advantages compared to some of European neighbors, they are not perfect. In fact, there are still some deficiencies, such as shortage of medical staff, which we will discuss in the conclusion of this article.

Figure14: Number and cumulative incidence (per 100,000 population) of the 139,897 electronically reported COVID-19 cases in Germany by county and federal state (19/04/2020, 12:00 AM)



State	(n)	/100,000
Baden-Wuerttemberg	27,883	251.9
Bavaria	37,407	286.1
Berlin	5,159	137.6
Brandenburg	2,221	88.4
Bremen	585	85.7
Hamburg	4,167	226.3
Hesse	7,108	113.4
Mecklenburg-Vorpommern	651	40.4
Lower Saxony	8,797	110.2
North Rhine-Westphalia	28,471	158.8
Rhineland-Palatinate	5,432	133.0
Saarland	2,303	232.5
Saxony	4,190	102.7
Saxony-Anhalt	1,350	61.1
Schleswig-Holstein	2,417	83.4
Thuringia	1,756	81.9
Summe	139,897	

Source:Coronavirus Disease 2019(COVID-19)Daily Situation Report of the Robert Koch Institute19/04/2020 - UPDATED STATUS FOR GERMANY.

2.4 The efficient Healthcare System in Germany

The German healthcare system is one of the oldest and improved healthcare systems in the world, and its history can be traced back to the 1880s. The system is divided into two main areas: public and private health insurance. The German healthcare system is based on the principle of solidarity. All people on public health insurance (GKV:Gesetzliche Krankenversicherung)

receive the same medical care regardless of their financial status. 1 Everyone who earns up to 62,550 Euros per year (the standard of 2020) is legally obliged to take out public health insurance.2 The law stipulates that every person who earns below this specified value must pay the same premium fees. In 2020, all residents registered with public health insurance funds have to share around 14.6% (generally 14.6%, each state is different) of their gross earnings for their health insurance.3 If you earn more than 62,550 Euros per year, you can opt for private health insurance (PKV: Private Krankenversicherung) .4 Some other groups of persons, such as civil servants and self-employed people, may also take out this type of insurance. According to official statistics, more than 70 million inhabitants or about 90% of the total population in Germany are entitled to public health insurance. In general, GKV covers you for primary care with registered doctors, hospital care and basic dental treatment etc.5

Doctors are known as Ärzte in German; Hausarzt is equivalent to a GP (general practitioner) or primary care doctor. Under the German medical system, you are free to choose your own doctor. Hospital is known as Krankenhaus in German, including three main types: public hospitals (öffentliche Krankenhäuser) operated by local and regional authorities; voluntary non-profit hospitals (freigemeinnützige Krankenhäuser) operated by churches or organizations of the German Red Cross and private hospitals (Privatkrankenhäuser). The German family doctor system has become very popular and mature. When ordinary people get sick, they usually go to see the family doctor instead of going to the hospital first. If

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1 GERMANY HEALTH INSURANCE SYSTEM, https://www.germanyhis.com/de/.
2 „Wie hat sich die Beitragsbemessungsgrenze und Versicherungspflichgrenze entwickelt?“, https://www.krankenversicherung.net/beitragsbemessungsgrenze.
3 „Wie hoch ist der Krankenkassenbeitrag 2020?“, https://www.krankenversicherung.net/krankenkassenbeitrag.
4 „Private Kranken--versicherung: Voraus-setzungen, Gesundheits-fragen, Leistungen im Vergleich“, https://www.krankenversicherung.net.
5 GERMANY HEALTH INSURANCE SYSTEM, https://www.germanyhis.com/de/.

you need further diagnosis and treatment by a specialist, the family doctors will issue a list for you to go to the specialist. Most of these specialists are not in hospitals, but in their own small clinics, scattered throughout the community. After the diagnosis and treatment by specialists, only a small number of patients with serious illnesses need to go to a large hospital. During the COVID-19 epidemic, most patients with mild symptoms will first contact their family doctor, and then follow the doctor's instructions to isolate themselves at home. During the isolation period, if their symptoms change, they will communicate with the doctor at any time. With the participation of family doctors, most mild patients have received effective treatment and do not need to be admitted to hospital, which also reduces the pressure on residents.

Germany also benefited from its federal structure, particularly the decentralized structure of its healthcare system. Germany is a federal state with 16 states, like education, health belongs to the jurisdiction of each state. German is generally referred to as Ländersache, the power of each state is free from the power of Federal Ministry of Health (BMG). The power of the Federal Ministry of Health is enshrined by the Basic Law. The three levels of the federal health system (federal, state, and local) have clearly defined divisions of labor and perform their duties separately. Faced with a large number of infected people, the staff of the tertiary health system took positive action. At the same time, the federal and state governments as well as local administrators and research institutions (such as the Robert Koch Institute) keep in constant contact, which greatly shortened the emergency response time. In the fight against COVID-19, rapid and effective actions played a decisive role. The joint cooperation of the three-tier institutions in the German federal health system, as well as the decentralized structure of the medical system such as family doctors are important reasons for Germany to avoid the shortage of medical resources in this epidemic. The above factors also made the German medical system more effective in this crisis.

2.5 The contributions of civil society and political consensus

On March 18th, German Chancellor Angela Merkel delivered an extraordinarily rare nationwide televised speech that is about the Coronavirus, in which she stressed that the COVID-19 is Germany's greatest challenge since World War II and hoped that everyone would take it seriously, "Only by working together can we meet the challenge". Therefore, she wants everyone to do their part, and called on the Germans to abide by the government's series of recommendations and change their living habits temporarily. Under the appeal of German politicians (such as Spahn, the health minister, who has called on the public to increase their sense of personal responsibility and forgo concerts and games), scientists (such as Drosten urged people to take responsible actions in private life to protect older family members) , social celebrities and angels in white (WE WILL STAY HERE FOR YOU !! PLEASE STAY AT HOME FOR US !!!), the German society gradually formed a consensus: the infected people follow the suggestions of the government and doctors, isolate at home, and do not contact with the elderly; Various social groups are also actively contributing to the fight against the epidemics. For example, college student groups in the medical department volunteer to support the medical staff in the hospital. Social Media has become an important platform for social groups assembly and action. People have been launching various public activities on social media to provide help to those in need within their power, such as helping the elderly who are at high risk of the epidemic to purchase daily necessities.

At the same time, in the fight against the epidemic, we have also observed that all political parties and government agencies temporarily abandoned ideological barriers, united and cooperated to jointly cope with the "Germany's greatest challenge since World War II", the Green Party and other opposition parties have also actively put forward suggestions to fight the epidemic. The federal and state governments have been taking drastic measures against the spread of the corona virus for a few weeks. Since July 2018, the current ruling coalition, the Union Party (CDU / CSU) and the

Social Democratic Party (SPD), have achieved more than half of the opinion polls for the first time.1 In terms of policy coordination, the federal level has set up an inter-ministerial crisis headquarters, which meets every two weeks to coordinate policies; in the economic sphere, the German Grand Coalition Government has introduced economic assistance measures to deal with the COVID-19. The Bundesrat and Bundestag have been remarkably efficient in the fight of epidemic. On March 27th, Germany's €156 billion (4.9 percent of GDP) bail-out plan has been signed by the President, and has officially come into force, providing financial assistance to enterprises and individuals affected by the outbreak.2

3. Conclusion

Germany's achievements are the result of multiple factors and efforts. We have summarized some reasons in the article. Infected persons returning from ski resorts in Italy and Austria are younger, have better health and are more resistant. Even if they have been infected, they are mostly mild patients who are not prone to complications or develop into severe patients. At the same time, the family size in Germany is relatively small, reducing the probability of mutual infection among family members. Germany started early decentralized large-scale testing and implemented rapidly anti-epidemic operations nationwide. Compared with other European countries, Germany has sufficient and high quality medical resources, and the operation of its tertiary health system is powerful and efficient. In this battle against the COVID-19, German civil society has made a great contribution, and all the parties have temporarily reached a political consensus to unite against the epidemic.

With the severity of the COVID-19, the death rate in Germany is likely to continue to rise. For example, the German death rate has climbed from 0.2%

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1 Infratest dimap: Umfragen & Analysen, https://www.infratest-dimap.de/umfragen-analysen/bundesweit/ard-deutschlandtrend/2020/april/.

2 Key Policy Responses of Germany as of April 16, 2020, https://www.imf.org/en/Topics/imf-and-covid19/Policy-Responses-to-COVID-19#G.

at the beginning to the current 3.19% (as of 20.04.2020). The reason lies that, first of all, Germany has a high degree of aging, 21.4% of the German population is older than 65 years, this ratio is certainly extreme on a global level. In addition, the elderly are the high-risk group in the epidemic, and the deaths median age in Germany is 82 years. If the infection rate of the elderly increases, the death rate in the later period will probably continue to rise. Secondly, the German medical system is far from perfect. As mentioned above, the lack of qualified doctors and nurses is a huge challenge facing the German public health system. Currently, widespread effects of the COVID-19 lie in the catastrophic conditions in hospitals. Doctors and nursing staff are completely overworked and there is still a lack of protective equipment such as face masks, protective gowns and disinfectants.[1] There are also many discussions about it. Social groups also have a lot of activities, for example, many medical college students volunteer to support. However, the shortage of staff in the German medical system is an issue that has plagued all sectors of German society for a long time. The fundamental solutions of this problem still remain to be considered and observed. Finally, under the German federal system, there are still some altercation between the Federation and the States in the measures taken in the epidemic. For example, on a conference on March 22, Chancellor Angela Merkel and Governors of the federal states adopted new rules to control the spread of the COVID-19. This raises the obvious dispute between the federal and state governments over the further measures, particularly between Bavarian governor Markus Söder and Armin Laschet, governor of North Rhine-Westphalia.[2]

Although the current death rate in Germany is indeed relatively low, the future trend of the German epidemic remains largely uncertain. On the one

1 "German hospitals become COVID-19 hotspots for health care workers", https://www.wsws.org/en/articles/2020/04/11/hosp-a11.html.

2 "Kontaktsperre:Die neuen Regeln", https://www.deutschlandfunknova.de/beitrag/kontaktsperre-gegen-covid-19-neue-regeln-von-bund-und-ländern.

hand, Chancellor Merkel announced on April 15 that the contact restrictions will be extended to May 3, schools will gradually reopen since May 3, and the store may also reopen. However, we must be aware that due to these easing restrictions, the virus may start to spread again. Merkel also mentioned in an April 20 media interview that the effects of these deregulations will not be seen until 14 days. If the number of infections rises, the country will shut down again. On the other hand, despite the risk of continued spread of COVID-19, compared with some of European neighbors, we believe that Germany's advantages in medical resources, R & D capabilities, super economic strength, and the government's crisis management capabilities make Germany's prevention and control situation relatively optimistic. Meanwhile, with the vaccine research and large-scale corona virus antibody testing, we can't rule out the possibility that the epidemic can be controlled in Germany in the near future. Everything is constantly changing; nothing remains static. The follow-up development of the situation in Germany remains to be seen.

When the COVID-19 epidemic just raged in Europe, European countries behaved as "Sweep the snow in front of own door". After the initial panic had passed, European unity has repeatedly been emphasized. Germany, a neighbor of the severely affected countries, with a relatively low death rate, began to provide treatment for critically ill patients in Italy and France and provided Italy with medical equipment such as ventilator. German and French politicians continue to call on European countries to work together to strengthen European unity. Under the situation that the COVID-19 has a serious impact on the global economy and society, the solidarity and cooperation of European countries may bring a glimmer of light to the stagnant European integration in recent years.

Why France Failed to Contain the COVID-19 Pandemic

Peng Shuyi1

Abstract

Compared with France's world-class healthcare system, the country's response to COVID-19 pandemic is far from being satisfied. With more than 100,000 confirmed cases and a high death rate, France actually becomes one of the worst-hit countries by COVID-19 pandemic, although the country is the sixth largest economic power in the world. The comparison between France and Germany (as countries with strong comparability in many ways and as the most powerful member states in the EU) could further help people better understand France's failure to efficiently respond to this public health emergency. The main factors that have caused such an undesirable result include lack of decisive actions with relatively low recognition of the severity of the disease at the beginning stage, relatively limited bed capacity due to the budget cuts, and the shortage of test means. In addition, the pandemic further exposed social problems relating to social inequality and aging population, over which the French government has been struggling for a quiet long time.

Keywords: *France; COVID-19 pandemic; Low awareness of the crisis*

1. French health care and hospital system

1.1 Health care system

French health care system was created in the aftermath of World War II, within the framework of France's construction of social security system. Organized according to the Bismarckian model, it was initially an employment/business-based system, aimed at working people and their

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families; It has been gradually expanded to cover all the population with the creation of "Universal health coverage" (CMU, Couverture maladie universelle) and MAE (MAE, Aide médicale d'Etat) on 1999. CMU protected those not covered through employment/business-based schemes, while MAE aims at the undocumented residents.

French health system is currently a multi-layered insurance-based system, having elements of both Beveridge and Bismarck, increasing towards the mixed model. It follows the principle of universality and solidarity. Universality means universal coverage, namely all people have access to healthcare; solidarity implies those with greater wealth and better health finance those with less health and in poorer health.

The first layer is state-sponsored statutory social health insurance (SHI), covers almost the entire population, funded initially by wage-based contributions shared between employers and employees. The contributions have been increasingly replaced or reinforced by earmarked income tax—the "General Social Contribution" (contribution sociale généralisée; CSG) based on all income—as well as specific taxes such as taxes on potentially harmful consumption (tobacco, alcohol) and taxes on pharmaceutical companies. The percentage level of reimbursement by SHI varies, depending on the type of treatment received and from whom. Normally, it will pay for about 70% of general practice (GP) fees and between 30% and 65% of prescribed medicines.

The second layer is voluntary health insurance (VHI). As complementary insurance, it aims at providing better coverage for medical goods and services that are poorly covered by SHI. It finances 14% of total health expenditure and covers more than 90% of the population. VHI could be purchased by individuals or by employers for their employees, 85% of VHI are offered by employers. Two actors play key roles in this field,

commercial insurance companies and Mutual insurance companies[1]. The former represents 13% of the total VHI contracts while the latter 82%. The third actor is provident institutions, they have a non-profit-making aim and have specialized in mandatory group contacts, which account for 5% of the total VHI contracts.

The third layer is the publicly financed complementary universal health coverage (UCM) created in 1999, replaced in 2016 by the so-called "Universal health protection" (PUMA (protection universelle maladie), aiming at granting an automatic and continuous right to health care in France to those who are legally resident in the country but without any of the mandatory health care insurance, it covers around 7% of the population. Despite the above triple protection, individuals still need to pay a little part of the total fee, but the out-of-pocket (OOP) payment counts only 7-8% of the total fee, almost the lowest in EU.

In general, less healthy and less wealthy persons have better insurance coverage, the serious debilitating or chronic illness such as cancer, heart disease, diabetes is almost free of charge; people whose income is below a minimum ceiling are paid by state.

1.2 Hospital system

French is a public-private mixed model in the provision of health care services.[2] state plays a key role in the field.

Health services are provided by independent physicians (the self-employed doctors) and hospitals. There are different kinds of hospitals: public hospitals, private non-profit-making hospitals funded especially by foundations, religious organizations or mutual-insurance associations, and private profit-making hospitals funded increasingly by large international

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1 Mutual insurance companies are non-profit-making basis, aiming at achieving mutual aid among their members by avoiding differentiation in premiums for a given level of coverage.

2 Karine Chevreul et al., "France Health system review", *Health Systems in Transition*, Vol.17, No.3, 2015, URC Eco
http://www.euro.who.int/__data/assets/pdf_file/0011/297938/France-HiT.pdf

groups. The regulatory framework for hospitals formulated by government applies equally to all the hospitals. Primary care that does not require hospitalization is largely carried out by independent physicians working in their own practices, while hospital beds are predominantly offered by public or private non-profit-making hospitals, in general, public health institutions account for 61% of hospital beds.

There is also a combined health and social care sector, the so-called "medico-social" sector (établissement hospitalier pour personnes âgées dépendantes, EHPAD), namely the nursing houses, which provide nursing care and supportive services to dependent elderly people. France has currently 7000 nursing houses, 40% of which are public, with more than 700 000 persons living there.

1.3 Strengths and vulnerabilities exposed by COVID-19 pandemic

The French health care system is rated as one of the best in the world, its main advantage is: state plays a key role in the field, which ensure not only a universal coverage, but also a better protection for the poorest and the lest healthy people, that's one of the reasons why the French are broadly satisfied with their health care system and proud of it.

In the case of COVID-19 pandemic, once hospitalized, the cost will be totally covered by the insurances. Just as mentioned the health official: whatever the cost of the hospitalization, social health insurance will ensure that the coronavirus "does not cost a penny". For the patients with mild symptoms who (only the severe cases can be hospitalized), the cost will be covered by SHI and VHI, the latter will cover about 30% of the final invoice. Cost of coronavirus test are also shared between SHI and VHI.

However, the system is under increasing stress due to the deficit—the SHI has faced large deficits over the past 20 years. Reducing deficit in order to ensure the long-term sustainability of the system has been being the priority, and resulted some negative impacts, especially the cut of hospital beds.

In order to reduce the deficit of SHI, outpatient surgeries without overnight in hospital have been encouraged, leading to the decrease of hospital beds. The statistics showed that outpatient surgery went from 36.2% in 2009 to 54% in 2016, but the government thought it's not enough, the former Minister of Health Agnès Buzyn once pointed out that: "In surgery, the goal is that by 2022, seven of ten patients who enter the hospital in the morning will leave in the evening, compared to five today." Which means increasing ambulatory medicine to 55% and ambulatory surgery to 70%1. This allows to close more beds and therefore to save more money. In 2019, more than 50 hospital emergency rooms across France have held strike against the funding cuts. Emergency room doctors and nurses have protest outside the French health ministry, warning that budget cuts were leading France's world-class health system to the brink of collapse and putting patients' lives at risk. As pointed Christophe Prudhomme, an emergency room doctor "Over the past 20 years, little by little, I've seen the breaking of our health system. We have a very good system, but if these cuts continue, we'll be joining the misery of the NHS (of UK) and I fear people who need treatment won't get treated." Another one said: "Our health system was among the best in the world, but I'm afraid it's collapsing."2 Unfortunately, what they said was becoming true when facing COVID-19 pandemic in 2020. We will come back to this point later.

Furthermore, COVID-19 pandemic also revealed some other weaknesses of French health care and hospital system:

First of all, the hospital-centric approach. France adopts a hospital-centric approach. Resources is concentrated on hospitals at the expense of basic health care. With the arrival of COVID-19, hospital capacity must be preserved for the most severe patients, who represent around 20% of all

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1 « Favoriser l'ambulatoire à l'hôpital pour faire des économies », La Santé Publique, 07/11/2017, https://www.lasantepublique.fr/favoriser-ambulatoire-hopital-economies

2 "French medics warn health service is on brink of collapse", The Guardian, 11/Jun/2019, https://www.theguardian.com/world/2019/jun/11/french-medics-health-service-collapse-doctors-nurses-protest-outside-french-health-ministry-strikes

those affected, then primary care medicine is essential to conduct an initial triage. But the liberal doctors were not clearly and quickly informed about their role to play and what to do, and they are not equipped with basic protections such as medical masks, that's why they can't effectively help to relieve the pressure on hospitals.

Second, the less use of telemedicine. Telemedicine has two major advantages, avoid the contact with patients and avoid thus the eventual infection; ensure the continuity of health care for the confined people, so it's also an effective way to limit the overburden of hospital. But in France, barely 2,000 doctors practiced telemedicine at the end of 2019. Despite the encouragement of government and rapid mobilization of teleconsultation platforms Since March 8th 2020, most of the doctors are still not used to using telemedicine.

Third, the shortage of staff in nursing houses. Older people are more at risk of coronavirus, but due to the shortage of staff, it's difficult to limit the epidemic from spreading in nursing houses, one third of them were affected by COVID-19 pandemic. Although "due to technical issues", the Minister of health Olivier Veran said, date collection and update in nursing houses is difficult, but deaths number there is "objectively chilling"1. Finally, the French authorities has had to make a nationwide call for volunteers such as retired doctors and medical students to help.

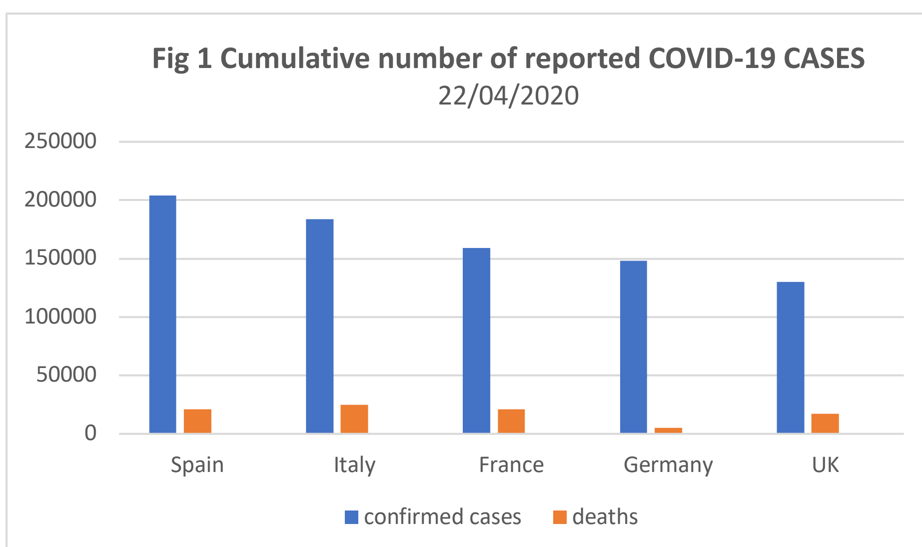
2. French response to COVID-19

The first three confirmed cases of COVID-19 in France was reported on the 24 January 2020. According to the statistics published by French government, as of April 22, France has reported 159,297 confirmed cases

1 "France struggles with 'chilling' COVID-19 data from nursing homes", msn news, /04/09/2020, https://www.msn.com/en-us/news/world/france-struggles-with-chilling-COVID-19-data-from-nursing-homes/ar-BB12m05W

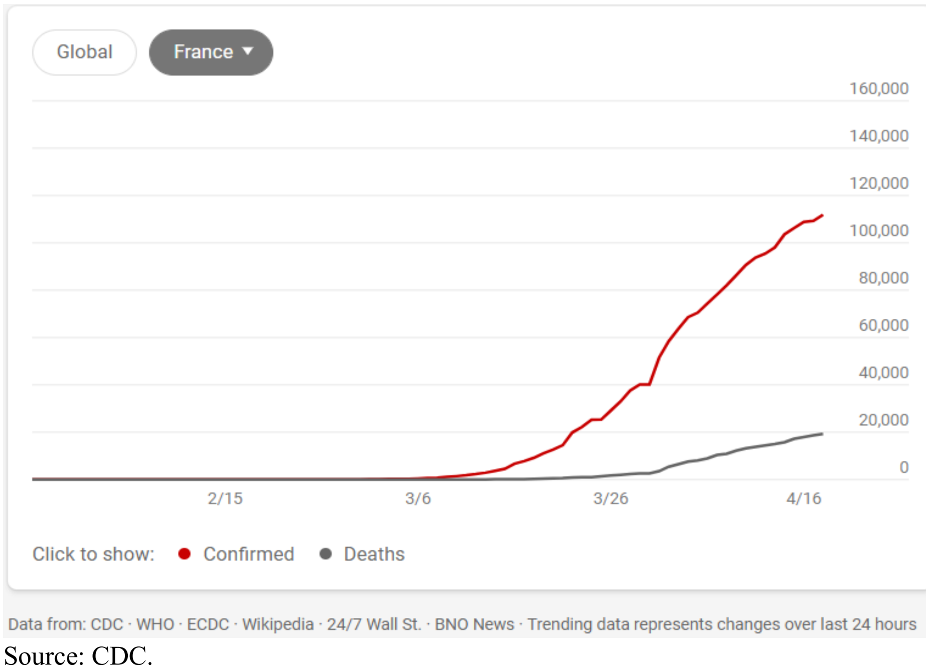
and 20,829 deaths,[1] one of the highest in EU in terms of death. Since nursing house deaths were not included in the official death toll for a period of time, so the number of deaths may be much higher.

Although the trajectory of France is less tragic than that of Italy or Spain, its death rate is much higher than that of Germany. As of April 22, Germany had 145,694 confirmed cases and 4,879 deaths. In the following sections, the author gives a brief overview of how France handles the COVID-19 pandemic.



Source: Cartes et chiffres sur l'évolution de l'épidémie du Coronavirus COVID-19, 22/04/2020, https://www.ouest-france.fr/sante/virus/coronavirus/tableau-de-bord-evolution-epidemie-COVID-19-carte-chiffres-graphiques/

1 Cartes et chiffres sur l'évolution de l'épidémie du Coronavirus COVID-19, 22/04/2020, https://www.ouest-france.fr/sante/virus/coronavirus/tableau-de-bord-evolution-epidemie-COVID-19-carte-chiffres-graphiques/



Source: CDC.

2.1 The four-stage strategy

To respond to COVID-19 pandemic, France has implemented the "four stages" mothed set by the government in the "national pandemic influenza prevention and control plan" in October 2011. These phases represent above all the evolution of the epidemic management according to its diffusion.

Stage 1: Prevent or stop the entry of virus (January 24- March 6)

Theoretically, Stage 1 began since the 24 January, the day when the first cases were confirmed. This stage aimed at stopping entry of virus into France from outside. During this phase, the measures such as case detecting and isolating, contact tracing were implemented. Persons showing symptoms or returning from the risk area were isolated. In early February, confirmed cases must isolate for 14 days.

Stage 2: Contain the spread of the coronavirus (March 6-March 14)

According to the statement of French government, France officially stepped into stage 2 since March 6. Stage 2 aimed at slowing down the spread of the virus. It is essentially a matter of saving time so that the health system could prepare. More measures were implemented, such as closure of school, closure of museums, travel restriction, cancellation of large events (concerts, sporting events etc.), prohibition of public gatherings of more than 5000 people in closed space, visits suspended in establishments for the elderly etc.

Stage 3: "Epidemic stage" (March14 - May 11)

Since March 14, France stepped officially into stage 3. In this phrase, the virus actively circulates throughout the territory, the cases were rapidly increased, that signals the start of the epidemic wave. From March 16, French government announced more tougher measures to minimize contact and travel, the near-total lockdown was imposed by the government from March 17 both to contain the spread of the coronavirus and to decrease the number of hospitalizations, residents were ordered to stay at home except to buy food, go to work, seek medical care or get some exercise on their own. Since the situation continued to deteriorate, the lockdown initially planned to last some days has been extended several times, and will last until at least May 11. From mid-April, France, like most of the European Union member has closed the borders to non-European countries.

But at this stage, France's testing range has been limited due to the lack of testing capacity, only a certain group of people could be tested, and French health authorities tried to step up measures to test more people. The labs of the city were allowed to perform the tests, while previously, only the labs of hospitals could do so. But, according to what the President Macron said, by May 11 the date of lifting the lockdown, France could be able to test anyone showing symptoms.

In this stage, with the national-wide outbreak of the pandemic, hospitals were at high risk of getting overwhelmed, especially in the Grand Est region and the Region of Paris—regions that was hit the more severely by

the disease. In fact, the Grand Est region was considered overwhelmed, and army helicopters were mobilized to transport patients to neighbour countries such as Switzerland, Germany and Luxembourg, in order to free up the hospital beds. According to what the President Macron said, it's the biggest crisis since the Second World War. Besides the military forces, social forces were also widely mobilized in the effort to cope with the pandemic, patients were transferred by plane, or even high-speed train from hospitals of the east to the west, medical students and retired medical staff were also mobilized to give a hand in the hospitals and nursing houses.

From May 11, According to what the Prime Minister said on April 19th, France will begin to lift its strict lockdown conditions, in a slow and gradual way: schools, creches and business would progressively re-open will the university should remain closed; Restaurants and cafés will not reopen until at least early summer while public gatherings will be allowed until mid-July; The most vulnerable people (elderly, severely disabled, chronically ill) were still asked to remain at home at least until the end of the year. People was advised to adopt telecommuting, minimize the use of public transport and stagger work timings after lifting the confinement. People need to wear masks on public transport, the masks are going to be distributed to the citizens, free of charge. The external borders of the Schengen Area and the Schengen Associated States may remain closed until September in order to prevent another eventual wave of Coronavirus infection that may be caused by an outer factor. In Short, Life will not go back to normal after May 11th, there will still be a lot of uncertainties.

Stage 4: Theoretically, in this phase, the pandemic will be under control, focus will be put on the evaluation of its impact on both social and economic terms, the preparation for a possible new wave and the revival of economy.

France is currently at stage 3. According to what the President Macron said, progress had been made. Although the confirmed cases are still high, the deaths are slowing down. Nevertheless, the country has not won the battle yet.

3. France versus Germany

With more than 100,000 confirmed cases and the highest death roll in the world, France's response to the coronavirus public health emergency is considered to be a failure, especially compared with France's world-class health care system. On the contrary, Germany has been resisting the epidemic wave and doing better than most of the European countries including France, its mortality rate is extremely low (refer to fig 1). The comparison between France and Germany, two similarly sized, most powerful countries in EU could help us to better understand why France failed in his battle again the disease. Several factors could explain the situation.

3.1 Testing capacity

Testing is the pillar of German strategy to battle again the pandemic from the very beginning. In Germany, testing for COVID-19 began at a very early stage, two or three weeks before his neighbor: from the first confirmed case in Bavaria in mid-January, a massive screening policy was put into place on the initiative of the Robert-Koch Institute, a benchmark establishment for applied research and public health, on relying on independent laboratories. According to Prof. Dr. Christian Drosten, director of the institute of virology at the Charité – Universitätsmedizin Berlin, one of Europe's largest university hospitals, German's success in battling the coronavirus depended on its vast program of screening[1]. Each week, between 300,000 and 500,000 people are tested, exceeding the target of 200,000 per day set by the government. Both people showing symptoms and those who have been in contact with the confirmed case were tested. And tests were carried out in both hospitals and general practitioners, sometimes even directly on the cars. The objective is to isolate the confirmed cases as quickly as possible.

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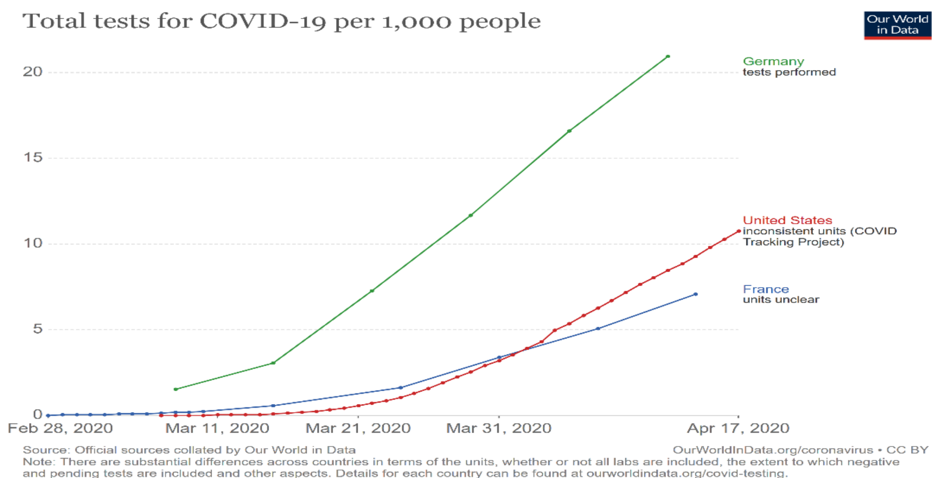
1 "Is Germany Handling the Coronavirus Crisis Better Than France?" LEADERS, 08/04/2020, https://www.leadersleague.com/en/news/is-germany-handling-the-coronavirus-crisis-better-than-france

Compared with Germany who has Europe’s best pharmaceutical industry which allowed an extensive testing, the testing rate was much lower in France (10,000 cases each day). The main reason is the lack of nasal PCR tests which allow immediate detection of the virus, which need to be imported from abroad. “We are totally incapable of testing on a very large scale because there is no molecular biology industry in France”,1 explained pharmacist biologist Michel Bendahan. That’s why France has adopted a selective testing strategy, only those who have showed severe symptoms, or who had been in “close contact” with a confirmed case, or who had travelled to a risk zone, could be tested. After WHO’s calling for massive test of all suspected cases, France reviewed its method and set a new objective—gradually multiply the number of tests from 10,000 each day to 50,000 by the end of April, 60,000 in May and 100,000 by June.

Another reason for France’s lag on testing is its highly centralized health system: before March 9, only several hospitals had the right to do carry out tests. On the contrary, Germany’s decentralized health system seems to have helped encouraging the rapid development of tests in the laboratories located in the whole country, as well as their early use. According to



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1 « Coronavirus : pourquoi l'Allemagne semble-t-elle mieux gérer l'épidémie que la France ? » Franceinfo, 03/04/2020, https://www.francetvinfo.fr/sante/maladie/coronavirus/coronavirus-pourquoi-l-allemagne-semble-t-elle-mieux-gerer-l-epidemie-que-la-france_3894519.html

François Heisbourg, member of the Foundation for Strategic Research, who was involved in France's disaster planning 15 years ago: "On testing, we have seen a beautiful centralized system failing abjectly."1 Only from March 9 that France gave the green light to all labs of the city to do the test, but it seemed too late.

According to experts, Early testing helped the country's public health officials get a better understanding of there the outbreaks were and how far the disease had spread before things got out of control. But France doesn't produce its own testing kits, which hindered him from carrying out more tests, that's why he couldn't get a clear picture of how the things go and thus respond as quickly as possible.

3.2 Hospital-bed capacity

In terms of hospital-bed capacity, France is also far behind its neighbour country. Germany is particularly well equipped in intensive care with 28,000 intensive care beds, and 25,000 of them are equipped with respirators, which makes the country become one of the best equipped OECD countries. This could be explained by the fact that Germany has two of the main respirator manufacturers in the world, Draeger and Löwenstein. After the epidemic, Germany quickly increased his bed capacity to 40,000, of which 30,000 beds are equipped with respirators. This greatly facilitates the care of the seriously ill patients and alleviates pressure on the hospitals: in March, 31,5% of the beds were still empty, stated the Minister of Health Jens Spahn.[2] That's why German could accept the patients from Eastern France (the most badly affected areas of France) since mid-March.

Although France has a first-class health system in the world, its system has reached its maximum hospital capacity due to the limited availability of

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1 "Mobilising against a pandemic France's Napoleonic approach to COVID-19", *The Economist*, 04/04/2020, https://www.economist.com/europe/2020/04/04/frances-napoleonic-approach-to-COVID-19

2 « Coronavirus : pourquoi l'Allemagne semble-t-elle mieux gérer l'épidémie que la France ? », op.cit.

intensive care beds. France initially had 5,000 intensive care beds, which gradually increased to 10,000. Nevertheless, the number was still not enough. The French government intended to increase the beds to 14,000 or 14,500. Obviously, it is a race against time as hospitals in some regions are going to be fully packed. In some regions, such as Seine-Saint-Denis, which is the poorest department in the great Paris region, the hospitals have been overwhelmingly pressured, death toll is increasing more rapidly than the rest part of Paris region, and its death toll is the highest. In addition, due to the scarcity of beds, doctors had to decide on whom to save first. In principle, priority is given to the younger and healthier patients.

The gap between France and Germany in terms of hospital-bed capacity could be explained by the budget cuts as the author mentioned above. In order to reduce the deficit of Health care insurance, outpatient operations without hospital nights has been encouraged, resulting in the decrease of hospital beds. The statistics showed that outpatient surgery went from 36.2% in 2009 to 54% in 2016, but the government thought it's not enough. The former Minister of Health Agnès Buzyn once pointed out that "In surgery, the goal is that by 2022, seven of ten patients who enter the hospital in the morning will leave in the evening, compared to five today." In detail, it is about "raising ambulatory medicine to 55% and ambulatory surgery to 70%"1. In short, the hospital-bed capacity has been declined by about 10% over the last decade.

In addition, the 2019 OECD statistics indicate that France has the third largest healthcare budget in the world, but it falls to the twelfth place when it comes to the ratio between the expenses and the number of inhabitants. Namely, the country is only the twelfth in the terms of per-capita healthcare spending. According to the French newspaper (Le Monde Diplomatique), in 2019, the per capita medical expenditure was €5,200 in Germany and €4,300 in France, but the former has 18 million more people than the latter.

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1 « Favoriser l'ambulatoire à l'hôpital pour faire des économies », op.cit.

3.3 R&D investment.

R&D plays a key role in determine whether the government could give an effective response to the public health emergency. Germany is one of the leaders among OECD countries in terms of R&D expenditure, which has been growing despite the budgetary restrictions in other areas[1]. More than 90 billion euros are spent each year in the fields of public and private research, against 50 billion euros in France.[2] According to Samuel Alizon, director of research on infectious diseases at the CNRS. "The funding of research and development in France is laughable compared to Germany," that's why "German had already simulated the most probable post-coronavirus scenarios last month, while France is only now beginning to sketch them out."3

Due to the tax cuts that the government granted in order to appease the "yellow vest", the draft budget shows that France's spending on research will be €7 billion in 2020, the total higher Education, Research and Innovation budget will be 25.35 billion, increased by 2%4 compared to the previous year, but still far from the expectation of the scientists.

In fact, at the moment when SARS epidemic emerged in 2002, France has augmented its spending on coronavirus research, but with the disappearance of SARS, the spending had been decreased. "The COVID-19 crisis reminds French government of the importance of scientific research and the need to invest it massively for the long term", according to what President Macron said, He decided to make a much more effort on pledging to invest more than €5 billion over the next decade to strengthen science and research, which means an increase in spending by around €500 million per year, with €50 million due to be released as part of an

1 « Coronavirus : pourquoi l'Allemagne s'en sort mieux que ses voisins européens pour le moment ». op.cit.

2 "Mobilising against a pandemic France's Napoleonic approach to COVID-19," op.cit.

3 « Coronavirus : pourquoi l'Allemagne semble-t-elle mieux gérer l'épidémie que la France ? », op.cit.

4 https://www.nature.com/articles/d41586-019-02953-2

emergency fund for research on the coronavirus, adding to the €8 million already put up for COVID-19. Tests, treatments and the vaccine were listed as priorities[1].

3.4 Crisis awareness

Objectively speaking, although France isn't as powerful as Germany in some fields as mentioned above, he still has good hospitals capacity with thousands of ICU beds and well-trained physicians. It could be listed between the better prepared counties at least in theory. Another key reason that France failed to give an effective respond when facing the spread of the virus, is that French government has completely missed the chance to eliminate the disease as soon as possible. Even the French President Emmanuel Macon acknowledge: "our country was not sufficiently ready for the crisis, we will all draw the consequences."

During the stage 1, the French government did not seem to be clearly aware of the seriousness of the disease, and the health authorities insisted that it was just an influenza, with a very low mortality (1-2%). The citizens were just advised to wash hands, keep a safe distance from others, cover mouths when sneezing etc. Few concrete actions were taken to impose strict social distancing measures or promote large-scale testing. The trade unions continued to mobilize protest against the pension reform. In early March, the government still allowed gatherings of up to 1000 people to proceed, the President Macon even attended himself a theatre performance and visit a retirement house on March 6, partly to show that nothing to be worried while the virus was rapidly spreading. The municipal election still went on as scheduled (although the second round of vote was obliged to be postponed), that's why the government and health officials were severely criticized afterwards.

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1 "France reaches for research bazooka, adding over €5B over 10 years to fight COVID-19 and future epidemics", *Science Business*, 20/03/2020, https://sciencebusiness.net/news/france-reaches-research-bazooka-adding-over-eu5b-over-10-years-fight-COVID-19-and-future

Two events finally attracted the President's attention: first, the rapid deterioration of Italy's coronavirus situation; second, a mass outbreak linked to a five-day (from 17 - 21 February) 2500-strong church gathering in the east of the country, near the border with Germany. That's why the beginning of the 3rd stage was hastily announced—We noticed that there are only 8 days between stage 2 (began from March 6) and stage 3 (from March 14). In fact, stage 3 even stage 2 should have been declared much earlier!

In short, France has missed the early opportunity to bring the disease under control while Germany was two to three weeks ahead. The French government failed for weeks to take decisive actions. Germany, on the other hand, immediately began to test all the people with symptoms. Now, France is still under lockdown, Meanwhile, Germany plans to reopen part of its economy.

4. Conclusion

Several conclusions can be drawn based on the previous observations.

First, quick decisions and initial actions are critical to bring the outbreak under control before the number of confirmed cases even reaches the so-called crisis level. Otherwise, it may be too late to prevent a spike in cases which may lead to much pressure on the hospitals. Italy's experience has already showed this. Unfortunately, France partially repeated the path of Italy. The French government failed for weeks to take decisive actions. The country was supposed to be well prepared for the crisis earlier as it's a bit too late when France officially entered its second and third phases of fighting the virus. Furthermore, the relatively limited bed capacity due to the budget cuts and shortage of test means has added the fuel to the fire. On the contrary, Germany did much better.

Second, the COVID-19 pandemic has revealed the problem of dramatic social inequality in France. Many inhabitants in Seine-Saint-Denis, which is the poorest department in the Paris region regrouping a large number of immigrants, are the people from lower classes in both economic and social

terms. Many of them work in sectors such as cleanliness, the food industry or nursing houses. That's why Seine-Saint-Denis is above all the least confined department in the region of Paris. The poor living condition (e.g., several people share a small apartment) increased also the chance to be infected. Besides, the supply of care in Seine-Saint-Denis is largely insufficient. Although it is the most populated department, Seine-Saint-Denis has three times fewer doctors than Paris, which actually has less inhabitants.

Third, in France, "around a third of all deaths from the disease have come from within retirement communities".1 The number of deaths in nursing homes has long been out of the statistics, although French according to the government, it was due to technical reasons, people still suspected that government has been a passive bystander instead of doing something actively for these elder people.

To be brief, the pandemic further exposed the social problems relating to social inequality and aging population, over which the French government has been struggling for a long time.

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4. « Coronavirus : pourquoi l'Allemagne semble-t-elle mieux gérer l'épidémie que la France ? » Franceinfo,

1 "French care homes hit hard as COVID-19 deaths mount", euronews, 08/04/2020, https://www.euronews.com/2020/04/08/french-care-homes-hit-hard-as-COVID-19-deaths-mount

03/04/2020,https://www.francetvinfo.fr/sante/maladie/coronavirus/coronavirus-pourquoi-l-allemagne-semble-t-elle-mieux-gerer-l-epidemie-que-la-france_3894519.html

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China-Spain relations amid COVID-19 in a comparative perspective: An enduring partnership facing potential uncertainties[1]

Mario Esteban & Ugo Armanini[2]

Summary

There are a lot of debates on how COVID-19 health and socio-economic crisis will impact on the relations between the People's Republic of China (PRC or China) and the European Union (EU) countries. At least for the time being, the Spanish case indicates that COVID-19 would not involve radical changes, but rather act as a catalyst, consolidating existing, and sometimes opposing trends. Building on a strong political relationship, both countries have shared diplomatic and material support to face the epidemic. China has established itself as a vital supplier of medical equipment. Nevertheless, Chinese governance shortcomings and the limited scope of its cooperation have also become more apparent. This has increased the perception of threat from China in the Spanish population while identifying China as the second preferred ally for Spain outside the EU. In addition, relations with China have entered Spain's political debate for the first time due to Vox critical stance. In this context, China's public diplomacy has proved more active than ever.

In the longer-term perspective, COVID-19 may have contradictory effects on China-Spain relations too. Spain, like other EU countries, has explicitly defended multilateralism in this time of crisis and China is regarded as a

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key international actor. International cooperation is required to deal with a crisis global in nature, which would severely affect common areas of diplomatic engagement like Latin America. At the same time, the magnitude of the crisis calls for a solid and unified European response. While the COVID-19 crisis is again revelling political and economic divides among EU countries, this could strengthen the European turn towards strategic autonomy driven by external – foreign dependency – and domestic factors – structural reforms – which would tackle complex issues like supply chain diversification and European industrial policies.

1. Introduction

COVID-19 has brought China and China-Spain relations under national spotlight. Traditionally, Spanish authorities have promoted good political relations with China but Spain's overall interest for Asia has remained low and instead turned toward historical and closer areas of diplomatic engagement like Latin America and MENA. But this has recently, and relatively rapidly changed as China's economic development has made it a major international player with an increasing influence within the EU itself. China-Spain relations were put forward in the aftermath of the 2008 economic and financial crisis when China became a significant international lender, supplier, and export market for Spain. More recently this has also been the case during the European debate on 5G foreign providers and the Belt and Road Initiative (BRI), officially endorsed by other Southern EU countries like Greece, Italy and Portugal. Unlike these former examples, Covid-19 marks a sudden irruption of China as a prominent and immediate issue in the public debate, first as the apparent source of the COVID-19 outbreak, and second, as Spain's main provider of medical equipment. Through medical supplies, China-Spain relations have showcased a direct and immediate impact on Spanish public health,

in a country with the fourth highest COVID-19 death toll worldwide.1 At the same time, this spotlight is also linked to a new stage of China's public diplomacy in Europe with a substantial deployment of activities in traditional and social media to influence European perceptions and promote China's image.

It is crucial to analyse the dynamics of China-EU relations amid COVID-19, and especially in the case of EU member states which remain the key players of the EU's foreign policy. The Spanish case appears quite representative of the variety of European responses to the crisis, highlighting common elements: A consensual political and material support, a necessary trade partnership with China, a relative polarization of the political debate on China, as well as the evolution of Chinese public diplomacy with uncertain impact.2 Eventually, COVID-19 turns to be less of a breaking point than a catalyst of pre-existing trends. In the long-term, this may pose some challenges to the bilateral relationship between China and Spain linked with autonomy in strategic sectors, in this case, medical supplies.

2. China and the EU battling COVID-19: Necessary cooperation in a changing strategic context

COVID-19 has had a dramatic impact on EU economies and societies which have responded with unprecedent restrictions to freedom of circulation. This epidemic has focused attention on China, first when the epidemic was spreading in the country, and later, as a major supplier of medical equipment to EU countries.

Like Spain, many EU countries have provided political support to China's management of the crisis as well as material assistance, including coordinated shipments of medical supplies. Once the centre of the epidemic

1 As of 9 May 2020.
Worldometer. 9 May 2020. COVID-19 Coronavirus Pandemic. https://www.worldometers.info/coronavirus/

2 Seaman, J. (ed.). 2020. *Covid-19 and Europe-China Relations: A country-level analysis*. European Think-Tank Network on China.

shifted to Europe, China has reciprocated at several levels, through the mobilization of central and local governments, Chinese business sector, and Chinese society at home and abroad. This massive Chinese engagement has provided opportunities to underline close bilateral relations and promote bilateral agreements such as the strategic partnership with Portugal or the Memorandum of Understanding on the BRI signed by Italy, March 2019.[1] Several EU countries have levered political and business contacts and networks in China to secure and facilitate the furniture of medical equipment. In Spain, like in several other EU countries, assistance provided by Chinese business sector has dwarfed that from public authorities. Several Chinese private actors have stood out, like Jack Ma Foundation and several firms with high visibility and commercial interests in the EU, including Huawei, China Three Gorges and Cosco Shipping Corporation. Nevertheless, it did not go unnoticed that, despite the emphasis on cooperation and assistance, the bulk of Chinese supplies have been shipped on a commercial basis. In addition, a significant volume of equipment did not meet quality standards and have been rejected by several EU countries like Belgium,[2] Finland,[3] or the Netherlands, where

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more than half a million masks failed to meet expected results despite Chinese KN95 certification[1].

Almost all EU countries have witnessed a significant increase of Chinese public diplomacy activities. Chinese embassies and diplomatic officials have been particularly proactive actors on traditional and social media. Chinese public diplomacy has been quite consistent throughout Europe in highlighting international solidarity and cooperation, promoting China's measures and experience to fight the epidemic, and seeking to counter negative narratives on China's management of the crisis. However, there are significant differences in the communication strategies of Chinese diplomatic legations in Europe: Ranging from charm offensive to aggressive.[2] In Spain, Chinese public diplomacy has remained largely constructive and non-confrontational with the exception of retweets spreading disinformation on the possible origin of Covid-19 from the US and shared by several Chinese diplomatic missions across the EU.[3]

The impact of this increased profile is yet to be seen. Most EU countries have neither been essentially critical neither overoptimistic on China's role in the crisis. As in Spain, most EU members states' authorities and media have generally been less talkative on high-level exchanges and political

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cooperation than their Chinese counterparts. And in most EU countries there seems to be no sign of significant changes on the image of China. Polls suggest this image has become more positive in Italy[1] and slightly less in Spain (see Figure 2) but it would be too soon to assess lasting evolutions. On the other hand, the COVID-19 crisis may have polarized political opinions on China, between adamant and more critical political actors and parties. Finally, with few exceptions, China has failed to appear as model to fight COVID-19. In comparison South Korea stands as a more noticed example.

COVID-19 has left little room for US-China competition in the EU. Despite some criticism, EU countries have maintained a non-confrontational approach towards China and focused instead on international cooperation. Countries like France, or Spain, have explicitly reaffirmed their attachment to multilateralism to resolve the current crisis. However, the COVID-19 crisis still unfolds in a context of sharpened geopolitical competition between the US and China, where EU countries have become more aware of the challenges posed by China's rise and its role in the global economy. The increased awareness was evident in the EU's Commission communication on China which was characterized as a partner, but also as 'an economic competitor in pursuit of technological leadership and a systemic rival promoting alternative models of [political, economic and social] governance'.[2]This initial reassessment of EU-China relations has materialized on a number of European initiatives on screening inward foreign investment, 5G foreign providers, and industrial policy and has contributed to the debates on strategic autonomy and European sovereignty.

This perspective does not conceal that China has proven to be a necessary partner amid the COVID-19 crisis, but it may entail long-term uncertainties and several challenges to current EU-China relations. Indeed, in many EU

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countries, there have been signs, if not explicit declarations, that have acknowledged national vulnerabilities to (over)concentrated supply chains and outlined a better diversification to mitigate (over)dependence to single suppliers.1 Amid the crisis, the Czech Republic Senate even went on to pass a resolution to favour domestic and EU medical goods over foreign ones.2 This is not to say that there will be a European push for 'decoupling' with China, but a possible long-term supply chain restructuration in *some* sectors of strategic importance should not be ignored. In that sense, Josep Borrell, the High Representative of the European Union for Foreign Affairs and Security Policy, has envisioned a post-coronavirus world with reformed supply chains through diversification, a reduction of EU's dependence on essential products and a partial relocation of some strategic market segments.3 Such prospect should not be a particularly worrisome issue for China, which itself has engaged in a transition process toward a domestic consumption-driven model of development, that is, less reliant on exports. In any case, COVID-19 has been a harsh reminder that health supplies – i.e. public health – are a top strategic sector to be closely monitored. There has been a renewed interest for EU's industrial polices, e.g. in Austria, and some countries, like Bulgaria, seem to anticipate

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https://www.ecfr.eu/publications/summary/the_post_coronavirus_world_is_already_here

positive outcomes for their domestic industries.1 Across EU member-states, national and regional industries have already retrofitted or highly boosted their production to respond to the initial shortage of medical equipment, like in the Autonomous community of Valencia, Spain's first textile cluster.2 Last but not least, many EU countries have appeared concerned about potential foreign takeovers amid the looming economic crisis. Some, like Germany (also driven by Donald Trump's attempt to acquire CureVac for the sole benefit of the US market), Sweden, or Spain, have recently strengthened – or plan to do so – their investment screening mechanisms to protect critical infrastructures and domestic firms from foreign investors.3 In a way, this shows that the EU has learned from the 2008 crisis, despite a concerning sense of déjà-vu.

Indeed, COVID-19 has led to a certain resurgence of EU's North-South divide. EU countries have been quick to favour massive economic and financial stimulus, easing EU's standard fiscal rules through the suspension

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'Germany intends to tighten the rules for foreign direct investments.' 14 April 2020. Simons & Simons. https://www.simmons-simmons.com/en/publications/ck8zy54il0t470a65h4tewry5/germany-intends-to-tighten-the-rules-for-foreign-direct-investments
Granlund, J. 20 April 2020. 'Riksdagen överens om M-förslag: främmande uppköp ska stoppas'. *Aftonbladet*. https://www.aftonbladet.se/nyheter/a/zGJow9/riksdagen-overens-om-m-forslag-frammande-uppkop-ska-stoppas

of the Stability and Growth Pact.1 But they fell short to agreeing on the hot topic of joint debt, requested by Italy, with the notable opposition of Germany and the Netherlands.2 In this context, China's assistance have sometimes stood out in contrast to a perceived inaction and lack of solidarity from other EU countries. This appears to be an increasing perception in Portugal or Italy.3 In addition, in countries like Italy, UK or the Czech Republic, COVID-19 has also led to intra-state polarization between pro-Chinese and more critical political actors and parts of the civil society.

These trends may have ambiguous impact on the relations between China and EU member states. In the Spanish case, VOX4 has emerged sometimes as a fierce critic of China echoing the arguments of the American alternative-right. On the other hand, closer ties, and more positive perceptions in some EU countries, may not fully deliver for China, as Southern countries in particular may emerge in a vulnerable situation possibly at the expanse of their political leverage within the EU and on the redefinition of EU's relations with China. In addition, public authorities of a country like Portugal, with good relations with China, and with a public opinion relatively critical of the EU, have nevertheless mentioned the necessity to 'reinvent' the EU's productive organisation.5 Indeed, for some

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1 Council of the European Union. 23 March 2020. Statement of EU ministers of finance on the Stability and Growth Pact in light of the COVID-19 crisis. European Union. https://www.consilium.europa.eu/en/press/press-releases/2020/03/23/statement-of-eu-ministers-of-finance-on-the-stability-and-growth-pact-in-light-of-the-covid-19-crisis/

2 Lane, A. 7 April 2020. 'North-South Divide: European Unity Strained By Coronavirus.' Forbes. https://www.forbes.com/sites/alasdairlane/2020/04/07/north-south-divide-european-unity-strained-by-coronavirus/#1d4f0f1330b1

3 Rodrigues, C. 2020. Portugal: 'Everything is worthwhile, if the soul is not small' – relations with China avid Covid-19. In Seaman, J. (ed.), *Covid-19 and Europe-China Relations: A country-level analysis*, 54-56. European Think-Tank Network on China.

4 VOX is a far right-wing populist party that holds the third biggest number of seats in the Spanish parliament.

5 'Portugal: 'Europe will have to reinvent its productive organisation' – PM.' 27 March 2020. *Lusa - Portuguese News Agency*. https://www.lusa.pt/article/ZkPq2KPaOHJYqLd04xIUPTMSZM5iuSI1/portugal-europe-will-have-to-reinvent-its-productive-organisation-pm

economies, European industrial policies and the revitalization of domestic production capabilities might appear as beneficial alternatives in the coming socio-economic crisis.

3. Spain's crucial connection with China: An opening for Chinese public diplomacy

The COVID-19 crisis has showcased the good political relations between China and Spain as well as bilateral solidarity in times of need. When the pandemic hit China the hardest, Spanish authorities sent medical supplies to China twice – end of January and in the first week of February. These aid shipments were jointly arranged with the United Kingdom and took place in a context of high-level political support by the Spanish authorities towards the Chinese community in Spain, and Chinese people and leaders. For example, February 5, Spain's Head of State, Felipe VI, expressed its explicit support to the measures taken by Chinese authorities to fight the coronavirus: 'Spain values very highly the critical efforts and measures put in place by the Chinese government to achieve an effective management of this crisis which affects us all; and it has expressed from the very beginning its willingness to cooperate with China, in whatever is in our power, to help contain and overcome it.'[1] Spanish authorities have also been very keen to addresses concerns expressed by their Chinese partners and counterparts. February 4, President Pedro Sánchez met with representatives of the Association of Chinese in Spain in the Moncloa Palace. He not only conveyed his solidarity and support in the face of the health emergency in China but also rejected any stigmatization of the Chinese community in Spain. Together, Spanish gestures of support have been welcomed by Chinese authorities and media and were the prelude to the cooperation Spain subsequently received from China.

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1 Embassy of Spain in Beijing. 6 February 2020. 'Palabras de SM el Rey al pueblo amigo de China'.
http://www.exteriores.gob.es/Embajadas/PEKIN/es/Noticias/Paginas/Articulos/20190403_dele_esp.aspx

Since the second half of March, when the health emergency decreased in China but intensified in Spain, aid flows have been channelled in the opposite direction. China's central and local governments, Chinese business sector, as well as the Chinese community in Spain, have all mobilized to assist Spain in its fight against the coronavirus. The most significant Chinese public donation – 22 March – came from the central government and was comprised of 834 diagnostic kits for 20.000 people, 50.000 face masks, 10.000 gowns, 10.000 protective glasses, 10.000 pairs of gloves and 10.000 pairs of shoe covers. In addition, several Chinese local governments such as Fujian, Gansu, and Nanning have donated medical supplies to Spanish local governments with which they have collaboration agreements (respectively Cantabria, Navarra, and Murcia). Among private donations, those made by the presidents of Huawei and Alibaba group – both with a significant presence in Spain – are particularly noteworthy and have been explicitly praised by Spain's Royal House. The volume of Chinese private donations has exceeded that of public ones and has involved direct talks between Chinese business leaders and Spanish authorities. In addition, the Chinese community in Spain – more than 225.000 people – was actively mobilized throughout the country to make donations of medical supplies, especially to health centres and state's and security institutions as shown in many videos and social networks posts. The Chinese community also acted as a liaison between Spanish administrations and Chinese medical providers.

China has been the basic provider of the medical supplies purchased by Spain's central government and autonomous communities (whose competences in public health have been transferred) to face the pandemic. The amount for contracts signed to acquire medical material and supplies from China exceeds EUR726 million, among which EUR628 million from Spain's central government, and, among autonomous communities, EUR35 million from Catalonia and EUR23 million from Madrid.[1] This has

1 Garcia Pagan, I. 29 March 2020. 'La Generalitat distribuye el mayor envío de material sanitario procedente China'. *La Vanguardia*.

evidenced both the essential role of China as the only country capable of supplying such volume of medical material at a time of crisis and the various challenges in doing business in this country. Despite significant monitoring by Spanish officials and authorities, transactions with China have not been without problems such as shipments of defective products, lack of required technical specifications, or failure to meet deadlines.1

Chinese authorities are well aware that the COVID-19 crisis may have a significant impact on the country's position within the international community. The scale of the threat and its possible origin in Wuhan have led multiple actors inside and outside China to question the role of Chinese authorities in the origin and management of the crisis, stressing governance shortcomings like an ineffective regulation of wild animal consumption and the lack of transparency. In this context, Chinese public diplomacy is being very proactive in sharing a narrative about the coronavirus crisis that defends and improves China's international image. This is true in Spain, where Chinese diplomatic and consular missions have endorsed a high visibility in the media. The Chinese Consulate General in Barcelona has actively promoted the assistance provided by the Chinese community while

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https://www.lavanguardia.com/vida/20200329/48158533532/material-avion-china-barcelona-mascarillas.html
Government of Spain. 28 March 2020. 'Comparecencia del presidente del Gobierno sobre medidas frente al Covid-19'.
https://www.lamoncloa.gob.es/presidente/intervenciones/Paginas/2020/prsp28032020.aspx
José Mateo, J. 22 March 2020. 'Madrid invierte 23,3 millones de euros en traer material sanitario desde China'. *El Pais*. https://elpais.com/espana/madrid/2020-03-22/madrid-gasta-233-millones-de-euros-en-comprar-material-sanitario-en-china.html
1 Chicote, J. 2 April 2020. 'Un avión procedente de China con material comprado por el Gobierno aterriza en Madrid semivacío por falta de permisos'. *ABC*.
https://www.abc.es/sociedad/abci-aterriza-avion-china-material-sanitario-comprado-gobienro-semi-vacio-falta-permisos-202004021141_noticia.html
Pinheiro, M. 2 April 2020. 'China endurece los controles y retrasa la importación de material contra el coronavirus'. *El Diario*. https://www.eldiario.es/politica/China-endurece-controles-importacion-coronavirus_0_1012449855.html
Sevillano, E. G. 21 April 2020. 'El Gobierno trata de recuperar el dinero de los test defectuosos tras comprobar que el reemplazo tampoco funciona'. *El Pais*.
https://elpais.com/sociedad/2020-04-20/el-gobierno-trata-de-recuperar-el-dinero-de-los-test-defectuosos-tras-comprobar-que-el-reemplazo-tampoco-funciona.html

the Chinese embassy in Madrid has remained focused on the official and business dimension. Chinese diplomacy has stressed the speed and effectiveness of the sanitary and economic measures adopted in China to face the crisis caused by the coronavirus, quoting the support received from various international institutions like the World Health Organization and the International Monetary Fund.1

In Spain, when referring to the coronavirus, Chinese public diplomacy had a prominent defensive orientation until March, as evidenced by the contents published by the Embassy of China in Spain on its website and social media and by the interviews of Chinese diplomats during this period. The Embassy's communication efforts during the first two months of 2020 sought to avoid the stigmatization of the Chinese community in Spain, any restrictions on transport and communications with China, and criticism of Chinese authorities for their role in the origin and spread of COVID-19. On the last point, Chinese official narrative tries to avoid the association between the consumption of wild animals without adequate sanitary controls and the origin of COVID-19, and the lack of transparency of the regime with the spread of the disease.2

Once China had passed the peak of the pandemic and its epicentre moved to Europe, the tone of Chinese diplomacy turned more assertive. From March, Chinese official discourse started to emphasize China's contribution to stop the spread of COVID-19, both through domestic measures it had adopted and through the assistance it could now provide to other countries in terms of medical material and good practices to fight against the disease. China is presented as a top scientific and medical power capable of developing and producing state-of-the-art vaccines, medicines,

1 Embassy of China in Spain. 26 February 2020. Twitter.
https://twitter.com/ChinaEmbEsp/status/1232603242988789760
Embassy of China in Spain. 31 March 2020. Twitter.
https://twitter.com/ChinaEmbEsp/status/1244897331201409025

2 Between 11 February and 23 March 2020 the Embassy of China in Spain published forty reports on the evolution of COVID-19 in China on its Twitter account.

health protocols and medical equipment.1 The contrast between these defensive and assertive phases was evidenced with great clarity in the two interviews of Yao Fei, Charge d'affaires of the People's Republic of China in Spain, in one of the most listened Spanish morning shows 24 February and 17 March 2020.2 This enhanced confidence also translated into an extensive coverage from the official Chinese news agency, Xinhua, of the telephone conversation between Minister Arancha González Laya and her Chinese counterpart, March 15, in contrast with the brief news published by EFE Press agency.3 On March 21, Xi Jinping sent a message of solidarity and support to Felipe VI similar to those sent by Spanish authorities to China a month and a half earlier. The main difference is that President Xi offered China's experience in 'prevention and control, [as well as] diagnosis and treatment plans' and used core concepts of Chinese diplomacy such as 'mutual benefit' and the 'Community of shared future for mankind'.4 This explicit link between the fight against the coronavirus

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1 Embassy of China in Spain. 31 March 2020. Twitter.
https://twitter.com/ChinaEmbEsp/status/1244949854272524288
Embassy of China in Spain. 2 April 2020. Twitter.
https://twitter.com/ChinaEmbEsp/status/1245655528593707008
Embassy of China in Spain. 5 April 2020. Twitter.
https://twitter.com/ChinaEmbEsp/status/1246726939982868481

2 At that time Yao Fei was the highest-level Chinese diplomat in Spain after the ending of ambassador Lyu Fan's diplomatic mission.
'Yao Fei: "En China estamos pensando en enviar equipo de médicos y expertos en coronavirus a España"'. 17 March 2020. *Onda Cero*.
https://www.ondacero.es/programas/mas-de-uno/audios-podcast/entrevistas/yao-fei-china-coronavirus-espana_202003175e708a20cf7ab300010d2f7f.html
'Yao Fei, ministro consejero de la Embajada china en Madrid: "Algunos gobiernos han actuado de forma muy excesiva ante el coronavirus"'. *Onda Cero*.
https://www.ondacero.es/programas/mas-de-uno/audios-podcast/entrevistas/yao-fei-coronavirus_202002245e538e010cf2a8ef178b4a3e.html

3 'China to take actions to help Spain fight COVID-19 epidemic: Chinese FM.' 16 March 2020. *Xinhua*. http://www.china.org.cn/world/Off_the_Wire/2020-03/16/content_75817649.htm
'Exteriores trata de agilizar los intercambios comerciales con China'. 15 March 2020. *EFE*. https://www.efe.com/efe/espana/politica/exteriores-trata-de-agilizar-los-intercambios-comerciales-con-china/10002-4196285

4 MOFA. 21 March 2020. 'Xi Jinping Envía Mensaje de Condolencias al Rey de España, Felipe VI por el Brote de la Epidemia de COVID-19 en España'.
https://www.fmprc.gov.cn/esp/zxxx/t1760077.shtml

and some key concepts of Xi Jinping's foreign policy had already been promoted by the Embassy of China in Spain, which published a statement of the Chinese Foreign Minister on its website: 'Resolutely Defeating the COVID-19 Outbreak and Promoting the Building of a Community with a Shared Future for Mankind.'[1] The statement was latter forwarded by the Consulate General of China in Barcelona.

Regarding the concerns expressed by the European External Action Service (EEAS) about Chinese disinformation on COVID-19,[2] March 20, the official Twitter account of the Embassy of China in Spain forwarded a message from Hua Chunying, spokeswoman of the Chinese Foreign Ministry, which generated confusion about the origin and spread of COVID-19 from the United States. However, beyond this instance, the Embassy of China and the Consulate General of China in Spain had not explicitly confronted the advantages of the Chinese model with those of other countries, neither explicitly discredited the European Union nor Spain's traditional allies. Rather, Chinese authorities have displayed various joint initiatives conducted between China and those actors to combat the coronavirus.

4. A strong political relationship under strain? Evolving Spanish perceptions of China

Chinese assistance, cooperation, and experience have been positively regarded by Spain's Head of Government and by the King of Spain but not rated above those of other actors or used to criticize the response of other countries inside or outside its borders. To date, Spanish authorities have not changed their posture like the governments of other European countries – e.g. France – by publicly asking Chinese authorities to provide more

1 Embassy of China in Spain. 4 March 2020. 'Ganar Resueltamente la Batalla contra la Epidemia y Promover la Construcción de la Comunidad de Futuro Compartido de la Humanidad'. http://es.china-embassy.org/esp/zxgx/t1752052.htm

2 European External Action Service [EEAS]. 1 April 2020. 'EEAS Special report update: Short assessment of narratives and disinformation around the COVID-19 pandemic'. https://euvsdisinfo.eu/eeas-special-report-update-short-assessment-of-narratives-and-disinformation-around-the-covid-19-pandemic/

detailed information on the onset of COVID-19 in China. As for the controversies over the quality of some medical supplies purchased in China, in particular rapid diagnostic tests, and the motivations of Chinese assistance to Spain, the Spanish government has adopted a conciliatory attitude. The interview of Spain's Foreign Minister Arancha González Laya for CGTN program The Point offers a clear example of this posture. The Minister explained that China and Spain are countries that help each other in times of need and that 'in exercising generosity [China projects soft power [like any other country].' 1 She also acknowledged that the malfunctioning testing kits were bought through a Spanish contractor, not through direct agreements with Chinese authorities, and that the issue had been solved with a new shipment of kits.

Likewise, although Pedro Sánchez himself stated that 'it is as important and necessary to buy abroad as to be self-sufficient and buy domestically',2 and whereas the difficulties in purchasing healthcare equipment and materials in China's overcrowded market have been acknowledged, there have been no publicized concerns about overdependence towards China. In any case, this issue has become an internal issue within the public administration and many Spanish companies. In addition, Covid-19 has driven local initiatives of industrial retrofit towards production of medical supplies with the support of public authorities. This has notably been the case of the textile industry in the province of Valencia, which quickly reorganized itself to produce individual protections. As a result, a localized narrative has emerged which seems favourable to a partial relocation of production, providing better resilience to external chocs and praising

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1 'The Point Exclusive interview with Spain's foreign minister.' 1 April 2020. CGTN. https://www.youtube.com/watch?v=mVZYUsydduc

2 Government of Spain. 28 March 2020. 'Comparecencia del presidente del Gobierno sobre medidas frente al Covid-19'. https://www.lamoncloa.gob.es/presidente/intervenciones/Paginas/2020/prsp28032020.aspx

Spanish technical know-how. 1 The nature of economic relations with China may be a pending issue in the medium and long term.

In Spain, the strongest criticism of the Chinese government's management of the coronavirus crisis arises from two sectors. On the one hand, non-governmental organizations that consider COVID-19 within the context of their causes, be they press freedom, wildlife preservation, or Human Rights protection. On the other hand, conservative and liberal politicians and media groups critical of the Spanish government which have not only condemned domestic measures in China, but also China's cooperation with Spain. The most critical political leaders toward China belong to VOX, and, to a lesser extent, to the Popular Party. Senior officials of these two parties have referred to COVID-19 as the 'damned Chinese viruses' or 'the Chinese plague.' They have described the Chinese market as a total 'bazaar', and have spread conspiracy theories about the origin of the COVID-19.2

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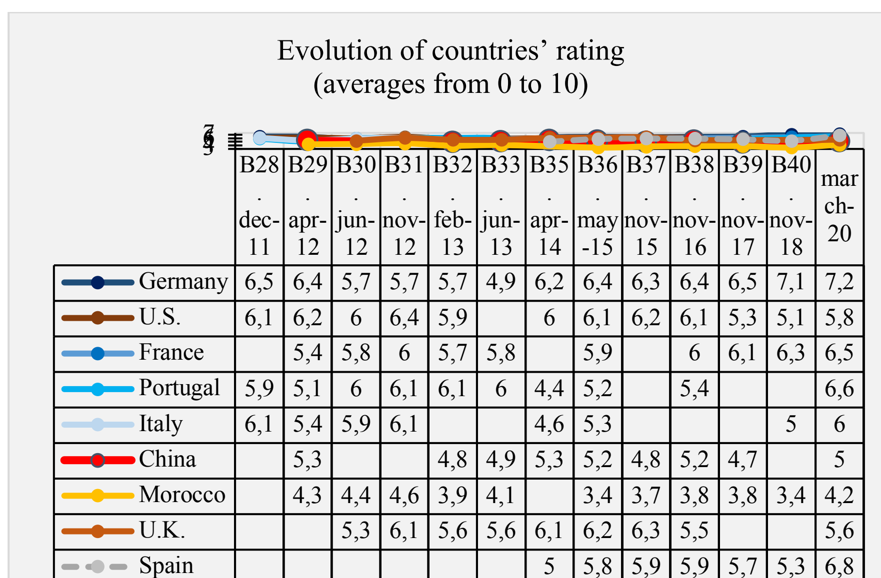
1 'El textil de Ontinyent (Valencia) se reconvierte en clúster sanitario para garantizar el abastecimiento'. 13 April 2020. *La Vanguardia*.
https://www.lavanguardia.com/local/valencia/20200413/48458429857/el-textil-de-ontinyent-valencia-se-reconvierte-en-cluster-sanitario-para-garantizar-el-abastecimiento.html
Romero, V. 17 April 2020. '¿Reindustrializar para fabricar mascarillas? Suelo hay, pero el 'made in Spain' saldrá caro'. *El Confidencial*.
https://www.elconfidencial.com/empresas/2020-04-17/espana-reindustrializacion-coronavirus_2548580/
2 'El polémico vídeo de Ortega Smith en cuarentena recuperándose de los "malditos virus chinos"'. 14 March 2020. *El Independiente*.
https://www.elindependiente.com/politica/2020/03/14/el-polemico-video-de-ortega-smith-en-cuarentena-recuperandose-de-los-malditos-virus-chinos/
Hernando R. 7 April 2020. Twitter.
https://twitter.com/Rafa_Hernando/status/1247457954552516608
'Isabel Díaz Ayuso: "Comprar en China material para el coronavirus es como un mercado persa"'. 25 March 2020. *Antena 3*.
https://www.antena3.com/noticias/espana/isabel-diaz-ayuso-comprar-en-china-material-para-el-coronavirus-es-como-un-mercado-persa_202003255e7b6e9e4626fc0001c0da36.html
Martinez Vidal, F. 31 March 2020. Twitter.
https://twitter.com/FMartinezVidal_/status/1244766515355885570

The 41st wave of the Barometer of the Elcano Royal Institute1 can be useful to assess how this has affected the image of China in Spain although the collected data should be considered with caution as the study's fieldwork was carried out 2-19 March 2020. In other words, at the time of the survey, many interviewees had not been meaningfully exposed to the events analysed in this article. In any case, from the data in Figure 1, it could be tentatively noted that by mid-March the coronavirus crisis had neither bolster or harmed the image of China in Spain. Between April 2012 and March 2020, China's rating has ranged from 4.7 to 5.3, reaching a valuation of 5 point in March of this year.

Figure 1:



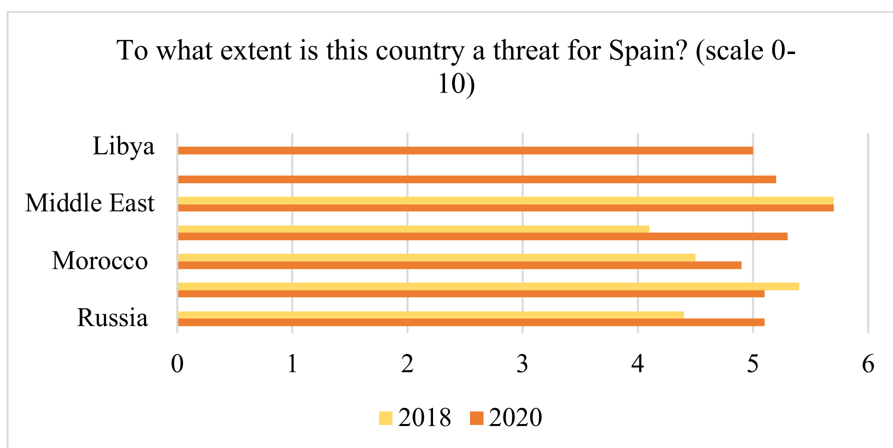
	B28 . dec-11	B29 . apr-12	B30 . jun-12	B31 . nov-12	B32 . feb-13	B33 . jun-13	B35 . apr-14	B36 . may-15	B37 . nov-15	B38 . nov-16	B39 . nov-17	B40 . nov-18	march-20
Germany	6,5	6,4	5,7	5,7	5,7	4,9	6,2	6,4	6,3	6,4	6,5	7,1	7,2
U.S.	6,1	6,2	6	6,4	5,9		6	6,1	6,2	6,1	5,3	5,1	5,8
France		5,4	5,8	6	5,7	5,8		5,9		6	6,1	6,3	6,5
Portugal	5,9	5,1	6	6,1	6,1	6	4,4	5,2		5,4			6,6
Italy	6,1	5,4	5,9	6,1			4,6	5,3				5	6
China		5,3			4,8	4,9	5,3	5,2	4,8	5,2	4,7		5
Morocco		4,3	4,4	4,6	3,9	4,1		3,4	3,7	3,8	3,8	3,4	4,2
U.K.			5,3	6,1	5,6	5,6	6,1	6,2	6,3	5,5			5,6
Spain							5	5,8	5,9	5,9	5,7	5,3	6,8

Source: Barómetro del Real Instituto Elcano (BRIE) nº41 (2020): 6.

1 Elcano Royal Institute. April 2020. Barómetro del Real Instituto Elcano: 41ª oleada, April 2020.
http://www.realinstitutoelcano.org/wps/portal/rielcano_es/encuesta?WCM_GLOBAL_CONTEXT=/elcano/elcano_es/barometro/oleadabrie41
The Elcano Royal Institute Barometer (known by its initials BRIE in Spanish) is a periodic survey conducted since 2002 using a sample of 1,000 people, representative of the Spanish general population. The BRIE is focused exclusively on the opinions, values and attitudes of the Spanish population towards international relations and Spanish foreign policy.

However, among the Spanish population the perception of China as a threat has indeed increased significantly (see Figure 2) to the extent that China is the country whose perceived threat has increased most since 2018; Only Middle Eastern countries were identified as a biggest threat.

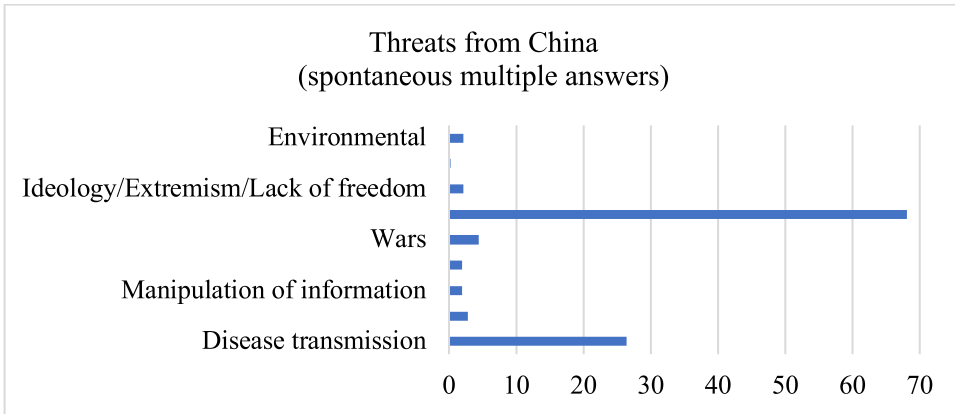
Figure 2:



Source: Barómetro del Real Instituto Elcano (BRIE) nº41 (2020): 11.

This is partly linked with COVID-19 since traditionally the perceived threat from China was exclusively associated with economic factors while today more than 25% of Spaniards who identify China as a source of threats quote the threat of diseases originating from the country (see Figure 3). It is very likely that perceptions of China as a source of threats for Spain, especially with regard to disease transmission, have increased since the fieldwork of the survey was carried out. The state of emergency was not declared until March 14 and the health emergency the country was facing was not fully evident until later.

Figure 3:



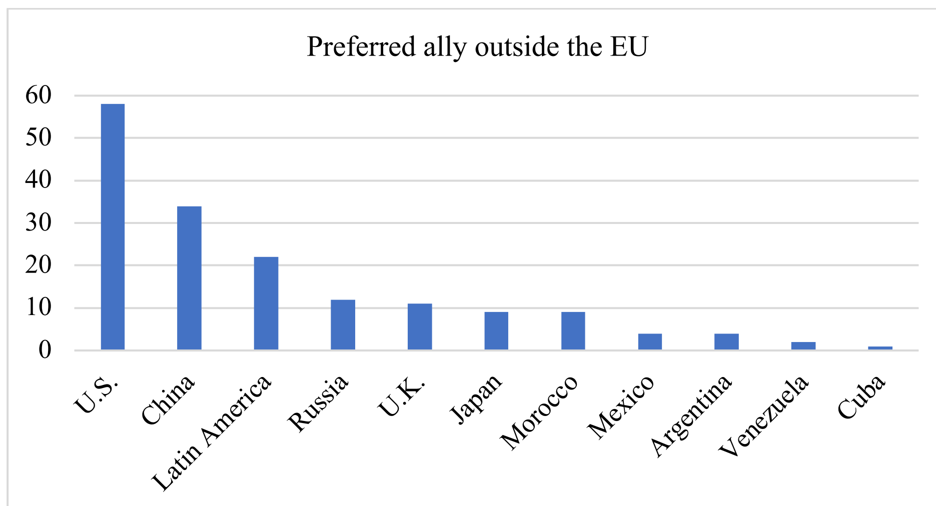
Source: Barómetro del Real Instituto Elcano (BRIE) nº41 (2020): 12.

5. Implications for future bilateral relations

Faced with the coronavirus, Spanish authorities have followed a diversified foreign policy and defended multilateralism as the most effective way to deal with the crisis. This suggests they will continue to bet on maintaining close relations with China. Among others, because the health emergency has highlighted China's role as a provider of medical equipment and supplies to Spain and because the reinforcement of multilateralism that Spain defends requires an active participation of China. On the last point, it is evident that any coordinated response by the international community to face the socioeconomic crisis caused by the pandemic will be more effective if it includes the second largest economy in the world rather than if it does not.

This is in line with Spanish public opinion which identifies China as Spain's second preferred ally outside the EU (see Figure 3).

Figure 4:



* Weighted index = (%First x 1) + (%Second x 0,66) + (%Third x 0,33).

Source: Barómetro del Real Instituto Elcano (BRIE) nº41 (2020): 17.

What is not so clear, in such an uncertain context, is whether this crisis will strengthen bilateral relations in the way the Chinese government wishes. The press release by the Chinese Ministry of Foreign Affairs on the talks between Pedro Sánchez and Xi Jinping on 17 March 2020 stated that: 'it is believed that, following the epidemic, relations between the two countries will develop even further.'1 This will probably depend on three interrelated issues. The first issue is how Spanish authorities will assess the impact that a further rapprochement with China might have on Spain's relations with its traditional allies. The second factor will be to what extent Spanish political authorities and companies want to depend on Chinese suppliers in such sensitive sectors like medical supplies or 5G communication networks. Third is the evolution of Spanish domestic politics. Multiple statements by VOX leaders suggest that, if they were to be part of the government, the

1 MOFA. 17 March 2020. 'Xi Jinping Mantiene Una Conversación Telefónica con Primer Ministro Español Pedro Sánchez Pérez-Castejón'. https://www.fmprc.gov.cn/esp/zxxx/t1757669.shtml

consensus on the advisability of maintaining privileged relations with China that the Spanish Socialist Workers Party and the Popular Party had upheld for almost four decades could break down.1

Eventually, these factors and China-Spain relations may also depend of Spain's economic recovery in the post-COVID-19 period. In the end, the 2008 economic crisis has proven crucial to determine current bilateral relations. The COVID-19 crisis is of different nature: It is conjunctural, and primarily a sanitary one. But its short- and medium-term impact on Spanish socio-economic macro-indicators economy will be of a similar magnitude, be there unemployment or public debt.2 Spanish domestic demand would be slow to recover3 and it remains to be seen if the Chinese market may once more provide a valuable trade outlet. For now, Chinese authorities have avoided stimulus packages of the same magnitude than those post-2008 crisis, suggesting a minor role in the global economic recovery as they appear more concerned with financial stability and domestic issues including consumer spending hampered by debt.4 On the other hand, and in line with previous remarks, the socio-economic impact of COVID-19 may also turn upgraded domestic production in strategic sectors as an attractive alternative. Finally, Chinese tourism, a sector promoted by Spanish authorities, 5 will be constrained by the epidemic and travel restrictions in the near future. Overall, Spain is suffering from its high

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1 These two parties have rotated at the presidency of the Spanish government since 1982.

2 Chislett, W. 2020. COVID-19 in Spain: tentatively moving toward a 'new normality'. Elcano Royal Institute.

3 Ortega, A. 2020. Coronavirus: trends and landscapes for the aftermath. Elcano Royal Institute.

4 Watts, G. 13 April 2020. 'Don't expect China's consumers to bail out the world.' *Asia Times*. https://asiatimes.com/2020/04/dont-expect-chinas-consumers-to-bail-out-the-world/

Weinland, D., & J. Kynge. 18 March 2020. 'China lacks the appetite to save the world economy, analysts warn.' *Financial Times*. https://www.ft.com/content/27740b3a-6875-11ea-800d-da70cff6e4d3

5 Spanish Ministry of Industry, Trade, and Tourism. 2018. Plan PASE China. https://www.comercio.gob.es/es-ES/comercio-exterior/instrumentos-apoyo/Documents/PDF/PASE%20CHINA.pdf

dependence to tourism sector, which represented around 12% of its Gross Domestic Product in 2018-19.[1]

Beyond the bilateral focus, COVID-19 may provide a window of opportunity for China-Spain cooperation in third-countries. Coordinated and effective foreign assistance will be crucial for the global economy recovery, as developing countries are expected to be the most affected by the economic impact the epidemic. Latin America, a traditional space of Spain's diplomatic engagement, and an ever-increasing trade and financial partner of China, appears ill-prepared to face it. The region is notably in a more delicate macro-economic situation than in 2008 amid the commodities boom. Weak public infrastructures add to other unfavourable socio-economic factors hampering lockdown measures including a significant share of the informal economy which exceeds 50% of total employment.[2] This situation has been worsened by peculiar, if not unsatisfactory crisis management by the region's top economies: Brazil and Mexico. Estimates point out to a significant economic recession throughout the region with increasing levels of poverty up to one third of the total population.[3]

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1 Page, D. 21 January 2020. 'El turismo de España 'vale' más de 150.000 millones de euros tras los años del boom'. *El Independiente*.
https://www.elindependiente.com/economia/2020/01/21/el-turismo-de-espana-vale-mas-de-150-000-millones-de-euros-tras-los-anos-del-boom/
Spanish National Statistics Institute. 23 December 2019. Cuenta satélite del turismo de España. 2016-2018.
https://www.ine.es/dyngs/INEbase/es/operacion.htm?c=estadistica_C&cid=1254736169169&menu=ultiDatos&idp=1254735576863

2 Economic Commission for Latin America and the Caribbean. 2020. *Latin America and the Caribbean and the COVID-19 pandemic: Economic and social effects*. United Nation.
https://repositorio.cepal.org/bitstream/handle/11362/45351/1/S2000263_en.pdf

3 Blanco Estévez, A. 2020. El profundo, pero transitorio, impacto del COVID-19 en la economía latinoamericana. Elcano Royal Institute.
http://www.realinstitutoelcano.org/wps/portal/rielcano_es/contenido?WCM_GLOBAL_CONTEXT=/elcano/elcano_es/zonas_es/ari63-2020-blanco-profundo-pero-transitorio-impacto-covid-19-en-economia-latinoamericana

Although the economic crisis may inevitably refocus Spain on domestic issues, and will likely affect Spanish development cooperation, the current administration has shown a great interest for Latin America and seemed very keen to spotlight the region at the EU level, traditionally more focused on its immediate neighbourhood. Moreover, Spain has significant economic interests in Latin America which is a significant market and investment destination for Spanish multinational corporations and an extended network of small and medium-sized firms. This could provide a common ground for China and Spain. It could be an opportunity to materialize the prospects of third party cooperation highlighted during the renewal of their bilateral Comprehensive Partnership back in 2018[1] while encouraging a much needed economic diversification and integration in Latin America.[2]

6. Conclusion

It is far from clear that COVID-19 will trigger immediate and dramatic changes in China-Spain relations as it has created contradictory and to a great extent countering trends. Bilateral cooperation has once more underscored the good political relationship between both countries, through high-level solidarity and material support. China has established itself as an essential trade partner and provider of much-needed medical supplies for Spain. Cooperation with China under a multilateral framework will also be required to provide global solutions to the epidemic and the economic recession it will trigger, including in third countries.

1 Government of Spain. 28 November 2018. *Declaración conjunta de la República Popular China y el Reino de España sobre el fortalecimiento de la Asociación Estratégica Integral en un cambio de época*.
https://www.lamoncloa.gob.es/presidente/actividades/Documents/2018/281118-Declaraci%C3%B3n%20Conjunta%20Espa%C3%B1a%20-%20China.pdf

2 Malamud, C., & R. Núñez. 2020. Una ventana de oportunidad para América Latina tras una década perdida. Elcano Royal Institute.
http://www.realinstitutoelcano.org/wps/portal/rielcano_es/contenido?WCM_GLOBAL_CONTEXT=/elcano/elcano_es/zonas_es/ari59-20202-malamud-nunez-ventana-de-oportunidad-america-latina-tras-una-decada-perdida

In Spain, this role plus the widespread perception that the COVID-19 originated in China and that the initial official reaction facilitated its transformation in a pandemic has put China under unprecedent spotlight. Chinese stakeholders in Spain have been very active to deal with this increased visibility, defending and promoting a positive image of the Asian country. It is still too early to assess the lasting impact of these public diplomacy efforts. Arguably, China's image in Spain remains relatively positive, but concerns have expanded in the general population, especially in relation to public health.

In this context, the lessons extracted by Spanish and other European authorities from COVID-19 could have mixed repercussions on Chinese interests in Europe. One the one side, the same way that concerns related to China are behind some recent EU initiatives in areas such as screening mechanisms, 5G, and industrial policies, the over-reliance on Chinese medical equipment suppliers to face the COVID-19 could spark further debate in Europe about strategic autonomy and European sovereignty downsizing exchanges with China in some fields. On the other, China has proved an essential partner for Europe in facing a critical threat, hence, it would be less likely for Europe to support a bipolarization of the international order seconding an eventual alliance to contain China.

New Wine in Old Bottle: Hungarian Anti-Epidemic Measures and Their Political Implication

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Abstract

Strong redistribution, local economy, family and employment are Viktor Orbán's emphases since 2010. These features are also fully reflected in Hungarian anti-epidemic measures. The effect of these measures is relatively moderate, although Hungary faces serious problems, such as insufficient input and labor shortage in medical system, more susceptible people in the country, etc. As usual, these measures are highly politicized with fierce critics. European Parliament fiercely criticizes Orbán for his violation of the EU treaty. The friction between Hungary and the EU is intensified and reveals the internal differences between EU institutions again.

Keywords: *Hungary, epidemic, illiberal democracy, EU*

Introduction

Since the emergence of the first confirmed patient in Europe on January 24, the COVID-19 swept across Europe. Hungary was also not spared. On March 4, the first confirmed patient appeared in Hungary. Up to June 17, a total of 4,077 people had been diagnosed in Hungary, 7,545 were forced to quarantine, 565 died, and 2,516 were cured.[1] The Hungarian government

1 https://koronavirus.gov.hu/#/

is optimistic about its epidemic situation. Hungarian Prime Minister Viktor Orbán stated on May 1 that Hungary had won the first battle against the epidemic.[1] Cecília Müller, Hungarian Chief Medical Officer, said the epidemic has arrived at a rest point, which is confirmed by the fact that in the past twenty-four hours there have been no significant changes in the epidemic data.[2] Data from European Centre for Disease Prevention and Control also shows that the situation in Hungary is indeed relatively better than other European countries which have not officially declared the end of the epidemic. Up to June 17, Hungary's total number of diagnoses ranked 11th among the 27 EU countries. Malta is the least hit member state with 622 confirmed cases. Due to the different population of various countries, the average level can better reflect the effect of prevention policies. 40.5 out of every 100,000 people in Hungary are diagnosed, which ranks 4th among the 27 EU countries. The lowest diagnosis rate was Bulgaria, at 36.8. Hungary has 5.5 deaths per 100,000 people, which ranks 12th among the 27 EU countries. The lowest mortality rate is 0.5 in Slovakia.[3] However, longitudinal comparison of Hungary's national data shows that Hungary's mortality rate is gradually increasing compared with other countries. Hungary had 3.6 deaths per 100,000 people on May 4, ranking 8th in the EU. By June 6, this rank fell to 12th. Although the number of diagnoses per 100,000 people is increasing, the ranking remains unchanged. Overall, Hungary's epidemic prevention effect is not outstanding, but the epidemic is under control.

2019 State of Health in the EU (Hungary) may be able to provide some explanation for its increase in mortality. According to this report, the Hungarian medical system is relatively backward, and the health status of Hungarians is lower than the EU average. The mortality of patients with cardiovascular disease and cancer is high in the EU, and the former is the disease with the highest mortality rate in Hungary. The report also pointed

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1 https://www.kormany.hu/en/the-prime-minister/news/we-won-first-battle-against-virus

2 https://www.kormany.hu/en/news/epidemic-has-arrived-at-a-rest-point

3 https://www.ecdc.europa.eu/en/cases-2019-ncov-eueea

out that 60% of people over the age of 65 suffer from at least one chronic disease. Unfortunately, all three groups belong to the susceptible population to COVID-19. This greatly increased the difficulty of preventing and controlling the epidemic in Hungary. Regarding the medical system, the Hungarian government's public investment in the medical sector only accounts for 10% of total public investment and 4.9% of GDP, while the EU average of these two is 16% and 7.8 %. Although the Hungarian government has increased the wages of doctors and nurses in recent years and the brain drain slowed down, the medical sector still lacks labor. In addition, insufficient attention is paid to the system of disease control and prevention.[1]

The anti-epidemic measures are fundamental to the health of a nation. Most studies in this field have focused on epidemic control, economy recovery or comparison between countries. There have been fewer detailed investigations of political implication for a country. Politics always follow policies. The aim of this article is to explore the relationship between Hungarian anti-epidemic measures and Viktor Orbán governance, and between Hungary-EU friction and the conflict aroused by the current epidemic. The paper will adopt the approach of empirical research. The first section of this paper will examine the features of Orbán’s economic and social policies since 2010 and the current anti-epidemic measures, then will go on to Hungary-EU relations, especially under the Article 7 and COVID-19 epidemic. The paper argues that there is nothing new under the sun. The features of Orbán’s economic and social policies are fully embodied in the anti-epidemic measures. Due to this factor and the EU internal divergence, the Hungary-EU friction caused by the epidemic will only become a political tool again, and lure for people to buy some apple of Sodom.

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1 https://ec.europa.eu/health/sites/health/files/state/docs/2019_chp_hu_english.pdf

1. Features of Orbán's social and economic policies

Since 2010, Viktor Orbán has been claiming that he will re-transform Hungary to follow the transition in the beginning of 21th century and to corrects the mistakes deriving from the transition.[1] He also considers the previous socialist government as a failure and the victory of FIDESZ will realize the requests from unsuccessful transition.[2] On social policy, Orbán government puts much emphasis on family and employment by strong redistribution in order to build the so-called "work-based society". On economic policy, Orbán introduces the re-nationalization to reduce the foreign share in certain sectors, such as in banking, in order to increase the local share.

1.1 Social policy and redistribution

Orbán claims that after the crisis, Western European countries can no longer continue the previous welfare state model. Each country must adjust this model. The adjustment in Central European countries will not be as difficult as that of the Western Europe, since the Central European countries have never built a welfare state model. Hungary is to build a work-based society rather than the less competitive Western welfare state model.[3] His policy is realized in the following directions.

Subsidize families by comprehensive measures. After alleviating the debt crisis in the public and private sectors, the Orbán government has launched various policies for the family sector and the labor market, aiming at encouraging childbirth, raising wages and employment rates. Since 2010, the Hungarian government has been increasing its investment in family policy. Expenditure in this area was 960 billion HUF in 2010, accounting for 3.5% of GDP, and then rose all the way to 1.9 trillion HUF in 2018,

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1 https://2010-2014.kormany.hu/hu/miniszterelnokseg/miniszterelnok/beszedek-publikaciok-interjuk/orban-viktor-unnepi-beszede-a-kossuth-teren-2010-oktober-23

2 https://2010-2014.kormany.hu/hu/miniszterelnokseg/miniszterelnok/beszedek-publikaciok-interjuk/orban-viktor-eloadasa-a-nemzeti-erdek-cimu-konferencian

3 https://www.napi.hu/magyar_gazdasag/orban_nem_joleti_allam_epul.534599.html

accounting for 4.8% of GDP. Among them, the various services provided to families, housing subsidies and subsidies for women over 40 years of age were mainly increased. Since July 2010, the government has lowered the tax base based on the number of children owned by households and reduced household expenditures on energy such as hydropower and natural gas. In 2012, the government gave preferential housing loans to eligible families. In 2014, the government gave individual families preferential income tax and subsidies for childcare expenses. The year of 2018 was named "A Családok Éve" by the government. In that year, the government comprehensively increased tax benefits for families, subsidies for family and student loans, and subsidies for kindergarten construction.[1]

Encourage employment by raising wages. In the labor market, the unemployment rate once reached 11.9% in the first quarter of 2012, the highest unemployment rate since 2006, but it has dropped to 3.3% in the third quarter of 2019.[2] The average gross salary of employees in 2018 was about 330,000 HUF, an increase of 11.1% over the same period last year, and the increase in 2017 was 12.8%. According to statistics from January 2020, the average gross salary in Hungary from January to November 2019 was 364,000 HUF, an increase of 11.2% over the same period last year. The government has also reformed individual income tax and introduced a single tax of 16%.[3] However, in response to Hungary's low unemployment rate, many voices questioned the authenticity of this figure. Such views hold that the government has created so many public jobs that people who have never actively sought a job, have found this job. This group of people should not be counted in employment.[4]

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1 A családtámogatások rendszere Magyarországon, Az Állami Számvevőszék, https://asz.hu/storage/files/files/elemzesek/2019/20190618_csaladtamogatasok_rendszere.pdf?download=true

2 A 15–74 éves népesség gazdasági aktivitása nemenként, http://www.ksh.hu/docs/hun/xstadat/xstadat_evkozi/e_qlf001.html,

3 http://www.ksh.hu/docs/hun/xftp/gyor/ker/ker1911.html

4 https://www.portfolio.hu/gazdasag/20180502/azt-hitted-hogy-alacsony-a-magyar-munkanelkuliseg-akkor-nezd-meg-ezt-a-grafikont-284126

Redistribute by public policies. Differing from the previous government, the model implemented by Orbán after 2010 is essentially a redistribution of resources, rather than directly raising welfare through debt. The Orbán government first reduced spending in several sectors. The government shortened the period for receiving unemployment benefits from nine months to two months to encourage the unemployed to find a job as soon as possible. The current two-month time limit is the shortest standard in EU countries. The government has also reduced the level of pensions for early retirement to encourage employees to continue working and re-examined the eligibility of people receiving disability benefits. Second, the government expanded the source of income. The main part of income comes from the pension system. In 1998, Hungary established a pension system with three pillars: one is a traditional pay-as-you-go pension system; and the other is a mandatory pension fund for employees. Today, such funds only cover 3% of all employees. The last pillar is pension funds that employees voluntarily deposit. After the pension reform in 2011, the first two pillars were basically merged, and the mandatory pensions became completely pay-as-you-go managed by the government. In this regard, the OECD research report believes that this approach increases the cost of government management.[1]

1.2 Industrial policy and localized economy

After his re-election in 2018, Orbán's government began to implement the next stage of economic policy, shifting its focus from restoring economic growth to improving its competitiveness. This competitiveness is mainly reflected in the following aspects: In the investment field, Hungary focuses on seeking business relations, financing and further integration of SMEs; in the economic structure, reducing dependence on traditional automobile manufacturing and increasing high value-added industries; in financial sector, further reducing financial risks and strictly controlling the growth

1 OECD, Sustainability of pension systems in Europe – the demographic challenge, Grou pe Consultatif Actuariel Européen Position Paper, July 2012

of public debt. Orbán interpreted this in a public speech: "We believe that the proportion of local industrial products in Hungarian products should be increased. We call this re-industrialization."[1] The government accordingly initiated the Irinyi Plan (Irinyi Terv) and the Industry 4.0 project (Ipar 4.0 Program). The former's key policy objectives focus on reducing dependence on the automobile manufacturing industry, leading the industry with innovation, improving the efficiency of SMEs, and deeply integrating into the export-oriented value chain. The latter aims to increase the technological content of SMEs.

But up to now, the most visible result of this strategy is the government's intervention by re-nationalization which spreads to the entire Hungarian economy, not just the banking sector. Rogán Antal, the minister of Cabinet Office of the Prime Minister, even publicly stated that the country's public service industry should be integrated into one system.[2] For example, in the energy field, the Hungarian State-owned Asset Management Corporation (Magyar Nemzeti Vagyonkezelő Zrt., MNV) in 2011 purchased 22% share of Hungarian Oil and Gas Industry Group (Magyar Olaj- és Gázipari Részvénytársaság, MOL). In 2012, the local government of Budapest acquired the Budapest Water Plant, and in 2014, acquired the AVE waste treatment company. In the media sector, in 2011, the central government acquired Duna TV through its wholly-owned subsidiary, Media Services Support and Property Management Fund (Médiaszolgáltatást Tamogató és Vagyonkezelő Alap).

1.3. Anti-epidemic measures of Hungarian government

The characteristics of Orbán's government are fully embodied into the Hungarian anti-epidemic measures. Hungarian protective measures started earlier than the outbreak. After the outbreak, the government focuses on

1 https://www.portfolio.hu/gazdasag/20140415/ujraiparositas-minek-197831

2 https://m.portfolio.hu/vallalatok/rogan_ismet_elohozta_a_nonprofit_kozmuszolgaltatast.188845.html

protection of family and employment by redistribution of resources and the local production of materials.

1.3.1 From the beginning to the end of the first phase

As early as January 31, before the outbreak in Hungary, the Hungarian government issued Government Order No. 1012/2020, and formally established the Operational Group (Koronavírus-járvány Elleni Védekezésért Felelős Operatív Törzs). A clear division of labor was carried out.[1] The task of the Group is to prevent and control the spread of the virus in Hungary and to assess and analyze the outbreaks abroad. The group was co-led by Sándor Pintér, Minister of Interior, and Miklós Kásler, Minister of Human Resources. Other team members include the Chief Medical Officer, representatives from the Hungarian Counter-Terrorism Center (TEK), National Medical Center, Emergency Center and other departments. On the same day, the government announced the establishment of a dedicated website on the epidemic in Hungary.

After the first confirmed patient appeared on March 4, the Operational Group immediately took measures in border control, public health, transportation, and local governance. On March 11, the government declared a state of danger nationwide, valid for 15 days.[2] The embargo on emergencies mainly includes suspension of flights from several countries, prohibition of entry of foreign nationals, strengthening of border control, and 14-day compulsory isolation for Hungarians from abroad. On March 16, Hungary closed its border. In addition to the San Laszlo Hospital, the government designated several hospitals as isolation and treatment centers in other cities. In terms of daily life, bars and various cultural venues are

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1 https://www.kormany.hu/hu/belugyminiszterium/hirek/az-operativ-torzs-akcioterve-a-koronavirus-jarvany-elleni-vedekezesert

2 Although "State of emergency" is a popular translation for "Veszélyhelyzet", but accor ding to the English version of Hungarian basic law on the government website, it is "Stat e of danger" as the English translation of "Veszélyhelyzet", which refers the event of a n atural disaster or industrial accident endangering life and property. This phrase will be us ed in this article.

ordered to close. Restaurants, cafes and shops were only open until 3 pm. Local governments had to cancel various large-scale activities. Budapest Liszt Ferenc Airport suspended routes between Hungary and several Italian cities. On March 27, the government officially imposed curfew with comprehensive regulations on public transportation, and store business hours etc. On March 30, Parliament passed Law No. 12 of 2020 on the prevention and control of epidemics, and agreed that the government extend the period of validity of the national emergency. The government announced an indefinite extension of the state of danger on the March 31. On May 3, the government announced that the national epidemic prevention has entered the second stage. Except for Budapest and Pest county, the bans in other counties have been relaxed.

1.3.2 Family and industrial policy

The Hungarian government increases direct assistance to the household sector. On April 25, the Hungarian government announced that it would re-implement the 13-month pension system to protect the lives of retired people. Bence Rétvári, Parliamentary State Secretary of the Ministry of Human Capacities, said in February 2021, the elderly will receive an extra one quarter of a monthly pension, in 2022 an extra half a month, in 2023 an extra three-quarters of a month, while finally in 2024 elderly persons will receive an extra full monthly pension.[1] In addition to subsidies, another focus of the Hungarian government is to preserve employment. Prime Minister Viktor Orbán once wrote a public letter that Hungary will create as many jobs as wiped out by the coronavirus.[2] Gergely Gulyás, the Minister heading the Prime Minister's Office, said on June 5 that with the measures implemented so far and those planned for the future, the

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1 https://www.kormany.hu/en/ministry-of-human-resources/news/reintroduction-of-13th-monthly-pension-enhances-financial-security-of-the-elderly

2 https://www.kormany.hu/en/the-prime-minister/news/we-will-create-as-many-jobs-as-wiped-out-by-coronavirus

government is playing a role in the protection of 1,144,125 Hungarian jobs, including both labour market and training support.[1]

The above rescue measures for the corporate and household sector depend on the government's strong redistribution capabilities. On March 30, Orbán said that the government needs to make comprehensive adjustments to the 2020 and 2021 budgets.[2] Then on April 4, Gergely Gulyás illustrated that the funds will withdraw from ministries and regroup HUF 1,345 billion which will be available in the fund set up with a view to protecting and restarting the economy. They will transfer HUF 663 billion to the fund whose mission it is to contain the coronavirus epidemic; 50 per cent of this year's party grants, the trade tax payable by multinational companies, the contribution of the financial sector and the part of the automobile tax due to local governments will all have to be paid into the fund. All political parties, multinational supermarket chains, banks and local governments, to share the burdens. [3]

Opposite views come from the opposition parties and society. Schmuck Erzsébet, the co-chairman of green party (Lehet más a politika), said Orbán will use this to increase the strength of his cronies in the agricultural sector through a series of new agricultural policies and establish nobles for the landlords system.[4] Tordai Bence, the parliament representative of Dialogue for Hungary (Párbeszéd) pointed out that the government's rescue plan is the worst in Europe. Subsidies and assistance to medical staff, unemployed and other groups are far from enough. Lawmaker from the Democratic

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1 https://www.kormany.hu/en/prime-minister-s-office/news/hungarian-economy-is-stable

2 https://www.kormany.hu/en/the-prime-minister/news/this-year-s-budget-must-be-drastically-transformed

3 https://www.kormany.hu/en/prime-minister-s-office/news/huf-663-billion-to-be-transferred-to-disease-control-fund-huf-1-345-billion-to-economy-protection-and-restarting-fund

4 https://index.hu/gazdasag/2020/04/05/lmp_kormany_foldmutyi/

Coalition expressed similar views.[1] Some Hungarian economists believe that the government has introduced a rescue plan late and has invested far less than other European countries. The government lacks consultation with relevant social groups.[2]

In terms of material supply, the Hungarian government purchases globally and has also been actively promoting the localization of material production. In February, the government announced that the enterprises under the Prison Administration began to produce protective masks in prison factories, and implemented a 12-hour production with a daily output of 20,000. The product will be distributed directly to medical institutions in Hungary. Hungary also purchased an automated production line with a monthly output of 2.8 million masks from China to further increase production capacity. In order to meet the demand for disinfectants in Hungary, on March 25, the Hungarian oil giant, the MOL, began to produce 2-liter disinfectants. Its products are distributed directly on the market. The Budapest University of Technology and Economics has developed a prototype of a Hungarian-made ventilator which will enter into production recently, with an estimated daily output of ten.

In addition to the aforementioned measures against epidemic, the Hungarian government has also formulated policies to promote economic recovery. On March 10, Mihály Varga, the Deputy Prime Minister and Minister of Finance of Hungary stated that the government needs to actively respond to the economic needs arising from the epidemic. Although the economic growth in 2020 was predicted to be 4% last year, the possibility of a direct economic decline of 0.3% cannot be ruled out.[3] On April 16, Péter Szijjártó declared Eximbank will offer a preferential loan opportunity towards investments on the part of Hungarian enterprises,

1 https://hirado.hu/belfold/belpolitika/cikk/2020/04/07/elo-torvenyjavaslatokrol-targyal-a-haz

2 https://euobserver.com/opinion/148201

3 https://infostart.hu/gazdasag/2020/03/10/varga-mihaly-a-jarvany-hatasainak-megfeleloen-fog-reagalni-a-kormany

as well as in the form of a working capital loan in such a way that the rate of interest for small business that take on the loan within a year will be just 0.1 percent.[1] According to Foreign Minister, up to June 4, 806 enterprises submitted applications within the framework of the program, undertaking to realize 377 billion forints (EUR 1.09 billion) in investment and protecting 143,618 workplaces as a result.[2]

All these measures are in line with the features of Orbán's social and economy policies, with focus on foreseeability, household, employment, security and crisis. Objectively speaking, the focus of the Hungarian government's anti-epidemic measures is no different from other European countries, mainly focusing on preventing the spread of the epidemic, assisting enterprises, and protecting employment. However, its implementation depends on the government's redistribution capability, which kill two birds with one stone. On the one hand, redistribution relies on existing resources rather than debt, which directly reduces Hungarian public debt rate, and thus maintains a low fiscal deficit level. It will be described as Orbán's achievement in the future. Especially when other European countries rely on debt to bail out the economy. On the other hand, by reducing the subsidies to political parties, the strength of the oppositions is weakened. The maneuver space of other political parties has been declining since Orbán government in 2010, and the reduction of political party funding has made the situation worse. Another issue should be mentioned is that economically losers are not necessarily those who get compensation from the government, since the government only compensate those, who politically important (vote) and at same time, economically losers, or sometimes not even losers.

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1 https://www.kormany.hu/en/ministry-of-foreign-affairs-and-trade/news/government-to-launch-new-export-funding-and-investment-promotion-program

2 https://www.kormany.hu/en/ministry-of-foreign-affairs-and-trade/news/hungarian-enterprises-will-be-able-to-stand-their-ground-in-the-new-global-economic-competition-if-they-gain-strength

2. The illiberal democracy and Hungary-EU relations

2.1 The threads behind Hungary-EU friction

Since the Rui Tavares report in 2013, Article 7 has been the main topic between Hungary and EU debates. But there are several threads behind these endless debates. First of all, EU institutions pass the buck to each other on the potential investigation on Hungary. Since Tavares first proposed the need to invoke Article 7 against Hungary in 2012, various resolutions have continuously called on the European Commission and the Council to take action, but the two major institutions have been slow to take the substantive action expected by the European Parliament, which provoked dissatisfaction among lawmakers. So that all the related EP resolutions in the past two years made it clear that EP regret the inaction of these two institutions, especially the Council. In the 2013 EP public debate, the rotating chairman of the council publicly kicked the ball to the European Commission.[1] It can be seen that the "inaction" of these two EU institutions for several years has put the European Parliament on the front line to a certain extent, which is also one of the main reasons for the adoption of the Sargentini report and the current firm position towards Hungary.

After the Sargentini report was adopted, the European Parliament continued to exert pressure on other EU institutions through various means. In November 2018, the European Parliamentary Research Service published a report on Protecting the EU budget against generalised rule of law deficiencies, urging the Council to vote on the matter as soon as possible. [2]In the same month, the service published another report, The EU framework for enforcing the respect of the rule of law and the Union's

1 Constitutional situation in Hungary (debate), 2018.12.21, http://www.europarl.europa.eu/sides/getDoc.do?pubRef=-%2f%2fEP%2f%2fTEXT%2bCRE%2b20130417%2bITEM-002%2bDOC%2bXML%2bV0%2f%2fEN&language=EN

2 Protecting the EU budget against generalised rule of law deficiencies, 2019.1.5, http://www.europarl.europa.eu/RegData/etudes/BRIE/2018/630299/EPRS_BRI(2018)630299_EN.pdf

fundamental principles and values, emphasizing cooperation between the two institutions.[1] But there is not clear sign on initiating these proposals in EU.

Secondly, politicization is becoming more and more serious. At present, the issue of democracy and the rule of law in Hungary is not only a matter of the institutional construction inside Hungary, but has become a tool for the left and right parties within the European Parliament and within Hungary. During the debates in Hungary, the focus was on how to use the friction to gain greater support or to demolish the FIDESZ. At the level of the European Parliament, it can be seen from the public debates on the various issues of Hungary in the two major parliamentary groups that the focus is not on how to analyze, understand and resolve these issues, but on how to oppose or support Hungary.

The European Parliament, which was supposed to exercise political supervision and advisory functions under the EU Treaty, never put forward effective advisory advice on the Hungarian issue, but merely urged all parties to implement sanctions as soon as possible. Sargentini even participated in a demonstration organized by the Hungarian opposition in Brussels in January 2019 and gave a public speech. Member of the European Parliament acted directly as opposition of a member state, and failed to effectively exert any political supervision and advisory functions.

Thirdly, the EU and its member states can't communicate with each other. Some of the problems between Hungary and the EU have been unable to be resolved, partly because the EU and Hungary have never conducted in-depth and effective communication. For example, on the issue of refugees, the representatives of the European Commission have insisted on calling refugees as asylum seekers in their speeches in the European Parliament, deliberately ignoring the question of whether they are illegal or not, and

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1 Relations between the European Council and the European Parliament-Institutional and political dynamics, 2019.1.5, http://www.europarl.europa.eu/RegData/etudes/STUD/2018/630288/EPRS_STU(2018)630288_EN.pdf

more from the perspective of human rights and morality. Orban and others insisted on calling this group as refugees or immigrants, with more emphasis on whether this group complies with relevant laws. Both sides have their own opinions based on their own interests. The adoption of the Sargentini report was also interpreted as a showdown between the two camps of supporting refugees and opposing refugees in Hungary, but in fact the refugee issue is only a small part of the report. The Hungarian government has never responded positively to the rest of the report. It can be seen that although various communication mechanisms exist between the EU and member states, when problems emerge, the EU not only lacks a formal regulatory mechanism, but also shirks each other from each other, and the EU and member states are unable to carry out effective communication.

2.2 The friction between Hungary and EU under the epidemic

These features are also fully reflected in the epidemic. Although the above measures are also controversial in Hungary, the real trigger this time was the so-called authorization law. The Hungarian Parliament passed Law No. 12 of 2020 on March 30, authorizing the government to extend the period of national emergency. Because the state of danger allows the government to bypass various laws, and the time limit for this state is indefinite, fierce criticism from Hungary, EU institutions and the international community are caused. Critics believe that Orbán deliberately weakens the principles of democracy and the rule of law. However, there are certain different opinions within the EU institutions on this issue, as in the case of Article 7 in the last two years.

The basic law passed in 2010 includes five special legal orders. State of National Crisis (A rendkívüli állapot) refers a state of war or an imminent danger of armed attack by a foreign power. State of Emergency (szükségállapot) refers event of armed actions aimed at subverting the lawful order or at exclusively acquiring power, or in the event of serious acts of violence endangering life and property on a massive scale. State of Preventive Defense (A megelőző védelmi helyzet) refers event of a danger

of external armed attack or in order to meet an obligation arising from an alliance. Unexpected Attack (A váratlan támadás) refers the event of an unexpected incursion of external armed groups into the territory of Hungary. State of Danger (A veszélyhelyzet) refers the event of a natural disaster or industrial accident endangering life and property. Regarding the last one, the decrees of the government shall remain in force for fifteen days, unless the government, on the basis of authorization by the Parliament, extends those decrees.[1]

Against this legal background, the Hungarian government issued government order 40/2020. (III. 11.) on March 11, announcing the state of danger.[2] During this period, the government has the right to restrict or interfere with personal freedom, religious freedom, peaceful assembly and property rights. On March 20, Semjén Zsolt, the Deputy Prime Minister of Hungary, formally submitted a legal proposal to the parliament, asking the parliament to pass a law authorizing the government to extend the state of danger.[3] On March 30, Parliament passed Law No. 12 of 2020 on the prevention and control of the epidemic, agreeing to the government to extend the validity of the state of danger. The government has the right to take various measures related to epidemic prevention based on the government order 40/2020. (III. 11.), to suspend some laws without being bound. The government is obliged to report its anti-epidemic measures. Besides, the dissolution procedures of local governments or national autonomous governments should be suspended. No temporary elections or national or local referendums are allowed.[4]

Various EU institutions have expressed their concerns about this incident. Among them, the European Parliament still plays the role of "pioneer". As

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1 https://www.kormany.hu/download/e/02/00000/The%20New%20Fundamental%20Law%20of%20Hungary.pdf

2 https://net.jogtar.hu/jogszabaly?docid=a2000041.kor

3 https://www.parlament.hu/irom41/09790/09790.pdf

4 https://magyarkozlony.hu/dokumentumok/9b48945c85f190378f67e253337be4299edf743f/megtekintes

early as January 6, it adopted a resolution on the rule of law in Hungary and Poland, calling on the Council to hold more frequent and regular hearings in 2020, and proposed that the EP should participate. Before the Hungarian parliament passed the authorization law, the EP's Committee on Civil Liberties, Justice and Home Affairs stated on March 24 that although member states need to take necessary measures during the outbreak, member states should ensure that they do not undermine fundamental rights, the rule of law and democratic principles. The European Commission needs to assess whether the upcoming authorization law of the Hungarian Parliament violates Article 2 of the EU Treaty.[1] On April 17, the EP once again passed a resolution on Hungary. The resolution clearly stated that EP members are seriously concerned about the Hungarian government's decision to extend the state of danger indefinitely. This decision weakened the parliamentary oversight function. The lawmakers called on the European Commission to urgently assess whether this measure complies with the EU Treaty and use all EU tools to sanction this serious act, including the multi-annual financial framework. The lawmakers also called on the Council to hold hearings on the violation of Article 7 by Hungary and Poland.[2] Ursula von der Leyen, the President of the Commision also expressed her concern.[3] Marija Pejčinović Burić, The Secretary-General of European Council, wrote an open letter stating that the measures taken by the members of the Council under special circumstances must comply with their own constitutions and international standards, and they must always pay attention to the principles of democracy. An indefinite and

1 https://www.europarl.europa.eu/news/en/press-room/20200324IPR75702/ep-stands-up-for-democracy-in-hungary-during-covid-19

2 https://www.europarl.europa.eu/news/en/press-room/20200415IPR77109/covid-19-meps-call-for-massive-recovery-package-and-coronavirus-solidarity-fund

3 https://www.euractiv.com/section/justice-home-affairs/news/von-der-leyen-concerned-over-hungary-virus-emergency-law/

uncontrolled national emergency does not guarantee democratic principles.[1]

But there is a clear gap between EU institutions. According to the German news agency, the European Commission's internal investigation concluded that there was no clear evidence that Hungary violated democratic principles. The European Commission will continue to follow the Hungarian government's measures in the coming months.[2] Věra Jourová, Commission Vice President for Values and Transparency, showed ambiguous attitude towards the questions regarding this issue during several academic conferences. However, the latest progress shows that Věra Jourová is definitely not the supporter of Hungary. The government sent out a questionnaire, billed as a national consultation to some eight million eligible voters. One of the questions claims the European Union is preparing an offensive against the immigration-related regulations of the Hungarian constitution. Věra Jourová calls this as fake news.[3] As for the potential end of emergency on 20th of June, Věra Jourová warns that This will be the moment of truth, [as to] whether the situation and the legal order and the balance of powers in Hungary will come back to the old normal ... or there will be some remainders of the emergency regime.[4] In this case, the Council didn't make position as in the case of Article 7.

By takes advantage of EU's divergence, Viktor Orbán said after reading the law line by line, they found nothing about the Hungarian special legal order that would be contrary to the EU's civilizational traditions. He highlighted, observing that in normal circumstances, Hungary should be receiving letters of apology on an hourly basis, but at this time he is not

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1 https://www.coe.int/en/web/portal/-/secretary-general-writes-to-victor-orban-regarding-covid-19-state-of-emergency-in-hungary

2 https://rmx.news/article/article/media-fail-eu-finds-no-grounds-to-act-against-hungary-s-emergency-law

3 https://euobserver.com/political/148616

4 https://www.politico.eu/article/hungary-faces-moment-of-truth-over-rule-by-decree-jourova-says/

expecting an overwhelming number of apology messages.[1], Justice Minister Judit Varga said in German broadcaster ARD interview that, the law on the effort to contain the coronavirus is democratic. Parliament can revoke the authorization granted to the government at any time. legislature will decide on the termination of the state of danger declared due to the coronavirus epidemic as well.[2] In another interview, she said in Europe criticizing Hungary has become something of a trend as the liberal mainstream that rules Western European media rejects politicians who disagree with them. Hungarians are true Europeans, but critical ones, and they are attacking Hungarians because of this.[3] Gergely Gulyás said in the past few years they have grown used to the fact that it is something of a hobby for many to criticize, slander and make false accusations about Hungary.[4] On June 11, Judit Varga stated that during the coronavirus crisis, the European Parliament was part of the problem, not the solution.[5]

Conclusion

Hungary faces serious problems under the epidemic, such as insufficient input and labor shortage in medical system, more susceptible people in the country. But the anti-epidemic measures achieved moderate effect, comparing with other countries in the EU. The causality between these measures and effect should be clarified by the scientists. All we can conclude is that these measures and their effect are relevant. Regarding the recovery, the Hungarian government follows its path since 2010, focusing

1 https://www.kormany.hu/en/the-prime-minister/news/we-won-first-battle-against-virus
2 https://www.kormany.hu/en/ministry-of-justice/news/justice-minister-judit-varga-to-german-public-service-broadcaster-ard-law-on-containment-effort-is-democratic
3 https://www.kormany.hu/en/ministry-of-justice/news/justice-minister-judit-varga-to-austrian-television-broadcaster-orf-containment-legislation-will-remain-in-force-as-long-as-state-of-danger-prevails
4 https://www.kormany.hu/en/prime-minister-s-office/news/huf-663-billion-to-be-transferred-to-disease-control-fund-huf-1-345-billion-to-economy-protection-and-restarting-fund
5 https://www.kormany.hu/en/ministry-of-justice/news/european-parliament-was-part-of-the-problem-not-the-solution-during-crisis

on family and employment by redistribution, and also on the local production of materials. of course, the task of boosting economy should be observed further, since there must be a gap between the design of a policy and the implementation of it.

However, these measures are politicized again as usual, especially the authorization law. EU institutions argue that the epidemic becomes another opportunity for Orbán to concentrate powers, which further harms European values and violates the EU treaty. The conflict between Hungary and EU arouses again, but it is still nothing but a political quarrel. The epidemic is a "New Wine" in "Old Bottle" of Hungary-EU conflict.