Who fought the pandemic best - governments or local authorities?

Two European countries who handled the covid-19 pandemic poorly entertain opposite ideas of the root cause. Many British public-health experts believe that the failures in response to the covid-19 pandemic have been the result not just of slow political decision-making, but also of the highly centralized nature of the British state.

In Sweden, with an exceptional number of covid-19 deaths per capita, the government as well as the doctor's union claims that decentralization of health- and old age care is the main culprit.

Both have probably got it wrong.

In Sweden 21 regional authorities are in charge of health care, and old age care is in the hands of 290 municipalities. The split responsibility causes frictions. Health care for elderly in old age care homes is all too often given low priority by regional health authorities whose main preoccupation is running hospitals. On the other hand, both regions and municipalities have good knowledge of local conditions and feet on the ground to get things done when necessary. Most policy mistakes and delays in national response have been down to errors of judgement and delays by state authorities. Several of these seemed unsure about the width of their mandate. The central government has remained mostly passive. It asked parliament for extraordinary powers during the crisis, but then never used them. None of this suggests that more centralization would have saved lives.

In Britain health used to be in local hands. In 1974, public health was detached from its local roots, as directors of public health were taken out of local government and placed within the NHS, the National Health Service, the fifth biggest employer in the world. In 2013 responsibility for public health was split between a national agency, Public Health England with responsibility for infectious diseases, and local authorities with few resources in charge of other health issues. When covid-19 broke out, Public Health England was quickly overwhelmed. Neither the NHS, nor the local authorities were capable of quickly beefing up operations.

Compare that to Germany, Norway and South Korea, some of the countries that responded most successfully. They all have public-health systems embedded in local government. In Germany, the federal government provided extra resources, but the response was run by 375 local authorities. These quickly reallocated resources from functions that had been put on hold during lockdown—such as libraries or sexual health—and were given money by the federal government to hire medical students to help. Early on wide scale testing and tracking was up and running.

In Norway hospitals are state run, but municipalities are in charge of primary care and public health as well as old age care. Local public health officials and doctors provided old age facilities with medical care, advice and inspections all through pandemic and ran testing and tracking. Similarly, in South Korea, decision-making was mostly done by central government, but implementation was local.

Both the Swedish and British debate appear to be motivated by a search for scapegoats. Successful countries have strong local organizations. Sometimes they can be helped by assistance or guidance from state authorities. But they also provide a line of defense when governments and their agencies remain passive or get it wrong.