COVID-19 And Europe

Q&A with Julia Lynch, Associate Professor of Political Science, University of Pennsylvania

What explains the variation in the EU member states' responses to the pandemic?

This is indeed a puzzling question, and I suspect that comparativists will be grappling with this for a long time to come. With a relatively small number of member states, it's easy to devolve into speculative "theories" that are really just *ad hoc* explanations for individual cases. I think at this point it makes most sense to try to generate a list of possible explanations that we have good grounds to think MIGHT be related to state-level responses, and then evaluate their explanatory power jointly. A number of the "usual suspects"—type of public health or health care system, type of welfare regime, pre-pandemic fiscal capacity, partisanship of government, region of Europe—don't seem on their own to be explaining a lot of the variation. But we should also be thinking about levels of trust in government and in fellow citizens (both of which are like to affect how policy-makers think about what types of social distancing or quarantine policies are likely to be effective); the degree to which epidemiologists are integrated into policy-making circles; the openness of policy-making elites to European-level influences (e.g. from WHO Europe or the EU); state capacity; the influence of pharmaceutical and medical device manufacturing lobbies; etc.

How do pre-COVID-19 social, labor market and healthcare policies influence West European states' coping with the pandemic?

The timing of the arrival of the pandemic clearly had its own impact on how governments responded, with countries hit earlier taken by surprise and often faring worse. And at this point we really don't have reliable, cross-nationally comparable data on the health effects of the pandemic (see below). But based on what we know about how social policies generally impact population health, we can be pretty confident that pre-COVID-19 social policies have an impact on how many and who are exposed to the virus in a population, and how much they suffer conditional on that exposure.

Where social (and labor market) policies do more to protect people from job and income loss if they take time off from work; allow greater access to health care services; and make it easier to socially isolate (e.g. by providing social services to the elderly), the spread of the pandemic seems to be easier to contain. Social and labor market policies also mediate the effects of mar-

ket-generated inequality on health, and so they affect who is most likely to die conditional on exposure to the virus. Robust social policies tend to be associated with lower rates of the kinds of complicating conditions like asthma, diabetes, cardiovascular disease, and exposure to particulate air pollution that are otherwise concentrated among lower-status groups and that make death from COVID-19 more likely.

Health policies are also likely to shape the results of the pandemic at the country level. While the type of health care system (single- versus multi-payer, share of public versus social insurance financing, mainly public versus mainly private providers, etc.) probably doesn't matter all that much, health system capacity clearly does. Countries that experienced deep cuts to public hospitals during the 1980s-2010s, often under the guise of New Public Management and/or austerity philosophies, have had to scramble to come up with enough slack in their systems to accommodate a very rapid rise in the demand for public health surveillance, laboratory facilities, intensive care beds, and nursing staff.

Has Brexit affected the UK pandemic responses?

Dreams of Brexit do seem to have affected the British government's initial response to the pandemic in a few ways, though it's hard to be sure. Brexit thinking very likely affected the decision of Boris Johnson's government to opt out of joint EU arrangements to buy ventilators and PPE in bulk, even though it could have done so during the Brexit transition period. One of the companies that received a contract from the UK for its own supply of ventilators is run by James Dyson, a key advocate of Brexit – although I don't know if there is any significance other than symbolic to that fact. It also seems plausible that the government's reliance on a small group of British scientists pushed them to adopt the controversial "herd immunity" strategy rather than enacting the social distancing measures that were taken up by most EU countries.

It's clear, though that Brexit will make it much harder to fight the pandemic. The departure of EU nationals working in the NHS will reduce the health care system's capacity, and the UK government has announced that it does not plan to maintain its membership in European health organizations that oversee surveillance of communicable diseases, new drug licensing, and clinical trials. This means UK patients will likely experience delays in getting access to new treatments, in addition to missing out on any European economic support packages for pandemic recovery.

Are our current conceptual tools for analyzing and explaining health system differences adequate for understanding responses to and coping with the COVID-19 pandemic across countries?

The main focus of scholarship on health in political science has always been health care systems, by which we usually mean systems of insurance and provision of curative medical services. Political science has not invested nearly as much in understanding variation in the functioning of public health systems in different settings, or in the determinants of population health. Both of these tendencies put us at a disadvantage as we try to understand why different countries respond differently to the crisis, and the ultimate effects on the well-being of populations in the face of the pandemic.

If I want to understand how governments are responding to this crisis, I'm going to want to know why their public health services look the way

they do, why they have the capacities and organizational cultures that they do, why they interact with other branches of government in the way they do – and there isn't to my knowledge much work in political science that examines the origins of or contemporaneous variation in public health care systems.

Lack of attention in political science scholarship to the social determinants of health, including how fundamental causes of health inequalities like socioeconomic inequality and racism are related to population health, also makes it harder for us to understand how public policy may affect the pandemic's outcomes for population health. The good news is that there is nothing to stop us from learning from other social scientists with expertise in this area, including social epidemiologists, who have devoted considerable attention to just these kinds of questions.

At this point, however, I think the most important obstacle to analyzing cross-national variation in coping with the pandemic is the fact that we simply don't have good comparative data on either the incidence of the disease or the outcomes for e.g. mortality. Very significant cross-unit differences in testing and in how deaths are recorded, as well as the more common differences in the recording of relevant information about patients (e.g. sex, race/ethnicity, class or occupation), mean that it's not possible at this point to make any claims about cause and effect. It's likely that the data will never be truly comparable, so we will always need to be somewhat circumspect in the claims that we make. ●