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Policy Responses to the COVID-19 Pandemic and Potential Outcomes in Central and Eastern Europe: Comparing the Czech Republic, the Russian Federation, and the Slovak Republic

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ABSTRACT *This article compares policy responses to the COVID-19 pandemic and their probable results in three countries: the Czech Republic, the Russian Federation, and the Slovak Republic. The article is based on a multiple case study method. It confirms that in the three countries studied, the timing of policy responses and the success in motivating compliance represent important critical factors in containing the pandemic. It discusses the innovative experiment with nationwide blanket testing in Slovakia and suggests that antigen testing should not be the single and independent policy tool to combat the pandemic.*

Keywords: comparative analysis; anti-pandemic interventions; timing of policy responses; compliance; nationwide blanket testing in Slovakia

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Introduction

The number of publications related to the COVID-19 pandemic has been quite comprehensive. As of mid-November, the World Health Organization (WHO) database included almost 100,000 different publications with different foci and various territorial coverages.

Many studies try to explain the varying success rates of anti-pandemic policies implemented by national governments and propose different core factors. For example, Liu and Saltman (2020) propose that timing and compliance are core factors determining the epidemic situation. Scholars have discussed the necessary scale and scope of preventive measures (for example, Nicola et al. 2020) and have proposed, in particular, case isolation at home, voluntary home quarantine, social distancing, school closures, and travel restrictions.

This article compares the policy responses to the COVID-19 pandemic and their probable results in three countries, each with different results in different stages of the pandemic: the Czech Republic (Czechia), the Russian Federation (Russia), and the Slovak Republic (Slovakia). The article aims to respond to critical questions generated by country case studies: *Why do the COVID-19 health outcomes (measured by the number of newly infected cases) differ so significantly among the selected countries and in different time periods?* And: *Are the COVID-19 health outcomes of selected post-Soviet countries specific and do they differ from worldwide patterns?* The article also summarizes the advantages and disadvantages of the Slovak nationwide blanket testing experiment from the October–November period.

This text is intended to contribute to the worldwide discussion on responses to the COVID-19 pandemic and their outcomes by covering a region that is typically under-represented in comparative public policy scholarship. Our study covers former socialist countries in Central and Eastern Europe with a shared past but with different political systems today (Czechia and Slovakia have been European Union members since 2004). This unique context is expected to contribute to comparative public policy scholarship and to improve lesson drawing and extrapolation. The specific added value of this article is its brief evaluation of the unique and innovative blanket testing experiment in Slovakia.

Methodology

This study uses the multiple case study approach and the approaches of qualitative comparative policy analysis (for example, Hudson and Kühner, 2017). We selected three countries from Central and Eastern Europe with differing results for COVID-19 spread – Czechia, Russia, and Slovakia.

The reason for the choice of countries investigated is based on three core arguments. The critical factor was the differing COVID-19 health outcomes at different stages of the pandemic. We also wanted to include countries that are not in the focus of the current COVID-19 literature and that share a similar past, without previous experience with similar pandemics, thereby preventing different path-dependence tracks. We are aware that we are comparing countries that differ greatly in size and that have different political systems. However, current opinions suggest that size factors such as territory and population density do not matter from a worldwide perspective (compare, for example,

data from the United States and Luxembourg). The issue of political systems is more questionable, as scholarly opinions on this aspect differ (compare, for example, Christensen and Læg Reid, 2020; Ang 2020); however, we do not consider the issue to be a major limitation for this study.

The text of the three included country case studies is developed by the authors based on their own secondary analysis of existing public data. The data were collected by monitoring official national COVID-19 related sites (Czechia: koronavirus.mzcr.cz, Russia: <https://coronavirus-monitor.ru/>, and Slovakia: <https://korona.gov.sk/>) and by monitoring three of the most popular newspapers in each country (www.idnes.cz, www.pravo.cz, www.lidovenoviny.cz; www.kp.ru, www.rg.ru, www.mk.ru; and www.pravda.sk, www.sme.sk, www.novycas.sk). The sample of monitored journals included journals that are viewed as pro-government as well as journals viewed as anti-government.

To limit the problem of unreliable or manipulated data about COVID-19 spread as much as possible, we decided to utilize only the indicator “number of newly infected cases” as the measure characterizing the health outcomes and the probable success of anti-pandemic policies. Statistics delivered by Czechia and Slovakia on this indicator are internationally accepted; similarly, Russia has no major reason to manipulate the reported figures. In all three countries, a similar relative size of testing was delivered (see next section), allowing for careful comparison.

Core Government Responses to COVID-19 in Czechia

Czechia is a Central European country with a territory of 78,866 km² and 10.5 million inhabitants. The Czech healthcare system is based on compulsory public health insurance, which assures universal access to a broad benefits package.

During the first phase of the pandemic, Czechia had registered 13,475 cases as of July 15 when approximately 600,000 tests had been conducted. After easing the anti-pandemic measures, the number of new cases increased, and by late October the country had shown the highest daily incidence rates in Europe, with a one-day peak of 15,727 new cases on November 4 – more than the total number of infected cases in the spring.

The first three COVID-19 cases in Czechia were identified on March 1, and the government quickly reacted with a set of measures. A state of emergency was declared on March 12 and was extended several times until May 17. The most critical measures applied were the mandatory quarantine for returnees from abroad; a full ban on mass activities; the closure of restaurants, most shops, sports, and similar facilities; closing borders; and a restriction on free movement. Simultaneously, several regional quarantines were imposed. A massive emphasis on the obligation to wear face masks was a significant feature of the Czech response. The first stage for the relaxation of measures started in late April and the country gradually returned to an almost normal mode.

However, by the second half of June, new regional centers of outbreak had been identified. At the end of July, new daily cases started rising sharply and reached record levels in October and November, moving Czechia to the position of one of the countries most affected by COVID-19 worldwide. Compared to March, the reaction of the Czech government to the rise of COVID-19 was very slow. When the numbers of infected cases

achieved record numbers, the prime minister publicly announced on September 21 the return to a set of strict anti-pandemic measures similar to those applied in March. Despite relatively strong anti-pandemic measures, due in particular to very limited compliance, the infection spread had not been brought under control in the country by December. The main hope for reducing the number of newly infected cases are vaccinations, which were started on December 27.

Core Government Responses to COVID-19 in Russia

Russia is one of the largest federations in the world in terms of population and territory, with 146,745,098 inhabitants in a territory of 17,098,246 km². The Russian healthcare system is mostly financed through budget appropriations and compulsory health insurance, resulting in almost universal coverage; private health expenses consisting mainly of out-of-pocket payments amount to about 36 percent of current health expenditures in Russia.

During the first and second phases of the COVID-19 pandemic, Russia registered 765,437 cases and 12,247 deaths (by July 15). Both the absolute and relative number of cases in the country was among the highest in the world; the total number of tests was claimed to be approximately 24 million. The number of infected cases in Russia decreased in the summer to approximately 50 percent of the top incidence in May, falling from roughly 10,000 to 5,000 new daily cases; it started to increase significantly in early October during the third phase of the COVID-19 pandemic. In November, the daily incidence of newly infected cases reached almost 30,000, double the highest numbers of the spring.

The first phase of the COVID-19 pandemic in Russia might be connected with two cases in Siberia reportedly originating in China that were reported on January 31. The reaction to the emergence of COVID-19 was rather swift in this phase and the enacted measures, especially strict border control, delivered temporary success.

The real outbreak of infection, the second phase of the COVID-19 pandemic, arrived in Russia from a different front. On March 1, the first European case was registered in Moscow: a Russian national returning from Italy. The reaction to the European threat was delayed, and anti-pandemic measures were only gradually developed. The set of measures was similar to those of other countries: tightened border controls, introduction of a 14-day quarantine for those coming from abroad, closing schools and universities, canceling theatre and concert performances, sports, and other mass events. A federal lockdown was announced during the Easter holiday in April and extended until the end of April. Obligatory wearing of face masks and gloves in public areas was required beginning on April 12.

The measures were eased very early; a three-stage plan was announced on May 9 to remove COVID-19 restrictions subject to the decisions of regional authorities. Moscow was among the first to start easing measures on June 6, when the epidemiological indicators were still quite high. Following a visible decrease of new cases in the summer, the COVID-19 incidence started to increase again in October, the third phase of the pandemic in Russia. The policy reaction to the start of this third phase was predominantly regional. Central bodies provided recommendations and regional bodies implemented them according to their actual situation. Despite the stronger outbreak, the anti-

pandemic measures undertaken in the third phase seemed less strict than in the spring, with the most typical examples being the wearing of protective face masks and working from home, plus some restrictions on operations of services. In December, the infection spread in Russia was not under control. Vaccinations started in mid-December using Russia's own vaccine, called Sputnik.

Core Government Responses to COVID-19 in Slovakia

Slovakia is a small country in Central Europe with a territory of 49,035 km² and 5.458 million inhabitants. The Slovak healthcare system is based on compulsory public health insurance, which assures universal access to a broad benefits package.

In addressing the first phase of the COVID-19 pandemic, Slovakia was the most successful country in the European Union. Slovakia registered 1,951 cases and only 28 people were reported to have died of COVID-19 as of July 15. The number of completed tests exceeded 235,000. The situation started to worsen in late July, as the number of infected cases began to increase; it reached critical levels in October, surpassing 3,600 cases on October 29. The infection spread was not under control in December. Vaccinations were started on December 26.

During the first phase of the COVID-19 pandemic, the initial activities connected with the possible risks started before the first case appeared. A comprehensive set of anti-pandemic measures was introduced a few days prior to and immediately after the appearance of the first case on March 6. An emergency situation was announced on March 11 and lasted for 90 days, the maximum period allowed by the legislation. The set of restrictive measures was similar to those of other countries – closing schools, banning all mass activities, closing borders, introducing compulsory home quarantine, closing most shops and services, and ordering the use of protective face masks everywhere. From early March, people were advised to limit movement of any kind, and a countrywide lockdown was announced for the period of the Easter holidays in April.

The relaxation of the adopted measures started in mid-May, and by mid-June the country had returned to an almost normal mode of operation. Growing numbers of infected cases during late July and early August were not considered in time by the government. In early September, the prime minister rejected proposals from epidemiologists for the immediate reintroduction of strict anti-pandemic measures. On September 25, he changed the rhetoric, telling people that strict measures were necessary and stating, “People . . . you let me down.” Anti-pandemic measures similar to those in the spring were reintroduced in a slightly milder form. Because of the critical increase in the number of newly infected cases, in late October the Slovak prime minister embarked on a unique experiment – blanket antigen testing of almost the entire population. Testing during the first stage was carried out in three phases: the four most critical districts on October 23–25, the whole country on October 31 to November 1, and 45 more districts with a higher incidence rate from the second phase on November 6–7. In the largest scale second phase, 3,625,332 people were tested, with 38,359 positive results. This mass testing was presented by the prime minister as a “nuclear weapon” against the spread of COVID-19; most experts did not share this optimism.

Anti-Pandemic Public Policy Responses: Comparative Analysis

Our comparative analysis is presented in [Table 1](#), which summarizes the main comparative items characterizing the anti-pandemic policies and their potential health outcomes, and in [Figure 1](#), showing how the pandemic developed in the three selected countries by illustrative curves.

Regarding the health outcomes of the anti-pandemic policies, we expect that for most countries the main goal of the adopted anti-pandemic measures is to flatten the incidence curve as much as possible, in part to prevent a collapse of the health system. This objective was successfully achieved in Czechia and in Slovakia in the spring. Compared to Russia in its second pandemic phase, the spring situation in Czechia and Slovakia was characterized by the rapid implementation of a set of anti-pandemic measures in conjunction with a high level of compliance within the population. Russia implemented a similar set of measures, but with some delay, and it did not successfully create a high level of compliance.

Czechia and Slovakia failed to control the incidence curve for the second phase of the pandemic. They significantly delayed the renewal of anti-pandemic measures – the return of the COVID-19 pandemic was clear in midsummer, but real reactions started in late September – and they did not successfully reactivate the atmosphere of compliance.

Our findings in this specific sample of post-Soviet countries support the existing international evidence (see, for example, [Liu and Saltman 2020](#)) arguing that reacting quickly and managing compliance are critical factors for the control of the virus spread.

Our research highlights the major differences between Czechia and Slovakia in the pandemic spread in the spring and autumn. The fact that early timing and compliance were absent during the second COVID-19 pandemic phase could be explained by more factors. The political and popular support for harsh measures or even a lockdown were much weaker in the autumn than they had been in the spring. Moreover, many people still do not believe that the threat is real; current polls in Slovakia estimate that this is true for almost 40 percent of the population. The fact that the COVID-19 issue is now the central subject of political fights between coalition and opposition governments in both countries, even generating visible conflicts between the prime minister and the president in Slovakia, is also critical – in such an atmosphere, trust and compliance are impossible.

Blanket Testing in Slovakia

Slovakia was the only small-to-medium sized country that conducted semi-compulsory blanket antigen testing of almost the entire population, and its experience should serve as an important benchmark for other countries.

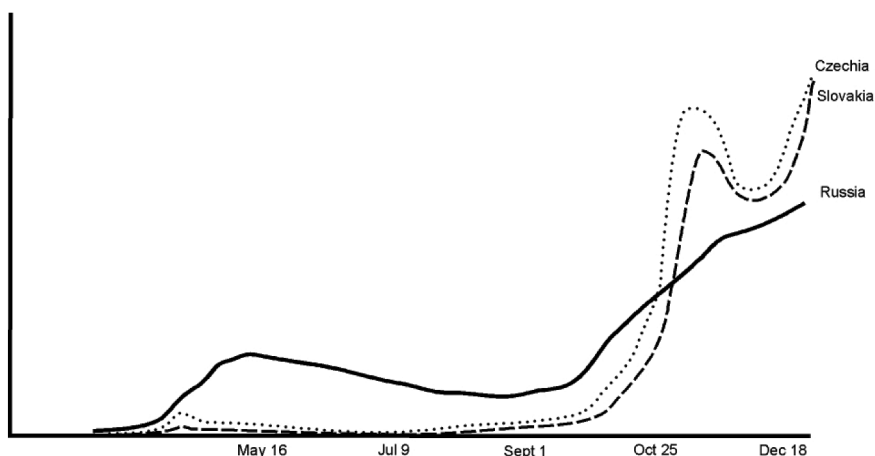
The direct benefit of blanket testing is indisputable – during its three phases, the testing identified almost 60,000 infected cases, who were required to stay in quarantine, thereby certainly slowing the spread of the virus.

However, several disadvantages should be noted. Formally, the testing was voluntary; however, the related sanctions for non-participation (especially a “hard” lockdown for these without a “blue paper” certificate) created frustration, fear, and opposition. The logistics required the involvement of healthcare workers, assistants, and the military; 12 hours before the start of the main testing wave, only 60 percent of the necessary posts

Table 1. Anti-pandemic policies and their potential health outcomes in selected countries

	Czechia	Russia	Slovakia
	Spring wave of COVID-19		
Timing of policy reactions	Very fast	Very fast for first wave of infection from China; some delay for the wave from Europe	Very fast
Scale of policy reactions	Fully comprehensive	Very comprehensive	Fully comprehensive
Compliance level	High	Moderate to high	High
Number of newly infected cases	Small	Moderate	Very small
	Late summer–winter wave of COVID-19		
Timing of policy reactions	Very delayed	Delayed	Very delayed
Scale of policy reactions	Limited and chaotic	Limited	Limited and chaotic
Compliance level	Low	Moderate	Low
Number of newly infected cases	Extremely high	Moderate to high	Extremely high

Figure 1. Relative numbers of newly infected cases – illustrative curves



had been filled. The crowded testing was connected with the risk of infection at testing sites, as hundreds of people lined up for hours, especially in the bigger cities on the first day of the nationwide testing. The direct costs of testing are estimated at more than €100 million; the varying social costs should be much higher.

The prime minister maintained that the testing was extremely successful and served as a “nuclear weapon” against the spread of COVID-19. However, most medical experts have a different opinion, arguing that the reliability of antigen tests is rather limited; existing experiments indicate these tests have a 50–70 percent success rate for identifying positive cases in asymptomatic people. For Slovakia, this would mean that after the blanket antigen testing, up to 50,000 infected cases received a “blue paper” certificate, granting them the option to behave as healthy people and not to comply with social distancing measures. The blanket testing did not stop the pandemic spread and its impact on the incidence curve was brief: the number of newly infected cases went slightly down for a few days after testing but returned to pre-testing figures soon after. It seems highly probable that compulsory mass testing, if not accompanied by other social distancing measures, cannot deliver much beyond extreme social and economic costs.

Conclusions

This multiple case study analyzed public policy responses to the COVID-19 pandemic in three selected countries – Czechia, Russia, and Slovakia – using morbidity rates as the indicator of the success of such policies. Its main added value is connected with two elements.

The first element was that the collected data confirm, on a specific sample, the international experience that the timing of anti-pandemic responses and the level of success in creating an atmosphere of compliance in society play important roles in

limiting the pandemic spread. We provide examples of countries that did not differ greatly in terms of the scope and scale of responses in the spring, but achieved different anti-pandemic results, probably because the timing of their public policy responses and their success in promoting compliance were different. A specific feature of our sample is that “democratic” countries (Czechia and Slovakia) were more successful in the spring phase than the more authoritarian regime in Russia. This element would call for additional research.

The second element was that we briefly evaluated the innovative Slovak experiment of blanket testing of the population using antigen tests. The question of whether the benefits from such an enterprise outweigh the costs cannot be definitely answered, but the collected data suggest that such blanket testing with antigen tests should not be a single and independent policy tool to combat the pandemic.

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References

- Ang, Y. Y., 2020, When COVID-19 meets centralized, personalized power. *Nature Human Behaviour*, **4**(5), pp. 445–447. doi:10.1038/s41562-020-0872-3.
- Christensen, T. and Lægreid, P., 2020, Balancing governance capacity and legitimacy: How the Norwegian government handled the COVID-19 crisis as a high performer. *Public Administration Review*, **80**(5), pp. 774–779. doi:10.1111/puar.13241
- Hudson, J. and Kühner, S., 2017, Qualitative comparative analysis and applied public policy analysis: New applications of innovative methods. *Policy and Society*, **32**(4), pp. 279–287. doi:10.1016/j.polsoc.2013.10.001
- Liu, Y. and Saltman, R. B., 2020, Policy lessons from early reactions to the COVID-19 virus in China. *American Journal of Public Health*, **110**(8), pp. 1145–1148. doi:10.2105/AJPH.2020.305732
- Nicola, M., O’Neill, N., Sohrabi, C., Khan, M., Agha, M., and Aghae, R., 2020, Evidence based management guideline for the COVID-19 pandemic - Review article. *International Journal of Surgery*, **77**, pp. 206–216. doi:10.1016/j.ijssu.2020.04.001