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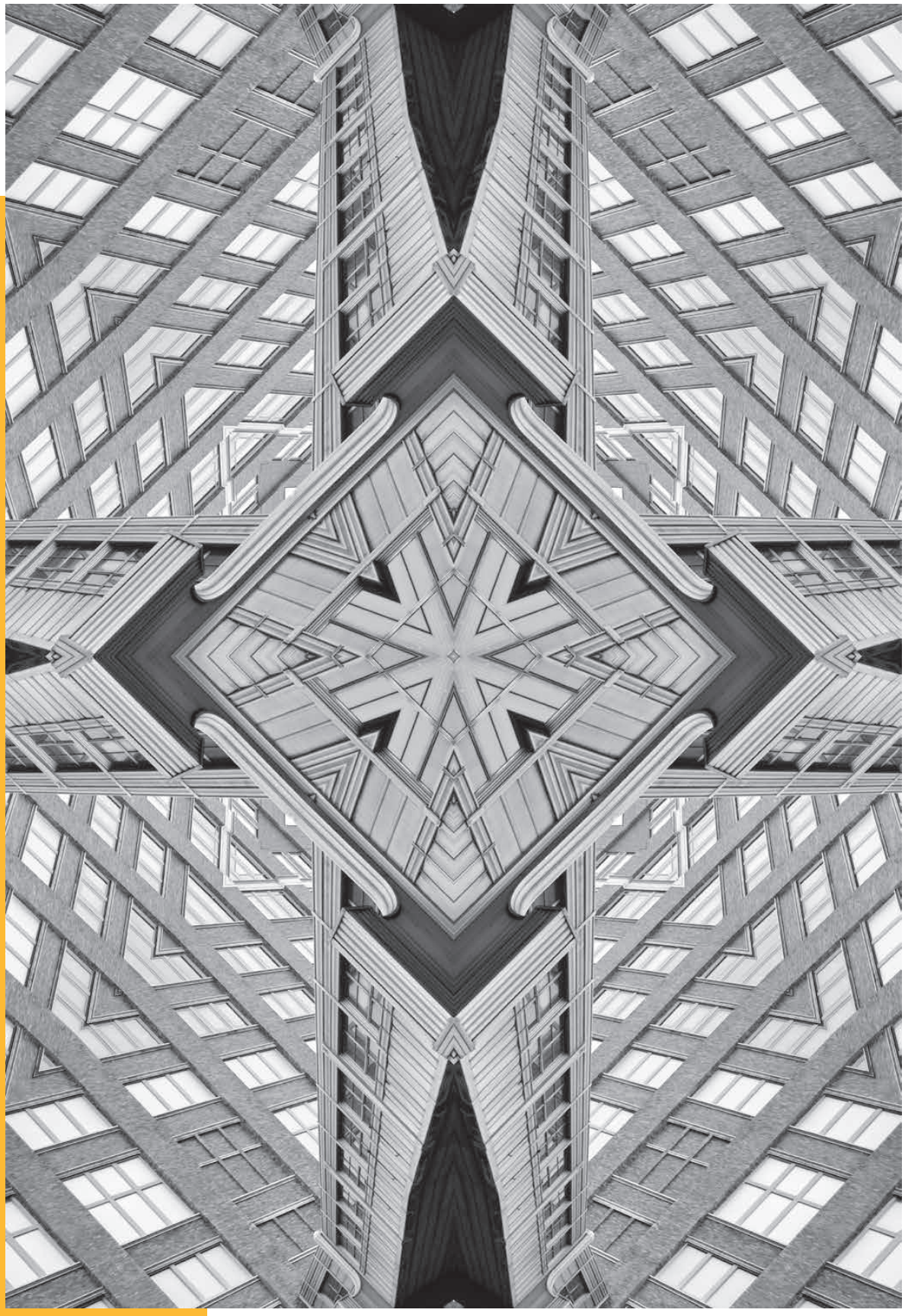

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Leadership Challenges and the COVID-19 Pandemic

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Abstract

The paper examines the role of political leaders, public and private agents (governments, private agencies, NGOs), and followers (public, citizens, community) in the war on COVID-19. It argues that the role of *agents* and *followers* is often underestimated; that while the *leaders'* contributions are important and *necessary*, they are not *sufficient*. The success or failure of leaders will depend as much on these actors as on their own competence, commitment, and sense of responsibility. This paper proposes and tests an integrated framework based on institutional theory developed by Nobel laureate in Economics, Douglass North, by reviewing the actions of selected leaders during the first year of the pandemic. The analysis shows that a health crisis does not always lead to a leadership crisis, evident in the instances of successes in countries such as New Zealand, South Korea, and Vietnam.

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Introduction

During the initial onslaught of the COVID-19 pandemic, most political leaders were in denial of its severity, despite likening it to a war. Their rhetoric was not followed by adequate policy actions, leading many scholars to observe a leadership crisis within a health crisis.[1] At the same time, however, there were leaders who were pragmatic and modest, and took the severity of the disease seriously. They acted quickly and communicated adequately with the public. Consequently, they succeeded to some degree in controlling the spread of the virus, achieving an unusual synergy with agents and followers.

This paper discusses three approaches to understanding leadership and assessing their success or failure in the fight against COVID-19: i) analysing traits and styles; ii) using an institutional approach focusing on human behaviour and choices; and iii) using a war analogy for the health pandemic.

The first, which views the nature and performance of leaders in terms of their character, personality, traits and style, is the most common. There is no dearth of studies on leadership in governments and organisations, but most focus narrowly on traits. However, such conventional approaches are inadequate as they underestimate the importance of the role of institutions, organisations, agents and followers.

This paper proposes an integrated institutional 'leaders-agents-followers' framework as a comprehensive tool for assessing the successes and failures of a leader.

> "This paper outlines three approaches to understanding leadership in the time of crises."

A Traits-based Approach

There are several variants of the leadership debate, based essentially on the traits and characteristics of a leader. One observer associates it with different phases: first phase refers to the *traits* of a leader, the second to *styles* of leadership, the third to a '*contingency*' approach, which distinguishes between *people-oriented* and *task-oriented* leaders. Studies have also been conducted on "charismatic and transformational" leadership.[2] Moreover, the success of many female political leaders in managing COVID-19 has now started a *gender-based* leadership debate.[3]

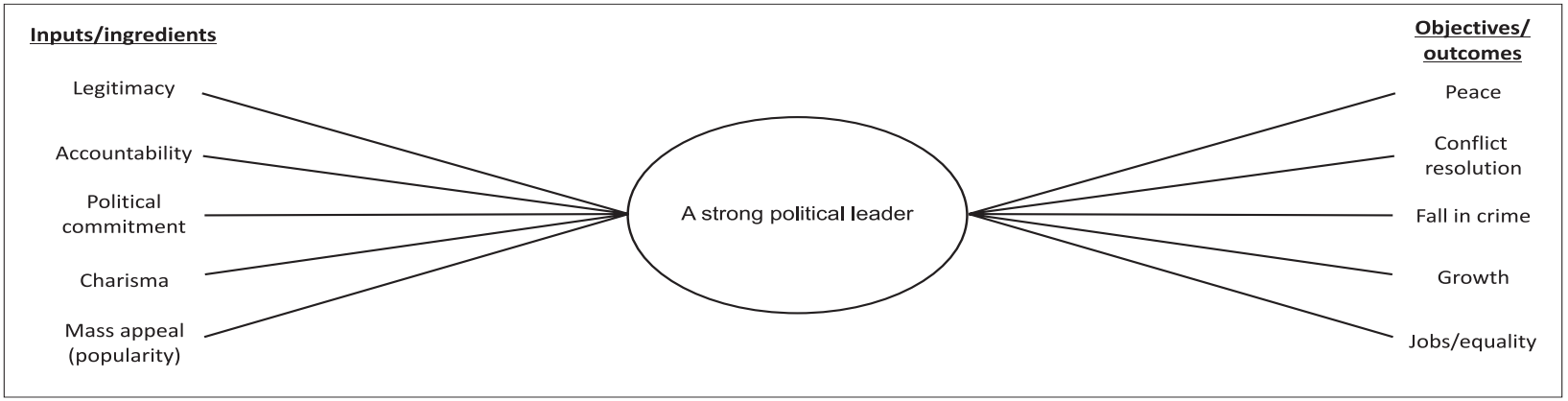
Based on the personality and characteristics of a leader (See Figure 1), it is observed that the criteria for a leader's success can be either input-oriented or output-oriented, or both. The necessary ingredients of a strong/good leader often include legitimacy, accountability, political commitment. They may also include personal traits or attributes such as charisma, popularity, experience, and communication skills, which can help a leader generate soft power to win followers. Figure 1 presents a list of objectives or outcomes, such as growth and equity, based on which a leader's successes or failures may be judged. In the context of COVID-19, healthcare and human welfare must be added to the economic and social objectives.

However, these traits and characteristics, while *necessary*, are not *sufficient* to determine outcomes. The impact of leaders and their success or failure may depend far more on the interventions and responses of government agents, civil servants and local administration; followers; and the external environment, over which a leader may have no control. Nevertheless, a central leader has both the power and the authority to provide incentives for agents and followers to work in harmony. Moreover, in addition to formal institutions, there is non-state *informal* capacity enshrined in community and civil-society groups.

> "The characteristics of a strong leader include legitimacy, accountability, and political commitment."

Evaluating Leadership: Three Approaches

Figure 1:
Characteristics of a Strong Political Leader



Source: A.S.Bhalla, Asia's Trouble Spots: the Leadership Question in Conflict Resolution *(London: Rowman & Littlefield International, 2019), p. 18*

Institutional and Behavioural Approach

Douglass North distinguishes between institutions and organisations, and between rules and players, in developing a theory of institutions.[4] An institution, according to North, is intended to reduce uncertainty by offering a stable structure to the interactions between agents and followers and by reducing the (information) cost of transactions. However, these institutions can be either efficient or dysfunctional. Moreover, there are other formal and informal constraints in ensuring the *certainty* and *stability* of institutions. Formal constraints may relate to political pressures and interference for narrow partisan interests, which contradict welfare goals, such as the protection of society and citizens. Partisan and political pressures can take several forms: for example, political, executive, and judicial or fiscal decisions that widen the divergence between private and social goals; tampering with the conclusions of scientific agents; political appointments to technical departments; and cutting of funds for the opposition. Additionally, there may be informal societal constraints such as culture, codes of conduct, and social mores that cannot be changed overnight through financial or physical incentives, unlike formal constraints.

North's main concern was to explain differences in economic growth across countries through the performance of institutions and public and private agents, inefficiencies of political markets due to high transaction costs, and perceptions of risk and uncertainty among individual participants in these markets. His institutional approach is based on the foundations of individual choices and human behaviour. In theory, widespread competition should weed out inefficient firms, agents or institutions, and reward efficient ones with a proven record of problem-solving and working for the common good.[5] In practice, however, neither the competition nor the market/price incentives can correct distortions. This, combined with conflicts between leaders, institutions and followers, result in the coexistence of efficient and dysfunctional institutions. North explains this mismatch as a result of the interaction between organisations and institutions, which can determine the shape of institutional change—either incremental or discontinuous. Organisations evolve based on the incentive structure created by institutions. Inefficiencies occur when both political and economic markets function poorly, which raises transaction costs.

> "Leaders can be evaluated based on either personal traits or the institutions they oversee."

North's emphasis on distortions in the enforcement of rules is also relevant to the limitations to the control of the COVID-19 pandemic. He notes, "The development of credible commitment on the part of political bodies, such that one has assurances that political bodies will not violate contracts of parties or engage in conditions that will alter radically the wealth and incomes of parties, is always relative."[6] North argues that even in the most advanced countries, political bodies (political leaders and enforcement agents) often violate contracts, guided by their narrow self-interest, which makes enforcement costly. The state and its agents use coercive force to protect their interests at the expense of those of society and its people.

The War Analogy

Many world leaders, notably, those from China, France, India, the UK and the US, as well as the UN Secretary-General have likened the COVID-19 health crisis to fighting a war, in an attempt to underline the gravity of the situation. This "war analogy" has been useful in tackling the current pandemic, since some of the essential aspects are common to both, e.g. advanced planning and preparedness, developing an early warning system, central and coordinated command, logistics, minimising collateral damage, and enforcing discipline and boosting morale, and public support. In wars, the dependence on external sources for supplies can be fatal. This holds true for the current pandemic as well, as most countries have found out. Germany, China and South Korea became the few nations that produced adequate numbers of essential medical supplies such as masks, testing kits and ventilators, while most Western countries saw a shortage due to underproduction, presumably because it is not profitable to manufacture these products.

> "In a pandemic as in a war, advanced planning and preparedness is key."

Formulating an Integrated Framework for Understanding Leadership

The different approaches to leadership discussed in this paper are not necessarily mutually exclusive. Indeed, a leader's behaviour and performance will be influenced by their *traits* and *style* of leadership, by the *context and environment*, and by the interactions with public and private agents as well as with *citizens and society* at large. The war analogy, too, provides useful indicators for assessing an individual leader's performance in coping with COVID-19. However, an essential aspect is missing in these approaches, i.e. the behaviour of and interactions between the three critical players: leaders, agents, and followers.

Leaders

In crisis situations, strong and decisive leadership is crucial for time-critical decision-making. During the COVID-19 pandemic, the virus has affected different places at different time phases and waves, without any warning or notice. Moreover, it is a crisis that needs to be fought both within a country and globally. The situation has been likened to a forest fire, which can be put out in some places but not in others, where it may keep burning as long as there is wood.

In such a situation, the main aim of political leaders has been to provide for advanced planning and preparation as well as central design and strategy for taking necessary action. Further, the leadership has to undertake a coordinating role for crisis management, which is especially essential in large federal systems. Unless state and local leaders receive clear overall guidelines and objectives, optimal and timely mobilisation of medical and health manpower and other resources cannot be achieved. Fighting a pandemic requires containing and suppressing infections until the relevant vaccines and drugs become available. This must be done in a manner that minimises human casualties and limits the impact on economic activity. Thus, it is important to define a clear objective, from which a strategy and course of action can emerge.

Other leadership tasks during a health pandemic include making decisions to offer incentives and disincentives to different public and private agents as well as followers to ensure that their actions are coordinated and geared towards achieving common objectives. Furthermore, leaders must formulate common rules and develop suitable institutional structures and machinery for their implementation and compliance. These rules are formulated through bargaining between different parties (trade unions, private sector lobbyists, contractors). Consequently, they may reflect vested interests of special groups—designed to restrict entry, curb competition, and raise transaction costs. Since markets are imperfect, rules and institutions can often be a mixed bag—some efficient, with lower transaction costs; while others inefficient, with higher costs.

Agents

A public health crisis requires public and private agents across disciplines (e.g. industry, economy, health departments) to work together in implementing common objectives, strategies, and plans of action to prepare and disseminate public health guidelines, mobilise and deploy medical and health personnel, and supply equipment and PPEs where they are most needed. Treasury and economic ministries must weigh the costs and benefits of public health measures and economic and social relief measures, which are crucial for alleviating the negative impact of the prolonged lockdowns that were put in place to control the virus. Private industry and drug and vaccine developers must contribute to the timely development of cures through basic research as well as massive investments in uncertain and risky ventures that offer little profitability. Moreover, governments may need to provide risk insurance through public investment to reduce the associated risks.

In this process, it is likely for different agents to come into conflict. Some may pursue their own interests, whereas others may aim at social/public good. A committed leader must be able to reconcile such conflicting objectives and persuade agents and followers to fall in line. However, few national political leaders have such powers of persuasion or charisma, moral stature, and commitment. (To be sure, some leaders might even add to the problem by pursuing their own agenda.) Despite a leader's attempts at reconciling such conflicts, some agents may be strong or smart enough to continue to pursue their narrow self-interests. In such a situation, the leader can punish the dissidents and rule by pitting agents against each other. However, if the agents are powerful, they may bypass the leader to mobilise followers for a common cause, to fight the pandemic.

> "How does a leader reconcile the agendas of public and private agents, and those of the public, in the war against the pandemic?"

Followers

The behavioural responses of all three players are important in determining outcomes. The behaviour and motivation of each player is influenced by a host of factors such as self-interest or altruism, blind faith in traditions, religious and political orientation, and trust (or lack of it) in government and institutions. Above all, their actions are driven by the state of social capital and social cohesion. In this context, the three elements of social capital are relevant: (1) the level of trustworthiness and the social environment that determine obligations and expectations arising from relations between individuals, between them and the state and society; (2) channels of information; and (3) social norms, moral codes and institutions and organisations that regulate social relations. Social obligations provide security and insurance against the risk and uncertainty created by the COVID-19 pandemic. Formal and informal channels of communication reduce transaction costs. Trust and social networks play an important part in the formation of social capital.[7] In societies suffering from a low degree of social cohesion, individual behaviour is less likely to change for public health compared to more cohesive societies, where community spirit is widespread.

> "Addressing public health crises requires social cohesion and strong community spirit."

Collective and synchronised action is required on the part of all players – public health officials, medical professionals, political leaders at state and local levels, national and state-level bureaucrats, industry leaders that control the production of medicines and medical equipment, and the public. While it is difficult to achieve unity within this wide range of players, countries that have succeeded in doing so, e.g. South Korea and New Zealand, have managed to control the virus in a remarkably short time.

Human beings often make decisions based on the above factors and the perceived risk of COVID-19 and the health hazards associated with it. However, since several aspects of information about the virus are still unknown, people's responses are based on the information at their disposal, obtained mainly through the press and social media, in addition to what the public agents, political leaders, scientists, public health officials and medical specialists convey. Thus, followers' confidence and trust (or lack thereof) in their leaders and public and private agents is crucial in determining the outcome of public perceptions about the risk of COVID-19. There is a two-way relationship between leadership and

public trust. Effective leaders (and governments) can inspire the public's trust and confidence. In turn, the public's confidence in leaders and governments can ensure greater compliance with rules.

A 2020 study suggests a direct link between risk perception and human behaviour for its mitigation.[8] Risk perception is influenced by socio-demographic factors (e.g. gender, age, ethnicity); education and experience; socioeconomic variables (e.g. income, jobs, economic inequalities); and political environment. Thus, the risk mitigation behaviour of followers will vary based on a combination of these factors. Some have greater foresight and empathy for others; some will be motivated and guided by the past and current best practices; some may act based purely on instinct, or by trial and error; many will simply imitate others. Consequently, individual and collective behaviour will not naturally converge. To ensure convergence, which is essential for achieving a desired objective, nations must rely on the enforcement of rules and public guidelines.

Relations between Key Players

The three groups—leaders, agents, followers—can be cohesive if they are bound by a common purpose to achieve a common goal. Equally, they may be at cross-purposes. For example, agents such as public bodies are designed to be apolitical to achieve social objectives, whereas private agents may be guided more by self-interest and profit-maximisation. Thus, the vested interests of agents and their strong bargaining skills, besides political partisanship, can create imperfections and hinder the achievement of objectives for health and human welfare.

Unsuccessful leaders will fail to provide sufficient incentives to agents and followers to act in unison. They may be selfish, self-centred, incompetent, or blinded by hubris to grasp the gravity of the situation. On the other hand, a successful leader with empathy, charisma, and dedication (in addition to proper scientific understanding, which is essential in a pandemic), will be able to ensure agents' and followers' trust and compliance with rules.

In the context of interactions between leaders, agents and followers, three situations can be postulated, which will determine the nature of outcomes:

1. **Full consensus amongst the three players**. This is a precondition for an optimal outcome of success.
2. **Two out of three players in sync**. Here, the outcome might be indeterminate and ambiguous—a case of partial success or failure.
3. **Complete lack of unity among all three players**. This will lead to a negative outcome—a failure to contain and control the virus.

Formulating an Integrated Framework for Understanding Leadership

Table 1 shows that success and failure in controlling the pandemic depends more on the combined and synergic response of leaders, agents, and followers—not on enlightened leadership alone. While a leader's charisma, pragmatism and commitment are important in leading the way, the actions of public and private agents in planning and preparations, mobilisation and deployment of medical and health resources, and enforcement of rules are equally important. Finally, followers' behaviour—trust and confidence in leaders and agents and self-discipline and acceptance of rules—are significant factors in achieving successful outcomes in terms of low deaths per capita and infection rates.

> "Effective leaders inspire public trust; the public's confidence in turn ensures compliance with rules."

Having outlined a framework, the paper will illustrate its validity based on clusters of success and failure. In quantitative terms, success may be measured in terms of low cases and fewer deaths per capita (See Table 2). Since there are wide variations in rates of testing across countries, mortality rate is a better measure than case rate for inter-country comparisons. The table shows that high deaths per capita appear mostly in the West and low deaths per capita in Southeast and East Asia. In Table 2, Belgium is an outlier since it uses a much broader approach to and definition of COVID-19 deaths compared to those in other countries.

Table 1: A Matrix of an Integrated Framework

Roles and outcomes	Success	Partial success	Failure
Leaders			
Planning & preparedness	Excellent	Moderate	Poor
Strategy design and formulation	Good	Reasonable	Non-existent
Communications, information	Excellent	Moderate	Poor
Agents			
Implementation, rule enforcement	Excellent	Good	Poor
Resource mobilisation	Excellent	Good	Poor or nil
Followers			
Trust and confidence in leaders/governments	High	Medium	Low
Discipline	High	Medium	Low
Social solidarity	Good	Moderate	Low
Relations between Players	Cooperation	Competition	Conflict
Outcomes			
Deaths per capita	Low	Moderate	High
Cases per capita	Low	Moderate	High

Testing the Framework

Three types of clusters emerge:

1. **Failure:** *Conflict* or *competition* between leaders, agents and followers; lack of preparedness, poor mobilisation of medical resources; low public trust in leaders and governments; and a politicisation of the pandemic.

2. **Partial Success**: *Limited cooperation* between only two out of the three key players; good resource mobilisation; and moderate public trust and confidence in government measures.

3. **Success:** Full cooperation between leaders, agents and followers; excellent resource mobilisation, effective communication with the public; and a high degree of trust and confidence in leaders and the government.

The validity of the above integrated framework is discussed in the following paragraphs, using six brief cases of (1) failures (US, UK); (2) partial success (Japan); and (3) success (Vietnam, New Zealand and South Korea).

> "Success or failure in controlling the pandemic depends on the combined response of leaders, agents, and followers."

Table 2:
Deaths in the First and Second waves in Western countries and Asia *(numbers per million)*

Region/ country	1st wave (2 July 2020)		2nd wave (4 Jan. 2021)	
	Deaths per capita	*Cases per capita*	*Deaths per capita*	*Cases per capita*
Europe & North America				
Belgium	887	5,591	1,767	59,092
Italy	580	4,013	1,255	36,104
United Kingdom	666	4,773	1,138	41,236
Czech Republic	30	1,095	1,097	67,883
Spain	603	5,312	1,078	41,027
United States	391	8,215	1,075	63,150
France	459	3,123	1,002	41,738
Hungary	59	416	998	32,885
Sweden	537	6,969	873	43,738
Poland	39	915	767	34,814
Portugal	158	4,245	720	43,162
Austria	78	1,986	706	40,823
Netherlands	361	2,269	692	49,368
Greece	17	312	455	12,775
Ireland	348	5,308	452	20,377
Canada	234	2,872	429	16,478
Germany	108	2,360	419	21,613
Russia	66	4,570	407	22,565
Denmark	104	2,240	231	28,573
Finland	59	1,315	112	7,384
Norway	50	1,779	87	10,207
Asia				
Iran	133	2,807	677	15,238
India	13	443	109	7,570
Australia	4	320	36	1,140
Japan	8	149	27	1,973
South Korea	5	248	19	1,236
Singapore	6	11,030	7	14,680
New Zealand	4	306	5	436
China	3	61	3.4	69
Thailand	0.9	49	1	130
Vietnam	0	4	0.4	16

Sources: *Johns Hopkins University data* for cases and deaths; *UN and World Bank data* for population.

Note: Countries are ranked in the two groups in a descending order, according to the number of deaths per capita during the second wave of the pandemic.

1. Cases of Failure

United States

In the context of COVID-19, the United States is a case of failure, wherein the leaders (at central, state and local levels), agents, and followers were uncoordinated. Former President Donald Trump failed in crisis management, accountability, and providing accurate information on the virus. The agents did not manage to enforce public health guidelines and restrictions. Finally, confused by mixed messages, the followers ignored public health guidelines about masks, testing and tracing, staying at home, and social distancing. Consequently, the US recorded one of the worst mortality rates in the world.

The abject leadership failure in the US was partially compensated by voluntary and independent initiatives by several non-governmental agents such as universities, the National Domestic Workers Alliance, and many business leaders and charity organisations. Overall, however, the US—the richest and most advanced country in the world, with the highest expenditures on health and the greatest concentration of scientific and medical talent—has utterly failed to control the pandemic.

Leader

"We have it totally under control. It's going to be just fine."

–Donald J. Trump, 22 January 2020

"The federal government is not supposed to be out there buying vast amounts of items and shipping, you know we are not a shipping clerk."

–Donald J. Trump, 12 March 2020

A cursory look at Trump's statements during the pandemic show that he downplayed the gravity of the situation. His character and leadership style is of an autocratic, self-centred populist, whose actions were more personality-driven than strategy-driven. He claimed to be a war-time president, yet failed to act like one to unite the country.[9] Instead, Trump's statements and actions divided states, governors and citizens; trivialised the severity of the virus; spread misinformation and conspiracy theories; ignored experts; and failed to build public trust and confidence.

Trump called supporters to organise mass protests to "liberate" states (run by Democrat governors) from stay-at-home orders. His own campaign rallies,

where few kept physical distance or wore masks, became super-spreader events. It took nine days for Trump to ban travellers from China coming into the US. However, the action was likely rendered ineffective since Americans and the British were exempted from this ban. In a *New York Times* article on 27 May 2020, Carl Zimmer cites a study that concluded that the virus arrived in the US two weeks *after* the ban was imposed on 2 February 2020. Interestingly, as far back as January, Trump's own advisers within the White House had warned him of the devastating impact of COVID-19. Additionally, Bill Gates recommended a nationwide lockdown.[10] The president not only ignored such counsel but, to make matters worse, also made dangerous statements recommending unproven drugs and the use of cleaning products against the virus.[11]

Under the Trump administration, a COVID-19 Task Force was established. However, since its leadership changed frequently, the body lacked continuity, which is essential for planned action and enforcement. Moreover, important agents such as the Food and Drug Administration (FDA), Federal Emergency Management Agency (FEMA), or the Health and Human Resources Department (HHR) were not given any incentives to work closely with the Task Force, and the Centres for Disease Control and Prevention (CDC) was actively excluded from the Task Force.

The President's actions—mixed messaging, open scepticism about scientists and health experts, promoting competition between the US administration and state governors (especially those from the Democratic Party)—accentuated coordination issues and made the enforcement of rules and guidelines difficult, if not impossible. Consequently, leaders at the province and local levels (state governors and mayors) too performed below expectations. Overall, states run by Democratic governors treated the threat of the virus more seriously. Cuomo, the Democratic governor of New York, rose to the occasion, unlike the president, despite his initial lack of preparation. Understandably, he had an approval rating of over 80%.

Agents

Government departments and private agents failed to mobilise medical/health manpower and other resources in time. State governors, mayors, and medical and nursing staff registered complaints about the lack of all types of critical medical supplies, for which they had to compete with FEMA. One year into the pandemic, Trump continued to oppose mass testing, for fear that it might make the country look bad. Personal and protective equipment (PPEs) for healthcare workers remained in short supply, and masks could not be obtained. The testing facilities (including new drive-in stations) were set up too late and were inadequate for testing in larger numbers. An article on why the US testing

efforts failed concludes that the challenge required "highly efficient government leadership … such leadership did not appear to exist."[12]

The HHR performed below expectations, despite ample resources and a large staff at its disposal. Globally, the US spends 17 percent of GDP on health, which is higher than the health expenditure of any other country. Yet, it has been one of the worst performers in the fight against COVID-19. Its healthcare systems and services are inefficient, uncoordinated and inequitable. The poorer sections of society, especially, African Americans, have little access to private health insurance. Many who lost their jobs during the pandemic also lost their employer-based health insurances. Stiglitz, Nobel laureate in Economics, observes, "America's private health insurance system is far more costly with far poorer results from public programs in Europe."[13] Similarly, Horton, Editor-in-Chief of the *Lancet* journal, notes that despite Trump's attempt to blame the World Health Organization and China for the havoc wreaked by COVID-19 on American society, "it was lack of readiness of the US public health care system that played a more important part." [14]

Hitherto renowned public institutions (e.g. CDC and FDA) failed to perform due to political interference. The CDC could not trace passengers returning from China due to an outdated data-reporting system, continuous cuts in funding and staff, poor and irregular communication with the public and the states, unwillingness to learn from known best practices, and complicity in yielding to unscientific theories promoted by the president. Under pressure, it withdrew its guidelines (albeit temporarily) on testing, wearing of masks and social distancing. Further, it failed to communicate regularly with the states and the public about COVID-19.

To its credit, the US administration and private vaccine developers (Operation Warp Speed) succeeded in quickly developing vaccines. However, the country failed to invest adequately in setting up the right infrastructure for their distribution and delivery. Consequently, logistical difficulties have resulted in a slow rate of vaccination, well below the target of 20 million persons as of the end of 2020.

Followers

Amidst a highly charged polarised environment, American public's compliance with public health restrictions has been poor. In March 2020, the response of Trump supporters was muted even in states that had introduced such measures as school closures and social distancing.[15] For the African American community, the prolonged lack of access to healthcare has fostered a mistrust of the government and the medical establishment. Moreover, the speed with which

the vaccines were developed have now sown some doubt amongst the public regarding their safety and efficacy. According to a Pew Research Report, fewer African Americans are willing to get vaccinated compared to Whites, Hispanics and Asian Americans.[16] A nationwide poll conducted by the Kaiser Family Foundation (August–September 2020) showed that two-thirds of the respondents believed that the vaccine development was rushed for political reasons.

To conclude, lack of 'soft power', that is, good governance, crisis management and effective coordination, is one of the major reasons why the US has failed to control Covid-19 despite its strong economic power, highest health expenditure and the greatest concentration of scientific and medical talent.

United Kingdom

The UK's experience is similar to that of the US in that both the leader and public agents showed incompetence, rendering the public unable to trust them. However, it is different from the case of US insofar as the government eventually relied adequately on scientists and health experts.

Leader

> *"Britain would soon send coronavirus packing… an option is not to close schools or sporting events but to take it on the chin, take it all in one go and allow the disease as it were, to move through the population."*
>
> –Boris Johnson, 5 March 2020

The above statement by the UK prime minister shows lack of urgency or seriousness of purpose. Like Trump, he initially downplayed the virus and spread misinformation. When other European leaders were shutting down non-essential businesses, schools and universities, Johnson carried on with business as usual. He listened to a narrow group of epidemiologists and modellers, 'insiders' in the Scientific Advisory Group for Emergency (SAGE). Public health experts and behavioural scientists were left out. The insiders' advice was kept secret from "outsiders … to escape scrutiny," as noted by a former president of the Royal Society.[a] Frequent U-turns ruined Johnson's credibility with local governments (e.g. Manchester whose mayor defied the government's lockdowns). Moreover, the failure to consult local governments and the four nations (England, Wales, Scotland and Northern Ireland) resulted in poor enforcement of rules.

a The lack of agreement amongst scientists may have further encouraged Johnson to ignore advice or become complacent.

Johnson has been widely criticised by the press, distinguished scientists, and two parliamentary inquiries for leadership failure. He missed five meetings of SAGE and was nicknamed a "part-time prime minister" who was "missing in action." He failed to gain the trust of agents and followers alike, despite his generally appreciated communicative skills. His approval rating for handling the crisis had a free fall, from 40 percent in May 2020 to minus six percent in July.[17] An increasing number of people believed that the Labour Opposition leader would make a more competent prime minister than Johnson.

Agents

The UK government relied on a highly centralised National Health Service (NHS) and specific technical task forces, including a group of scientific advisers to fight COVID-19. Public Health England insisted on testing to be done in its central laboratory, which led to long delays. Despite the ample testing capacity across the country, it could not be utilised due to turf wars and bureaucratic infighting. Samples had to be sent to Italy and Germany for processing. Under attack for slow testing, the government gave over-inflated estimates of testing kits and failed to communicate the difficulties—reflecting a tendency to hide bad news, even in democracies. Eventually, testing and tracing was discarded too quickly during the early phase of the pandemic. Moreover, the government failed to mobilise local capacity and resources of communities. It neglected care homes in which elderly residents were particularly vulnerable and liable to COVID-19 infection.

The NHS failed to provide clear central guidance or adequate number of PPEs to healthcare staff in the early months. Inability to source sufficient protective equipment for the NHS staff was partly due to the government missing several opportunities to participate in a European Union bulk-buying scheme. Its remote online consultations for primary care may have worsened pre-existing health inequalities, since some patients are not computer-literate, not English-speaking, or suffer from hearing impairment.[18] A decade of budget cuts for the NHS under government's austerity policy had already resulted in thousands of nursing vacancies. Even before the pandemic, the NHS staff was under stress, absenteeism was serious, and turnover had reached alarming proportions. The Institute of Public Policy Research believes that the NHS is fragmented and cannot adapt to cope with such pandemics.[19]

In the midst of propaganda, conspiracy theories and fake news, it is the responsibility of the public agents to provide regular and accurate information. However, as one author observes, "Government misinformation was a frequent occurrence during the British pandemic."[20] Communications were often vague and contradictory, instead of being clear and transparent. Inconsistent

messaging "resulted from a mixture of conflictual relationships at different governance levels…"[21]

Followers

The government's lack of transparency, accountability and failure to communicate led the people to rely more on news media, and their own knowledge and personal experience.[22] In the first wave of the pandemic, the public showed considerable interest about the virus, according to several surveys.[23] A YouGov COVID-19 tracker poll of 22 countries [24] found that the UK sample (by 29 May 2020) ranked it at the bottom of the table with regard to how people thought the government was managing the pandemic.[b] The initial public trust in the government declined rapidly as the pandemic developed and cases and deaths started soaring. Eventually, when Johnson decided to do course-correction and announced stay-at-home and social distancing measures, the public initially did not heed his call. Thus, the prime minister's frequent U-turns further eroded public confidence.

> "The US failed to control Covid-19 for reasons including lack of soft power: good governance, crisis management, effective coordination."

Few people in the UK self-isolated, which is explained partly by the failure of the government to compensate them for the negative financial and psychological impact of self-isolation. The unwillingness was particularly marked amongst young adults. However, there was some willingness to observe social distancing. The lack of proper healthcare precautions rightly contributed to scepticism amongst parents about sending their children back to schools. Moreover, parents with very young children could not return to work in the absence of adequate child-care facilities. Similarly, socially disadvantaged groups (e.g. ethnic minorities) were unable to practice self-isolation for financial reasons. Structural inequalities, which reduce social solidarity, compliance, and government legitimacy, have led to calls for protective measures (mental health support, for example) and additional financial aid to disadvantaged groups.[25]

b People had already started losing confidence in the UK government after three years of infighting over Brexit.

The failure of the government to consult nations, local governments, and the people led to public defiance and low compliance. Public mistrust was further fuelled when Johnson and his advisers (Cummings and Ferguson) flouted social distancing and lockdown rules but demanded the public to comply.[26] The failure of leaders and agents notwithstanding, nearly one million youth volunteered to work for the NHS to fight the COVID-19 pandemic and mutual good-neighbour organisations were set up to keep volunteers in contact through social media. A 100-year-old World War-II veteran raised over £35 million for the NHS by walking in his garden.

2. Case of Partial Success

Japan

Japan offers an interesting example of the combination of poor leadership, efficient performance of the health department and rule enforcement, and full public compliance. The lowest mortality rate in the G7 was achieved without strict lockdowns and mass testing.

Leader

> *"Frankly, it isn't possible to conquer this fight with only the Government's power. We are aware that we are causing trouble for the Japanese people but we also humbly ask for cooperation from each and every person."*
>
> —Shinzo Abe, 29 February 2020

Prime Minister Abe's role in containing COVID-19 is minimal, compared to the government's response and that of the citizens. However, since Abe was not as disruptive or divisive as Trump or Bolsonaro (of Brazil), he did not politicise the pandemic or object to the efforts of the agents or followers in controlling the spread of the virus.

In the early months of the pandemic, Abe seemed in denial and slow in ordering necessary public health measures. He insisted on hosting the Olympic Games, presumably for national pride and economic recovery following the Fukuyama disaster. However, two-thirds of the Japanese preferred postponing them for fear of the virus. In a press conference, Abe declared that the virus was under control in the hope that the games would go ahead.

While Abe set up a central scientific task force and an expert panel for COVID-19, he assigned no clear-cut responsibility. A Kobe University academic noted that no one was in charge.[27] Further, Abe had no central strategy or plan of action to cope with the emerging crisis. At the local level, each prefecture adopted its own strategy without any central input.

For the lunar New Year, Abe and his government welcomed Chinese visitors despite knowledge of the virus that had erupted in Wuhan. His popularity took a nosedive although it recovered somewhat when he declared a state of emergency at the end of February 2020, closing schools and quarantining passengers coming from abroad. However, the state of emergency was lifted before long and the economy was reopened. Abe's scheme to send each household two masks backfired. Many masks were either dirty, defective or too small, which were dubbed as "Abenomasks."

Abe's failure to communicate with the public was widely noted. Local leaders such as the governors of Osaka and Tokyo became more popular for their regular TV appearances to urge the citizens to take precautions and adhere to public health guidelines.[28] According to opinion polls, more than half the Japanese population thought that Abe mishandled the response to COVID-19. A former opposition member of parliament believed that "citizens and the private sector were far ahead of the government."[29]

Agents

Despite poor political leadership, Japan managed to control the virus, largely due to the country's efficient and well-funded healthcare systems and services, its scientists, virologists and its public. The Japanese minister in charge of COVID-19 carries a device that monitors the quality of ventilation (carbon dioxide) during his meetings. Fugaku, the world's fastest supercomputer was used to model different scenarios. Japan's public health department and expert panel on COVID-19 adopted public health restrictions and guidelines, albeit belatedly. A cruise ship, the *Diamond Princess*, which arrived in Japan in February 2020, turned out to be a blessing in disguise, in retrospect. A member of the government's expert panel discovered that trained quarantine officers and nurses (who treated patients on the ship) had contracted COVID-19, despite having followed protocols for viruses spreading through droplets. This led him to conclude that infection spreads through the air, which guided him and other scientists to formulate and enforce public health care measures.

The Japanese public health department relied on such targeted restrictions as avoiding closed spaces, crowded places and close-contact settings. Other public health guidelines included avoiding dinner parties with alcoholic drinks,

drinking/eating in groups exceeding four persons, talking without masks, and living in dormitories and other small shared spaces. Despite a disproportionately large elderly population, Japan succeeded because of its robust and well-functioning healthcare system, a number of well-staffed and equipped hospitals, and well-trained contact-tracers. Japan continues to rank high in terms of healthcare readiness, quarantine efficiency and government efficiency.

A resurgence of cases at the end of 2020, which is not peculiar to Japan, can be attributed to a premature normalisation of economic activity; domestic tourism (which is subsidised with meals out, to boost the economy); and the advent of winter, forcing people indoors in crowded spaces.

Followers

The Japanese are known for cleanliness and discipline. Japanese culture (no handshakes or hugs and maintaining physical distance routinely), cleanliness, public discipline, pressure to follow the rules, and a habit of wearing of masks at the slightest sign of even mild infections may largely explain why Japan managed to control COVID-19 cases and deaths. It has a long tradition of social solidarity and respect for central authority, which is also shared by other Southeast countries such as Vietnam and South Korea.

Most Japanese heeded the government's *voluntary* guidelines to stay at home and self-quarantine as soon as symptoms of virus were noticed. Further, the people wore masks and stood in queues to buy essentials, even as many in the US considered mask wearing an assault on personal freedom. Peer pressure and admonitions ensured a high rate of compliance with public health guidelines.

> "Despite unremarkable leadership, Japan controlled the virus owing to efficient healthcare systems, its scientists, and its public."

3. Cases of Success

Vietnam

Vietnam is a communist/socialist government, unlike Japan, the US and the UK—all democracies. Yet, it is amongst the most successful countries in controlling COVID-19 despite being relatively poor with a weak healthcare system. During the first wave, it recorded no COVID-19 deaths for several months. Its death per capita (0.4 per million) remained unchanged during the first and second waves of the pandemic.

Leader

> *"Every business, every citizen, every residential area must be a fortress to prevent the epidemic."*
>
> — Nguyen Xuan Phuc

Vietnam's prime minister was amongst the first to act, since the country shares the border with China and timing was critical. Nguyen Phuc closed the borders and appealed to the population to fight the pandemic as though it was fighting an enemy. He committed his government to sacrifice short-term economic benefits for the protection of public health. He mobilised the entire nation to help Vietnam's healthcare services at different levels of governance/administration. In contrast to the US president, who sowed discord and divisiveness, Nguyen Phuc mobilised a successful people-driven and community-driven campaign to eradicate COVID-19 long before WHO declared it as a pandemic. Cognisant of the nation's weak healthcare system and limited resources, he sent out soldiers, teachers, students and business people to support healthcare workers. His community-based approach raised social solidarity and fostered people's trust and confidence in their leader and the government.

The prime minister set up a Task Force under the chairmanship of the vice-prime minister to fight COVID-19, which coordinated the government's response at all levels of governance. It consisted of 24 members from 23 ministries, committees, press, media and TV representatives. Further, he made daily appearances on TV to give updates on the situation and to explain the rationale behind the restrictive measures. His transparency, political commitment, and consistent and truthful messages to the public are in sharp contrast to the misinformation spread in the UK and the US.

Agents

The government acted promptly and efficiently. After the first case of COVID-19 infection was identified on 23 January 2020, the Emergency Epidemic Prevention Centre was activated the next day, and a pandemic declared on 1 February 2020. One study concludes that "early responses prevented around 35,000 infected cases and 350 deaths from COVID-19."[30]

The government also introduced land-border controls and airport screening to check imports of cases. Other public health measures included quarantining infected patients; social distancing; school closures; cancelling festivals and social events; temperature screening at shopping malls and large buildings; and requisitioning military buildings, university halls and dormitories as quarantine camps, which won public confidence. An example of the government's seriousness was its decision to quarantine a community of 10,000 people near Hanoi after four cases were diagnosed there.[31]

A National Steering Committee, chaired by the vice-prime minister, as well as a committee in each ministry and province was established to ensure quick dissemination of information on instructions, guidelines and implementation. An official website was created as part of information campaigns. Additionally, national media would broadcast daily information on the virus.

A mobile app, NCOVI, was launched to trace high-risk cases. It was made compulsory for people to declare their health status and travel history through the app. Two strategies, namely, (1) "three in advance," i.e. identify, proactively prevent, and plan; and (2) "four on the spot," i.e. onsite resources, onsite leadership, onsite facilities, and onsite logistics, were strictly enforced by the centres of disease control at all levels of administration.[32]

In September 2020, Vietnam was faced with a new outbreak in Da Nang, its biggest city, which attracts millions of tourists every year. This was quickly brought under control through mass testing and tracing. Healthcare workers were sent from Hanoi to assist the local staff. Quick government action and local participation by the people and their communities prevented the virus from spreading to other places. One survey conducted in rural and urban areas concludes that Vietnam has only a moderate level of operational capacity at the grassroots level, which must be strengthened to effectively meet future challenges of a pandemic.[33]

Followers

There was a high degree of public trust and confidence in the prime minister and his government. In a survey of 45 countries, over 62 percent of participants supported the government measures.[34] Vietnamese people accepted intrusive measures such as sharing of health data on an app and compulsory stay-at-home orders as *emergency* measures, essential for public safety. While sceptics view this as the lack of freedom under the socialist regime of Vietnam, similar measures were also accepted in democratic societies of Japan and South Korea.

Social solidarity and responsibility, an important secret of Vietnam's success, was inspired by smart leadership, which invoked patriotism and mobilised people on a war footing to ensure compliance. If frequent curfews are accepted during war, *temporary* restrictions on freedom during a war on the pandemic makes just as much sense.

New Zealand

New Zealand, a small and remote country of only five million, may have benefited from its remoteness, small size, low density of population and a late start, which made learning from others (e. g. China and Italy) possible. However, full cooperation between leaders, agents and followers remains a key reason that the country achieved one of the lowest COVID-19 mortality rates.

Leader

"Go hard and go early, and do everything we can to protect New Zealanders' health."

–Jacinda Arden, 14 March 2020

Young and relatively inexperienced, Prime Minister Jacinda Ardern showed decisive leadership, acted quickly, mobilised people and communities, and accepted expert advice. Her approach and style of leadership was close to that of Nguyen Phuc of Vietnam. She was quick to learn lessons from China and Italy, and imposed early lockdown, recognising that the underfunded healthcare system would not be able to cope with the epidemic if the virus infections were allowed to spread. Her initial strategy of containment and flattening the curve soon culminated into eliminating the virus.

Ardern set a personal example and ordered a 20 percent cut in her salary for six months, along with that of her Cabinet colleagues and public-service CEOs. She involved local communities to solve common problems through regular

sharing of information at daily press conferences, public posters, an official website in 28 languages, and Facebook and other social media.[35]

Moreover, instead of taking the credit for herself, Ardern attributed New Zealand's success in controlling the pandemic to her "team of five million."

Agents

The government set up an Epidemic Response Committee to monitor and evaluate progress and to adapt to changing circumstances. It played an effective coordinating role in providing oversight on the agents participating in the COVID-19 response. It deployed the New Zealand Defence Force to help manage the quarantine and shut out foreign tourists, a costly decision for a country that relies heavily on tourism. A 4-level (highest alert) alert system was introduced to decide when and how much to relax restrictions. Although the country was very successful during the first wave of the pandemic, it could not escape a spike in infections in Auckland in August 2020, following three COVID-free months.[36] However, a timely new lockdown brought the virus under control once again, and prevented it from spreading elsewhere.

Despite the country's eventual success, there were some early lapses, such as the release of two women on compassionate grounds without proper testing; the failure to introduce effective measures of quarantine for international passengers or returning citizens (in the post-lockdown period); and poor security of quarantine hotels. The healthcare system was not well prepared. Although slow in the beginning, testing was stepped up. PPEs were not adequately provided to nurses and healthcare workers. However, proper feedback regarding the shortcomings allowed the Ardern government to step in and commit to spending US$55 million to strengthen healthcare capacity. Gradually, the Ardern government learnt from its mistakes, which were rapidly corrected.

Followers

New Zealand demonstrates how a strong and charismatic leader can change public behaviour to achieve nearly 90 per cent support for the government. According to a Colmar Brunton poll a week after the lockdown, respondents "trust the government to make the right decisions."[37] For the G7, such support was only 59 percent.

New Zealand achieved a high rate of public compliance despite declining personal incomes, business profits and public hardships, and pessimism about a return to normalcy. A key secret of success was frank and regular communications

with the public and businesses, adequate incentives (wage subsidies and financial guarantees for small and medium enterprises), healthy cooperation between public and private sectors, quick adaptation to changing circumstances, and learning lessons from early mistakes.

People trusted Ardern because she empathised with their hardships and set a personal example by taking a cut in her own salary. Trust is built when leaders are willing to follow the rules and enforce them uniformly. For example, unlike Johnson in the UK who defended his political advisers, Arden dismissed the health minister who breached the rules.

South Korea

In South Korea, leadership, agents and followers worked together to manage the pandemic, fuelled perhaps by a similar experience before—that of SARS and MERS. The nationalised health system and the private sector acted quickly, in collaboration and on a war footing. Measures to control COVID-19 were introduced with the full and voluntary cooperation of the followers (the citizens) and responsive public and private agents. Indeed, the ruling party was rewarded a landslide victory in the subsequent elections, for its commendable success in controlling the virus.

Leader

> *"The crisis in Daegu and North Gyeongsang Province reached its peak, and the whole country has entered a war against the infectious disease … All government organizations should switch to 24-hour emergency situation room system … Time is never right for complacency, yet preemptive and transparent quarantine measures combined with the public's voluntary and democratic participation in such efforts are bringing gradual stability."*
>
> —Moon Jae-in, February 2020.

The president's statement shows political and social commitment, which was reinforced by the government agencies. Though initially unprepared and slow to shut the country's borders, Moon Jae-in managed COVID-19 with grit and determination. All government institutions were shifted to a "24-hour emergency situation" after only a few dozen casualties. Moon's crisis management was facilitated by the country's earlier experiences of SARS and MERS outbreaks and the availability of toolkits for mass contact tracing. He signed several presidential decrees to fast-track mass testing and expand the production of medical supplies. Lessons from the failed experience of his

predecessor (Ms Park) to control MERS in 2015 proved helpful. Consequently, Moon understood the need for speedy action based on scientific advice. He gave the highest priority to the pandemic by devoting 36 out of 76 presidential addresses delivered from 30 January to 8 May 2020 exclusively to the subject.[38] Other addresses too included frequent references to COVID-19 and the need for popular participation.

Agents

The South Korean government is known for advanced planning and preparedness. Quarantine facilities and screening measures were in place before the first COVID-19 case was diagnosed. People's movements were restricted, social distancing enforced, and widespread testing undertaken in testing centres, drive-in stations, walk-in centres and public phone booths (where medical professionals were present to swab patients).

The country established a central command under the prime minister, a Central Disaster and Safety Countermeasures Headquarters with two deputies, the Health Minister supported by the Centre for Disease Control, and the Minister of Interior and Safety, whose task, inter alia, is to coordinate central and local governments. A commitment was made to the local authorities to meet any shortages in medical supplies and hospital beds.[c]

The private sector was quickly mobilised to produce medical equipment and supplies, such as testing kits, to meet both domestic and foreign demand. By end of March 2020, South Korea was already producing 100,000 kits a day and testing nearly 300,000 people.[39] Decentralisation of testing facilities reduced the need for mass redeployment of medical resources.

Other reasons for South Korea's success include a coordinated network of public health centres at the district level, which regularly transmit information to the centres for disease control and prevention; timely hiring of epidemiologists to do mass testing; centralised decision-making; and the adoption of intrusive measures (e.g. the use of drones and app, which contained medical data of individuals) to enforce compliance. IT firms (e.g. NAVER) provided servers to encourage the diffusion of information on patients' movements.

As with Vietnam and New Zealand, South Korea had an effective communications system to inform the public about COVID-19. While some vaccine reluctance

c Moreover, each local government in South Korea has its own disaster and safety countermeasures headquarters.

was noted following the sudden deaths after flu vaccination (which turned out to be accidental, and not related to the vaccine), public health officials managed to handle the matter quickly by conducting a transparent investigation and curbing misinformation through effective information campaigns. Despite some political partisanship (during the elections), not only the public but also the country's opposition leaders rallied behind the Moon government.

Followers

The political commitment and foresight of a national leader cannot go far without a sense of discipline, community spirit and social consciousness amongst its people. Public trust in their leader and the government was partly responsible for South Korea's success in checking the spread of COVID-19. In the first week of May 2020, over 77 percent of the people thought that president Moon handled the pandemic well.[40] People's participation in government initiatives and a sense of social responsibility ensured the smooth enforcement of rules and public health guidelines.

Some observers argue that South Korea's experience is of limited applicability to Western countries due to its culture, i.e., people's discipline and respect for authority. However, the South Korean case is not unique and can be replicated in the West, albeit not in the current environment of political polarisation, disconnect between the governments and the citizens, and populist backlash.

> "In countries like Vietnam, social solidarity and responsibility—inspired by smart leadership—was key to their success."

Conclusion

This paper illustrates the validity of the analytical institutional framework using the limited sample of six countries. Detailed country case studies will be presented in a forthcoming study and are beyond the scope of this paper.[41] Of the six cases discussed here, only two represent leadership crisis—that of Trump's and Johnson's, who promoted misinformation that resulted in a colossal failure to control the pandemic. Japan, a country that showed partial success in the face of the pandemic, is an example of a lesser degree of such a crisis. Meanwhile, the success stories of Vietnam, New Zealand and South Korea reflect common features: committed and accountable leadership, effective communication with the public, strict enforcement, high public trust and confidence, and quick adaptability to changing circumstances. While leadership is widely shared between politicians, public agents (e.g. civil administration), the private sector (industry and scientific community), and followers (community, local citizens), a strong central leadership is crucial for a sound national strategy and a plan of action to fight COVID-19.

Factors that adversely affected leaders' performance across countries include local circumstances such as low cooperation of communities, religious groups and citizens; varying capacities of the existing healthcare systems and infrastructure; and early or late start in fighting the virus. Further, the context or environment and the capacity of agents and institutions play important roles in determining the outcome of a leader's performance. While it is believed that a committed and strong leader possesses the power to discipline agents and use their charisma and popularity to command their followers' respect, the context and the circumstances can expose this myth of a 'strong leader'.[42]

Surprisingly, powerful leaders in most Western countries failed to effectively tackle the pandemic. In countries with moderate mortality rates, success has been *partial* due to the poor behaviour of leaders, agents, or followers. Compared to this, many Asian countries demonstrated responsible leadership in crisis management (China, New Zealand, South Korea, Thailand, Vietnam), greater foresight, quick action and empathy, and the ability to gain public trust and confidence. Japan can be considered successful to some extent, especially compared to all Western countries, considering its low mortality rate. In terms of gender, female leaders seem to have fared better than their male counterparts, as seen in New Zealand, Denmark, Finland, Germany, Iceland, Norway and Taiwan.

Conclusion

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The COVID-19 pandemic has shown that in explaining leadership patterns, it is limiting to use divides such as North and South, advanced and developing, rich and poor, and democratic and authoritarian. While remarkable performance is generally associated with rich countries that have well-funded healthcare systems and services, a relatively poor socialist country such as Vietnam has shown rare but notable success in fighting the pandemic.

Similarly, democracies are considered better for the people than authoritarian regimes, yet China managed to control the virus long before any of the Western democracies. Cuba, another communist country, also performed well, as did Thailand, under a government led by a military general. Thus, the pandemic has also exposed the myth of the West's edge over the East, with regard to both healthcare systems and strong leadership.

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