

One Pandemic, Many Recipes: Managing COVID-19 in China, South Korea, Germany, Spain, Brazil and US

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Abstract: The social and economic impact of a pandemic respiratory crisis (COVID-19) is more potent than any previous one. Nevertheless, there is a lack of consensus on the measures to deal with and to overcome it. Backward-looking and forward-looking theories from different scientific areas are taken into account while managing crises. However, it is crucially essential the confidence, credibility, and if the heterogeneous agents and the general population trust them. This article presents contrasting approaches been used to manage the COVID-19 in the East Asian countries (China and South Korea), European (Sweden and Spain) and American ones (United States and Brazil. They are critically presented in order to call attention to the much-needed knowledge of the nowadays crisis of the crisis management.

Keywords: COVID-19; crisis management; different approaches; East Asia; Europe; Americas

Evidence for Practice

Agile-adaptive; hard-forced and soft-passive approaches are the known alternatives available to manage the COVID-19;

The pandemic is universal while the responses to it are different in East Asia, Europe and the Americas;

Leaders acting as "strategists" but not taken into account the scientific knowledge are the main responsible for the paradox of managing the crisis of the crisis management.

What is "crisis management"? Before considering definitions and concepts about crisis management, it is equally important to know what "management" is? Textbooks of business management have been teaching that the functions of management are: planning, organizing, directing, and controlling. However, according to Mees (2018, p.16), "In 1916, Henri Fayol had argued that prudence (*prévoyance* - the term is still used in French to refer to prudential matters) was a key feature of business administration". The term was mistranslated into English as "planning" and was militarized as "strategy".

Using social and behavioural science to support COVID-19 pandemic response (Van Bavel et al., 2020) forty-two well-respected scholars systematized 253 scientific papers to consider a century of threats, social and cultural influences on behaviour, science communication, moral decision-making, leadership, and stress and coping "crises", "disasters", "calamities", "catastrophes" and so on. They identified responses and "important gaps researchers should move quickly to fill in the coming weeks and months". However, in the case of combating the Pandemic in Brazil, for the editorial of Lancet (2020), "perhaps the biggest threat to the country's COVID-19 response is its President, Jair Bolsonaro".

The Brazilian case and other cases around the world, especially in the U.S., show that politics without been based on science have not been able to deliver efficient solutions to overcome the

COVID-19. The pandemics are universal; the responses are local. Leaders acting as "strategists" that do not take into account the scientific knowledge have not been able to support the management of the Pandemic, instead, they are the main responsible for the paradox of managing the crisis of the crisis management. In this sense, the COVID-19 Pandemic is challenging the scientific community to discuss and find out reasonable solutions for the crisis of the crisis management.

Reviewing some of the local approaches employed, in East Asia (China and South Korea), Europe (Sweden and Spain) and in the Americas (US and Brazil), to manage the COVID-19 is the primary goal of this article. The other goal of the article is to show that "politics" is what matters while management crises. However, "politics" without following and respecting the scientific knowledge are prone to building up crisis of the crisis management.

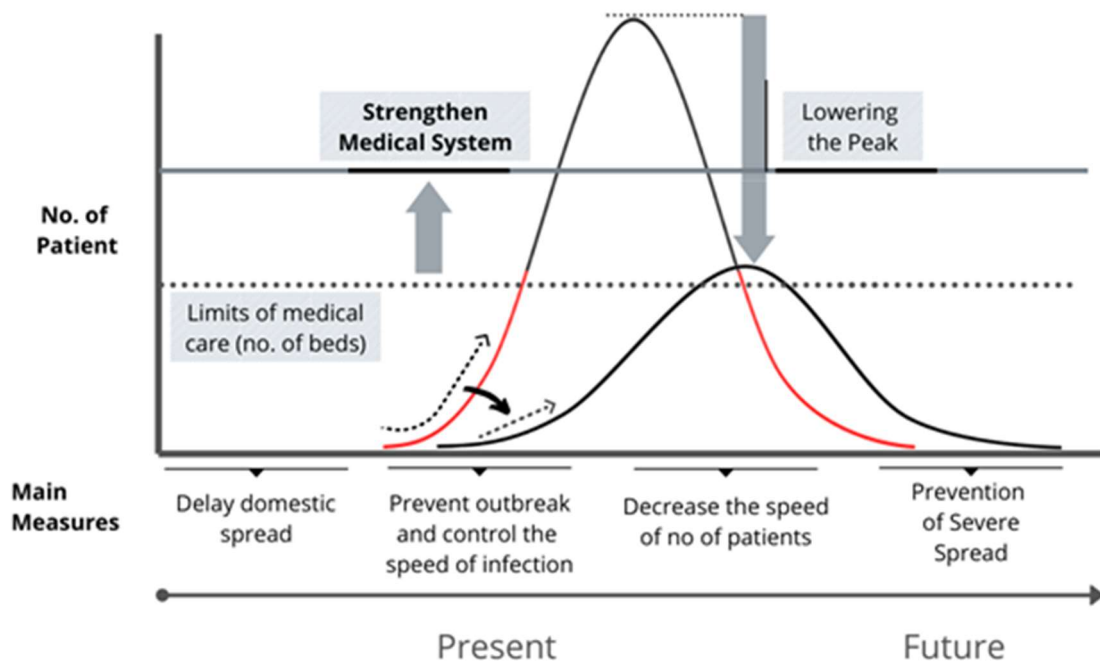
The article is organized as follows. The first item characterizes the uncertain and unknown crisis of the COVID-19. The second presents the management of the crisis in East Asian countries, focusing in the approaches of China and South Korea. The third item considers the European approaches emphasizing the cases of Sweden and Spain and the fourth considers the approaches of the American countries, the United States and Brazil. The fifth item discusses the different approaches highlighting the crisis of the crisis management. Limitation and recommendations for future studies conclude the article.

The uncertain and unknown crisis: the COVID-19

Crises are seen as situations in which an individual's or organization's life suffers a functional disruption in their "normal" activities. Natural disasters, radical economic changes, and corporate crises – such as accidents, scandals, and product safety incidents (Marcus & Goodman, 1991) – exacerbate conflicts among the interests of different stakeholders, especially the crisis victims. There are also other types of crises like family disruptions, broken social relationships, suicides, life events as birth, or loss of a loved one and health issues. These different situations are considered in the definitions or concepts of "crisis management". The largest-ever crises, including all these situations, have been challenging the scientific knowledge since December 2019.

On March 11, 2020, the COVID-19 virus was declared a pandemic by the World Health Organization. Many authorities around the world have been adopting measures in order to diminish its impacts. According to Ferguson et al. (2020), there are two fundamental strategies to reduce the transmission of the virus, which is, flattening the curve: i) mitigation and ii) suppression. However, for Peña et al. (2020), these two actions should not be enough for authorities. For these authors, governments must implement four main types of policies to deal with the COVID-19 crisis: i) flattening the curve; ii) raising the line (strengthening the medical system); iii) mitigating negative impacts, and iv) strengthening governance. In some way, these measures are summarized in Figure 1.

Figure 1. Countermeasures to combat COVID-19.



Source: Reproduced from Shaw, Kim, Hua, 2020, with small changes.

Although these necessary countermeasures are the same between countries, responses are local and notably varied. China, the first country to report the virus, used strong government actions and a variety of technology and community collaborations. South Korea, otherwise, was able to stabilize its situation with building upon its considered disastrous previous experience in dealing with other respiratory diseases like SARS and MERS, this time working emphasizing transparency in all its measures, putting science above politics and implementing measures intensively using technology and citizen participation (Shaw, Kim & Hua, 2020). These two approaches as well contrasting European and American approaches as considered in the coming items.

East Asian approaches to manage the COVID-19: the Chinese and South Korea experiences

In China, on January 20, Dr. Zhong Nan Shan, in CCTV, made an official announcement alerting people about the new virus, and a second announcement declared a state of emergency in the Hubei province, where Wuhan city is located. In late January, additional hospitals were constructed to treat an expected raise of patients, and by February 3, a massive city sanitization started. Chinese protocols enable officials to check virus symptoms by entering people’s houses, which allowed the high coverage of tested people. On February 18, a system using Q.R. code technology was released to citizen’s use, and a strict policy for monitoring the following of the government recommendations was applied.

China had notably learned from the Severe Acute Respiratory Syndrome (SARS) crisis between 2002 and 2003, which improved the government's response actions. (Wu & McGoogan, 2020). Highlights from the China case are robust government control, proactivity of Hubei province, community governance (community watch to restrain transit of people); use of technologies (big data, 5G, health barcode); citizen collaboration including physicians' voluntary mobility as well financial donations. Furthermore, social media strongly supported government actions, but human rights concerns were voiced in this and the international media.

The same social support was intense in the cases of other Chinese citizens living in Singapore and Taiwan. Taiwan was predicted to be one of the most affected countries due to its proximity to mainland China. However, the situation was quickly controlled. According to Wang, Ng, & Brook (2020), one of the main factors was the leverage in the database, which established specific procedures for the identification of infections to protect the general public and helping in the correct allocation of resources. These authors pointed out that a rigid data analysis helped to integrate immigration and customs to start creating real-time alerts during a clinical consultation based on travel history and clinical symptoms. It was crucial to identify and treat infected cases.

The measures for Singapore in public health were quickly instituted that included procedures for aggressive contact screening and quarantine. By February 19, Singapore had 84 cases that were quickly hospitalized and had no deaths at that time (Wong, Leo, & Tan, 2020). The country took an approach due to its experience with other related diseases such as acute respiratory syndrome (SARS). From that experience, Singapore built a new National Center for Infectious Diseases and a National Laboratory for Public Health. It expanded the number of beds, storage of personal protective equipment (PPE), and masks. Furthermore, a large number of Singapore's investments were addressed to biomedical science and research resources to understand better infectious diseases (Wong, Leo, & Tan, 2020).

Since the outbreak of coronavirus disease caused by the SARS CoV-2 in Wuhan, China, at the end of December 2019, there has been a great deal of chaos in the world and neighboring countries (Wu & McGoogan, 2020). Although South Korea is one of the closest to China's countries, the country was not fully alerted about the need for precautions and extensive preparedness concerning this newly emerging virus until mid-February (Her, 2020). However, the Korean government was already controlling the unusual pneumonic patients coming from Wuhan to South Korea. In December of 2019, the Korea Centers for Disease Control and Prevention (KCDC) promptly quarantined those people respecting their internal protocols.

On January 8, A Chinese female living in Korea demonstrated symptoms of the disease, and immediately the Korean government declared a Blue Level Alert, the lowest between the four existents. KCDC, Ministry of Interior and Safety (MoIS), Ministry of Justice (MoJ), and other agencies set up a sharing immigration information system for a response for the occurrence (Shaw, Kim & Hua, 2020). The first and second confirmed cases of COVID-19 were detected on January 20 and 24, respectively, making the authorities raise the alert level to Yellow, the second one, and a 24-hour emergency was initiated by the Central Discharge Countermeasures Headquarters (CDCHQs).

Visitors of Wuhan were then monitored, and there was an effort to transport Korean citizens living in Wuhan back to Korea. February 19 was a turning point of the COVID-19 crisis in Korea, with the confirmation of the 31st case of a woman attendant of the “Shincheonji Church of Jesus”, in Daegu City. After further investigation, a Red Alert Level, the highest one, was issued due to the diagnosis of the virus in a significant number of members of the Shincheonji Cluster, hitting a peak of 909 cases (Moon, 2020).

South Korean response to the COVID-19 crisis was based on its agility and transparency (Moon, 2020). Instead of deploying aggressive measures such as immigration control, lockdown, or roadblocks, South Korea mounted a trace, test, and treat strategy (Park, Choi, & Ko, 2020). Various approaches, such as extensive COVID-19 screening, effective patient triage, the transparent disclosure of information, and information technology use, were introduced to stop the transmission of the virus (Her, 2020). However, at the same time, there was an intense debate and controversies related to data privacy.

The government conducted a series of measures to contain the spread of the virus, as listed: i) the conduction of a survey of members of the “Shincheonji Church of Jesus”, ii) the hiring of 724 doctors earlier than planned and their deployment to each infected region, iii) the development of drive-through testing centers’ guidelines and implementation, iv) the designation of 254 hospitals for “public use”, for use without risk of infection, v) the call for citizenry participation in personal hygiene practices and social distancing, vi) the release of an application for self-diagnose health status for those, inform self-isolation rules and send alerts to a dedicated official when a person leaves their house without approval, and vii) the implementation of a five-day rationing system for selling and purchasing facemasks, due to the shortage of the item (Shaw, Kim & Hua, 2020).

South Korea learned essential lessons from the Middle East Respiratory Syndrome (MERS) crisis in 2015, in which the government did not succeed in responses and mitigation (Moon, 2020). Highlights from the Korea case are transparency and democracy; centralized response plan by experts; proactivity of local government; community governance (finding suspected cases and reporting, disinfecting public spaces, supporting vulnerable groups, and producing face masks); use of technology (as the big data analysis; the development of rapid diagnosis test kit, drive-through screening method, and walk-through test booth; and the release of the mobile application), voluntarily citizen collaboration (as the hygiene practices, volunteer services, and donations and “good landlord movement”).

European approaches to manage the COVID-19

The first case of COVID-19 was confirmed by the Swedish Public Health Agency on January 31 in a traveler from China, and a few weeks after that, during the second week of March, community spread was confirmed. As a response, various restrictions were imposed to slow down the spread (or “flattening the curve”). These restrictions have been relatively mild compared to other European countries (Hensvik & Skans, 2020) like Italy, Spain, UK, and France that have been hardly affected by the COVID-19.

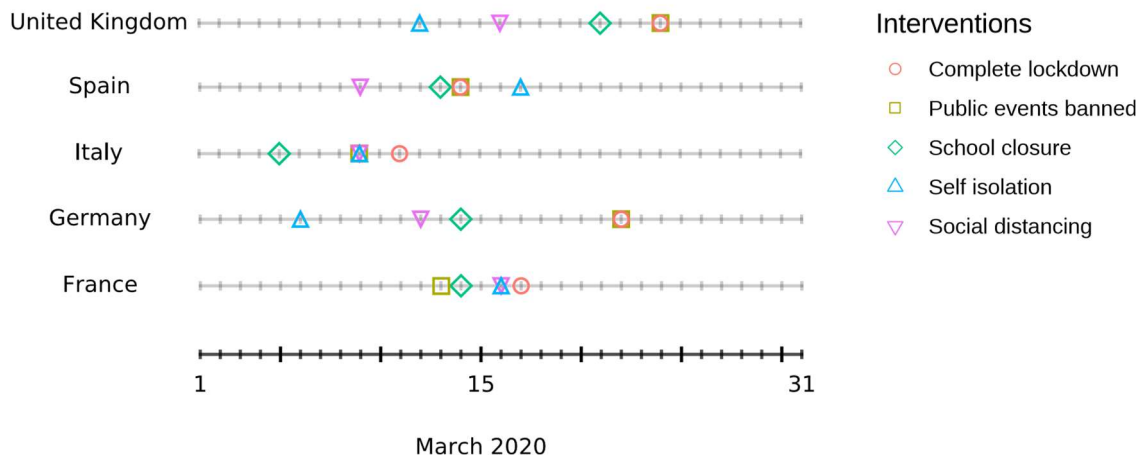
Different from the pathway adopted by other countries in Europe, Sweden's response to Pandemic was a community-based strategy. According to Giesecke (2020), comparing Sweden with the U.K., Belgian, and Spain, "*has become clear that a hard lockdown does not protect old and frail people living in care homes—a population the lockdown was designed to protect*". Besides that, based on the infected rate presented by neighboring countries, Giesecke (2020) also affirmed that everyone will be exposed to the COVID-19 and that the "*measures to flatten the curve might have an effect, but a lockdown only pushes the severe cases into the future—it will not prevent them*".

However, the adopted measures based on the population's self-discipline following the NPI protocols were not able to prevent a high death rate, especially among the vulnerable population. In the way of not having hard controls, fines, and policing to promote social isolation, most workplaces remained opened. Much of the implemented Swedish measures were strongly influenced by the infect list, which became a symbol of the controversial country's approach to combat the COVID-19. On April 21, Anders Tegnell declared to Nature (Paterlini, 2020) that the nation's "trust-based" approach to tackling the Pandemic was the only right measure, and for him, "*closing borders is ridiculous*".

There is no just one best approach to combat such a great pandemic. Smaller and well-developed countries may be in a better situation than other large and persistently considered developing countries. Nonetheless, as pointed by Heston (2020), the Swedish approach "stands out as an exception in the West". In addition to the voluntary social-distancing, it is possible to affirm that one implicit goal for the Swedish authorities is to reach herd immunity. On the one hand, Sweden tried to preserve the economic balance. However, on the other, the criticism was huge for presenting higher per capita death rates than other Nordic countries and for not being able to protect the high-risk population: old and immigrant population.

Since the outbreak of Covid-19 on December of 2019 until 4 July of 2020, it was reported 11.241.655 confirmed cases of the disease. According to the European Centre for Disease Prevention and Control, Europe countries sum up to 2.471.084 cases, corresponding to near 23% of all global cases. Of this number, 196.335 (8%) are found in Germany, and 250.545 (10%) in Spain, which, along with United Kingdom (284.900), Italy (241.419) and France (166.960) correspond to the five countries in the EU/EEA and the UK with more cases. Notwithstanding, the peak, which occurred on 9 April, is passed to all countries, except for Sweden and Poland. The 14-day incidence, period in which an estimative of active cases can be made, declined over 80%, as the overall number of new cases (Assessment, 2020).

Figure 2 – Cases and kind of interventions.



Source: Addapted from Soltesz et al., 2020.

The first cases in France, the UK and the Italy occurred, respectively, on 24 January, 31 January and 21 February (Pang et al., 2020). The first country to come across a large number of infections and deaths due to Covid-19 in Europe, followed by Spain, France, Germany and the UK. The Italian case brought lessons to other European countries, that rapidly applied measures aiming to flatten the curve, so the medical systems wouldn't be overwhelmed (Mavragani, 2020). As the Figure 2 shows, Italy implemented complete lockdown on March 11, followed by Spain, on March 14, France, on March 17, Germany, on March 22, and the UK implemented lockdown only in 24 March. By April 4, the highest rate per million was on Spain, and the lowest was in the UK, scenario that has changed substantially until 4 June (Pang et al., 2020).

The first reported infection in Germany was on 27th January by the Bavarian Health and Food Safety Authority, when a man in the region presented symptoms. Since then, the German government issued a Corona Crisis Team and initiated a pandemic plan, including financing of research and cancelation of large gathering events. The first death on national territory occurred on 9th March, and subsequent days were marked by the first strict restrictions on public life, such as physical distancing and quarantine regulations, and the mandatory use of face masks, according to the official German website. Other following measures include the release of Corona-Warn-App, the restriction of arriving travelers from other countries, the suspension of school classes and the availability to the population of data and reports concerning the novel coronavirus on official websites (Stafford, 2020). By 15th April, measures concerning the pandemic started to ease as total daily cases were decreasing in numbers.

Germany has outstaded as with a relatively low rate of mortality by the SARS-CoV-2 virus compared with other countries, corresponding to about 3,6%. For comparison, in the UK, Spain and Italy, over 13% is the rate of fatalities. According to the official German website, many are the explanations for that low number, but some provided by the Robert Koch Institute, the public health institute of Germany, include the rapid response and suppression measures taken by the government, and the wide capacity of testing. While other countries were testing only older people presenting severe cases, Germany tested also younger patients with milder cases with the support of quality-controlled laboratories all over the country. This permitted the

country not only detect and treat early cases, but also decrease the fatality rate with the increase of known cases (Stafford, 2020).

In Spain, the first confirmed case occurred on 31 January, in La Gomera, of a man of German nationality (Press, 2017). Only 13 days after the epidemic outbreak started its exponential growth, the Spanish government took measures applied to all country (Saez et al., 2020). Social distancing, including government recommendation to work from home, avoid the use of public transport and reduce other non-essential contact (Flaxman et al., 2020), started at 9 March, followed by schools closure on 13 March and finally the complete lockdown was implemented on 14 March, along with the banning of public events. The protocol for testing was to leave mild and asymptomatic cases untested, even though the South Korean case showed that the testing as many as possible people strategy was an important tool to contain the spread of the virus (Saez et al., 2020).

Spain applied statutory policies in general, and combined public health measures with policy responses to expand medical capacity, that is, raising the line strategy, as well as mitigation strategies to flatten the curve (Peña et al., 2020). The governance on national territory was also a discussed topic on the Plan to the transition to a new normal, published by the Ministry of Health of Spain. Those mitigation measures taken by the Spanish Government on 14 March was able to flatten the curve, since the peak has passed to the country (Saez et al., 2020). However, the Covid-19 crisis brought several casualties to Spain, since by 4 June, 28.385 deaths were reported in national territory (Assessment, 2020). It represents a 11% rate of fatalities, and proves that the suppression strategy is possible in a short term, but at certain point is crucial the timing of containment measures and the necessity of the combination of strategies, such as governance applied to all territory, raising the line strategies, flattening the curve strategies and the mitigation of negative impacts (Cimini et al., 2020).

COVID-19 from a global perspective and the Brazilian and US approaches

The first known case of pneumonia caused by an unknown virus was recorded on December 8 in Wuhan City, located in Hubei province in China. On December 31, this virus was reported to the Beijing Office of the World Health Organization (WHO). Scientists from China identified the until then unknown pathogen as a new coronavirus on January 7, and on January 13, it was confirmed in Thailand, the first place to report the virus outside China. The WHO Director-General met with the Chinese president on January 28, and two days later, the virus was declared as a “public health emergency of international concern” (PHEIC). On the following day, Italy also declared an emergency (Wu & McGoogan, 2020).

The naming of COVID-19 occurred on February 11, and the next day a United Nations Crisis Management Team was formed, with the leadership of WHO. On day 21 of the same month, the WHO selected well-known health specialists to assist three countries: Italy, on February 24; China, on February 25; and Iran, on March 2. Also, on February 24, cases outside China overcame the domestic ones, establishing a change in the epicenter of COVID-19. On March 6th and 7th, the WHO declared a road map research and discovered that the virus has spread to more than 100 countries and infected more than 100.000 people. COVID-19 was declared as Pandemic on March 11, and two days later the USA’s declaration of emergency (Shaw, Kim & Hua, 2020).

Over the past months, the spread of the COVID-19 has been steady in Asia and other regions. Latin America was an exception until February 25, 2020, when the Brazilian Ministry of Health confirmed the first case (Rodríguez-Morales et al., 2020). The response began promisingly but was soon hampered by the president's clashes with the Ministry of Health and other officials, who failed to convince him that economic fate depended on how effectively the country handled the public health emergency.

In Brazil, the first reported case dated February 26rd, when a 61 years old male, who had traveled to Italy, was diagnosed with the virus. Although almost a month before, authorities had already begun preparing responses, creating the "Emergency Group in Public Health for the Conduction of Actions Referring to the New Coronavirus", Brazil seems to be mismanaging such a crisis. To Cimini *et al.* (2020), the country had a considerable number of measures taken, but it does not represent intensity, coverage, or convergence of responses. Schmidt, Mello, & Cavalcante (2020) define the multiparty system, federalism, citizens' participation in the formulation of policies, and the autonomous systems of control of the Brazilian political system as hindering the coordination of government responses.

Bolsonaro's opposition to social detachment and refusal to support local authorities in their attempts to impose isolation contributed to undermining compliance with these measures. Health experts were dismissed, and Bolsonaro even adopted a drug with no proven efficacy – chloroquine – to treat COVID-19 infections. Federal coordination sank. Governors – some of whom Bolsonaro considers rivals for re-election – were isolated to define their policies of distancing and guarantee a large part of their tests and equipment. Brazil also struggled to secure tests for COVID-19, making it difficult to track and control the virus in the country.

In the United States, the first cases and deaths related to Covid-19 were confirmed in late February (Tanne et al, 2020). The first case officially released by the World Health Organization, in the United States, was confirmed in the state of Washington, in a traveler who had visited Wuhan, in China, and when he returned he became symptomatic (McIntosh, Hirsch & Bloom, 2020). However, restrictive policies were determined only a few weeks after these incidents (Brzezinski et al, 2020). On March 13, when COVID-19 reached 49 out of 50 US states, the government declared a national emergency, in addition to announcing 50 billion dollars financial aid to contain the disease (Tanne et al, 2020).

It can be said that the United States had a slow initial response to the disease. As of March 16, it had performed only 74 tests per million inhabitants, compared with 5200 tests per million in South Korea (Cohen & Kupferschmidt, 2020). In response, and after testing negative for covid-19 (he had had contact with an infected Brazilian official), the President of the United States promised many more test kits and ordered that the vice president be responsible for responding to the outbreak, in a partnership involving the government, private companies and commercial and public laboratories to make tests available on a larger scale (Tanne et al, 2020). The numbers of cases have exploded and, in turn, the number of deaths. "This is bad," the US president finally acknowledged on March 16. (Cohen & Kupferschmidt, 2020).

By the end of March, all states had adopted school closure policies and approximately half of them gradually introduced business closings and recommended that people stay at home (Brzezinski et al, 2020). Amid growing criticism of the government's response to the disease,

The American Medical Association, which represents about half of US doctors, called the emergency statement “necessary to help ensure that America’s health care system has sufficient resources. “. In addition, many doctors called for access to Medicaid, which is safe for poor patients, to be expanded and accelerated in order to serve a larger number of people in a shorter period of time (Tanne et al, 2020).

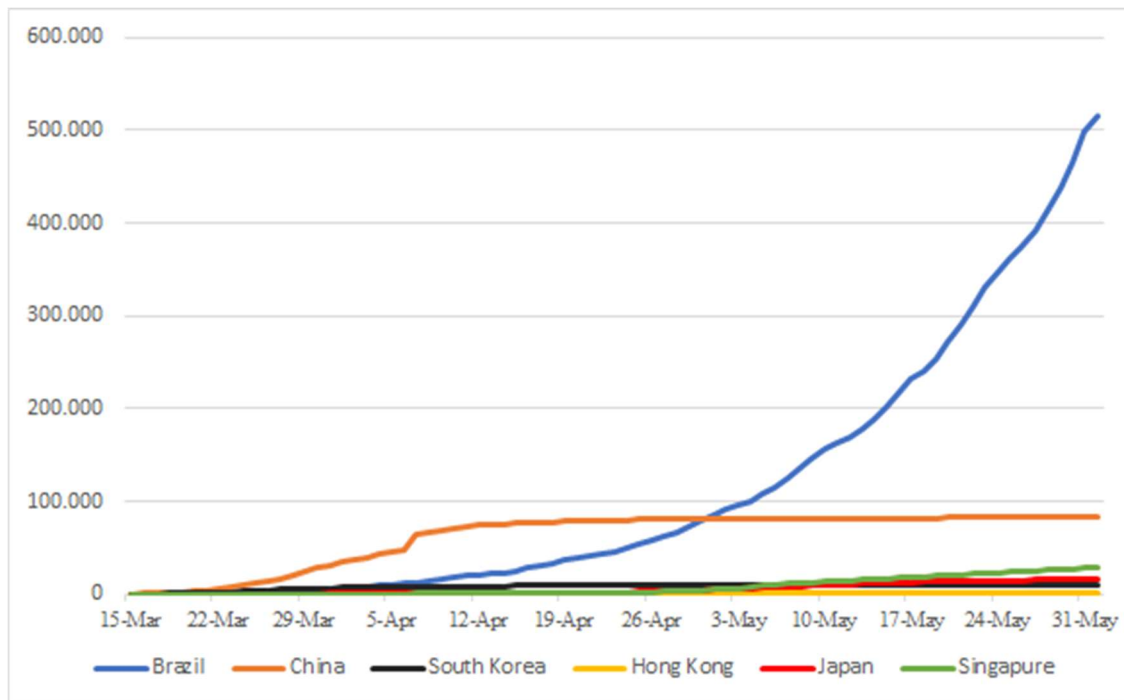
To mitigate the import of the virus into the United States, the government used temporary restrictions on commercial air travel to the United States. In addition, there was also a temporary suspension of cruise ship travel during the COVID-19 pandemic (Moriarty, 2020). But how to fight the disease is still under discussion. The measures introduced hastily vary between countries and even within countries. The US government does not recommend meeting more than 10 people, but San Francisco has ordered everyone to stay at home (Cohen & Kupferschmidt, 2020).

Criticism of the government’s response continues, as several states complain about the lack of a coordinated national response and confusing messages from the White House that have had huge impacts on the ground (Tanne et al, 2020). However, US public health officials are trying to overcome these conflicting messages from the White House, which sees a boost in the press by the disease, with the aim of undermining the president’s chances of reelection in November. For Trump, “they are doing everything possible to make the Coronavirus look the worst possible, including panicked markets, if possible” (Dyer, 2020).

Discussion

As the Pandemic has been affecting populations around the world and as each specific country has been combating the COVID-19 employing distinct approaches, it is hard to say which one is the most appropriate. Pandemic is global, but its response is local (Shaw, Kim & Hua, 2020). In this case, the theoretical analysis must help us to better contrast some cases. If we consider the evolution of the disease as being equal on March 15, 2020, in a group of East Asian countries like the ones represented in Graph 1 and Brazil, we can see its progress. In a period of disaster (Zaneti Jr, 2020), some disasters are bigger than others, like the Brazilian one. The same can be said to the US case.

Graph 1. Selected countries COVID-19 cases progression.



Source: IPT (2020).

It is possible to verify that Asian countries were more effective in combating COVID-19. They better managed than Brazil to flatten the curve or keep it low. The same cannot be observed in Brazil, which after two months, the curve had a considerable increase. Brazil has not the same development level as South Korea, Japan, and China; however, even in the most developed areas of the country, as São Paulo, the Pandemic seems to be running out of control (Marson & Ortega, 2020).

Comparing the main measures being implemented by these Asian countries to combat the COVID-19 with Brazil, it can be seen that its universal health system, despite being very good (Burki, 2020), was not well prepared to combat such a great pandemic. While Asian countries are better technologically prepared and have experience in dealing with previous respiratory diseases like SARS or MERS (Wong, Leo & Tan, 2020), Brazil is still struggling to combat its tropical diseases like the Zika, Dengue, or Yellow Fever epidemics. Furthermore, the country's leading authorities were not able to unite the social and economic structures to follow the WHO protocols or even implementing other more “radical” measures as those of the neighboring countries of Argentina and Uruguay (González, 2020).

The Brazilian president is challenging the WHO orientations and protocols while most of the provincial governments are doing their best to follow them. While the central government seems to believe that the Swedish approach is the most adequate to combat the COVID-19 in Brazil, regional authorities are prone to follow the WHO guidelines and delay implementing more radical measures like lockdowns and curfews. The Brazilian president “is encouraging people to go out and resume their normal lives, while the mayors and governors are stressing the

importance of maintaining quarantine” (Burki, 2020). They are also doing their best to expand testing measures like those implemented in other Asian countries despite the lower technological and availability of material and trained human resources.

The East Asian countries' approaches to combating the COVID-19 Pandemic, as well as the controversial Swedish approach, show a clear and united orientation of measures and actions. While in Brazil, it is clear the governance problem is based on "politics" without following and respecting the scientific and common sense. The central government seems to believe in a similar Swedish approach (Ortega & Orsini, 2020), without having the same population, educational and socio-economic levels, while the Governors and Mayors are more prone to sooner or later implementing more strong social distance measures like the ones already adopted in other Asian or European countries. When leaders are not able to find out a consensual outcome that is trusted by the general public, the paradox of crises of crisis management must be addressed in order to save lives and livelihoods.

Some of the most important countries in Europe, such as Germany, Italy, England, Spain and France were one of the most affected by COVID-19 in the world (Anderson, Mckee, & Mossialos, 2020). So they took strict isolation measures, reaching complete lockdown periods. In this way, they managed to flatten the curve, preventing the health system from collapsing, as it was happening at the beginning of the pandemic. Brazil, despite having growth curves of cases and deaths similar to those of these countries, took time to take these measures, mainly due to conflicts between local governments and the federal government. For Germany, in addition to these restrictive measures and having carried out the largest mass testing in Europe, it became important to be governed by a woman. Countries led by women, including New Zealand's Jacinta Ardern and Germany's Angela Merkel are leading the way in coordinated responses that are not only evidence-based but also grounded in empathy and a collective ethic of care (Ortega & Orsini, 2020). Unlike Germany, Brazil has a more authoritarian president, in which these attributes are not present, which can be compared to the Prime Minister of England, who also had problems with local governments, regarding the unification of restrictive measures.

Like Brazil and England, the United States was severely affected by the COVID-19 pandemic and has a president with a similar style to the president of Brazil and the British prime minister. Thus, it followed the same course of not being able to reach an agreement with the local government as to the measures to be taken (Van Dorn, Cooney, & Sabin, 2020). Like the Brazilian president, he also sought to diminish the importance or the danger caused by the disease and treats it as a political game, given the proximity of the presidential elections. For him, his opponents are exaggerating the threat of coronavirus to “weaponize” it and hurt him politically (Dier, 2020). However, when the news that the deaths were accentuated, resulting in the largest number of deaths worldwide, the American president adopted a more conciliatory tone, which favored the unification of measures within the country. This change of opinion regarding the dangerousness of the disease proved to be evident when he emphasised that social distancing could “flatten the curve” of the infection's rise and reduce the number of deaths (Tanne, 2020).

Conclusions

Despite questions of culture and political regimes that influence the country's strategy to win the war against this Pandemic, different pillars must be explored simultaneously. Efficient access to testing and symptoms monitoring and rapid diagnostic capacity can be set as the main pillars. If countries would have introduced them at the beginning of the disease, together with clear and timely communications and health advice, many contaminants could be contained. In addition to that, the development of comprehensive contact tracing platforms can offer secure information about the evolution of the contagion, providing more accurate information to the public managers to be used as support measures regarding hospitalize needs and supplies to treat the infection.

By the scarcity of resources or political reasons, not by scientific recommendations, these procedures were followed in the contrasting approaches that we have considered in this paper. Some examples and lessons can be followed from any approach being it Asian or European. The main conclusion of the analysis is that any approach must have a united interest. The health versus economy debate in the Brazilian case, among Provincial and Federal authorities, highlights the lack of governance in combating the COVID-19 but calls attention to the challenging issues of managing the crisis of the crisis management.

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