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Löblová, Olga; Rone, Julia; Borbáth, Endre

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23 COVID-19 IN CENTRAL AND EASTERN EUROPE

Focus on Czechia, Hungary, and Bulgaria

Olga Löblová, Julia Rone, and Endre Borbáth

Countries of central and eastern Europe (CEE) are rarely accustomed to praise when compared to their western European neighbors. During the early months of the COVID-19 pandemic, however, as core European countries such as Italy, Spain, or the United Kingdom reported hundreds of confirmed cases and even deaths per day, all CEE countries managed to contain the disease with considerably lower rates of infection and deaths. This changed with the second wave in late summer and fall of 2020, when many CEE countries overtook western Europe in the number of new COVID-19 cases, as well as deaths, per population, but for a few months the region could enjoy its unusual accomplishment.

A number of hypotheses have been suggested to explain the surprising containment success in the spring, including the widespread prevalence of the bacille Calmette-Guérin tuberculosis vaccine, lower population density and exposure to tourism, lack of trust in the healthcare system and government in general (leading the population, in theory, to fear the health threat more than in wealthy countries), low testing numbers (which may have led to underreporting of cases), and an autocratic advantage leaders of imperfect democracies, such as in CEE, enjoy when imposing lockdowns and other restrictive policies (Cepaluni et al., 2020; Gotev, 2020; Shotter & Jones, 2020; Toshkov et al., 2020; Walker & Smith, 2020). One thing is certain: in the spring, CEE governments implemented strict measures to protect public health at a time when their countries had few COVID-19 cases and deaths at most in the single digits.

This chapter focuses on three CEE countries: Czechia, Hungary, and Bulgaria. These three countries are not necessarily representative of all CEE countries, but they share several important structural characteristics with the rest of the region. Before COVID-19, the three countries were hardly obvious candidates for successful health threat management. All three are often categorized as backsliding democracies (Cianetti et al., 2018; Dimitrova, 2018; Hanley & Vachudova, 2018). Compared to western Europe, they score lower on indexes of government effectiveness and regulatory quality (Kaufmann & Kraay, 2020) and, despite a common legacy of strong public health governance (Apostolova, 2020; Szabó & Wirth, 2020), their investment in health care has been lower than in countries of the European

core ("Healthcare Expenditure Statistics," 2020). The Global Health Security Index (2019) ranked Hungary, Czechia, and Bulgaria thirty-five, forty-two, and sixty-one, respectively, in terms of pandemic preparedness, well behind projected frontrunners such as the United States, United Kingdom, or Sweden.

Even when focusing on agency instead of structural factors, as emphasized by recent re-examinations of the public health preparedness literature (Kavanagh & Singh, 2020), the three countries hardly had an advantageous starting position: their political leaders (prime ministers in all three cases) are frequently qualified as populist, either of the radical right, authoritarian variety as in Hungary (Mudde, 2019; Scheiring & Szombati, 2020), the anticivic kind in Bulgaria (Kabakchieva, 2020), or the technocratic sort in Czechia (Buštíková & Guasti, 2019). In this they resemble the trend of democratic backsliding under populist/illiberal leadership, observed in other postcommunist EU member states, such as Poland, Romania, Slovakia, or Slovenia (Cianetti et al., 2018). Populist leaders' policies are often understood to be of questionable rationality, driven by clientelism or the whims of public opinion, and, crucially for a health threat, antiscientific and anti-elitist (Scheiring, 2020). Their actions are rarely seen as responsible policymaking in the public interest—this hypothesis was to a large extent confirmed during the early months of the COVID-19 pandemic by the populist leaders of the United States, United Kingdom, or Brazil (see chapters 12, 26, and 27), as well as by the Czech, Bulgarian, and to some extent Hungarian, governments later in 2020. In health policy, an emerging literature has tentatively associated populist leaders and parties with negative consequences for public health (Falkenbach & Greer, 2018; Rinaldi & Bekker, 2020). The initial strong emphasis on public health protection in Czechia, Hungary, and Bulgaria is therefore puzzling from theoretical and comparative empirical perspectives.

Notwithstanding these commonalities, there are important differences among the three countries. Despite comparable population sizes, Czechia's gross domestic product (GDP) per capita is 3.8 times as much as Bulgaria's and 1.6 times as Hungary's. Czechia is also a country with net immigration, unlike Hungary and Bulgaria, which have known significant emigration since joining the European Union. This trend is especially noticeable among healthcare workers, with Czechia importing nurses and doctors notably from Slovakia, Ukraine, and Russia, and Bulgaria and Hungary exporting health workforce to western Europe (Hervey, 2017). Quality of democracy in the three countries differs, too, as shown by a combination of institutional indicators and expert assessment, collected, aggregated, and published in the form of the electoral or liberal democracy indices of V-Dem (Coppedge et al., 2020). Hungary and Bulgaria are comparable, whereas Czechia has better functioning democratic institutions, even if democratic consolidation has declined in all three since 2010. In terms of social policy, Czechia and Hungary combine elements of the Bismarckian welfare state with neoliberal policies (although neoliberal elements have been somewhat attenuated in Czechia by two center-left coalitions in power since 2014); Bulgaria attests to a more clear-cut neoliberal type as a result of policy preferences and low state capacity (Bohle &

Greskovits, 2012). As expected by Greer et al. (2020), these differences in regime type, existing welfare state, and state capacity proved significant for the divergence in the three countries' response to COVID-19, which accentuated, rather than modified, existing trends (see also Guasti, 2020).

The swift and decisive adoption of public health measures initially revealed eastern European populist leaders as "responsible" regarding health. It is of course possible that the responsible impulse to protect public health came from a place of responsiveness: in March 2020, populations in CEE were significantly concerned about the new disease (certainly more than later in the year) (National Pandemic Alarm, 2020). Nevertheless, instead of minimizing or denying the threat, in the manner of Donald Trump or Jair Bolsonaro, the Czech, Hungarian, and Bulgarian populists made a distinct choice to prioritize public health over concerns about the economy or even, initially, particularistic sectoral interests. Their authoritarian tendencies found an outlet elsewhere throughout the COVID-19 crisis: in power grabs and attacks on the rule of law and, to a degree less obvious in the immediate term, in redistributive issues. In Hungary the pandemic provided a key opportunity for even deeper concentration of power; in Bulgaria it acted as background for ongoing oligarchic rearrangements and mass protests; and in the Czech Republic the parliamentary opposition and civil society successfully checked governmental power. In all three countries the governments redistributed resources in line with their interests, including bonuses to retirees who traditionally constitute their core constituencies (cf. Bohle & Greskovits, 2012). In Hungary the government cut budgets of political parties and local governments, especially of opposition-led Budapest. At the same time, the level of politicization and polarization of COVID-19 as well as economic measures along party political lines remained remarkably low during the first wave, especially compared to, for example, Brazil or the United States. The seriousness of the health threat, as well as the need for strict measures and mandatory face coverings, did not become objects of political competition or divide the public in the first months of the pandemic. In late summer 2020, face masks and restrictions became controversial in Czechia, although not along clearly articulated political lines. Throughout the spring and summer, the three countries witnessed only small, episodic protests. Bulgaria was the only country that experienced mass protests in the summer, but protesters' demands were not related to the COVID-19 pandemic.

The responsibility of the three governments could be questioned in the summer. Czechia and Bulgaria relaxed containment measures rapidly in April and May 2020 but saw new peaks in cases in July and August 2020, with a major rise in cases in September and October 2020. In October 2020 Czechia had the highest number of new cases per population in Europe, with infections regularly surpassing five thousand a day. The governments found it difficult to reimpose even relatively minor public health measures, although Hungary had maintained some containment measures throughout the summer and only saw increased infection rates in late August 2020. Testing and tracing systems in all three countries were overwhelmed, suggesting the time the three "responsible populists" gained by

swift action in March 2020 had been misspent. It is nevertheless difficult to assess how not ramping up testing, tracing, and supporting capacities during the summer had been an adequate response to still relatively low infection rates and how far it constitutes a failure of crisis management or structural capacity limits; none of the three governments communicated openly or provided detailed rationales and scientific evidence for its choices. Indeed, although the populist leaders acted responsibly during the first months of the pandemic, they behaved throughout the whole COVID-19 crisis in a highly unaccountable way.

This chapter provides details of the public health as well as social policy and economic measures in Czechia, Hungary, and Bulgaria, before discussing issues of rule of law and broader governance linked to COVID-19 in the three countries and broader lessons for political science and health policy. The focus is predominantly on the first months of the pandemic until August 2020.

Public Health Measures

Early responses of the Czech, Hungarian, and Bulgarian governments followed similar patterns. One of the first measures adopted by all three governments involved border closures and extensive travel bans in early March 2020. Czechia banned, already in early February, all incoming flights from China, followed on March 1, 2020 (when the first positive tests were confirmed), by flights from northern Italy, and later mandated self-quarantine upon arrival from Italy and a list of other EU and Asian countries. In one of the most controversial measures, Czech citizens and residents were banned from leaving the country from March 16, 2020, (a first since 1989), and no foreigners without a residence permit were allowed entry (notable exceptions included cross-border workers, especially with Germany and Austria). When there were fewer than twenty infections in the country, Hungary canceled flights to and from Iran and Italy, and by the time the number of confirmed cases rose to thirty-nine, only Hungarian citizens were allowed to enter Hungary via air or land border crossings. A focus on border control was clear in Hungary throughout the spring and summer of 2020, as the country continued to impose quarantines on travelers from numerous European countries (including, notably, the United Kingdom). In late August 2020, Prime Minister Viktor Orbán announced borders would again close to foreigners beginning September 1, and Hungarian nationals coming from abroad would be subject to quarantine, although foreign football fans were granted an exemption (Kaszás, 2020c). In Bulgaria, freedom of movement into and out of the country was not suspended, but quarantines were introduced. On March 17, the Ministry of Health imposed quarantine for all Bulgarian citizens arriving from several EU and Asian countries. During the height of the lockdown, many Bulgarian seasonal agricultural and care workers were flown to western Europe, despite the acute labor force shortage within Bulgaria (Weisskircher, et al., 2020). Numerous cases of returning *gastarbeiters* (guest workers) importing the virus to Bulgaria were

documented ("Gurbetchiite, natupkani v busove i leki koli" ["Returning Guest Workers, Packed in Buses and Cars"], 2020).

The three governments also introduced lockdowns with relatively few confirmed COVID-19 cases: on March 13, 2020, in Bulgaria (24 cases total), and March 16 in Czechia (383 cases) and Hungary (19 cases). Schools and universities closed, as did most retail shops, restaurants, and theaters, with exemptions for essential businesses in all three countries. In Bulgaria, the use of parks, city gardens, sports, and playgrounds, even for health walks, was forbidden, thus making the lockdown one of the strictest in Europe despite the low numbers of infections. Breaking the quarantine rules in Bulgaria became subject to a prison sentence of up to three years and a fine between EUR 5 and 25,000 ("Do 10 godini zatvor" ["Up to 10 Years in Prison"], 2020). In Czechia and Hungary, apart from isolated incidents ("Městská policie" ["Municipal Police"], 2020), there were no reports of exaggerated police enforcement of the lockdown rules.

The Czech government mandated the use of "respiratory protective devices" everywhere outside of one's home on March 18, 2020. Given the shortage of surgical face masks and respirators, the decree clarified that scarves and other cloths were acceptable, and within hours the Czech population responded by sewing do-it-yourself cloth masks (Tait, 2020). Homemade cloth masks quickly became a symbol of national pride, with Czech civil society and politicians promoting their use as good practice internationally (ČTK, 2020a). Paradoxically, masks became a point of contention in late summer. From July 2020, the health minister lifted the obligation to face masks indoors and in public transport (authorities argued that masks are less effective in hot weather, without presenting scientific evidence to support the claim). In August 2020, the health minister announced a renewed obligation to wear masks indoors, but Prime Minister Andrej Babiš softened the rules two days later after unfavorable public opinion feedback (Brodcová, 2020). In Hungary, face mask use was made obligatory in shops and public transport in late April 2020 in Budapest and on May 4, 2020, throughout the country ("Budapest Makes Masks Mandatory for Shoppers and Commuters," 2020; "Itthon" ["At Home"], 2020). Bulgaria had seen several volte-faces on face masks: initially made mandatory indoors and outdoors on March 30, 2020, and subject to fines up to 2,500 EUR, the Minister of Health made masks "recommended" but not obligatory on March 31 after public anger at the low availability and high prices of masks. Face masks later became mandatory in public spaces from April 12, 2020, to be canceled on May 1 and reintroduced in closed spaces (with notable exceptions of cafes and bars) from June 23, 2020.

Testing and tracing systems shared similarities across the three countries. Testing relied on a mixture of private and public laboratory provision and test financing. In Czechia and Bulgaria, contact tracing relied on regional public health bodies, while in Hungary the national-level public health body cooperated with local government authorities. The Czech Republic's early efforts at ramping up its testing and tracing system seemed promising. In May 2020, the Czech government launched a test-and-trace system called "Smart Quarantine," which included

a Bluetooth-based application developed by volunteers, a collaboration with banks and mobile phone operators to share location data to aid contact tracers, and an update of contact-tracing processes. Maximum testing capacities, including in private, public, and academic laboratories, were reported at around twelve thousand tests a day ("Chytrou karanténou si kupujeme pojištění, tvrdí Jurajda " ["We're Buying Insurance with Smart Quarantine, Says Jurajda"], 2020); the actual testing rate was about six to seven thousand tests per day (about 0.60 per 1000 population, similar to Austria in May), but by the time infection rates began to rise again in mid-June, testing numbers were down to about four thousand a day, which the government explained by low COVID-19 incidence. By August, despite re-upped testing rates, positive test ratios were often over 5 percent (Ministry of Health of the Czech Republic, 2020a). Regional public health offices, tasked with contact tracing, were overwhelmed and did not make use of data from banks and phone operators or the app, whose uptake remained limited (Pokorná, 2020). This was similar in Bulgaria, where understaffed regional public health authorities were reportedly failing to trace and notify people on time in July ("RZI ne uvedomilo" ["The Regional Health Inspectorate Did Not Inform"], 2020), and a contact-tracing app developed by a private company and donated to the Bulgarian government for a symbolic price never reached widespread use because of concerns about privacy. Testing levels in Bulgaria grew consistently since March 2020, to about 0.58 per 1000 population. PCR tests for people with COVID-19 symptoms were mandatory but not free—they were covered by public health insurance only upon referral to an infectious disease specialist by the patient's general practitioner—a process that included physically visiting all three providers ("PCR testovete" ["PCR Tests"], 2020). Thus, most patients ended up paying for their own tests, which typically cost between 60 to 130 BGN (EUR 30 to 75), with discounts for group tests. Hungary's official testing numbers were systematically lower than elsewhere in the region, with about two to three thousand tests a day throughout July and early August 2020, although privately purchased negative tests had not been tallied in official statistics. This changed in late August when Hungary ramped up testing numbers up to a maximum of six thousand tests on some days (0.43 per 1,000 population) ("Daily COVID-19 Tests per 1,000 People," 2020). Accessing testing was difficult, even according to government-friendly media (Schőnviszky, 2020). Overall, the three countries tested noticeably less than western European countries.

Measures within the healthcare sector differed across the three countries. Czechia restricted the provision of non-COVID-19 care in March 2020 and required hospitals to allocate bed capacity to potential COVID-19 patients, but reopened routine care provision mid-April (Ministry of Health of the Czech Republic, 2020b). In contrast, Hungary implemented an unsophisticated, controversial measure to increase COVID-19-specific care capacity: in April 2020, the minister of human capacities, in charge of the healthcare portfolio, ordered hospitals to vacate 60 percent of hospital beds within eight days to make space for COVID-19 patients (Pintér, 2020). The order was implemented hastily and chaotically, resulting in many cases

in discharging patients without ensuring adequate home care. Given the low rate of COVID-19 transmission in Hungary, the decision was criticized by opposition parties as unwarranted. Some observers have put it in context of the government's plans for hospital privatization (Scheiring, 2020). The government also spent EUR 1.5 billion on COVID-19-related equipment (Urfi, 2020). More than half of the budget (0.86 billion) was spent on approximately sixteen thousand ventilators—a figure that manifestly well exceeded the medical need, even as anticipated by Prime Minister Orbán himself ("300 milliárd forintért" ["The Government Spent 300 Billion Forints"], 2020; Haász, 2020).

In Bulgaria, the health minister declared that hospitals in the country have 7,391 beds to treat COVID-19 patients, with 1,324 beds reserved in anesthesiology departments, for a population of seven million. Yet the problem in Bulgaria was not the number of beds, which is in fact one of the highest in the EU—756.9 per 100,000 inhabitants ("Hospital Beds," 2020) but rather staffing levels (similar to Hungary and to some extent Czechia). Because of significant emigration of doctors and nurses to western Europe since 2004, Bulgaria has been facing a dramatic shortage of health professionals, especially in areas outside the capital, and an aging health workforce ("Bez aparatura is lekari v pensionna vuzrast" ["Without Adequate Machine and with Doctors in the Age of Retirement"], 2020). Combined with the lack of personal protective equipment, this led to entire hospital departments resigning, citing a lack of safety measures and adequate COVID-19 planning ("Masovi ostavki vuv Vtora Gradska Bolnitza sled prevrushtaneto i v infekciozna" ["Mass Resignations in the Second City Hospital after It Was Transformed into an Infectious Diseases Hospital"], (2020). In July 2020, some hospitals, including in Bulgaria's second biggest city, Plovdiv, and in the historical capital, Veliko Turnovo, called for paid and unpaid volunteers to supplant medical personnel (Maslyankova, 2020).

Lockdown relaxation was initially gradual in all three countries, starting in April 2020 in Czechia and early May 2020 in Bulgaria and Hungary, but accelerating as immediate rises in COVID-19 cases did not immediately materialize. However, all three countries lacked clear guidance on reintroducing public health measures, which made responses to dramatic surges in cases in July and August 2020 politically difficult. The Czech government's first plan of the lockdown relaxation timeline respected a fourteen-day distance between easing stages (Government of the Czech Republic, 2020) but had been repeatedly accelerated, and many areas of social and economic activity opened simultaneously. By May 25, much of daily life was back to normal, including a reopening of schools and indoor pubs. Similarly, in Bulgaria, the government, led by Prime Minister Boyko Borissov, quickly relaxed most public health measures beginning May 13, 2020, opening shopping malls, trade centers, and fitness and sports halls. The Bulgarian government opened indoor restaurants, bars, and night clubs on June 1, 2020.

Czechia and Bulgaria had low levels of infection in April and May 2020, which hardly justified a continuous strict lockdown, but economic concerns may have

played an additional role. In Czechia, a court ruling in late April 2020 potentially exposed the state to damages liabilities. Within hours, the minister of health announced a precipitated opening of shops and lifted the ban on freedom of movement, including on travel abroad. In Bulgaria, it was considered that Bulgarian tourism, which represents 12 percent of the country's GDP, would not be able to survive continuing public health measures. Another force, potentially important for electoral politics in Bulgaria, were football fans: beginning June 5, 2020, stadiums were officially allowed to operate at maximum 30 percent capacity. In practice, thousands of football fans celebrated the 2020 Bulgarian cup final in close proximity.

In Hungary, a major controversy concerned school reopening. On April 19, 2020, Prime Minister Orbán announced on Facebook that infections were expected to peak on May 3, one day before the start of the centralized high school final examinations. Despite protests from teachers, parents, and students, as well as the opposition, the examinations (mandatory for eighty-four thousand students and supervised by sixty-five hundred teachers) took place. Indoor restaurants and pubs, as well as cultural and tourist establishments, reopened in late May 2020, but the ban on gatherings of over five hundred people remained in place, with a tangible impact throughout the summer on the music festival industry (Kaszás, 2020a).

Reintroduction of public health measures proved difficult in Czechia and Bulgaria over the summer, despite infection rates higher than during March and April 2020 (both countries regularly saw two to three hundred daily new cases in the summer), but smooth in Hungary, which had consistently low infection rates in July and August 2020 (below one hundred daily). In Czechia, an infection outbreak in a coal mine in the northeast in May and June 2020 initially seemed controlled by the regional public health body, but by July, the public health office noted widespread community transmission and immediately banned events over one hundred people, including an ongoing music festival. This provoked a two-thousand-strong demonstration (ČTK, 2020b). By early September 2020, the chief public health officer of Prague publicly apologized for no longer being able to trace new infections (ČTK, 2020c). Despite skyrocketing infection rates, few public health measures were introduced throughout September 2020, which many commentators put in the context of local and Senate elections in early October.

In Bulgaria the government attempted to close down night clubs and discotheques in July 2020, only to give in to public pressure and reopen them a few days later ("Praven Svyat" ["Legal World"], 2020). Hungary maintained public health measures, notably mandatory face masks indoors, bans on large events, and mandatory quarantine for visitors and returning residents from numerous EU and non-EU countries, throughout the summer, without significant pressure for further easing from the affected sector or the public. No major protests followed Prime Minister Orbán's announcement of Hungary's tightened travel restrictions from September 2020 (Bayer, 2020), suggesting an autocratic advantage may well be at play.

In summary, all three countries implemented similar, swift, and far-reaching measures to protect public health in March 2020, including travel bans and lockdowns. Where they diverged was in the extent to which these measures were relaxed in the summer. Hungary maintained some restrictions, such as face masks and large event bans, whereas Czechia and Bulgaria lifted virtually all measures in May 2020, and their governments hesitated to reimpose even partial restrictions. They also diverged in their adaptation of health systems, with Czechia coping with the shock of COVID-19 relatively well (at least until the severe second wave in the fall of 2020), Hungary overreacting by crudely restricting routine care, and Bulgaria having to deal with a health system with a high number of hospital beds but low number of doctors and nurses.

Social Policy Measures

All three countries adopted social policy measures supporting businesses and individuals. Support for businesses relied chiefly on guaranteed loans and public funding of furloughs and other short work week schemes. In all three countries, measures targeted at individuals through lockdowns and mitigating the effects of economic downturn in Czechia, Hungary, and Bulgaria have been characterized by a relatively heavy administrative burden. Beyond that, however, the responses of the three governments differ significantly.

In Czechia, the government's furlough scheme contributed 60, 80, or in some cases 100 percent of wages and social security contributions (capped at average gross wage) to employers for employees in quarantine, on caretaker leave, or if the business had been reduced or closed as a result of the pandemic or government measures (Eurofound, 2020). The government further waived the part of social security contributions paid by employers for small businesses in June through August 2020. In April the government implemented a lump-sum of 500 CZK (EUR 20) per day since March 12 for the self-employed. The program initially excluded workers on zero-hour contracts but was retroactively extended, at 350 CZK (14 EUR) per day, in July, following criticism by the opposition and the public. In August, it proposed (and later adopted) a lump-sum of 5,000 CZK (190 EUR) for all retirees. The government introduced interest-free guaranteed loans for businesses across several consecutive financing schemes. Advance payments on personal and corporate income tax were suspended for the second quarter 2020 and penalties waived for failing to pay property tax and file income tax returns on time, rents for businesses were subsidized and repayments of business and household loans and mortgages became subject to a three- to six-month moratorium. According to an independent group of economists, the eventual amount of direct and indirect state support to businesses and individuals amounted to about 300 billion CZK (EUR 11.4 billion) or about 5.4 percent of GDP; however, only about 100 billion CZK (1.7 percent of GDP) had been disbursed by mid-August (KoroNERV-20, 2020). Businesses notably complained about excessive bureaucratic burden and

slow processing of the initial loan programs (Hospodářská Komora ČR, 2020). The government approved grants for tourism, notably a voucher system for spa tourism (International Monetary Fund, 2020). It further proposed to finance a large advertising campaign for domestic tourism, the revenues of which were to benefit progovernment media—it later retracted the plan following opposition criticism ("Návrh kampaně na dovolenou v Česku ministerstvo stáhlo" ["Ministry Retracts Proposal for PR Campaign for Holidays in Czechia"], 2020).

Compared to countries in the region, the Hungarian government acted relatively late and did little to decrease the impact of the crisis on the national economy. The government provided tax exemptions for the most hard-hit sectors of tourism, catering, entertainment, sport, culture, and transport. It introduced a furlough scheme available from May 1, but only businesses who lost 30 to 50 percent of employee working time could prove that their orders have not fallen by more than 50 percent and are working toward the "interests of the national economy" were eligible, if employees worked at least four hours daily (later reduced to two hours) and remained in training for another 30 percent of their time. The measure was later made more flexible but has been criticized as restrictive and belated (Krokovay, 2020). The government did not provide direct transfers to employers or employees, except for a one-time payment of about 1,500 EUR (500 000 HUF) to all healthcare workers, and did not prolong the three-month limit on unemployment benefits (after which health insurance contributions were no longer covered by the state), one of the shortest in Europe. In response to criticism from the opposition and civil society, the government pointed to its heavily criticized workfare program (see, e.g., Szikra, 2014), and Prime Minister Orbán suggested that those who remained without a source of income join the military. Pensioners, however, were promised an extra week of pension benefit in the coming three years (International Monetary Fund, 2020). Take-up of the furlough scheme was less than expected: about 200,000 employees benefited from the scheme by July 2020, as opposed to some 500,000 expected beneficiaries. Given the late introduction of the policy, Hungarian trade unions complained that little had been done for workers who had already been laid off by May (Krokovay, 2020). The size of the April economic package is hard to estimate because of the lack of transparency and creative accounting. However, the pledge includes an immediate 630 billion HUF (EUR 1.76 billion) to cover the immediate costs of the pandemic and an additional 8,370 billion HUF (EUR 23.32 billion) the government claims to invest to temper the economic effects of the crisis, although it announced an intention to keep the budget deficit below 2.7 percent, effectively amounting to an austerity policy (Csiki, 2020; Scheiring, 2020). One study puts the immediate fiscal impulse, as adopted, at 0.4 percent of Hungary's 2019 GDP (Anderson et al., 2020).

Bulgaria implemented a "60:40" furlough scheme, expected to cost beyond EUR 500 million: 60 percent of employee salaries were to be covered by the state and 40 percent by employers (Government of Bulgaria, 2020). Yet only EUR

26.3 million were spent on the 60:40 scheme by end of May 2020; at the same time, expenses for unemployment benefits rose sharply and reached 30.5 million EUR (Grigorova, 2020). Many companies applied for support from the 60:40 measure only for some of their workers, usually the top management, while laying off other workers. In March, the Bulgarian government pledged to provide 4.5 billion BGN (approximately EUR 2.25 billion) in guaranteed loans ("Pravitelstvoto s ikonomicheski merki za 4.5mlrd. lv. za borba s coronavirusa" ["The Government Offers Economic Measures for 4.5 Billion for Fighting the Coronavirus"], 2020). Further EUR 250 million were allocated for covering the increased expenses of the Ministry of Health, Ministry of Defense, and the Interior Ministry, and EUR 100 million were pledged to guarantee zero-interest consumer credits up to EUR 750 for individuals on unpaid leave.

As in Czechia, most of the money allocated for tackling the crisis and reviving the economy remained unused. The Bulgarian government further adopted several new social policy measures targeting individuals (Government of Bulgaria, 2020), which were nevertheless often subject to excessively complex means-testing. For example, parents could apply for a one-time sum of approximately EUR 190 but only provided that they could prove satisfying a total of nine conditions. Thus, a large part of the population was practically excluded from benefiting from the support. Less cumbersome new measures included the possibility for parents to receive help in hiring a carer for children, including their own unemployed relatives. EUR 25 million were distributed among retired people with low pensions: pensioners were to receive EUR 25 extra for August, September, and October 2020. Meanwhile, the government of Bulgaria pledged to provide EUR 500 extra per month for frontline health workers fighting the virus. Unemployment benefits were slightly increased (by EUR 1.50 per day), and the term for which they could be paid was increased by three months. The salaries of social workers as well as standards for financing delegated social services were increased. In the fall, the government introduced a new series of social measures and direct transfers. Yet, rather than addressing the impact of COVID-19, these late and partial measures aimed to decrease social pressure and buy support for the Bulgarian government in the context of mass protests and approaching elections.

Overall, the social policy response demonstrates diversity, rather than commonalities, among these three countries. Czechia's social policy measures followed, in principle, broad lines of responses of western European governments by offering unconditional direct transfers to the self-employed and loans to businesses, as well as furlough schemes for employees, although their effects are still up for debate. Bulgaria, in comparison, implemented few measures to alleviate the economic impact of the COVID-19 for the population, offering support subject to excessively complex means-testing and a furlough scheme with limited impact. Finally, the Hungarian government refused to abandon its "workfare society" social policy, declining to adjust its restrictive unemployment benefit rules, and

implemented a narrow furlough scheme. Notably, however, all three governments implemented bonus transfers to pensioners, traditionally their core electorates.

Discussion

If the initial successes of the Czech, Hungarian, and Bulgarian governments in containing the spread of COVID-19 stand out in the European context, so do two other kinds of actions common to the three countries: the use of the public health and economic crises to effectuate power grabs and the opaque, top-down, and arbitrary decision-making style of governments and their crisis teams. The approach of these three CEE countries to the COVID-19 crisis can be summarized as responsible initially, unaccountable throughout. Here again, these governance issues affected the three countries to varying degrees.

In Hungary, the government treated the pandemic as an opportunity for further executive power grabs. Perhaps unsurprisingly, given Prime Minister Orbán's long-established craftsmanship in using technical pretexts to centralize power, Hungary's government implemented an ostentatious power grab in March 2020. Orbán seized the opportunity and relied on his two-thirds parliamentary majority to introduce special provisions, allowing the government to indefinitely rule by decree, despite criticism from domestic opposition parties, EU leaders, national, and international observers (Borbáth, 2020). In addition, the legislation allowed the government to postpone elections and prosecute those who deliberately "spread misinformation" regarding the pandemic. The latter provision was heavily criticized and led to high-profile arrests of a political activist and a farmer (charges were later dropped) (Kaszás, 2020b). The law was rescinded in June 2020, as new regulations were introduced to allow the government the continued exercise of some of its special powers. The government further appropriated some of the funding initially allocated for party financing and for local governments, arguing with the need to finance the economic recovery package. The move was widely seen as a power grab for two reasons: one, opposition parties had ascended to power in Budapest and other urban centers in 2019, and two, party financing made up a minor part of the state budget. As an immediate consequence, local governments were left without funds to mitigate the economic and public health effects of COVID-19 despite being designated as first responders. In an even clearer power grab move, the 2021 budget, adopted in July 2020, appropriated further funds from opposition-run Budapest, leading to a political clash with the mayor. As in pre-coronavirus times, decision-making and government communication in Hungary remained highly centralized around Prime Minister Orbán, with little transparency and public involvement of experts. The main channel of information provided by the government was regular press briefings by the surgeon general, mainly picking up questions from government-friendly media outlets. New measures, including, for instance, the economic package or organization of high school exams, were frequently announced by Orbán on his

Facebook page. Data on testing have been seen as unreliable: in July 2020, Norway excluded Hungary from its list of COVID-19 safe countries on the basis of incomplete reporting on testing to the European Centre for Disease Prevention and Control (Flachner, 2020).

In Bulgaria, abuses of rule of law were more limited than in Hungary, but the pandemic served as a backdrop to existing cleavages. Decision-making during the pandemic was highly centralized in the hands of Prime Minister Borissov. Dealing with the pandemic was presented as a matter for experts. In practice, however, Borissov's government created two expert advisory teams: one supported strict lockdown measures, whereas some members of the other downplayed the threat of the virus and argued in favor of herd immunity. Borissov frequently played the two teams against each other as "opposing experts" to avoid taking the blame for decision regarding the virus. Mainstream media invited experts from both teams, thriving on the conflict and doing little to address the widespread confusion caused by the spread of fake news online. All in all, however, COVID-19 seemed to have little importance in Bulgaria's political life, which developed in parallel. Although the nationalist party Vuzrazhdane organized in mid-May 2020 small protests against the lack of economic support, strict lockdown measures, and 5G (seen in some conspiracy theories as responsible for the spread of COVID-19), the massive protests in July were primarily targeted at the capture of the state by oligarchic players. Rather than the government's handling of the pandemic, the protests reflected the population's frustration with state capture, which had transpired in a series of scandals before as well as during lockdown ("Anti-corruption Protests Enter Thirtieth Consecutive Day in Bulgaria," 2020). Only in August 2020 did nurses join the antigovernment protests demanding better salaries and working conditions. Connections between the protests and COVID-19 were thus mainly indirect—reflected in Borissov's reluctance to reintroduce strict measures to avoid popular anger and in the social measures meant above all to appease key groups in the electorate in a complex political situation.

Finally, Czechia withstood attempts at executive overreach relatively well. Government measures were met with scrutiny by the parliamentary opposition, civil society watchdogs, and the judiciary, which proved to be an effective source of checks and balances. In May, the Parliament refused to approve a second extension of the state of emergency, and opposition politicians criticized numerous parameters of individual measures: for instance, the restrictive rules for cross-border workers. When the government proposed a bill that would make due diligence unnecessary for selected public procurement contracts, the parliamentary debate was eventually postponed until after the end of the state of emergency following pressure from nongovernmental organizations and the opposition ("Korupční zákon i legalizace zlodějin" ["Corrupt Law and Legalization of Theft"], 2020). Private individuals as well as senators also contested the constitutionality of key government measures (notably the travel and shopping bans) via the judiciary, including the Constitutional Court. In April 2020 a Prague court ruled that the limits to fundamental rights imposed by the lockdown and shop closure

measures were too great for the measures to be issued single-handedly by the minister of health as decrees based on the Public Health Protection Act ("Soud zrušil opatření omezující obchod a volný pohyb" ["Court Cancels Measures Limiting Retail and Free Movement"], 2020). Instead, the court insisted they be reissued by the government based on the Crisis Act, subject to parliamentary scrutiny. In fact, the measures were initially, in mid-March 2020, issued under the Crisis Act but canceled only days later and replaced with identical measures under the Public Health Protection Act—possibly because the state was potentially liable for damages under the Crisis Act (Zíta, 2020). The ruling led to an immediate easing of the lockdown. Despite numerous expert advisory teams, the government rarely provided detailed scientific rationale for its policies, which at times seemed to follow public opinion and had been criticized for a lack of transparency by experts as well as politicians (Bidrmanová, 2020).

Several conclusions can be drawn from the responses of the Czech, Hungarian, and Bulgarian governments to the COVID-19 pandemic. First, structural factors typically assessed in health threat preparedness indexes, such as state capacity or health system resilience, may not be sufficient to explain eventual outcomes. Observing the failures to prevent deaths of several typically high-capacity countries such as the United Kingdom and United States led to calls for reintegration of agency, specifically the role of political leadership, to future thinking about preparedness (e.g., Kavanagh & Singh, 2020). Eastern Europe's experience with COVID-19, however, suggests that what is perhaps needed is a nuance of the kind of capacity necessary for particular threats: in the case of COVID-19, the appropriate first response to the threat involved crude measures such as stay-at-home orders, which hardly correlate with measures of government effectiveness or regulatory capacity, for example. Building effective testing and tracing systems and designing and implementing more nuanced public health measures, however, requires more sophisticated capacity. The dramatic rise in new infections and deaths in the region since August 2020 (Shotter & Hopkins, 2020) show that CEE countries have not been, and likely will not be, as successful in the long run as in the first months of the pandemic.

Second, leadership matters, but even leaders traditionally associated with suboptimal policies such as populists can adopt responsible policies in a crisis. In contrast to other populist leaders, the three prime ministers of Czechia, Hungary, and Bulgaria placed surprising emphasis on the protection of public health, contrary to assumptions of some of the literature on the impact of populism on public health (Rinaldi & Bekker, 2020). This emphasis surely contributed to halting the exponential growth of new infections (although other confounding variables are likely to have played a role, notably the presumably low COVID-19 incidence in CEE in January and February 2020). Given the low transparency of government decision-making in the three countries, it is difficult to determine what prompted the adoption of the "responsible" option (i.e., in what aspects was leadership of central and eastern European populists different from, for example, Brazil's Bolsonaro or the United States' Trump).

There are few indications suggesting the three governments engaged in complex reviews of scientific evidence; it is more likely the initial policies, such as lockdowns and border closures, were the result of learning or emulation of other countries. After the initial swift reaction, however, experience with face masks in Czechia or nightclub closures in Bulgaria suggest leaders may become less responsible in terms of infection prevention and more responsive in terms of catering to public opinion, which had shifted from scared to unconcerned by June 2020 (National Pandemic Alarm, 2020).

Third, there were some indications in favor of the authoritarian advantage hypothesis in the three countries (Cepaluni et al., 2020; Toshkov et al., 2020). In Hungary, Prime Minister Orbán, who rules the country virtually unchecked, was able to maintain restrictive public health measures longer and introduce new restrictions easier than Czechia's Prime Minister Babiš, constrained by effective parliamentary opposition, independent judiciary, and active civil society, or than Bulgaria's Prime Minister Borissov, weakened by oligarchic infighting and mass protests. However, in the case of early COVID-19 pandemic (Cepaluni et al., 2020), the authoritarian advantage should lead to fewer deaths: Hungary, despite its low overall case numbers, had a remarkably high mortality rate from COVID-19 during the first wave, which the authorities explained by an unusually high proportion of transmissions occurring in hospitals. In autumn 2020, though, COVID-19 deaths per population seemed to rise slower in Hungary than in the other two countries. Furthermore, this advantage is, by definition, accompanied by abuses of power and disrespect of rule of law and limited pluralism in decision-making, which may have nefarious consequences on policies, including on health (Rinaldi & Bekker, 2020), as day-to-day policy-making retakes precedence over the initial period of high uncertainty.

Fourth, unlike, for example, in Brazil or the United States, responses to the pandemic need not become a politicized topic in all polarized societies, or at least not immediately. The three CEE countries are polarized along partisan identities (Reiljan, 2020; Vegetti, 2018), but the broad directions of government measures as well as the severity of the health threat itself were subject to general cross-party consensus. Similarly to other European countries, opposition parties found it difficult to contest the incumbent party's policies, as executive power became more important vis-à-vis parliaments (Merkel, 2020). In Bulgaria, notably, anti-government protests were effectively decoupled from COVID-19, and there was little criticism of anti-COVID-19 measures along party lines. Face masks became a polarizing topic in Czechia in late summer, but no major political party overtly claimed an anti-face-mask line. Similarly, in Hungary and in Bulgaria, political opposition did not oppose public health measures introduced by the government. One potential explanation for this relates to populists' monopolization of anti-establishment sentiments: when populists adopt a responsible policy, competitor parties may not be able, or willing, to credibly exploit antisystem, antiscience moods in the population, for fear of alienating their core electorate and failing to reach supporters of the populists in power.

Conclusions

Czechia, Hungary, and Bulgaria, and much of the rest of central and eastern Europe, provide a counter-example to some pre-COVID-19, as well as post-COVID-19, received wisdom on the role of structure and agency in crises. Among the old ideas, the region's successful initial containment of the virus questions the assumption that higher state capacity leads to better outcomes. Among the new ones, it qualifies some of the emerging hypotheses about ineffective leadership of populist leaders, as well as about politicization of the pandemic in polarized societies. To be sure, the region is certainly not the only case puzzling for theories of COVID-19 politics induced from a handful of prominent policy failures (the United States) and textbook successes (South Korea); similar unexpected successes have been noted, for example, in Vietnam and on the African continent (Dabla-Norris et al., 2020; Pilling, 2020). It is nevertheless interesting because of its particular combination of successful initial leadership followed by the "responsible" populists' rule of law abuses, which were mediated by democratic institutions in some countries (e.g., Czechia, Bulgaria) or left unchecked in others (e.g., Hungary), and in all cases opaque and unaccountable.

The subsequent rise in COVID-19 cases in CEE in the summer and fall put to test the limits of individual leaders' agency as a replacement for institutions prepared to tackle the health and societal risks of a pandemic without plying to the partisan interests of those in power. As governments hesitated to impose renewed restrictions, new cases overwhelmed test and trace systems, as well as hospitals, and COVID-19 deaths rose to levels on par with the worst-hit western European countries during the first wave. It is therefore tempting to conclude that the CEE populists' responsibility in spring 2020 was likely a case of a broken clock. The clock shows the correct time twice a day; from time to time, populists act responsibly. In the longer run, however, initial responsibility may not be enough to compensate for subsequent responsiveness to irresponsible public opinion or economic interests. Judging from the experience of a deadly second wave, central and eastern European countries are likely to join the ranks of other countries led by populist leaders—and end up with poor public health, as well as economic, outcomes regardless of their initial successes (Greer et al., 2020).

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