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20 A TALE OF TWO PANDEMICS IN THREE COUNTRIES

Portugal, Spain, and Italy

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and Pedro C. Magalhães*

On February 20, 2020, a young man admitted to the hospital in Italy with COVID-19 marked the start of uncontrolled COVID-19 transmission in Europe (Livingston & Bucher, 2020). Like other times in the past, Italy played the central role in the history of European epidemics: from the Antonine plague, described by Galen during the Roman Empire, to Genoa and the Black Death in the fourteenth century.

Over the next two weeks, in late February and early March 2020, the epidemic kept expanding in the Lombardian region in Italy. On March 8, 2020, the Italian government implemented a localized lockdown in the region, restricting movement to minimize social contact (Remuzzi & Remuzzi, 2020). The lockdown was expanded to the entire country on March 9, 2020.

In Spain, transmission had been underway, mainly undetected, since mid-February (Fuertes et al., 2020). On February 28, the Basque Country reported the first case, and by March 13, 2020, its regional government declared a health emergency. By then, all the provinces already had cases, motivating the national government to issue a royal decree (463/2020), declaring the state of emergency and a curfew.

In Portugal, the first cases were detected on March 2, 2020, in the northern regions, with links to Italian cases. The government rapidly convened the National Public Health Council, a committee composed of national experts (Peixoto et al., 2020), to gather advice about the necessary measures to control the pandemic. This council suggested on March 12 (Gomes, 2020) that no action be taken, but the prime minister ignored this advice, and between March 13 and March 16, 2020, a total lockdown of the country was implemented, even before the first death from COVID-19 was registered.

The synchronicity of physical distancing policies between these south European countries hides different epidemic dynamics, as well as diverse speeds in responding to the events. It is also noteworthy that different structural challenges existed when it came to responding to the most challenging health crisis in over a century. The COVID-19 pandemic is remarkable in many ways: first, never before

in the history of modern health systems in Europe have we witnessed the spectacular collapse of two of the most regarded national health systems (Arango, 2020; Horowitz, 2020; Remuzzi & Remuzzi, 2020), the Italian and the Spanish; second, the resilience of the Portuguese health system in the early stages of the pandemic was, in many ways, surprising, given decades of underfunding reinforced by more recent austerity policies.

After the great lockdown that took place during the months of March and April of 2020, the epidemic took another twist in the subsequent months. Spain and Italy managed to suppress the transmission to levels of less than 20 cases per 100,000 inhabitants. Instead, the pandemic resurged in Portugal, in the deprived areas on capital suburbs, with reports of outbreaks in factories and among the immigrant population. Combined with inefficient contact tracing, this led to a prolonged plateau of the epidemic curve. Although the health system managed to avoid collapse at the time, the inability to suppress the transmission led to Portugal's exclusion from the safe travel bubbles and to consequent damage in the tourism industry.

This chapter explores the structural similarities and differences between these three countries: on the one hand, in their respective health sectors' capacities and reorganization; and on the other hand, in the different degrees of state capacity to respond to the pressing needs of their populations. In the last great epidemic, the 1918 flu, there was a transparent north-south gradient in the extent to which European countries were hit by the pandemic, with Portugal, Spain, and Italy among those that were hit the hardest (Ansart et al., 2009). How was it this time? To what extent does the impact of COVID-19 reflect resilient societal and institutional vulnerabilities in these countries? And to what extent have national specificities interacted with those shared vulnerabilities, leading to different outcomes?

Public Health

Public Health Strengths and Vulnerabilities

Italy, Spain, and Portugal's health systems are financed through general taxation, are generally free at the point of care, and provide universal health coverage (de Almeida Simões et al., 2017; García-Armesto et al., 2010; Lo Scalzo et al., 2009). The three national health systems emerged in the late 1970s, in Italy as the result of the collapse of the previous social health insurance system and in Spain and Portugal as part of their democratization. They share some standard organizational and performance features that constitute potential strengths and vulnerabilities when facing a pandemic event.

One of the most salient of these features is the impact of a decade of fiscal austerity. During the Great Recession and the Eurozone crisis, the governments of Italy, Spain, and Portugal decreased the budget available for health care (Stuckler et al., 2017), leading to cuts in long-term infrastructure investments and making it even more difficult to deal with the problem of an aging

workforce (Karanikolos et al., 2013; Legido-Quigley et al., 2016). Nevertheless, compared with northern European countries, these countries have very efficient healthcare systems (Cylus et al., 2017; Perleth et al., 2001). In other words, the return in terms of population health is very good for every Euro invested. However, in what is only apparently a paradox, efficiency is not an advantage during a pandemic. If all the resources are fully optimized, any significant surges in demand, such as those experienced during early March 2020 in Italy and Spain, this favors a collapse of the health system. Portugal seemed especially vulnerable, as it had the lowest number of intensive care unit beds per inhabitant in Europe and one of the lowest levels of investment in public health services in Europe (Rhodes et al., 2012). In 2015, on average, the countries of the Organization for Economic Co-operation and Development (OECD) allocated 2.8 percent of their total healthcare budget to health promotion and disease prevention. Portugal and Spain devoted below 2 percent to prevention, whereas Italy (2.9 percent) was above the OECD figure (OECD, 2017).

Another feature important to consider is the governance structure of the national health system. Italy and Spain have a rationalized governance model in which regions play a more decisive role in the definition of delivery, managing human resources and budget allocation (García-Armesto et al., 2010; Giovannini & Vampa, 2019; Lo Scalzo et al., 2009). In contrast, Portugal has a highly centralized health system, with a national agency responsible for budget, and regional health administrations play only a minor role in health system organization, serving mainly as links in the transmission chain under the command of the national level. In theory, Spain and Italy's regional organization has many advantages, such as greater flexibility in adjusting delivery to local needs and preferences and an increased room for innovative experiences in delivery models. However, during a pandemic that requires an unprecedented level of coordination and speed, this regionalization can be a disadvantage. A centralized governance model such as the one in Portugal will tend to be faster in implementing the dramatic reorganization that is needed. In sum, efficiency level and governance model are the salient features that directly determine the capacity of the health system to respond to the pandemic.

Public Health Response to the Pandemic

Why did the Italian and the Spanish health systems collapse in the early stages of the pandemic, and not the Portuguese? A quote attributed to Franklin D. Roosevelt illustrates one of the reasons for this difference: *"I think we consider too much the luck of the early bird and not enough the bad luck of the early worm."*²¹ Italy and Spain were the first countries experiencing uncontrolled transmission in Europe, when a lot was still unknown about the virus, from clinical management to the appropriate non-pharmacological interventions. As late as February 2020, the ability of this virus to lead to a health system collapse in high-income countries was not yet evident. The influential paper by Neil Ferguson, the British mathematician

and epidemiologist, stating that only suppression (lockdowns) measures would prevent health system collapse was published March 16, 2020 (Flaxman et al., 2020; Walker et al., 2020). The knowledge transferred by Italian doctors to the European medical community was an important factor in changing clinical practices and helped health systems elsewhere (Grasselli et al., 2020). In sum, the bad luck of being an early worm should not be understated, as countries that were hit later had the opportunity to benefit from the knowledge transfer from Italy and—partially—Spain. Portugal was one of these countries.

Furthermore, when Italy and Spain had accumulated one hundred cases, their levels of mobility were still close to normal. In contrast, by the time Portugal reached the same number of cases, mobility was already more than 30 percent below average. The first death attributed to the virus in Italy was reported on February 22, 2020. The Italian press was caught by surprise by the quick spreading of the pandemic and did not act in sync with government decisions regarding the best ways to prevent the virus to spread. On March 8, 2020, the day before the northern region of Lombardy, Italy's COVID-19 epicenter, went into lockdown, *Corriere della Sera*, Italy's most widely read newspaper, published an early draft of the government decree ordering inhabitants to stay indoors. This leak provoked a general upheaval, and more than 41,000 people anticipated their traveling plans and moved around the country without any barriers or control. Prime Minister Giuseppe Conte was forced (amidst an outcry from some political parties, echoed by the press) to close the country the next day. Similarly, in Spain, wealthy and middle-class madrileños flight to their second homes—spreading the virus over the weekend before the first state of alarm was declared—had a huge impact in the countryside levels of contagion. In contrast, a social self-lockdown was already happening in Portugal even before governmental actions, as the media were saturated with catastrophic news about Spain and Italy.

The differences in the virulence of the COVID-19 epidemic among Italy, Spain, and Portugal are best shown comparing excess mortality from all causes (Kontis et al., 2020). How many more people are dying than usual for a specific time of the year? Italy and Spain have staggering numbers of 44 percent and 56 percent, respectively, and these numbers hide significant variations between regions (e.g., in Madrid the excess mortality is 157 percent higher than usual). In Portugal, the excess mortality increased by only 11 percent. This put Portugal close to Germany, Austria, and Denmark, countries with some of the best performances on this indicator. Hence, differences between Portugal, on the one hand, and Italy/Spain, on the other, are a tale of two pandemics in three countries. At the earlier stage of the pandemic, Portugal managed to protect the population more efficiently and avoid the detrimental effects of the collapse of the health system in the COVID-19 hotspots.

However, in the months right after the end of the lockdowns, June and July 2020, Spain and Italy achieved a level of suppression of transmission never achieved by Portugal. On the one hand, Italy and Spain had decreases in mobility that were more severe than in Portugal, whereas “deconfinement”—the return

to a new baseline close to normal—happened faster in Portugal. On the other hand, Portugal's inability to “crush” the epidemic curve in the same way as Italy or Spain can also be explained by a public health workforce that was not sufficiently large to deal with the pandemic, and by difficulties implementing an effective test-trace-isolate-support system. The epidemic in Portugal maintained a “slow burn” level in the deprived areas in the outskirts of the Lisbon metropolitan region, in a population that was dependent on crowded public transportation, living in sub-standard housing conditions, and suffering low literacy levels (Instituto Nacional de Estatística, 2020). Although the health system was never in danger of collapsing in Portugal, the “slow burn” and the inability to “crush the curve” damaged the country's image of having excelled in pandemic management.

Finally, all three countries faced common governance problems. Several studies have suggested that national variations in the quality of response to the COVID-19 pandemic across the world seem to be linked to countries' differential *state capacity* (Bosancianu et al., 2020; Liang et al., 2020; Serikbayeva et al., 2020). Whether these broad cross-sectional snapshots will find confirmation as more evidence emerges and the full consequences of the pandemic unfold is yet to be determined. However, a priori, none of these three countries seemed particularly well positioned from this point of view. Although commonly used cross-national and cross-regional indicators have shown signs of improvement in the quality of governance in Portugal and northern Spain (Charron & Lapuente, 2018), government effectiveness in all three countries—particularly Italy—is below the average of the high-income OECD countries (Kaufmann et al., 2010).

How this played out in the ability to mount an effective public health policy response in the three countries can be illustrated in different ways. In Portugal, as concerns about the spread of infection in nursing homes mounted, it was soon “discovered” that there were more illegal such establishments in the country than legal ones, hosting close to 35,000 older or disabled adults and raising enormous challenges for testing, isolation and contact tracing (Penela, 2020). In Italy, although approved in mid-April 2020, the “test, trace, and treat” strategy was still not entirely on the ground by mid-June (Capano, 2020), whereas in Spain, data collection and contact tracing suffered from lack of expert personnel and minimally appropriate information systems (Llaneras, 2020). Although the supply of medical material was problematic in many European countries, such problems were particularly egregious in Spain, as defective equipment continued to be deployed by the Ministry of Health and used by professionals for several weeks despite early suspicions (Ramos, 2020). Characteristically, although the Portuguese government approved a plethora of highly detailed rules about “physical distancing” as the country abandoned confinement in May 2020, the government was ultimately forced to admit that it was “impossible” to enforce some of those rules, particularly those related to safety in public transportation (Santos, 2020). As stated by Saboga-Nunes et al., the decrease of preventive disease measures and proactive health promotion strategies is detrimental to the pandemic control (Saboga-Nunes, 2020).

In sum, deficits in these countries' "state capacity," understood as "their ability to exert control over their populations and territories, and their ability to formulate and implement policy," (Bosancianu et al., 2020) encumbered their public health response to the crisis.

Social Policy

Socioeconomic and Political Vulnerabilities

Portugal, Spain, and Italy also share several features that made their societies and economies particularly vulnerable to the pandemic. The first is a very strong economic dependence from the tourism sector. In 2019 the total contribution of travel and tourism to the gross domestic product (GDP) of Italy, Spain, and Portugal was, respectively, 13 percent, 14 percent, and 17 percent, far above the median of high-income countries and, in all cases, only behind the contribution of financial services and—another hard-hit sector—retail (WTTC, 2020). Second, a comparatively high proportion of the workforce in these countries is composed of low-skilled manual and service sector workers (Afonso & Bulfone, 2019) as well as by temporary employees (22 percent in Spain, 17 percent in Portugal, and 13 percent in Italy, against an EU average of 11 percent) (Eurostat, 2020b). That results in large shares of jobs at risk of destruction by the pandemic and that cannot be performed remotely (OECD, 2020), and, on the other hand, in comparatively high numbers of employees that enjoy limited social protection and job security (Sabat et al., 2020). Finally, the three countries have been fiscally constrained for a considerable time. The consequences of the austerity policies adopted to address the 2010–2013 financial crisis left a resilient mark in the material and human resources available to their public sectors (Petmesidou et al., 2014). Although the worst depths of the crisis had been overcome by the end of 2019, Italy, Portugal, and Spain still had the second, third, and sixth largest public debts in the European Union.

The lockdowns that followed the epidemic combined with these vulnerabilities to generate profoundly negative economic consequences and limit the scope and depth of the possible policy responses. On the one hand, during the second quarter of 2020, our three countries, along with France, experienced the most significant economic contractions among all Eurozone countries (Eurostat, 2020a). On the other hand, although their governments provided cash-based transfers, wage subsidies, and increased benefits to a variety of vulnerable sectors of the population (Gentilini et al., 2020), these measures represented a significantly lower share of each country's GDP than similar policies in less constrained economies. Instead, the lion's share of the fiscal effort in southern Europe was devoted to deferrals of tax and social security contributions (in Italy and Portugal) and credit lines/liquidity guarantees (again in Italy, and to a lesser extent, in Spain)

(Anderson et al., 2020), “a textbook example of what limited fiscal elbow room allows when the rainy days come” (Nicola Rossi, 2020).

Finally, in the same way deficits in state capacity encumbered the health policy response, they also encumbered the social policy response. In all three countries, social and economic support strategies were affected by inefficiencies and delays. In Italy, redundancy funds for employees of small firms and credit guarantees for enterprises suffered from extremely cumbersome procedures, with the result that, by July 2020, such measures had only reached a small number of the potential beneficiaries (Mascio et al., 2020). In Portugal, the implementation of credit lines for enterprises and financial support for self-employed workers was also protracted (Andrada, 2020). Meanwhile, unemployment benefits for temporarily redundant workers failed to reach many thousands of beneficiaries in Spain (Rodriguez, 2020).

Explanation

The Challenges of Multilevel Governance

There is, however, one aspect in which our countries differ significantly. As argued by Dergiades and others, “the greater the strength of government interventions at an early stage, the more effective these are in slowing down or reversing the growth rate of deaths” (Dergiades et al., 2020; see also Petherick et al., 2020). And in this respect, Portugal benefited not only from avoiding being “the early worm” but also from its centralized chain of command, allowing a faster and broader implementation of the lockdown measures.

Portugal is a unitary state, and one of the most centralized in Europe. Although the country is divided into regional health authorities, responsible for implementing national health goals, they respond directly to the Ministry of Health, which concentrates planning, regulation, and management of the national health service. In other words, “[i]n Portugal, most of the health system steering happens at a central level” (OECD, 2015). Centralization facilitated a unified and coordinated emergency response, and it has also helped deliver one of the Portuguese system’s significant strengths, a well-developed, coherent, and rich information infrastructure (OECD, 2015).

In contrast, in the other two southern European countries, regions (Italy) and autonomous communities (Spain) enjoy vast competencies in health care, elder care, and economic assistance policies. That has the potential to create coordination problems. In Italy, the regional governments started by completely failing to implement their regional pandemic plans as requested by the Ministry of Health in January. In Lombardy, for example, the regional government leader started by downplaying the threat posed by COVID-19 and criticized lockdown decisions based on their potential economic consequences. That led the national

government to dispense consulting with regions when issuing lockdown decisions (Capano, 2020). Still, despite the explicit advice from experts to declare two municipalities in the province of Bergamo as “red zones,” both the central and the regional government failed to do so, an omission now is seen as having had catastrophic consequences but that both the central and regional governments, in typical blame-shifting mode, have assigned to each other’s inaction. A fundamental misalignment between the central government and regional authorities seems to have contributed to “severely undermine the management of the crisis, increase confusion, and create an image of chaos outside” (Ruiu, 2020).

In Spain, the initial coordination problems between the seventeen autonomous communities and the central government around the closing of schools appeared to be solved with the state of emergency decree’s approval on March 14, 2020 (Jiménez, 2020). However, such problems were soon to make their comeback. By late March 2020, at the height of the rise in new cases, the much-needed reallocation of resources and personnel between regions struck very differently by the pandemic was “a bureaucratic tangle in which, for the moment, no community wants to get bogged down” (Sevillano & Linde, 2020). Different protocols and resources for contact tracing, isolation of infected medical professionals, and collection and sharing of data about new cases and fatalities contributed to a high asymmetry of information and performance between communities (Fresno, 2020). None of this is particularly new: the lack of coordination between health services of the different communities has long been signaled as a pending issue in Spain’s healthcare reforms (Sánchez Fierro, 2016), which the pandemic only served to bring to fore with particular intensity (Molina et al., 2020).

Facets of Public Response

How did the publics of these countries respond to the pandemic crisis and the measures adopted to face it? A look at survey data allows us to trace a few similarities and differences among Italy, Portugal, and Spain.

Approval of the government’s management of the pandemic seems to show different patterns in the three countries. In Portugal, a government whose popularity had changed little since the October 2019 elections experienced a small decisive burst after the pandemic. Studies conducted in both March and May 2020 showed that more than 70 percent of respondents trusted the government’s and national health authority’s response to the pandemic, an attitude only weakly related to partisanship or ideology (Magalhães et al., 2020). The governing party experienced a five-point increase in voting intention from February until May 2020, which remained stable until early August (“Europe Elects: Portugal,” 2020). In Italy, the government started facing the crisis in a more disadvantaged position, with an approval rate below 40 percent and a significant gap in evaluations by partisans of the *MS5* and *Partito Democratico* in government and by those of the opposition parties. Since then, however, the government appears to have benefitted from a “rally ‘round the flag” effect (Segatti, 2020) that has dramatically neutralized

partisan differences in government evaluations. The primary victim seems to be Lega Nord, which experienced a significant drop in the polls in one of the hardest hit regions by the crisis in Italy. Finally, in Spain, no “rally ‘round the flag” effect seems to have existed. The approval level of the government’s response to the crisis always stayed below Portuguese and Italian levels (“COVID-29: Government Handling and Confidence in Health Authorities,” 2020), and voting intentions for the Spanish Socialist Party (PSOE) and for United We Can (Unidas Podemos), the main parties in government, have remained mostly stable. The perception of government competence in dealing with the pandemic and how that translates to government approval seem to be very heterogeneous in these three countries. However, the unfolding public health and economic situation in all three countries could change this picture quickly. For example, in a similar poll conducted in September 2020, confidence in the Portuguese government’s public response to the pandemic had already dropped almost twenty points in relation to May.

A second important dimension concerns the adoption of personal measures to avoid contagion. Italians and Spaniards led European countries (on which we have data) in the use of masks. By late March 2020, 70 percent in Italy, 42 percent in Spain, and 27 percent in Portugal reported the use of masks in public places, above countries such as France, Germany, and, especially, the United Kingdom and Scandinavian countries. By May 2020, these percentages had increased to much higher levels, around 80 percent, and have remained mostly stable ever since. Similar patterns can be found in the self-reported avoidance of crowded public spaces, increased personal hygiene, and avoidance of physical proximity (“COVID-29: Government Handling and Confidence in Health Authorities,” 2020). In other words, with a lag that approximately fits the staggered severity of the pandemic in each country, the self-reported adoption of personal protective measures seems generalized in the south by July 2020 to a majority of citizens. However, a false sense of safety, economic necessity, and deeply ingrained patterns of sociability seem to have conspired, at least for a minority of citizens, to reverse some of previous behaviors. In Spain, for example, the resurgence of cases in August was attributed to a return to close interpersonal contacts, partying, and social gatherings (Güell, 2020).

A third relevant dimension concerns citizens’ support for the government’s measures to contain the pandemic. By April 2020, when the epidemic situation remained most challenging, and all three countries had their most stringent measures in place, one distinguishing feature of Southern European countries was more robust support of their populations for such restrictive measures than that found among Northern European countries (“COVID-29: Government Handling and Confidence in Health Authorities,” 2020). That could correspond to a worse situation on the ground: by mid-April, Spain and Italy were experiencing, respectively, twelve and eight new COVID-19-related daily casualties per million inhabitants. However, Portugal’s situation was much less dramatic, with about three new daily casualties per million, numbers that were not very different from those in countries that had less stringent policies at the time, such as Germany or Denmark. This suggests—and will need to be more systematically tested—that cross-national

differences in popular support for stringent measures seem to be more directly related to what government policies happen to be at the moment than with the epidemiological situation on the ground. Congruently with this notion, as both Spain and Italy started adopting measures reversing some aspects of deconfinement in July 2020, support for enforced quarantines, which had been dwindling since April 2020, increased again (“COVID-29: Government Handling and Confidence in Health Authorities,” 2020).

Another (and potentially darker) aspect of this endorsement of government policies is visible in the public support for measures that might impinge more grievously on privacy and personal freedoms. For example, by April 2020, a study had already found that the most polarizing issue in Europe was the use of mobile data for tracking cases and their contacts, with important shares of the population in Denmark, Netherlands, and Germany opposing such measures. Such use, however, found greater acceptance in Italy or Portugal (Sabat et al., 2020). Similarly, a panel study showed that, after the outbreak, Spaniards became more willing to support “strong leaders,” give up individual freedoms, and endorse technocratic governance (Amat et al., 2020). However, as we have discussed previously in the case of Spain, although elements of political culture—such as the comparatively lower value placed on individual freedom and autonomy in southern than in northern Europe (Welzel, 2013)—may contribute to produce a more passive acceptance of government-dictated restrictions, that may not be enough to curtail deeply ingrained patterns of sociability.

Political Polarization

The problems faced by Italy and Spain have been compounded by the more intense political rivalry and polarization that can be observed in those two countries when compared to Portugal. In the former, Matteo Salvini, the leader of the populist Lega Nord, the party controlling two of the most affected regions—Lombardy and Veneto—but out of the coalition supporting the national government since September 2019, was intensely critical of the government’s response from the start, beginning by downplaying the importance of the pandemic, then criticizing the slow response, and later the delay in ending the lockdown. One study suggests that this overt public dissent affected compliance with lockdown orders: reductions in mobility—as captured through geolocation data—in response to physical distancing orders were less sharp in areas with higher vote shares for Lega Nord, whereas they were sharper in areas with higher shares of votes for the largest party in government, MS5 (Barbieri & Bonini, 2020). The same effect was seen in the United States (Adolph et al., 2020).

In Spain, a background of rising political acrimony, affective polarization, and distance between the political parties on the country’s crucial ideological issue—the territorial cleavage (Alfonso, 2020)—has also played out in the management of the COVID-19 crisis. Following a brief period of respite at the height of the pandemic, disputes about the extension of lockdowns, struggles between the gov-

ernment and nationalist parties around the centralization of health policy, blame-shifting between the government and opposition-controlled municipalities, and even the refusal of one the major parties—the far-right Vox—to discuss future COVID-19-related measures with the government (Gallardo, 2020) have been observed. Sánchez, Spain’s prime minister, ultimately evoked Portugal’s case and the leader of its opposition party, the PSD, as an example of cooperation that was missing in Spain. However, the absence of a territorial cleavage in Portugal, the much smaller political weight of the populist far-right, and a horizon of likely governmental stability and distant elections were background conditions favoring a more robust political consensus that Spain could not replicate.

Tourism and the “Race to the Bottom”

One of the pandemic’s impressive political dimensions is the impact of the measures imposed to travelers to and from different European countries, whereby some nations imposed quarantines—not fully endorsed by the scientific community—to their own citizens if they had traveled from nations deemed of high risk. The central political aspect that emerges is southern European countries’ willingness to take more risks of admitting citizens from other countries with worse incidence indicators. That aspect was very salient for Italy, Spain, and Portugal, where no travel restrictions were imposed for countries such as the United Kingdom. That shows that the economic relevance of keeping the tourism economy afloat was more important than the risk of importation of COVID-19 cases. Spain was in the first UK safe-travel list published on July 3, 2020; it was later removed on July 25, 2020, at the time with a lower incidence of COVID-19 than the United Kingdom. Portugal was only added to the list on August 22. The exclusion from the UK safe-travel list prompted a ferocious political response at the highest level, labeling this exclusion unfair and arbitrary. The “Race to the bottom” term was used to describe the competition between countries for lower taxes to attract foreign capital (Plümper et al., 2009). A similar effect seems to be happening in the competition for tourism in southern European countries.

Conclusions

This chapter explores the similarities and differences between Portugal, Spain, and Italy, and how they played out in the response to public health and social policy responses to the pandemic. Italy, Spain, and Portugal shared similar vulnerabilities before the pandemic started: a decade of austerity, limited fiscal room to implement new social policies, and an employment sector poorly prepared for working from home and vulnerable to unemployment resulting from lockdowns. However, Italy and Spain faced an additional challenge: a multilevel government structure, where taking and implementing political decisions takes more time and is more complicated. The inability to coordinate a fast response in the early days

of the pandemic seems to have played a role in the initial collapse of the health system in Italy and Spain and in the higher levels of excess all-cause mortality. Higher levels of political polarization in Spain and Italy and the weight of the populist far-right were also factors that have surely not contributed to a more effective political response.

In contrast, Portugal benefited not only from the early warning from Spain and Italy, but also from a faster, more coordinated, and politically consensual response. The Portuguese health system avoided collapse, and mortality was kept at comparatively lower levels in the early stages of the pandemic. However, after the first lockdown, and as restrictions eased, this relative advantage of Portugal began to dissipate. Deficits in state capacity and economic pressures created conditions that prevented the country from maintaining the previous levels of suppression of the transmission, leading to a prolonged plateau of the epidemic curve. As the “second wave” unfolded in the last quarter of 2020, the structural similarities between the three countries exerted their influence, leading to much less dissimilar outcomes than those that could be observed at the earliest stages of the pandemic.

Note

1. Letter from FDR to Judge Henry M. Heymann, December 2, 1919.

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