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Multi-level responses to COVID-19: crisis coordination in Germany from an intergovernmental perspective

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ABSTRACT
This article is aimed at analysing local and intergovernmental responses to the COVID-19 pandemic in Germany during the 'first wave' of the pandemic. It will answer the question of how the intergovernmental system in Germany responded to the crisis and to what extent the pandemic has changed patterns of multi-level governance (MLG). The article argues that the coordination of pandemic management in Germany shifted between two ideal types of multi-level governance. While in the first phase of the pandemic the territorially defined multi-level system with the sub-national and local authorities as key actors of crisis management was predominant, in the second phase a more functional orientation with increased vertical coordination gained in importance. Later on, more reliance was given again on local decision-making. Based on this analysis, we will draw some preliminary conclusions on how effective MLG in Germany has been for coordinating pandemic management and point out the shortcomings.

KEYWORDS Intergovernmental relations; crisis; covid-19; federalism; coordination; multi-level governance

1. Introduction: the COVID-19 pandemic as a local and intergovernmental challenge

The COVID-19 pandemic represents a historical challenge for the German federal politico-administrative system. It required a rapid response from all actors within the multi-level system and activated multiple vertical and horizontal coordination mechanisms in the complex intergovernmental setting of the German 'unitary federalism' (see Kuhlmann and Wollmann 2019; Fuhr, Fleischer, and Kuhlmann 2018). Sub-national, specifically local governments, have been key in Germany's pandemic management and containment strategy. This article is aimed at analysing German local governments' institutional responses to the COVID-19 pandemic from an intergovernmental

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perspective focusing on the time from February to September 2020. It will answer the question of how the intergovernmental system in Germany responded to the crisis and to what extent the pandemic has changed pertinent patterns of multi-level governance, paying particular attention to the role of *Länder* and local governments. Making a distinction between three major phases of pandemic management, we will investigate how different actors in the intergovernmental setting have managed crisis mitigation, which challenges and tensions have become apparent in the multi-level system and which patterns of intergovernmental coordination have unfolded throughout the crisis. Particular emphasis will be given to coordination mechanisms and collaboration patterns across levels and between interrelated policy sectors or task units. In the final part of this article, we will draw some preliminary conclusions on how effective MLG in Germany has been for coordinating pandemic management and point out the shortcomings.

The concept of multi-level governance and the distinction of two major types of coordination and organisation in the sub-national space form the theoretical basis. Drawing on Hooghe and Marks (2003), we distinguish two ideal-types of MLG: 'type I' and 'type II' (see also Hooghe and Marks 2001). Whereas the ideal-type MLG I refers to a primarily territorially defined multi-level system within which all territorial functions fall to a politically responsible (local/subnational) unit, the type of MLG II is characterised by a functional orientation and vertical, function-based administrative organisation, in which more centralised coordination is predominant linking-up the state and local levels (see also Kuhlmann and Wollmann 2011, p. 489; Kuhlmann 2015). From a local government perspective, MLG I represent a territorially based mode of steering with the subnational/local governments assuming the mandate to define the common good for their territories and thus to balance multiple single-purpose actors with specific interests. It is predominantly based on a 'territorial rationality' and emphasises the role of decentralised governments for horizontal coordination and harmonisation of potentially conflicting policy goals. By contrast, MLG II institutionally separates political accountability and administrative execution and privileges vertical coordination across levels of government. It is premised on functional rationality and relies more on centralised decision-making rather than local discretion.

In this article, we argue that multi-level governance and the coordination of pandemic management in Germany shifted between the two MLG ideal-types. Traditionally, German intergovernmental relations are pronouncedly shaped by MLG I with the principle of territoriality being predominant and the subnational entities as fairly autonomous actors of coordination. Within the highly decentralised federal system, MLG II usually plays a less important role, which contrasts to unitary and more centralist countries like France and Italy (see Bouckaert et al. 2020; Kuhlmann et al. 2021b; Galli and Parrado

2021), where functionally oriented governance mechanisms are fairly prevalent. However, the pandemic crisis has temporarily changed these coordination patterns. While in the first phase of the pandemic, the intergovernmental relations still largely corresponded to the usual type MLG I with the territorial perspective being predominant and the subnational authorities as key actors of crisis management, in the second phase MLG II became more relevant and functionally oriented vertical coordination between actors from various levels of government gained in importance. With the infection case numbers declining towards the end of the 'first wave' a return to the common pattern of MLG became apparent and more reliance was given by political actors on local initiative and discretionary decision-making.

2. Intergovernmental set-up

Two potentially opposing principles mark the German 'unitary federation' (*unitarischer Bundesstaat*). On the one hand, the 16 federal states (*Länder*) enjoy a powerful position and autonomy in having their own legislatives, executives, and judicative bodies as well as a high degree of discretion, specifically regarding the execution of federal, EU and its own laws. Additionally, the Länder participate through the *Bundesrat* in the legislation of the federation. On the other hand, the unity of law, economy and living conditions are constitutionally protected. Multiple mechanisms provide for an enforcement of collaboration and joint decision-making across levels and jurisdictions in order to guarantee for unity of the federation (see Fuhr, Fleischer, and Kuhlmann 2018; Kuhlmann 2020). Manifold intergovernmental collaboration mechanisms have been institutionalised, some of which involving the *Länder* only (horizontal collaboration), whereas others involve the federal and the *Länder* level (vertical collaboration). Within this setting, the principle of an 'executive federalism' is another essential feature, which also played out during the pandemic. According to this principle, the federal level is mainly responsible for policy formulation, whereas the *Länder* and the local governments as parts of *Länder* administration are mostly engaged in policy implementation (see Kuhlmann and Wollmann 2019).

The federal level has no hierarchical control, no legal supervision, and also no financial appropriation over the *Länder* level and local governments which goes in line with the principle of territoriality within MLG I (see above). As a consequence, the federal executive has only very little direct involvement in implementation and service delivery and thus does not operate with regional or local offices (exceptions include defence, customs, inland waterways, and the federal police). This also applies to the implementation of pandemic containment measures based on the Federal Law on the Prevention of Infection (*Infektionsschutzgesetz* – IfSG), which stipulates an exclusive

administrative competence of the *Länder* and local governments. Thus, the MLG I type is also institutionalised in pandemic regulation.

From a comparative perspective, the German local government system can be regarded as one of the functionally and politically strongest in Europe possessing a broad multi-purpose task profile, robust administrative structures and manifold competencies, inter alia in public health issues and implementing the IfSG. While local governments carry out tasks delegated to them by the *Land*, which is the case with the implementation of the IfSG, they also discharge tasks which derive from the 'general competence' clause, an essential of local self-government as guaranteed by article 28 of the Federal Constitution (Basic Law – *Grundgesetz*) and by the *Länder* constitutions. Accordingly, the municipalities and the counties (to a somewhat lesser degree) have the right 'to regulate all matters relevant for the local community under their own responsibility within the limits set by the laws'. From an intergovernmental perspective, the German local government system represents a key component of MLG I as it guarantees the bundling of all territorially incurring tasks and the horizontal harmonisation of potentially conflicting sectoral policy issues.

3. Crisis preparedness and the role of the local governments in pandemic management

Preparedness of the health system

The capacity and resilience of the German health system have been assessed as high compared to other countries, particularly in Southern and Eastern Europe, but also the UK and the US (see Bouckaert et al. 2020; Kuhmnann et al. 2021b; Kuhlmann 2020). The German health system is highly decentralised and involves a multitude of subnational and local institutional actors, self-governing bodies and sub-state authorities. Whereas the federal level is basically limited to monitoring, surveillance, research and legislative functions (see below), the lion's share of health-related tasks is assigned to the *Länder* and local governments. Besides the two other pillars of German public health service (outpatient and inpatient patient care), they form its so-called third pillar. Within this system, the *Länder* are responsible for health protection and supervision of professions and health care facilities, based on specific *Länder* health service laws.

In quantitative terms, Germany ranks amongst the leading countries in Europe, especially regarding health expenditures. With 4,300 € per capita or 11.2% of the GDP, which is approximately 50% above the EU average, Germany has the highest health expenditures in Europe (see European Commission 2019). Additionally, Germany has 'some of the highest rates of beds, doctors and nurses per population in the EU' (OECD/European

Observatory on Health Systems and Policies 2019, p.3). Around 84.4% of the total German health expenditure is financed by government programmes and compulsory insurance, including statutory and private health insurance, additionally private households contributing 12.5%. Health care industry is one of the largest sectors of the German economy with 11.2% of GDP. Around 85% of the population is covered by statutory health insurance, the rest by private ones (European Commission 2019, p. 9). In 2017, 37% of German hospitals were in private ownership, 29% publicly owned, and 34% managed by non-profit providers (Statistisches Bundesamt 2020). They still form a dense nation-wide network of health facilities, guaranteeing for proximity and short distances, which continues to be criticised however by health economists for efficiency reasons[1] (see OECD/European Observatory on Health Systems and Policies 2019).

With regard to the qualitative indicators, by contrast, a number of deficits in the German health system have revealed, which have been criticised since many years without being resolved. These shortcomings have become acute and visible to the wider public during the pandemic. The major problem lies with the severe staffing deficits in hospitals and nursing services as well as with their inadequate technical equipment. The OECD therefore valued the German health system as only 'moderately effective' (OECD/European Observatory on Health Systems and Policies 2019, p. 22).

Role of local health authorities

Local governments' most important task during the COVID-19 was to implement the IfSG on their discretion and under the supervision of the *Länder*. In this context, they were not only responsible for health-related issues but, more generally, for pandemic crisis management in their territory and the horizontal coordination of various crisis-related administrative units at the local level. Furthermore, they had to ensure vertical coordination with the respective *Länder* authorities and the federal level, specifically with the federal authority for disease monitoring and prevention Robert Koch Institute (RKI). Yet, it needs to be emphasised that dealing with epidemic crises is nothing new to the German public health service. Specifically, local health authorities can draw on longstanding experiences in managing health threats and in containing local outbreaks of various infectious diseases (e.g., measles). These tasks constitute an essential element of their multi-purpose task profile and institutionally underpin the predominant governance principle of territoriality (MLG I). This institutional key feature constitutes a salient difference to unitary centralised countries (such as the UK) where function-oriented governance and vertical coordination (MLG II) are more relevant in central-local relations and accordingly local know-how in pandemic management is less valued and trusted by central governments.

Most of the 401 local health authorities (*Gesundheitsämter*) are located in the counties and county free cities. Whereas in some *Länder*, they are organised as lower state (*Länder*) authorities (e. g. in Baden-Württemberg and Bavaria), in others they legally belong to the local self-government. Equipped with at least one local physician, local health authorites perform tasks delegated to them and supervised by the state (*Länder)*, inter alia executing the federal IfSG, including local infection protection. According to the IfSG, a distinction is made between local health authorities' rather limited technical tasks and their operational tasks 'with extensive powers to intervene' as special regulatory authorities (see Kersten and Rixen 2020: p. 115 f.).

Local health authorities have become 'one of the central pillars of Germany's crisis response'(Financial Times, 4.6.2020). 'Every county's public health officer has more powers than the Federal Minister of Health' stated a German newspaper(Der Tagesspiegel, 12.4.2020), illustrating the outstanding importance of the local public health service in Germany. A survey by the German County Association (DLT) and the German Association of Cities (DST) conducted in August 2020 attested a fairly good performance to the local health authorities in the pandemic (see Deutscher Landkreistag 2020). Quickly beefed up with additional money and manpower by the federal and Länder governments,[2] they employed about 5,900 additional staff members until June 2020,[3] mainly to organise contact tracing, testing and quarantine control.

These achievements notwithstanding, the public critique on local health authorities in handling the crisis became increasingly severe and vociferous. To explain this development it must be taken into account that local health offices used to have a more or less shadowy existence in public administration, before the crisis broke out. Their capacities were rather limited[4] and some of them were hardly able to fulfil their tasks even under non-crisis circumstances (Bayer 2020). This situation became suddenly acute when the pressures caused by the containment policies accellerated and local health authorities were forced to quickly respond to a dramatically growing workload arising from the implementation of local containment measures according to the IfSG. These difficulties worsened from October 2020 onwards when many local health authorities reached their limits and about three thirds of all corona contacts were not traceable anymore.

The shortcomings mentioned above have not been addressed appropriately by the goverments at various levels so far. This applies on the one hand to the local health authorities which were overwhelmed by executing the containment measures, particularly in view of soaring numbers of cases to be traced by them. For reporting and monitoring, they were also lacking digital tools and IT systems and thus continued to transmit relevant data to the federal monitoring authority by phone or fax, with subsequent mistakes, delays and inconsistencies in data transmission. On the other hand, the

hospitals and care services showed major shortages, particularly regarding an unsufficiant recruitment and payment of specialised personnel. In this context, it is also surprising that the number of intensive care units was reduced from 33,000 to 27,000 between July and November 2020 (DIVI 2020) and that about 20 hospitals (with more than 2,000 beds and 4,000 jobs) were closed during the pandemic (Bündnis Klinikrettung 2020), which contributed to an even more restraint situation in the 'second phase' of the pandemic. The same applies to local care homes which were not put in centre of governments' pandemic policies and continued to be in urgent need of more focused, targeted and at the same time human protection concepts. In view of these failures, the preparedness of the hospital and care sectors as well as the local health authorities to the second pandemic wave must be assessed as rather poor.

4. Shifts in multi-level governance during the pandemic

In Germany, the COVID-19 management during our investigation period was marked by a swinging pendulum from MLG I to MLG II and back. Starting from the traditional pattern of territory-based crisis mitigation at sub-national and local level emphasising local discretion and territorial steering, a shift towards more functionally-oriented vertical governance (MLG II) could be discerned when the pandemic reached its first peak (March/April 2020). More intervention from above, hierarchical coordination across levels and streamlined *Bund-Länder* decision-making with rather unifying and even centralising impetus were practised, followed, again, by more reliance on territorial initiative towards the end of the 'first wave'. These shifts in MLG patterns were paralleled by sequences of tightening the containment (phase II) and easing it (phase III), the latter however accompanied by diverse, at times very bureaucratic regulations on hygiene and protection measures. In general, it is notable that, during the crisis, the intergovernmental system exhibited a certain degree of institutional flexibility and adaptability. Figure 1 displays the major events and the timeline of the pandemic crisis.

From an intergovernmental point of view, three phases of pandemic management can be distinguished in which a repeated re-balancing between MLG I and MLG II occurred (see also Franzke and Kuhlmann 2021) and the intergovernmental system adapted to new circumstances.

First phase: local pandemic management and reliance on MLG I

From the detection of the first COVID-19 case on the 28th of January in Bavaria until mid-March, when on the 17th of March the infection risk level was rated 'high' by the RKI[5] for the first time, the logic of pandemic management predominantly followed the logic of MLG I. Apart from the cancellation of

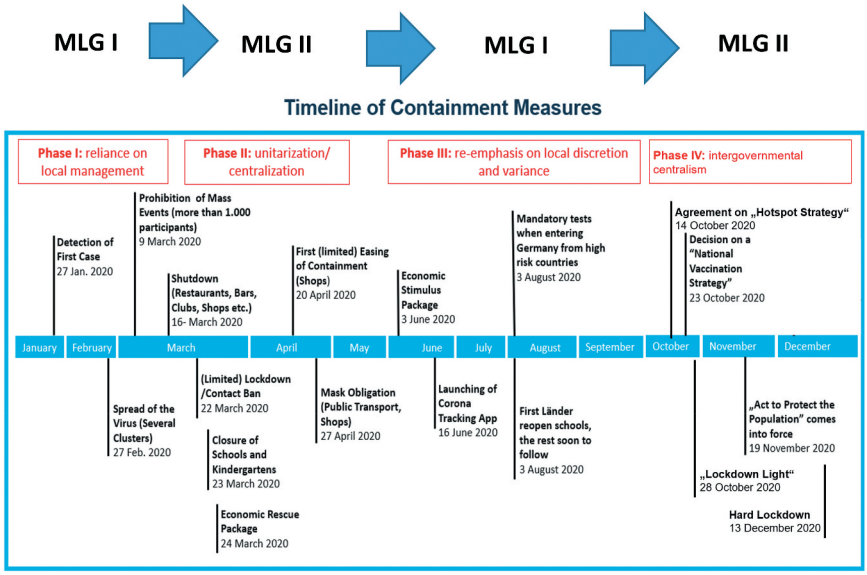

Figure 1. Local government studies.

major events by the *Länder* governments, no country-wide measures of containment were considered necessary. During this phase, the sub-national administrations (*Länder*, local governments) managed the pandemic on their own discretion by executing the IfSG (see above). Based on a general clause of paragraph 28 IfSG, the *Länder* and local authorities have the right to impose restrictions on their populations and to temporarily suspend fundamental rights in case of specific epidemic risk situations.[6] The Federal Government, by contrast, is limited to a consultative function and can only give recommendations, without being in a position to impose them.

On this basis, local health authorities enacted punctual containment regulations, such as school closures and shutdowns of facilities. The county of Heinsberg in North-Rhine Westphalia (NRW), for instance, was the first local government to enact the closure of all schools and kindergartens on the 26th of February. Furthermore, the task of contact tracing and accompanying the domestic quarantine was assumed by local authorities. Central to local crisis coordination were the so-called 'Corona crisis teams' which had been formed in all counties and county-free cities since mid-February 2020. Their aim was to support the local executives in all crisis-related issues, internally coordinate mitigation measures and guarantee for the coherence of crisis management across administrative units and with other local jurisdictions. The composition of the Corona crisis teams varied across local authorities, yet in general they reflected the multi-functionality and the cross-cutting horizontal coordination capacities of local governments.[7] The Corona crisis teams had to take

over a couple of key functions, nicely illustrating, again, the broad range of functions assumed by local authorities in pandemic management: (1) Bundling and coordinating all local activities on pandemic containment, drawing up process plans and developing scenarios for further crisis mitigation; (2) Collecting all available information on the local pandemic situation, evaluating and distributing it to the responsible local administrative units; (3) Organising temporary staff transfers and resource re-allocations within local administrations, mainly from various sectoral units to the local health departments; (4) Informing and communicating about the pandemic management towards the local public; (5) Procuring protective equipment for the staff in the local health authorities.[8]

In general, during this phase, local governments (counties, county-free cities) enjoyed a fairly high level of discretion in managing the pandemic, while centrally defined standards and rules – beyond the IfSG – were largely absent. They took responsibility for enacting containment measures tailored to the local situations and necessities, perfectly in line with the coordination type of MLG I.

Second phase: unitarization, centralisation and shift towards MLG II

From mid-March onwards, after the RKI adjusted the infection risk level from 'low/medium' to 'high', intergovernmental coordination partially and temporarily shifted towards more MLG II. Discretionary territory-based crisis management was not seen as an appropriate approach anymore, and a uniform national strategy of containment was considered to be the suitable response to raising case numbers including centralising attempts in federal legislation (see below). 'Speaking with one voice' became the predominant narrative of an increasing and rapid tightening of the containment measures and a (temporal and partial) suspension of almost all fundamental rights and civil liberties, including the right to free assembly, the right to free movement, and the right to pursue a profession. With the 'joint guidelines to slow down the spread of the coronavirus' adopted on the 16th of March, the Federal and the *Länder* governments attempted a uniform proceeding in pandemic containment across the entire country, followed by a multitude of further intergovernmental agreements over the course of the pandemic. Nationwide shutdowns were enacted by all *Länder* and, step by step, all schools and kindergartens were closed, contact-bans imposed and subsequently extended. In general, this phase can be characterised as a 'race to the top' regarding the *Länder* responses to the pandemic (see Eckhard and Lenz 2020, p. 7): after the lockdown was decided in Bavaria and the Saarland on the 21st of March, the other 14 *Länder* followed only a day later – all executing the containment decision jointly agreed at the central level. The same applies to the introduction of monetary fines for non-compliance with the regulations,

which were first introduced in NRW on the 27th of March, followed by all other *Länder* in April (Eckhard and Lenz 2020, p. 7).

An important centralising step was taken by (temporarily) upgrading and significantly enhancing the operative powers of the Federal Ministry of Health regarding the (otherwise decentralised) pandemic management system of the German administrative federalism. Thus, on the 27th of March, the German *Bundestag* declared an 'epidemic emergency of national concern' based on a new law on 'the protection of the population in the event of an epidemic emergency of national concern' which entered into force the same day. According to the amended § 5 IfSG, within this decision, the Minister of Health gains considerable additional discretion and is authorised to issue orders unilaterally and centrally in the (otherwise decentralised) pandemic management system as long as this emergency situation persists.[9] The Ministry of Health is then authorised to enact exceptions from IfSG by way of simple statutory ordinances without parliamentary approval and without consulting the *Länder* and their parliamentary chamber (*Bundesrat*), which some lawyers consider as unconstitutional (Thielbörger and Behlert 2020) or at least constitutionally questionable (See Wissenschaftliche Dienste des Deutscher Bundestag 2020; Thielbörger and Behlert 2020). Although not being the result of systematic regulatory analyses or evidence-based assessments, the Federal Minister of Health thus succeeded in strengthening his institutional position by shifting powers in the multi-level system and gaining additional competencies regarding sub-national pandemic management (see Kuhlmann et al. et al. 2021b; Kuhlmann 2020).

As a result, the amendment of the IfSG pushed towards more centralisation and a strengthening of the federal level (Ministry of Health and RKI) in times of a pandemic threat. Hence, MLG II by way of functionally-oriented intergovernmental coordination, with a conspicuous centralising and unifying impetus, became ever-more crucial features of pandemic management, specifically regarding high-stakes decisions on lockdowns, shutdowns, and the suspension of fundamental rights. While local governments remained the primary implementation level of these decisions formally enacted by the *Länder* by way of executive orders (so-called 'corona-orders'), their territory-based (MLG I) discretion in deciding on local mitigation measures tailored to their specific (pandemic) situation shrunk. With the tightened coordination across levels tending to increase unitarization and centralisation a new quality in joint decision-making became apparent, even more pronouncedly towards the end of the year (fourth phase), which we label as 'intergovernmental centralism' (see Figure 1).

Third phase: re-emphasising sub-national discretion and tailor-made responses within MLG I

With the numbers of cases, hospitalisations and deaths decreasing and later remaining stable on a very low level over spring and summer 2020, the pendulum swung back again, towards the MLG I pattern, that is, more reliance on territorial coordination, sub-national discretion and locally determined crisis responses. Debates and decisions regarding regulations on how to exit the lockdown and to deal with new cases became more diverse and less coordinated across levels. Subnational and local actors re-entered the scene as major crisis managers responding quite differently to regionally diverging pandemic circumstances. At *Länder* level, North Rhine-Westphalia and Bavaria represented two extremes, with the former standing for a more permissive approach and the latter supporting a stricter one. Although the *Länder* prime ministers and the Chancellor decided on the 15th of April to extend most containment measures (apart from the re-opening of smaller shops and schools for higher classes in compliance with the Corona hygiene regulations), much leeway was granted to the *Länder* and local authorities in determining concrete measures. As such, they could decide about possible deviations from the general rule, stipulate more relaxed or stricter rules for their respective territories and determine the concrete timing of school re-opening. Consequently, increasing variation and complexity occurred in the concrete details of the 'exit regulations' in the different *Länder* and cities, with some of them enacting stricter and some looser rules according to regional particularities and political preferences. To give an example, the re-opening of schools was handled quite differently across the country (also with regard to different periods of school holidays) with some *Länder* re-opening earlier and some later. Thus, an increasing variance and diversity of approaches was practised paired with growing complexity and frequent obscurity of hygiene and protection regulations differing in details from one *Land* to the other or even from one local authority to the other. In some cases, newly created bureaucratic procedures were contested by considerable parts of the population due to their unmanageable, incomprehensible and incompatible rules across sectors.

With the agreement between the Federal Government and the *Länder* adopted on the 6th of May, the Federal Government almost entirely withdrew from the centrally driven corona decision-making in most relevant matters and left the further process up to the *Länder* and local governments. Only some common rules and parameters which were uniformly adopted in joint federal-*Länder* agreements (of 6th of May and 17th of June) remained in force. The most important was a uniform regional response model to possibly increasing case numbers which provided that counties and county-free cities with more than 50 new cases per 100,000 inhabitants registered within seven

days (so-called 'incidence rule') had to elaborate a more severe containment concept including contact-bans and possible local lockdowns. Major events remain prohibited nationwide, too, and physical distancing of 1,5 m, hygiene rules and wearing face masks in public transport and other public spaces also continue to apply throughout Germany.

In general, however, *Länder* and local governments' discretion in defining mitigation strategies and elaborating protection concepts became more important again in this phase. Also, because of the intensified attempts at contact tracing and testing, local authorities re-conquered the institutional scene and assumed even increasing responsibilities in managing the situation. The MLG II pattern of vertical coordination according to the principle of functionality thus gave way to more varied territorial approaches, political competition regarding different possible solutions, and enhanced local autonomy in taking tailor-made mitigation measures. Hence, MLG I gained ground again, to give way, however, to an even re-enforced intergovernmental centralism with pronounced MLG II patterns in a fourth phase of pandemic management from October onwards which cannot be treated in this article.

6. Local service delivery and organisational adaptations under Corona rules

In the previous sections, we have highlighted the shifts in MLG throughout the 'first wave' of the pandemic pointing to the predominance of MLG I, particularly in the first and third phase. As mentioned further above, the MLG I type is marked by the territorial bundling and horizontal coordination of multifaceted locally incurring tasks within one jurisdiction acting as the politically and administratively responsible unit. This implies that besides the narrower pandemic-related tasks, local governments had to continue to fulfil a multitude of additional functions, particularly regarding service delivery to the citizens, however under tremendously complicated conditions. These duties constitute essential elements of local governments' territorially oriented task profile characteristic for MLG I. Against this background, the following section will shed light on how local governments have coped with the pandemic challenges and how local service delivery was affected by the crisis.

German municipalities have a large number of constitutional sovereignties. In the pandemic, some of them formed the basis of their quick and flexible adaptations to the changed framework conditions. Among the most important municipal sovereignties in this context are the authority to carry out legally relevant acts and to exercise sovereign powers within the municipal territory, the possibility to autonomously decide on the internal organisation and processes including the way of decision-making as well as the

right to select, employ, promote and dismiss employees and civil servants. This means that the municipalities can also decide themselves on temporary internal personnel transfers in times of the pandemic. The same applies to the counties, whereby they have to fulfil state tasks in addition to their municipal tasks.

Municipal action in the COVID-19 pandemic is mainly based on three strategies (see Pöhler et al. 2020, 4ff.). (1) The *structural adjustment strategy* was adopted when, during the pandemic, it became clear that standard administrative procedures are not enough to solve the associated administrative tasks. Organisational and personnel adjustments had to be quickly implemented to cope with the crisis successfully. Meanwhile, some of the changes have solidified due to the ongoing pandemic. Some municipal offices such as the health or public order office have been working under extreme constant stress since March 2020. Regular operation in many offices of local authorities is still impossible. (2) Through the *network strategy*, innovative action in the pandemic was shaped thanks to improved interaction and communication between relevant actors in the local administrative environment. Taking a governance approach, this strategy involves various local actors: the local municipal utilities and companies, which mostly no longer belong to the core administration and enjoy more autonomy. The other local state actors include the police, fire brigade, job centres, etc. Some municipal services are offered in autonomous institutions of inter-municipal cooperation (such as water and wastewater associations), for which this approach also applies. Finally, the various local civil society actors should not go unmentioned. All these networks aim to provide better and above all faster access to information, knowledge and resources in the pandemic. (3) Since effective crisis management involves not only coping with the pandemic itself but also analysing it retrospectively and drawing conclusions to be better prepared for future crises, a *reflection strategy* was also pursued. With the help of this strategy, the diverse learning experiences are already taken into account during the pandemic.

Local governments also extended their social network activities and invested into greater internet visibility to respond to the citizens' need for information regarding current developments of the novel virus, the content of containment ordinances, the local economic rescue regulations for companies, the emergency child care, the re-opening of schools and day care centres etc. Various lines of communication were set up, among them 'Corona telephone hotlines', but also municipal apps or chatbots.

Despite the reasonably high quota of local servants working from home and the many efforts at extending digital service offers, in many local governments the necessity of suddenly switching from analogue processes to working fully digitally posed severe problems. Many local authorities were not prepared to flexibly substitute analogue processes by well-functioning digital

ones. From mid-March onwards, almost all services with direct contact to citizens closed temporarily (e.g., local one-stop-shops, municipal libraries, adult education centres, archives, local licencing and regulatory authorities). Frequently, this resulted in considerable performance deficits, for instance, the default of legally binding consultations and approval deadlines, which may not only cause delays but also legal risks for citizens, e.g., if they want to build a house.

These shortcomings in costumier-related services notwithstanding, many back-office departments as well as municipal companies were able to adapt their organisational structures and procedures to the new circumstances so that essential general services were continuously offered even during the shutdown. These basic services not only included pandemic management and containment (contact tracing, quarantining of people) but also coping with its 'second round effects' (see Collins, Florin, and Renn 2020) like unintended consequences and follow-up problems resulting from the crisis management itself. To this end, resources were reshuffled from less requested or even closed administrative units to those most urgently needed for crisis management, albeit suffering from the general understaffing and overburdening. Many employees voluntarily took over new tasks on a temporary basis, especially in the local health authorities. Besides these, a number of other local services were salient for pandemic management or to remedy its unintended 'second round effects'. For instance, the local boards for public order and safety were, together with the police, responsible for the supervision of citizens' and businesses' compliance with the pandemic containment rules and the executive orders of the *Länder* which regulated the lockdown, contact-ban and shutdown.

Local welfare services, by contrast, were more concerned with the abovementioned unintended second-round consequences of crisis management. Thus, the local services for youth welfare were responsible for supervising and preventing an increase in domestic violence against children and young adults, which had been forecasted by experts as a typical consequence of lockdowns. They also had to make sure that children in problematic families were not neglected and out of reach during the school closures. Another important area for managing second-round effects of the crisis were local licencing and regulatory services (e.g., building supervisory boards). They assumed the task of facilitating the implementation of economic rescue measures to remedy the economic damage caused by pandemic containment measures to local businesses, solo-entrepreneurs and small or mediums sized enterprises. Their primary concern was speeding up approval and licencing processes, granting state subsidies to companies in a non-bureaucratic manner. Finally, municipal utilities, such as energy, water and transport companies reliably continued their services. They flexibly adapted

their facilities to the new distancing and hygiene precautions so that basic local services of general interest were well-functioning during the pandemic.

However, as part of the *Länder* executive orders and directives regarding the shutdown, several local facilities were forced to completely close down (e.g., kindergartens in the first lockdown) or at least to temporarily interrupt public traffic (day care centres, community offices, adult education centres, museums, swimming pools, etc.) from mid-March to May. To protect local employees against layoffs, to secure their income, but also to save the economic existence of municipal facilities, the trade unions and the Local Employers' Associations agreed on a temporary agreement on short-time work in municipal utilities (*Tarifvertrag COVID*) in April 2020, extended in the meantime until December 2021. Nevertheless, the situation in some local facilities remained dramatic. This particularly applies to the kindergartens and schools, which had to close during the shutdown and which, at time of writing, have not been able to return to normalcy.

The pandemic led to serious financial burdens for all German municipalities due to falling income, rising expenditure and problems with budget stabilisation. For the 2019/2020 period, a significant decline in local tax revenues is expected (–9.8%), particularly related to the business tax (*Gewerbesteuer*) with an expected decrease by almost one-quarter (- 23.8%). Municipalities' share in income tax (*Einkommenssteuer*) is likely to fall by 7.4% (see Bundesvereinigung der kommunalen Spitzenverbände 2020).[10] Additionally, there will be heavy losses due to the closure of municipal facilities like libraries, swimming pools, theatres, kindergardens etc. There are also crisis-related additional expenditures related inter alia to the financing of corona crisis teams, local testing stations, the purchase of protective clothing and face masks as well as for new IT equipment. Finally, municipal spending on social welfare and for locally compensating the societal costs of containment policies are expected to increase (see Freier and Geißer 2020). As a result, for many financially weak municipalities the financial consequences of the pandemic are estimated to be extremenly difficult to cope with. We can therefore assume that, in the short term, local governments will become more dependent from state subsidies. So far, it remains an open question as to what extent this dependency will decrease on the long run under the condition that the post-pandemic economic recovery accelerates.

7. Conclusions and implications

Taking an inter-governmental approach, we have shown in this paper, that the mode of MLG changed over the course of the pandemic with a clear predominance of MLG I in the first and final stage of the 'first wave' and a temporary shift towards more MLG II when the pandemic was at its peak in March/April, and containment was significantly tightened. We have also seen

from our material that the handling of the crisis by subnational governments, specifically local authorities, was, in general, an appropriate response to the crisis, although several shortcomings and failures occurred, too (see below). In general, the local authorities have proved to be viable actors in managing the pandemic challenges and, at the same time, continuing to deliver services to the citizens, though temporarily in a reduced form. There was no crash down of local service delivery and in many fields of activity, local governments could ensure reliable service provision despite general shutdown regulations. This particularly applies to public utilities and services of general economic interest (energy, water, waste disposal, public transport etc.) as well as to many local services which were directly involved in crisis management, such as local boards for local safety and order, boards for youth welfare, social services etc. This viability of local governments as crisis managers can be traced back to their institutional starting conditions within the MLG I arrangement granting them with a territorially comprehensive mandate to bundle (almost) all services related to territorial pandemic management under one roof and the responsibility of powerful local leaders. They were able to shift resources between departments or sectors quite easily and to flexibly coordinate administrative units of different related task areas. These circumstances have largely supported and facilitated crisis management because local governments could harmonise major tasks relevant to pandemic mitigation in their territory, which contributed to an agile implementation of decentralised pinpointed mitigation measures.

These positive assessments notwithstanding, major shortcoming have also become apparent during the crisis, some of which attributable to local governments' own defaults, while others were caused by upper-level (non-)decisions and still others fall to a shared responsibility of different levels. Regarding the former ones, specifically the missing digital preparedness and the resulting service constraints during the shutdown merit attention. Lacking digital tools and channels to proceed transactions with citizens, many citizen-related services, e.g., in local one-stop shops, building supervisory boards and other licencing authorities could not be provided while maintaining the physical distance and therefore had to close down during the pandemic. This shortage must at least partially be attributed to local governments' reluctance in this regard. Another problem concerns the institutional overload of local health authorities for numerous reasons. Besides the lacking digital preparedness, one major reason lies with the federal and *Länder* policies which have failed so far to appropriately equip the public health and care sectors with sufficient human resources (including attractive payment and working conditions) in order to make them resilient for a major crisis.

Another reason for local health authorities' overload is to be discerned in the containment approach itself as fostered by the federal and *Länder* governments. Especially the comprehensive tracking and tracing system faced the local health authorities with capacity problems because they had to scrutinise each individual

case with the aim of tracing and quarantining all possible direct contact persons or, in case of major clusters or untraceable 'infection chains', closing the respective facilities. Because of the amended testing strategy[11] more cases (also without a clinical picture and symptoms) were identified and thus the 'infection chains' to be traced and tracked amounted to a magnitude which was difficult to manage. As a result, many local health authorities reached their capacity limits in October at the latest. After the case numbers had soared again, in about 75% of all cases the infections chains were not traceable anymore by the local health authorities, which was a primary justification for the second lockdown in Germany enacted on October, 29th (see ZDF 2020). In regions with high case numbers or larger populations, even the federal army (*Bundeswehr*[12]) was called by some overburdened local health authorities to support them in tracing 'infection chains' and supervising quarantining. Against this background, some experts questioned the appropriateness and effectiveness of the centrally pushed containment approach, particularly the comprehensive contact tracing as well as the mass testing and predominance of authoritative prohibitions, unspecific mass quarantining, and lacking evaluative knowledge about pandemic mitigation measures (see Kassenärztliche Bundesvereinigung 2020). Local health experts also pointed to the fact that a more targeted protection of high-risk populations[13] was necessary while the general lockdown approach was blamed to neglect vulnerable groups. The predominant focus on contract tracing as a major element of pandemic management was also criticised being ineffective and threatening the operational procedures in the local health authorities which were entirely absorbed by corona management and could not fulfil other obligations anymore, such as important prevention tasks.[14]

Over the course of the pandemic, several hundred executive orders, directives and ordinances[15] have been passed by the *Länder*, leaving aside the local governments directives (*Allgemeinverfügungen*). The Corona-crisis has thus undoubtedly been a prime age for German (subnational) bureaucracy and 'Corona regulation', more specifically, the various forms of 'Corona hygiene regimes' introduced by *Länder* and local bureaucrats have significantly contributed to increasing regulatory density and complexity, bureaucratisation, and over-regulation. In the meantime, there are more and more critical voices complaining about the over-complex and frequently contradictory character of these fast-changing rules, which have partly proved to be un-implementable or even useless in practice. Anyway, strict compliance with these regulations and the implementation of respective hygiene concepts could many local businesses not prevent from being closed in the second pandemic wave.

Our article revealed that the German intergovernmental system tended to shift from MLG I to MLG II when the crisis was at its worst and containment was tightened. The same shift happened before the second lockdown was enacted (on the 2nd of November) and another phase of more intensified MLG II started.

Although this mirrors certain flexibility and adaptability of the German intergovernmental system, the question arises whether the 'back and forth' in MLG and in containment stringency, which has also been labelled as a 'lockdown yo-yo' questioned by some in its effectiveness[16] can be considered a sustainable solution for long-term pandemic management. Taking the viability of subnational governments in Germany into account and their experiences in managing epidemic threats, it is also striking that the appropriate response to regionally varying pandemic challenges was/is seen in more centralisation towards the federal executive, reaffirmed by the third 'pandemic law' passed in November 2020. Undoubtedly, political actors also seized this crisis as an opportunity to reshuffle powers in the multi-level setting (see also Kuhlmann et al. 2021b) by way of authorising the federal executive to take decisions without the *Länder* and the parliament. Furthermore, the executive powers of the *Länder* were strengthened by enhancing the legal foundation of their executive orders, some of which had been repealed by the courts due to unconstitutionality. By virtually 'copying and pasting'[17] the *Länder* executives' containment measures (lockdowns, shutdowns, curfews, physical distancing rules, mask obligation etc.) explicitly in the IfSG (new §28a of the IfSG), the federal parliament in fact 'certified' their lawfulness (see Kießling 2020, p.4). While in the early periods of the crisis (phase 2), the up-scaling of pandemic decision-making to the federal level was seen as a necessity in an unpredictable situation by many, in the meantime concerns have been raised about the appropriateness of the executive decision-making and the effectiveness of the centrally agreed regulations with national scope. Regarding federal government's extended powers in the pandemic, there was a clear decline in public support from March, when almost 80% were in favour of such an upgrade, to April 2020 when this support had almost halved and shrunk to roughly 40% (see Juhl et al. 2020, p. 6). Against this background, it remains to be seen as to whether and to what extent the institutional shifts, which have been analysed here and which are still ongoing, will indeed mark a critical juncture for the German intergovernmental system.

Notes

1. In this context, the still ongoing privatisation and commercialisation of hospitals in Germany since the 1990s (see Klenk and Reiter 2012, p. 410) merit attention. A consequence of this New Public Management-driven trend is that efficiency and profitability have become increasingly important in hospital management – partly at the expense of employees and patients as well as health care in rural areas.
2. Staff expansion in local health authorities continued in 2021 since the federal government provided 4 billion euros to this purpose based on a specific 'Pact for the public health service'.
3. Figures do not include the three City-States.

4. Until 2020, less than 2% of German health expenditure was spent on financing local health authorities. Their number of physicians had fallen by about one third between 2000 and 2018 as a result of staff cuts, general shortage of medical staff and long-term vacancies. At the beginning of the pandemic, around 2,500 physicians and 17,000 employees worked in the local health authorities (Bundesverband der Ärztinnen und Ärzte des Öffentlichen Gesundheitsdienstes 2020; see also Bayer 2020).
5. The main analytical capacity for pandemic decision-making is centralised in the federal authority for disease monitoring and prevention (*Robert Koch Institut* – RKI). The higher federal authority (*Bundesoberbehörde*) is directly subordinated to the Federal Ministry of Health. Its major tasks are biomedical research and epidemiological analyses on communicable and non-communicable diseases based on which the RKI provides advice to the Federal Government, public health authorities and the general public regarding prevention and containment measures. Although the *Länder* also have their own experts, particularly from *Länder*-affiliated university clinics, their analytical capacity remains limited and in practice all levels of government have drawn on the RKI's advice when determining pandemic containment measures.
6. The IfSG was amended up to now three times during the pandemic in March, May and November 2020.
7. In the county of Neuss (NRW), for instance, the heads of the following departments were members of the 'corona crisis team': local health authority, local board for public safety and public order office (*Ordnungsamt*), school and youth offices, social welfare board, personnel office, municipal supervisory authority (*Kommunalaufsicht*), press office, county fire brigade control centre (*Kreisleitstelle*) and county liaison command of the *Bundeswehr* (*Kreisverbindungskommando*) as well as the medical director of the rescue service and the county fire brigade chief (see Rhein-Kreis Neuss Press Release, 20.3.2020). Depending on local circumstances, additional external experts were involved, e.g., from the police or from municipal hospitals.
8. Although, this did formally not belong to local governments tasks, yet to the portfolio of the federal and the *Länder* governments. However, the latter largely failed regarding the procurement issue in the pandemic.
9. This authorisation is limited in time, but must be withdrawn on 31 March 2022 (Section 5 (4) IfSG, new version) or when epidemic emergency does not persist anymore.
10. The costs of the second lockdown since November 2020 are not yet included.
11. Testing was significantly extended from roughly 125,000 weekly tests in March to more than one million in September (Franzke and Kuhlmann 2021 with further references).
12. On April 15, the federal and *Länder* governments had agreed that the *Bundeswehr* could provide support to the local authorities in contact tracing.
13. Although the protection of vulnerable groups (care homes) without totally isolating people had been jointly decided by the federal and *Länder* governments on 15 April, this strategy played a less dominant role as compared to the general containment approach.
14. These points were, for instance, raised by the heads of the local health authorities in Frankfurt, in Aichach-Friedberg, and the head of the Charité institute for forensic medicine (see Berliner Zeitung, 1.10.2020; BR24, 5.10.2020; Hessisches Ärzteblatt 10/2020).

15. For an overview on the Covid-19-related regulation see https://de.wikipedia.org/wiki/Liste_der_infolge_der_COVID-19-Pandemie_erlassenen_deutschen_Gesetze_und_Verordnungen#Gesetze_2.
16. See: https://www.focus.de/gesundheit/coronavirus/aeltere-weiter-ungeschuetzt-scharfe-kritik-an-corona-politik-aneinanderreihung-von-lockdowns-voellig-wirkungslos_id_12856904.html, 21.1.2021.
17. See https://www.welt.de/kultur/article220209690/Bevoelkerungsschutzgesetz-Demokratiedaemmerung.html, 13.1.21.

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