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Common Challenge – Different Response? The Case of H1N1 Influenza[1]

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Introduction

Dealing with epidemics constitutes an undisputable part of civil security governance. Of all communicable diseases, the pandemic influenza is probably the most feared by both policymakers and health practitioners (Kamradt-Scott, 2012, p. 90). However, due to high levels of uncertainty which require contentious political choices it also challenges the most common view of disaster management, which typically focuses on technical and natural disasters in a narrow sense. Pandemics are a type of risk of a supranational and sometimes even of a global scale. In case of an emergency, coordinated action is needed in order to control the spread of the illness within and across borders. At the same time, actions are undertaken basically within the national jurisdictions. Thus, there is a tension between nationally focused efforts and coordinative demands.

Although the European Union (EU) and the World Health Organization (WHO) have played an important role in enhancing uniformity and coherence of national pandemic strategies across Europe, significant differences still exist in pandemic influenza policies of the European countries (Martin and Conseil, 2012). Agencies such as the European Centre for Disease Prevention and Control are instrumental in the harmonization of disaster management, but when it comes to pandemics there is little interaction between the policies and legislations of many member states. Among the European countries, various types of civil security governance systems have developed and are also responsible for dealing with special risks, such as pandemics (see Bossong and Hegemann, in this volume).

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This chapter focuses on the so-called swine flu (H1N1 influenza), which resulted in global pandemics declared by the WHO in 2009/2010. The virus appeared first in Mexico being a new strain of an earlier known influenza virus. Despite containment efforts, it spread globally and evoked various reactions of governments and responsible bodies. In the history of mankind, pandemics have caused enormous losses. For this reason, governments put a significant emphasis on preventing and dealing with such events. In the case of H1N1, the 1918 flu epidemics was a sinister reference point.

Usually, the H1N1 pandemic is portrayed in terms of an overreaction, be it on the side of the WHO which, according to many, has exaggerated the pandemic alert (Kamradt-Scott, 2012), or on the side of nation states who tended to apply precautionary approaches *en masse* (Seetoh et al., 2012). In this respect, the case of H1N1 does seem to showcase an example of a 21st century global risk where decisions often have to be taken 'on the basis of more or less unadmitted not-knowing' (Beck, 2006, p. 335), and where the boundary between rational response and an overreaction becomes blurred. In cases of pandemics, it is the fear, rather than the disease itself, which threatens to break the society apart, thus posing a high challenge for governments and emergency responders trying to retain public trust (Upshur, 2005; Lagadec, 2009, p. 483). In a situation where the pandemic risk cannot be interpreted accurately, the necessity to manage uncertainty arises (Seetoh et al., 2012; see also Kuipers and Boin, in this volume).

This has an important implication for legitimacy. On the one hand, risks alienate people from expert systems as they cannot be controlled fully rationally even by scientists or governments (Beck, 2006, p. 336). On the other hand, current crises often pose a challenge to the legitimacy of governance structures and processes, which sometimes turn out to be inadequate (Boin, 2009). Such a decrease in legitimacy leads to declining societal, political or legal support for extant decision-making procedures, instruments or ideas in the given policy domain (Nohrstedt, 2008).

Due to the nature of the crisis, which was assumed to be uncontainable within smaller geographical areas, central coordination mechanisms were in place in most of the countries, including those where disaster response typically rests at the regional or local level. The disease created a 'natural experiment' as it posed a similar threat for national civil security systems in parallel and in many countries. That is, the case of the swine flu allows us to analyse the reaction in the European countries all of which were hit by the same kind of crisis at the same

time. Based on these similarities, preparedness and response actions are compared in this chapter, employing the notions of overreaction and precaution (Beck, 2006). The chapter builds on data for 22 European countries that was compiled the collaborative European research project ANVIL,[2] covering both the 'old' (joining the EU before 2004) and the 'new' member states (accessing the EU in 2004 and later), as well as all geographical regions of Europe.

The first part of the chapter touches upon the general functioning of the civil security governance systems and their overall legitimacy in the context of the H1N1 crisis. We examine such issues as the level at which the crisis was addressed, main actors, the overall reaction of the government, as well as the overall public perception of the authorities' reaction. Taking into account the implications for legitimacy, we analyse whether there were any official reviews of the actions taken during the H1N1 crisis and, consequently, whether the H1N1 crisis resulted in any changes in the countries' civil security governance systems in order to 're-legitimize' them in the eyes of the public.

The second part, then, goes into more practical aspects of crisis management and focuses on the actual procedures. As it was pointed out by Martin et al. (2010) based on a survey of national public health laws concerning pandemic influenza, differences among European countries exist when it comes to the legitimacy of their conduct of crisis management in this field. Here, we focus on some core factors which are typically described in the crisis management literature as potentially determining the success of policies to fight pandemics. In particular, these are the involvement of a large array of stakeholders and communication with the public.

Theoretical underpinnings

Suchman (1995) distinguishes three forms of legitimacy: a pragmatic, a moral and a cognitive one. The first one is based on self-interested calculation; the second one on positive normative evaluation; the third one is connected with permanent, structurally legitimate organizations, such as nation states (Suchman, 1995, pp. 578–584). These three forms can be well associated with different levels of policy-making: politics, policy and polity (see for example Hajer, 2003).

To study the response to the H1N1 influenza pandemic, we focus on the 'moral legitimacy', that is, one based on normative approval and on judgements about whether an activity promotes values of the respective society. Thus, we focus largely on the policy domain with which

relevant operational responsibilities are connected. Although there are also important questions concerning responsibility which are related to the internationalization of the H1N1 issue, we focus here exclusively on the national responses and legitimacy connected with them.[3]

From the viewpoint of the moral legitimacy in policy-making, both outputs and procedures can be examined[4] (Suchman, 1995, p. 579). The outputs are mostly associated with effectiveness and correspondence with desired ideas and values (Schmidt, 2013, p. 8). Hence, our operative definition of legitimacy is based on the absence of political crisis and/or the need to make significant changes to the system in the aftermath of the pandemic as a post hoc reaction. When seen as unsuccessful, we might expect the civil security governance systems dealing with the influenza in some countries to attempt a 'relegitimation through (...) restructuring' (Suchman, 1995) and thus to undergo structural changes. Below, we review the reaction of the European countries to the pandemics – whether the legitimacy of those in authority or of the governance system was shaken.

Procedures, or 'throughput' (Schmidt, 2013), touch upon a more practical level as legitimacy is also linked to the success of the actions undertaken by the agencies and officials dealing with disasters (Quarantelli, 1988). Here, the 'openness and inclusiveness in institutional processes and constructive interactions' (Schmidt, 2013, p. 8) are particularly important. A survey conducted in Canada in the aftermath of the H1N1 pandemic revealed that – although there was not any single best model of how to handle the crisis – the comprehensive planning, the involvement of multiple stakeholders and communication (both among the official bodies as well as with the general public) were crucial to address the crisis successfully (Masotti et al., 2013). Similarly, the literature on disaster management stresses also the inclusion of various stakeholders and both internal and external distribution of information as factors crucial for success (Harrald, 2006; Moe and Pathranarakul, 2006; Fitzgerald et al., 2012; Schemann et al., 2012). Thus, these are the aspects we deal with in the second part of the chapter, where the inclusion of stakeholders and communication are discussed.

Response to H1N1: Similarities and differences

In most of the countries, addressing the H1N1 pandemic involved significant efforts of bodies responsible for public health and crisis management. The issue reached media headlines and was politically discussed in several cases. Interestingly, the material effects of the crisis

Table 4.1 Overall public perception of how the crisis was handled by the authorities

Public perception of handling the crisis	**Country**
Positive	Croatia, Estonia, Finland, Malta, Norway, Sweden
Negative	France, Switzerland, UK

Source: Authors' compilation based on ANVIL project data.

were often sidelined and, in most cases, did not lead to the perception of the H1N1 management as a failure. As the human losses were relatively low, the actions were commonly perceived neither as a success nor as a failure.

In some countries, however, a positive overall perception was reported (Table 4.1). In Croatia, the public continued to view the governmental reaction in a positive light, despite the fact that there was mistrust towards the vaccines and their potential negative effects. Positive citizens' perception was reported also for Malta, Norway and Sweden. Also in Estonia and Finland, no public criticism of the governmental reaction arose and, especially in the latter country, the population complied with the vaccination strategy. Contrastingly, the authorities' reaction in France, Switzerland and in the UK was seen as rather problematic.

As it was argued in the introductory section, preventing and responding to a pandemic influenza represents an integral, yet somewhat special part of civil security governance. In this section, we look into how the crisis was addressed by the analysed European countries and what implications these reactions had for legitimacy as discussed above.

The level at which the crisis was addressed

Despite the fact that the main responsibility for crisis management rests at different levels in different countries of Europe and is quite often decentralized (see Bossong and Hegemann, in this volume), the H1N1 crisis was addressed by the central level in almost all the countries (Table 4.2). The only exception was Germany, where the level of federal states was the most important one. This applies to both decision-making and bearing the costs of purchasing antiviral vaccines as the central government refused to provide any financial support here, despite the recommendation to start the vaccination campaign that came from the Permanent Vaccination Commission, a body resting under the Federal

Table 4.2 The main administrative level, which was addressing the H1N1 crisis

Main administrative level addressing the crisis	**Countries**
Central	Austria, Croatia, Czech Republic, Estonia, France, Hungary, Ireland, Latvia, Malta, the Netherlands, Norway, Poland, Romania, Serbia, Slovakia, Switzerland
Central and Regional	Italy
Central and Municipal	Finland, UK
Federal states	Germany
All levels largely involved	Sweden

Source: Authors' compilation based on ANVIL project data.

Ministry of Health (Hegemann and Bossong, 2013a). In Germany, the lack of central coordination during a nationwide epidemic was criticized as a weakness and the need for emergency decision-making at the central level in such cases was stressed (Hegemann and Bossong, 2013a). Similarly, in the UK – which is otherwise perceived as a rather centralized state – the responsibility of the local authorities in decision-making concerning the epidemics was relatively large. This was also regarded a weakness, and it was suggested that the active involvement of the Cabinet Office should have been larger (Fanoulis et al., 2013a).

In most of the countries, the main body governing the crisis was the Ministry of Health or, alternatively, the Ministry of Social Affairs (where it is also responsible for the public health agenda) in Estonia, Finland and Sweden. In France, the crisis was a test for a new joint crisis management organization driven by the Ministry of Interior – a result of the changes following the 2008 White Paper on Defence and National Security. The Ministry of Health, however, played an important role here as well. Although there were several deficiencies in the management of the crisis in France (see further below), the system setup was not questioned (Coste et al., 2013). In some countries where the overall civil security governance system also tends to be centralized, such as in Romania, Slovakia and the UK, the role of the government and/or Prime Minister in dealing with the H1N1 pandemics was significant.

The European countries were prepared to meet such crisis as the H1N1 pandemic. The preceding years were marked by growing concerns stemming from the experience with the so-called bird flu (H5N1) in the late 1990s. There had been substantial activity on both international

Table 4.3 Plans for dealing with a pandemic already in place before the crisis

Plans for pandemics already extant	**Country (year when the plan was drafted)**
Yes	Austria (2005), Czech Republic (2006), Finland (2007), France (2004), Ireland (2001), Italy (2006), Norway (2006), Serbia (2006), Slovakia (2006), Sweden (2007), Switzerland (January 2009)
No	Hungary, United Kingdom

Source: Authors' compilation based on ANVIL project data.

and national levels aimed at preparation for the next pandemic. This included the drawing up of contingency plans and training of critical personnel, as well as large investments in procuring and/or securing access to antiviral pharmaceuticals in many Western countries (Kamradt-Scott, 2012, p. 90). Worldwide, expenditures on pandemic influenza preparedness and control tripled between the years 2004 and 2009 (Seetoh et al., 2012, p. 717), driving many countries into a 'pandemic overdrive' (Kamradt-Scott, 2012, p. 95).

Looking across European countries, most of them had plans for dealing with pandemics in place, typically drafted between 2005 and 2007 (Table 4.3). The countries lacking such plans were made to issue them when the crisis started. In Hungary, a new decree was issued on coordination of H1N1 related tasks. A National Pandemic Plan was adopted in August 2009 (Takacs and Matczak, 2013). While the crisis was not perceived as mismanaged in Hungary, giving rise to no large criticism (Takacs and Matczak, 2013), a different situation occurred in the UK. Here, the government was largely blamed for missing out on a five-year period which it had at disposal for preparation for a pandemic crisis. Consequently, the authorities – especially the Cabinet Office – were criticized for having been very poor on such issues as the procedural details of coping with the influenza pandemic (Fanoulis et al., 2013a).

Priority groups

The already existing research on the topic points to a mixed policy landscape when it comes to the identification of priority groups to access antiviral vaccines. This is especially marked in situations of limited supply (Martin and Conseil, 2012). The need to decide on priority groups over longer term and over the whole of the population also makes the issue more politically challenging compared to a 'classical' disaster

management, where for example the criteria for evacuation are much more clear-cut (as in a case of floods).

Although commonalities exist (such as the health care workers being included among the priority groups in all the countries), differences concern the size of the target population as well as ranking of priority groups. Not all countries took the decision to regard the protection of everyone as their public health goal (Martin and Conseil, 2012, pp. 1106–1107). In our sample, the majority of states indeed opted for the strategy of vaccinating specified target groups first and – eventually – the entire population later on demand. Vaccines were typically procured to cover a certain percentage of the population (for example, in the Czech Republic this was 40 per cent; in Slovakia 20 per cent; in Italy, the purchased pandemic vaccine would cover 4 per cent of the population but there was already a stockpile of 40 million doses of antiviral drugs stored by the Ministry of Health and distributed during the H1N1 alert). Outliers from this approach were Serbia, where the focus was on priority groups only and – on the other side of the reaction scale – Finland, where the decision was taken to immunize the entire population. In the Netherlands, there were set priority groups but vaccines were eventually purchased for the entire population – an action criticized later on as unnecessary.

As it turns out, even the plans to vaccinate (some of) the priority groups met specific challenges, which needed to be overcome when designing a vaccination strategy. This concerned the decision to make the vaccination compulsory for some groups crucial for the functioning of the security system in particular. Such decision was reported for example in the USA in some hospitals where the medical staff was threatened with sanctions if not getting vaccinated (Winston et al., 2014).

From the countries under study, such a decision was made in the Czech Republic with respect to the army (as one particular priority groups), causing a large controversy. While other priority groups (such as medical staff or politicians) were encouraged (but not ordered) to get vaccinated, thousands of soldiers were obliged to get vaccinated at the beginning of January 2010 by an order stemming from the resolution of the chief sanitary inspector of the Ministry of Defence (MoD). Noncompliance was to be sanctioned. The first to intervene against such practice was the president of the country. Thereafter, the issue was discussed at the State Security Council and, eventually, the government reached the decision that such a declaration legally rests only in the competences of the Chief Sanitary Inspector of the country, who is subordinated to the Ministry of Health. Hence, the professional soldiers and

employees of the MoD were to be also vaccinated upon their request only (Nový, 2013).

Governmental (over)reactions

The H1N1 was not the first example where an overreaction could be observed. During a pandemic emergency in the USA in 1976, for example, strong precautionary measures were applied despite the lack of strong scientific evidence for the severity of the threat (Seetoh et al., 2012). As 'the political costs of omission are much higher than the costs of overreaction' (Beck, 2006, p. 336), we can assume that in the case of H1N1, the strong precautionary approach was perceived by the decisionmakers in the European countries as an adequate strategy.

Of all the countries under study here, only two did not seem to overreact with respect to the purchasing and using of the antiviral vaccines. These were Estonia and Poland. On the other side of the spectrum, Finland and Sweden represented examples of a precautionary principle applied. In Sweden, not only was there a massive vaccination campaign, and the decision was taken to opt for the maximum quantity order, but also – as it was revealed later – the key officials were in possession of information suggesting that the pandemic would be milder than anticipated. The Swedish public, though, appreciated the governmental actions and the approach was justified by it being better than neglecting the issue (Bakken and Rhinard, 2013).

With respect to the countries where an overreaction did not occur, in the case of Estonia, after a certain delay, only a limited number of vaccines were purchased by the Estonian government. In the case of Poland, the final decision was taken by the government not to purchase the vaccines at all. These findings seem to correspond with general patterns of national cultural differences as grasped for example by the World Values Survey: while both Poland and Estonia belong to the same group of countries concentrated more on survival values; both Finland and Sweden belong to another category which is concentrated on secular-rational values on the one hand and self-expression (as opposed to survival) on the other hand (Bossong and Hegemann, 2013, p. 16).

It has to be noted, however, that there were other factors than the cultural ones at play. In Estonia, it was the economic crisis that hit the country quite severely and heavily impacted on the public sector (Purfield and Rosenberg, 2010). The main reason for the hesitation and for the limited vaccine purchase, therefore, was found to be the economic downhill of that time rather than other considerations related to the national security culture (Hellenberg and Vissuri, 2013).

Excursion: The exceptional case of Poland

In terms of the crisis management conduct during the H1N1 crisis, Poland revealed to be an exceptional case among the European countries. The government did not buy the vaccines. Eventually, this strategy appeared to be appropriate and efficient. Not only did it avoid unnecessary expenses, but also the post-vaccination side effects, which in several countries caused severe criticism of the governmental strategies. Thus, what was the path to reaching this strategy in Poland?

At the end of April 2009, the Chief Sanitary Inspectorate announced that despite reports from around the world there was no imminent threat of influenza in Poland, but appropriate protective measures were undertaken. A special hotline providing information on the virus was established. In early May 2009, the first case of H1N1 was detected in Poland, which was confirmed by the Minister of Health at a press conference (Table 4.4). On 11 June 2009, the WHO declared there was an influenza pandemic in the world. An increase in cases of influenza occurred in early November, and on 13 November 2009, the first fatal case of the virus in Poland occurred. In mid-November 2009, the Minister of Health summarized the spread of the virus, confirming 344 cases

Table 4.4 Main events in the H1N1 epidemic in Poland

Date	Description
26.04.2009	Poland takes initial steps (Chief Sanitary Inspector)
04/2009	Hotline launched providing information about the virus
06.05.2009	first case of A/H1N1 in Poland detected – 58-years-old female
11.06.2009	WHO declares flu pandemic
13.11.2009	The first case of death, 37-year-old man
17.11.2009	Meeting of the Minister of Health with Ombudsman – delaying the purchase of vaccines
19.11.2009	Summary of the Minister of Health – 344 cases of flu in Poland, 4 deaths, 101 people in hospitals, 644 people under the epidemiological supervision
17.02.2010	World Report – in Poland 2521 cases and 178 deaths
24.06.2010	Resolution of the Parliamentary Assembly of the Council of Europe – approves the government position on the purchase of vaccines
10.08.2010	WHO announces entry into post-pandemic phase

Source: Authors' compilation based on ANVIL project data.

of infection in Poland. At the same time, the Minister of Health met the Ombudsman, and it was decided to postpone the purchase of vaccines against H1N1. In the end, the purchase was not made.

The issue of the purchase of vaccines was debated. The previous health ministers criticized the conduct of the Ministry of Health. The Ombudsman firmly recommended purchasing the vaccines and so did the parliamentary opposition. The president of the Polish Chamber of Physicians and Dentists also demanded the purchase of vaccines (Gazeta Wyborcza, 2010). Polish officials explained that the postponing of the purchase was due to the fact that there had not been sufficient testing of the vaccines. The Minister accused the pharmaceutical companies of pressing for the purchase and hiding the information about potential side effects (Polskie Radio, 2009). These statements were criticized by the European Medicines Agency, accusing the Polish ministry of populism. The Ministry of Health contacted the Swedish and Hungarian officials to buy surpluses of vaccines. Therefore, the reluctance of the Polish government was supposedly caused by facing a lack of supply caused by a surprisingly large demand. At the end of June 2010, the Parliamentary Assembly of the Council of Europe passed a resolution confirming the validity of the position of the Polish Minister of Health of not purchasing the vaccine (Ministry of Health, 2010). On 10 August 2010, the WHO (2010) declared that the pandemic had entered its post-pandemic phase.

Despite a fierce political conflict in Poland, the decision of the Ministry of Health not to buy the vaccines was not strongly criticized by the parliamentary opposition (Dmochowski, 2012). The parsimony of the government met a cool headed public reaction. Overall, the outstanding conduct of the Polish government can hardly be explained by the excellence of the civil security governance systems and procedures. Instead, it was seemingly the result of contingent factors combined with the general expectation that the issue should be dealt with by the responsible governmental bodies.

Consequences of the H1N1 pandemic for the civil security systems

Despite the large political and media attention to the H1N1 pandemic, only very limited change could be observed in the aftermath of the crisis. This corresponds with the finding that the crisis was perceived neither as a success (especially due to economic overspending on the response) nor as a failure (due to the low number of fatalities) in many countries.

Only in few countries was the H1N1 pandemic followed by changes to the civil security governance system. In Estonia, better support of the inter-agency cooperation between the authorities in charge of epidemics was introduced. This included both the budgeting of additional financial resources and the creation of administrative solutions, such as improved monitoring and communication systems (Hellenberg and Vissuri, 2013). In Sweden, only minor changes took place, based on recommendations for more flexible agreements with the vaccine providers (Bakken and Rhinard, 2013).

The only country which underwent considerable changes to the security system was Switzerland. It was the only country where a revision of epidemic law took place after the H1N1 crisis, resulting in a stronger lead position of the central government (Hegemann and Bossong, 2013b). This change in the Swiss civil security system contrasts with Germany. Here, coordination problems also occurred, yet – despite intensive discussions – the H1N1 crisis did not lead to any major revision of the decentralized approach in place (Hegemann and Bossong, 2013a).

While – with the exception of Switzerland – no restructuring took place after the pandemic, in several countries political and/or professional inquiries occurred, investigating the appropriateness of the authorities' reaction (Table 4.5). Yet, generally speaking, the H1N1 pandemic does not seem to have provoked many public inquiries – neither political nor professional ones. In Italy, Norway, Slovakia and Sweden only an evaluation took place, typically concerning the influenza as such and not questioning the actions taken by the authorities.

Among the countries where more rigorous inquiries occurred were representatives of both the old and the new member states of the EU. In the Netherlands and the UK, the operational response to the H1N1

Table 4.5 Official review of the actions taken during the H1N1 crisis

Professional or political inquiries applied	**Country**
No	Austria, Croatia, Czech Republic, Estonia, Finland, Germany, Ireland, Latvia, Malta, Romania
Evaluation only	Italy, Norway, Slovakia, Sweden
Yes	France, Hungary, the Netherlands, Poland, Serbia, Switzerland, UK

Source: Authors' compilation based on ANVIL project data.

influenza (including the lead authorities) was in the focal point of the inquiries. In France and Hungary, the financial issue was stressed. The use of funds was examined in the former case; while the agreement conditions with vaccine supplier were explored in the latter one.

Serbia and Poland were an exception. In Serbia, the inquiries were undertaken by the Anti-corruption Council of the Serbian government and took the form of a criminal affair regarding frauds in vaccine procurement of which the ex-director of the National Institute for Health Insurance was accused, together with three of her associates (Kešetović, 2013). Thus, in the Serbian case the crisis also accentuated some otherwise salient issues such as corruption. In the case of Poland, on the other hand, it was the Parliamentary Assembly of the Council of Europe which examined the validity of the opposition to the purchase of the vaccines by the Polish Minister of Health. A resolution confirming this position was passed in June 2010. Finally, in Germany, Transparency International called for a public investigation on the appropriateness of the reaction to the pandemic and the related costs in 2011, yet this has not been conducted yet.

Defining success: The importance of 'throughput'

'Success' of the actions undertaken by the authorities dealing with a crisis is another aspect crucial for legitimacy (Quarantelli, 1988). For moral legitimacy in policy-making, procedures are also important, including the openness of the processes and their inclusiveness. As suggested by a relatively large body of literature on crisis management, the inclusion of various stakeholders is among the key conditions for handling an influenza pandemic successfully (see for example Harrald, 2006; Schemann et al., 2012).

The array of stakeholders involved

The pandemic influenza can be treated as a global risk and the activation of diverse stakeholders and their connections across borders – what Beck (2006, p. 340) terms 'enforced cosmopolitanization' – could be expected. Therefore, for a successful management of the crisis we might expect a rather large array of stakeholders to be involved in the planning, prevention and response actions.

Yet, with respect to the stakeholders, including individuals, groups or organizations having the interest and the potential to influence the respective policy-making and implementation (Brugha and Varvasovszky, 2000), the EU countries varied substantially (Table 4.6).

Table 4.6 The inclusion of different stakeholders in the H1N1 response

Array of stakeholders	Country
Narrow	Croatia, Czech Republic, Estonia, Hungary, Poland, Romania, Slovakia
Broad	Ireland, Malta, the Netherlands, Sweden

Source: Authors' compilation based on ANVIL project data.

In Eastern Europe, the response to the pandemic was almost entirely left in the hands of public administration at the central level. This does not mean that no role was played by lower levels, but that they usually only took part in the implementation of the plans and decisions. With the exception of Poland (as portrayed above), the centralized reaction did not prevent the countries from an overreaction to the H1N1 crisis. In some cases, such as the Czech and French ones, however, the exclusion of some of the stakeholders seems to have had an adverse effect upon the legitimacy of the government's conduct.

Contrastingly, relatively broad array of stakeholders took part in the reaction to the pandemic in Ireland, Malta, the Netherlands and Sweden. This included not only independent experts, but also for example non-governmental organizations and others. In Ireland, tackling the crisis was not limited to the Irish state only but included also cross-border cooperation with the public authorities of Northern Ireland in pre-planning the management of the influenza pandemic (Fanoulis et al., 2013b). In Malta, the involvement of the voluntary sector was relatively large and the Red Cross, in particular, played an important role there (Fanoulis et al., 2013c).

A broad range of stakeholders was included in governmental action also in the Netherlands. These came from both the private sector (such as private medical practitioners) and from the non-governmental one (such as the Dutch Red Cross). Medical experts from the private sector were also invited by the government to join the Outbreak Management Team advising the Minister (Kuipers and Boin, 2013). In Sweden, the inclusion of different stakeholders reflected the variety of entities typically involved in the Swedish civil security governance system where – due to the responsibility principle – a large number of authorities, agencies and institutions have key executive responsibilities (Bakken and Rhinard, 2013).

In some countries, a consensus among stakeholders was not reached when it comes to the governmental reaction. This made the

implementation of the vaccination strategy particularly difficult and shed a negative light on the appropriateness of the official approach addressing the pandemic. While the media were reportedly exaggerating the pandemic threat and – later on – the negative effects of the vaccines in many countries, it was the medical professionals in particular who questioned the official approach.

In the Czech Republic and Serbia, a large number of medical practitioners were actively opposing vaccination, which also undermined the credibility of the vaccination in the eyes of the public (Brazova and Matczak, 2013; Kešetović, 2013). Besides the potential side effects, the main argument here was that the vaccination was beginning too late to be effective. In the Czech Republic, many practitioners were claiming the H1N1 influenza to be a media bubble (Brazova and Matczak, 2013). Interestingly, however, these two countries differed when it comes to consensus at the political level. While the decision to purchase the antiviral vaccines was agreed unanimously in the Czech Republic, in Serbia, there was an opposition also among the politicians.

Dissatisfaction of the health professionals with the management of the H1N1 crisis occurred also in France. Here, however, the criticism was not questioning the vaccines (as it was in the two cases above) but rather the system setup. Independent medical doctors and nurses in particular criticized the fact that they were not sufficiently involved in the preparation process. The decision of public authorities to resort to vaccination centres instead of relying on the existing structures, such as general practitioners, was deemed to be an unfortunate one (Coste et al., 2013).

The role of the media and the medical staff deserves further distinction with respect to civil security governance during the H1N1 crisis. While all these voices were potentially undermining the legitimacy of authorities' conduct, their role with respect to the governance issue was different. The alarmist approach of the media (see further below) could be said to have made the crisis management more difficult and to contribute significantly to the overreaction, making the political cost of a more sober approach very high. The role of the medical staff, on the other hand, was very different in some cases as discussed above, providing a more practical perspective and thus representing a positive feature of the civil security governance system.

Communication

Providing information is crucial in crisis management (Lagadec, 2009, p. 482), as conflicting or confusing information can be destructive

during emergencies (Fitzgerald, 2012, p. 162). The role of the media proved to be particularly ambiguous during the H1N1 crisis. On the one hand, the information had to be disseminated to the population and some countries, such as the Netherlands, launched large information campaigns. On the other hand, however, in many countries (notably in Austria, Czech Republic, Estonia, Germany, Italy, Latvia, Slovakia and the UK) the media were reported to exaggerate the severity of the pandemic threat and thus to alarm and confuse the population.

Slovakia and Latvia are examples of countries where the media portrayed the government as not doing enough. In Slovakia, the media presented the amount of vaccines to be purchased as low and was comparing the situation to other states where the decision was taken to buy larger quantities. Somewhat similarly, in Latvia, the media at first reported that the government was not going to purchase vaccines at all – a message which created a lot of concern among the citizens (Hellenberg and Vissuri, 2013b).

Even the countries that involved traditional media channels, such as TV and radio, in their crisis management – as France did – were facing challenges from 'open' media (especially the internet) through which negative information about the vaccines were spread. The authorities then were not able to adopt an efficient strategy to deal with the rumours launched in this way, which were competing with the official communication (Coste et al., 2013). The growing role of the Internet poses a challenge for civil security governance. On the one hand, it can help in information dissemination, but, on the other hand, it also can undermine the credibility of governmental bodies' decisions and provoke panic reactions.

Leaving the interfering role of the media aside, the way in which the authorities themselves communicated with the public during the crisis was crucial. Here, Germany can serve as an example of a rather sober and informing approach. The official bulletin provided recommendations to the media and the public, yet it was stressed that the advice was based on relatively less certain data and predictions (Hegemann and Bossong, 2013a). Contrastingly, the communication with the public was characterized as poor in Switzerland and the UK. In both cases, the public was rather confused, receiving inconsistent and often even contradicting information from various official sources (Hegemann and Bossong, 2013b; Fanoulis et al., 2013a). In the UK, the exchange of information was also problematic, not only as far as the public was concerned, but also among different participants involved in the management of the H1N1 crisis (Fanoulis et al., 2013a).

Conclusion

Analysing the responses to the H1N1 influenza in Europe, both diversity and similarities of the actions can be observed. Starting with similarities, the actions of the states (with few exceptions) were serious and can be characterized as strongly precautionary. The pressures from the media, the public and possibly from the pharmaceutical industry led the governments and the responsible bodies to purchase vaccines and to implement vaccination as well as other measures. The actions were clearly presented as proper in a situation of high uncertainty. It helped building an image of the situation being under control.

At the beginning, the chapter set out to focus on the legitimacy of the authorities' conduct, operationalized through output and throughput. In none of the countries, the legitimacy seems to have been shaken dramatically (or even at all). In most of the cases (with the exception of Switzerland and, to a lesser extent, Estonia), there were no important changes to the national civil security governance systems in the aftermath of the crisis.

Among the different European countries, the reaction was not completely uniform. Poland did not purchase the vaccines and Estonia purchased only a (comparably) small number. In most of the cases, stakeholders (such as medical professionals) were involved in decision-making; but different ones, and in different positions. Some were criticizing the governmental actions while others were more directly involved in the decision-making. Also the public reaction varied: in some countries, the governments and the responsible bodies were criticized; in others, the public remained relatively calm. In some countries, the governments put a significant emphasis on communication with the public (by launching information campaigns), while in others the communication with the public was modest.

Furthermore, civil security governance systems are differently organized in terms of dealing with pandemics. In most of the countries, the response was highly centralized, although exceptions could be found. The countries used different procedures to react – some of them equally effective – without any single best model to be drawn. Coordination deficits were noted within both centralized (UK) and decentralized (Germany) systems dealing with the H1N1.

While coordination (or a lack thereof) is a typical feature for crisis management in general, the uncertainty and the related overreaction are specific to pandemic crises. The reaction to the H1N1 influenza caused (as became clear eventually) most of the European countries to

overreact. The only states not overreacting to the crisis were Estonia and Poland. As for the former, other factors were also at play, such as economic ones. Thus, the differences here seem to correlate with cultural and economic differences rather than with different civil security institutions and governance processes.

It could be summarized that the H1N1 pandemic showed that despite a significant diversity in terms of the organization scheme of civil security governance system, and particular courses of action, there is a general tendency to rely on precautionary action in the European countries. This seems to have been perceived as legitimate by the public as well. Although the cases showed that the response was indeed exaggerated, this did not lead to widespread or significant reforms. Similarly, a few countries launched political or professional inquiries in the aftermath of the crisis. Thus, there seems to be a consensus that the reaction was largely acceptable and appropriate.

Except for Serbia, where a H1N1-related corruption scandal took place, the overreaction did not seem to have had more far-reaching consequences. In the cases where the reaction was perceived as rather mismanaged (Switzerland and the UK), the problems were mainly associated with the tasks performed in crisis management in general – that is poor coordination and poor communication, especially with the public, which was receiving conflicting information from different official sources during the crisis. By the same token, in Estonia – one of the countries not overreacting with its limited vaccines purchase – the changes in the aftermath of the crisis included the budgeting of additional financial resources to deal with such crises in the future. Hence, across Europe, economic overspending seems to be much less critical to legitimacy than the (potential) fatalities.

Notes

1. The analysis was funded by the Specific Research Grant of the Charles University in Prague, Faculty of Social Sciences Nr. SVV 2014 260 112.
2. The international governance issues concerning the H1N1 pandemic have been already addressed elsewhere (see for example Wilson et al., 2010) and are beyond the scope of this chapter.
3. ANVIL stands for Analysis of Civil Security Systems in Europe. All country studies and reports are available on the project website, http://www.anvil-project.net.
4. Moral legitimacy in Suchman's terms does not directly focus on the 'inputs' in the policy process in the sense of representative participation in decision-making. In this chapter, we somewhat overcome this by discussing the array of stakeholders involved in the H1N1 decision-making and response actions.

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