

Comparative Report on COVID-19 Leadership Responses: Spain, South Korea & Canada

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Abstract: The COVID-19 pandemic posed an extreme challenge to the healthcare system of the world. People faced serious problems during that phase. This report mainly discusses the leadership responses of Spain, South Korea, and Canada to evaluate the influence of leadership. Hence, the evaluation identifies the possible preparation for the future health crisis.

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1. Introduction

The COVID-19 pandemic has become one of the harshest global crises of the 21st century. It has become a pandemic that has challenged not only global health systems but also economies and societies. In December 2019, an outbreak of pneumonia of unknown source was first reported in Wuhan, Hubei Province, China. Many of which were linked to the Huanan Seafood Wholesale Market. Laboratory research led to the finding of a new virus, which was later isolated as a coronavirus. As a result, the World Health Organisation declared COVID-19 a public health crisis of international concern in January 2020, and they announced it as a global pandemic in March 2020 (Jebril, 2020). Beyond medical resources, the pandemic has played a role in highlighting the need for leadership and good governance. Decisions by political and health authorities have influenced the national response. Comparing the experiences of Spain, South Korea, and Canada provides a valuable perspective for understanding the exact dynamics of the virus. Spain faced many challenges in coordinating their decentralised health system. South Korea's centralised model enabled repaid technology, which drives interventions (Rim, 2023). Canada's federal system has resulted in the creation of various

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2.Comparative Analysis of Pandemic Responses

2.1 Spain

2.1.1 Pre-COVID Health System Capacity

Before the pandemic, Spain's health system had both advantages (universal reporting, generally good public health infrastructure) and limitations (capacity barriers). These things include:

- **Public funding:** SNS is primarily funded by the government through taxes paid by the public (Sura et al., 2017). But investment in infrastructure and manpower has been limited due to Financial contraction compared to previous years.
- **Hospital infrastructure and ICU capacity:** In the term of hospital infrastructure and ICU capacity is fewer. Spain had fewer ICU beds per capita than some European peers. Which creates a precarious situation due to increasing demand. The impact has also been observed badly during COVID-19.
- **Workforce:** Shortages also existed in Nursing and first aid. Especially in some autonomous regions.
- **Preparedness:** Spain has their own general preparedness plans. But many of the plans were not fully updated or stress-tested for the acute crisis of COVID-19.

2.1.2 Emergency Preparedness Before COVID-19

The institutional framework for the Spanish state of emergency includes the Coordination Centre for Health Alerts and Emergencies (CCAES) under the Ministry of Health (Mattei and Del Pino, 2021). These are responsible for awareness, collaboration and support to regions. Before COVID-19, although formal response mechanisms existed, the scale and novelty of the pandemic revealed some gaps. Spain has a well-established national health system (López Casanovas and Pifarré i Arolas, 2022). But its decentralised governance model and variable regional power hampered the initial response to the pandemic.

2.1.3 Spain: Delayed Action and Regional Tensions Detailed Analysis

Spain has experienced one of the harshest COVID-19 outbreaks in Europe. The country has a universal, tax-funded health system. However, the governance structure is highly localised. Its

17 Autonomous Communities (ACs) control most operational features of healthcare, such as hospital management, monitoring applications, and public health interventions.

Early Phase: Fragmented Decision-Making and Delayed Measures

In the first months of 2020, Spain's response was slower than that of other European countries. One reason for this was that the warning signals from Italy were not fully implemented. In addition, the epidemiological surveillance activities distributed to the Autonomous Communities (ACs) produced inconsistent initial data (De Vries et al., 2021). As a result, there was a delay in detecting infections in uncontrolled communities. In February and early March:

- Regional governments applied different risk assessments; large gatherings continued in spite of a surge in cases in some ACs.
- Events such as International Women's Day protests, football matches and cultural festivals on March 8th were held in a few cities.

Studies challenge that these unstable actions were partly due to political fragmentation. Because each AC followed its own analysis of risk.

Central–Regional Tensions and Coordination Problems

Spain's localised model requires intergovernmental coordination through the Interterritorial Council of the National Health System (CISNS). Though in early 2020:

- There were common meetings, but the decisions were not binding, so regions could either follow or ignore recommendations.
- Experts have recorded that “multi-centric health governance without unified emergency protocols” supplied to the fragmented response.

As a result, tension has arisen between ACs and Madrid. Especially in the opposition-controlled areas (De Marinis et al., 2028). There, disagreement over the severity of the situation and the necessary measures has led to the politicisation of public health.

Escalation and Centralisation: State of Alarm (March 2020)

The number of cases increases dramatically in Madrid, Catalonia and the Basque Country. So the national government concluded that it was not possible to take coordinated action under a

localised framework. As a result, on 14 March 2020, Spain declared a nationwide State of Alarm (Estado de Alarma) by Royal Decree 463/2020.

This declaration:

- Regional autonomy has been paused during the state of emergency.
- The Ministry of Health has been given full authority over all regional facilities, personnel and resources.
- Nationwide rules have been implemented to procure PPE, medical equipment, and laboratory capability.

This centralisation has effectively transformed Spain's health system into a temporary command-and-control model. Which is unprecedented since the development of regional health autonomy in the 1980s (Pecchia et al., 2020).

Controversies and Political Conflict

Although the State of Alarm has solved the coordination problem, it has also given rise to major political and constitutional debates.

- Some regions statement that the central government acted too late. This led to the virus spreading unchecked in February and March. For example, Catalonia and the Basque Country.
- Other regions believe that the government took excessive measures to regain political control, as seen in Madrid.

The opposition has accused the government of underestimating scientific warnings, especially after the surge in infections in Italy in late February.

Scholars have described this period as one of high intergovernmental conflict. Where the pandemic is deepening long-standing regional politics.

Impact of Delayed Decision-Making

It is widely believed that the delay in implementing national restrictions exacerbated the severity of the first wave in Spain. Modelling studies have shown that if strict measures had been taken

earlier at the national level, a significant proportion of infections and deaths could have been prevented.

- Modelling studies have shown that earlier action, even if taken just 7–10 days earlier. It could have significantly reduced the number of cases and deaths (Romero-Brufau et al., 2021).
- Decentralised governance slowed “risk alignment,” with different regions making decisions at different times.

Pressure on the health system: Pressure on the health system increased rapidly (Romero-Brufau et al., 2021). By late March, hospitals in Madrid and Catalonia were operating beyond their normal bed capacity. Field hospitals were set up to handle the additional patient load, the most notable of which was the IFEMA field hospital in Madrid.

Structural Challenges Exposed by the Pandemic

Spain has experienced points out several systemic limitations:

Decentralisation without a unified emergency framework

- While the ACs were highly autonomous, there was no clear and uniform protocol for taking coordinated action in a national health emergency.
- The CISNS (Interterritorial Council of the National Health System) had limited authority and did not have the power to apply its decisions (Ricciardi and Tarricone, 2021).

Political Polarisation

- The long-standing political challenges over regional autonomy. This is particularly around Catalonia and Madrid have complicated a unified and coordinated involvement at the national level.

Data Fragmentation

- Regional observation systems use different reporting structures and timelines. By slowing down situational evaluations at the national level.

2.2 South Korea

2.2.1 Public Health Infrastructure

South Korea's public health infrastructure was remarkably well-prepared for a pandemic, partly because of:

- **MERS experience:** Following the 2015 MERS outbreak, South Korea started important reforms, legal changes, and capacity-building steps.
- **Surveillance system:** Syndromic surveillance, real-time data collection, and data sharing - all of these capabilities have been seriously improved.
- **Laboratory capacity:** The country has rapidly increased testing capacity through connections with public and private labs. In addition, South Korea has further increased the speed and supply of testing by opening drive-through and walk-through testing centers.
- **Legal and institutional preparedness:** COVID-19 is declared an observable disease under the IDCPA. This gives the KDCA and local governments the legal authority to apply quarantine (Kim, 2023). They also receive full legal support to conduct contact tracing and obtain the necessary resources.

2.2.2 Digital and Technological Integration

One of the features of South Korea's COVID-19 response was its active and forceful use of technology:

- **Contact Search:** Joined with credit card exchange history, CCTV footage and mobile phone location information.
- **Legal Capability:** The IDCPA provides the legal basis for collecting infectious disease data, enforcing quarantines, and mobilising necessary resources.
- **Whole-nation approach:** According to the analysis, Korea's success is partly due to its "whole-nation" model. In this model, national institutions, local governments, the private sector, and citizens have coordinated around a strong legal and institutional framework(샤오한, 2022).

Moreover, health financing was sustainable. Funding came from both central and local governments, and the national health insurance system helped to ensure a broad scope and capacity.

2.2.3 South Korea: Rapid Mobilisation and Early Testing

South Korea's early response to COVID-19 was particularly notable for its speed, legal strength, technological invention, and coordination. They adopted a different strategy rather than relying on blanket lockdowns. Based on the legal and institutional framework, Korea actively implemented the "3T" strategy means Testing, Tracing, Treatment. This integrated approach helped the country quickly control the infection. As a result, they were able to significantly inhibit the outbreak by April 2020 (Knudsen, 2020).

Here are the key elements and mechanisms of that early phase:

Legal and Institutional Foundations

Infectious Disease Control and Prevention Act (IDCPA)

- After classifying COVID-19 as a "highly contagious disease," the IDCPA issued a directive to the Korea Disease Control and Prevention Agency (KDCA). The directive gave the KDCA a clear legal mandate to carry out the key measures. The measures included testing, monitoring, quarantine, resource mobilisation, and coordination across government levels.
- Under this law, the Central Disaster and Safety Countermeasures Headquarters (CDSCHQ) was selected as the main coordinating body. The CDSCHQ task was to ensure effective coordination between various government institutions and organisations.
- Article 16 of the IDCPA set out how quarantine methods and case management should be conducted (Park, 2025). It provides a formal framework for what were once special decisions.

Whole-of-Nation (WoN) Approach

- South Korea adopted a one-nation response model. This model brings together the central government, local governments, civil society, the private sector, and scientific societies.

Resource Mobilisation & Early Preparations

Financial & Material Mobilisation

- Very quickly, from late January to February 2020, the government allocated funds for critical resources. These resources included mobile X-ray units, tents, negative-pressure rooms, masks and sanitisers. Also allocated were quarantine infrastructure and support for local governments to scale up testing and quarantine activities.
- The production of diagnostic test kits was widely supported. The government granted emergency approval to several biotech companies to produce RT-PCR kits.

Testing, Tracing, and Quarantine (“3T” Strategy)

Testing and Innovation

- South Korea quickly started drive-through testing, reducing the risk of infection and allowing more people to be tested. People can easily get tested through walk-through and mobile clinics. The government has been conducting group testing, not just for patients, but also in high-risk areas.

Contact Tracing

- Korea used credit card data, CCTV and GPS to detect infections. KDCA and local teams have not only traced individuals but also entire groups. People are able to report their information and comply with quarantine using a mobile app.

Quarantine & Isolation

- Tests were conducted at ports and airports, and people had to stay at home for 14 days. Patients with mild or asymptomatic symptoms stayed in treatment centers, and hospital beds were set aside for serious patients. Local governments, in coordination with the central government, would check whether everyone was following the quarantine.

Governance Structure & Decision Platform

The government quickly created an emergency decision-making platform through CDSHQ. This platform included central and local authorities, health experts and other stakeholders. The decision-making process moved from top to bottom and became more horizontal, comprehensive and evidence-based. The rules and guidelines were regularly updated with stakeholder input and real-time feedback.

Risk Communication & Transparency

- KDCA has opened a risk communication office to send messages to the public. The government has focused on providing quick, clear and information-based messages and has held frequent press briefings to build public confidence. Scientific explanations have influenced public perception of risk, not just warnings.

Outcomes and Impact

Containment of Transmission

- Despite the spike in initial infections like the Shincheonji cluster, South Korea brought the effective reproduction number (R_t) below 1 by early April (Choi and Ki, 2020). Cluster-based following has played a key role; the newest cases have been traced back to existing clusters, rather than widespread community transmission.

Effectiveness of Testing and Tracing

- A recent study found that South Korea, following the Korean model, was able to detect more than 60% of cases, combining contact tracing and pre-emptive group testing (Yang, 2022). This high tracing ratio helped control the infection without a lockdown.

Resource Efficiency & Health System Relief

- Hospitals were not put under additional pressure as minor cases were sent to the RTC. Financial and operational support enabled hospitals to function effectively and on a larger scale.

Speed & Agility

The key to Korea's success was speed and coordination in testing, tracing, communication, and resource mobilisation. The legally enabled EISS enables rapid communication and hotspot mapping, identifying cases in less than 10 minutes.

Challenges & Criticisms

- Privacy concerns: The use of credit cards, GPS, and CCTV has created some privacy issues. The IDCPA legally allows this, but critics have warned of excessive surveillance.
- Sustainability: It is not always possible to run the system long-term using more resources.
- Social burden: Quarantining and monitoring stressed individuals raises concerns about mental health, justice, and compliance.
- Cluster outbreaks: The reliance on cluster tracing means that large clusters (such as nightclubs or churches) can still cause infection points.

2.3 Canada

2.3.1 Public Health Agency of Canada (PHAC)

The Public Health Agency of Canada (PHAC) serves as the primary central public health agency. Its responsibilities include surveillance, emergency preparedness, public health guidance, risk communication, coordination with other departments, and cooperation with the regions. During the COVID-19 pandemic, PHAC has activated a multi-sectoral coordination framework (El-Jardali et al., 2024). Through the Public Health Network (PHN) and special suggestive and technical committees, it has sought to coordinate among all actors at the central, provincial, and territorial levels.

2.3.2 Pre-pandemic Capacity and Limitations

Before COVID-19, Canada's public health system had various limitations:

- **Emergency preparedness:** PHAC already had pandemic and emergency response plans. These included the Health Portfolio Emergency Response Plan and the Federal-Territorial Public Health Response Plan. However, in the context of COVID-19, these plans needed to be significantly expanded or scaled up (Pandey et al., 2025).
- **Stockpiles and surge capacity:** The National Emergency Stockpile System (NESS) was already in place. However, during the pandemic, a review revealed some limitations in its capacity. In particular, shortages of PPE and other critical supplies were noted.
- **Data and interoperability:** Fragmented data systems in provinces have complicated real-time and combined decision-making. Post-pandemic evaluations have highlighted the need for improved and combined data infrastructure.
- **Equity issues:** The COVID-19 pandemic has exposed deep health inequalities. The 2020 report of the Chief Public Health Officer emphasises that not only overall capacity but also health equity must be prioritised during pandemic response and preparedness.

In addition, the work of independent scholars suggests that there was a lack of uniform integration throughout regional public health agencies. Adaptability was enhanced by the more centralised public health system within the healthcare system in some regions.

2.3.3 Canada: Mixed Response Across Provinces

British Columbia (BC): Using the SARS experience, early communication, information sharing, and movement restrictions were implemented quickly. This resulted in the first wave of non-pharmaceutical interventions (NPIs) being controlled (Birnbaum et al., 2023).

Testing, Tracing, and Isolation

- BC and Alberta: Used digital tools for rapid testing and contact tracing.
- Ontario: Slow testing and lab backlogs have allowed infections to spread rapidly.
- Quebec: Staffing shortages and high caseloads have hampered testing and tracing.

PHAC's Role and Limitations

- The federal health agency PHAC primarily advised, coordinated, and issued guidelines, but could not mandate local approval. As a result, recommendations such as border screening, mask use, and quarantine were not uniformly implemented.

3. Public Health Measures

3.1 Testing and Contact Tracing

Spain: They are initially suffering, regional organisations are under pressure, manual tracing is labour-intensive, and testing is limited.

South Korea: Their mass testing (drive-through) under IDCPA and efficient digital monitoring (credit cards, GPS, CCTV).

Canada: They are decentralised, some regions are fast, but others are delaying. PHAC is helpful but not a guide. Early human-driven approach was inefficient, later technology-driven approach was unevenly adopted.

3.2 Lockdowns and Social Restrictions

Spain: First to impose Europe's strictest lockdown such including movement restrictions, business closures, and social distancing.

South Korea: Avoided a full lockdown. But used local quarantines, cluster isolation, and risk-based restrictions.

Canada: Provincial lockdowns have resulted in some irregular rules, which have complicated enforcement and messaging.

3.3 Coordination Between Government Levels

3.3.1 Spain: Centre–Region Coordination Issues

Challenges of Spain's decentralised model of governance:

Despite central efforts, regional governments have maintained effective control. Overlapping authorities have, in some cases, created confusion, policy inconsistencies, and delays in the allocation of resources or public health services. Decentralised financing has limited the fiscal flexibility of some regions. Interregional councils have attempted coordination, but their impact has been limited by political fragmentation and competition.

3.3.2 South Korea: Centralised Command Structure

South Korea's centralised health administration was strong:

KDCA and CDSCHQ coordinated the government response. Rapid resource mobilisation, quarantine, and trace-and-isolate were possible under the IDCPA (Umeda, 2024). Policies were consistent, and cooperation between different departments was facilitated.

3.3.3 Canada: Federal–Provincial Coordination Challenges

Canada's response was complicated by its federal structure:

PHAC provided scientific guidance and risk messages that provinces implemented locally. Coordinating bodies existed, but ultimate control remained with the provincial governments. While decentralisation was effective in some cases, policy fragmentation, inconsistent messaging, and resource allocation sometimes caused delays.

3.4 Vaccination Rollout

Spain:

Spain initially faced a limited vaccine supply. Using universal healthcare and strong primary care, doses were distributed efficiently as supplies increased. High vaccination coverage was achieved, with a rapid local rollout made possible through decentralized governance.

South Korea:

Korea has maintained transparency in the creation of initial priority lists and vaccine allocation. Mass vaccination centres have coordinated with local governments, KDCA, and private suppliers. These consistent communications and public trust have helped in high vaccination uptake.

Canada:

Canada initially faced delays in vaccine supply and complex negotiations with manufacturers. After supplies stabilised, provinces implemented vaccination programs at different speeds. PHAC provided guidance, but there were variations due to provincial differences. Post-pandemic analysis shows that Canada ultimately achieved high vaccination rates, but disparities remain in disadvantaged and remote communities.

4. Critical Analysis of the Leadership Styles

4.1 Spain

4.1.1 Structure of the National Health System (SNS) of Spain

Spain's Sistema Nacional de Salud (SNS) is built following a highly decentralised model. The country's central government plays the main policy and regulatory role. It manages and provides healthcare to approximately 17 autonomous communities (ACs) (Armenteros-Ruiz et al., 2024). The Interterritorial Council (Consejo Interterritorial) brings together the national health minister and regional health ministers for high-level health policy coordination (Nikogosian, 2020). This organisation grants the decentralisation regions considerable autonomy over budgets, planning, hospital management, and public health. During an emergency, coordination can become more complicated due to this breakdown. For example, at the beginning of COVID-19, the central government used a Royal Decree to temporarily centralise authority, but tensions remain as it damaged trust between levels of government (Navarro and Velasco, 2022).

4.1.2 Leadership in Spain

The COVID-19 response in Spain has been very complex. The main reason for this is the decentralisation of the country's political and health systems. The 17 Autonomous Communities (ACs) have broad powers in healthcare, surveillance, and public health planning. This creates a regionally powerful but nationally combined structure. In March 2020, Health Minister Salvador Illa believed central leadership. He together managed the complexities of a public health

emergency and a semi-federal political system. Illa quickly became a key figure in the national reaction due to his philosophical background and political experience. It is important to consider various frameworks to analyze his leadership. These include transformational leadership, situational leadership, crisis leadership, administrative leadership, and divided leadership.

4.1.3 Crisis and Situational Leadership

Crisis leadership theory highlights rapid decision-making, resource activation, clear communication. It is a balance between central and local austerity. The context of the Spanish pandemic clearly exhibits these challenges. The outbreak in Madrid and Catalonia, the high population, and the weak hospital infrastructure created pressure for immediate action. Illa's leadership was adaptive to the situation (Mbarek, 2025).

Early stage (February–March 2020):

When the outbreak began, Illa used a directive, centralised method. The declaration of a “state of alarm” centralized the country's lockdown, travel restrictions, and PPE collection. The command-and-control model secured rapid action.

Mid-stage (Summer 2020):

When the outbreak temporarily declined, Illa shifted to a distributed leadership model. Decision-making power shifted back to the AC. Interventions were facilitated by using the relevant knowledge of local leaders. The hybrid approach allowed for customisation to regional controls.

Late stage (Winter 2020–2021):

Illa applied a hybrid leadership style. It combines central coordination with local autonomy and reflects the concept of joint leadership. Research shows that this model is essential for a system with regional power.

4.1.4 Transformational Leadership

The key characteristics of transformational leadership are vision, motivation, and trust. These elements are partially revealed in Ella's behavior. Her communication was calm, measured, and neutral, which helped create a sense of shared responsibility. She used social influence to apply public health guidelines, highlighting support.

Strengths:

- She was able to reduce public anxiety during times of political polarization.
- Her efforts to bring local and national authorities together reduced potential struggles in decentralised systems.
- She used moral authority to encourage people to freely follow guidelines.

Limitations:

- A clear long-term goal is essential in progressive leadership, but Ella's future plans. Especially regarding reopening and growth were sometimes unclear.
- Some ACs viewed her as technically weak, which created a tension between moral authority and practical capability (Giunco et.al., 2020).

4.1.5 Bureaucratic and Technocratic Leadership Elements

Ila's leadership also had bureaucratic features. Bureaucratic leadership depends on formal rules, ranking, and legal authority. It provides validity. But it slows down the pace of application.

Advantages:

- Legal, strong central decisions can be made during a critical situation.
- Structured protocols have helped maintain national unity.

Disadvantages:

- Administrative delays occur, especially in PPE supply.
- The essential rigidity of the bureaucratic system is exposed.
- ACs, frustrated by formal limitations, respond slowly.
- This creates a tension between systematic correctness and the priority of the crisis.

4.1.6 Nurse leadership

nurse leadership played a key role in the healthcare system. A qualitative ethnographic study found that Executive Nurse Leaders (ENLs) in different self-governing communities in Spain were actively engaged in different public health issues (Ribera-Almandoz, 2019). These issues could be emergency management, decision-making, and internal/external communication. Their roles ranged from policy making to hospital management and shared governance. They also demonstrated that nursing executives were an important part of crisis leadership.

4.2 Leadership in South Korea

4.2.1 Structure of the Korean Health Care System

South Korea has developed a centralised public health infrastructure to control infectious diseases. The country has integrated universal healthcare into its infrastructure. The national health insurance system covers more than 97 per cent of the population.

The Ministry of Health and Welfare (MoHW) sets the country's health policy. On the other hand, the Korea Agency for Disease Control and Prevention (KDCA) is formerly part of the KCDC (Chu,2025). KDCA is the main agency for infectious disease control and coordination. The legal framework, particularly the Infectious Disease Control and Prevention Act (IDCPA), empowers these agencies to take swift and decisive action during pandemics (Park, 2025). The KDCA has the capacity to conduct testing, tracing, quarantine, resource mobilisation, and inter-agency cooperation. These help centralise and execute the overall response activities.

South Korea's response to the pandemic is commonly considered notable. It is recognized to a centralised, technical, and flexible leadership system. The Korea Disease Control and Prevention Agency (KDCA), led by Commissioner Jung Eun-kyeong, provided a centralized authority-led structure (Oh et.al., 2021). Unlike Spain, South Korea had administrative memory of the 2015 MERS outbreak. This significantly improved crisis awareness. South Korea's leadership combined technical, transformative, adaptive, and distributed elements. This resulted in a quick and logical response.

4.2.2 Technocratic Leadership

South Korea had a technocratic leadership based on skill rather than political authority. Jung Eun-kyeong made evidence-based choices. He trusted on pandemic modeling, communication, and testing guidelines. Key features:

- Clear daily briefings, explaining the rationale for each mediation.
- Fast expansion of testing, drive-through, and mobile units.
- Data-driven quarantine and isolation steps.

Similar leadership increased public trust. The literature highlights that credibility and expertise are essential in public health disasters. Post-MERS modifications gave the KDCA legal authority. This allowed for rapid centralised action(Lee, 2024).

4.2.3 Transformational Leadership

Jung showed transformational qualities. He acknowledged public fears and expressed insight. He inspired voluntary submission by taking tough measures. He modeled personal ethics, which helped build rapport and trust. The literature on transformational leadership suggests that emotional resonance increases agreement during times of crisis. Jung's approach also encouraged loyalty and civic collaboration.

4.2.4 Adaptive and Agile Crisis Leadership

South Korea's adaptive leadership included rapid learning, analysis, and adjustability. Digital contact tracing was created by combining credit card, telecom, and CCTV data. Quarantine and isolation measures were managed in a steady manner according to infection trends. Rapid local production of PPE and masks was ensured.

4.2.5 Distributed Leadership within Centralisation

Despite centralised command, distributed leadership was visible. Local government officials carried out testing, isolation, and community observing. Public-private partnerships increased technology deployment. Central policies were implemented locally with minimal struggle. The combination of central authority and local operational adaptability was crucial for effective outbreak control

4.3 Leadership in Canada

4.3.1 Governance Structure of the Health System

Canada's health system is governed under a federal framework. The federal government, through PHAC and Health Canada, provides direction, border control, and national strategies (Bhagaloo, 2022). However, the provinces and territories are primarily responsible for running health services, such as hospitals, public health units, and vaccination clinics. This decentralisation means that during a pandemic, each province can adopt slightly different policies. These lead to variation in testing, contact tracing, and restrictions.

4.3.2 Distributed Leadership

Leadership was divided at the federal and local levels. Provinces made choices on school closures, lockdowns, testing, and vaccinations. But federal government coordinated boundary controls and vaccine purchasing. This allowed for flexibility in actions based on local needs and regional trends. According to the literature, distributed leadership, while essential for local responses, complicates united crisis management.

4.3.3 Transformational Leadership

Trudeau used some transformational leadership to promote collective responsibility.

- Sensitive communication and public comfort.
- Economic measures like the CERB to support agreement.
- Promoting solidarity among the public in spite of divided governance.

The effectiveness of transformational leadership was limited by federal barriers. Trudeau could essentially inspire provincial authorities, but not govern (Ellis, 2022).

4.3.4 Provincial Leadership Styles

Dr. Bonnie Henry (British Columbia)

Dr. Bonnie Henry was the provincial health officer of British Columbia. She demonstrated transformational, participatory, and conditional leadership during the pandemic. She combined evidence-based decision-making with understanding communication. This earned her high public trust.

Actions and Practices:

Transformational Leadership:

- She inspired the public to take shared responsibility.
- Her message was—"Be kind, stay calm, stay safe."
- This was accepted as a moral and social duty.
- She provided information with clarity, honesty, and honesty.

Participatory Leadership:

- She actively engaged with local government, health officials, and the community.
- This was to ensure the significance of the intervention.

- He consulted with local and original leaders on masking instructions or social gathering limits.

Situational leadership:

- He adjusted the response to the speed of infection.
- He allowed for gradual restarts during low infection times.
- He took extreme measures quickly when the outbreak escalated.

Results:

British Columbia had the lowest COVID-19 infection and death rates in Canada during the first and second waves. She has become a model for effective public health communication in a decentralised unified system (Detsky and Bogoch, 2021).

Doug Ford (Ontario)

Doug Ford was the premier of Ontario. His leadership style was characterised by both commercial and regulation. It also included awareness and situational adaptation. He played a political role, adjusting public health guidelines with political and economic pressures.

Transactional leadership:

Ford leaned on rules, enforcement mechanisms, and formal authority to govern the state. For example, during the first lockdown, clear laws were performed to close businesses, social functions, and schools.

Directive leadership:

He often made individual decisions under emergency orders. For example, declaring a provincial state of disaster and closing non-essential businesses (Deere, 2021).

Empathetic communication:

While his approach was regulation, he tried to show empathy by acknowledging the personal and economic hardship caused by the limitations.

Situational leadership:

He adjusted his strategy over time. He reapplied strict lockdowns and curfews in hotspot areas when infections spiked in late 2020. This is an example of reactivity to pandemic data.

The result:

Ontario's long-term care complexes had large outbreaks early on. This shows the limitations of directive commercial leadership. Later, stricter restrictions and vaccination programs improved coordination and control (Stall et.al., 2021).

However, the challenge of political versus skill-based leadership in a decentralized system remains.

5. Critical Discussion

5.1 Strengths and Limitations in Each Country's Response

Spain: Despite universal health care and strong primary care, decentralised governance has created fragmentation, delays, and political conflict. Nursing leadership has helped somewhat, but system-wide coordination is weak (Mahmood et al., 2024).

South Korea: Rapid centralised action, legal preparedness, and technology have reduced regulator delays. However, there are privacy concerns and risks of centralised authority dominance in surveillance and data use (Hong et al., 2022).

Canada: Provincial flexibility, health capacity, and financial support are strong. But federal-provincial fragmentation and under-resourced public health systems have slowed the response (Denis et al., 2023).

5.2 Contrasting Scholarly Perspectives from Literature

Centralisation: Rapid decision-making and common resource management strengthen crisis response (South Korea example).

Decentralisation: Increases flexibility and local adaptation; Spain and Canada benefit but coordination challenges.

Canada: Centralised health governance helps; fragmented public health authorities reduce responsiveness.

Accountability: Weak under emergency powers, strong laws are needed.

6. Conclusion

The COVID-19 pandemic has exposed a lot about the health systems of Spain, South Korea, and Canada. It has also exposed the strengths and weaknesses of governance structures and leadership. This centralised authority. Centralisation allowed for coordinated action. But this centrality came too late. Nursing leadership helped reduce some of the challenges. However, overall methodological coordination was limited.

South Korea has exhibited the benefits of a strong centralised system. This system is governed by a clear legal structure. South Korea has organized rapid testing. Rapid contact monitoring has also been ensured. Quarantine measures have also been applied quickly. Transparent communication has strengthened the entire process. The “whole nation” method has involved the overall society in the response. Together, the country has been able to regulate the infection without a full lockdown. This strategy highlights the importance of preparedness. It has also demonstrated the power of critical leadership. Canada's federal system has exposed both its advantages and limitations. However, localization has led to conflicts in the application of testing, following, lockdowns, and vaccinations. Comparative analysis shows that effective pandemic responses depend on a balance of central coordination, regional adjustability, legal preparedness, and transparent communication. Leadership is critical to public trust, resource organisation, and collective action, displaying. The health system ability is not enough without governance, strategy, and communication. These lessons are helpful in ensuring strong global preparedness and resilient responses to future health emergencies.

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