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A Comparative Report on COVID-19 Leadership Responses
(Spain, South Korea, and Canada)



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Introduction

The COVID-19 outbreak represented a never-before-seen global health crisis that challenged the strength, governance, and leadership of health systems globally. It became a natural experiment that revealed how different governance structures influenced the ability of states to effectively manage complex crises that evolved dynamically (Bosancianu et al., 2023). This report explores the governance of the COVID-19 response in Spain, South Korea, and Canada, including differences in health system organization, territorial governance, and leadership that shaped health policy (Erkoreka & Grau, 2022; Kim et al., 2021; Flood et al., 2021).

One of the key focuses of the report is the contrast between centralized or decentralized systems of governance during the pandemic. While Spain's National Health System is largely decentralized, South Korea's system is centralized with decentralized implementation, while Canada's federal system is decentralized with a large degree of provincial authority, making it an interesting point of comparison for understanding where power lay during the pandemic (Navarro et al., 2022; Migone, 2020). Decentralization refers to the distribution of power from the national authority to the sub-national level, while centralization implies concentrating power at the national level, with both systems having their own strengths and weaknesses in crisis situations (Bosancianu et al., 2023).

Furthermore, the importance of leadership strategies is highlighted by the report in addressing public health crises. This is because leadership influences communication, trust, public sector coordination, and public compliance with strategies (Frontiers in Public Health, 2024). Using systems thinking, including current models of leadership, the study explores the relationship between governance structures and leadership in responding to COVID-19 in the three nations.

Critical Analysis of Centralised and Decentralised Approaches to the COVID-19 Pandemic

Systems Approach to Pandemic Governance

The COVID-19 pandemic highlighted the importance of viewing health systems as complex adaptive systems, where outcomes emerge from interactions between institutions, policies, leadership, and societal behaviour rather than from isolated interventions (Bosancianu et al., 2023). A systems approach acknowledges that social care, public health surveillance, political decision-making, and healthcare delivery are interrelated subsystems that function at several levels of government. This interdependence was especially clear during COVID-19, when national decisions affected public compliance, frontline service delivery, and regional capacity.

Different approaches to organising authority within such systems are represented by centralisation and decentralisation. Decision-making authority is concentrated at the national level through centralised approaches, which can facilitate quick coordination, consistent standards, and economies of scale in communication and procurement. Decentralised approaches delegate authority to regional or local governments, potentially enhancing responsiveness to local needs, innovation, and contextualised policy implementation (Bosancianu et al., 2023). However, purely centralised or decentralised models were rarely followed in pandemic governance. Rather, nations adopted hybrid arrangements that changed over time in response to institutional capacity, political pressures, and epidemiological trends.

Spain, South Korea, and Canada illustrate how different system designs shaped pandemic responses. Each country combined centralised and decentralised elements, but the balance between them, and the effectiveness of coordination mechanisms, varied considerably. The

following sections critically analyse how these systems approaches operated in practice, their advantages and disadvantages, and their implications for health outcomes.

Pandemic responses must also be viewed as dynamic processes rather than static policy decisions from the standpoint of systems thinking. Through feedback loops, where policy decisions impact population behaviour, healthcare demand, and institutional capacity, which in turn influence subsequent decisions, health systems are constantly adapting (Bosancianu et al., 2023). During COVID-19, feedback effects were evident in how public compliance affected infection rates, how hospital pressure triggered policy tightening, and how political legitimacy influenced the sustainability of restrictive measures. Systems that were able to monitor these feedback mechanisms and adjust governance arrangements accordingly tended to respond more effectively over time.

Significantly, systems approaches emphasise that centralisation and decentralisation are governance tools that must be in line with system capacity and crisis phase rather than just administrative decisions. When speed, coordination, and uniformity are crucial during the acute phase of a pandemic, centralised decision-making may be especially beneficial.

Decentralised governance, on the other hand, may be more beneficial in longer stages when local expertise, adaptability, and focused interventions are essential. System flexibility and institutional learning are reflected in the ability to switch between these modes.

In this context, Spain, South Korea, and Canada provide valuable comparative insights into how governance structures either constrained or enabled adaptive responses. Their experiences demonstrate that successful pandemic governance depends not only on where authority is located, but on how effectively different system components interact, communicate, and learn under conditions of uncertainty.

Spain: Decentralisation under Stress and the Turn to Co-Governance

Systems Approach during COVID-19

Spain has one of Europe's most decentralised healthcare systems. While the central government serves as a coordinator, the 17 Autonomous Communities (ACs) are primarily in charge of managing the health workforce, providing public health services, and delivering healthcare (European Observatory on Health Systems and Policies, 2024). From a systems perspective, this structure relies heavily on intergovernmental cooperation, shared information systems, and trust between levels of government.

Health authorities used a decentralized system that fractured decision making. Surveillance capacity, testing availability, and hospital preparedness had long differed widely across regions, and central coordination mechanisms were weak and nonbinding — which hampered the central government's ability to impose uniform measures and delayed containment during the initial outbreak (Erkoreka and Grau, 2022).

Centralised and Decentralised Decisions

In March 2020, Spain shifted dramatically towards centralisation through the declaration of a state of alarm. Under this emergency framework, the central government assumed direct authority over regional health systems, mobility restrictions, and procurement (Navarro et al., 2022). This recentralisation enabled the rapid imposition of a nationwide lockdown, central coordination of intensive care capacity, and unified public health messaging.

However, this centralised phase was temporary. As infection rates declined, Spain transitioned towards a co-governance model, whereby decision-making authority was shared between the central government and the ACs through sectoral conferences and joint committees (Navarro et al., 2022). Regions regained discretion to tailor restrictions, testing strategies, and reopening measures to local epidemiological conditions.

Advantages and Positive Outcomes

The team emphasized the obvious benefits of the first phase of centralization. As national measures limited population movement, the task of coordinating the distribution of

resources, patients and equipment within a country was vastly simplified (Erkoreka and Grau, 2022 –). It's possible that centralisation made sense during the immediate crisis, pulling together disparate efforts.

The second phase — decentralized — provided some returns, but with limited impact. The fact that regional governments are responsible for health matters enabled autonomous communities to plan and execute their own policies (Hernández Moreno, 2024). In some regions, this meant advanced testing, digital health tools and reorganisation of primary care.

Disadvantages and Challenges

Spain's decentralized system, which gave its regions greater authority to run services. They track debt more than they track income. Additionally, because banks charge fees when an account balance is low, many lower-income borrowers may not have a bank account. The long-term care sector proved particularly fragile: mortality in nursing homes remained high, associated to disjoint governance between the health and social protection domains, and unequal regulation amongst regions (Hernández Moreno and Vélez, 2023).

The move from centralised command to co-governance contributed to mixed messaging and public confusion. A patchwork of differing regional rules also did little to encourage compliance (Hernández Moreno, 2024).

From a broader systems perspective, Spain's experience highlights how decentralized systems can exacerbate structural weaknesses in response to systemic shocks. Where formerly pre-existing arrangements seemed adequate, significant gaps were exposed during the pandemic, particularly with regards to vertical integration between national and regional levels — for instance, around data sharing, the standardization of monitoring or crisis communication (Bolleyer et al., 2023). These limitations left it unable to foresee regional outbreaks and thus to deploy resources reactively rather than proactively. Moreover, political polarization between central and regional governments disrupted the feedback loops upon which effective adaptation depends. Despite scientists' warnings, policies failed to respond in a timely and consistent manner.

Many questioned how long the institutions themselves could survive, but every crisis seemed to lead to another burst of emergency recentralisation. In the short term, the state of alarm worked, but it also exposed limited preparedness for large-scale health emergencies within Spain's decentralised framework (Navarro et al., 2022). Subsequent devolvement of these powers activated coordination challenges, with later waves highlighting how increasing public fatigue and economic pressures exacerbated those challenges. This cycle suggests that even in good times Spain lacked mechanisms of stable governance that balanced cohesion and regional autonomy.

The Covid-19 response demonstrated that decentralized systems without institutionalized coordination face difficulties under duress. When they remove these safeguards, decentralisation is associated with fragmented responses and inequitable health outcomes.

South Korea: Centralised Coordination with Decentralised Implementation

Systems Approach during COVID-19

South Korea's response reflects a systems approach built on institutional learning and strong central capacity. Following the 2015 MERS outbreak, reforms strengthened the Korea Disease Control and Prevention Agency (KDCA) and clarified legal authority for infectious disease control (Kim et al., 2021). These reforms enhanced system preparedness by embedding surveillance, data sharing, and crisis coordination into the national governance framework.

During COVID-19, South Korea activated a centrally coordinated emergency response through the Central Disaster and Safety Countermeasures Headquarters, while implementation responsibilities were distributed across local governments and healthcare providers (Kim et al., 2020).

Centralised and Decentralised Decisions

At the national level, critical strategic decisions—such as who would be tested, which diagnostic tests would be approved, how data would be handled and how information and misinformation would be communicated to the public—were centrally controlled. This rapid scaling of testing was facilitated by nationally consistent clinical guidelines and public dashboards to ensure transparency.

Local governments were given powers to administer themselves. Municipalities that tailored interventions to local outbreak patterns — for instance, by establishing drive-through testing centers and quarantine facilities — generally improved their pandemic response (Kim et al., 2021). This decentralized execution preserved overall alignment but did so with flexibility.

Advantages and Positive Outcomes

South Korea's hybrid model offered some key benefits. Centralised authority allowed for speed, consistency and a rapid mobilisation of resources; decentralised delivery allowed for greater responsiveness. Moreover, the use of digital tools aided in swift contact tracing and allowed health authorities to make real-time decisions. They were also able to sustain low early mortality and avoid a nationwide lockdown (Park, 2021).

One was South Korea. While institutions might not be the first thing that comes to mind in this context, it was clear that they had to be adaptable and resilient (Bosancianu et al., 2023).

Disadvantages and Challenges

The Korean strategy wasn't without its problems. The heavy reliance on digital surveillance raised alarming ethical concerns about privacy, civil liberties and the normalization of emergency powers. But as pandemic fatigue sets in, compliance wanes and contestation begins, even if initially public trust is high (Lee et al., 2025).

Such tensions expose a fundamental weakness of centralized power: It depends on continued public trust and legitimacy to function. Without these ingredients even technically efficient systems can be rejected by stakeholders who do not understand their value.

Despite being a case of hyper-centralised systems governance, South Korea's experience

also points to the continued importance of having some power rooted in institutions that learn, operate transparently and are guided by expert decision makers. The Korean response to Covid-19 was built on post-MERS reforms, which preconfigured governance arrangements were that able to snap into action rapidly without creating major legal or political friction (Kim et al., 2021). Preparedness also enhances system coherence and reduces negative coordination costs across governance levels.

The sustainability of this model is still up for debate. By relying on technological surveillance as a key pillar, the architects of the system riddled it with long-term governance problems concerning accountability, proportionality and democratic oversight (Park, 2021). But systems thinking would suggest that, in the long run, they risk creating negative feedback loops if new tools are not matched by new assurances about privacy, transparency and control. When people take fright at the idea of uploading their intimate biometrics, when they are sceptical of side effects or when they vaguely fear that big government or big pharma has too much power, they are less likely to follow rules or get vaccinated.

Therefore, the centralised and relatively powerful decision-making capabilities of South Korea placed great onus on national leaders to constantly update and revise policies as risks evolved. As the country moved toward a “living with Covid-19” strategy, and as leaders faced increasing pressures to balance public health protection with economic normalisation, they relied on adaptive governance rather than rigid control (Bosancianu et al., 2023). In short, South Korea is a vivid demonstration of how centralized coordination and decentralized implementation can be a potent combination when well-supported by strong institutions and good transparency that enables mechanisms to maintain public trust through extended crises.

Canada: Federalism, Coordination, and Fragmentation

Systems Approach during COVID-19

Canada's healthcare system operates within a federal structure, where provinces and territories hold primary responsibility for healthcare delivery and public health, while the federal government influences the system through funding, regulation, and national agencies (Flood et al., 2021). This decentralised arrangement creates a complex system of overlapping responsibilities requiring extensive coordination.

During COVID-19, Canada relied on cooperative emergency federalism, characterised by frequent intergovernmental meetings and informal collaboration rather than hierarchical control (Migone, 2020).

Centralised and Decentralised Decisions

In other words, federal governments took responsibility for borders, vaccines, national guidance and large-scale economic support programs. Provinces (or states, in the United States) retained authority over how to lock down, close schools, set up testing strategies and roll out vaccines, and, in a large federation of provinces, if each follows its own approach, there is bound to be a lot of variation across jurisdictions (Migone, 2020).

Advantages and Positive Outcomes

And decentralisation, in the form of allowing the provinces real latitude, enabled responses to local conditions not just in terms of epidemiology but also of politics. The federal government played a key role by centralising vaccine purchasing across the country, but it did so in a way that did not immediately ensure adequate supply or — as was eventually the case — extraordinarily high coverage (Ingenium, 2024). But this division of labour also helps show that decentralisation can be combined with effective central co-ordination.

Disadvantages and Challenges

Canada's decentralized system was praised for its flexibility, the pandemic also exposed critical gaps in coordination and accountability. It is far more difficult for national agencies to coordinate surveillance and compare outcomes in real time if the data systems themselves don't align (Government of Canada, 2024). Long-term care homes in provinces with fractured governance, inconsistent regulation and chronic underfunding experienced devastating outbreaks that highlighted issues that were largely unchanged after the crises passed (Usher et al., 2025).

In fact, a 2024 federal expert panel noted that unclear governance arrangements and volatile public health funding meant that Canada headed into the next crisis with its overall preparedness compromised (Government of Canada, 2024). Without strong integrative mechanisms, decentralisation can pose a threat to equity and, more broadly, to overall system coherence.

Canada's experience suggests that federal systems, which devolve power across different levels of government, can both facilitate and hinder effective pandemic governance.

Cooperative emergency federalism meant not only that governments worked together despite the constitutional limits on federal authority, but also that they shared information, learned from one another's policies and solved problems together in the crisis (Flood et al., 2021). Importantly, governments built flexibility into the system to minimize the risk of overt intergovernmental conflict, which would have undermined the legitimacy of public health measures. Shortcomings include a reliance on informal, back-room co-ordination mechanisms and an absence of mandatory national standards for surveillance, data reporting and long-term care (Government of Canada, 2024).

Public health agencies are fragmented across the provinces, reducing the ability to produce timely, comparable data — limiting the feedback loops essential to adaptive decision-making. Central actors' ability to sense emerging risks and coordinate pre-emptive early action interventions was hampered. Despite increasing budgets, uneven provincial public health investments led to inequitable system performance (Usher et al.,

2025).

The pandemic laid bare the tensions between decentralized autonomy and national equity goals. Provinces valued policy flexibility, while the federal government lacked the leveraging capacity to ensure that all vulnerable populations in long-term care were equally protected. Post-pandemic reviews emphasized the need to improve Canada's system resilience by ensuring clearer role definition, stronger national surveillance capacity and consistent public health funding — without infringing on provincial rights. Canada's experience demonstrates that, if countries choose to pursue decentralization, they must do so alongside robust coordination and accountability mechanisms to ensure equitable health outcomes in times of crisis.

Comparative Critical Discussion

However, no one model of centralization or decentralization stood out across the three countries. Second, effectiveness depended not directly on policy per se, but on the match between governance structures and institutional capacity, leadership, and public trust. Spain shows that in acute situations, it may be necessary to temporarily re-centralize. South Korea demonstrates the power of strong national coordination, but local flexibility, too. Canada showcases both the strengths and limitations of federalism when it comes to responding to emergencies.

During the pandemic, hybrid systems of emergency management, where power shifts over time and function, were expected as realistic. To understand this, it helps to look at what researchers in governance studies have been learning about what makes an administration effective.

Knowing that isn't a silver bullet, but it is a good reminder of what works. Centralisation was most successful when it allowed for quick co-ordination and clear communication, along with

fair allocation of resources, as seen in South Korea and in Spain's early lockdown period (Kim et al., 2021; Erkoreka and Grau, 2022). Politically fraught as decentralisation may be, it worked best when local authorities had sufficient capacity and were guided by clear co-ordination frameworks, allowing policies to also be tailored in line with local epidemiological, social and economic conditions without undermining national coherence (Navarro et al., 2022; Flood et al., 2021).

Recognizing the comparative evidence highlights the importance of institutional learning and preparedness. While Spain and Canada were more reliant on emergency adaptations — suggesting holes in pre-existing governance arrangements — South Korea's ability to quickly operationalize central authority was grounded in reforms introduced after previous outbreaks: a stronger governance framework (Kim et al., 2021; Government of Canada, 2024). The key is to build learning into systems. This path dependence means that systems cannot learn.

The pandemic revealed that in order to improve health outcomes we must build the legitimacy in governance and public trust that are critical mediating factors between institutional design and population health. In both cases, even technically efficient systems were undermined by eroding public confidence in later phases of the pandemic, which increased noncompliance in all three countries (Lee et al., 2025). In comparing cases across countries, we find that resilient pandemic governance is not about choosing between centralization versus decentralization, but building flexible hybrid systems, that are supported by transparent leadership, institutional memory, and a strong coordination mechanism that can evolve.

Critical Analysis of the Leadership Styles Taken in Each Country

Leadership Theories and Styles in Spain

Like other governments, the COVID-19 pandemic in Spain was, first and foremost, a crisis of governance. Namely, the demands of governing through crisis in a highly decentralised political system. This is in accordance with crisis leadership theory, in which there is often an expectation that in acute phases of an emergency, the ability to act decisively rules the day, a necessary corrective to ward off total system collapse (Frontiers in Public Health, 2024).

The declaration of the state of alarm represented an inflection point: Leadership became more authoritarian. The central government took charge of regional health systems, the movement of people and goods, and the distribution of resources. This was a massive exercise in transactional leadership, commanding compliance through power and regulation. As a result, they adopted this style to manage the acute phase of the crisis extremely rapidly by reducing uncertainty (Erkoreka and Grau 2022).

Despite the potential for this leadership style to get us through moments of great uncertainty and need during its most pivotal moments, it is also when its greatest limitations are revealed. Spain remained politically polarised, and the suspension of regional autonomy was met with resistance from several Autonomous Communities (Hernández Moreno, 2024).

Transactional and authoritative style leaders are less effective in contexts that require prolonged periods of co-operation and trust across a number of actors in decentralised systems. But as the pandemic progressed beyond the initial emergency phase, the limits of centralized management became clear.

Spanish leaders moved toward a network-based leadership model that included co-governance arrangements with the country's regions. Decision-making forums involving both

national and regional leaders were established to prioritize shared responsibility (Navarro et al., 2022). This change is consistent with distributed and relational leadership models (Frontiers in Public Health, 2024).

Their approach does have the advantage of being more flexible and presumably more legitimate if its stakeholders accept it. Regional leaders were able to develop measures according to local epidemiological needs and shared decision making reduced overt intergovernmental conflict (Bolleyer et al., 2023). But the downsides were just as big. Steering clear of a strict hierarchy sometimes led to delayed decisions, murky communication and — amid public frustration everywhere — widespread confusion about rules and restrictions.

In Spain's case, the findings suggest that no one style of leadership can sustain effective performance across all phases of a prolonged crisis. Specifically, while authoritative leadership was highly effective in the “shock” phase of the crisis, delivering strong short-term results, it could not be sustainable in a decentralised political system. Collaborative leadership enhanced legitimacy at the expense of decisiveness. The Spanish case illustrates adaptive leadership, in which leaders intentionally adapted their style to meet the dynamic requirements of the system and expectations of stakeholders (Frontiers in Public Health, 2024).

Spain's experience in the first great pandemic of the highly politicised and decentralised 21st century highlights the struggle of leaders to maintain legitimacy in protracted crises. Adaptive leadership theory made the leap from books and classrooms to real life, as leaders were challenged to mobilise diverse actors and manage conflict in an atmosphere of trust and uncertainty. In Spain, however, relational leadership was more difficult. National and regional leaders engaged in political polarisation and public arguments, hindering collective sense-making and reducing the effectiveness of our adaptive responses (Hernández

Moreno, 2024).

For organizations, shaping perceptions of leadership effectiveness is a communication activity. And entering an initial centralized phase with a rhetoric of urgency, discipline and national solidarity may also support compliance (Erkoreka and Grau, 2022). Some restrictions were extended and others became geographically differentiated. Communication became more complicated — organizations struggled to keep people aligned and on the same page. When national and regional actors were not aligned in their messaging, it undercut clarity and led to public fatigue and decreasing trust.

The governance of long-term care represented the most obvious example of Spain's leadership problems. Nursing home deaths remained high, and this reflected frailties in system integration — a key element of coordinated care — and in leadership accountability in health, social care and inspection agencies (Hernández Moreno and Vélez, 2023). These gaps in leadership and co-ordination contribute to systemic risk. Where crisis leadership spans multiple levels of governance, the most effective crisis leadership requires clear roles, rapid escalation channels and accountability.

But the pandemic also highlighted that Spain's leaders had either an outdated or incomplete understanding of what it means to lead, and what can be expected of followers. Leaders shifted governance modes to demonstrate adaptive leadership, but were hampered because they remained entrenched in institutionally fragmented and politically contested fields. The Spanish case underscores the fact that adaptive leadership, rather than a personal quality, is a systemic capability that depends not just on individual leaders but on institutional design, intergovernmental trust and coherent, coordinated communication. Without those enabling conditions, it's hard for adaptive leadership to produce consistent and equitable results during sustained public health emergencies.

Leadership Theories and Styles in South Korea

South Korea's COVID-19 response has been similarly hailed as an example of successful crisis leadership, as officials set about governing in technocratic, evidence-based, and communicative ways, not only through blunt means of emergency centralisation but also by drawing on institutional learning from previous outbreaks, including the 2015 MERS crisis (Kim et al., 2021). Spain on the other hand, was more reliant on sudden emergency centralisation. Covid-19 also highlighted to primary leadership styles: servant leadership and transformational leadership.

Senior political figures, including the president and prime minister, repeatedly deferred to scientific expertise, allowing the Korea Disease Control and Prevention Agency (K.D.C.A.) to take visible charge of public messaging and policy direction (Kim et al., 2021). Instead of using more autocratic and transactional methods, the leadership was based on established transformational leadership theory — building relationships of trust, credibly selling a vision, empowering autonomous experts. In the early stages of the pandemic, countries that maintained high levels of public trust and compliance did so by holding frequent press briefings, sharing data openly and clearly explaining the rationale for their policies.

This leadership style was not without challenges, but its merits were significant. Korean leaders characterised pandemic management as a scientific and collective problem rather than a partisan one, thereby decreasing political polarization and increasing system coherence to ensure that citizens weren't preoccupied with ideological wrangling (Kim et al., 2020). By 2021, the organization worked to mesh leadership with digital governance tools to facilitate speedy decision-making and agile response and to integrate these changes with effective testing, tracing and isolation (Park, 2021).

Scholars of South Korean leadership often tout its strengths in maintaining traditional organizational structures while adapting to rapid social and technological change. The widespread deployment of digital surveillance apparatus that consolidates authority in the executive sparked fears about privacy and civil liberties (Park, 2021). From the perspective of leadership theory, this represents a clash between instrumental rationality and democratic accountability. But without an electoral mandate, assuming the consent of the governed isn't enough.

South Korean leaders faced increasing opposition as the pandemic entered later stages. Recent surveys indicate that as the pandemic progressed and political debate about the balance between public health protection and individual freedom increased, British people were less likely to comply with the rules (Lee et al., 2025). This transition tested leaders' capacity for adaptive leadership: it demanded policy recalibration; it required heightened responsiveness to changing public expectations.

South Korea's leaders demonstrate the promise of technocratic, transformational leadership styles when they are backed by high levels of trust in institutions, transparency and experience with past crises. But the experience of the other countries, combined with South Korea's own challenges as the crisis extends, suggest some caution about the sustainability of such approaches, and the importance of strong moral oversight in situations where emergencies become more protracted, along with mechanisms to sustain democratic legitimacy.

South Korea's experience suggests that when it comes to navigating a crisis, individual authority matters less than institutional credibility and prior learning. Leadership theorists teach that effective leaders need to interpret evolving risks and modulate distress to get people through uncertainty. Authority was clearly delegated to the KDCA, freeing political leaders to focus on coordination and public reassurance (Kim et al., 2021). This separation

of political and technical leadership likely increased the public's confidence in decision making.

But this epistemic authority, when concentrated in expert institutions, created new fragilities. For leaders, the pandemic's unpredictable nature—and persistent scientific uncertainty—posed a grave challenge to maintaining a coherent message. Scientific advice developed so quickly that changes in policy appeared shocking to the public. But systems thinking also points to the translation of uncertainty as imperative and reveals how weak feedback loops can erode trust, compliance, and cooperation over time (Bosancianu et al., 2023).

South Korea's leaders also achieved quick success by leaning on cultural norms of collectivism and social responsibility. But when leaders rely too heavily on these norms, it can obscure underlying tensions — until crisis fatigue sets in. As economic and other pressures grew, public tolerance fell, and leaders had to move from giving direction to brokering compromise (Lee et al., 2025).

The later uptake of a “living with COVID-19” strategy also exemplifies this. At the same time, leaders needed to balance epidemiological risk with social and economic sustainability and, as such, move from a control-oriented style of leadership to one focused on risk management and shared responsibility, all while sustaining public trust. It highlights that transformational leadership needs to be adaptive over time and include elements of participatory leadership to retain legitimacy over long-term crises (Frontiers in Public Health, 2024).

But over time, legitimacy and resilience depend on the emergence of adaptive, ethically driven leadership to complement them. The case reveals both the limits of centralized crisis leadership, as well as the importance of sustained public engagement, transparency around uncertainty, and the kind of institutional checks that help maintain trust.

Leadership Theories and Styles in Canada

In Canada, one of federalism's strengths during COVID-19 was that national and provincial governments had to share leadership. Unlike Spain and South Korea, Canada did not have a single dominant decision-making authority in charge. In essence, this context closely tracks with collaborative and relational leadership theories that have emerged in recent years.

At the federal level, Prime Minister Justin Trudeau's leadership style is characterised by empathy and openness, but bolstered by consistent public messaging. She stood at the podium with hands clasped, her daily briefings couched in language of pulling together, taking advice from the scientists, and protecting the vulnerable (Flood et al., 2021). At first, there was little emphasis on the "our NHS" message of austerity.

But provincial leaders took different approaches that reflected regional political cultures and priorities. Premiers who worked closely with public health officials made precautionary choices and when others made economic-oriented decisions. This version illustrates the strength of distributed leadership, but also exposes its weakness.

Public health leaders were particularly visible in Canada. Political leaders were often accompanied by the federal and provincial Chief Public Health Officers, to bolster the credibility of decision making (Flood et al., 2021). This is consistent with the leadership literature, which emphasizes credibility of those in leadership roles during times of crisis (Frontiers in Public Health, 2024).

Canada's leadership model also encountered its own limits. In some cases, weak or fractured central authorities appeared to delay co-ordinated action." (Government of

Canada, 2024) During a crisis, we expect our leaders to, well, lead and to speak with a unified voice to reduce potentially conflicting messaging across jurisdictions. These included leaders who were in charge of long-term care at the provincial level (Usher et al., 2025).

Canada's experience highlights that even when distributed leadership is embraced, it is effective only with strong coordination mechanisms and shared goals. Relational leadership was effective for securing legitimacy and cooperation, but less effective in delivering consistency and equity without clearer national standards. Future leadership needs to be supported by stronger institutional frameworks (Government of Canada, 2024).

An adaptive leadership lens on Canada's pandemic experience reveals both the potential and the limits of leadership by persuasion. Adaptive leadership theory, a recent focus of public health scholarship, highlights the role of leadership in galvanising collective action when formal authority may be absent, to which all contribute their expertise — and when power becomes the ability to persuade others to collaborate, rather than comply. In Canada's federal context, that burden was borne heavily by the leaders working across levels of government, and when they lacked interpersonal trust and political good will, the system strained under the weight. This approach was beneficial insofar as it avoided direct constitutional confrontation, but it also meant that the effectiveness of leadership varied greatly based on provincial capacity and political alignment (Migone, 2020).

Although effective leadership required vision, empathy and resilience, communication was the most important challenge. While the federal messaging was largely coherent and empathetic, the provincial messaging varied dramatically. New research in systems thinking demonstrates that this type of inconsistency weakens those all-important feedback loops by creating public uncertainty and eroding compliance with restrictions, as well as confidence in leadership. Provincial restrictions and reopening timelines would also make a difference here, as they varied widely and changed multiple times during the later phases of

the pandemic.

This appeared to be most challenging in long-term care, although other settings struggled as well. Even though federal leaders were responsible for financing the homes and publicly reprimanding homes for having substandard conditions (“the long-term care calamity”), they lacked the direct authority over regulation and staffing that provincial leaders had. This blurring of responsibility lines was a perfect example of how distributed leadership can cause problems if not accompanied by clearly defined roles. Leadership in these contexts requires leaders to come together and delineate who is accountable for what — both in the case of failure, and success.

To support effective leadership potential across federalist systems, we need to focus on the institutions that will support it. The 2024 federal expert panel on pandemic preparedness noted that coordinated federal leadership in Canada will require clearer national standards, increased surveillance capacity and stable investment into public health (Government of Canada, 2024). These recommendations suggest that Canada’s problems lay not only in the realm of “leadership,” but in the institutional constraints that choked off the ability of relational leadership to deliver equitable outcomes.

Canada’s experience suggests that collaborative and relational leadership can maintain legitimacy and cooperation in decentralized systems because leaders use it to buttress institutional mechanisms that enable coordination, accountability and consistency. Without these supports, distributed leadership runs the risk of uneven protection and piecemeal crisis management in the context of a sustained public health emergency.

Conclusion

The report seeks to understand why the pandemic trajectories of Spain, South Korea and Canada differed so drastically, based on the organization and governance of their health systems and also the style and type of leadership. Using a systems-thinking approach, the authors argue that pandemic outcomes were determined not by the centralized or decentralized nature of decision-making, but by how well authority, coordination and leadership flexed and adapted to rapidly changing conditions. In Spain, the highly decentralised health system required recentralisation followed by co-governance, exposing both the flexibility and the fragility of multilevel governance under stress. In South Korea, a centrally co-ordinated but locally implemented response was ultimately effective, drawing on institutional learning, strong public health capacity, and technocratic leadership, but also raising enduring questions about surveillance and democratic accountability. There were, however, significant weaknesses in co-ordination, data, and long-term care.

In the U.K. and Germany, like in Canada, adaptive leadership also showed better performance than rigid centralized or decentralized leadership models. Leaders also tailored their approach to the different phases of the pandemic, balancing the need for decisive action in the acute phase with ongoing collaboration, transparency, and public engagement. Their analysis is strengthened by linking leadership effectiveness to the levels of institutional capacity and public trust, as well as the ability to learn from past crises.

It shows that we must have strong mechanisms for coordination, clear role definition and sustained funding for public health infrastructure. For this report I used as reference.

Policymakers can learn important lessons from the experiences of these three countries as they seek to design health system responses to future global public health challenges that are resilient and equitable.

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