Routledge
Taylor & Francis Group

Review of International Political Economy

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/rrip20

COVID-19 and the failure of the neoliberal regulatory state

Lee Jones & Shahar Hameiri

To cite this article: Lee Jones & Shahar Hameiri (2021): COVID-19 and the failure of the neoliberal regulatory state, Review of International Political Economy, DOI: 10.1080/09692290.2021.1892798

To link to this article: https://doi.org/10.1080/09692290.2021.1892798

Published online: 01 Mar 2021.

REVIEW OF INTERNATIONAL POLITICAL ECONOMY
https://doi.org/10.1080/09692290.2021.1892798

COVID-19 and the failure of the neoliberal regulatory state

Lee Jones[a] and Shahar Hameiri[b]

[a]School of Politics and International Relations, Queen Mary University of London, London, UK; [b]School of Political Science and International Studies, University of Queensland, Brisbane, Australia

ABSTRACT

The COVID-19 pandemic has exposed massive failures of governance at the global and national levels. Global health governance failed rapidly, with action quickly becoming nationally based, uncoordinated, and often zero-sum. However, domestic health governance also often fared very poorly, even in some of the wealthiest countries, which were ostensibly best-prepared to deal with a pandemic. Why? We argue that this reflects the inherent pathologies of the shift from 'government to governance' and of the 'regulatory state' it had spawned. This has resulted in the hollowing-out of effective state capacities, the dangerous diffusion of responsibility, and *de facto* reliance on *ad hoc* emergency measures to contain crises. We demonstrate this through a detailed case study of Britain, where regulatory governance and corporate outsourcing failed miserably, contrasting this with the experience of South Korea, where the regulatory state form was less well established and even partially reversed.

KEYWORDS

Covid-19; coronavirus; global governance; regulatory state; governance; United Kingdom; global health; neoliberalism; South Korea

Introduction

As this article went to press (January 2021), the novel coronavirus (COVID-19) had infected over 89 million people worldwide, killing 1.93 million. The pandemic has exposed massive governance failures at the global and national levels. Global health governance rapidly collapsed. While the World Health Organisation (WHO) initially took a prominent role, once COVID-19 spread beyond China, it was rapidly marginalised. Attention shifted to national responses, which were typically uncoordinated, and even zero-sum. However, national health governance has also proven inadequate in many countries.

Especially in the first wave, the 'advanced' countries of Europe and North America fared worst, despite ostensibly being best-placed to withstand a pandemic. The World Economic Forum's Global Security Index had ranked the United States

CONTACT Lee Jones l.c.jones@qmul.ac.uk School of Politics and International Relations, Queen Mary University of London, London E1 4NS, UK

(US) and Britain as the best-prepared in the world (World Economic Forum (WEF), 2019), but by mid-2020 they had performed worst. Similarly, an 'Epidemic Preparedness Index', published in the prestigious *British Medical Journal*, had placed the US, Britain, Italy, Spain, France and Germany in the 'most prepared' cluster (Oppenheim et al., 2019), yet these countries experienced some of the world's worst death rates. Many also performed very poorly in the second wave, during the northern hemisphere's winter. In Britain, as of 12 January 2021, the number of infections and deaths per million population remained the fifth and eighth highest globally (excluding microstates; see Table 1). Meanwhile, the US had the highest number of confirmed COVID-19 infections of any country on Earth, over 22 million, and the eleventh highest death-rate, with more dying daily than were killed in the terrorist attacks of September 11, 2001.

In trying to explain (or excuse) this woeful performance, many officials have claimed that the pandemic was 'unprecedented' and unexpected. This is nonsense. The WHO and its members states have ostensibly been preparing to combat pandemics since the 1990s, and especially since the 2003 SARS outbreak. The WHO's 2005 International Health Regulations (IHRs) had specified in detail how pandemics should be managed, prompting apparent transformations in domestic governance to implement these changes. Furthermore, bodies like the WHO, the World Economic Forum, the European Union (EU), philanthropic organisations and clinical experts had all recently described the risk of a pandemic as high, with potentially devastating consequences (e.g. Global Preparedness Monitoring Board, 2019; World Economic Forum (WEF), n.d.). Major governments had apparently absorbed these messages and 'securitised' pandemic disease. For example, the US Homeland Security Council's 2005 *National Pandemic Strategy* warned that a pandemic risked 'overwhelming our health and medical capabilities, potentially resulting in hundreds of thousands of deaths, millions of hospitalizations, and hundreds of billions of dollars in direct and indirect costs' (Homeland Security Council, 2005, p. 1). The British government had also been planning for a pandemic for decades, starting with its 1997 *Pandemic Influenza Plan* (see Table 2). There is thus a yawning – and ostensibly puzzling – gap between discursive securitisation and hyper-preparedness, on the one hand, and the material reality of weak capacities, easily overwhelmed by COVID-19, on the other.

Any truly comprehensive explanation of variable national outcomes will doubtless need to explore many different factors, from geography and demography to culture and the significance of viral mutations. This is clearly beyond the scope of any single article. More modestly, we seek to contribute to the emerging debate by focusing attention on the failures of the neoliberal regulatory state that has emerged across many 'advanced' capitalist states since the late 1970s. Our perspective builds on recent, general accounts of the relationship between global capitalist development and global health (e.g. Sell & Williams, 2020). However, we seek to demonstrate how this relationship manifests concretely in particular societal contexts, drawing closer attention to the specific modes of governance that have emerged under late capitalism. Moreover, we demonstrate that these pathologies manifest not only in poorer 'southern' countries, historically the main focus of much of the scholarship and policy interventions around global health (e.g. Gill & Benatar, 2020; Sparke, 2020), but also in the capitalist heartlands of the global 'north'.

Table 1. Britain's COVID-19 performance compared.

	COVID-19 Cases		COVID-19 Deaths	
	Total	Per Million Population	Total	Per Million Population
World	89,048, 345	11,407	1,930,265	247
Britain	3,072,353	45,257	81,431	1,200
Rank in Western Europe* (/28)	highest	10th highest	highest	5th highest
Rank in World** (/236)	7th highest	30th highest	5th highest	5th highest
South Korea	69,114	1,348	1,140	22
Rank in World** (/236)	87th highest	110th highest	85th highest	110th highest

*European Union plus Britain; excluding micro-states (population $<$ 1 m).
**Excluding micro-states.
Source: World Health Organization (2020), as of 12 January 2021.

Table 2. Key UK pandemic preparation measures.

Year	Measure
1997	*UK Health Departments' Multiphase Contingency Plan for Pandemic Influenza*, implementing WHO *Pandemic Influenza Plan*
2005	*UK Influenza Pandemic Contingency Plan*, implementing WHO 2005 IHRs
2008	UK's first *National Security Strategy* (NSS) securitises pandemic disease
2010	Second NSS identifies pandemics as a 'tier one' threat; National Security Council Committee on Threats, Hazards, Resilience and Contingencies commences 'horizon scanning'
2011	UK Influenza Pandemic Preparedness Strategy, responding to independent inquiry into handling of H1N1 (swine 'flu) pandemic
2014	Public Health England issues *Pandemic Influenza Response Plan* and *Strategic Framework*
2015	Third NSS identifies pandemics as 'tier one' threat with risk rising in medium term National Health Service (NHS) *Emergency Preparedness and Resilience and Response* plan and *Operating Framework* identifies pandemics as 'top risk'
2017	NHS *Operating Framework for Managing the Response to Pandemic Influenza*

The regulatory state has emerged as part of the wider shift from 'government' to 'governance' since the late 1970s. 'Government' denotes statecraft based on hierarchical, command-and-control systems which authoritatively mobilise resources and intervene directly to secure desired social and economic outcomes. As part of the wider shift towards neoliberalism, 'government' has been largely replaced by 'governance', whereby resources, authority and responsibility are dispersed to diverse public and private actors, while central state managers retreat to a 'regulatory' role, using 'negative coordination' to 'steer' these actors in broadly favoured directions (Jayasuriya, 2001; Majone, 1994). An outgrowth of this state transformation process has been the emergence of 'meta-governance' at regional and global levels, where international organisations seek to harmonise domestic regulation around shared international principles and 'best practice' – like the WHO's IHRs (Hameiri & Jones, 2016).

We argue that the regulatory state has fundamentally failed in the COVID-19 context; indeed, it was never fit to address serious societal challenges. As Section 1 argues, the shift from government to governance entailed key pathologies, including: the deliberate reduction of popular expectations of public authority; the outsourcing of responsibility to technocratic, private and quasi-autonomous actors, weakening lines of control and accountability; and the hollowing-out of state capacities and authority to the benefit of frequently inept large-scale corporations. Global meta-governance, such as the IHRs, did not compensate for but often

compounded these national weaknesses, by promoting further state transformation that created only the illusion of effective governance. Section 2 demonstrates how these pathologies were expressed in the failure of the hollowed-out regulatory state to deal with the pandemic, through a detailed case study of Britain. This is briefly contrasted to the South Korean case, which has been more successful due to the relatively limited shift to regulatory statehood.

The pathologies of the shift from government to governance

The shift from 'government to governance' and the rise of regulatory statehood has been extensively documented by political scientists (e.g. Leibfried et al., 2015; Rhodes, 1997). Rather than simply rehearsing this discussion, this section instead highlights the pathologies arising from this transformation by contextualising it historically. We argue that ruling elites' primary motivation for this development was to deal with the so-called crisis of rising expectations in the 1970s by diminishing public expectations of, and influence over, public policymaking. The relative success of this project, however, has left states hollowed out, politically and bureaucratically, radically diminishing their ability to address basic social problems. Globally, the same dynamics manifested as a shift from 'international organisation' to 'global governance' and meta-governance. Global governance does not strengthen or supplant states' substantive capacities, but mainly seeks to harmonise domestic policies and institutions, thus placing the onus of substantive implementation on hollowed-out states.

From government to governance

In the existing literature on the shift from 'government to governance', 'government' refers to the period from 1945 to the mid-1970s when the command-and-control structures of wartime planning were repurposed for peacetime (alongside continued military mobilisation in the Cold War context). This reflected an underlying imperative, in the West, of maintaining working-class loyalty against the lure of communism and, in post-colonial countries, of binding individuals to newly-emerging states. This entailed developing and deploying state capacities along broadly Keynesian-Fordist lines to reduce uneven development (spatially and socially) through direct, positive intervention. Many states nationalised key industries, engaged in national development planning, and used welfare programmes to offset market failures. Internationally, the Bretton Woods institutions supported such national economic management (Ruggie, 1982). This consolidated 'the primacy of national economies, national welfare states, and national societies managed by national states concerned to unify national territories and reduce uneven development' (Jessop, 2009, p. 99).

From the late 1970s this system was unravelled; understanding why is crucial to grasping the resultant pathologies. Keynesian-Fordist governance entailed two decades of wage increases and welfare gains, generating a so-called 'revolution of rising expectations'. By the early 1970s, coupled with the collapse of the gold standard and successive oil crises, this became incompatible with continued capitalist profitability, prompting businesses and states to try to curtail wages and welfare

provision. Organised labour's unwillingness to accept this precipitated the return of open class struggle, creating a crisis of governability. As the Trilateral Commission's *Democracy in Crisis* report complained:

> The democratic idea that government should be responsive to the people creates the expectation that government should meet the needs and correct the evils affecting particular groups in society… it becomes difficult if not impossible for democratic governments to curtail spending, increase taxes, and control prices and wages (Crozier et al., 1975, p. 164).

This view reflected a growing consensus among many prominent business and policy elites in advanced capitalist states, several of whom subsequently occupied senior government positions, notably in the Carter and Reagan administrations (Chomsky, 1981; Mills, 1992).

Since the malaise afflicting the advanced capitalist societies was understood as unrealistic popular expectations from government and the economy, the policy response was to make government less 'responsive to the people'. In many third-world capitalist states, reactionary forces – encouraged by Western analysts and governments – instituted authoritarian regimes to contain popular pressure (Huntington, 1968). A different but parallel counter-revolution was pursued in the West by the so-called 'new right', exemplified by Reagan and Thatcher. Politically, these forces sided with capital to terminate inflationary wage and welfare demands by crushing organised labour, pursuing recessionary policies, and embracing deindustrialisation. The state's social purpose was transformed from protecting domestic business and mitigating social disparities to promoting international competitiveness (Cerny, 1997). Capital markets and trade barriers were deregulated, allowing business-owners to shift production to lower-wage economies, and evade national regulation, taxation, and trade union pressure, thereby restoring profitability (Harvey, 2005).

State apparatuses were also reconfigured to reduce their responsiveness to popular demands. Corporatist institutions were dismantled, excluding labour from decision-making, while state-owned industries were privatised, ending the period of limited democratic control over the economy. Monetary policymaking was transferred from elected officials to independent central banks focused on price stability, not full employment. Indeed, authority and control over resources were extensively transferred to unelected technocrats, independent regulators, quangos (quasi-autonomous nongovernmental organisations) and public-private partnerships. Responsibilities were also devolved to elected subnational governments, though often without adequate resourcing. Central agencies retreated from 'command-and-control' interventions to 'negative coordination', using broad regulations to try to 'steer' these diverse actors in favoured directions: the 'regulatory state' (Jayasuriya, 2001; Majone, 1994). States further retreated from direct responsibility over socio-economic outcomes by establishing markets as key governance instruments, including within ostensibly public services (Leys, 2003). This revolution was spread to the third world through enforced structural adjustment programmes following the 1980s debt crisis and subsequent governance projects (Harrison, 2004).

British minister Lord Falconer celebrated these changes as involving 'the depoliticisation of key decision-making':

> What governs our approach is a clear desire to place power… not with [elected] politicians but with those best fitted in different ways to deploy it. Interest rates are not set by politicians in the Treasury, but by the Bank of England. Minimum wages are not

> determined by the Department of Trade and Industry, but by the Low Pay Commission. Membership of the House of Lords will be determined not in Downing Street but in an independent Appointments Commission (cited in Flinders & Buller, 2006, p. 312).

Ideologically, then, the shift to regulatory statehood sought to allow ruling elites '*to move to an indirect governing relationship*' over citizens, seeking to '*persuade the demos that they can no longer be reasonably held responsible for a certain issue, policy field or specific decision*' (Flinders & Buller, 2006, p. 296, original emphasis).

Understanding this insulation of decision-making from democratic control as the central aspect of state transformation helps to correct many mistaken assumptions and apparent paradoxes surrounding 'neoliberalism'. Contrary to popular notions of neoliberalism requiring a pared-back state, the neoliberal regulatory state is actually characterised by greater bureaucracy and considerably higher governmental spending (including on welfare) than its predecessor (Poynter, 2021). However, the *character* of that bureaucracy and spending has fundamentally changed. Precisely because markets are not natural and spontaneous phenomena, they have required extensive state de- and re-regulation in order to create and maintain them, spawning vast, complex bureaucracies (Kiely, 2018). However, unlike 'command and control' bureaucracies, these are insulated from democratic control and exist not to promote majoritarian objectives but values like 'competition' and 'efficiency'. Meanwhile, rising government spending has often been directed to maintaining this burgeoning 'quangocracy' and related private-sector consultancies, and the outsourcing of public services to capitalist enterprises (Poynter, 2021; Raco, 2016).

Indeed, the main beneficiaries of the rise of the regulatory state have been the large-scale businesses for whom it has opened up new avenues for capital accumulation. This obviously includes finance capital, which has benefited from state-led financialisation, but also a range of 'new private-sector elites' specialising in outsourced public service provision, as well as the financial, services and consultancy firms clustered around them (Poynter, 2021; Raco, 2016, ch.5). In healthcare, for example, the decommodified public provision of the era of 'government' has increasingly been replaced by privatised services, even within an ostensibly public framework (Pollock, 2020a; Sparke, 2020). In Britain, government contracts supply private hospitals and care homes with 25 and 40 percent of their incomes, respectively (Poynter, 2021, pp. 106, 110). Such outcomes reflect Harvey's (2005) understanding of neoliberalism as the restoration of capitalist class power, rather than the enactment of abstract and naïve ideas about the ideal relationship between states and markets.

From government to meta-governance

This internal transformation of the state has also facilitated the rise of transnational governance frameworks, as national political elites, regulators or quangos network across state borders to share 'best practice' and harmonise regulation. The demand for such harmonisation arises from the growing transnationalisation of capital, which seeks pro-business regulatory certainty and protections, and in response to transboundary threats which arise from, or piggy-back on, the intensification of capitalist production and transnational flows – such as pandemic disease (Hameiri & Jones, 2015). Efforts to address such problems predominantly involve the

development of shared regulations or governance templates, which governments enact by reworking their domestic state apparatuses: global governance through (further) state transformation (Hameiri & Jones, 2016). This distances decision-making power from democratic control even further, as regulators increasingly draw their policies and legitimacy from their relations with one another, rather than from a process of domestic political representation.

The WHO exemplifies this shift towards pro-business transnational regulation. In the post-war decades, especially under the pressure of communist and post-colonial states, the WHO was gradually co-opted into a broader agenda of nation-state-building, focused on disease eradication and the expansion of public primary healthcare services under the 'Health for All' agenda (Litsios, 2002). However, in the neoliberal era, wealthy donor states have drastically reduced WHO funding, making it dependent on voluntary contributions and therefore beholden to donor agendas. Today, its core budget is just US$5.6bn, less than the healthcare expenditure of Morocco WHO, 2017), and only a fraction of this is under the discretionary control of its secretariat. Donors have also shifted funding to the World Bank and private philanthropic organisations like the Gates Foundation, which promote privatisation and public-private partnerships (Brown et al., 2007; Harman, 2016; Lethbridge, 2017; Rushton & Williams, 2011). The WHO has gradually accommodated itself to this agenda, reframing healthcare as 'investment' in 'human capital' (Sparke, 2020). It has embraced and promoted public-private partnerships to member-states as a means of addressing funding gaps (Buse & Waxman, 2001). And, reflecting donor priorities, it has reoriented away from the development of broad-based, public-provided primary healthcare services towards 'siloed' interventions designed to contain infectious diseases that might affect the global north (Rushton, 2011).

The WHO's 2005 International Health Regulations (IHRs) manifest a shift towards meta-governance. Reflecting a more 'Westphalian' era, the original 1969 IHRs had only required states to report outbreaks of six diseases and focus containment efforts on key transit points. By contrast, the 2005 IHRs – issued in response to the 2003 SARS outbreak – comprised a detailed governance template for member-states to follow to contain future pandemics. Although the WHO gained additional surveillance capacities to monitor compliance, it did not acquire supranational powers. Moreover, unlike in the 1960s–70s, the WHO was not resourced to build member-states' capacity, or to take concrete containment actions itself (Bhattacharya, 2007). The regime ultimately depended on member-states transforming themselves to implement the IHRs domestically (Hameiri & Jones, 2015, pp. 131–134).

The pathologies of regulatory governance

Despite being promoted as harbinger of efficiency, the shift from government to governance entails critical pathologies, which the COVID-19 pandemic brutally exposed. The regulatory state has been hollowed out, both politically, in terms of its connection to the citizenry, and bureaucratically, in terms of its actual capacity to manage social problems.

The regulatory state's deliberate insulation from democratic contestation cuts both ways. On the one hand, it allowed capitalists to restore profitability and

political elites to defuse rising expectations by disclaiming responsibility for political outcomes. However, it also led to a growing 'void' between rulers and ruled (Mair, 2013). Since the late 1980s, electoral turnout, party membership and civic participation collapsed across the world. Political parties, converging around a neoliberal template, were increasingly divorced from their former social bases, with elites retreating into the state and inter-elite networks, including regional and global governance regimes. This has eventually provoked a severe legitimacy crisis, manifesting especially since 2016 in the form of the Brexit vote, the election of Donald Trump, and populist ructions across Europe (Eatwell & Goodwin, 2018).

A second pathology of regulatory statehood is its inherently fragmentary character. This reflects the privatisation and dispersal of authority downwards (to subnational governments), upwards (to regional/global governance institutions) and horizontally (to quasi-independent regulators). Although this is functional for political elites wishing to disclaim responsibility and evade accountability, it is frequently dysfunctional in terms of organisational coherence and performance. To continue the British example, in 2015 the National Audit Office identified no fewer than 405 'arms-length bodies', costing £205bn per year, comprising a 'confused and incoherent' bureaucratic structure (quoted in Poynter, 2021, p. 146). Far from being lean, these bodies employed 278,262 people by 2018 (Poynter, 2021, p. 147). Bureaucratic profusion and confusion are compounded by decentralisation, with devolved administrations in Scotland, Wales and Northern Ireland each developing their own quangocracies in their areas of competence.

Thirdly, the regulatory state's capacity to secure desired policy outcomes has been severely hollowed out. Fundamentally, the regulatory state involves shifting the implementation and compliance burden away from state agencies towards the entities being regulated. Thus, for instance, a regulatory state is less likely to employ inspectors to enforce laws than to set out regulations and reporting mechanisms, with companies expected to develop internal enforcement capacities. In practice, however, this often reduces governance to a 'box-ticking' exercise, designed more to demonstrate compliance than to change substantive outcomes. Consequently, 'governance' is frequently better at generating reams of paperwork than substantive real-world impacts, creating a false sense that meaningful action is being taken.

The illusory quality of governance is compounded by the existence of meta-governance regimes and monitoring institutions, which often rely on the same sort of hollow, technocratic exercises as those being regulated. For example, the existence of the IHRs creates a misleading impression that global health is 'being governed' in a meaningful way, when substantive implementation may actually be weak. As of 2018, the WHO's Global Preparedness Monitoring Board (2019, p. 20) estimated that only 'one-third of countries [had] the capacities required under the IHR[s]'. However, the judgement of WHO auditors clearly relied not on a substantive assessment of the actual healthcare capacities of member-states, but rather on the bureaucratic documentation of such capacities. The same is evidently true for technocratic ranking systems like the Global Security Index and the Epidemic Preparedness Index (Oppenheim et al., 2019; World Economic Forum (WEF), 2019). This reflects the wider metricisation of governance, which entails not 'a direct comparison of … performance and output, but a comparison between the audited *representation* of that performance and output', which often refocuses efforts

on 'the generation and massaging of representations rather than … the official goals of the work itself' (Fisher, 2009, p. 42).

Fourthly, these weaknesses are further compounded by the specific relationships developed between the state and the private-sector entities that it now relies upon to govern society. Where governments once directly supplied public goods and services, in regulatory states 'client-operator contractualism' prevails, with public bodies becoming 'negotiators, rather than providers' (Raco, 2016, p. 3). This entails an asymmetric relationship of co-dependency: significant fractions of capital have become parasitically dependent on states for their survival, but states also depend upon them to maintain the most basic of social services. Moreover, these businesses engage in 'a politics of contractual-capture', and indeed regulatory capture (Raco, 2016, pp. 98, 46-7). Because the expertise required to contract with and regulate these firms is often monopolised by private sector, they are frequently 'consulted' when regulations are developed, and a 'revolving door' has emerged between ministries, quangos and the businesses they ostensibly regulate (Crouch, 2011). In the British case, for example, consultancies specialising in private-sector contracting have been directly seconded, sometimes for several years, into senior positions within state apparatuses engaged in outsourcing, then subsequently profited from advising other companies on how to secure the contracts arising from their work (Raco, 2016, p. 94). Contractors also excel at privatising profits and socialising risks, 'cherry-picking' only lucrative services and ensuring that costly risks remain the burden of the state (Raco, 2016, p. 43). Well before COVID-19, the British parliament's Public Accounts Committee (2014, p. 3) documented a raft of failures and unethical practices among private-sector contractors, concluding that the government was 'clearly failing to manage [their] performance … and to achieve the best for citizens'.

COVID-19 and neoliberal state failure

We now turn to exploring how these pathologies of regulatory governance manifested in the response to COVID-19, through a detailed case study of Britain. We selected this case for three key reasons. First, as preceding empirical illustrations have hinted at, the shift to regulatory statehood is deeply entrenched in Britain, making it a clear exemplar of the pathologies of this mode of governance. Second, alongside the US, it was ranked highest for pandemic preparedness, and is a self-proclaimed global health leader, yet performed extraordinarily badly during the pandemic (see Table 1). Finally, the case selection also reflects one of the authors' personal involvement in grassroots pandemic management in Britain, at a time when fieldwork research in other contexts remains impossible. To reinforce the importance of state transformation in generating negative outcomes, we briefly contrast Britain's experience to that of South Korea, where the shift to regulatory statehood was more partial and even reversed in the field of domestic health, resulting in far more successful management of COVID-19.

The following sub-sections demonstrate how the pathologies of regulatory governance contributed to this outcome. The first sub-section shows how Britain's preparation for a pandemic displays the hallmarks of regulatory governance, following the meta-governance templates of the WHO, dispersing responsibility across a poorly-coordinated, fragmented and decentralised array of public and private

entities, and failing to ensure the provision of concrete state capacities. The second sub-section explores the failure of this regulatory system to protect British citizens from COVID-19, showing how the government's attempt to salvage the situation remained dependent on private-sector outsourcing, generating continued state failure. The final sub-section contrasts Britain's experience to that of South Korea, where early moves towards regulatory statehood had been replaced by strong, centralised, command-and-control systems and state-guided development of private-sector capacities.

Britain's regulatory healthcare governance

To explain the failures of British healthcare during COVID-19, we must first understand how it had been transformed with the shift to regulatory statehood and marketisation, and how this, combined with global meta-governance, conditioned its pandemic preparedness system.

Governance fragmentation in Britain's National Health Service

Since the early 1980s, Britain's National Health System (NHS) has been steadily marketised, with the Department for Health (DoH) retreating to a regulatory role. Although this has deliberately facilitated the entry of private providers into the NHS, the most consequential issue is not the extent of privatisation *per se*. In 2019, only eight percent of its budget (£9.2bn out of £115bn) went to private healthcare providers (Poynter, 2021, p. 106). More significant is the remarkable fragmentation of healthcare governance required to effect even this relatively small transfer of 'market share' (Pollock & Price, 2011; Pollock, 2020a). This began in 1990 with the creation of an 'internal market' within the NHS, entailing a division between 'commissioners' and 'providers' of healthcare services. Subsequently, five different models of market competition have been introduced, with private healthcare providers admitted in 2002. This has involved the steady 'unbundling' of NHS operations to allow lucrative elements to be contracted out. In 1992, the Private Finance Initiative (PFI) was launched, allowing corporations to bid for construction projects, facilities management and other enabling activities. By 2012, PFI contracts had committed NHS Trusts to pay £300bn over the next 30–40 years, at an effective interest rate of 10–12.5 percent per annum (Raco, 2016, p. 19). Meanwhile, NHS 'providers' were corporatised, becoming 'semi-autonomous bodies', with central government control abolished entirely in 2003 for organisations that qualified as 'Foundation' Trusts (Pollock & Price, 2011, pp. 297–8). A new contract for general practitioners (GPs, family doctors) in 2004 also facilitated the unbundling of primary care and the entry of private providers, with the DoH's role now 'reduced to providing a national framework' for market competition (Pollock & Price, 2011, p. 299). As an official report states, national health ministers and officials are no longer 'directly involved in operational matters' but rely 'on Arms-Length Bodies who commission and regulate care' (National Assembly for Wales, 2015, p. 10).

This entails a highly complex bureaucratic structure, in which responsibility is so widely dispersed that accountability is virtually impossible. Figure 1 displays a *simplified* overview of the governance framework for England from 2011 onwards. Complicating matters still further, the devolved administrations of Wales, Scotland

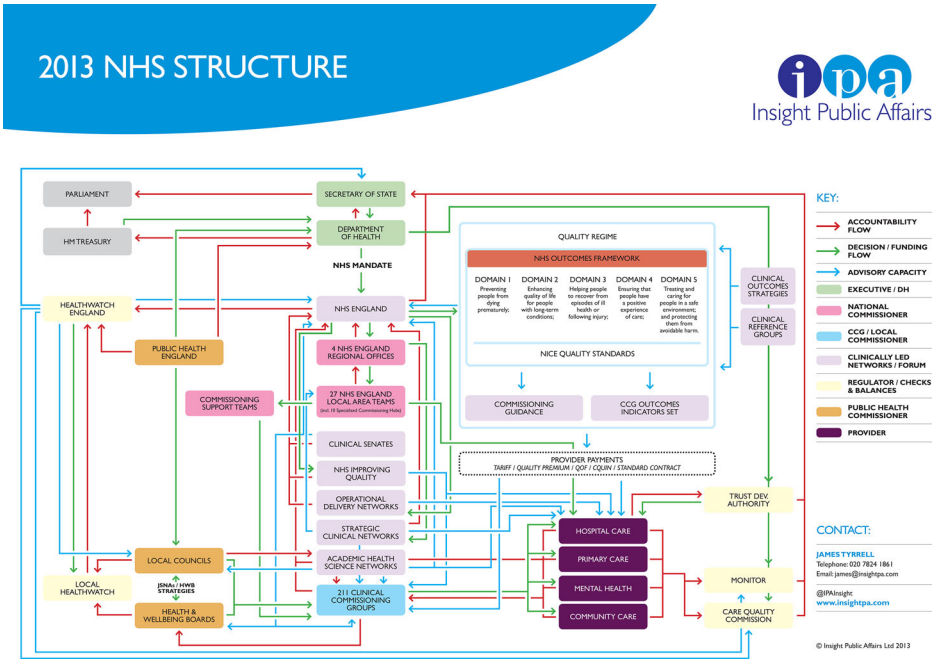

Figure 1. 2013 NHS Structure (England). Source: Tyrell (2013).

and Northern Ireland have different arrangements (see National Assembly for Wales, 2015). Insofar as Figure 1 ultimately traces accountability back to the DoH and parliament, however, it is rather misleading. Decisions about what healthcare services to provide are actually taken at the 'lowest' tier of this system, by local GP consortia called 'Care Commissioning Groups' (CCGs), which contract with NHS and private providers. The DoH's role is limited to disbursing funding and providing regulatory direction to the confusing array of quangos concerned to regulate market competition and 'quality'. The sheer complexity of this system means that even state actors struggle to identify 'exactly *who* is responsible for healthcare planning' (Raco, 2016, p. 112). Indeed, insofar as CCGs only cover relatively small populations – 226,000, on average – there is arguably very little strategic planning for the system as a whole. Consequently, rather than a traditional, hierarchical organogram – a relic of the era of 'government' – healthcare governance is more commonly depicted using circles or flows, often notionally centred around the patient-consumer, where no one is authoritatively in charge (see Figure 2).

In addition to bureaucratic complexity, the shift from government to governance has also entailed the hollowing-out of state capacities, compounded by post-2008 austerity measures. From 2009/10 to 2016/17, real-term healthcare spending per capita rose just 0.1 percent annually while demand rose sharply, entailing serious service-level deterioration, while adult social care funding fell by 10 percent (Charlesworth & Johnson, 2018, p. iii). This hollowing-out was especially acute with respect to public health and infectious disease. In the era of 'government', infectious disease control was supported by over 60 national, regional and local public health laboratories. However, in the 'governance' era, these functions were

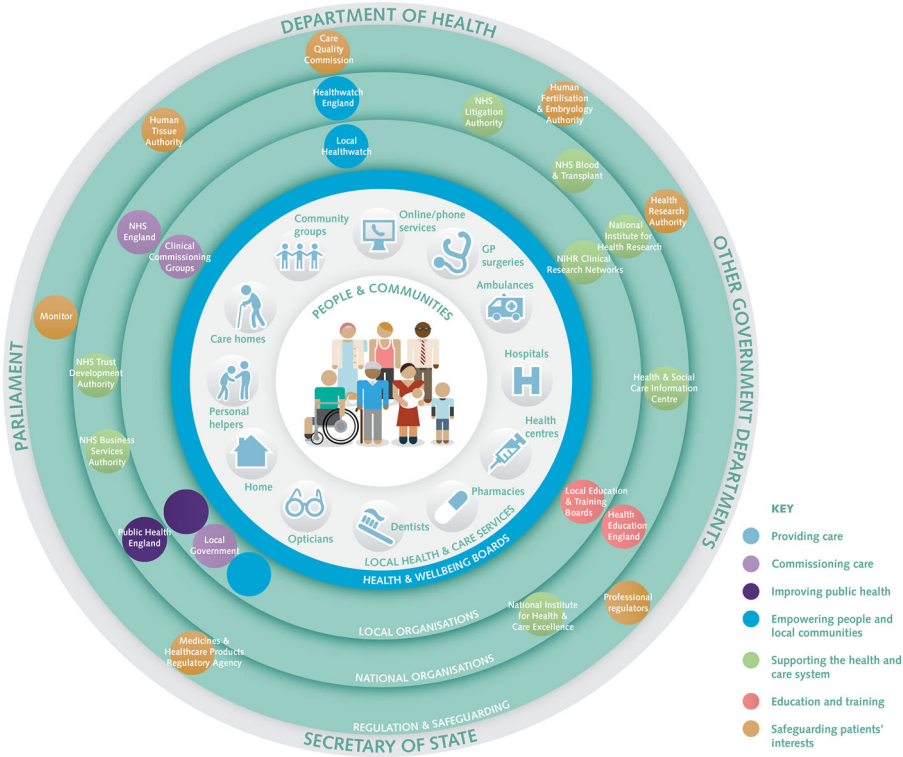

Figure 2. The Health and Care System from April 2013. Source: Department of Health and Social Care (DHSC),) (2013).

first centralised and hollowed-out, then de-centralised in emaciated form. In 2003, local laboratories were absorbed by NHS Trusts while public health functions were centralised. After 2012, Public Health England (PHE), the main responsible agency, operated just nine laboratories and eight regional centres (Roderick et al., 2020). Meanwhile, operational responsibility for public health was devolved to local governments, whose funding was then cut by £700 m in real terms from 2015/16 to 2019/20 (Local Government Association, 2019). This was the crucial context in which Britain's preparation to combat pandemics occurred.

A regulatory approach to pandemic preparedness

On paper, Britain has been robustly planning for a pandemic since the 1990s, following the meta-governance templates of the WHO (see Table 2).[1] Given the immense quantity of bureaucratic documentation generated, it is understandable that superficial technocratic audits concluded that Britain was well-prepared. In reality, however, this planning contained all the hallmarks and pathologies of regulatory governance.

All of these documents adopt a regulatory approach, setting out broad principles and directions of travel, but devolving all key operational decisions to others. For example, the 2011 *Strategy*, despite identifying pandemics as 'one of the greatest threats facing the UK', contains very few concrete instructions and devotes virtually

no additional capacity to the issue DoH, 2011, p. 6). Rather, the *Strategy* is 'intended to inform the development of operational plans by local organisations and emergency planners' (p. 7), guided by epidemiological assumptions and broad principles like 'precaution', 'proportionality' and 'flexibility' (pp. 15–17, 20). Reflecting the fragmented nature of the regulatory state, a bewildering array of national-level agencies – from the DoH to the National Security Council – are confined to providing 'coordination' and 'information', while 'primary responsibility for developing preparedness plans for an effective operational response' is delegated to 'Local Resilience Fora', comprising local authorities and healthcare services (pp. 31–32). Likewise, despite noting that pandemics may seriously affect many sectors – from energy to education – the *Strategy* outsources planning and responsibility to employers, regulators and functional bodies within these sectors, which are directed to develop their own guidelines (pp. 58–59). Thus, rather than establishing authoritative control mechanisms for emergency response, the DoH essentially behaves as a meta-governor, trying to steer other agencies to develop plans within its own loose framework.

Crucially, however, this relied upon a governance system that, as we have seen, had been fragmented and hollowed out, while noticeably avoiding making any additional capacity commitments. The *Strategy* openly anticipates that even a 'moderate' pandemic would overwhelm health and social care services, noting that 'increas[ing] the capacity of [critical care] services [is] an important part of planning' (p. 54). Yet, rather than actually bolstering this capacity, it devolves decisions on 'surge planning' to healthcare providers, directing them to use '*existing* systems and processes' and 'escalation procedures' – which are supposedly 'well established, tried and tested' – despite an admission that NHS services struggle badly even during seasonal influenza outbreaks (pp. 31, 53–54, 56, emphasis added). Similarly, despite having warned against 'complacency' (p. 13), the *Strategy* states that 'stockpiles of facemasks and respirators for health and social care workers' were 'already … in place', while passing responsibility for supplying and training other workers to their employers, and declining to stockpile personal protective equipment (PPE) for public use (p. 37). The *Strategy* discusses neither the size of government stockpiles nor their vulnerability to supply chain disruptions. In fact, the only additional capacity pledged in the entire document is a 'National Pandemic Flu Service', a telephone helpline where operators would use questionnaires to route callers to appropriate healthcare services (pp. 52–53).[2]

The 2011 *Strategy* also reflects two other hallmarks of regulatory governance: the elevation of technocratic expertise and the deliberate lowering of public expectations of state performance. The *Strategy* is justified with repeated reference to scientific expertise, not the wishes of the public. On this basis, the *Strategy* concludes that it 'will not be possible to halt the spread of a new pandemic … virus, and it would be a waste of public health resources and capacity to attempt to do so' (p. 28; also p. 11). Instead, the *Strategy* prioritises economic 'business as usual' (p. 57). Rather than investing in the capacity required to protect citizens, it directs healthcare personnel to make 'hard choices and compromises' using a 'checklist' prepared by ethical experts (p. 30) – implying healthcare rationing, leaving some patients to die. 'Government alone cannot mitigate the progression and impact', the document warns, diffusing responsibility to 'people' and 'communities' (p. 46). The *Strategy* also states that 'expectations around the performance of health and social care

services should be tempered' even further after a pandemic (p. 56). Most grimly, buried towards the very end is the key ministerial decision on the 'levels of death for which planning is appropriate': 'local planners' considering whether 'to extend capacity' were directed to 'cope with up to 210,000–315,000 additional deaths across the UK over a 15-week period' (p. 62). Thus, Britain's pandemic 'preparedness' system was actually geared to accept 2,000–3,000 additional excess deaths *per day*.

The flaws of this regulatory approach to pandemic management were exposed long before COVID-19. In 2016, the UK war-gamed its system in 'Exercise Cygnus'. The findings were initially suppressed, then published due to a court order following media exposure during the COVID-19 pandemic (Public Health England, 2017). The report concludes that 'the UK's preparedness and response, in terms of its plans, policies and capability, is currently not sufficient to cope with the extreme demands of a severe pandemic that will have a nation-wide impact across all sectors' (p. 6). The regulatory approach of the 2011 *Strategy* was clearly flawed, as many of the agencies expected to develop their own, more concrete plans had not actually done so, while some no longer existed thanks to the perpetual refashioning of state apparatuses (pp. 7, 10). The report warned that 'the scenario demand for services outstripped the capacity of local responders, in the areas of excess deaths, social care, and the NHS' (p. 8). Accordingly, participating healthcare officials had effectively invented capacity elsewhere, turning to the military, social care and voluntary sector – which, the report warned, would actually be unable to cope (pp. 22–25). Unsurprisingly, 'the key policy decision' taken during Exercise Cygnus was to adopt 'population triage', i.e. to deny treatment to sections of the population (p. 17). Social care was expected to bear the burden of so-called 'reverse triage' – i.e. discharging patients from hospitals into care homes – despite acknowledgement that it lacked the capacity to manage this (pp. 24– 25). The report also flagged the mismatch between the technocratic assumptions underpinning the *Strategy* and public opinion, warning that the 'public's reaction' to measures like 'mass burials' and 'reverse triage' had not been 'factored in' (p. 8).[3] Nonetheless, the proposed solutions were constrained to the toolkit of regulatory governance: clearer guidance, better communication, and improved coordination.

Regulatory state failure

Given this context, it is hardly surprising that the British state failed spectacularly in 2020. This was not, contrary to popular commentary, simply a consequence of ministerial or prime ministerial incompetence, nor a function of the specific party in control at the time – the Conservatives. As the preceding analysis makes clear, even if the Labour Party had won the 2019 elections, it would have inherited a regulatory state apparatus that was both intensely bloated, in terms of sheer bureaucratic size and complexity, yet substantively weak, with the ostensible 'levers of power' in central government scarcely connected to hollowed-out front-line services. Moreover, this was a state that both main parties had a hand in creating, both under the Conservatives (1979–97, 2010–) and New Labour (1997–2010), reflecting their convergence around a neoliberal policy set. These pathologies clearly played out in the UK's pandemic response. This initially followed the flawed 2011 *Strategy*, which swiftly failed, necessitating unplanned and improvised emergency

responses. These relied heavily on the same regulatory state processes that had failed, notably partnerships with frequently inept private corporations.

Pandemic unpreparedness

When COVID-19 emerged, the British government clearly followed its 2011 *Strategy*. Although its behaviour was widely misinterpreted by political opponents as ignoring scientific advice, in fact, its decisions not to close Britain's borders, introduce airport screenings, or restrict public life all followed the 2011 *Strategy*, with each position underpinned by scientific evidence (see DoH, 2011, pp. 34, 38–40). Minutes of the Scientific Advisory Group on Emergencies (SAGE), a key technocratic advisory body, and interviews of SAGE members, also show that the government was following their advice in the first three months of the pandemic (Grey & MacAskill, 2020; Simpson, 2020). The government's *Coronavirus Action Plan*, issued on 3 March 2020, also reflected the 2011 *Strategy*. It accepted that containment would fail and, accordingly, 'delaying' COVID-19's spread and 'mitigating' its impact would be the government's primary objectives (Department of Health and Social Care (DHSC), 2020, p. 18). The Plan echoed the *Strategy*'s complacency, citing Britain's 'track record of success' and insisting that 'well-rehearsed plans' would enable 'excellent care for all patients', while 'tried and tested procedures' existed to test and trace infected individuals (DHSC, 2020, pp. 20, 12–13).

In reality, Britain's pandemic management system performed disastrously. On 18 February, SAGE noted that Britain's 'tried and tested' system could actually handle only five COVID-19 tests per week; by 12 March, test-and-tracing was secretly abandoned, with Prime Minister Boris Johnson seeking to lower public expectations, warning that 'many more' lives would be lost (Donnelly & Morgan, 2020). Meanwhile, the NHS's 'tried and tested' surge planning processes triggered the immediate cancellation of most non-emergency care and diagnostics. This will entail an enormous public health burden that, according to standard healthcare accounting methods, will outweigh the lives ostensibly saved (e.g. Miles et al., 2020). Moreover, following the *Strategy*'s 'reverse triage' processes, from 17 March to 16 April, 25,060 elderly people were discharged from hospitals into care homes, at a time of acute PPE shortages and 30 days before routine testing for residents was introduced – thereby seeding COVID-19 into the most vulnerable part of the population (Lintern, 2020). Care home residents accounted for 55 percent of England's excess deaths from 28 December 2019 to 1 May 2020 (Comas-Herrera & Fernández, 2020).

The privatisation of key state responsibilities also had disastrous consequences, particularly with respect to medical supplies. In the mid-2010s, under the direction of the management consultancy firm Deloitte, the NHS's main procurement arm, NHS Supply Chain (NHS-SC) had been placed beneath a corporatised arms-length body, Supply Chain Coordination Ltd, with procurement outsourced to private companies through 11 different contracts (Hall et al., 2020). As a National Audit Office report belatedly found, 'the operating model was not designed to respond to a pandemic' (National Audit Office (NAO), 2020a, p. 6). The contractors were mostly middle-men, not manufacturers. To maximise their profits, they predominantly sourced supplies overseas, often on a 'just-in-time' basis, leaving them

extremely vulnerable to global supply chains disruptions. All of these just-in-time providers failed to supply required items on time (NAO, 2020a, p. 23).

Even the management of Britain's Pandemic Influenza Preparedness Stockpile had been outsourced, to the private company Movianto, a subsidiary of a French logistics company. Under austerity, from 2013–18, the value of its stockpile had fallen by 40 percent (Davies et al., 2020). By January 2020, Movianto had just two weeks' worth of supplies on-hand, buried deep in warehouses and unready to despatch (NAO, 2020a, pp. 7, 22). Its warehouses were understocked by 10-28 percent, key equipment, including masks, gowns and ventilators, was missing, and 45 percent of PPE stock had expired (Hall et al., 2020, p. 20). NHS-SC was forced to ration PPE supplies, entailing widespread shortages. According to media reports, health and social care workers were forced to improvise using snorkels, hardware store items, and even trash bags (BBC News, 2020). Occupational exposure to COVID-19 has been linked to 8,152 cases and 126 deaths among these workers (NAO, 2020a, pp. 10-11).

The government's technocratic policy framework also swiftly collapsed on contact with popular sentiment. As noted earlier, one of the key pathologies of regulatory statehood is the hollowing-out of popular participation in decision-making, as authority is allocated to non-majoritarian bodies. Technocrats had decided that it was pointless to try to contain pandemic disease but, as the report for Exercise Cygnus hinted at, this had never been ratified through any democratic process or debate. This lack of public support swiftly compelled the government to abandon its relatively lax, 'business as usual' approach – derived from the 2011 *Strategy* – particularly after Imperial College modelling released on 17 March projected 250,000 excess deaths if tougher controls were not introduced. This was well within the death toll accepted in the 2011 *Strategy* (210,000–315,000), but was clearly unacceptable to public opinion. Consequently, within six days, the government was forced to abandon all of its existing plans in favour of a nationwide lockdown.

The swift failure of existing regulatory measures forced British state managers to improvise with emergency and highly authoritarian measures. On 25 March 2020, parliament passed the Coronavirus Act, then promptly dissolved itself. Passed in a single day, without meaningful debate or scrutiny, the Act granted the executive sweeping authoritarian powers, enabling 'government by decree' until the present day (Ewing, 2020). Parliament's willingness to dissolve itself, rather than finding some way to continue sitting during the lockdown, symbolised the political void at the heart of Britain's regulatory state. It apparently did not occur to legislators that continuing to represent the people was 'essential' work, in contrast to the much-celebrated 'key workers' – cleaners, delivery drivers, care workers and so on – who continued to work throughout the pandemic.

Improvising through outsourcing

With existing frameworks abandoned, the lockdown marked the beginning of policymaking on the hoof. The most striking aspect of this *ad hoc* approach was its overwhelming reliance on the business interests underpinning the regulatory state. Even as the government tried to develop new capacities and institutions to manage the pandemic, it was repeatedly thwarted by corporate ineptitude. Moreover, allegations of crony capitalism quickly surfaced, expressing the 'politics of contractual-

capture' characteristic of Britain's regulatory state, with 'private firms act[ing] in a parasitic role, feeding off welfare funds', while being 'insulated from democratic accountability and scrutiny' (Raco, 2016, pp. 98, 109).

Having plunged Britain into an unplanned-for lockdown, the government's first challenge was to prevent people from starving.[4] Some three million medically-vulnerable citizens were instructed to 'shield' at home, but with panic buying and supermarket delivery services overwhelmed, they had no way to access food. The central government procured emergency food supplies relatively quickly, but had no infrastructure to deliver it to shielding households. Large consignments were simply dumped at local authority facilities, with no lists of households needing help. Local voluntary services and spontaneously organised mutual aid groups had to fill the gaps left by state failure. Recognising the challenge, the central government called for more volunteers to help, with a remarkable 750,000 stepping forwards. However, again, no infrastructure existed to organise them. The task was delegated to a charity, Royal Voluntary Services, but it took several weeks to organise volunteers using a new smartphone app, and many reported being left idle throughout the pandemic. Ultimately, the government turned to two major wholesalers, Bidfood and Brakes, to supply food parcels directly to shielding households. Reflecting the aforementioned contractual power imbalance – now sharply exacerbated – the £208 m contract involved paying these firms twice the market value for 'barely edible' items (Chakelian, 2020).

This was the start of a general pattern of improvising state capacity through corporate outsourcing, expressing the British state's deeply entrenched dependency on private contractors. As in the past, this produced outcomes that were simultaneously hyper-centralised and yet highly fragmented and ineffective. This approach was led by the Cabinet Office's COVID-19 Task Force, supported by the consultancy firm McKinsey (Smith, 2020b). Rather than bolstering existing state capacities, McKinsey guided the Cabinet Office to develop new public-private partnerships. These often relied on the very same consultancies and contractors that had produced state failure in the first place, and proceeded to fail again. This expresses both the ineptitude of these parasitic firms and the difficulty involved in generating state capacity rapidly in an emergency.

This was perhaps clearest with respect to efforts to address the medical supplies crisis, where much of the work was led by Deloitte, architect of the dysfunctional NHS-SC. By March, the government had belatedly realised that this outsourced system had failed, establishing a 'parallel supply chain' to procure emergency supplies. Deloitte consultants contracted to support this effort focused on overseas suppliers. They ignored 8,000 offers of help from British manufacturers, allowing domestic supplies to be exported, while many items sourced overseas proved substandard, wasting 'hundreds of millions of pounds' (Hall et al., 2020, pp. 20–21, 12; NAO, 2020a, p. 9). Indeed, reflecting collapsing supply chains and surging demand, emergency PPE procurement from February to July 2020 cost £12.5bn for items that would have cost just £2.5bn in 2019 (NAO, 2020a, p. 9). In total, £18bn of emergency COVID-19-related contracts were issued by 31 July. In a clear reward for failure, £4.3bn of this was routed through NHS-SC contractors (National Audit Office (NAO), 2020b, p. 7). By November 2020, two-thirds of PPE orders had yet to arrive, and the extent of panic buying may leave Britain with five years' worth of surplus items (NAO, 2020a, pp. 11, 43).

A similar pattern emerged with respect to efforts to procure additional ventilators, led by PA Consulting. The firm's 'ventilator challenge' urged British manufacturers to develop new models and manufacturing capacity from scratch and deliver 30,000 ventilators within two weeks (Davies et al., 2020). Like Deloitte, PA Consulting ignored domestic manufacturers in favour of big-name but inexperienced conglomerates (Grey & MacAskill, 2020). The scheme delivered just 344 ventilators before COVID-19 peaked (Stone, 2020).

Similarly poor results followed the use of private contractors to establish a national test-and-trace system. This was led by McKinsey, who were awarded a £563,400 contract to determine the 'vision, purpose and narrative' of a new NHS Test and Trace (NHS-T&T) programme (Smith, 2020a). Expected to cost £22bn during 2020 alone (Cabinet Office, 2020), NHS-T&T effectively became a new outsourced wing of the NHS. Led by the corporate executive Dido Harding, and staffed with 2,300 private-sector consultants (Bright, 2021), it even absorbed the disease management functions of Public Health England. Rather than commandeering existing public and private laboratories, NHS-T&T contracted Deloitte to establish regional testing facilities and three large-scale 'lighthouse laboratories' from scratch. Deloitte then subcontracted the work to inexperienced companies. Their facilities have been roundly condemned for their remote locations and frequently botched testing (Hall et al., 2020, p. 24). Meanwhile, the outsourcing specialists Serco and Sitel were contracted to establish centralised call centres for contact-tracing. Employees complained of poor training and being left idle for long periods, and the service has never met the minimum level of contact-tracing required for effective disease containment. As of late June, even Britain's hollowed-out local public health agencies were tracing eight times more people than the outsourced call centres (McTague, 2020). However, again reflecting the privatisation of profit and socialisation of risk, Serco's £410 m-worth of contracts contain no penalty clauses for failure (Geoghegan, 2020).

The state's massive reliance on outsourced contracts has, understandably, given rise to (contested) accusations of cronyism. The National Audit Office found that of the £18bn in emergency procurement undertaken by 31 July, over half (£10.5bn) of contracts were awarded without competitive tender. Nearly 500 companies had been referred by ministers, Lords or senior officials to a 'high priority' channel, where they enjoyed a 10-times higher chance of securing a contract (NAO, 2020b). Although all involved deny any improper behaviour, the intimate connections between many contractors and officials does appear to reflect the 'revolving door' dynamic described above (see Hill, 2020). At the very least, Britain's corporatised response to COVID-19 has clearly been an enormous bonanza for private-sector contractors, while many state agencies continue to be starved of resources. As of September 2020, £10bn of private-sector contracts had been awarded for NHS-T&T alone, while local authorities received just £300 m to support the system (McTague, 2020; Pollock, 2020b). Just one contract, awarded to the private company Randox, exceeded Public Health England's entire annual budget for disease control: £133 m versus £86.9 m (Roderick et al., 2020, pp. 2–3).

Practically the only well-functioning state apparatus has been that most shielded from the shift to regulatory statehood: the armed forces. Although the 2011 *Strategy* had explicitly eschewed reliance on the military, in practice, the government has relied repeatedly on army personnel to compensate for wider state failure

– as foreseen in Exercise Cygnus. They have been used to staff NHS warehouses, build field hospitals, develop software to manage PPE supplies, distribute tests, and support vaccination centres. This signifies the continued utility of clear lines of accountability and control, which have been deliberately erased by the shift to regulatory statehood. This point is further underscored by contrasting Britain's experience to that of South Korea.

The South Korean contrast

Aside from sparsely-populated island states that quickly sealed their borders (e.g. New Zealand and Australia), the countries that fared best in the pandemic's first wave – suppressing outbreaks and avoiding damaging, large-scale lockdowns – were those where the shift to regulatory statehood was least advanced or had even been partially reversed. In South Korea, Taiwan, and Singapore, for example, legacies of state-driven late-development, and perceived external military threats, have led central agencies to retain considerable infrastructural power, including over business, and a capacity to mobilise resources purposefully when required. Furthermore, their experience with previous coronavirus outbreaks had already demonstrated the pitfalls of a diffuse approach to pandemic management, leading them to build up genuine national capacities, which were then available to control COVID-19.

South Korea exemplifies this partial reversal of the shift from government to governance, and the positive outcomes arising therefrom. Although historically famed for its authoritative 'developmental state', South Korea has recently drifted towards regulatory governance, giving freer play to market competition (Carroll, 2017). This has had direct consequences for the country's capacity to manage pandemics. During the 2003 SARS epidemic, Korea's 'command and control' system fared well. Subsequently, however, neoliberal reforms fragmented and privatised key parts of Korea's healthcare system, leading to the world's second-worst performance during the 2015 Middle East Respiratory Syndrome (MERS) pandemic (Lim & Sziarto, 2020).

In response, the Korean government reversed this fragmentation, recentralising authority and building substantive state capacity. The Korean Centre for Disease Control (KCDC) was empowered to manage infectious disease, with autonomous power over budgeting, staffing and resource deployment. The KCDC established an Emergency Operations Centre, and an Immediate Response Team to investigate outbreaks. The government also established a dedicated infectious disease hospital and funded isolation wards, laboratories and temporary isolation facilities nationwide, directing them to hire more infection specialists and related workers and stockpile PPE. The government also supported the Korea National Institute of Health's research and development activities, building domestic capacity to find treatments and vaccines (Ministry of Health & Welfare, 2015). In a more troubling move from the perspective of civil liberties, central agencies were also empowered to access citizens' mobile phone and credit card data, and surveillance camera footage, to assist technology-driven contact-tracing (Kim, 2020). As a result of these measures, the initial large-scale outbreaks of COVID-19 in January and February 2020 were swiftly contained, without a retreat into *ad hoc* emergency measures.

Successful containment continued throughout 2020, notwithstanding periodic localised spikes and rising cases during the winter.

This successful change of direction reflects Korea's particular political economy context, which differs substantially from countries like Britain where regulatory statehood is more entrenched. Successive Korean governments have pursued export-oriented industrialisation through supporting vast conglomerates (*chaebol*) to become globally competitive in high value-added industries. Notwithstanding considerable neoliberal shifts, notably after the 1997–98 financial crisis, the government has retained a significant role in economic planning and development (Thurbon, 2016). This has enabled the development of useful industries while retaining state capacities to direct businesses for the public good – in stark contrast to the situation in Britain, where the state has instead become dependent on corporate interests.

Such interventions paid clear dividends during the COVID-19 pandemic. For example, the government had supported the biotech industry since the early 2000s, most recently as part of a wider, nationally-planned 'fourth industrial revolution', launched in 2017. That year alone, the state invested ₩3.1tr ($2.59bn), of which ₩248bn ($206 m) was for biotech research and development, including ₩117bn ($97 m) for pandemic preparation, plus support for domestic PPE manufacturers (MTIE et al., 2017, pp. 3, 10, 17–18, 20–22, 26). An indigenous PPE manufacturing base was thereby maintained, avoiding dependence on fragile global supply chains. Accordingly, when COVID-19 hit, the government was able to requisition 50 percent of the sector's output for public sale, temporarily banning exports (Yonhap News Agency, 2020a). The government's ability to corral *chaebol* to support public policy was also striking. When materials for face masks ran short, the government directed Samsung to purchase overseas supplies, ship them to Korea, and sell them to domestic manufacturers (Jung, 2020). Thanks to earlier state support for its capital goods arm, Samsung was also quickly able to construct 'smart factories' for PPE, allowing output to double in February 2020 (Samsung Newsroom, 2020). Government investment had also fostered firms specialising in molecular diagnostics, with which KCDC partnered in early 2020 to develop rapid COVID-19 testing kits, enabling mass population testing (Seo, 2020). By April, with state support, the industry was exporting these kits worldwide. Government-backed biotech companies are also leading the development of vaccines and treatments (Yonhap News Agency, 2020b).

Conclusion

Writing about what is apparently required for an effective pandemic response, Fukuyama (2020) argues: 'it takes a state'. Indeed, it does; but what kind of state? Fukuyama worries that authoritarian states have coped better, risking the future of liberal democracy. But arguably it is not authoritar*ian* states that have fared best, but authoritat*ive* ones: those best able to mobilise people and resources thanks to strong political and institutional relationships with the societies they govern, and the associated retention of substantive state capacities. Unfortunately, it is precisely these features that have been lost with the shift from government to governance and the rise of regulatory statehood. In Britain, where this transformation is deeply entrenched, fragmentation and privatisation have hollowed out the state politically and bureaucratically,

leading to it being rapidly overwhelmed by COVID-19. Efforts to build new capacities relied on the very same outsourcing techniques implicated in initial state failure, generating additional poor outcomes. In November 2020 it was even revealed that the government had asked management consultants for advice on how it could 'manage without management consultants' (Gartside, 2020). Conversely, the South Korean state retained strong capacities for infection control and for planning and managing society's productive capacity for the public good.

Britain's miserable experience of COVID-19 entails important lessons for the way we think and write about 'global health', particularly the distinctions routinely drawn between the 'global north' and 'south'. As Harman (2020) observes, for decades the north's view was that global health security was a problem in and of the global south; 'it couldn't happen here'. In reality, with COVID-19, many northern countries endured experiences parallel to those of southern societies in previous pandemics: healthcare services overwhelmed; desperate, *ad hoc* emergency responses featuring military deployments; widespread human suffering and immiseration. Arguably, the underlying reason for this convergence is the similar trajectory of state transformation in north and south, underpinned by the increasingly predatory development of global capitalism. Much commentary rightly describes the negative impact of structural adjustment, austerity and marketisation on healthcare in the global south (e.g. Sparke, 2020). But dominant social forces are increasingly inflicting these same processes upon populations in the global north, too. Sparke (2020, p. 66) quotes criticisms of the 'failed neoliberal prescriptions' of 1990s World Bank interventions, which contributed to 'the shrinkage of government institutions and massive privatisation and fragmentation of healthcare systems' in the global south. But these same problems are now clearly manifest in the heartlands of global capitalism. Similarly, discourses of 'state failure' were once applied exclusively to the global south, but we can now speak meaningfully of 'failed states' in the global north. To draw such parallels is not to suggest that the extent of suffering or deprivation is equal, or that 'state failure' means the same thing, across all world regions. Rather, it is to draw attention to the macro-processes that are generating these parallel outcomes, and to encourage the use of analytical frameworks foregrounding them.

If our analysis is correct, COVID-19 also signals the need for urgent reconsideration of neoliberal models of political economy and governance. So far, this has begun only very modestly, with calls to 're-shore' some sensitive industries, for example. As the COVID-19 pandemic demonstrates, neoliberal states may be highly functional for large-scale, internationally-oriented capital, but they have clearly become dysfunctional for solving very basic social problems. Importantly, this is a feature, not a bug: the origins of this form of governance lie in efforts to make states less responsive to popular demands. To achieve meaningful reform, a new democratic movement will have to re-subordinate state institutions to the needs and wishes of citizens, establishing clear lines of responsibility, accountability and control. Public services, like healthcare, must be redesigned around human needs, not market logics or principles like 'efficiency', which ultimately deliver highly inefficient outcomes at great human and economic cost.

Notes

1. As with many countries, British pandemic planning focused on influenza, not coronavirus. This is not materially relevant here because: both are respiratory diseases,

requiring similar treatments, supplies, etc; plans anticipated a new disease with no vaccine, as with COVID-19; and basic planning assumptions (rates of infection, hospitalisation, etc) exceeded the realities of the COVID-19 pandemic (see DoH, 2011, pp. 15–17).
2. This became subsumed into the NHS's 111 helpline, which uses this approach for all illnesses, mainly to limit pressure on primary and acute care.
3. Media reports of Exercise Cygnus, before the report was finally published, claimed that it had also revealed serious shortcomings around the availability of PPE, ventilators, critical care beds, oxygen, etc (Nuki & Gardner 2020). However, remarkably, Exercise Cygnus does not actually seem to have considered such matters; the report contains no reference to equipment stocks.
4. The following draws heavily on author's observations and discussions with council officials, local voluntary service hub managers and volunteers, March-April 2020.

Acknowledgements

The authors thank Chang Shin for excellent research assistance. They are also grateful to Toby Carroll, Philip G. Cerny, Tom Chodor, Philip Cunliffe, Sophie Harman, George Hoare, Ray Kiely, Peter Ramsay, Owain Williams and the journal's editors and anonymous peer reviewers for very useful feedback on earlier drafts. The article's basic arguments were first developed in Lee Jones and Tara McCormack, 'COVID-19 and the Failed Post-Political State', *The Full Brexit*, 17 April 2020.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

Research for this article was funded by Australian Research Council (grants DP110100425 and DP1701102647).

Notes on contributors

Lee Jones is Reader in International Politics at Queen Mary University of London. His research focuses on state transformation, governance, security and political economy. His latest book, co-authored with Shahar Hameiri, is *Fractured China: How State Transformation is Shaping China's Rise* (Cambridge University Press, 2021).

Shahar Hameiri is Associate Professor in the School of Political Science and International Studies, University of Queensland. His research focuses on security, development and aid, governance, political geography and international relations. His books include *Governing Borderless Threats: State Transformation and the Politics of Non-Traditional Security* (Cambridge University Press, 2015), co-authored with Lee Jones.

ORCID

Lee Jones http://orcid.org/0000-0003-1290-5141
Shahar Hameiri http://orcid.org/0000-0001-7262-2448

References

BBC News. (2020). UK failed to stockpile crucial protective kit. *BBC News*, April 28. https://www.bbc.com/news/newsbeat-52440641

Bhattacharya, D. (2007). An exploration of conceptual and temporal fallacies in international health law and promotion of global public health preparedness. *The Journal of Law, Medicine & Ethics*, *35*(4), 588–598. https://doi.org/10.1111/j.1748-720X.2007.00182.x

Bright, S. (2021). Government reveals total number of private sector consultants working for 'test and trace'. *Byline Times*, January 5. https://bylinetimes.com/2021/01/05/government-total-number-private-sector-test-and-trace-consultants

Brown, T. M., Cueto, M., & Fee, E. (2007). The World Health Organization and the transition from 'international' to 'global' health. In A. Bashford (Ed.), *Medicine at the border: Disease, globalization and security, 1850 to the present* (pp. 76–94). Palgrave Macmillan.

Buse, K., & Waxman, A. (2001). Public-private partnerships: A strategy for the WHO. *Bulletin of the World Health Organization*, *79*(8), 748–754.

Cabinet Office. (2020). COVID-19 winter plan. *Gov.UK*. December 2. https://www.gov.uk/government/publications/covid-19-winter-plan/covid-19-winter-plan

Carroll, T. (2017). Late capitalism and the shift from the 'developmental state' to the variegated market state. In D. S. L. Jarvis & T. Carroll (Eds.), *Asia after the developmental state: Disembedding autonomy* (pp. 93–123). Cambridge University Press.

Cerny, P. G. (1997). Paradoxes of the competition state: The dynamics of political globalization. *Government and Opposition*, *32*(2), 251–274. https://doi.org/10.1111/j.1477-7053.1997.tb00161.x

Charlesworth, A., & Johnson, P. (2018). *Securing the future: Funding health and social care to the 2030s*. Institute for Fiscal Studies.

Chakelian, A. (2020). Revealed: The £208m food box rip-off. *New Statesman*, October 16. https://www.newstatesman.com/politics/uk/2020/10/208m-food-box-rip-off-private-outsource-government-contract-covid-corona-virus

Chomsky, N. (1981). *Radical priorities*. Black Rose Books.

Comas-Herrera, A., Fernández, J.-L. (2020). *England: Estimates of mortality of care home residents linked to the COVID-19 pandemic*. London: International Long-Term Care Policy Network. https://ltccovid.org/wp-content/uploads/2020/06/England-mortality-among-care-home-residents-report-17-May-1.pdf

Crozier, M. J., Huntington, S. P., & Watanuki, J. (1975). *The crisis of democracy: Report on the Governability of Democracies to the Trilateral Commission*. New York University Press.

Davies, H., Pegg, D., Lawrence, F. (2020). Revealed: Value of UK pandemic stockpile fell by 40% in six years. *The Guardian*, April 12. https://www.theguardian.com/world/2020/apr/12/revealed-value-of-uk-pandemic-stockpile-fell-by-40-in-six-years

Davies, R. (2020). The inside story of the UK's NHS coronavirus ventilator challenge. *The Guardian*, May 4. https://www.theguardian.com/business/2020/may/04/the-inside-story-of-the-uks-nhs-coronavirus-ventilator-challenge

Department of Health (DoH). (2011). *UK influenza pandemic preparedness strategy 2011*. London: DoH. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/213717/dh_131040.pdf

Department of Health and Social Care (DHSC). (2013). The health and care system explained. *Gov.UK*. https://www.gov.uk/government/publications/the-health-and-care-system-explained/the-health-and-care-system-explained

Department of Health and Social Care (DHSC). (2020). *Coronavirus action plan: A guide to what you can expect across the UK*. London: DHSC. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/869827/Coronavirus_action_plan_-_a_guide_to_what_you_can_expect_across_the_UK.pdf

Donnelly, L., Morgan, T. (2020). UK abandoned testing because system 'could only cope with five coronavirus cases a week.' *The Telegraph*, May 30. https://www.telegraph.co.uk/news/2020/05/30/revealed-test-trace-abandoned-system-could-cope-five-coronavirus

Eatwell, R., & Goodwin, M. (2018). *National populism: The revolt against liberal democracy*. Pelican.

Ewing, K. (2020). Covid-19: Government by decree. *King's Law Journal*, *31*(1), 1–24. https://doi.org/10.1080/09615768.2020.1759398

Flinders, M., & Buller, J. (2006). Depoliticisation: Principles, tactics and tools. *British Politics*, *1*(3), 293–318. https://doi.org/10.1057/palgrave.bp.4200016

Fukuyama, F. (2020). The pandemic and political order. *Foreign Affairs*, *99*(4), 26–32.

Gartside, B. (2020). Government asks consultants for advice on ending use of consultants. *The Telegraph*, November 19. https://www.telegraph.co.uk/business/2020/11/19/government-asks-consultants-advice-ending-use-consultants

Geoghegan, P. (2020). Cronyism and clientelism. *London Review of Books*, November 5. https://www.lrb.co.uk/the-paper/v42/n21/peter-geoghegan/cronyism-and-clientelism

Gill, S. R., & Benatar, S. R. (2020). Reflections on the political economy of planetary health. *Review of International Political Economy*, *27*(1), 167–190. https://doi.org/10.1080/09692290.2019.1607769

Global Preparedness Monitoring Board. (2019). *A world at risk: Annual report on global preparedness for health emergencies*. World Health Organization. https://apps.who.int/gpmb/assets/annual_report/GPMB_annualreport_2019.pdf

Grey, S., & MacAskill, A. (2020). Special report: Johnson listened to his scientists about coronavirus – but they were slow to sound the alarm. *Reuters*, April 7. https://uk.reuters.com/article/uk-health-coronavirus-britain-path-speci-idUKKBN21P1X8

Fisher, M. (2009). *Capitalist realism*. Zero Books.

Hall, D., Lister, J., Hobbs, C., Robinson, P., & Jarvis, C. (2020). *Privatised and unprepared: The NHS supply chain*. University of Greenwich/We Own It. https://weownit.org.uk/privatised-and-unprepared-nhs-supply-chain

Hameiri, S., & Jones, L. (2015). *Governing borderless threats: Non-traditional security and the politics of state transformation*. Cambridge University Press.

Hameiri, S., & Jones, L. (2016). Global governance as state transformation. *Political Studies*, *64*(4), 793–810. https://doi.org/10.1111/1467-9248.12225

Harman, S. (2016). The Bill and Melinda Gates Foundation and legitimacy in global health governance. *Global Governance: A Review of Multilateralism and International Organizations*, *22*(3), 349–368. https://doi.org/10.1163/19426720-02203004

Harman, S. (2020). It could happen here. *Discover Society*, May 14. https://discoversociety.org/2020/05/14/it-could-happen-here

Harrison, G. (2004). *The World Bank and Africa: The construction of governance states*. Routledge.

Harvey, D. (2005). *A brief history of neoliberalism*. Oxford University Press.

Hill, S. E. (2020). *My Little Crony*. https://sophieehill.shinyapps.io/my-little-crony

Homeland Security Council. (2005). *National strategy for pandemic influenza*. Washington: United States government, the White House. https://www.cdc.gov/flu/pandemic-resources/pdf/pandemic-influenza-strategy-2005.pdf

Huntington, S. P. (1968). *Political order in changing societies*. Yale University Press.

Jayasuriya, K. (2001). Globalisation and the changing architecture of the state: Regulatory state and the politics of negative coordination. *Journal of European Public Policy*, *8*(1), 101–123. https://doi.org/10.1080/1350176001001859

Jessop, B. (2009). Avoiding traps, rescaling states, governing Europe. In R. Keil & R. Mahon (Eds.), *Leviathan undone? Towards a political economy of scale* (pp. 87–104). UBC Press.

Jung, M. (2020). KOTRA and Samsung team up to import fabric for mask filters. *BusinessKorea*, March 27. http://www.businesskorea.co.kr/news/articleView.html?idxno=43355.

Kiely, R. (2018). *The neoliberal paradox*. Edward Elgar.

Kim, T.-H. (2020). COVID-19 resurgence threatens South Korea's success story. *The Diplomat*, June 12. https://thediplomat.com/2020/06/covid-19-resurgence-threatens-south-koreas-success-story

Leibfried, S., Huber, E., Lange, M., Levy, J. D., Nullmeier, F., & Stephens, J. D. Eds. (2015). *The Oxford handbook of transformations of the state*. Oxford University Press.

Lethbridge, J. (2017). *World Bank undermines right to universal healthcare*. Bretton Woods Project, April. https://www.brettonwoodsproject.org/wp-content/uploads/2017/04/At-Issue-health-PDF.pdf

Leys, C. (2003). *Market-driven politics: Neoliberal democracy and the public interest*. Verso.

Lim, S. H., & Sziarto, K. (2020). When the illiberal and the neoliberal meet around infectious diseases: An Examination of the MERS response in South Korea. *Territory, Politics, Governance*, *8*(1), 60–76. https://doi.org/10.1080/21622671.2019.1700825

Lintern, S. (2020). Coronavirus: More than 25,000 patients discharged to care homes in crucial 30 days before routine testing. *The Independent*, June 2. https://www.independent.co.uk/news/health/coronavirus-care-homes-nhs-hospital-discharges-deaths-a9544671.html

Litsios, S. (2002). The long and difficult road to Alma-Ata: A personal reflection. *International Journal of Health Services*, *32*(4), 709–732. https://doi.org/10.2190/RP8C-L5UB-4RAF-NRH2
Local Government Association. (2019). *Health and local public health cuts*. House of Commons. https://www.local.gov.uk/sites/default/files/documents/LGA%20briefing%20-%20health%20and%20local%20public%20health%20cuts%20-%20HoC%20140519%20WEB.pdf
Mair, P. (2013). *Ruling the void: The hollowing of western democracy*. Verso.
Majone, G. (1994). The rise of the regulatory state in Europe. *West European Politics*, *17*(3), 77–101. https://doi.org/10.1080/01402389408425031
McTague, T. (2020). How the pandemic revealed Britain's national illness. *The Atlantic*, August 12. https://www.theatlantic.com/international/archive/2020/08/why-britain-failed-coronavirus-pandemic/615166
Miles, D. K., Stedman, M., & Heald, A. H. (2020). 'Stay at home, protect the National Health Service, save lives': A cost benefit analysis of the lockdown in the United Kingdom. *International Journal of Clinical Practice*, 1–14. https://doi.org/10.1111/ijcp.13674
Mills, D. (1992). Beware the Trilateral Commission! *Washington Post*, April 25. https://www.washingtonpost.com/archive/lifestyle/1992/04/25/beware-the-trilateral-commission/59c48198-9479-4c80-a70a-a1518b5bcfff/
Ministry of Health and Welfare. (2015). Press Release: [9.1] Measures to reform national infection prevention and control system for the purpose of immediate response to emerging infectious disease. *Ministry of Health and Welfare*, September 1. http://www.mohw.go.kr/eng/nw/nw0101vw.jsp?PAR_MENU_ID=1007&MENU_ID=100701&page=1&CONT_SEQ=326060
Ministry of Trade, Industry and Energy (MTIE), Ministry of Health and Welfare, Ministry of Science and ICT, Ministry of Education, Ministry of Agriculture, Food and Rural Affairs, Ministry of Environment, Ministry of Oceans and Fisheries, and Ministry of Food and Drug Safety. (2017). 바이오경제 혁신으로: 혁신성장·미래 일자리·국민 건강 이끈다 *[Innovative growth, future employment and national health will be improved by bioeconomy innovation]*. September 27. http://www.korea.kr/common/download.do?fileId=185702118&tblKey=GMN
National Assembly for Wales. (2015). *The organisation of the NHS in the UK: Comparing structures in the four countries*. National Assembly for Wales.
National Audit Office (NAO). (2020a). *The supply of personal protective equipment (PPE) during the COVID-19 pandemic*. National Audit Office. https://www.nao.org.uk/report/supplying-the-nhs-and-adult-social-care-sector-with-personal-protective-equipment-ppe
National Audit Office (NAO). (2020b). *Investigation into government procurement during the COVID-19 pandemic*. National Audit Office. https://www.nao.org.uk/report/government-procurement-during-the-covid-19-pandemic
Nuki, P., & Gardner, B. (2020). Exercise Cygnus uncovered: The pandemic warnings buried by the government. *The Telegraph*, March 28. https://www.telegraph.co.uk/news/2020/03/28/exercise-cygnus-uncovered-pandemic-warnings-buried-government/
Oppenheim, B., Gallivan, M., Madhav, N. K., Brown, N., Serhiyenko, V., Wolfe, N. D., & Ayscue, P. (2019). Assessing global preparedness for the next pandemic: Development and application of an epidemic preparedness index. *BMJ Global Health*, *4*(1), e001157. https://doi.org/10.1136/bmjgh-2018-001157
Pollock, A. (2020a). *The end of the NHS*. Verso.
Pollock, A. (2020b). Thanks to outsourcing, England's test and trace system is in Chaos. *The Guardian*, July 31. http://www.theguardian.com/commentisfree/2020/jul/31/outsourcing-england-test-trace-nhs-private
Pollock, A. M., & Price, D. (2011). The final frontier: The UK's new coalition government turns the english national health service over to the global health care market. *Health Sociology Review*, *20*(3), 294–305.
Poynter, G. (2021). *The political economy of state intervention: Conserving capital over the west's long depression*. Routledge.
Public Accounts Committee. (2014). *Contracting out public services to the private sector*. House of Commons. https://publications.parliament.uk/pa/cm201314/cmselect/cmpubacc/777/777.pdf
Public Health England. (2017). *Exercise Cygnus report*. July 13. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/927770/exercise-cygnus-report.pdf
Raco, M. (2016). *State-led privatisation and the demise of the democratic state: Welfare reform and localism in an era of regulatory capitalism*. Routledge.

Rhodes, R. A. W. (1997). *Understanding governance: Policy networks, governance, reflexivity, and accountability*. Open University Press.
Roderick, P., Macfarlane, A., & Pollock, A. M. (2020). Getting back on track: Control of Covid-19 outbreaks in the community. *BMJ*, *369*, m2484. https://doi.org/10.1136/bmj.m2484
Ruggie, J. G. (1982). International regimes, transactions, and change: Embedded liberalism in the postwar economic order. *International Organization*, *36*(2), 379–415. https://doi.org/10.1017/S0020818300018993
Rushton, S. (2011). Global health security: Security for whom? Security from what? *Political Studies*, *59*(4), 779–796. https://doi.org/10.1111/j.1467-9248.2011.00919.x
Rushton, S., & Williams, O. D. (2011). *Partnerships and foundations in global health governance*. Springer.
Samsung Newsroom. (2020). 삼성, 국내 마스크 공급 확대 긴급 지원 *[Samsung urgently supports domestic mask supply expansion]*. https://news.samsung.com/kr/%ec%82%bc%ec%84%b1-%ea%b5%ad%eb%82%b4-%eb%a7%88%ec%8a%a4%ed%81%ac-%ea%b3%b5%ea%b8%89-%ed%9995%eb%8c%80-%ea%b8%b4%ea%b8%89-%ec%a7%80%ec%9b%90?CID=afl-ecomm-cjn-cha-092118-53060&cjevent=b539bd63b60511ea81a000ef0a18050e
Sell, S. K., & Williams, O. D. (2020). Health under capitalism: A global political economy of structural pathogenesis. *Review of International Political Economy*, *27*(1), 1–25. https://doi.org/10.1080/09692290.2019.1659842
Seo, E. (2020). 대받던 진단기업 재평가 … 성능·품질, 시스템 '호평' *[Reassessment of a diagnosis company that was neglected … Performance, quality, and system 'praised']*. *The Bell*, March 19. http://www.thebell.co.kr/free/Content/ArticleView.asp?key=2020031807354598601076 35
Simpson, J. (2020). Highlights of the SAGE minutes. *Hector Drummon Magazine*, June 6. https://hectordrummond.com/2020/06/06/jodie-simpson-highlights-of-the-sage-minutes/
Smith, B. (2020a). McKinsey banks £560,000 consulting on 'vision, purpose and narrative' for new test and trace body. *Civil Service World*, August 18. https://www.civilserviceworld.com/news/article/mckinsey-banks-560000-consulting-on-vision-purpose-and-narrative-for-new-test-and-trace-body
Smith, B. (2020b). McKinsey nets £1.1m in new contracts supporting government's Covid-19 response. *Civil Service World*, August 28. https://www.civilserviceworld.com/news/article/mckinsey-drafted-in-to-support-task-force-coordinating-covid19-policy-and-implementation
Sparke, M. (2020). Neoliberal regime change and the remaking of global health: From rollback disinvestment to rollout reinvestment and reterritorialization. *Review of International Political Economy*, *27*(1), 48–74. https://doi.org/10.1080/09692290.2019.1624382
Stone, J. (2020). Boris Johnson's 'ventilator challenge' delivered just 4% increase in machines before coronavirus peak. *The Independent*, May 20. https://www.independent.co.uk/news/uk/politics/boris-johnson-coronavirus-ventilator-challenge-machines-nhs-uk-cases-a9522886.html
Thurbon, E. (2016). *Developmental mindset: The revival of financial activism in South Korea*. Cornell University Press.
Tyrell, J. (2013). *2013 NHS structure*. Insight Public Affairs: London. http://www.ukcab.net/wp-content/uploads/2014/01/2013-NHS-Structure.pdf
World Economic Forum (WEF). (n.d.). Global health security: Epidemics readiness accelerator. *World Economic Forum*. https://www.weforum.org/projects/managing-the-risk-and-impact-of-future-epidemics
World Economic Forum (WEF). (2019). These are the top 10 countries for pandemic preparedness. *World Economic Forum*, November 15. https://www.weforum.org/agenda/2019/11/countries-preparedness-pandemics/
World Health Organization (WHO). (2017). *Global health expenditure database*. https://apps.who.int/nha/database/ViewData/Indicators/en
World Health Organization (WHO). (2020). *WHO coronavirus disease (COVID-19) dashboard: Situation by country, territory & area*. https://covid19.who.int/table
Yonhap News Agency. (2020a). S. Korea to evenly supply face masks to public, ban mask exports: Prime Minister. *Yonhap News Agency*, March 5. https://en.yna.co.kr/view/AEN20200305002300315
Yonhap News Agency. (2020b). S. Korean bio firms in race for COVID-19 treatment, vaccine development. *Korea Herald*, October 3. http://www.koreaherald.com/view.php?ud=20201003000048