# Viral Myths:
# Why we risk learning the wrong lessons from the pandemic

*Kristian Niemietz,*

*Head of Political Economy, Institute of Economic Affairs*

*February 2021*

**Summary**

- The Coronavirus pandemic has given rise to the phenomenon of 'Coronfirmation Bias', the tendency to interpret the pandemic as a 'vindication' of one's own worldview. Three interpretations, in particular, have become part of the conventional wisdom:
  - The idea that the UK was unprepared to cope with Covid-19 because a decade of 'austerity' had hollowed out the public sector, thus eroding the state's capacity to act.
  - The idea that Covid-19 is a crisis of 'globalisation gone too far', which strengthens the case for economic nationalism and communitarian parochialism.
  - The idea that the NHS has been the star performer of the pandemic, and that we should be more grateful than ever for having it.

- All three of these conventional wisdoms can be challenged. We can see this by comparing the countries that coped best with the pandemic to the countries that coped worst.

- There is no obvious measure of 'Covid performance' which would allow us to rank countries by how well they dealt with the pandemic. Most countries got some things right and others wrong. We can, however, still identify the 'best in class' (the ones that did well according to almost any measure) and those that struggled most (the ones that did badly according to almost any measure).

- Among the 'best in class' are the four 'Asian Tigers' of Taiwan, South Korea, Hong Kong, and to a lesser extent, Singapore. They had exceptionally low levels of Covid deaths, they minimised the economic fallout, and they also managed to preserve personal freedoms and a semblance of normal life.

- Among high-income countries, the UK, Spain, Italy and Belgium are the ones that struggled most. All four had exceptionally high Covid-19 death rates and excess death rates, as well as particularly severe recessions, and stringent lockdown or lockdown-like measures.

- If we compare the best performers to the worst performers, three things stand out:
  - The best performers have much lower levels of public spending, including healthcare spending.
  - The best performers have open, highly globalised economies, with much higher levels of exposure to China than the UK ever had.
  - The best performers do not have national health services. Their healthcare systems are not similar to the NHS.

- The claim of this paper is *not* that best performers did well *because* they have low public spending levels, that they did well *because* they have open economies, or that they did well *because* they have non-NHS-type healthcare systems. The claim of this paper is that an effective pandemic response is compatible with a *variety* of public spending levels, a *variety* of trade regimes, and a *variety* of healthcare systems.

- The 'big story' of this paper, then, is that there is no 'big story' to be told here. Our long-standing ideological disputes about what the size of the state should be, how open our economy should be, or what type of health reform we need (if any) are not going to be settle by a virus.

## Introduction: the rise of 'Coronfirmation Bias'

In early January 2020, BBC News ran a short article entitled 'China pneumonia outbreak: Mystery virus probed in Wuhan', which discussed 'a mysterious viral pneumonia which has infected dozens of people in the central city of Wuhan'.[1] The *Guardian* also talked about a 'mysterious respiratory illness that has infected dozens of people in a central Chinese city'.[2]

Both articles were written in a dispassionate, matter-of-fact tone, as one would expect from an article covering a minor local curiosity from the other end of the world. The possibility that this 'mystery virus' might spread beyond the region, or cause any further problems down the line, was not specifically dismissed – it was just not even a consideration at all yet.

Fast-forward by a year or so to late January 2021. More than 100,000 people in the UK, and more than 2 million people worldwide, have died from Covid-19 (Worldometers 2021). The UK's death toll is still rising by over 1,000 people every day, which means that the rate of increase is the highest it has ever been, higher even than during the first wave in Spring 2020 (Our World in Data 2021a). Almost 30,000 Covid patients are being admitted to hospital every week, and almost 40,000 Covid patients are in hospital at any given time, which is nearly twice the level of the 2020 spring wave. Almost 4,000 of those hospital patients need intensive care at any given time.

The whole country remains in an open-ended lockdown. An exit strategy or timeline has yet to be announced. Economic output has already shrunk by one tenth, and much of the economy remains in a state of politically induced hibernation. Substantial parts of it will have atrophied, and are therefore unlikely to ever wake up again.

We could fill pages describing the myriad of devastating effects of the Covid-19 pandemic, but this would be quite unnecessary, because these will be just as familiar to the reader as they are to the author, or perhaps more so.

And yet, despite everything, there are grounds for cautious optimism. At the time of writing, the light at the end of the tunnel is clearly visible, if still at some distance. Just over three months ago, plenty of knowledgeable people were still warning that there may never be an effective Covid-19 vaccine. Today, we are arguing about the pros and cons of different brands of vaccine, and about how to speed up the rollout. In the UK, one in ten people have already been vaccinated – one of the highest levels in the world and easily the highest level in Europe. Far from slowing down, the vaccination effort is gaining further momentum.

There is a realistic chance that in a year from now, the pandemic will be little more than a bad memory.

In the short term, Covid-19 is clearly far worse than the last crisis Britain went through, namely, the Global Financial Crisis of 2008/09. Unlike the pandemic, the latter was 'just' an economic crisis, as opposed to a full-blown humanitarian crisis, and even if we reduced Covid-19 to its economic impact, it would still be a bigger hit than the financial crash.

But the latter had long-term scarring effects which Covid need not have. At least in the UK, it was followed by what was in many ways a lost decade. Some of its indirect after-effects, such

[1] 'China pneumonia outbreak: Mystery virus probed in Wuhan', *BBC News*, 3 January 2020 (https://www.bbc.co.uk/news/world-asia-china-50984025).
[2] 'Mystery illness in Chinese city not Sars, say authorities', *Guardian*, 5 January 2020 (https://www.theguardian.com/world/2020/jan/05/mystery-illness-to-strike-chinese-city-is-not-sars-say-authorities-wuhan).

as increased political and intergenerational polarisation, are still with us today. The effects of Covid-19 are much more likely to be limited to the short-to-medium run.

And yet, there is an important indirect way in which the current crisis could cast a long shadow. In his IEA paper, 'Going Viral – the history and economics of pandemics', economic historian Stephen Davies shows that pandemics have often led to long-term changes in the climate of opinion (Davies 2020: 30):

> [P]andemics often lead to increased particularism and xenophobia because of the way epidemics (which always come from 'somewhere else') are associated in the popular mind with the alien or foreign. This plays out in politics of course, and there is no reason sadly to think that this time will be any different.

Such shifts in ideas have real-world consequences (ibid.):

> Historically pandemics have tended to arrest or reverse economic integration. They […] often marked the end of [periods of greater economic integration with more trade, exchange and movement over long distances].

Davies's argument is not that pandemics lead to the emergence of ideas that people would not previously have considered. It is more that pandemics amplify existing ideological trends, which could have happened without them, but which might not.

The current situation clearly has differences to the historical cases Davies describes. Coronavirus, and the policy debates it has triggered, are not a replay of what happened in the wake of the Spanish Flu, or any other historical predecessor. But it has certainly given rise to a journalistic genre we might dub 'Coronfirmation Bias'[3], that is, a type of comment piece in which the author claims that their own pet cause has somehow been 'vindicated' or rendered 'more urgent than ever' by Covid-19.[4]

Coronfirmation Bias can be found across the ideological spectrum and among proponents from just about any ideological tribe. Authors with diametrically opposed, mutually incompatible worldviews have interpreted the pandemic as 'proof' that they were right all along. We can find proponents of particular dietary fads, who claim that their preferred diet would make us more Covid-resistant.[5] We can find proponents of 'nanny statism', who use tenuous evidence that some lifestyle factors might slightly increase people's Covid-19 risk, to promote far-reaching interventions into personal lifestyle choices.[6] We can find Remainers arguing that Covid highlights the importance of European cooperation and we can find Brexiteers arguing that Covid highlights the importance of national independence. We can find cycling enthusiasts arguing that Covid highlights the need for cycling-friendly cities (on the grounds that it is harder to catch the virus on a bike than on public transport). We can find environmentalists claiming that Covid has vindicated the environmentalist view of the world.[7] We can find industrial policy enthusiasts who believe that, since Covid has already led to a large increase in the role of the state in economic life, we might as well make that a permanent feature of our economy.[8]

---

[3] A portmanteau of 'Coronavirus' and 'Confirmation Bias'.
[4] For a sample, see: https://twitter.com/cjsnowdon/status/1238254866763571206
[5] See, for example, Malhotra (2020).
[6] See 'Beware the COVID-19 nannies!', *The Spectator*, 6 April 2020 (https://spectator.us/beware-covid-19-nannies/).
[7] For example: 'Coronavirus shows us it's time to rethink everything. Let's start with education', *Guardian*, 12 May 2020 (https://www.theguardian.com/commentisfree/2020/may/12/coronavirus-education-pandemic-natural-world-ecology).
[8] For example: 'Capitalism After the Pandemic. Getting the Recovery Right', *Foreign Affairs*, 2 October 2020 (https://www.foreignaffairs.com/articles/united-states/2020-10-02/capitalism-after-covid-19-pandemic).

We can find feminists who read a lot into the fact that some of the countries which coped best with the pandemic were governed by women. We can find socialists who claim that the problems associated with Covid-19 are really ‘a product of a social system called capitalism’ and proof that ‘we need a new economic system’ (which, as the reader will have guessed, happens to be socialism).[9]

Much of this is harmless agenda-peddling, or people feeling obliged to put a ‘Covid spin’ on anything they say, fearing that otherwise nobody would listen to them, given how the pandemic has crowded out nearly everything else. But it becomes a problem when dubious claims become part of the conventional wisdom, because this will, sooner or later, have real consequences.

Unfortunately, this has already happened. Several Coronfirmation Bias-driven narratives have already reached the status of conventional wisdoms, and may set the agenda for years to come.

[9] For example: ‘The coronavirus crisis shows we need an entirely new economic system’, *New Statesman*, 18 March 2020 (https://www.newstatesman.com/politics/economy/2020/03/coronavirus-crisis-economic-collapse-capitalism).

## False Covid-19 narratives

We can identify at least three popular interpretations of the Covid-19 crisis that have gained a high degree of clout, by virtue of being frequently repeated by high-profile commentators on both conventional media and social media. These are:

> 1. 'A decade of brutal spending cuts has reduced the British state to a shadow of its former self. As a result, when the pandemic hit us, the public sector simply lacked the capacity to respond adequately. This is what explains Britain's poor performance when compared with other countries. The pandemic has made abundantly clear that we urgently need a significantly better-funded, better-resourced and better-staffed public sector.'
>
> 2. 'The pandemic has shown that globalisation has gone too far. In a borderless world, where people, capital, goods and services can move around freely – viruses can too. In that process, we have also become too dependent on foreign – particularly Chinese – imports and fragile international supply chains, a fair-weather arrangement, which crumbled as soon as the crisis hit. We need to start making things again, re-shore industries and reduce our overreliance on China.'
>
> 3. 'The pandemic has driven home how lucky we are to have the National Health Service, and how grateful we have to be for that. The NHS has done the most amazing job under the most difficult of circumstances. It has held the nation together. Insofar as there have been problems, these are the result of political mismanagement, underfunding, and outsourcing to private companies – not the NHS itself.'

These conventional wisdoms can, of course, also be combined: it is safe to say that virtually everyone who believes in the first also believes in the third, and quite a lot of people will believe all three of them. Nonetheless, they speak to different parts of the political spectrum.

Conventional wisdom no.1 is, unsurprisingly, particularly popular on the Left. For example, *Guardian* columnist Polly Toynbee writes about 'an incapacitated public realm, naked in the blast of this epidemic. It wasn't just the NHS and social care […] but every service crippled by cuts: public health, police, local government, the army and Whitehall – all denuded'.[10]

Similarly, the prominent socialist author and activist Owen Jones claims 'A state hollowed out by austerity and market dogma is, in large part, to blame: it cannot be stressed enough that it is mostly because of these ideologically driven failures that Britain has been – is – one of the worst-hit countries on Earth' (Jones 2020).

Michael Marmot, the 'inequality czar', wrote a *Guardian* article with the self-explanatory title 'Why did England have Europe's worst Covid figures? The answer starts with austerity', in which he argued:

> [T]he same set of influences that led to […] the UK looking unhealthy in the decade after 2010 led to us having the worst excess mortality figures in Europe because of Covid-19. […]
>
> The political mood of the decade from 2010 was one of the rolling back of the state […] This rolling back of the state was seen clearly in a reduction in public spending […]

[10] 'I've lived through plenty of social shocks – this time we must learn the lessons', *Guardian*, 30 March 2020 (https://www.theguardian.com/commentisfree/2020/mar/30/coronavirus-crisis-austerity-politics-boris-johnson).

> We limped into the pandemic, then, in a parlous state.[11]

In the *London Review of Books*, Pankaj Mishra (2020) claimed that in the UK and the US,

> the state has been AWOL for decades, and the market has been entrusted with the tasks most societies reserve almost exclusively for government […]
>
> Covid-19 […] [forced] many to realise that they live in a broken society, with a carefully dismantled state. […]
>
> [S]uccessive […] governments have ruthlessly shredded what was left of the social safety net […], hastening Britain's decline into a flailing – if not failed – state that can't even secure supplies of gowns and masks for its hospital workers. […]
>
> The pandemic […] has now shown […] that the Reagan-Thatcher model […] condemns an unconscionable number of people to premature death.

*Guardian* journalist and writer George Monbiot also linked the Covid-19 crisis to his favourite theme, which is the supposed retreat of the British state and the concomitant rise of 'corporate power':

> [T]he government knowingly and deliberately stood down crucial parts of its emergency response system. […]
>
> There is a consistent reason for the multiple, systemic failures the pandemic has exposed: the intrusion of corporate power into public policy. Privatisation, commercialisation, outsourcing and offshoring have severely compromised the UK's ability to respond to a crisis.[12]

Conventional wisdom no.2 – which is closest to the historic pandemic responses that Davies identifies – is particularly popular with the communitarian Right. Theresa May's former advisor Nick Timothy, the 'guru' of communitarian conservatism, argues:

> The interconnected nature of the world economy means we are more exposed than ever […]
>
> As a country that prides itself on its adherence to international free trade, the UK has long been content for its companies to take their place in transnational supply chains. But with coronavirus, […] we may come to rue the lack of a national […] capability to produce what we need. Countries have strategic necessities that can trump the purity of the market. This is just one lesson we need to learn if we want to improve our resilience.[13]

In an article with the self-explanatory title 'Farewell free trade, and good riddance', David Goodhart, another guru of communitarianism, makes a similar argument:

---

[11] 'Why did England have Europe's worst Covid figures? The answer starts with austerity', *Guardian*, 10 August 2020 (https://www.theguardian.com/commentisfree/2020/aug/10/england-worst-covid-figures-austerity-inequality).

[12] 'Tory privatisation is at the heart of the UK's disastrous coronavirus response', *Guardian*, 27 May 2020 (https://www.theguardian.com/commentisfree/2020/may/27/privatisation-uk-disatrous-coronavirus-response-ppe-care-homes-corporate-power-public-policy).

[13] 'Coronavirus is one danger among many in our fragile globalised world', *The Telegraph*, 1 March 2020 (https://www.telegraph.co.uk/news/2020/03/01/pandemics-data-security-globalisation-means-must-resilient/).

> The coronavirus pandemic is the perfect metaphor for the perils of hyper-connection. We no longer need the help of rats or fleas to spread disease — we can do it ourselves thanks to mass international travel and supply chains. And we are no longer self-sufficient when things go wrong. […]
>
> The pandemic also illuminates a wider retreat from full-on free trade that has been gaining in support and legitimacy over recent years […] Democratic politics and national social contracts are starting to assert themselves against the laws of comparative advantage […] This was brought home to me a few days ago when I heard a very senior Tory say that he was, until recently, an orthodox free trader/free marketeer but now regarded himself as an economic nationalist. He is not alone.[14]

Rupert Lowe, the former MEP for the West Midlands, tweeted 'The Coronavirus is demonstrating the strategic error of relying too heavily on food imports. With Brexit we have a golden opportunity to reinforce our country's food security. Only a fool could argue producing more food in our country is a bad idea!'[15]

Covid-inspired protectionism is not limited to the UK. The *Financial Times* reports:

> [EU commissioner] Thierry Breton […] suggested […] that 'globalisation has gone too far', not just in medical equipment but all strategic industrial sectors and agriculture. [The French president Emmanuel] Macron said in an interview with the FT last week that offshoring had become 'unsustainable' and that the EU should regain industrial sovereignty. […]
>
> Commission president Ursula von der Leyen and Charles Michel, president of the European Council, issued a paper saying there was a 'pressing need to produce critical goods in Europe, to invest in strategic value chains and to reduce over-dependency on third countries in these areas.'[16]

And again, six months later:

> [T]he Japanese government announced $2bn for its companies to subsidise diversifying or reshoring supply chains. […] EU member states will ask the European Commission […] to assess vulnerabilities in strategic sectors that might later be filled by an active industrial policy. Joe Biden is promising […] a big expansion of Buy American domestic procurement and bringing production in sensitive products home from China.[17]

Conventional wisdom no.3 is popular with both the Left and the communitarian Right, as well as among people with no particular ideological affiliation. It found a clear expression in a speech by the Prime Minister, in which he said that:

> [T]he British public had 'formed a human shield around this country's greatest national asset – our National Health Service […] [O]ur NHS has been unbeatable. […] We will

[14] 'Farewell free trade, and good riddance', *UnHerd*, 6 March 2020 (https://unherd.com/2020/03/its-time-liberals-embraced-economic-nationalism/).
[15] *Twitter*, 3 March 2020 (https://twitter.com/RupertLowe10/status/1234740651331330048).
[16] 'EU should 'not aim for self-sufficiency' after coronavirus, trade chief says', *Financial Times*, 23 April 2020 (https://www.ft.com/content/95dcaac2-162e-4ff4-aca5-bb852f03b1e9).
[17] 'Coronavirus-induced reshoring is not happening', *Financial Times*, 30 September 2020 (https://www.ft.com/content/e06be6a4-7551-4fdf-adfd-9b20feca353b).

win because our NHS is the beating heart of this country. It is the best of this country. It is unconquerable. It is powered by love'.[18]

Health Secretary Matt Hancock tweeted:

> 'The NHS is the best gift a nation ever gave itself. […] [W]e will keep supporting our nation's most cherished institution – for this pandemic and into the future'.[19] And later, 'It's been a difficult year for so many, but our collective love of the NHS has brought us all together'.[20]

Its most famous expression, though, was not made by any individual, and it was not made verbally. It was the weekly 'Clap for the NHS' ritual, in which thousands, perhaps millions of people took part between March and May 2020. It was soon followed by self-made posters and adverts saying 'Thank you NHS' or some variation thereof, usually showing hearts and rainbows drawn around the NHS logo, popping up everywhere. Crises often trigger a collective 'Rally-Round-the-Flag Effect', and 'Rally-Round-the-NHS' is the modern British version of that.

In an international survey by the communications company Kekst CNC, respondents in various countries were asked about how they evaluate the performance of various institutions in their respective countries during the pandemic. Throughout 2020, the NHS consistently received net approval ratings (that is, the share of respondents rating it positively minus the share of respondents rating it negatively) between 80 per cent and 88 per cent. This is a far higher rating than healthcare-related organisations received in any other country; indeed, as the pollsters point out: 'The UK National Health Service has the highest rating of any institution in the world for its response to the pandemic' (Kekst CNC 2020: 24).

The three emerging conventional wisdoms have two things in common.

Firstly, they have long-term implications, which could outlive Covid-19 by years or decades. We might still hear statements beginning with 'As we learned during the Covid-19 pandemic of 2020/21…' in a decade's time, just as we still hear statements beginning with 'As we learned during the Financial Crisis of 2008/09…' today. It therefore matters *what it is* people think we have 'learned' during the pandemic.

Secondly, the three wisdoms are almost certainly incorrect, at least in their incarnation as grand, sweeping statements (which is not to say that more restrictive and specific versions could not contain elements of truth.)

If the conventional wisdoms were true, we would, at least as a very general tendency, expect to see one or more of the following patterns during Covid-19:

- We would expect countries with higher levels of public spending to outperform countries with lower levels of public spending.
- We would expect less globalised economies with lower levels of exposure to China to outperform more globalised economies with higher levels of exposure to China.
- We would expect countries with national health services to outperform countries without national health services.

[18] 'Coronavirus: Boris Johnson praises NHS as country's greatest national asset after saying "he could have gone either way"', *Independent*, 12 April 2020 (https://www.independent.co.uk/news/uk/politics/coronavirus-boris-johnson-health-news-hospital-nhs-video-tweet-a9461616.html).
[19] *Twitter*, 8 October 2020 (https://twitter.com/MattHancock/status/1314246071456018433).
[20] *Twitter,* 13 November 2020 (https://twitter.com/MattHancock/status/1327265695382577153).

But as this paper will show, in reality, we do not observe any of that. If anything, we frequently observe the opposite. Some of the best performers are characterised by very low levels of public spending, open economies with high levels of exposure to China, and healthcare systems that are nothing like the NHS. In contrast, some of the worst performers are characterised by very large public sectors, by economies that are not particularly globalised or exposed to China, and by state-run health services that are not too dissimilar from the NHS.

What does this tell us? The answer is: not very much. The purpose of this paper is not to replace conventional forms of Coronfirmation Bias with 'contrarian' versions that are more in line with the author's own ideological preferences. The claim of this paper is *not* that the best performers did well *because* they have small states, or *because* they are open economies, or *because* they do not have NHS-type healthcare systems.

The claim of this paper is a much simpler and more modest one. It is that a sensible pandemic response is compatible with *a variety* of public spending levels, *a variety* of trading arrangements, and *a variety* of healthcare systems.

Put differently, the claim of this paper is that a pandemic is not going to solve our long-standing ideological disputes for us. Age-old arguments about the appropriate balance between the state and the market, about how open our economy should be, or about what type of health reforms (if any) we need, are not going to be settled by a virus. Those who want to make the case that we should raise public spending, de-globalise the economy, or hold on to our current healthcare system, should make that case on its own merits – *not* by presenting it as the 'lesson' we should supposedly learn from Covid-19.

This paper will rebut existing grand narratives about how the pandemic will, or should, change everything. But it will not seek to replace it with an alternative grand narrative of its own. It would be tempting for a liberal, free-market economist (like the author of this paper) to claim that liberal, relatively free-market economies are best placed to deal with a pandemic. But that is nonetheless emphatically not the claim of this paper. Because as easy as it would be to find examples which fit that story, it is just as easy to find examples which do not. The Socialist Republic of Vietnam, a self-described Marxist-Leninist state under the rule of the Communist Party of Vietnam (CPV), has come up with one of the world's most effective pandemic containment strategies. The Nordic social democracies of Norway, Denmark and Finland, characterised by very high levels of public spending and NHS-type healthcare systems, have been among the best performers in the developed world on both health and economic outcomes.

In short, it is not hard to see why Coronfirmation Bias is so widespread: engaging in it is easy and tempting. A talented storyteller, who knows where to find the relevant statistics, can easily construct a plausible-sounding Covid narrative that suits their ideological preferences.

In this paper, we will avoid that temptation by deliberately not trying to offer yet another grand narrative. The 'big story' of this paper is that there is no big story to be told.

## Pandemic performance

What does it mean to say that a country has been 'coping well' or 'coping badly' with the pandemic? There is no obvious answer here. 'Well' on what metric? 'Badly' compared with what?

We can see this in the debates around Sweden's relatively permissive, voluntarist approach. Supporters often point out that Sweden has a lower Covid-19 death rate than the UK and a less severe economic downturn. They therefore see Sweden as a relative success story in terms of both health outcomes and economic outcomes. Critics counter that if we compare Sweden to its nearest neighbours and closest trading partners, rather than to the UK or the European average, its record looks markedly less favourable: Sweden's Covid death rates have been substantially higher and its economic situation no better. They therefore see the Swedish approach as a failure, again in terms of both health outcomes and economic outcomes.

This is before we get into a discussion of the difficult trade-offs and value judgements involved. To what extent are we prepared to disrupt the lives of millions of people and accept major reductions in their quality of life in order to prevent extra deaths? How should we trade off the current versus the future costs of various pandemic response strategies? How should we trade off the risks versus the potential rewards of different courses of action? How should we trade off the wellbeing of one population subgroup (say, schoolchildren or university students) against that of another subgroup (say, the elderly)? And how should we trade off health outcomes versus civil rights and individual liberties? As long as there is widespread disagreement on such questions, we will find it hard to agree which countries are 'doing well' and which are 'doing badly'.

However, there are cases where the performance of some countries is so unambiguously superior to that of others, across the board, that there is no need to even get into arguments of that sort. There is no such thing as an 'Index of Covid Performance', on which we can rank countries from best to worst. But we can identify a few unambiguous (if not unqualified) success stories and a few unambiguous cautionary tales. Most of the developed world falls somewhere in between, where things may not be clear-cut – but at the extremes, they very much are. One could compare this to a classroom where different pupils have different strengths and where one could not rank them on overall performance without getting into arguments about the relative importance of different subjects. But there may still be a handful of students who are almost always among the best in class, regardless of the subject, and a handful of students who are almost always among the worst in class, again regardless of the subject. We can then still identify the best and the worst in class, even if we cannot say much about those in between.

The Covid-19 situation is not unlike that. The star pupil in the Covid classroom has to be Taiwan. Located less than 200km off the coast of mainland China, and a two-and-a-half-hour flight away from Wuhan, Taiwan could easily have been among the hardest hit in the world. Yet at the time of writing, Taiwan only had 7 confirmed Covid deaths, which amounts to less than one per million people. Taiwan's economy did not suffer from a Covid-induced recession in 2020 at all, or if it did, its magnitude was that of a rounding error. Taiwan never had a lockdown, or even particularly severe mandatory social distancing requirements. For Taiwan, 2020 was simply a fairly normal year.

Hong Kong and South Korea are also clear examples of success stories. The Hong Kong Special Administrative Region is technically part of China and not even geographically separated from the mainland, with Wuhan a mere two-hour flight away. A busy international

travel and business hub with an extremely high population density, Hong Kong had all the ingredients of a Covid-19 catastrophe. But at the time of writing, it had fewer than 30 Covid deaths per million people, and its economic recession, while severe, probably had more to do with the political situation than with the pandemic. Hong Kong imposed social distancing measures, but stopped short of a full-scale lockdown.

South Korea is home to several densely packed regional travel and business hubs, some of which, including the capital, are a three-hour flight away from Wuhan. It could also easily have become Covid-19 clusters, and indeed, in the early stages of the pandemic, it very briefly looked as though it would. But at the time of writing, South Korea had fewer than 30 Covid deaths per million people, and during 2020 its economy shrank by no more than during a normal recession. At the time of writing, there has been no national lockdown, although there were short lockdown-like measures in a few selected areas.

With some qualifications, we can include Singapore in this list of success stories. Singapore's economic outlook is not much better than that of an average European country, and it did not manage to avoid a ten-week lockdown-like 'circuit breaker'. But it managed to 'bend the curve' earlier than most: to date, Singapore has not experienced a second wave. Most notably, its Covid death rate to date remains exceptionally low.

At the opposite end of the spectrum, we have the UK, Italy, Spain and Belgium, with exceptionally high levels of Covid-19 deaths, a particularly heavy economic blow and prolonged, severe lockdown measures. In these countries, the Covid death toll is still rising significantly on a daily basis, which means that some of the figures in this paper will almost certainly be out of date again by the time it is published.

There has been some discussion about the reliability and international comparability of Covid-19 death figures. Sceptics have pointed out that such figures may be biased by differences in the prevalence of testing, by false positives, by a failure to distinguish between 'dying *with* Covid' and 'dying *of* Covid', and by the inclusion of people who were already in the very final stages of their lives. These seemed like reasonable objections in the beginning, but we can now say that they have been greatly overblown. There is a simple way to check whether Covid death figures are in the right ballpark and that is to contrast them to excess death figures – the number of deaths over and above what we would expect in a normal year (Our World in Data 2021b; New Scientist 2020).

In January, February and early March 2020, excess mortality rates in almost all developed countries fluctuated within a fairly narrow corridor of between –10 per cent to +10 per cent. This suggests that had it not been for Covid-19, 2020 would have been a perfectly ordinary year in terms of population health. Excess mortality rates then started to rise in early-to-mid-March, initially only in Italy, then also in Spain, then in the Benelux states, and eventually in most developed countries (ibid.).

If a country has a high Covid-19 death count, but few excess deaths, it would be fair to suspect that their Covid death count is inflated. If a country has a low Covid death count, but lots of excess deaths, it would be fair to suspect that they are undercounting Covid deaths. In reality, both of these scenarios are rare, at least among developed countries. Covid deaths and excess deaths are closely correlated, both across countries as well as within countries over time. Within countries, excess deaths tend to peak around the same time as Covid deaths. In cross-country comparisons, the countries that top the list for Covid deaths also top the list for excess deaths. The exact numbers differ (Covid deaths and excess deaths measure different things, after all), but the time trends and rankings are similar.

Thus, if we are interested in precise numbers, then yes, the sceptics' objections need addressing. But if we are interested in broad trends and international rankings, we are on the safe side. Taiwan does not just have an exceptionally low Covid-19 death count, but also an exceptionally low excess death count, or more precisely, no excess deaths at all (at least during the first wave of the pandemic, after which, unfortunately, the time series for Taiwan ends). South Korea has more excess deaths than Covid deaths, but even if we assume that each excess death is really a concealed Covid death, South Korea would still remain near the bottom of international rankings. Unfortunately, we do not have excess mortality data for Hong Kong and Singapore, but if their excess death figures fundamentally changed the impression we get from their Covid death figures, it would make them highly unusual.

The UK, Belgium, Spain and Italy, meanwhile, top the list for excess deaths (see also New Scientist 2020; Our World in Data 2021b). This may have changed somewhat in the meantime, because in the winter of 2020/21, some upper-middle income countries in Central and Eastern Europe experienced a surge in excess deaths comparable to the surge experienced by the UK, Italy, Spain and Belgium during the spring of 2020. At the time of writing, a complete database for excess deaths covering all countries over the entire period is not yet available. However, the UK, Italy, Spain and Belgium definitely topped the list throughout most of 2020, and even if one or two of them have since been pushed out of the 'Top 4', they will not have dropped very far.

**Table 1: Health and economic outcomes during Covid-19**

| | Covid deaths per million (cumulative, late January 2021) | Covid cases per million (cumulative, late January 2021 | Excess deaths per million (cumulative, March-September 2020)[21] | GDP growth 2020 (preliminary) | Days spent in lockdown (local or national) |
|---|---|---|---|---|---|
| Taiwan | 0.3 | 37 | 0 | -0% | 0 |
| South Korea | 27 | 1,472 | 163 | -1.9% | 28 |
| Singapore | 5 | 10,100 | n/a | -6% | 72 |
| Hong Kong | 23 | 1,349 | n/a | -7.5% | 0 |
| | | | | | |
| UK | 1,447 | 53,896 | 945 | -9.8% | 110 |
| Italy | 1,422 | 40,975 | 905 | -10.6% | 172 |
| Spain | 1,186 | 55,671 | 1,280 | -12.8% | 199 |
| Belgium | 1,788 | 59,705 | 811 | -8.3% | 209 |

Sources: Worldometers (2021), IMF (2020a), Human Mortality Database (2021), Our World in Data (2021e)

To cut a long story short, it should be uncontroversial to say that, at least among developed economies, the four 'Asian Tigers'[22] of Taiwan, Hong Kong, South Korea and Singapore are

[21] 'Excess deaths', in this case, are defined as the number of deaths in excess of the average for the 2015-2019 five-year period during the same months. The length of the periods is dictated by data availability and not a choice of the author. Since it is quite implausible that Covid has *reduced* the number of deaths, negative figures are reported as 0.

[22] The term 'Asian Tigers' (or 'Four Tigers') was originally adopted in the 1960s and 1970s, when Hong Kong, Singapore, South Korea and Taiwan, which had been developing countries until then, entered a phase of extremely rapid economic modernisation. Nowadays, the term sounds rather dated, because today we

the relative success stories of the pandemic, while the UK, Italy, Spain and Belgium are the cautionary tales (see Table 1). In order to reach this conclusion, we do not need to agree on what exactly constitutes 'success', or a 'good job'. We do not need to agree on whether the top priority of government policy should be to minimise the Covid-19 death rate and/or the excess death rate, to cushion the economic blow, or to preserve civil liberties and enable people to continue to live their lives with semblance of normality. The four Asian countries in our sample outperform the four European countries in all of these respects, across the board. We can disagree in good faith on the merits of, say, the Swedish approach vis-à-vis a more conventional European alternative. But it is hard to see on what grounds anyone could claim that the UK has done a better job at handling the pandemic than Taiwan, or that Spain is in a better place than Hong Kong.

Are the Asian Tigers suitable comparators for European countries? It has often been pointed out that Asian countries were better prepared, because they were able to fall back on their experience with the SARS pandemic of the early 2000s. There is almost certainly some truth in this, especially given that the virus responsible for SARS – a relative of the current Coronavirus – spread in similar ways and could be prevented in similar ways.

But then, what does it mean to be 'prepared' for a pandemic? We can prepare for flooding by erecting flood barriers, and we can prepare for war by building up a well-resourced, well-trained army. But what would be the Coronavirus equivalent of that? If we had somehow known that a pandemic of some sort was going to hit us, but without knowing anything about the nature of this particular virus, or where it would emanate from – what exactly would we have done differently?

Asian countries obviously gained some knowledge about coronaviruses during the SARS pandemic, whereas most Westerners (including the author of this paper) will never even have heard the word 'Coronavirus' before 2020. But this knowledge has always been in the public domain. Asian countries did not 'hoard' it, or withhold it from their Western peers. In fact, it was a team of Western scientists (led by Dr Christian Drosten, who has since re-emerged as a leading Covid-19 expert) who discovered the SARS-Coronavirus in the first place.

And indeed, as Terence Kealey from the University of Buckingham points out, on conventional measures, the UK seemed extremely well prepared for a pandemic.[23] On the 2019 Global Health Security Index, an index which tries to measure pandemic preparedness, the UK was ranked the second best in the world (Johns Hopkins Center for Health Security, Nuclear Threat Initiative and Economist Intelligence Unit 2019). The US was ranked best in the world, while South Korea only ranked 9th, and Singapore only 24th. Spain was about on a par with Switzerland and Germany, and Belgium was ahead of Singapore.

Unsurprisingly, this study has since been widely mocked on social media, because with the benefit of hindsight we can see how badly some of its findings have aged. But rather than holding this against the authors of the study, we could also draw the conclusion that there is no obvious way to measure 'pandemic preparedness', because there is no obvious way to prepare for a pandemic. This suggests that the 'prior experience' argument only gets us so far.

Ultimately, nobody was truly 'prepared' for this pandemic. Covid-19 is not a re-enactment of SARS. It is not as if people in Asian countries had been able to simply convert their old SARS testing kits into Covid-19 testing kits, or reinstall their old track-and-trace apps on their

---

simply think of these four as developed high-income economies on a par with the West, not as 'emerging' economies anymore. But for lack of a better term, we will nonetheless use it throughout this paper.

[23] 'Britain's original pandemic sin', *IEA Blog*, 4 August 2020 (https://iea.org.uk/britains-original-pandemic-sin/).

smartphones. There were no tests for Covid-19 until the beginning of 2020[24] and there were, of course, no apps and no smartphones during SARS.

The SARS experience must have helped in the form of generating 'tacit knowledge' and a 'folk memory' of how to behave during a pandemic. Simple things such as washing one's hands thoroughly multiple times a day, disinfecting surfaces, wearing facemasks, keeping a greater distance from other people etc., had to be adopted from scratch in the West. Social norms had to adjust: most of us will remember socially awkward moments from early 2020 when, for example, one person wanted to shake hands and the other refused.

But the Asian Tigers also adopted specific, identifiable policy measures, which most of the rest of the world did not adopt until much later, and usually not with the same rigour. The Asian Tigers did not do anything magical. They adopted measures which, with the benefit of hindsight, do not seem too far to seek: mass testing, digitally aided contact tracing and tracking, rigorously enforced quarantining and isolating of positive cases (combined with financial incentives), and selective travel restrictions.

A second argument is that Asian countries have a culture of compliance and deference to authority, which enables them to enact policies that would not work in the more individualistic, culturally egalitarian West. The problem with that argument is that most Western countries ultimately had to adopt much more intrusive and restrictive measures than the likes of Taiwan. The latter were, indeed, rigorous in enforcing self-isolation and quarantining requirements, and they were prepared to override privacy concerns in their tracking and tracing efforts. But these are targeted and selective measures, and it was because of these that the vast majority of people could continue to go about their business in a relatively normal way. It was in the supposedly individualistic West where governments expected a huge collective effort from their citizens and it was in supposedly collectivistic Asia where some governments enabled an individualistic response with minimal restrictions.

A third argument is that the comparison is unfair, because Hong Kong and Singapore are city states with populations of fewer than 8 million people, and smaller political units can be more agile and nimble than large nations like the UK. That may be so – but it is a political choice to run the UK (or at least England) in the current, centralised fashion. It would be entirely possible to run England as a federation of several Hong Kong- or Singapore-sized units. That would be a possible *conclusion* from the comparison with Hong Kong and Singapore, not a reason for not comparing them at all.

Nor is this a general case of 'Europe', or 'the West', versus 'Asia'. There are success stories in Europe and the wider Western world as well, just as there are cautionary tales in Asia. These are just not as unambiguous as the examples we have chosen to focus on here.

In short, there is a lot of space between 'We could have had the exact same outcomes they had' and 'The comparison is entirely meaningless and their experience irrelevant to us'. There was nothing specifically 'Asian' about the measures adopted by the Asian Tigers. If we could set the clock back to 31 December 2019, we would probably all more or less do what they did. Journalist and writer James Bloodworth was only being mildly sarcastic when he tweeted 'Britain couldn't manage the pandemic as well as Asian countries because it doesn't share their mysterious Confucian ways like... functioning border control and hotel quarantine'.[25]

[24] Ibid.
[25] *Twitter*, 27 January 2021 (https://twitter.com/J_Bloodworth/status/1354377613410709504).

## The size of the state

Conventional wisdom no. 1 holds that Britain was unable to cope with the pandemic because the British state was too emaciated and hollowed out. It simply lacked the resources, and the capacity, to react adequately. Did it really?

Before the pandemic hit, public spending in the UK was about two fifths of GDP. This is not a lot by Northern European standards: in Sweden and Denmark, public spending accounts for about half of GDP. Nor is it a lot by the standards of the recent past: it is on a similar level today as during the years leading up to the financial crisis (when it temporarily surged).

It is, however, a lot more than in the Asian Tiger economies. In Singapore, Taiwan and Hong Kong, public spending accounts for about one fifth of GDP, or less. Data for South Korea differ from source to source (presumably because of differences in the definition of what exactly counts as public spending) but fall within a range from about 20 per cent to just over 30 per cent of GDP.

Public spending is even higher in those European countries which have been about as badly hit as the UK, or worse. Italy matches Scandinavia in terms of public spending and the Belgian state is one of the largest in the world, relative to the size of the economy. Even the keenest anti-austerity-campaigner would struggle to portray the Belgian state as 'underfunded', or to claim that Belgium had been led astray by a neoliberal small-state ideology.

One would generally struggle to find a correlation between the size of the state and a country's Covid-19 outcomes. In France, public spending accounts for 56 per cent of GDP, which is the highest level in the world (apart from, presumably, North Korea and Cuba). France had better outcomes than the UK, but still had higher excess death rates than most of Europe (Our World in Data 2021b) and a steeper economic decline (IMF 2020a). In Switzerland, where public spending only accounts for a third of GDP (OECD 2020), excess death rates were less than half of the French level (New Scientist 2020), despite the fact that most cantons took a fairly relaxed approach to Covid. Australia and New Zealand, which are as much examples of 'Anglo-Saxon capitalism' as the UK or the US, and where public spending is lower than in the UK, had no detectable excess deaths at all (New Scientist 2020).

The absence of a correlation between public spending and Covid performance should not surprise us. 'Public spending' is a massive aggregate, the vast bulk of which has nothing to do with crisis preparedness. One can make a case for spending more money on infrastructure projects, or labour market programmes, or climate change policies, or old-age benefits, or education, or arts and culture, or national defence, or regional development programmes, or foreign aid, or social housing, and so on. All of this may well be desirable in its own right. But it will not help us in dealing with a virus.

The problem with the 'austerity' or 'state capacity' narrative is that it tries to explain a very specific kind of state failure with reference to an aggregate which is simply far too big for that purpose. It is as if we tried to pick the right clothes for a holiday by checking the average annual temperature in the destination country, rather than checking the weather forecast for the next 14 days and in the specific region we are travelling to.

We can break down those figures a bit and look more specifically at areas of spending that are relevant to a pandemic, such as health. But this does not change very much. Healthcare spending in the UK accounts for about one tenth of GDP, four fifths of which is public spending. This is, again, not particularly high compared with some neighbouring countries.

Sweden, Germany and France spend between 11 per cent and 12 per cent of GDP on healthcare and Switzerland spends more than 12 per cent.

It is, however, substantially more than in the Asian Tiger economies. Taiwan and Hong Kong spend less than 7 per cent of GDP on healthcare, and more than a third of that is private spending. Singapore (and the Singaporean state in particular) spends even less (see Table 2). At the other end of the Covid performance spectrum, Belgian healthcare spending figures are almost identical to the UK's, while Spain and Italy are closer to the UK and Belgium than to Taiwan or Hong Kong (let alone Singapore).

Unfortunately, the data is not fine-grained enough to specifically compare those areas of spending that might be most relevant during a pandemic. But these are, in any case, not the areas in which there have been any spending cuts in recent years. In the five years leading up to the pandemic, Public Health England's budget for the spending category 'protection from infectious diseases' increased from £52 million to £87 million (Snowdon 2020a: 9).

**Table 2: Public spending and healthcare spending in percentage of GDP, 2019 or latest available year[26]**

| | Public spending in % of GDP | Healthcare spending in % of GDP | Public spending on healthcare in % of GDP |
|---|---|---|---|
| Singapore | 14.3% | 4.9% | 2.1% |
| Taiwan | 17.3% | 6.1% | 3.9% |
| Hong Kong | 20.9% | 6.2% | 3.2% |
| South Korea | 30.3% | 8% | 4.9% |
| | | | |
| UK | 40.9% | 10.3% | 8% |
| Spain | 41.6% | 9% | 6.4% |
| Italy | 48.3% | 8.7% | 6.4% |
| Belgium | 52% | 10.3% | 7.9% |

Sources: IMF (2020b), OECD (2020), HM Treasury (2020), Ministry of Health and Welfare (Taiwan) (2020), Food and Health Bureau (Hong Kong) (2020), WHO (n.d.).

None of this means that money is irrelevant. Obviously, other things equal, an organisation with a large budget can do more than an organisation with a small budget. Proponents of the 'state capacity' argument could still make the case that the funding of some specific government programmes and some specific public sector institutions, which would have come handy during a pandemic, has been inadequate. (This could still be true even if there have been no recent budget cuts: it could have been inadequate for a long time.)

It is also worth pointing out that while the Asian economies are *generally* small-state economies, this is not how they fought the Coronavirus. They achieved their success, in part, by *deviating* from their small-state tradition, *not* by sticking to it. Singapore, for example, quickly ramped up an economic and health support package worth over 12 per cent of GDP (Chua et al. 2020). So, proponents of the 'state capacity' argument can still point out that there are no small-state libertarians during a pandemic.

It would just not be much of an insight. Once we argue about the merits of support packages during a once-in-a-century emergency situation, we have moved beyond the boundaries of our

[26] The fourth column is a subset of the third one (all public spending on healthcare is healthcare spending) and of the second one (all public spending on healthcare is public spending).

‘peacetime’ ideological disputes. Virtually all small-state liberals are prepared to accept a larger role for the state during extreme emergency situations than they would in normal times. By the same token, most advocates of a larger state would not argue that every Covid-related spending programme must be carried over into normal times and retained indefinitely. During a pandemic, the rules are different. What is sensible and desirable in normal times can be counterproductive during a pandemic, and vice versa. A pandemic can therefore not tell us much about what we should do in normal times.

But what we can say with certainty is that for an effective crisis response, permanently maintaining a public sector of French or Belgian proportions is neither necessary, nor sufficient.

## Globalisation, openness and trade with China

Conventional wisdom no. 2 holds that Covid-19 is a crisis of globalisation. In a trivial sense, this is true. Had the virus developed half a century earlier, we would probably never have heard of it. China was a hermit kingdom and an economic nonentity. When people talked about ‘the global economy’, they meant North America, Western Europe and Japan. Contacts with China, economic or otherwise, were minimal. Chinese people were usually not allowed to leave the country, and Western tourism to China was mostly confined to political pilgrims who wanted to see Chairman Mao’s socialist utopia first-hand (see Hollander 1981).

Of course, nobody is suggesting that we should try to go back to that world of half a century ago. Today, China is the second largest economy in the world, or the largest one once we take purchasing power parity into account. Nobody is seriously suggesting that we could somehow pretend it is not there. Economic nationalists are arguing for *less* trade with China rather than *no* trade; they are arguing for a trade relationship with China that is actively managed by the state, rather than driven by consumer demand. They want the state to define ‘strategic’ sectors, in which trade is severely restricted, and thereby limit trade to sectors they deem ‘non-strategic’.

But this is where the problem starts. It is true that Covid-19 would probably not have reached us fifty years ago, when the UK had nearly zero contact with China. But it does not follow from that that reducing contact with China today, starting from where the UK is now, would have reduced the risk. A country’s Covid risk is not proportional to the extent of interaction with China. It is not as if a country’s death rate or economic contraction during the pandemic could be modelled as a function of trade volumes with China or FDI in China.

The Asian Tiger economies are, in multiple ways, much more closely connected to China than the UK ever was, or could conceivably become any time soon. China accounts for about 7 per cent of the UK’s imports and 4 per cent of its exports (House of Commons Library 2020: 13). This is a huge increase compared with 20 years ago, when China accounted for less than 2 per cent of UK imports and less than 1 per cent of UK imports. It is also more than in some of the UK’s neighbouring countries. But it is a lot less than in South Korea or Taiwan, where Chinese imports account for a fifth of total imports, let alone Hong Kong, where they account for almost half (see Table 3).

**Table 3: Freedom of trade and trade with China, 2019 or latest available year**

| | Index of freedom to trade internationally (0 – 10) | Imports from China in % of total imports |
|---|---|---|
| Belgium | 8.28 | 4% |
| UK | 8.50 | 6.8% |
| Italy | 8.59 | 7.3% |
| Spain | 8.34 | 8.4% |
| | | |
| Singapore | 9.44 | 13.4% |
| South Korea | 7.69 | 19.9% |
| Taiwan | 7.94 | 21.8% |
| Hong Kong | 9.49 | 46.6% |

Sources: House of Commons Library (2020), Bureau of Trade (Taiwan) (2020), Trade and Industry Department of Hong Kong (2020a), Global Edge (2020).

The Asian Tigers' relationships with China are characterised by relatively high degrees of economic openness. But it is a peculiar kind of openness: it is an economic openness combined with political distrust, or even hostility.

Taiwan is the most clear-cut example. Taiwan, or officially, the Republic of China, was part of China until the Communist Revolution, and then declared itself independent from the mainland. The two Chinas do not officially recognise each other. China regards Taiwan as a renegade province and the Taiwanese state as illegitimate. For half a century, China has been pursuing what could be described as an extreme version of the 'Hallstein Doctrine', under which West Germany initially refused to have diplomatic relations with governments that officially recognised the East German state. It is for this reason that Taiwan is, for example, frozen out of the World Health Organization (WHO).

And yet, political hostility between the two Chinas has not prevented them from achieving a high degree of economic integration over the past two decades. Just before the pandemic, China was Taiwan's most important trading partner (Bureau of Trade 2020). Nearly 3 million Chinese people visited Taiwan every year (Taiwan Government n.d.) and more than three quarters of a million Taiwanese citizens reside in China (Wang et al. 2020), presumably returning regularly for family visits etc.

However, for Taiwan, China is a business partner – not a trusted friend. This became abundantly clear in the early stages of the pandemic. When the Chinese government was still trying to downplay the situation, and Western governments, as well as WHO, naively took information from China at face value (Snowdon 2020b: 6-17), Taiwan started to act unilaterally. The actions of the Taiwanese authorities demonstrate that they clearly did not believe a word the Chinese government was saying.
As early as 31 December 2019, Taiwan's public health authorities started to screen passengers arriving from Wuhan for symptoms of fever or pneumonia (Wang et al. 2020). A few days later, this was retroactively expanded to people who had arrived from Wuhan since 20 December 2019, with quarantines for people displaying symptoms. A general travel ban for the Wuhan region soon followed, alongside more selective travel restrictions for other areas.

In mid-January, a team of Taiwanese medical experts was sent to mainland China to carry out their own investigations into the new virus. One of them reported: 'They didn't let us see what they didn't want us to see, but our experts sensed the situation was not optimistic'.[27]

Taiwan never tested on a large scale, but it started testing much earlier than most, carrying out about 30 tests per million people per day from mid-to-late February.

The case of South Korea is less clear-cut, but not wholly dissimilar (see Pak 2020). China is a political ally of South Korea's arch enemy, North Korea. An ally of North Korea will always have a troubled relationship with South Korea, for the same reasons that close allies of East Germany did not enjoy great relationships with West Germany.

But again, political tensions have not prevented China and South Korea from developing a close trading relationship. China is South Korea's most important trading partner by a very large margin. South Korea attracts millions of Chinese tourists, and tens of thousands of Chinese students, every year (Pak 2020).

[27] 'Taiwan has only 77 coronavirus cases. Its response to the crisis shows that swift action and widespread healthcare can prevent an outbreak', *Business Insider*, 17 March 2020 (https://www.businessinsider.com/coronavirus-taiwan-case-study-rapid-response-containment-2020-3).

But like Taiwan, South Korea acted early on, and unilaterally, during the pandemic, rather than taking Beijing's word for anything (EGH 2020). They developed the world's first Covid-19 test and quickly scaled up testing capacity. At the end of February, when hardly anyone else was testing on a meaningful scale, South Korea was already conducting nearly 200 tests per million people every day. People who had tested positive were quarantined and isolated. In March, more than 3,000 people passed through temporary isolation wards, which doubled up as specialised healthcare treatment centres.

The situation of Hong Kong is different. Hong Kong is technically part of China, and has been since it was returned by the British in 1997, although the agreement at the time was that Hong Kong would remain a largely self-governing, autonomous territory ('One Country, Two Systems'). Politically, this has turned out not to be a viable arrangement. The Chinese government is not prepared to respect Hong Kong's autonomy and frequently tries to undermine it. These efforts are then met with fierce resistance and mass protests in Hong Kong, which, in turn, are then met with police violence.

Unsurprisingly, the political turmoil has taken its toll on Hong Kong's economy as well. But however undesirable those political developments are, so far they still coexist with a high degree of economic integration.

The 'reunification' of Hong Kong with China in 1997 did not automatically create a common market, or even free trade area: they still had to sign a separate trade agreement six years later. Hong Kong and China still do not form a single market or a customs union, and there is no free movement of people between them either. Still, cross-border movements of goods, services, capital and people are frequent (or at least *were*, until Covid-19 hit). Mainland China accounts for almost half of Hong Kong's imports and a quarter of incoming foreign (if 'foreign' is the right word) direct investment (Trade and Industry Department of Hong Kong 2020b). About a million Chinese people have migrated to Hong Kong since 1997.[28]

None of this stopped Hong Kong from imposing travel restrictions and strict quarantining requirements, alongside general social distancing measures, early on.[29] The first Covid-19 wave was quickly contained. It did not prevent the outbreak of a second wave in March, and even a third wave in summer, but none of these waves spiralled out of control.

Singapore has a slightly more distant relationship with China than the other three, but China is still Singapore's most important trading partner and 3.4 million Chinese people visit Singapore each year (Budget Direct 2020). Most Singaporeans are ethnically Chinese and Mandarin is one of the country's official languages.

As in the case of Taiwan, Singaporean health authorities acted very early on. A press release from Singapore's Ministry of Health from 2 January 2020 reads:

> The Ministry of Health (MOH) is aware of the cluster of severe pneumonia cases in Wuhan city, Hubei Province, China and is monitoring the situation closely.
>
> As a precautionary measure, MOH has alerted all medical practitioners to be vigilant to look out for suspected cases with pneumonia who have recently returned from Wuhan. Suspect cases with fever and acute respiratory illness or pneumonia and with travel

---

[28] 'An influx of mainland Chinese is riling Hong Kong. Locals view the newcomers as boorish spongers', *The Economist*, 20 October 2018 (https://www.economist.com/china/2018/10/20/an-influx-of-mainland-chinese-is-riling-hong-kong).
[29] 'Covid-19: Why Hong Kong's "third wave" is a warning', *BBC News*, 30 July 2020 (https://www.bbc.co.uk/news/world-asia-china-53596299).

> history to Wuhan within 14 days before onset of symptoms will be isolated as a precautionary measure to prevent transmission.
>
> From the evening of 3 January 2020, temperature screening will be implemented at Changi airport for inbound travellers arriving on flights from Wuhan, and suspected cases will be referred to hospitals for further assessment.[30]

On 23 January, the Ministry reported Singapore's first confirmed Coronavirus case:

> [T]his case presented at SGH Emergency Department with fever and cough on 22 January. He was classified as a suspect case and immediately isolated. […] Subsequent test results were confirmed for the novel coronavirus […]
>
> MOH has initiated contact tracing […] The health status of all close contacts will be monitored closely. As a precautionary measure, they will be quarantined for 14 days from their last exposure to the patient. Those who develop symptoms will be brought to hospital in a dedicated ambulance for further assessment. [31]

More cases soon followed. The ministry announced additional measures:

> [T]he Ministry of Health (MOH) is contacting all recent travellers from Hubei province who are in Singapore. MOH estimates that about 2,000 such persons have arrived here in the last two weeks […]
>
> MOH will assess who among this group are at higher risk and will place them under quarantine. […]
>
> From 29 January 2020, 12pm, all new visitors with recent Hubei travel history within the last 14 days, or those with PRC passports issued in Hubei, will not be allowed entry into Singapore, or transit through Singapore.[32]

Until about mid-March, this approach worked very well: despite its early exposure to the virus, Singapore's cumulative caseload did not exceed 40 per 1 million people – fewer than in South Korea and on a par with the UK.[33] Unfortunately, this initial success was not sustained. The cumulative caseload then exploded. This was partly because Singapore employs large numbers of temporary migrant workers, who often stay in crowded dormitories, some of which then turned into Covid-19 hubs. By early August, the cumulative caseload had risen to nearly 10,000 per 1 million people – twice the UK level. At that point, however, the situation in Singapore had stabilised. The number of new infections has been brought down to a level with which the test-track-and-isolate system could cope again. In the UK, by contrast, cases soared again.

---

[30] 'Precautionary measures in response to severe pneumonia cases in Wuhan, China', press release, 2 January 2020 (https://www.moh.gov.sg/news-highlights/details/precautionary-measures-in-response-to-severe-pneumonia-cases-in-wuhan-china).
[31] 'Confirmed imported case of novel Coronavirus infection in Singapore; multi-ministry taskforce ramps up precautionary measures', press release, 23 January 2020 (https://www.moh.gov.sg/news-highlights/details/confirmed-imported-case-of-novel-coronavirus-infection-in-singapore-multi-ministry-taskforce-ramps-up-precautionary-measures).
[32] 'Additional precautionary measures to minimize risk of community spread in Singapore', press release, 28 January 2020 (https://www.moh.gov.sg/news-highlights/details/additional-precautionary-measures-to-minimise-risk-of-community-spread-in-singapore).
[33] 'Coronavirus tracked: see how your country compares', *Financial Times* (https://ig.ft.com/coronavirus-chart).

In short, the Asian Tigers have much closer economic and personal ties with China than the UK has, for geographic and linguistic reasons alone. If 'too much globalisation' or 'too much exposure to China' had been the problem, they should have been among the worst hit in the world.

Meanwhile, Belgium, which was about as badly hit by Covid-19 as the UK, does not trade very much with China. This is not because of any deliberate anti-globalisation strategy pursued by the Belgian government, but simply because Belgium is more of a Europeanised than a globalised economy. Its most important trading partners are its larger neighbours, not China. (Spain and Italy trade about as much with China as the UK does, in relative terms.)

There have, of course, been problems with disrupted international supply chains.[34] But then, economic activity has been disrupted almost across the board, with very few sectors escaping entirely unscathed. Just like some economies are more globalised than others (for example, the UK is more globalised than Belgium), some sectors within any given economy are more globalised than others (for example, manufacturing is more globalised than construction). We can buy trainers or household electronics from China, but we cannot teleport ourselves to China to get a haircut or to go to a pub. If we look at a sectoral breakdown of the performance of the UK economy in 2020, we can see no indication that the less globalised sectors have been any more resilient than the more globalised ones (ONS 2020). If anything, we can find a weak effect in the opposite direction. International supply chains have, on the whole, held up fairly well during the pandemic.[35]

Economic nationalists are mixing up a number of different arguments. They are partly motivated by a general aversion to 'reliance' on other countries, which they associate with 'vulnerability', and partly by a specific dislike of the Chinese government. It therefore makes sense to briefly recapitulate some of the liberal arguments in favour of free trade and globalisation.

First of all, economic liberals reject the idea that importing things makes a country 'vulnerable' or 'exposed', while striving for self-sufficiency makes it 'resilient'. Importing products from a variety of sources is, on the contrary, an effective form of risk-spreading, while aiming for self-sufficiency means putting more of one's eggs into the same basket. The UK would not specifically notice a bad wine harvest in Australia, because it imports wines from all over the world, and substitutes from California, Chile, Argentina, Spain, France, Italy etc. would very quickly fill the gap. Thus, the UK's level of 'wine self-sufficiency' is extremely low, but its level of 'wine security' is very high.

Equating imports with 'vulnerability' is a style of thinking for which there may have been some justification in the first half of the 20th century, given the experience of both World Wars, when German submarines targeted cargo vessels bound for Britain. Of course, under conditions of a blockade, having a large network of willing suppliers around the world would not help. However, 'U-boat economics' is unlikely to be a useful guide to the trade policy challenges of today.

Liberals also emphasise that most trade does not take place between countries, but between individual households and companies that just happen to be located in particular countries. When we say that 'the UK' imports 'from China', this is a figure of speech. It is an aggregation of millions of separate transactions between individuals, such as Mrs Miggins from

[34] See, for example, 'Covid-19 crisis highlights supply chain vulnerability', *Financial Times*, 28 May 2020 (https://www.ft.com/content/d7a12d18-8313-11ea-b6e9-a94cffd1d9bf).
[35] 'Coronavirus-induced "reshoring" is not happening', *Financial Times*, 30 September 2020 (https://www.ft.com/content/e06be6a4-7551-4fdf-adfd-9b20feca353b).

Wolverhampton ordering an ink cartridge made by a company set up by Mr Zhang from Beijing.

This means that it is not necessarily a problem to have close trade links with a country ruled by an autocratic regime, even if we strongly disapprove of many of its actions, and even if that regime is hostile towards us. We are not trading with the regime. We are trading with people who happen to live under it.

It also means that the protectionist language of 'reliance' is fundamentally misplaced. Unless we live like hermits, we all inevitably 'rely' on other people for most of the things we consume. Why is it more secure to 'rely' on a domestic producer than on a foreign one? Economic nationalists see foreign sellers as fickle fair-weather salesmen, who cannot be trusted, and who might drop us at a moment's notice, while domestic sellers would go through thick and thin with us.

In reality, neither foreign nor domestic suppliers are particular motivated by our wellbeing, and neither are trading with us out of the kindness of their hearts. They do so because it is mutually beneficial. It is in their interest as much as ours and they 'depend' on us as much as we 'depend' on them. That situation can, of course, change. A foreign seller might find a more lucrative activity elsewhere and stop trading with us. But then, this is equally true of domestic sellers. A 'resilient' arrangement is an arrangement that gives us access to a large variety of potential suppliers and the flexibility to change them quickly – *not* an arrangement in which these suppliers are all geographically close to us and have the same nationality.

This liberal view of trade and globalisation has certainly not been, in any way, 'debunked' or 'weakened' by the pandemic. However, it has not been specifically vindicated either.

While the Asian Tiger economies *generally* have a fairly open-border regime, including with China, this is not how they contained Covid-19. During the pandemic, they all imposed severe travel restrictions and quarantining requirements early on. They achieved their success, in part, by *deviating* from their general open-border policy, not by sticking to it. They quickly ramped up production of masks and personal protective equipment, but they did not leave this entirely to the invisible hand of the market: governments actively promoted this development.

However, once we discuss the merits of travel restrictions and government purchases of medical equipment during a pandemic, we have ventured outside of the realm of our usual ideological disputes. Even the most enthusiastic open-borders liberal would accept that in such an extreme situation, travel restrictions can be perfectly justifiable. At the opposite end of the spectrum, even the most implacable opponents of globalisation would not argue that in normal times we should indiscriminately clamp down on cross-border movement, on the off chance that a pandemic might one day hit us.

We can see this more clearly if we ignore China for a moment and focus on Europe. This makes sense anyway, because most European countries did not 'import' the Coronavirus directly from China. They caught it from each other. It is thought that Covid-19 was first brought from Wuhan to Northern Italy, presumably by Chinese visitors, and then spread further afield from there.[36] It spread, for example, to the Alpine region, which became a 'Covid hub' because of its popularity with ski tourists from all over Europe and beyond. It originated in China, but once it had reached Europe, intra-European travel – not 'globalisation' – finished the job. Genetic analysis shows that about three quarters of the UK's cases during the first

---

[36] 'Coronavirus started in China, but Europe became the hub for its global spread', *The Intercept*, 2 April 2020 (https://theintercept.com/2020/04/02/coronavirus-europe-travel/).

wave can be traced back to Spain, Italy and France, while only one in two hundred can be traced back directly to China (du Plessis et al. 2020).

Yet, we do not hear anyone claim that the Covid-19 crisis was one of intra-European mobility gone 'too far' and that we need to 'curb' its 'excesses'. Why not? Because this would not tie in with any of our pre-Covid ideological disputes. Intra-European travel (as opposed to intra-European *migration*) is not ideologically controversial. Not even arch-Brexiteers such as Nigel Farage or Mark Francois have ever suggested clamping down on intra-European business travel, tourism, or student exchanges.

This is not an ideological dispute in which any side can claim to have been 'vindicated'. The truth is more mundane. Arrangements that are convenient and useful during normal times can be a hindrance during a pandemic. Conversely, emergency arrangements that are justifiable during a pandemic can be burdensome, costly and needlessly repressive in normal times. During a pandemic, the rules are different. Pandemics can therefore not tell us much about what we should do during normal times.

The lesson from this section is not that our current relationship with China is fine and requires no revision. One can make plenty of non-Covid-related cases, from the Hong Kong issue to the treatment of the Uyghurs, for taking a tougher stance on China – whatever that means in practice. The idea that greater economic openness would, over time, make China adopt the political habits of a Western democracy has so far turned out to be illusory.

China's peculiar economic model, officially known as 'Socialism with Chinese Characteristics', also makes the distinction between the state and the private sector less straightforward. This, in turn, makes the conventional liberal argument that we are not trading with 'China', but with individual people and companies based in China, less applicable. When it comes to trade in sensitive areas (for example, where matters of national security are concerned), one can therefore make a case for applying different rules to China than we would to almost any other country (see, for example, Davies and Kamall 2020: 19).

But this is not an argument about overall volumes of trade or investment. It is not about whether Chinese imports should account for 5 per cent, 10 per cent or 20 per cent of the total.

The claim that the pandemic has generally vindicated proponents of economic nationalism or communitarian parochialism is wrong. Hong Kong and Singapore are the two most open economies in the world. They are also among the best performers of the Covid-19 crisis. More generally, more protectionist economies have fared no better than more open ones. You cannot put tariffs on a virus and you cannot keep it out with import quotas.

### Health outcomes and health systems

Conventional wisdom no. 3 holds that the NHS has emerged as the star performer of the pandemic - which it has, but only in the way in which for proud parents watching a school performance, their own child will always stand out as the 'star performer', even if nobody else sees it that way.

There is no obvious way of assessing how well different countries have been dealing with the health impact of Covid-19. But if we had to pick a single measure, the aforementioned excess death rate – the number of people dying over and above what we would expect at the same time in a normal year – might well be the best bet.

This is because the excess death rate captures some of the indirect effects of the pandemic, especially the crowding out of 'conventional', i.e. non-Covid healthcare. We could imagine a healthcare system which keeps Covid deaths low by simply dropping everything else it is doing and focusing exclusively on Covid-related matters. But that would merely shift the problem elsewhere. There would then be plenty of people dying from curable diseases that just happen not to be Covid-19. Excess death rates can tell us something about a health system's ability to manage not just Covid, but the situation as a whole, its ability to redirect and reprioritise its resources.

The UK, as mentioned, had one of the highest excess mortality rates in the developed world. It would, of course, be absurd to say that a high excess death rate is 'proof' that a country has a bad healthcare system. Pandemic-induced excess deaths are not specifically, or even predominantly, attributable to the healthcare system. A myriad of other factors come into play, such as the type and timing of lockdown policies, of social distancing measures, of travel bans and quarantining measures, the effectiveness of contact tracing, demographics, employment structure, geography, scope and uptake of furlough schemes, the clarity of scientific advice and guidance, compliance with that advice, and, of course, brute luck. An island nation like New Zealand has options that a small, landlocked country like Luxembourg does not have. Neighbouring countries have often fared rather similarly (for example, the Benelux countries, the Baltic states, Central Europe), which highlights the importance of spillover effects and regional clusters. And so on.

We obviously cannot blame the NHS for the fact that the UK introduced its first lockdown later than many of its neighbours. We cannot blame the NHS for the fact that the UK government decided to keep its large hub airports open, or for the lax enforcement of quarantining measures. We cannot blame the NHS for the effects of the misguided 'Eat Out to Help Out' scheme. Nonetheless – we can identify some specific healthcare policy decisions, and specific healthcare-related factors, which must have contributed to Britain's poor outcomes.

For a start, the UK's healthcare policy response revolved around the aim to 'protect the NHS'. This came at a cost. A special report by Reuters explains (Grey and Macaskill 2020):

> Policies designed to prevent hospitals from being overwhelmed pushed a greater burden onto care homes. With hospitals given priority by the government, care homes struggled to get access to tests and protective equipment. The elderly were also put at potentially greater risk by measures to admit only the sickest for hospital treatment and to clear out as many non-acute patients as possible from wards. […]
>
> [S]taff and managers of many care homes say they believe the British government made a crucial early mistake: It focused too much attention on protecting the country's National Health Service at the expense of the most vulnerable in society, among them

> the estimated 400,000 mostly elderly or infirm people who live in care homes across Britain. […] The approach gave the country's publicly-funded hospitals priority over its care homes.

Secondly, the UK was also slow to roll out mass testing, thus missing out on its benefits in the crucial early stages of the pandemic (Lesh 2020: 6-11):

> The UK began testing for COVID-19 in January, initially using just one lab […] The UK chose a single state-run lab, initially capable of doing 100 or fewer tests a day. This is in stark contrast to the likes of South Korea and Germany, and later, the United States, who have activated a large network of public and private laboratories. PHE also chose to develop and encourage the use of its own diagnostic tools, rather than seeking the development of a range of private sector tools and providing fast-track approval.
>
> […]
>
> The UK is now ranked 26 of 34 OECD for COVID-19 testing per capita […] This places the UK in the bottom quarter of countries. As of March 30, the UK had undertaken 1,998 tests per million people. This is much lower than the likes of Norway (13,617), Australia (9,670), South Korea (7,622), Germany (5,812) or the United States (2,914).

In this regard, Britain only really caught up in May, when the peak of the first wave had already passed (Our World in Data 2021c).

Thirdly, since March, a lot of non-Covid healthcare has ground to a halt, as appointments were cancelled and delayed en masse. In the beginning of 2020, median NHS waiting times for non-emergency surgery and specialist treatment were about 8 weeks; 83 per cent of NHS patients were seen within 18 weeks and virtually all of them were seen within one year (NHS England 2020). By July, median waiting times had soared to 20 weeks and one in fifty patients had been waiting for longer than a year. This has to be one major reason for the UK's high excess mortality, and it also shows that excess mortality cannot be more than the tip of the iceberg. Once we add people unable to access primary care, and people who do not appear on any waiting list because they do not even bother trying to get on it, there must be millions of people who have, for all intents and purposes, been going without healthcare in 2020.

So, while we cannot blame the NHS for policy failures in areas completely unrelated to healthcare, neither can we claim that the UK's high excess death rate had nothing to do with healthcare. But, if the NHS has not excelled during the pandemic, is there a type of healthcare system which clearly has? Is there a model of healthcare provision that has proven itself to be exceptionally 'pandemic-proof'?

The short answer is no. The good performers are not especially similar to each other in terms of their healthcare systems.

Taiwan has a public health insurance system. This means that there is single state-owned health insurance company, the National Health Insurance Administration (NHIA), which covers the entire population and pays for most healthcare costs. Enrolment is mandatory. Insurance premiums depend on income and household size, but not on health status. The state pays the premiums of those who cannot afford them, on a means-tested basis (NHIA 2020: 24-30).

The NHIA does not run any healthcare facilities of its own. It maintains contractual relations which both public and private healthcare providers, and patients can freely choose between them. According to Cheng (2015: 504):

> Taiwan's health care delivery system is a mixture of private nonprofit and government-owned hospitals, private clinics, and other healthcare facilities. For-profit hospitals are not allowed in Taiwan. However, many nonprofits behave as if they were for profit: They compete fiercely to maximize their revenues.

He describes it as a system characterised by 'fierce competition among providers' (ibid.: 508). Moreover, providers are mostly paid on a fee-for-service basis, a payment system which has the upside of promoting responsiveness to patients' needs, but which can also lead to overtreatment and push up costs.

The NHIA pays for over half of all healthcare costs, but in the Taiwanese system healthcare is not generally free at the point of use: out-of-pocket payments account for about a third of total healthcare spending (ibid.: 505-506). There are co-payments for most medical services, although these are capped for people with high healthcare needs and there are exemptions for poor people (NHIA 2020: 63-67).

Gatekeeping is financially encouraged, but not mandatory. Patients can seek specialist care directly, without getting a referral from a GP first. However, if they do get a referral, the co-payment rate drops (ibid.: 43).

Thus, there is no particular ideological school of thought which could fully claim the Taiwanese system as 'theirs'. It contains substantial liberal elements, such as a high degree of freedom of choice for patients and a competitive market in healthcare provision. But it also contains strong social democratic elements, especially the fact that, due to the way insurance premiums are set, it redistributes from rich people to poor people, and from healthy people to sick people. It contains statist, communitarian elements, such as the ban on for-profit provision and the state monopoly in primary insurance. But, however we want to describe that mix, it is certainly not an NHS-style system.

While Taiwan has been the 'best in class' during the pandemic, we cannot specifically credit the Taiwanese healthcare system for that. Since Taiwan's overall pandemic response has been so effective, its healthcare system never came under exceptional strain. The heavy lifting was done elsewhere.

Still, the health system has played its part. Cheng – writing in 2015, and thus oblivious of the Coronavirus – explains (Cheng 2015: 507):

> Providers are required to report to the administration all services delivered daily, by patient. This allows the administration to perform detailed profiling of both patients and providers. The administration thus knows utilization and costs for the entire health care system in almost real time. Such rapid data transmission also makes it possible to efficiently detect and monitor public health emergencies.

This is a feature of the system which came in handy five years later. Wang et al. (2020) explain:

> On January 27, the National Health Insurance Administration (NHIA) and the National Immigration Agency integrated patients' past 14-day travel history with their NHI identification card data from the NHIA; this was accomplished in 1 day. [...] On January 30, the NHIA database was expanded to cover the past 14-day travel history for patients from China, Hong Kong, and Macau. […] On February 18, the government announced that all hospitals, clinics, and pharmacies in Taiwan would have access to patients' travel histories.

The Singaporean healthcare system defies classification: it is the only one of its kind. For a start, Singapore is the only developed country in which most healthcare spending is paid individually and at the point of use, rather than collectively and on a prepaid basis (via taxes or insurance). The system consists of a variety of financing agencies and funding streams. The most well-known one is MediSave, a programme of mandatory, individual medical savings accounts. Singaporeans have to put a percentage of their income into an earmarked account every month, which they can then draw upon to pay for medical expenses. MediSave accounts for about one tenth of total healthcare spending in Singapore, and the savings accumulated in those accounts are equivalent to about a fifth of Singapore's GDP (Ramesh and Bali 2017: 4-5). The single biggest funding stream is conventional out-of-pocket payments, which do not come out of the MediSave accounts.

While direct user payments cover the cost of most routine healthcare, a mandatory public insurance programme, MediShield Life, covers the cost of exceptionally expensive treatments such as chemotherapy. MediShield Life premiums rise with age, and while pre-existing conditions are covered, people have to pay a risk surcharge. Income- and age-related premium subsidies are available (Ministry of Health Singapore 2020). MediShield Life can be complemented by private insurance.

For the poorest, there is a means-tested programme, Medifund, to assist with healthcare costs. MediFund is an endowment fund, so it can only spend whatever returns it generates. It only accounts for a small share of total healthcare spending.

The government also subsidises hospitals directly. This is indirectly targeted at lower-earners, because the subsidies are only available for multi-bed wards with basic levels of accommodation. Those who want higher levels of comfort have to pay a higher proportion of the cost, or all of it.

There are plenty of systems in which healthcare is predominantly publicly *funded*, but to a large extent privately *provided*. The Singaporean system has to be the only one in which it is almost the other way around, or at least in the hospital sector, where public hospitals account for three out of four hospital beds (Ramesh and Bali 2019: 50). However, publicly owned hospitals still operate under private law, are organisationally independent, and stand in competition with one another.

Like the Taiwanese system, the Singaporean system is an ideological mishmash. It contains market elements, but it is far from a pure market system. Ramesh and Bali (2017: 2) explain:

> [T]he Singapore government intervenes heavily and comprehensively in the health sector, especially after the unsatisfactory experience with corporatisation, deregulation and marketisation of the sector in the mid-1980s which saw a massive rise in costs […]
>
> The 1993 White Paper, which critically reviewed the 1980s reforms, bluntly noted: 'Market forces alone will not suffice to hold down medical costs to the minimum […] The Government […] needs to intervene to prevent an oversupply of services, to dampen unnecessary demand and ultimately, to control costs'.

The Singaporean government's philosophy is, broadly, that markets in healthcare can drive up quality and responsiveness to consumer demand, but they cannot keep down costs. The latter requires active government management.

In Taiwan's case (and to a lesser extent, South Korea's and Hong Kong's), we cannot specifically credit the healthcare system: much of the heavy lifting was done elsewhere.

Singapore, however, had a sustained period of very high infection rates. In Singapore's case, the healthcare system must have carried a large part of the weight.

We cannot say which specific features of the system enabled them to do this, but we can point to a few organisational innovations which may have helped. Singaporean healthcare providers came up with innovative solutions such as 'swab booths', which allowed mass testing without physical contact with healthcare workers, thus reducing the risk for the latter while minimising the need for PPE (Chua et al 2020: 4). Service delivery was reconfigured, and appointments reprioritised and rescheduled. Movement of healthcare workers between hospitals and medical teams was minimised: people worked in fixed teams, so that they only had close contact with one group of people. When one team had to isolate because of a suspected case in their midst, another team could take over seamlessly. As in many other sectors, a lot of activity was moved online, with video conferences replacing in-person appointments (ibid.).

It has to be said that Singapore's health system achieved its success, in part, by deviating from its general principles. Cost-sharing can be a useful tool when the aim is to limit overuse of healthcare services. But in the case of a pandemic, seeking healthcare has positive externalities. People who get tested quickly, and who quarantine in a medically supervised setting if in doubt, are not just benefitting themselves; they are also less likely to pass on the virus to others. The Singaporean government acknowledged this early on and pledged to underwrite the full cost of Covid-related healthcare. Private health insurers did the same (Chua et al 2020: 3). An exception was made for people who disregarded travel advice: they had to pay for their treatment.

The South Korean system is a national health insurance system and thus belongs to the same family of systems as the Taiwanese one. Of the Asian Tiger economies, only Hong Kong has a health system which one could describe as a distant relative of the NHS. There is a state-run hospital service, the Hospital Authority, which handles over four out of five hospital admissions and most specialist care (FHB 2017: 2; Jingwei He 2017: 3). Publicly provided healthcare is heavily subsidised: over 90 per cent of the cost is funded from general taxation (FHB 2017: 3; Jingwei He 2017: 4).

Nonetheless, private healthcare spending accounts for about half of the total healthcare spending (FHB 2017: 3). Just over two thirds of private spending consists of out-of-pocket payments, the remainder coming from voluntary private insurance and insurance-like health plans provided through the workplace (Jingwei He 2017: 3).

The healthcare systems in Italy and Spain struggled at least as much as the NHS, as evidenced by their exceptionally high excess mortality rates. Both countries have systems of state-run, tax-funded regional health services, effectively a regionalised version of the NHS. Again, one cannot specifically blame these countries' healthcare systems for their high death rates. Italy was the virus's first European port of call, at a time when Covid-19 was still not well understood, and over the course of March, the country's hospitals quickly filled up (Our World in Data 2021a). It would be unfair to present this as a failure of a particular type of healthcare system. But neither is it a ringing endorsement of that type of system.

In Europe, the system that has been most frequently singled out for its strong performance is the German one. Germany's cumulative excess death rate from March to December 2020 has been less than half of the British rate (based on Human Mortality Database 2021).
The German system is a universal social health insurance system, in which people can choose between about a hundred competing health insurers, and a number of different healthcare plans from each. Healthcare provision is mostly private: public hospitals, usually owned by the

regional or the municipal level, only account for two out of five hospital beds (see Niemietz 2016: 90-113).

One area in which the difference between the British and the German systems became particularly visible was the rolling out of mass testing in the critical early stages of the pandemic. Until late April, Germany was well ahead of the UK on that front, performing about twice as many tests per 100,000 people per day. The UK then drew level, and even overtook Germany in May, but by then, the peak of the first wave had already passed. The German system's high degree of market-orientation sped up the initial rollout. The aforementioned Coronavirus expert Dr Christian Drosten, who had been involved in the development of one of the first Covid-19 tests, explained:

> Public Health England was in a position to diagnose the disease very early on – we worked with them to make the diagnostic test – but rollout in Germany was driven in part by market forces, which made it fast, and that wasn't the case in the UK.[37]

But while the German system was indeed quick to build up testing capacity, the Swiss system, which is relatively similar to its northern cousin, got there even earlier (Our World in Data 2021c). Testing is, of course, just one aspect of a Covid-19 response strategy, and 'more' does not automatically mean 'better'. But the UK's initial sluggishness in this regard was, in some ways, symptomatic of the country's pandemic response as a whole.

The one redeeming feature of the UK's pandemic performance is clearly the very fast approval of the first Covid-19 vaccine at the end of 2020 and subsequently the fast rollout of the vaccination effort. This programme has so far been a phenomenal success. The UK was one of not even a handful of countries which started the year 2021 with 1 per cent of the population already vaccinated and then hit the ground running, scaling up the effort further from there. At the time of writing, the UK remains one of the world's top performers in this regard and *the* top performer in Europe by quite a margin. More than one in ten people have now been vaccinated, which is more than four times the share in Germany and Switzerland (see Table 4).

**Table 4: Percentage of the population that had been vaccinated against Covid-19 by 25 January 2021[38]**

| Country | % |
|---|---:|
| Israel | 46.7% |
| United Arab Emirates | 27.1% |
| UK | 10.8% |
| Bahrain | 8.5% |
| US | 6.9% |
| Malta | 4.8% |
| Iceland | 4.7% |
| Germany | 2.3% |
| Switzerland | 2.3% |
| Canada | 2.2% |

Source: Our World in Data (2021d)

[37] Cited by Kealey, T. in 'Britain's original pandemic sin', *IEA Blog*, 4 August 2020 (https://iea.org.uk/britains-original-pandemic-sin/).

[38] Technically, this shows the number of vaccine *doses* that have been administered, not the number of *people* who have been vaccinated. But since relatively few people have received their second dose yet, we can so far treat them as more or less interchangeable. This will, of course, soon cease to be the case.

All in all, we cannot say that any one type of healthcare system emerges as the clear star of the pandemic, or that any one type of system has been discredited. There is simply too much variation within each family of systems. The state-run health services of the UK, Spain and Italy have been struggling throughout 2020. The state-run health services of Denmark, Norway and Finland have not. Germany's market-based social health insurance system has passed the 'Covid test'. But its 'first cousins', the Swiss and the Dutch systems, have recorded elevated excess death rates and its 'second cousin', the Belgian system, has suffered just as badly as the NHS. National insurance systems have held up well in Taiwan, South Korea and Australia, but far less so in France. The NHS deserves some credit for the fast vaccine rollout. But NHS-type systems elsewhere remain sluggish on this front, while the undisputed star of the vaccine rollout is the Israeli system, a system of competing Health Maintenance Organisations (see Niemietz 2016: 115-117).

One way or another, this is simply not the material that grand narratives are made of. What is safe to say is that there is no rational basis for the adulation the NHS is currently receiving, and no reason to be 'grateful' for the fact that we have it. It should go without saying that if the UK did not have the NHS, it would not have *no* healthcare system. It would have a different healthcare system. Maybe it would have a public health insurance system similar to the Taiwanese or the Australian one, or maybe it would have a social health insurance system similar to the Swiss or the German one. There is no guarantee that this would have served the UK better during the pandemic, but there is certainly no reason to believe that it would have done any worse. There is nothing special about the NHS, neither during this pandemic, nor at any other time.

## Conclusion

At the time of writing, people are still dying from Coronavirus in their thousands every week, much of the British economy remains in hibernation, and an end to the current lockdown is still not in sight. On any objective measure, the Covid-19 situation remains bleak.

And yet, a cautious optimism is entirely justified. An end is in sight. More than one in ten people have been vaccinated and it looks as if the vaccination effort is going to be sustained. This time, the UK is ahead of the curve, as one of the world leaders of the vaccination drive.

It may just be one redeeming feature after a long litany of failures, but then, if that one feature is *the* factor which changes everything – one redeeming feature is all it takes. Once enough people have been vaccinated, past policy failures no longer matter. We then no longer need a functioning track-and-trace system, we no longer need an effective quarantining strategy, we no longer need additional hospital capacity, we no longer need consistent and comprehensible scientific advice, and we no longer need to sort out the flaws in the tier system.

The only way in which Covid-19 could have long-term effects that will still be with us years or decades from now is if it leads to long-term shifts in the climate of ideas. It would not be the first time. Historically, pandemics have often accelerated pre-existing trends in the *zeitgeist*.

Perhaps the main ideological shift of the past decade is that large sections of British society have become increasing hostile to capitalism and economic liberalism. This manifests itself in various ways. On the political Left, it manifests itself in a crowding-out of market-friendly social democracy and a resurgence of socialism as a mainstream ideology. On the political Right, it manifests itself in the rise of an aggressively anti-liberal communitarianism and economic nationalism.

These trends existed before the pandemic, and Covid-19 has fuelled both of them because proponents of these styles of thinking have interpreted Covid as further confirmation for their worldviews. The former see Covid as yet further confirmation for their belief that Britain needs a much larger and much more active state. The latter see Covid as yet further confirmation that Britain needs to turn its back on free trade and strive for greater self-sufficiency. Both see Covid as yet further confirmation that the NHS is the ‘envy of the world’ and that we must cherish it ‘more than ever’.

But Covid-19 does not show anything of that sort. A country’s Covid performance, whether in terms of health outcomes or economic outcomes, is neither correlated with the size of the state, nor with its trade policy, nor with the type of healthcare system it has. Some of the best performers have small states, open economies, and healthcare systems that are not at all similar to the NHS. Some of the worst performers have large states, economies that are not particularly globalised, and healthcare systems that are fairly similar to the NHS.

The best performers got specific things right. For example, they got large-scale testing off the ground quickly, they came up with effective systems of contact-tracing and tracking, they rigorously enforced quarantining and self-isolation requirements (coupled with financial support to make this feasible), and they imposed selective travel restrictions. These are some of the practical measures that constitute an effective pandemic response. A wholesale restructuring of a country’s entire socio-economic system is not. It is neither necessary, nor sufficient.

A pandemic is, if not literally ‘historically unprecedented’, then at the very least, an extremely unusual situation. Short of the law of gravity, it upends all the rules that make sense during normal times. And yet, this exceptionality of the situation has not been reflected in our national

conversation around Covid-19. Too many commentators have seamlessly integrated Covid into the ideological battles they are always fighting and turned it into just another angle to make the arguments they always make. This tendency is perhaps best exemplified by *Guardian* columnist George Monbiot. Without a hint of irony, Monbiot wrote in May 2020 that 'Coronavirus shows us it's time to rethink everything'.[39] Yet throughout the pandemic, Monbiot continued to make similar arguments to the ones he always makes, except this time with a 'Covid spin'.

The Covid-19 pandemic may be a once-in-a-century 'black swan' event. If you interpret it as just another confirmation of everything you already believe and just another reason to double down on those beliefs, chances are that you are not being entirely honest with yourself and others.

[39] 'Coronavirus shows us it's time to rethink everything. Let's start with education', *Guardian*, 12 May 2020 (https://www.theguardian.com/commentisfree/2020/may/12/coronavirus-education-pandemic-natural-world-ecology).

## References


Budget Direct (2020) Singapore Tourism Statistics 2020 (https://www.budgetdirect.com.sg/travel-insurance/research/singapore-tourism-statistics).

Bureau of Consular Affairs (2020) Entry restrictions for foreigners to Taiwan in response to COVID-19 outbreak. Ministry of Foreign Affairs, Republic of China (Taiwan) (https://www.boca.gov.tw/cp-220-5081-c06dc-2.html).

Cheng, T. (2015) Reflections on the 20th anniversary Of Taiwan's single-payer national health insurance system. *Health Affairs* 34(3): 502-510.

Chua, A., Mei Jin Tan, M., Verma, M., Kai Lin Han, E., Yang Hsu, L., Cook, A., Ying Teo, Y., Lee, V. and Legido-Quigley, H. (2020) Health system resilience in managing the COVID-19 pandemic: lessons from Singapore. *BMJ Global Health* 5(9) (https://gh.bmj.com/content/5/9/e003317).

Davies, S. and Kamall, S. (2020) Chinese Puzzle: A classical liberal approach to post-pandemic relations with China. Covid-19 Briefing no. 11. London: Institute of Economic Affairs (https://iea.org.uk/publications/chinese-puzzle-a-classical-liberal-approach-to-post-pandemic-relations-with-china/).

du Plessis, L., McCrone, J., Zarebski, A., Hill, V., Ruis, C., Gutierrez, B., Raghwani, J., Ashworth, J., Colquhoun, R., Connor, T., Faria, N., Jackson, B., Loman, N., O'Toole, Á., Nicholls, S., Parag, K., Scher, E., Vasylyeva, T., Volz, E., Watts, A., Bogoch, I., Khan, K., Aanensen, D., Kraemer, M., Rambaut, A. and Pybus, O. (2020) Establishment & lineage dynamics of the SARS-CoV-2 epidemic in the UK. *medRxiv* (https://www.medrxiv.org/content/10.1101/2020.10.23.20218446v1).

FHB (2017) Strategic Review on Healthcare Manpower planning and professional development. Food and Health Bureau, Hong Kong Special Administrative Region Government.

FHB (n.d.) Domestic Health Accounts. Food and Health Bureau, Hong Kong Special Administrative Region Government (https://www.fhb.gov.hk/statistics/en/dha/dha_summary_report.htm).

Global Edge (2020) Trade Statistics (https://globaledge.msu.edu/countries/south-korea/tradestats & https://globaledge.msu.edu/countries/singapore/tradestats).

Grey, S. and Macaskill, A. (2020) In shielding its hospitals from COVID-19, Britain left many of the weakest exposed. Reuters Special Report (https://www.reuters.com/investigates/special-report/health-coronavirus-britain-elderly/).

HM Treasury (2020) Trends in public spending. Public Spending Statistics release: July 2020 (https://www.gov.uk/government/statistics/public-spending-statistics-release-july-2020).

Hollander, P. (1981) *Political Pilgrims: Travels of Western Intellectuals to the Soviet Union, China, and Cuba.* London: Routledge.

Human Mortality Database (2021) Short-term mortality fluctuation data series (STMF) (https://www.mortality.org/Public/STMF/Outputs/stmf.xlsx).

IMF (2020a) Real GDP growth: Annual percent change. Washington, D.C.: International Monetary Fund (https://www.imf.org/external/datamapper/NGDP_RPCH@WEO/BRA?year=2020).

IMF (2020b) Report for Selected Countries and Subjects: October 2020. World Economic Outlook Database, World Economic and Financial Surveys (https://www.imf.org/en/Publications/WEO/weo-database/2020/October).

Jingwei He, A. (2017) Introducing voluntary private health insurance in a mixed medical economy: are Hong Kong citizens willing to subscribe? *BMC Health Services Research* 17: 603.

Johns Hopkins Center for Health Security, Nuclear Threat Initiative and The Economist Intelligence Unit 2019 (2019) Global Health Security Index. Building Collective Action and Accountability (https://www.ghsindex.org/wp-content/uploads/2020/04/2019-Global-Health-Security-Index.pdf).

Jones, O. (2020) *This Land: The Story of a Movement.* London: Allen Lane.

Kekst CNC (2020) COVID-19 Opinion Tracker. Research Report (https://www.kekstcnc.com/covid-19/responding-to-covid-19).

Lesh, M. (2020) Testing Times. The urgent need to decentralise COVID-19 diagnostic testing in the United Kingdom. Briefing Paper. London: Adam Smith Institute (https://www.adamsmith.org/research/testing-times).

Malhotra, A. (2020) *The 21-Day Immunity Plan. How to rapidly improve your metabolic health and resilience to fight infection.* London: Yellow Kite.

Ministry of Health and Welfare (2020) National Health Expenditure, 2018 NHE Statistical Tables. Taiwan (https://www.mohw.gov.tw/cp-130-51491-2.html).

Ministry of Health Singapore (2020) Government Health Expenditure and Healthcare Financing (https://www.moh.gov.sg/resources-statistics/singapore-health-facts/government-health-expenditure-and-healthcare-financing).

Ministry of Trade and Industry Singapore (2020) MTI Narrows 2020 GDP Growth Forecast to '-7.0 to -5.0 Per Cent'. SingStat (https://www.singstat.gov.sg/-/media/files/news/gdp2q2020.pdf).

Mishra, P. (2020) Flailing states. *London Review of Books* 42(14) (https://www.lrb.co.uk/the-paper/v42/n14/pankaj-mishra/flailing-states).

NHIA (2020) 2020-2021 Handbook of Taiwan's National Health Insurance. National Health Insurance Administration, Ministry of Health and Welfare.

NHS England (2020) Consultant-led Referral to Treatment Waiting Times Data 2020-21 (https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-data-2020-21/).

New Scientist (2020) England & Wales had most excess deaths in Europe's covid-19 first wave. 14 October 2020 (https://www.newscientist.com/article/2256986-england-wales-had-most-excess-deaths-in-europes-covid-19-first-wave/#ixzz6kebaMitY).

Niemietz, K. (2016) *Universal Healthcare without the NHS: Towards a Patient-Centred Health System*. London: Institute of Economic Affairs.

OECD (2020) General government spending, OECD Data. Paris: OECD (https://data.oecd.org/gga/general-government-spending.htm).

ONS (2018) Who does the UK trade with? Newport: Office for National Statistics (https://www.ons.gov.uk/businessindustryandtrade/internationaltrade/articles/whodoestheuktradewith/2017-02-21).

ONS (2019) Geographical breakdown of the current account, The Pink Book. Newport: Office for National Statistics (https://www.ons.gov.uk/economy/nationalaccounts/balanceofpayments/datasets/9geographicalbreakdownofthecurrentaccountthepinkbook2016).

ONS (2020) GDP monthly estimate, UK: August 2020. Newport: Office for National Statistics (https://www.ons.gov.uk/economy/grossdomesticproductgdp/bulletins/gdpmonthlyestimateuk/august2020).

Our World in Data (2021a) Coronavirus Pandemic (COVID-19) (https://ourworldindata.org/coronavirus).

Our World in Data (2021b) Excess mortality during the Coronavirus pandemic (COVID-19) (https://ourworldindata.org/excess-mortality-covid).

Our World in Data (2021c) Coronavirus (COVID-19) Testing (https://ourworldindata.org/coronavirus-testing).

Our World in Data (2021d) Coronavirus (COVID-19) Vaccinations (https://ourworldindata.org/covid-vaccinations).

Our World in Data (2021e) COVID-19: Stay-at-home restrictions (https://ourworldindata.org/covid-stay-home-restrictions)

Pak, J. (2020) Trying to loosen the linchpin: China's approach to South Korea. Global China.

Ramesh, M. and Bali, A. (2019) The Remarkable Healthcare Performance in Singapore. In *Great Policy Successes* (eds. Hart, P. and Compton, M.). Oxford: Oxford University Press.

Ramesh M. and Singh Bali, A. (2017) The healthcare system in Singapore. Singapore: Lee Kuan Yew School of Public Policy (https://lkyspp.nus.edu.sg/gia/article/the-healthcare-system-in-singapore).

Snowdon, C. (2020a) False Economies: Myths about public health spending. Covid-19 Briefing no. 3. London: Institute of Economic Affairs (https://iea.org.uk/publications/false-economies/).

Snowdon, C. (2020b) You Had One Job: The shortcomings of Public Health England and the World Health Organization during the Covid-19 pandemic. Covid-19 Briefing no. 14. London: Institute of Economic Affairs (https://iea.org.uk/publications/you-had-one-job-the-shortcomings-of-public-health-england-and-the-world-health-organization-during-the-covid-19-pandemic/).

Taiwan Bureau of Trade (n.d.) Trade statistics (https://cuswebo.trade.gov.tw/FSCE050F/FSCE050F).

Taiwan Government (n.d.) Cross-strait relations. Fact focus (https://www.taiwan.gov.tw/content_6.php).

Tin, K., Tsoi, P., Lee, Y., Chong, D., Lam, D., Yeung, A., Ma, E. and Maw, C. (2015) Hong Kong domestic health spending: financial years 1989/90 to 2011/12. *Hong Kong Medical Journal* 21(3): 1-24.

Trade and Industry Department (2020a) Hong Kong's Principal Trading Partners in 2019 (https://www.tid.gov.hk/english/trade_relations/mainland/trade.html).

Trade and Industry Department (2020b) Hong Kong and mainland of China: some important facts. Press releases, speeches and publications (https://www.tid.gov.hk/english/aboutus/publications/factsheet/china.html).

Trading Economics (2020) GDP Annual Growth Rate - Forecast 2020-2022 (https://tradingeconomics.com/south-korea/government-spending-to-gdp); (https://countryeconomy.com/countries/compare/hong-kong/singapore).

Wang, C., Ng, C. and Brook, R. (2020) Response to COVID-19 in Taiwan: Big Data Analytics, New Technology, and Proactive Testing. *JAMA* 323(14): 1341-1342.

WHO (n.d.) Singapore. Statistics. Geneva: World Health Organization (https://www.who.int/countries/sgp/).

Worldometers (2020) Covid-19 Coronavirus Pandemic (https://www.worldometers.info/coronavirus/).

Worldometers (2021) Covid-19 Coronavirus Pandemic (https://www.worldometers.info/coronavirus/).

*IEA Briefing Papers are designed to promote discussion of economic issues and the role of markets in solving economic and social problems. As with all IEA publications, the views expressed are those of the author and not those of the Institute (which has no corporate view), its managing trustees, Academic Advisory Council or other senior staff.*