



CASE STUDY ANALYSIS REPORT

Comparative Report: COVID-19 LEADERSHIP RESPONSES

BISMA AMIN

Student ID: 2435002

Programme: MSc Public Health and Social Care in Practice

Module Title: Health Care System, Organisation and Leadership

Module Code: LCHS7002

Lecturers: Shepherd Ziko, Dr Christopher Mafuva

Assignment Title: Case Study Analysis Report



Executive Summary

This report looks at how Spain, South Korea & Canada organised their healthcare systems and led their responses to the COVID-19 pandemic. Public health systems literature, crisis leadership theory, and COVID-19 epidemiological data substantiate the analysis (WHO, 2020; OECD, 2021). The typology of each country's healthcare system, the level of centralisation and decentralisation in their pandemic responses, and the leadership styles of Salvador Illa for Spain, Chung Sye-kyun for South Korea, and Justin Trudeau for Canada are examined (Greer et al., 2020). Initially, coordination challenges confronted Spain's decentralised health system (Legido-Quigley et al., 2020). South Korea, on the other hand, was able to quickly contain the disease because it had a centralised system for controlling it (Moon, 2020). Canada's highly decentralised federal system posed coordination challenges but ultimately led to widespread vaccinations (Marchildon & Di Matteo, 2021). The report critically analyses the strengths and weaknesses of the organisational and leadership frameworks of each system and concludes with a reflection on the significance of governance structures in shaping responses to public health emergencies (Ansell, Boin, & Kuipers, 2014).

Ansell, C., Boin, A., and Kuipers, S. (2014) Managing transboundary crises: Identifying the components of an efficient response system. *Journal of Contingencies and Crisis Management*, 22(4), pp. 195–207.

Greer, S.L., King, E.J., da Fonseca, E.M., and Peralta-Santos, A. (2020) The comparative politics of COVID-19: The necessity of comprehending governmental responses. *Global Public Health*, 15(9), pp. 1413–1416.

Legido-Quigley, H., Mateos-García, J.T., Campos, V.R., Gea-Sánchez, M., Muntaner, C., and McKee, M. (2020) The study focuses on the ability of the Spanish health system to withstand the COVID-19 pandemic. *The Lancet Public Health*, 5(5), pp. e251–e252.

Marchildon, G.P. and Di Matteo, L. (2021) *Health systems in transition: Canada*. University of Toronto Press in Toronto.

Moon, M.J. (2020) Combatting COVID-19 through agility, transparency, and engagement: Complex policy dilemmas and emerging governance challenges. *Public Administration Review*, 80(4), pp.651–656.

https://eaesp.fgv.br/sites/eaesp.fgv.br/files/pesquisa-eaesp-files/arquivos/the_comparative_politics_of_covid_19_the_need_to_understand_government_responses.pdf

https://papers.ssrn.com/sol3/papers.cfm?abstract_id=1450738

[https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667\(20\)300608/fulltext](https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(20)300608/fulltext)

<https://pmc.ncbi.nlm.nih.gov/articles/PMC7267241/>

1. Introduction

The COVID-19 pandemic necessitated the swift mobilisation of healthcare systems, the coordination of public health infrastructure, and the implementation of adaptive leadership by governments in response to an unprecedented global crisis. This report compares Spain, South Korea, and Canada, three countries with different types of healthcare systems, ways of running the government, and ways of leading. The report evaluates the efficacy of each country's pandemic strategies by analysing the organisation of their health system responses and the use of centralised or decentralised mechanisms. It also identifies systemic factors that affect decision-making at both national and regional levels.

The two most important aspects of organisations that govern public health are centralisation and decentralisation. Centralisation means national structures have the most power to make decisions, which usually means policies can be implemented more quickly and standards can be set more uniformly. Decentralisation, on the other hand, empowers regional or provincial jurisdictions, which can lead to more relevant interventions, but it also makes coordination harder and raises questions about consistency. Saltman et al. (2016) say that knowing how much each country depended on these structures can help us understand why national responses were different in terms of speed, coherence, and public health effects.

The following sections offer a comprehensive, evidence-based analysis of the healthcare system and organisational responses in each country during COVID-19, followed by a critical leadership evaluation to determine the impact of political and executive leadership on pandemic outcomes. We finish the report with a summary of the main points about how governance structures and leadership choices worked together to shape how the country responded to the pandemic.

2. Critical Analysis of Each Country's Typology & Systems Approach for the COVID-19 Pandemic



2.1 Spain: Healthcare System Typology and COVID-19 Systems Response

From January 2020 to March 2020, Spain's response was characterised by delays in enforcing restrictive measures, inadequate testing capacity, and shortages of personal protective equipment (PPE) (García-Basteiro et al., 2020; The Lancet, 2020). Salvador Illa, the Minister of Health, assured the public on January 30, 2020, that the system was ready and that communication would be clear. However, evidence shows that community transmission is happening faster than the risk assessment suggests (Candel et al., 2021). These delays were worsened by the fact that the system was decentralised, which means different regions reported data in very different ways and had different levels of surveillance and readiness. For instance, Madrid and Catalonia saw very high spikes, which were partly due to differences in how people moved around the region and how early tests were done (Ministry of Health Spain, 2020).

Despite initial setbacks, Spain emerged as a leader in European vaccination by the end of 2021. All areas followed the same national vaccination plan, which led to high compliance and public trust. More than 80% of the population had received all vaccinations by the fall of 2021.

In short, Spain's healthcare system was highly decentralised and had uneven regional capabilities, which is why it had so many problems at the start of the pandemic. Emergency centralisation fixed some of the system's weaknesses, but the initial delays led to very high death rates. However, the pandemic's later stages have demonstrated Spain's ability to establish robust national coordination, particularly in its successful vaccination rollout.

2.2.1 Analysis of Centralised and Decentralised Approaches in Spain

Spain represents an entirely unique case. Its system is mostly decentralised, but it temporarily switched to a centralised model during an emergency. Decentralisation caused problems with surveillance, procurement, and early containment up until March 2020. The scholarly assessment says that decentralised governance, without strong coordination mechanisms, slows down unified responses and makes it harder to be ready for a crisis. Differences between regions in testing strategies and methods, laboratory capacity, and risk communication led to inconsistent mitigation measures in the first few months.

But decentralisation also had some advantages. Some of the autonomous communities, such as Galicia and the Basque Country, had already taken steps to stop the virus before national orders were given. It shows how decentralised systems can change their responses based on local epidemiological situations. But in a pandemic that moves quickly and spreads viruses exponentially, the need for uniformity across the country outweighed the benefits of tailored responses.

As the pandemic went on, Spain switched to a hybrid model. After the first wave, decentralisation was partially restored, with regions once again taking charge of containment measures, but this time with stronger national coordination frameworks. This hybrid structure was the backbone of Spain's very successful vaccination rollout. Strong national leadership, clear communications, and scientific advice support decentralised systems and demonstrate their effectiveness.

In general, the Spanish case shows that decentralisation without strong coordination can make it difficult to respond quickly to pandemics.



2.2 South Korea: Typology of the Healthcare System and COVID-19 Systems Response

When the COVID-19 pandemic started, South Korea's healthcare system was known for having a strong central public health authority, well-developed digital infrastructures, and experience dealing with outbreaks of infectious diseases like SARS in 2003 and MERS in 2015. The Korean Disease Control and Prevention Agency helps the National Health Insurance Service run the healthcare system from its main office. Private companies own more than 90% of hospitals and provide the majority of health care. However, public health heavily centralises the monitoring and management of infectious diseases (OECD, 2022). This structural model made South Korea ready to act quickly when COVID-19 hit.

Following the confirmation of the first COVID-19 case on January 20, 2020, South Korea instituted a stringent plan to curb the virus's spread. The plan encompassed early testing, digital surveillance, and open communication. Unlike many Western countries, South Korea avoided nationwide lockdowns. Instead, it used targeted containment based on real-time epidemiological data (Shim et al., 2020). The quick activation of the KDCA's infectious disease protocols was a key part of the response. Within days, South Korea allowed private labs to make diagnostic PCR tests, which made it possible to test many people at once, something that hadn't been done before in early 2020. The country established drive-through and walk-through testing centres to reduce hospital-acquired infections and expedite case identification.

The government's digital infrastructure was one of the most important things. After the 2015 MERS outbreak, the Infectious Disease Control and Prevention Act was changed to provide officials the power to acquire access to anonymous credit card transactions, mobile phone data, and CCTV footage to help with contact tracing. This incident raised a lot of international concern about privacy, but the South Korean approach had important epidemiological benefits because it quickly broke up

transmission chains. Park et al. (2020) reported widespread acceptance of this approach. It is generally accepted due to longstanding social norms, which include prioritising groups' needs and trusting public institutions.

Prime Minister Chung Sye-kyun's leadership stressed openness, daily public briefings, and coordination between ministries. People were always told to respect citizens, be clear about case numbers, and explain new measures. People all over the world praised the government's communication strategy. In early 2020, the WHO praised South Korea's approach to handling pandemics. It's important to note that there were no nationwide lockdowns. Instead, the country implemented a flexible social distancing framework, adaptable to the extent of the virus's spread in each area.

At first, the vaccination rollout was slower than in other OECD countries because it took longer to get early vaccine contracts. However, the country sped up its deliveries to achieve a high vaccination rate after improving procurement negotiations and adding more mass vaccination centres across the country by the end of 2021 (KDCA, 2021). Therefore, South Korea's response to the pandemic was to contain it early on and then suppress it later with vaccines.

The way healthcare works in South Korea, with centralised public health governance and decentralised service delivery, has made it possible to respond quickly, creatively, and in a coordinated way. The system's readiness, technological infrastructure, and high level of transparency were the main reasons why South Korea's death rates were lower than those in Europe and North America.

2.2.1 Centralised and Decentralised Approaches in South Korea - An Analysis

South Korea took a mostly centralised approach to pandemic governance, with the help of a strong national public health authority (KDCA), emergency laws, and coordinated action between ministries. Centralisation made it possible to make quick decisions, have the same rules for the whole country, and quickly put into action surveillance systems that were made after MERS. One of the main benefits of this approach was that it quickly increased testing capacity. South Korea approved testing kits in just a few weeks, long before most Western countries were dealing with regulatory and capacity issues (Shim et al., 2020). Centralization also made it possible for the KDCA, police, telecommunications

companies, and financial services to share data in a coordinated way through integrated platforms. These technologies made real-time contact tracing possible.

However, decentralisation was also vital. While public health authorities were centralised, disease control measures were tailored regionally based on local epidemiology in the country's decentralised municipal governments. For example, when community transmission was high, local governments could take stronger steps, like closing businesses for a short time or limiting gatherings. This mixed model of coexistence allows for interventions that are specific to each situation and keeps national coordination through the KDCA.

Due to the widespread use of monitoring technologies, centralised management could spark a public outcry about data privacy. Despite anonymising the data, extensive tracking sparked discussions among human rights organisations. One problem was how the vaccines were bought at first. Because they were bought centrally, regional governments couldn't make up for delays at the national level. But once the supply stabilised, the same central coordination made it possible to quickly scale up vaccinations.

In general, South Korea's response to the pandemic shows how strong a centralised public health system can be when supported by decentralised delivery. Central leadership made sure that protocols were the same everywhere and that mobilisation happened quickly. Local governments were flexible enough to make changes based on the situation. This balance was the reason South Korea was able to contain the virus early on and keep it under control in the waves that followed.



2.3 Canada: Typology of the Healthcare System and COVID-19 Systems Response

Canada has one of the most decentralised healthcare systems in any high-income country. The provinces and three territories are responsible for providing health care. The federal government pays for health care, controls drugs, manages border security, and coordinates national public health functions through the Canadian Public Health Agency. It is a single-payer system that is paid for by the government through general taxes, and it must obey the rules set out in the Canada Health Act. This high level of provincial autonomy leads to many differences in how health systems are set up, how resources are shared, and how public health responds in and between jurisdictions.

The prime minister, Justin Trudeau, led the federal government with a focus on unity, working with other governments, and making decisions based on evidence. Daily national briefings ensured that everyone was in agreement. Trudeau didn't have the constitutional power to unilaterally impose health measures across Canada, so he had to rely on the provinces to follow federal guidelines on their own. This decentralised model lets provinces respond based on local epidemiology, but it doesn't work in all cases. For example, Atlantic Canada put strict border controls in place to achieve some of the lowest transmission rates in North America. In contrast, populous provinces like Ontario had to endure repeated outbreaks and strain on the healthcare system (Rice et al., 2021).

Canada's testing and tracing strategies also varied a lot from province to province, depending on how many labs were available and how strong the public health workforce was. Some provinces, like Alberta and British Columbia, had strong early capacity, while others had long backlogs. Long-term care facilities emerged as a significant vulnerability nationwide, accounting for over 80% of COVID-19 fatalities during the initial wave, one of the highest proportions among OECD countries (Canadian Institute for Health Information, 2020). Some structural problems that led to this crisis included insufficient staff, outdated infrastructure, and unclear accountability.

2.3.1 Analysis of Centralized and Decentralized Approaches in Canada

Canada's constitutional division of powers significantly influenced the handling of the pandemic. This gave provinces the main responsibility for healthcare. The benefits of decentralisation include the ability to tailor responses to provincial needs based on local patterns of disease spread. For instance, the Atlantic provinces had strict travel "bubbles" and had a lot fewer cases than central Canada. In the same way, northern regions that are far away added extra protections to keep Indigenous communities safe, since they don't have a lot of access to health care.

But decentralisation's also been extremely unfair. The timing of lockdowns, mask mandates, reopening plans, and the speed of vaccinations varied across different provinces. These inconsistencies led to health outcomes that didn't become better for everyone. Long-term care failures in Ontario and Quebec demonstrate how decentralised supervision and a lack of robust national standards can exacerbate systemic deficiencies. (Estabrooks et al., 2020).

Centralisation has benefits like equal vaccine distribution, consistent border policies, and a unified federal message. But there were many problems with this approach. For example, federal guidelines were not binding, and provinces could often ignore recommended public health measures to protect their own political or economic interests. Sometimes, broken communication makes people unsure of what to expect.

Canada's response to the pandemic demonstrates the strengths and weaknesses of decentralised federalism. Decentralisation enables contextual flexibility, but it necessitates effective coordination among governments to ensure equitable and consistent treatment for all. When coordination mechanisms were in place, such as when purchasing vaccines, the system functioned effectively. Weak mechanisms, such as the disintegration of the long-term care regulation system, led to negative outcomes.

3. Critical Analysis of Leadership Styles in Each Country



3.1 Leadership Style in Spain: **Salvador Illa**

From January 2020 to January 2021, Salvador Illa was Spain's Minister of Health. He was responsible for the country's response to COVID-19 in the early stages of the pandemic. It is important to understand his leadership style in the context of Spain's healthcare system, which is highly decentralised and assigns a lot of power to autonomous communities (ACs) to run healthcare. Because of this, Illa's job was to coordinate things rather than issue direct orders, which was a very difficult job to do during a rapidly growing global health crisis.

From a leadership theory perspective, Illa's style showed traits of situational and bureaucratic leadership, as well as transactional leadership during the phase of emergency centralisation. Initially, Illa carefully considered the needs of the institution when making decisions. He relied heavily on technical advice from the ministry's scientific committees. His early messages stressed being calm, being fair, and knowing how to run a business, which is a typical bureaucratic stance. On January 30, 2020, he said in public that Spain was ready and that communication would stay open. This strategy was meant to build public trust, but later analysis indicates that it didn't take into account how big and urgent the threat was (Candel et al., 2021).

The decision to centralise power under the emergency decree was a change in Illa's leadership style, moving from a hands-off, bottom-up approach to a more directive, top-down one. Crisis leadership literature indicates that in acute emergencies, centralised command structures can improve coherence and expedite responses (Ansell & Boin, 2019). Illa's emergency leadership included nationwide

lockdowns, centralised purchasing, and consistent public health messaging. This sudden change, while necessary, caused political problems for regional leaders who saw the central government as a violation of their constitutional authority. The friction shows how challenging it is to use hierarchical commands in decentralised systems, where local autonomy is critical.

The rise of distributed leadership in Spanish health and scientific institutions also aided Illa's leadership. Expert committees, intergovernmental working groups, and regional health bodies collaborated to plan logistics, establish schedules, and monitor data. Evidence suggests that distributed leadership bolsters resilience in complex health systems by leveraging expertise across multiple tiers (Fitzgerald et al., 2013). In Spain, the distributed model worked much better for vaccination than it did for early containment. This improvement was mostly because the national government set up better ways to coordinate.

In short, Illa's leadership during COVID-19 went from careful bureaucratic management to quick central command and then to working together and using science to guide decisions. The effectiveness of these styles varied: early delays led to very negative results, but later adaptability allowed Spain to become a leader in vaccinations. Illa's case shows that the effectiveness of a leader depends on more than just their personal style. It also depends on the government structure, system limitations, and intervention timing.



3.2 Leadership Style in South Korea: **Prime Minister Chung Sye-kyun**

Prime Minister Chung Sye-kyun significantly shaped South Korea's pandemic response, which has gained international recognition. Prime Minister Chung Sye-kyun's leadership style was a mix of transformational, adaptive, and collaborative leadership, as well as openness, cooperation between sectors, and trust in the government. South Korea's governance system was very centralised when it came to public health surveillance but decentralised when it came to healthcare delivery. These characteristics necessitated the leader's ability to unite the country and coordinate institutions at various levels.

Chung's dedication to open communication during times of crisis marked his leadership. Daily public briefings offered comprehensive updates on cases, contact tracing results, and new regulations. Studies have shown that clear communication increases compliance, cuts down on false information, and builds trust, all of which are important for public health interventions to work (Van Bavel et al., 2020). Chung's way of communicating built public trust by showing respect, openness, and responsibility. His constant talk about social solidarity and collective responsibility showed transformational leadership, which inspires people by sharing a vision and values.

Chung also showed strong adaptive leadership, which is a way of leading that focuses on trying new things, making decisions based on evidence, and being flexible when things are unclear (Heifetz et al., 2009). Korea's quick changes to its policies, drive-through testing centres, community treatment centres, and digital surveillance tools showed how to adapt to problems. The Korean response was different from rigid bureaucratic systems because it let both central and local authorities try out new ideas and quickly spread successful ones across the country. Adaptive leadership also means getting

people with different skills to work together. Chung ensured the participation of epidemiologists, data scientists, technologists, and healthcare professionals in decision-making processes.

One of the primary problems for Chung's leadership was finding a balance between protecting people's privacy and protecting public health. Korea's widespread use of digital contact tracing, such as credit card records and CCTV data, led to debates around the world. However, the majority of Korea's population accepted these measures due to longstanding norms prioritising the well-being of the group and the government's clear explanation of reasons, protections, and limits regarding data use (Park et al., 2020). This study shows how society's values affect leaders' acceptance and performance.

Korea didn't have nationwide lockdowns, but Chung's leadership focused on a flexible social distancing framework that changed rules based on real-time epidemiological trends. This method showed situational leadership by changing the style and interventions based on how threatening the situation was becoming. Leaders swiftly transitioned between supportive and directive styles when outbreaks occurred in specific areas.

Overall, Chung Sye-kyun showed leadership that was open, based on facts, flexible, and very collaborative. These traits fit well with Korea's public health governance systems and the way society works. Korea's low death rate, lack of nationwide lockdowns, and strong international recognition show how well he leads. His case shows how important adaptive and transformational leadership is for dealing with complicated health crises in technologically advanced and centrally managed public health systems.



3.3 Leadership Style in Canada: **Prime Minister Justin Trudeau**

Canada's pandemic leadership under Prime Minister Justin Trudeau took place in a federal health system that was highly decentralised, which meant that the provinces had a lot of power while the national government had less. Trudeau's style of leadership was a mix of transformational leadership that brought people together, collaborative federalism, and symbolic crisis leadership. He focused on compassion, unity, and shared responsibility. But the limits of federalism affected both the beneficial and negative parts of his approach.

Trudeau's early leadership during the pandemic was mostly about communicating with empathy. This included conducting daily press briefings, recognising people's fears, and calling for national unity. Empathy is an important part of transformational leadership because it builds trust and unity during tough times (Bass & Riggio, 2006). Trudeau's message stressed that "we are all in this moment together," which indicated that everyone is responsible. This style helped people support the early steps, like closing the borders and requiring people to stay in quarantine.

On the other hand, Trudeau didn't have the constitutional power to impose national health orders, like leaders in more centralised systems do. This meant that federal, provincial, and territorial governments had to work together and share leadership. This model, often called "collaborative federalism" requires negotiating, building consensus, and making decisions together. Trudeau's leadership was all about getting different levels of government to work together. He did this through things like the First Ministers' Meetings and the Special Advisory Committee on COVID-19. These structures allowed the provinces agreed on broad strategies, but they could not prevent each other from implementing them

differently.

From a crisis leadership perspective, Trudeau was effective at getting resources and support from other governments. The federal government implemented a number of large financial programmes, such as the Canada Emergency Response Benefit (CERB) and wage subsidies, to help families and businesses during lockdowns. During the first outbreaks, the federal military was sent to long-term care homes in Ontario and Quebec. These events showed how the federal government can help solve problems in the provinces.

One of Canada's most significant successes is Trudeau's leadership in getting vaccines. The federal government used an aggressive procurement strategy to secure contracts with several manufacturers because it knew that the country didn't have enough manufacturing capacity. Canada's early vaccine rollout was slower than that of countries that made their own vaccines, but by the middle of 2021, Canada had one of the highest vaccination rates in the world (Murray & Henderson, 2021). This result indicates that there was strong central coordination of supply chains, military logistics, and distribution, as well as strategic, forward-looking leadership.

Trudeau's leadership also showed some signs of moral and symbolic leadership, especially when he spoke out against the unfair treatment of Indigenous communities, essential workers, and people of colour. The federal government set up programmes like the Indigenous Community Support Fund, but these would only work if the provinces worked together. The literature on leadership emphasises the necessity of structural changes that support symbolic gestures. Canada's mixed results in dealing with unfairness show this tension.

Trudeau's leadership during COVID-19 was kind, brought people together, and worked well with others. He was adept at talking to people, getting resources, and getting vaccines in a strategic way. But because of structural limitations, he couldn't ensure that the country was uniform, which led to broken results. Trudeau's leadership shows how federalism can help and hurt crisis governance: working together makes things more legitimate and adaptable to local needs, while breaking things up makes them less coherent and consistent.

4. Conclusion

This comparative analysis of Spain, South Korea, and Canada illustrates how the organisational structures of their healthcare systems and the styles of their leaders had a big impact on how each country responded to the COVID-19 pandemic. Spain's decentralised system initially had problems because of faulty surveillance and delayed coordination. However, strategic emergency centralisation later helped the country successfully roll out its vaccination programme. South Korea was able to quickly contain the virus without shutting down the whole country because it had a strong central public health authority, excellent digital infrastructure, and leaders who were able to change with the times. Canada's federal system is very decentralised, which made it easier to respond to local needs, but it also led to many differences in outcomes, especially in long-term care settings.

Leadership was crucial in getting around these structural problems. Salvador Illa had a difficult time coordinating a broken system, but he later led the country well during the vaccination phase. Chung Sye-kyun's open, flexible, and cooperative leadership worked well with Korea's centralised public healthcare system, which helped the world see how well it responded. Justin Trudeau's unifying, caring, and cooperative style helped bring the country together, but it was limited by the independence of the provinces.

In general, a favourable response to a pandemic requires governance structures and leadership styles that work well together, as well as strong coordination mechanisms, clear communication, and decisions based on evidence. The case studies emphasise the imperative for coherent healthcare system planning and robust leadership to navigate forthcoming global health crises.

References

- Ansell, C. & Boin, A. (2019) 'Taming profound uncertainty: The potential of pragmatist principles for understanding and improving strategic crisis management'. *Administration & Society*, 51(7), pp. 1079–1112. <https://journals.sagepub.com/doi/10.1177/0095399717747655>
- Bass, B.M. and Riggio, R. (2006) *Transformational Leadership*, 2nd ed. Mahwah: Lawrence Erlbaum. <https://www.scribd.com/document/41998558/Transformational-Leadership>
- Boin, A., Hart, P. 't., Stern, E. & Sundelius, B. (2017) *The Politics of Crisis Management: Leading the Public Under Stress*. Cambridge University Press, Cambridge
<https://scispace.com/pdf/the-politics-of-crisis-management-public-leadership-under-1jnjuu4xht.pdf>.
- Candel, F.J. et al. (2021) 'The COVID-19 pandemic in Spain: evolving epidemiological situation and its implications'. *The Lancet Public Health*, 6(5), pp.e316–e325.
- The Canadian Institute for Health Information (CIHI) published this in 2020. The effect of COVID-19 on long-term care in Canada.
- ECDC, 2021. COVID-19 Vaccine Tracker: How many people in Spain have been vaccinated? European Center for Disease Control and Prevention.
- Estabrooks, C.A. et al. (2020) 'Restoring trust: COVID-19 and the future of long-term care in Canada'. *FACETS*, 5(1), pp.651–691.
- Fitzgerald, L., Ferlie, E., McGivern, G., & Buchanan, D. (2013) "Distributed Leadership Patterns and Service Improvement: Evidence from an NHS Case Study." *Leadership Quarterly*, 24(1), pp.128–141.
- García-Basteiro, A.L. et al. (2020) 'The necessity for an autonomous assessment of the COVID-19 response in Spain'. *The Lancet*, 396(10250), pp. 529–530.
- González-Cancelas, N. et al. (2021) 'Digitalization and COVID-19 response in Spain'. *Telecommunications Policy*, 45(10), p.102231.
- Greer, S.L. et al. (2020) *Coronavirus Politics: The Comparative Politics and Policy of COVID-19*. The University of Michigan Press in Ann Arbor.
- Heifetz, R., Grashow, A., & Linsky, M. (2009). *The Practice of Adaptive Leadership*. Harvard Business Press in Boston.
- KDCA (2021) *The 2021 COVID-19 Annual Report*. The Korea Disease Control and Prevention Agency.
- Lee, J., Choi, J.Y., and Kim, M. (2021) "Community Treatment Centers for COVID-19 Patients in South Korea." *Journal of Korean Medical Science*, 36(7), p.e65.

- Marchildon, G.P. (2021) "Canada: A Review of the Health System." *Health Systems in Transition*, 23(5), pp. 1–240.
- Murray, D. & Henderson, J. (2021) "Canada's COVID-19 Vaccine Procurement Strategy." *Canadian Medical Association Journal*, 193(12), pp. E431–E432.
- OECD (2021) *Spain's Country Profile in OECD Health at a Glance 2021*.
- OECD, 2022, *Health at a Glance: Asia Pacific 2022*, OECD Publishing.
- Park, S. et al. (2020) "Contact tracing during the COVID-19 outbreak, South Korea." *Emerging Infectious Diseases*, 26(10), pp. 2465–2468.
- Public Health Agency of Canada (PHAC) 2020 Report on COVID-19 Surveillance.
- Raelin, J. (2016) "Imagine there are no leaders: Reframing leadership as collaborative agency." *Leadership*, 12(2), pp.131–158.
- Rice, G. et al. (2021) "COVID-19 in Canada: A Political Science Perspective." *Canadian Journal of Political Science*, 54(4), pp.776–788.
- Saltman, R.B., Bankauskaite, V., & Vrangbaek, K. (2016). *Decentralisation in Healthcare: Plans and Results*. Open University Press in Maidenhead
- Shim, E., Tariq, A., Choi, W., Lee, Y., & Chowell, G. (2020) "Transmission potential and severity of COVID-19 in South Korea." *International Journal of Infectious Diseases*, 93, pp. 339–344.
- Van Bavel, J.J. et al. (2020) 'Employing social and behavioural science to enhance the response to the COVID-19 pandemic'. *Nature Human Behaviour*, 4, pp. 460–471. WHO, 2020. WHO Country Report: Republic of Korea. An Evaluation of the COVID-19 Response.
- Kickbusch, I., Leung, G.M., Bhutta, Z.A., Matsoso, M.P., Ihekweazu, C., & Abbasi, K. (2020), 'Covid-19: how a virus is turning the world upside down.' *BMJ*, 369, m1336.
- Kluge, H.H.P. et al. (2020), 'Strengthening the global response to COVID-19: the role of health systems.' *The Lancet*, 395(10233), pp. 1680–1682.
- Mounk, Y. (2020) 'The extraordinary decisions facing European leaders'. *Journal of Democracy*, 31(4), pp. 59–73.
- Bossert, T. & Beauvais, J. (2002). 'Decentralisation of health systems in Ghana, Zambia, Uganda, and the Philippines: a comparative analysis.' *Health Policy and Planning*, 17(1), pp. 14–26.
- Greer, S.L., Jarman, H., Rozenblum, S., Wismar, M., & Palm, W. (2022) *Everything You Always Wanted to Know About European Union Health Policies*. Copenhagen: WHO Regional Office for Europe.
- Hooghe, L. et al. (2016) *Measuring Regional Authority*. Oxford: Oxford University Press.
- Royo, S. (2020), 'Responding to COVID-19: Spain's response and its implications.' *South European Society and Politics*, 25(3–4), pp. 545–569.

- López-Casasnovas, G. (2020), 'Health system decentralisation and COVID-19 response in Spain.' *European Journal of Health Economics*, 21(6), pp. 905–908.
- Kim, J.H., An, J.A.R., Oh, S.J., Oh, J. & Lee, J.K. (2021) 'Emerging COVID-19 success story: South Korea learnt the lessons of MERS'. *Our World in Data Working Paper*.
- You, J. (2020) 'Lessons from South Korea's COVID-19 policy response'. *American Review of Public Administration*, 50(6–7), pp. 801–808.
- World Bank (2020). *Managing Epidemics: Key Facts About Major Deadly Diseases*. Washington, DC: World Bank.
- Béland, D., Marchildon, G.P., Medrano, P.A., & Rocco, P. (2021). 'COVID-19, federalism, and health policy in Canada.' *Journal of Federalism*, 51(2), pp. 359–384.
- Flood, C.M., MacDonnell, V., Philpott, J., Thériault, S., & Venkatapuram, S. (2020), *Vulnerable: The Law, Policy, and Ethics of COVID-19*. Ottawa: University of Ottawa Press.
- Office of the Auditor General of Canada (2021). *Pandemic Preparedness, Surveillance, and Border Control*. Ottawa: OAG.
- Boin, A., Kuipers, S., & Overdijk, W. (2013). 'Leadership in times of crisis: A framework for assessment.' *International Review of Public Administration*, 18(1), pp. 79–91.
- Grint, K. (2010). 'Leadership, management, and command in the time of the coronavirus.' *Leadership*, 16(3), pp. 314–319.
- Kapucu, N. & Van Wart, M. (2008) 'Making matters worse: Anatomy of leadership failures in managing catastrophic events'. *Administration & Society*, 40(7), pp. 711–740.
- World Health Organization (2021). *Strengthening Preparedness for COVID-19 in Cities and Urban Settings*. Geneva: WHO.
- World Health Organization (2022) *Global Health Expenditure Database: COVID-19 Health System Financing*. Geneva: WHO

