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Comparative Swedish and Kerala notes on the pros and cons of decentralisation in fighting the Corona

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What are the best ways to come to terms with Covid-19, while keeping equal political and social rights in mind? The international debate has mostly focused on the effect of national strategies, but much suggest that other factors are more important. In Sweden as well as Italy, for example, there are huge differences in numbers of infected and deaths between sub-national regions, such as Stockholm as compared to Scandia, and Lombardy as compared to Rome – in-spite if open borders. (Svahn 2020) Moreover, radical lockdowns like in Belgium did not generate better results than less drastic measures in Sweden. It is too early to arrive at a major explanation but we need to discuss possible additional factors. One is density of population. Another is class in terms of varied opportunities to work from home and the presence of immigrants and others with lower standard of living and chances to practice physical distancing. Yet another factor may actually be even more crucial – the extent and character of decentralised governance.

This essay suggests that an odd comparison between historically social democratically oriented Sweden in the North and the Indian state of Kerala in the South provides new insights in this respect. Kerala did amazingly well against Covid-19 for half a year thanks to its decentralisation and citizen engagement, but are now up against increasing community transmission of the virus, political conflicts and economic challenges. Sweden, by contrast, suffered appalling numbers of deaths largely because of decentralisation, but are now stumbling on, partially thanks to more testing and tracing along with pragmatic restrictions and voluntary civic discipline. What are the explanations for these quite different experiences

and what are the lessons? The paper commences with a discussion of the Swedish case and then turns to Kerala. It concludes, firstly, that Kerala's decentralisation was remarkably democratic and participatory, while Sweden's age-old local governance has been undermined, especially by new-public management; secondly, that both roadmaps suffer from poor linkages and coordination – which need to be democratically shaped to counter the increasing global quests for strongmen and stateism.

Swedish exceptionalism

In contrast to laissez-faire regimes, such as Donald Trump's, and the most common state imposed lookdowns and obligatory regulations and instructions, such as in Norway, Sweden stands out with efforts at a third way to counter Covid-19. This is of limited lockdowns in selective sectors (excluding, for example, primary schools and kindergartens) and rules on public gatherings, but otherwise as open borders as possible and, most importantly, intensively campaigned recommendations by expert-authorities – instead of political commands. Most of these recommendations are the common ones: to work and study from home whenever possible, to stay there (with compensation) when not feeling well, that old people and those in other risk groups should act likewise, and apply self-quarantine when the virus affects the family. However, there are also unusually strong advice about extreme hygiene and extensive physical distancing – instead of trust in unreliable facemasks, when they can be avoided.[1]

In spite of the allegations, such as by certain misinformed U.S. and Norwegian left extremists (e.g. Jacobin 2020), there were neither an ethically dubious aim at herd immunity (though some suggested it might develop anyway), nor a neo-liberal rationale. Aside from the usual objectives to protect the elderly and 'flatten the curve', so that the health system could bear with the challenges, the most important aim was instead to develop a strategy that would be socially and economically sustainable during several months and perhaps years, before an efficient vaccine might be in place. The strategy is rooted in the historical Swedish combination of responsible citizens who also trust in evidence-based policies and democratically accountable expert-authorities that are politically quite autonomous in contrast to, for example, Norway. Equally important, there seems to have been an assumption on part

[1] Details of the Swedish strategy and statistics, and, for a contrast, the Norwegian model and developments, are on the webpages of their respective public health authorities – see the list of references.

of the Swedish health authorities and Ministry of Social Health and Social Affairs that what used to be one of the world's best welfare systems remained intact – which proved mistaken.

The national outcomes have certainly varied. Socio-economically, Sweden has done reasonably well, even though unemployment during 2020 may increase to some 10%. But while the rate of growth declined with more than 8 % in the second quarter of the year it is presently improving and the contraction of the GDP for 2020 as a whole is expected to be about 3,4%. (SVT 2020) In terms of general public health and wellbeing, moreover, the present hope is that there is now a modified way of handling Covid-19 that is realistic over time. More testing and trancing is finally in place and most people continue to respect the public recommendations. In-spite of the horrifying number of initial fatalities, to which we shall return, harsh state rules and instructions have apparently not been necessary to 'flatten the curve' and reduce the numbers of infected people to levels that are, at the time of writing (mid-October), lower than in many parts of Europe and the U.S., and similar to the other Scandinavian countries. Worryingly, the contamination is slowly increasing again, but mainly in local clusters and among younger people who tend to be strong enough to fight the disease without extensive treatment and who are thus lees keen to respect the recommendations than people of some age.

Initially, however, as mentioned, there were appallingly high numbers of deaths, especially as compared to the neighbouring countries. By October 15, Norway with about 5,4 million people only reported 278 deaths in Covid-19 – while the total number in Sweden with some 10,3 million people was 5910. In proportion to population, this is thus eleven times higher than Norway and the seventh worst figure in Europe. In late April, some 120 people passed away every day. By now, the deaths are fortunately rare, but why did intolerably many people perish in Sweden during the peak period?

New public management and poor decentralisation

As already mentioned, the causes for the Swedish debacle may be more due to other factors than the general strategy of voluntary precautions and trust in public recommendations instead of statist instructions. Most importantly, the high numbers of deaths relate to the deteriorating quality of public health administration. A public commission is working on a comprehensive evaluation of the Swedish experiences, and meanwhile responsible politicians and directors of the interest organisation of the municipalities and regions bury their heads in the sand. Most leading independent experts agree, however, that the debacle is rooted in the rise of neo-

liberalism in the 1980s and the new public management imported from Tony Blair's Britain in the 1990s, which was combined with decentralisation.[2] This is not to say that the previous system was perfect, suffering in particular from bureaucratic hurdles – but decentralisation along with market driven management made things much worse and eroded the fundamentals.

To begin with, the hospitals and local health centres – which are operated by 21 elected regionally councils with their own taxation right in addition to state funds – have only muddled through. This is in contrast to the more successful Norwegian state ownership of the major hospitals and stronger role in national coordination of regional and local primary care. The Swedish troubles are, firstly, at the expense of people with other illnesses who have to wait for treatment. Secondly, there have been a shortage of skilled personnel to handle the Covid-19. The staff have had to work heroically. Thirdly, there was a serious shortage of medicines and even basic protective equipment, which affected personnel as well as patients. There were no emergency stockpiles and the supply-chains of market-driven 'lean production' and administration almost collapsed. Fourthly, the regions have not until recently been able to implement extensive testing and tracking that was advised by the central authorities and supported the central government. It was not even clear who was to decide and carry out the various tasks involved.[3]

Worst, most of the deaths were in the municipality-managed care homes for the frailest old people, as well as among elderly who live in their own homes but depend on services from visiting nurses and assistants. Internationally, this was a general pattern. It applied, for example, in Norway too – but the number of fatalities were vastly higher in Sweden.

One may certainly argue that the harsher lock downs and compulsory regulations in Norway reduced community transmission of the virus and increased the chances to defend the elderly. However, the national Swedish strategy of limited lockdowns neither prevented those pensioners who manage on their own (such as this author) from taking good care of themselves, nor younger relatives and volunteers' from helping us out, for example by buying food, medicines and other necessities, and to be particularly careful with respect to physical distancing. Largely, this worked without statist commands. The Swedish problem is rather,

[2] So far there is a shortage of good analyses in English. The reader may try Google translation of Rothstein (2020), Ingvar (2020), and Lindahl (2020). For a comparison of the Scandinavian cases, visit the webinar in English (2020).

[3] The central government is also present locally through provincial governors, but most of their duties have been transferred to the regions and municipalities. The latter govern independently on numerous subjects through elected councils and with their own taxation rights.

firstly, that the nurses and assistants in the residential homes, and the assistants who visit and serve the elderly in their households, did not have sufficient chances to act similarly responsibly and carefully when carrying out their work. Secondly, again, that this is due to new public management, along with poor decentralisation to the locally elected municipality councils and private and cooperative institutions, supposedly supervised by the municipalities, plus weak coordination with the regions. At hindsight, an early brief lockdown in the worst affected capital region (in and around Stockholm) might have been useful – but it would have been far from sufficient to alter the deep structural and institutional deficiencies in the institutionalised care for the elderly.

Similarly, there should certainly have been much more extensive immediate testing and tracking. But the central, regional and local authorities and agencies were not even capable and sufficiently coordinated to handle this at a much latter stage, even though funds were made available by the central government. In the end, the provincial state governors had to intervene to facilitate cooperation.

With regard to the most serious deficiencies – the institutional care for vulnerable elderly people, which, as already pointed out, is the task of the municipalities – it is not so easy that privatisation is the major explanation. Usually this has been a negative factor, but there are also conscientiously managed private units and cooperatives; and there are rules and regulations for minimum standards, which the municipalities are to look after. In addition to poor supervision on part of the municipalities, however, they themselves have also quite often mismanaged the public residential homes and services in the elderlies' households, and by subcontracting parts of the operations to private companies. Typically, local politicians (conservatives and liberals as well as rightist social democrats), and their administrators, have tried hard to cut taxes by reducing costs, wages and investments. The result is shortage of personnel, equipment and difficulties to keep up hygienic standards and to separate infected people from others. To make things worse, the municipalities have no medical doctors and senior nurses under their jurisdiction in-spite of being in charge of the care for the elderly who frequently suffer from various illnesses. The medical doctors and nurses are instead private or employed by the regions – and not well coordinated with the localised care for the elderly. Further, the number of qualified senior and junior nurses in the local services are few as compared to the other personnel, which may well be devoted but is typically poorly trained, temporarily employed and, of course, even lower paid. Thus, many of them may not even

afford to stay home when not feeling well and about to develop Covid-19. In addition, the assistants are often immigrants who have to live with large families in small flats.

To sum up, the Swedish strategy was based on the false assumption that what might have been among the best welfare systems in the world remained intact. This system was rooted in the historical synthesis of responsible citizens with trust in transparent evidence-based policies, politically relatively autonomous public authorities and experts as well as democratic local governments. The mantra was not stateism but that a strong welfare state would foster as free, active and responsible citizens as possible. In reality, however, much of the state's responsibility for welfare and public health has been decentralised to the semi-autonomous regions and to some extent the municipalities, with their own councils, separately elected in the general elections. This may sound fine, but in reality it is very hard for ordinary people to find out who is responsible for what, keep politicians and administrators responsible and cast their vote based on sufficient information. Further, the regional medical services have proved insufficient and poorly coordinated with the municipalities – which are in charge of the care for the old.

Hence, the Swedish debacle is not primarily due to lack of statist commands on how the citizens should behave to fight Covid-19. Actually, most citizens followed the well-reasoned public recommendations anyway. Apparently, the collapse is instead due to poor public management and decentralisation with miserable coordination between central, regional and local governance, plus with privatisation and new-public management.

In short, the globally celebrated Swedish model of public welfare – based on, effective implementation by central government and independent regional and local governments, in addition to social pacts between unions and employers and their participation in public governance – has cracked. (C.f. Rothstein 2020) So many old people in particular who depended on public services could not be defended against the virus. Worst, they and others now lose trust in the welfare system. Those with sufficient economic resources may add private insurances and are likely to lose interest in sustaining the public system on the basis of solidarity.

Advances and challenges in Kerala

Remarkably, even very densely populated societies with much less resources than Sweden have been more successful by way of decentralisation. In sharpest contrast, as already indicated, the Indian state of Kerala with almost 35 million people on a narrow strip of land in

the south western part of the sub-continent did extremely well in handling Covid-19 with no deaths from January 2020 and almost half a year ahead. Seemingly, this proved to the rest of the country and the world what was possible. From late May and June, however, the rising numbers of infected and dead turned worrying. (Krishnakumar (2020 a and b, Special correspondent 2020, Chathukulam and Tharamangalam 2020) We shall return to the troubles, but first the success story.

One would have thought that this very heavily inhabited state with few nucleated villages, low GDP per capita and unusually many old people, as well as huge numbers of migrant labourers returning from other Corona affected Indian states and the Middle East, would suffer badly. But Kerala's Left Front Health Minister Mrs. K.K. Shailaja, a well-read former secondary school teacher, gained international rock star fame along with her medically trained team, backed by Chief Minister Pinarayi Vijayan and Finance Minister T.M. Thomas Isaac among others, for containing community spread of the virus. (Spinney 2020; Heller 2020) The strategy to fight Covid-19 was based on her successfully directed struggle in 2018 against the even deadlier Nipah disease. Essentially it was to check returning migrants and mobilise the local health care units in cooperation with civil society – along with a template for educating the residents on how to fight the virus plus organise localised quarantine with welfare for the affected, especially the elderly. The police was also enrolled (sparsely to begin with); and certain hospitals were dedicated to the Covid-19. (Menon et al. 2020; Chathukulam and Tharamangalam 2020)

The troubles occurred over how to control the health status of the many Keralites working outside the state when increasingly many of them wished to return home by air but also train and buses. This could not be handled through decentralisation only but called for coordination with the Central Government and other actors and institutions, which did not work well. Primary, therefore, the spread of the virus increased. But there were also additional political conflicts with the Centre. Similarly, the opposition of the left government was eager to find issues and ways of combatting the Left in face of upcoming local and later in state-wide elections. A troublesome contract with a US based company to assist in quickly handling sensitive data of quarantined people and a corruption scandal among public servants associated with the Chief Minister's office added to the quarrels. Hence, the consensual work against Covid-19 was undermined – both with regard to increasingly urgent general measures in the state but also in the so far effective decentralised and participative struggle to contain the virus. In face of the major harvest festival *Onam,* which was due in late-August, even

more people were on the move, from other states in India and within Kerala itself, including in market places. In this process, the localised containment strategy was increasingly insufficient and damaged. Numerous people neglected the official recommendations and instructions to fight the virus. The participatory public action was deficient and police had to step in, which in turn caused critique of authoritarian methods. (Krishnakumar (2020 a and b, Special correspondent 2020, Chathukulam and Tharamangalam 2020)

Obviously, all this calls for better capacity to test, handle seriously ill people and, most importantly, to coordinate local and other measures – while trying to retain as much as possible of democratic public action.

Meanwhile, in addition, Finance Minister Isaac himself – the primus motor of decentralisation and local development – has indicated that the economic consequences call for extensive stimulation programmes, which, it seems to me, are far beyond the capacity of the local governments. (The Hindu Net Desk 2020, The Wire 2020)

To understand the initial advances and then new challenges we need to return to the history of decentralisation and public action.

Insights from the decentralisation and people's planning campaign

There are two prime explanations for the initial success. The first is Kerala's long history of world reputed private and public investments in health and medical services, especially as compared to India in general. This was for example a vital source of inspiration for Nobel Laureate Amartya Sen as well as the United Nation's position on 'human development'. The second reason is the democratic decentralisation and popular participation in local development, pushed by public action from the late 1980s until the early 2000s.

But how do we explain the new challenges? Actually, they bring to mind the sympathetic but also analytically critical results from my own and others' studies of the efforts from the late 1980s until the early 2000s to renew the 'Kerala Model' of human development by way of democratic decentralisation.[4]

[4] For summaries and further references to the studies by other scholars too, see Heller, Harilal and Chaudhuri (2007), Isaac and Franke (2000), George (1998?), Isaac (2014), Rajesh (2020), Tharakan (1998) and (2004), Törnquist with Tharakan (1995), Törnquist and Harriss (2016), Törnquist (2019), Chathukulam and Tharamangalam 2020) and for more extensive analyses in comparative perspective, Törnquist (2021)

Let us recall the history and major achievements of the decentralisation and campaigns before turning to the problems.

By the late 1970s', Kerala's celebrated efforts at social democratic oriented development had stagnated. In-spite of India's most consistent land reform, most vulnerable people did not benefit, and those who did often invested outside production. Even competing leftist parties used central level public resources to favour their own sympathisers. Decentralisation was therefore crucial to generate a framework for less non-party-partisan development initiatives, by local government and civil society. The same applied to agreements between farmers and agricultural workers, and, more broadly, pacts between local capital and labour. From the 1980s, concerned civil society activists and scholars, along with reformist left-politicians, initiated remarkable campaigns for democratic decentralisation and participative development. In fact, they were so successful that the dominating conservative leftists at least nominally had accept the new ideas for short of a better alternative of their own. This helped bringing the left back in power, and between 1996 and 2001 the reformists efforts were scaled up to Kerala at large under the leadership of the State Planning Board.

One obvious positive outcome is functioning local governments, which people can turn to, participate in and state institutions can cooperate with. Recently, in 2018 in particular, this was proven by the vital role of the local governments in handling the devastating Nipah virus as well as severe flooding; and now it is obvious again in the struggle against Covid-19.

Ironically however, it seems to me, the decentralisation that constituted the basis for the initially very successful struggle to handle the Covid-19 is now insufficient and hard to scale up in order to both fight the pandemic beyond local clusters and to handle the economic and social consequences beyond the villages. This reminds of some of the previous insufficiencies of localised governance during the decentralisation and People's Planning Campaign.

Already there were numerous challenges even during the celebrated initial days of decentralisation and popular planning, several of which remain vital. By now the shortage of social audits may have been addressed. And while limited participation in *gram sabha* (town hall meetings) remains a problem, there have been efforts to institutionalise better combinations of direct and representative democracy plus participatory and professional governance. But what about the many crucial problems that cannot be solved in *panchayat* (local council) meetings? And how can those who have engaged locally take these issues

beyond the villages, without being dominated by mainstream politicians and the interest groups that organise in relation to production and thus transcend the local borders?

In short, there is an obvious need for more coordination. Moreover, the dilemma is how this can be achieved democratically, without returning to authoritarian centralism.

Lingering challenges of welfare

One of the previous deficiencies was that since the villages were increasingly open economies already in the 1990s, those active inside their borders could not be expected to also take the responsibility for their residents active outside. Another was that middle class people often did not engage in local development planning and joint work as most of the programmes were targeted for the poor. Consequently, there must also be firm links to welfare *state* programmes. Moreover, more programmes need to be universal, not just targeted, so that middle classes will feel there is something in it for them too.

This is exactly what happened in Scandinavia during the transition from a mainly agricultural to industrial economy in the late 19th and early 20th century. Local responsibility for the increasingly many underprivileged became impossible when many of them had to leave agriculture and find work elsewhere. Hence, the remaining farmers wondered why they alone should take care of the unfortunate labourers. (Sandvik 2016) In the early 20th century, social democrats added universal welfare state programmes to the important but insufficient community and civil society efforts plus self-help in unions and cooperatives. The programmes were universal by virtue of being inclusive of farmers as well as labourers and professionals. But they did also have a civic dimension so that people in many sectors and contexts could finance, support and perfect the reforms locally. Meanwhile, as welfare as such was thus universal, redistribution to the benefit of the poor must instead be promoted through policies for more jobs, better wages and progressive taxation – given the importance of universality to build broad and sustainable support for the welfare state, including in elections.

However, the main responsibility for healthcare and care for the elderly came to rest with regions and municipalities, along with national aims and standards. From the 1980s and 1990s and onwards, moreover, as we know, there was additional decentralisation and also

privatisation and introduction of new-public management. This generated a witches' brew that has now proved particularly dangerous in the struggle against Covid-19.[5]

Returning to Kerala in our comparative discussion, decentralised public action based on central templates against Nipah and Covid-19 proved remarkably successful at the outset, but at this point local implementation and lockdowns seem insufficient against community infection

Broadening the comparison, moreover, it is clear that both the Swedish and Kerala deficiencies with regard to linkages between local and central were better addressed in the most successful countries in handling both Covid-19 and regressing economic development – such as in South Korea, Vietnam and Taiwan. They did not only benefit from a good public health system that reached out all the way to the villages – even if Kerala's system may be deemed more democratic and participatory. They had also built up national infrastructure to fight SARS, including by way of contact tracing, laboratories, central databases and coordination of local efforts. (Kheng Kohr and Heymann 2020, An and Tang 2020)

Dilemmas of development

In a similar vein, effective local development planning must consider both public and private investments and links to the outside economy. It is certainly crucial that people can survive during the Corona by innovative local economic ventures, but it is also increasingly important to gain from outward linkages and support. One again we need to return to history to understand the current challenges.

The background for the emphasis on decentralised development in India and Kerala is that Nehru's top-down directed industrialisation and import-substitution had stagnated. In the 1980s and 1990s the dynamic reformists' in favour of the People's Planning Campaign aimed instead at a restart from below. Publicly supported group farming, for example, would promote production and decent wages, and be connected with other efforts within the framework of comprehensive local plans. This did not work well, however. Other options were more attractive for most farmers and their aspiring siblings. So given that the local economy cannot develop in isolation from wider markets, production and globalisation, additional links must be shaped in development planning. This is not easy. Not even the

[5] For comparative purposes, it may be added that similarly severe problems apply to the public education system too. From having been state-directed in favour equal chances and universality – which was favourable for integration of immigrants too – it is since the early 1990s been decentralised and open for privatisation.

authoritarian Chinese Communist party was able to connect people's communes in what Vivienne Shue (1994) called a "cellularised" economy, but conceded to Deng Xiaoping's market reforms. Which nourished collusion between politicians-cum-party people and businesspersons. Hence, a democratic alternative is imperative.

In Kerala, according to Professor K.K. George (1998, 2002, 2013, 2014), the reformists and the Planning Board put forward many good instructions for how to carry out local planning, but the focus was on public resources separate from private ones. Also, there was almost nothing about connecting the villages with the modern economy, including industry and the problems and options of so many people working and investing outside their home areas.

Comprehensive planning to sustain the economy during the pandemic and kick-start it as soon as possible can thus not encompass local public resources and self-help only, no matter how important. It must also consider wider markets and private undertakings. But who shall do this? The institutions for state and local planning cannot fix it alone. Politicians tend to be crucial as brokers and negotiators, and public bodies such as hospitals try on their own to mobilise funds from various sources. But all this is risky and insufficient. Historically the social democratic alternative in Scandinavia forged strong institutional links between central and local governments. The same applied to public planning, rooted in the representation of employees and investors/employers in public governance. But this has deteriorated; and since the 1980s, social democrats must also address globalisation, which they have also not been overly successful in doing. What would be the best way to address the challenges in Kerala?

Borrowing huge sums of money for public subsidies to companies and people when interest rates are low, which is practiced all over the North these days, is less feasible in much of the South. There are certainly huge potentials for productive development in Kerala, if more of its human capital can be put to use. But under pandemic conditions in particular, revenues and new investment are hard to mobilise. There is a need for cooperation with many private actors, from migrant workers to entrepreneurs, as well as coordination between local level investments and wider markets. Finance Minister Isaac's 2020 budget was a promising step in this direction. (Oommen 2020) Yet, cooperation and coordination must be negotiated.

Given Kerala's history of democracy and popular participation, it would be a contradiction of sorts if such negotiations towards social contract were to rest with individuals within the government and the leading party. The frequently appointed overseeing committees of noted experts are fine, but such esteemed panels are more about technocratic governance than

democratically oriented negotiations. And while the State Planning Board may play an active role in suggesting transformative productive reforms that many actors can unite behind, it is beyond the board's current mandate and capacity to negotiate comprehensive plans that involve public, cooperative and private actors.

Conclusion

While it is far too early to arrive at firm conclusions about the problems and options of fighting Covid-19, we need to discuss the importance of various factors – such as the often neglected extent and patterns of decentralisation.

In short, this essay suggests, on the one hand, that Kerala's initially successful struggle against Covid-19 was much thanks to more democratic and participatory decentralisation, in contrast to Sweden where the historically vital local governance is badly affected by privatisation and new public management. On the other hand, however, the current challenges in Kerala resound the recent Swedish experience of poor combination of public and local governance.

By implication, there must be efficient coordination between the institutions and actors involved at different level. This brings to mind the argument to pay more attention to the very linkages between state and society, beyond the otherwise common focus on their relative importance (Migdal, Kohli and Shue 1994), as well as the critique of flawed liberal as well as leftist views of representation (Törnquist, Webster, Stokke 2009).

In Sweden there is a long history of coordination between central and local governance; and since the 1930s, as already mentioned, there were also elements of democratic partnership governance, involving government and its authorities, capital and labour, plus issue and self-management organisations. However, it is more clear now than ever, after the failures in combatting Covid-19, that much of coordination of public as well as partnership governance has degenerated. The joint organisations for regions and municipalities, which negotiate with central government about division of labour and finance, is not even subject to public scrutiny and has developed strong special interests of the regions and municipalities in their role as employers. Bluntly speaking, they strive for low wages and temporary employment of often unskilled personnel. (Rothstein 2020) And the consultations with professional and interest organisations are less important. In addition, it is very difficult for citizens to understand who is responsible for what in the regions and municipalities, keep them accountable and take informed decisions about what politicians to elect. The unresolved issue is, thus, how the

democratic partnership governance and cooperation between state and local governance can be reinvented to promote national coordination.

In Kerala I trust that there are ambitions to scale up local level planning within frameworks set by the State Planning Board. But as already indicated, there must also be democratic ways of including non-public actors – from issue groups as well as capital and labour. It would be premature of me to suggest how such negotiations – and the democratic representation they necessarily involve – could be facilitated in an alternative way, but probably this is the lynchpin. Without trustworthy and efficient *democratic* linkages, the quests for authoritarian regimes and leaders to build stronger states and impose these links will increase – as they already are on a global scale.

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