

China's Public Health Response to the COVID-19 Outbreak

Yanzhong Huang

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This essay focuses on the pattern of China's public health response to the COVID-19 outbreak. While the government response suggests that important progress has been made in strengthening disease surveillance and response capacities in the post-SARS era, it also reveals a pattern of cover-up and inaction similar to what occurred during the SARS outbreak. This time, however, local government leaders and health authorities appear to have played a more prominent role in the making of the crisis. Once central leaders recognized the severity of the crisis, they—like their counterparts during the SARS crisis—did not hesitate to turn to draconian measures to contain the outbreak. However, compared to the reverse course during the SARS crisis, the COVID-19 containment measures were carried out more aggressively and extensively, aided by high-tech means. The speed and scale of the containment efforts and the government's ability to rein in the spread of the virus show the presence of a highly resilient and powerful state. Still, the tremendous social-economic costs incurred by strict disease control measures and the inability to completely break the transmission chain highlight the limits of the state reach. The essay concludes with a discussion on the replicability of the Chinese approach.

In November–December 2019, a new strain of coronavirus (COVID-19) emerged in Wuhan, Hubei province. As it turned out, the highly transmissible and potentially lethal virus spread rapidly and soon developed into a major outbreak in China and, through international travel, a global pandemic. As of May 13, the outbreak has affected 182 countries and has been responsible for more than 4.33 million confirmed cases and nearly 300,000 deaths worldwide.¹

The outbreak brings back memories of the SARS epidemic seventeen years ago. In the aftermath of the 2002–3 SARS outbreak, China has invested significantly in building core surveillance and response capacities, including constructing a web-based notifiable disease reporting system that enables grassroots healthcare workers to report on any potential outbreak directly to the China Center for Disease Control and Prevention (China CDC). Nevertheless, China still mishandled the COVID-19 crisis. It was not until after January 20 that the government kicked off more decisive containment measures. The draconian, even Orwellian measures appear to have worked to significantly bring down the number of new cases within a relatively short period of time.

Why did a seemingly well-designed public health system fail to nip the crisis in the bud after the SARS debacle? How did a reverse course in late January manage to contain further spread of the virus? In order to address these questions, this essay focuses on the Chinese public health response to the COVID-19 outbreak. It argues that while loopholes in China's public health system contributed to the initial mishandling of the crisis, the root cause of the problem remains political and institutional. Paradoxically, the political system also accounted for the effectiveness

in stemming the spread of the disease. The essay concludes with a discussion on the replicability of the Chinese approach.

The Making of the Crisis

1. Detection of the Outbreak

According to a *Lancet* article published on January 24, 2020, the onset of illness caused by COVID-19 can be traced back to December 1, 2019,² suggesting that the first case of infection occurred in mid-November 2019. Another study preliminarily published in *New England Journal of Medicine* on January 29 concludes that human-to-human transmission occurred as early as mid-December 2019.³ The identity of “patient zero” (the first person infected by the virus) remains unknown. Of the 59 cases announced by local health authorities on January 5, the earliest date of the start of the illness was December 12, 2019.⁴

According to state media, Dr. Zhang Jixian, a respiratory doctor in Wuhan, was the first to sound the alarm.⁵ Between December 26 and December 29, she came across seven pneumonia cases of unknown cause. On December 27, after noticing similar symptoms among the first three cases (all from the same family), she alerted Hubei Provincial Hospital of Integrated Chinese and Western Medicine where she worked. The hospital immediately informed the district CDC, which responded by sending representatives to the hospital to conduct an epidemiological investigation. Dr. Zhang’s concerns about possible human-to-human transmission of the virus increased after seeing another four patients— all of whom worked at the Huanan Seafood Market—showing symptoms similar to the first three cases. On December 29, for a second time Dr. Zhang alerted the local health authorities, who responded by transferring six of the patients to Jinyintan Hospital, the designated hospital to receive infectious-disease patients. In the afternoon of December 30, Dr. Zhang’s hospital received an “urgent notice” from the Wuhan Health Commission (WHC), asking that effective measures be taken to treat the cases.⁶

The disease surveillance system appeared to work at that time. By the end of December, both provincial and national health authorities had been alerted about the suspicious cases. The wording used by the WHC notice suggested that the provincial health authorities had been aware of the presence of the cases by December 30.⁷ On December 31, the National Health Commission (NHC) sent a work team and an expert team to Wuhan to provide guidance on the handling of the outbreak and to conduct a field investigation. On the same day, the WHC reported 27 pneumonia cases, but stated that the disease was “preventable and controllable” and that investigation had not found any apparent human-to-human transmission.⁸ Compared to the local health authorities, healthcare workers, especially those who experienced the SARS outbreak, were more cautious and vigilant. Zhongnan Hospital of Wuhan University immediately ordered 24 SARS test kits and on January 1 submitted samples to a medical lab of a local BGI (a global genomics organization) for gene sequencing. The test results, returned the next day, pointed to a novel coronavirus that had 80 percent similarities with SARS in terms of its gene sequence.⁹ The hospital shared the results with the local health authorities. On January 1, the government closed the Huanan Seafood Market. On January 3, the same day China shared information about the disease with the United States and the World Health Organization (WHO),¹⁰ Wuhan health authorities initiated emergency monitoring, case investigations, close

contact management, and market investigations.¹¹ On January 5, China CDC raised the level of its disease emergency response to Level II (with Level I being the most serious). (See the following figure.)

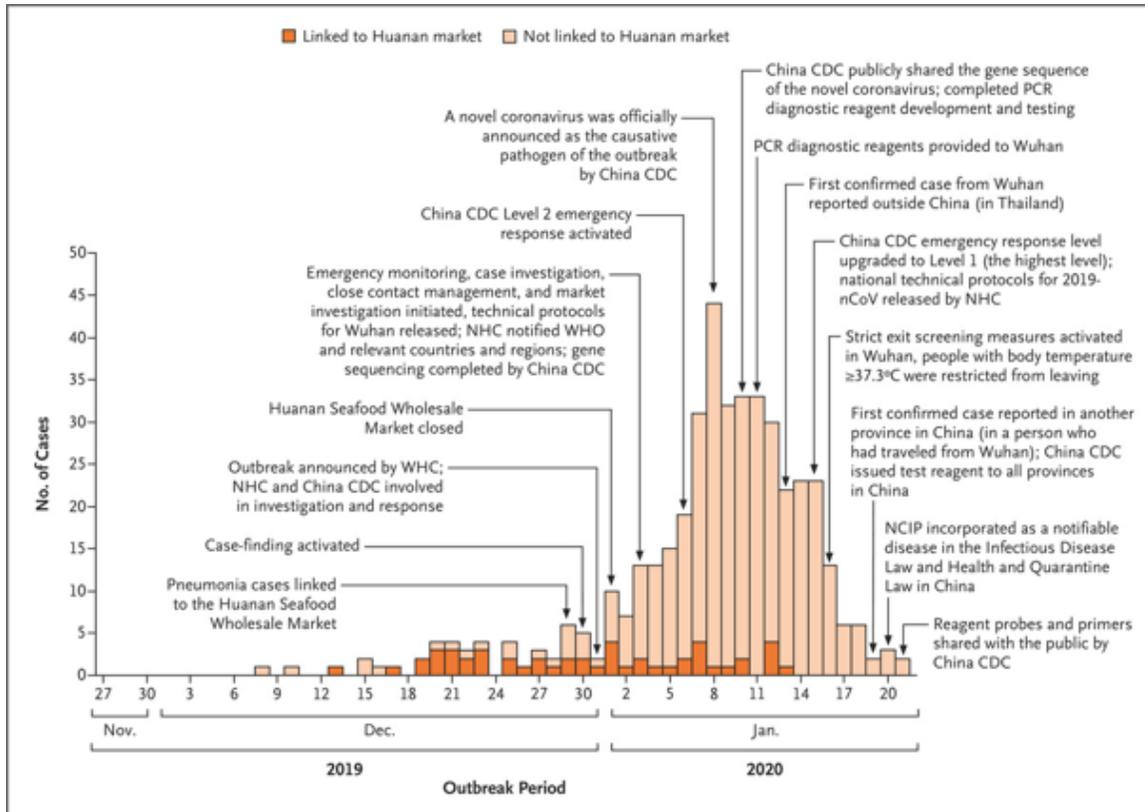


Figure. Onset of Illness among the First 425 Confirmed Cases of Novel Coronavirus (2019-nCoV)–Infected Pneumonia (NCIP) in Wuhan, China.

Source: *New England Journal of Medicine*,

<https://www.nejm.org/doi/pdf/10.1056/NEJMoa2001316>

In the meantime, at least five teams of Chinese scientists were racing against time to isolate the virus and sequence its genome. On January 5, researchers at a lab affiliated with the Shanghai Public Health Clinical Center (SPHCC) independently detected a SARS-like coronavirus in samples sent from Wuhan and reported this to the central health authorities.¹² Two days later, Chinese health authorities officially announced that a novel coronavirus was the causative pathogen of the outbreak.¹³ On January 11, the SPHCC lab published the world’s first genome sequence of COVID-19 online.¹⁴ This was immediately followed by the release of further genome sequences by other Chinese researchers on the Global Initiative on Sharing All Influenza Data (GISAID) (<https://www.gisaid.org/>).¹⁵ On January 12, the WHO confirmed that China had shared the genetic sequence of the novel coronavirus.¹⁶ Genome sequencing is critical for the development of specific kits to diagnose a virus more quickly. It also facilitates vaccine development by helping to identify genetic patterns related to the virulence of the pathogen and genetic factors contributing to immunity.¹⁷ According to officials at the Ministry of Science and Technology, as the first country to sequence samples of the virus China was also first to have a vaccine enter the second stage of clinical trials.¹⁸ China’s investment in building a core

surveillance and response capacity in the post-SARS era indeed paid off: to the extent that it took more than four months for China to identify the etiological agent of SARS after onset of the disease,¹⁹ it took less than two weeks for Chinese scientists to identify the virus that caused the COVID-19 outbreak.

2. The Cover-up

But the same period was characterized by a lack of transparency and risk communication problems. Although the first to report the outbreak, Dr. Zhang did not receive any government feedback about her reports or about the nature of the virus.²⁰ The government clearly sought to monopolize release of disease-related information. The December 30 WHC notice made it clear that “no units or individuals shall release treatment information without approval.”²¹ On December 30, Dr. Ai Fen of Wuhan Central Hospital shared with his friends and colleagues a test report from a patient whom she had seen three days earlier and asked them to be vigilant. Dr. Li Wenliang, a Wuhan-based ophthalmologist, received the message and shared it with his former college classmates. Both Ai and Li were admonished.²² Days later, Dr. Li was summoned by local police to sign a statement admitting making a false statement that disturbed public order. Police reports suggested that eight whistleblowers— all of whom were healthcare workers in Wuhan— were disciplined for spreading false information.²³ Moreover, the state began censoring news related to the virus on December 31, deleting terms such as “SARS variation,” “Wuhan Seafood Market,” and “Wuhan Unknown Pneumonia.”²⁴ Not surprisingly, there was little discussion of the virus on Chinese social media. Before late January, *Caixin* and *Caijing* were among the few media outlets that were reporting extensive stories on the outbreak.

In an odd move that is still puzzling to China watchers, on January 1 an official of the Hubei Provincial Health Commission ordered the company that had first sequenced the virus to stop testing additional samples, destroy all existing samples, and keep the information secret.²⁵ On the same day, after the city closed the Huanan Seafood Market, it disinfected the market, thereby undermining scientists’ ability to track down the source of the virus.²⁶ On January 3, the NHC issued an order to all provincial health commissions and biosafety Level 3 and 4 labs conducting research on pathogens that can cause human-to-human transmission, mandating that all virus samples be moved to designated testing facilities or destroyed.²⁷ The SPHCC lab was later ordered to close for “rectification.”²⁸

The government became even more tight-lipped after January 5. The WHC ceased to issue reports on the outbreak during the city’s “two sessions” (January 6–10), two of the most important local political events (annual local legislative meetings and political consultative conferences). On January 11, the WHC resumed reporting, announcing that by the end of January 10, there was a total of 41 cases, including one fatality. But the report seemed to indicate the outbreak was over, stating that there were no new cases identified during January 3–10 and “no explicit evidence” of human-to-human transmission.²⁹ On January 11, a meeting of the Hubei Provincial People’s Consultative Conference was held in Wuhan, kicking off the “two sessions” at the provincial level (January 11–17). During that period, in part because of the extremely rigorous requirements for case identification and reporting, the WHC’s daily reports maintained that there were no new cases. In the night of January 16, a second death was

reported.³⁰ There was no update the next day when the two sessions ended. It was not until the early morning of January 18 that the WHC announced four new cases occurring on January 16, bringing the total number of cases to 45.³¹ Yet, according to researchers at Imperial College in London, as of January 12 a total of 1,723 cases already had an onset of symptoms in Wuhan.³²

COVID-19 is a highly transmissible and pathogenic viral infection. Until January 20, however, the WHC's daily reports did not mention human-to-human transmission of the virus or the infection of healthcare workers (which would be clear evidence of human-to-human transmission). But by January 6, a respiratory physician at Xinhua Hospital had been infected, which was followed by another infection in the same hospital by January 11.³³ Instead of publicizing the two cases, the hospital organized an internal meeting stressing the importance of keeping the news out of the media.³⁴ Infection of healthcare workers occurred in other hospitals as well. Zhongnan Hospital, for example, saw the first infection of a physician on January 8. By January 10, human-to-human transmission became an open secret in the front-line hospitals.³⁵ An article by experts of China CDC and the Hubei Provincial CDC on January 29 suggested that seven healthcare workers had been infected between January 1 and January 11.³⁶ Yet on January 11, the WHC still claimed that no healthcare workers had been infected.³⁷

While the local government downplayed the severity of the outbreak when communicating with the public, it also intercepted the upward flow of information. According to China CDC officials, during January 3–10, Wuhan did report cases of pneumonia of unknown cause to the central health authorities via the web-based disease reporting system.³⁸ But local health authorities set the bar for hospitals to report cases so high that a majority of the suspected cases were excluded because they did not meet the requirements, which included being related to the Huanan Seafood Market. A *Caixin* report suggested that on January 9, the provincial health authorities intervened and deleted two cases submitted by Zhongnan Hospital.³⁹ On January 12, the Hubei Provincial Health Commission issued another order that made reporting on any new cases even more difficult: a case of pneumonia of unknown cause was not allowed to be reported unless it was confirmed by experts at the city and provincial levels and approved by the provincial health commission.⁴⁰ The direct reporting system ceased to function beginning on January 10 and did not resume functioning until January 24.⁴¹

3. Inaction

In tandem with denial there was inaction. Because of the problem of the upward flow of information, the central government did not have a clear idea about the nature and spread of the virus. On January 7, the CCP Politburo Standing Committee held a full-day meeting. The officially released news report focused on strengthening the authority of the party center, but it did not mention the Wuhan outbreak.⁴² Yet, according to President Xi Jinping's February 3 speech published by *Qiushi* (the party's main theoretical journal), Xi "put forward requests on the prevention and control of COVID-19" at the January 7 meeting.⁴³ What exactly Xi said at the meeting remains unknown, but based on the subsequent government response and leaked information,⁴⁴ it appears that Xi, who apparently was briefed by health officials on the outbreak in Wuhan, instructed that measures be undertaken to contain the outbreak, but they should not spoil the atmosphere for the Spring Festival (January 25, which was also the start day of the Chinese lunar new year, although the celebration period lasted from mid-January to mid-

February). Under this “*nei jin wai song*” (be intense inside and relaxed outside) policy, the NHC dispatched the second batch of experts to Wuhan on January 8. But during their 10-day trip, the experts were not informed about the infection of healthcare workers, which led them to conclude that “there is no explicit evidence of human-to-human transmission.”⁴⁵ Local government misinformation might explain why while he was in Wuhan the head of the expert team was infected by the virus.⁴⁶

The local government, however, had no control of the spread of the virus. On January 13, the first overseas case of novel coronavirus was identified in Thailand, involving a woman from Wuhan who had not visited the Huanan Seafood Market. The case prompted the NHC to host a teleconference the next day. NHC head Ma Xiaowei warned nationwide provincial health authorities of the “significantly increasing likelihood” of the spread of the disease, but his remarks showed that the NHC was not aware of the true nature of the outbreak, except to say that “the ability of human-to-human transmission remains to be closely monitored.”⁴⁷ This is perhaps the primary reason that the WHO continued to state that there was no evidence of human-to-human transmission on January 14.⁴⁸ The next day, China CDC raised the level of its disease emergency response to the highest level and decentralized authority of testing for the virus by making test kits available to Hubei province on January 16. At that time, the WHC still reported that the risk of sustained human-to-human transmission was low.⁴⁹ Wang Zhonghuan, president of Zhongnan Hospital, tried to alert many city and provincial government leaders about the coming epidemic, but most of them disregarded it as Cassandra’s prophecy. In February, party secretaries in both Wuhan city and Hubei province, as well as the party secretary and director of the Hubei Provincial Health Commission, were sacked. Since no NHC leaders or senior national-level government officials were removed from their posts due to the outbreak (unlike what had occurred during the SARS crisis), the reshuffling in Hubei province suggests that subnational government officials were largely responsible for the initial mishandling of the outbreak. Indeed, Wuhan Party Secretary Ma Guoqiang admitted on January 31 that he was “in a state of guilt, shame, and self-reproach” for not taking earlier preventive measures.⁵⁰

Misinformed and misled by local government officials, residents in Wuhan were barely prepared for the outbreak. On January 18, 40,000 families gathered at a lunar year banquet to share home-cooked food.⁵¹ By January 23, five million people had left the city, with some carriers shedding the virus in other parts of China and abroad. An analysis suggests that in January, more than 390,000 people arrived in the United States on direct flights from China, and thousands of them had flown directly from Wuhan.⁵² Furthermore, until January 19 no Chinese city other than Wuhan reported cases of infection, even though cases had already started to appear in Hong Kong, Thailand, and Japan.⁵³ According to a study conducted by scientists at University of Hong Kong, five Chinese cities (Beijing, Shanghai, Chongqing, Guangzhou, and Shenzhen) had imported 71 cases during January 1–17.⁵⁴ This led some people in China to call the pathogen a “patriotic virus.”⁵⁵ Indeed, no decisive action was undertaken in other parts of China until early February.⁵⁶ One study suggests that the total number of cases in China could have been cut by 86 percent if the government had deployed decisive containment measures (e.g., travel restrictions, social distancing, early case identification, and isolation) two weeks earlier.⁵⁷

Reverse Course

Despite local government efforts to conceal the true nature of the outbreak, alternative information was still channeled into the seemingly opaque and exclusive authoritarian decision-making system. During the SARS outbreak, Dr. Jiang Yanyong, a retired physician, publicized the government cover-up and forced the central government to take decisive actions by mid-April.⁵⁸ A similar development was observed during the COVID-19 outbreak. On January 18, the WHC reported 17 new cases on the previous day. While China CDC was emphasizing that human-to-human transmission could not be ruled out, the WHC continued to deny any confirmed cases among close contacts.⁵⁹ But during January 10–17, a Shenzhen-based hospital affiliated with the University of Hong Kong identified a family cluster infection of the virus, including one who had not visited Wuhan. In the night of January 17, Professor Yuen Kwok-yung sent an urgent email to China CDC and the Guangdong Provincial CDC, alerting them about human-to-human transmission of the virus.⁶⁰ Professor Yuen was then invited to join the high-level expert team to visit Wuhan on January 18.⁶¹ He shared the information with other members of the team, including Dr. Zhong Nanshan, who headed the expert group. According to Dr. Li Lanjuan, a renowned epidemiologist, the NHC, upon learning about potential infection of healthcare workers, decided to send the high-level team to Wuhan after Dr. Li had requested to visit Wuhan.⁶²

On the morning of January 19, the experts were accompanied by local health officials to visit the designated hospitals in Wuhan. They found themselves in a Potemkin village where doctors answered the experts' questions based on an orchestrated script.⁶³ But Dr. Zhong Nanshan insisted on getting to the bottom of what had happened. At Wuhan Union Hospital, he learned that 14 healthcare workers in the hospital had been infected by one patient. This key finding, as well as the human-to-human cases in Guangdong,⁶⁴ convinced the entire team that the virus indeed causes human-to-human transmission and should be treated as a top threat.⁶⁵ The NHC was immediately informed about the findings and the recommendation of the team.⁶⁶ The experts arrived in Beijing in the evening. NHC head Ma Xiaowei met with Zhong Nanshan and Li Lanjuan at midnight. The next morning, the expert team briefed Vice Premier Sun Chunlan. Thereafter, Drs. Zhong and Li were invited to brief the State Council Executive Meeting chaired by Premier Li Keqiang, which made the decision to include COVID-19 as a Class B disease to be treated with Class A control measures.⁶⁷ On the same day, Dr. Zhong announced during a CCTV interview that the disease can cause human-to-human transmission.⁶⁸ Meanwhile, President Xi Jinping ordered all-out efforts to curb the spread of the virus, while speaking of the need for a timely release of information.⁶⁹ On January 21, the NHC began to publish daily reports on the disease situation, including the number of newly confirmed cases, deaths per day, and recovery rates. Five days later, state media reported that Premier Li Keqiang was the head of a newly formed Central Leading Small Group (LSG) for Work to Counter the New Coronavirus Infection Pneumonia Epidemic. Although Xi did not have direct *ex officio* control over the LSG, the newly formed body was to operate under the leadership of the Politburo Standing Committee. During his January 28 meeting with the director-general of the WHO, Xi emphasized that he had been constantly “personally issuing commands and personally arranging deployments” for China’s containment efforts.⁷⁰

1. Unprecedented Containment Measures

The government reverse course is reminiscent of what Chinese leaders did after mid-April 2003 during the SARS crisis. However, the campaign against COVID-19 was pursued on a much larger scale and in a much more aggressive manner. On January 23, at the recommendation of Professor Li Lanjuan,⁷¹ Chinese authorities made an unprecedented move to lock down Wuhan, a city of 10 million people. The government canceled planes and trains leaving the city, suspended intra-city public transport, closed entertainment venues, and banned public gatherings. Meanwhile, it launched aggressive testing measures and placed—sometimes against the will of the people involved—thousands of individuals deemed to be “high risk” in one of the more than 500 makeshift quarantine centers throughout the city.⁷² The government soon extended the containment measures to the whole country, sealing off apartment complexes, villages, and entire cities, and deploying police officers and security guards to enforce mass social-distancing measures around the clock to keep people away from everyone but their closest family members. This move was facilitated by the rapid centralization of political power since 2012, which generated strong incentives for government officials to jump onto President Xi's bandwagon to demonstrate their political loyalty.⁷³ Not surprisingly, when Xi clearly signaled his policy priority and absolute control over the COVID-19 crisis after January 20, inaction and foot-dragging gave way to zealous and heavy-handed policy actions. There were reports of residents being arrested for stepping outside their homes or for not wearing masks while playing Mahjong at home.⁷⁴

In combating the virus, the Chinese state clearly demonstrated its “infrastructural power”—an ability to penetrate society and enforce its decisions. Unlike the former Soviet Union, which relied heavily on the formal bureaucracy and the police to enforce government policies, China used social forces for “community policing”—encouraging local residents to monitor each other's activities.⁷⁵ An extensive array of vehicles installed during the Mao era—village party branches, street subdistrict offices, and former barefoot doctors—was mobilized to take temperatures, quarantine people, and trace infections and close contacts. These traditional tools were made more efficient with the introduction of big data and information technology, such as QR codes and cell phones, to track and stop the spread of the virus.⁷⁶ Partly because the stringent quarantine measures were implemented during the spring festival holiday, Chinese people were generally cooperative with this Orwellian approach.

2. Beefing Up Surge Capacity

That said, implementing the draconian government measures was anything but a seamless undertaking. Because the campaign's top priority was to tame the spread of the virus, local policy actors not only turned to heavy-handed containment measures but also wanted to make them appear to be good by concealing the true scale of the crisis. From February 5 through February 14, the daily reports of mortality numbers became easily predicible using a simple mathematical formula.⁷⁷ This was compounded by the limited lab testing capacity. On February 13, prior to the arrival of a new provincial party secretary, Hubei added a new group of patients diagnosed by clinical symptoms, leading to the increase of COVID-19 cases by 45 percent within one day.⁷⁸ Also, in the absence of advance planning, the drastic lockdown of the city of Wuhan immediately caused public panic. Residents showing flu-like symptoms flooded into the hospitals seeking medical assistance. Hospitals in the city were pushed to the brink as patients in fever wards surged, despite serious shortages of hospital beds, oxygen, and medical supplies

(N95 masks, ventilators, and protection suits). Medical supplies that were donated by overseas Chinese failed to reach the recipient hospitals in time because of mismanagement by government-designated charities.⁷⁹ Consequently, many COVID-19 patients who could not get a proper diagnosis and/or treatment died at home. The already high fatality rate in Wuhan,⁸⁰ therefore, underestimates the actual mortality level. Later, the government had to add 1,290 COVID-19 deaths to Wuhan's previous tally, raising the official number of deaths by 50 percent.⁸¹ In addition, there were second-order problems caused by the shutdown, like the disruption or denial of access to healthcare or medicines for those who were suffering from other health conditions such as cancer or HIV. According to *China Newsweek*, a hospital in Wuhan discharged at least 15 terminal cancer patients to free up beds for suspected coronavirus patients.⁸²

The surge capacity problem, however, was soon resolved with the construction of more hospitals and the mobilization of additional healthcare resources. The government transferred 340 medical teams and more than 42,000 healthcare personnel to work in the front-line hospitals in Wuhan. For a time, approximately 10 percent of ICU healthcare personnel were concentrated in Wuhan, and about one-quarter of extracorporeal membrane oxygenation (ECMO) machines, which provide heart-lung bypass support outside of a patient's body, were deployed to Hubei.⁸³ Over the span of only a few days in January–February, China completed the building of two new hospitals—Huoshenshan and Leishenshan—in Wuhan, each having the capacity to treat 1,000 severe cases. In February, the central government also took the advice of Dr. Wang Chen to convert 16 exhibition centers and gymnasiums into temporary hospitals (*fangcang yiyuan*) to treat patients with mild symptoms. These hospitals enabled the authorities to launch a campaign on February 9 to “take in all who should be taken in” (*yingshoujinshou, yingzhijinshi*) to hospitalize the infected and ferret out the feverish and those who had had close contact with the sick.⁸⁴ By the time of their closure on March 10, the 16 makeshift hospitals had received a total of more than 12,000 patients.⁸⁵

3. Pros and Cons of China's Approach

Due to its aggressive containment measures, beginning in mid-February China saw a dramatic decline in the number of newly confirmed cases.⁸⁶ On March 19, for the first time, Wuhan reported no new cases. On April 8, China lifted the ten-week lockdown on the city. By the end of May 9, China reported a total of 82,901 cases, including 78,120 cases that had been cured. Despite concerns about the reliability of official data, there is no denying that China is among the first countries that stabilized the situation and started to reopen the economy. By mid-April, more than 80 percent of industrial firms had reportedly resumed operations.⁸⁷ The WHO praised China for “setting a new standard for outbreak control,” even suggesting that other countries should replicate its strict containment measures.⁸⁸

While the draconian measures are credited with taming the outbreak and buying the world time to prepare for the global spread of COVID-19, they also took a heavy toll on China's economy and society. Their disregard for civil liberties and human rights notwithstanding, the measures dealt a serious blow to Chinese manufacturing and service sectors, disrupted the global supply chain, and made it more likely that China will fall into a middle-income trap. The International Monetary Fund forecasted that China would only achieve a 1.2 percent annual GDP growth in

2020.⁸⁹ With the worldwide spread of the virus and the cancellation of international orders, a large number of Chinese firms are now struggling for survival, resulting in a rapid rise in the unemployment rate. During the first two months of 2020, five million people in China reportedly lost their jobs and 200 million others risked unemployment.⁹⁰

Worse, against the backdrop of the global spread of COVID-19, being the first country to significantly bring down the number of domestic cases turned out to be a mixed blessing for China. As shown in the resurgence of cases in Harbin (the provincial seat of Heilongjiang province) and the lockdown of Shulan (a city near the Russian and North Korean borders), China continues to face the threat of imported cases, and small-scale outbreaks are likely to be the new normal before vaccines become widely available. To avoid an outbreak of a second wave, China will have to sustain many of the preexisting containment measures, thus making a full economic recovery very unlikely.

Conclusion and Discussion

In a 2004 report published by the Institute of Medicine, I contend that “[i]n the absence of fundamental changes in the political system and a comprehensive epidemic control plan, not only is the same pattern of cover-up and inaction likely to be repeated [in China], but the government will find it increasingly difficult to control the multiple public health challenges it is now facing.”⁹¹ The COVID-19 outbreak suggests that in the post-SARS era, important progress has been made in strengthening China’s disease surveillance and response capacities, but it also reveals a pattern of cover-up and inaction similar to that which occurred during the SARS outbreak. Once the central leaders recognized the severity of the problem, they—like their counterparts during the SARS crisis—did not hesitate to turn to draconian measures to contain the spread of the virus. This time, however, local government leaders and health authorities appear to have played a more prominent role in the making of the crisis, and the ensuing containment measures were carried out more aggressively and extensively, aided by high-tech means. The speed and scale of the containment efforts and the government’s ability to rein in the spread of the virus show the presence of a highly resilient and powerful state. Still, the tremendous social-economic costs incurred by the stringent disease control measures and an inability to completely break the transmission chain highlight the limits of the reach of the state.

China’s experience in addressing the COVID-19 outbreak raises questions about the replicability of China’s pandemic control approach and, more broadly, the superiority of the so-called China model. The government now claims that its apparent “success” in containing the outbreak and Western countries’ seemingly “failure” to do so attests to the “powerful ability” of China’s political system to “rally, organize, mobilize, appeal, and act.”⁹² As part of the government’s campaign to reshape the narrative about its response to the outbreak, the fatal period of information blackout and bureaucratic inaction has been eliminated. True, Western countries including the United States faced similar pressures in downplaying the threat of the outbreak, but that is fundamentally different from China’s systematic clampdown on information crucial to disease control. Furthermore, as shown in the U.S. response after President Trump declared a state of emergency for COVID-19, the ability of liberal democracies to mobilize resources and undertake innovation cannot be underestimated. For example, within days after Governor Andrew Cuomo appealed for healthcare workers to come to New York and help fight the

outbreak, 40,000 volunteers signed up,⁹³ which were close to the number of healthcare workers the Chinese state had mobilized nationwide to support Wuhan.

Indeed, even if we disregard China's initial mishandling of the crisis, few countries can “copy and paste” China's approach to control. They may borrow some of China's containment measures (for example, mass social distancing or the shutting down of a city), but it would be a major challenge to strictly enforce social-distancing measures to the same level as seen in China.⁹⁴ In the United States, despite the implementation of mass social-distancing measures, grocery stores, pharmacies, and major retailers are still allowed to open, and public transportation remains operational. One can certainly attribute this to the lack of a strong state capacity. But in addressing this pandemic, a sound government response is not about choosing between maximum protection of health and minimum disruption of the economy and society. Instead, policymakers should carefully balance managing health risks and keeping economies and society afloat. By acting quickly and taking aggressive and innovative measures, including rigorous detection, a strict quarantine, social distancing, and effective communications, South Korea, Taiwan, and to a less extent Japan, have managed to contain the virus spread and present a more viable alternative to China's by-all-means and at-all-costs approach. In other words, China's draconian approach is hardly replicable, and it probably should not be replicated.

About the Author



Yanzhong Huang is a senior fellow for global health at the Council on Foreign Relations. He is also a professor at the School of Diplomacy and International Relations at Seton Hall University, where he developed the first academic concentration among U.S. schools of international affairs to explicitly address the security and foreign policy aspects of global health issues. He is author of *Governing Health in Contemporary China* (Routledge, 2013) and *Toxic Politics: China's Environmental Health Crisis and Its Challenge to the Chinese State* (Cambridge University Press, 2020). His writing has appeared in outlets including *Foreign Affairs*, *Foreign Policy*, the *New York Times*, and the *Washington Post*.

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<https://commons.wikimedia.org/w/index.php?curid=86272335>

Notes

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- ¹ Johns Hopkins University Coronavirus Resource Center, May 13, 2020.
- ² [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(20\)30183-5/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30183-5/fulltext)
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