

RENATO C. DE CASTRO, PH.D



**THE CHALLENGE OF MANAGING
21ST CENTURY PANDEMICS**
AMIDST THE U.S.-CHINA
STRATEGIC COMPETITION



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WRITTEN BY
RENATO C. DE CASTRO, PH.D

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Manila, Philippines

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ABSTRACT

The World Health Organization-led global public health system focuses on pandemic preparedness aimed at securing the global community against potentially catastrophic pandemics. The COVID-19 pandemic is the first major biological upheaval that has rocked the 21st century global society. Unfortunately, WHO failed to prevent the global spread of COVID-19. This is because a powerful and wealthy member state, China, has undermined the WHO from fulfilling its essential role in mobilizing the global public health system against the spread of the pandemic.

After China has successfully controlled the outbreak of COVID-19, it began an international campaign aimed to portray Beijing as victorious in its fight against the coronavirus, and being altruistic in helping the world against the pandemic by donating medical supplies and sharing scientific knowledge to countries afflicted by disease. These efforts aimed to project China's ability to lead the world in this time of crisis has poisoned its relations with the U.S., leading the only superpower in the world to adopt a policy of direct confrontation with this emergent power. Consequently, the Trump administration decided to withhold its financial contribution to WHO at the time "that there is an urgent need for unity and for the international community to work together to stop the virus (or pandemic) and its shattering consequences."¹ The dangerous mix of the pandemic and geopolitics has exacerbated the raging U.S-China strategic competition.

As a country geographically close to China and possessing one of the most fragile public health care systems in Southeast Asia, the Philippines has vital interests in reforming the global public health system. The current pandemic is a wake-up call for the Filipinos to prepare themselves against future EIDs that will hit and ravage the country in the 21st century. This will require the Philippines developing its public health infrastructure and systems as critical strategic and security assets that require public attention, legislations, funding, and a whole-government approach.

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“Pandemics are like terrorist attacks: We know roughly where they originate and what’s responsible for them, but we don’t know exactly when the next one will happen. They need to be handled the same way — by identifying all possible sources and dismantling those before the next pandemic strikes...”²

Peter Daszak, 2020

In early 2018, a group of medical experts met in a World Health Organization (WHO) sponsored conference in Geneva to project how a global pandemic would take place in the third decade of the 21st century.³ These medical experts took into account that the world is becoming increasingly vulnerable to infectious disease such as the Severe Acute Respiratory (SARS), the Middle East Respiratory Syndrome (MERS) to highly phylogenetic influenza A (H5N1), pandemic influenza A (H1N1), and Ebola virus disease.⁴ They also observed that human history shows that epidemics and pandemics occurred when previously isolated and autonomous human societies mixed and converged.⁵ In the early 21st century, ever-growing population, increased food production and animal-human interactions, rapid urbanization, and globalization have heightened the risk of pandemic outbreaks.

They boldly predicted a pandemic in the near future that will be triggered by an unknown novel pathogen that had not yet crossed into human beings from animals.⁶ They called it Disease X. They predicted that it would be a pandemic triggered by a virus originating from animals and would likely emerge in area around the globe where economic development has pushed people and wildlife to co-exist side-by-side. This contagion would probably be confused with known diseases early in its outbreak, causing it to spread quickly and silently as it would exploit growing networks of 21st century globalization made possible by the dramatic increase in human travel, commerce, and trade.⁷ Consequently, this disease would avoid early detection, and would be able to cross national borders and circumvent states efforts aimed at containing it. These medical specialists prophetically warned that Disease X would afflict more people and cause higher mortality rate than the seasonal flu.⁸ More significantly, it would unravel financial and social systems and achieve the condition of being the first global pandemic of the 21st century.⁹

In retrospect, the global society knows that Disease X is COVID-19. In early March 2020, WHO admitted that the said disease has been afflicting the world over far more rapidly outside of its country of origin, China—while its global trajectory was still unknown.¹⁰ During the period, the never before seen virus—COVID-19—had already infected more than 90,000 people in more than 70 countries and territories and killed more than 3,100 people—the majority of them in China. The WHO President Tedros Adhanom Ghebreyesus warned that the world is “in an uncharted territory” and that, “this never before seen respiratory pathogen is capable of community transmission, but which can also be contained with the right measures.”¹¹ However, as the global society grapples to control and eradicate the COVID-19

virus: it ignores the big picture that pandemics in the 21st century are on the rise, and the global society needs to contain the process that drives them, not just the individual diseases.

Like, natural calamities, famines, and hunger, major pandemics escalate underlying and existing security threats such as human conflicts like wars, rebellions, revolutions, insurgencies, and interstate rivalries.¹³ It has long been recognized that public health issues affect security and vice-versa.¹⁴ The reason is simple. Pandemics can shatter human lives, health, and productivity on a scale comparable to the effects of wars, natural disasters, and financial crises.¹⁵ Pandemics and epidemics—from the 1918 Influenza to HIV-AIDS and Ebola—disrupted national societies, undermined development, and caused and or intensified ongoing human conflicts. Inter-and intra-state wars can cause displacements of populations, which in turn affect the provisions of humanitarian assistance and public health. Pandemics are likely to emerge in conflicts zones where institutions are weak, and in turn, accentuate raging civil wars and interstate conflicts.

This is the case of the COVID-19 pandemic in light of its role in intensifying the U.S.-China strategic competition. This pandemic poured two very volatile mixtures into this great powers' competition-disease and fear. Since mid-March 2020, China has played a leading role in addressing the global pandemic; while simultaneously, blaming the U.S. for the transmission of COVID-19 in Wuhan City. These actions stemmed from China's apprehension that its international status has been severely damaged by the mishandling of the outbreak. China is repairing this damage by projecting an image of a responsible and generous great power by donating medical supplies.¹⁶ Given its pervasive influence in the WHO, Beijing is conveying to the world the following narratives:¹⁷ a) China created a new standard

for outbreak control; b) it is open or transparent in sharing with the world information about the virus; and c) Chinese harsh authoritarian measures in Wuhan City provided a “window of opportunity” for the world to counter the virus.

The United States and its Western European allies warily viewed China’s efforts for fostering international cooperation against the pandemic.¹⁸ They considered Chinese actions as components of a calculated diplomatic gambit aimed at giving China the opportunity to project itself not as a social incubator of human disease and epidemics; rather, a responsible great power now leading the global society in confronting this raging deadly pandemic. The U.S. saw China attempting to take advantage of the Trump Administration’s early missteps by taunting the effectivity of its authoritarian system in managing the epidemic, extending medical supplies and equipment to countries in need, and advising and even organizing other governments’ public health systems to cope with the global pandemic.¹⁹

Washington and its allies are convinced that Beijing is using its advantageous position as the world’s largest manufacturer of medicine and protective medical suits to temper the global anger over its initial mishandling of the COVID-19 outbreak that is now wreaking havoc on every continent except Antarctica. It also aims to prove that its authoritarian model of governance works effectively against all types of crisis.²⁰ No doubt, the 2020 COVID-19 pandemic has exacerbated the ongoing U.S.-China strategic competition.

Coming from a Security Studies perspective, this paper examines the challenge of managing the 2020 COVID-19 pandemic amidst the U.S.-China competition. It raises this main question: how can the international community manage the COVID-19 pandemic (and future pandemics) in the light of the intensifying U.S.-China strategic

competition? It also addresses the following corollary questions: (1) Why does Security Studies examine pandemics as a non-traditional security threat?; (2) How did pandemics become securitized in the mid-20th century?; (3) What is the global public health system?; (4) What are the key elements of the global public health system?; (5) How did the global public health system fare against the COVID-19 pandemic?; (6) How did the U.S.-China strategic competition affect the management of the global public health system?; and (7) how can global public health system be reformed amidst the ongoing U.S.-China strategic competition?

Pandemics as the 21st Century Quintessential NTS Threat

Throughout human history, disease has been the biggest threat to human existence despite the dramatic advances in the natural and medical sciences in the last two centuries. However, unlike other existential threats to human societies, identifying, containing, treating and eradicating the threat of pandemics require every element of a state to coordinate and manage. The capacity to control and protect the people from pandemics is considered the most delicate indicator and measure of an effective and accountable national and, in a globalizing world, international governance. For this reason, medical science alone is too narrow of a framework as an effective public health response and that it is difficult to explain past public health policy decisions or practices simply on the basis of medical or epidemiological terms.²¹ This is because pandemics do not behave in the public realm in a manner that the scientific community may desire and plan.²²

National societies react differently when confronted by pandemics as public health management involves the convergence of efforts and actions involving coercion, individual rights, distribution of wealth, community welfare, forms of domestic and international governance, and the science of public health. Accordingly, the history of public health system shows that past practices in current perceptions and policies unfold amidst shifting amalgams of politics, culture, law, security, and economics, in addition to increasingly sophisticated medical expertise.²³ The current COVID-19 pandemic and the expected outbreaks of unforeseen pandemics in the coming decades require the urgent need for domestic and global public health systems. There is recognition to treat pandemics as security issues in order to systematize and galvanize policy views, institutions, and outcomes. This is in the light of the emergence of new and more virulent pandemics; greater understanding of the cost of disease to economies, societies, interstate relations that are more deeply linked because of the process of globalization; the need to expand the participation of states, civil societies, and private companies; and the improvement of disease detection and surveillance because of the internet and information revolutions.²⁴

Security Studies was defined largely by the military agenda of questions surrounding the existence and use of nuclear weapons and a widely embedded assumption that the Soviet Union posed as a profound military threat to the United States and its Western allies during the Cold War.²⁵ This accounted for the fact that the discipline was dominated by the study of the threat, use, control, management and application of the military capability in the international system.²⁶ Defense and security traditionally focused on the protection of the state and the management of military threats to its territorial integrity

and political independence. This was the case during the Cold War when traditional security threats were as highly visible, predictable and direct because of the symmetry of both superpowers (the United States and the Soviet Union), the requirement of relative transparency for strategic deterrence to be effective, and the fact that it could be attributed to another state or group of states. This was also because the sources of the threats i.e., weapons and forces could be directly observed and counted in the form of sovereign territorial nation-states.

Since the end of the Cold War in the early 1990s, academic and policy sciences gravitated away from traditional security concerns towards a broader focus on security that included issues that were once considered lesser threats because they are non-military and non-strategic in nature such as resource scarcity, social disorders caused by overpopulation or rapid depopulation, massive environmental destruction, operations by transnational groups like criminal and terrorist organizations, and human diseases.²⁷ This led to a new awareness of the concept of security away from the state to the society then to individual human beings.

It was raised that the individual human beings should also be irreducible objects of security, leading to the notion that the security of the people is necessary to the security of the state, and that the state should provide a condition for the security of the people.²⁸ This trend coincided with the launching of the United Nations Development Program's (UNDP) concept of Human Security in 1994. The UNDP's formulation of Human Security argued that the need for an expansion of the logic of security should be broadened beyond territorial defense, national interests and nuclear deterrence to include universal concerns and the prevention of conflicts (rather than preparations for conflicts).²⁹ It also called for the eradication of poverty and underdevelopment.

The concept of Human Security calls for a shift of the referent object of security from the state to that of people and to be people-center. This requires being concerned with how people live and breathe in a society, how freely they exercise their choices, how much access they have to market and social opportunities—whether they live in conflict or in peace.³⁰ This involves protecting the people from critical (severe) and pervasive (widespread) threats and situations.³¹ The concept of Human Security calls for the creation of a complex system of political, social, environmental, economic, military and cultural elements to assure that the survival, livelihood and dignity of people can be well maintained.³² This led to a movement towards thinking beyond traditional security to include new types of threats (e.g. ecological, economic) to new objects of security (the human beings or the citizen, society), calling for a new means to ensure security. Several concepts have been developed to capture these or parts of these notions such as “human security,” “total defense,” “societal security,” “security of the citizen,” or the “all-hazards” approach. Consequently, so-called low politics issues like international terrorism, environmental degradation, scarcity of natural resources, the growing population and changing demographics, and pandemics are now labelled non-traditional security threats that deserved to be considered as relevant and pressing national security agendas.³³

Pandemics have attracted the most attention compared to other non-traditional security threats. This stems from the fact that diseases have long been the biggest threat to human existence despite the unrelenting advances in medical sciences in the two centuries.³⁴ It is for this reason that pandemics have been feared over the course of human history. There is the strong consensus of opinion that governments should adopt resolute public health and other protective measures to prevent pandemics from developing and managing risks should they

occur.³⁵ This led to the securitization of pandemics, which resulted from the fear and concerns about the global spread of communicable disease in particular (such as HIV/AIDS, but also the SARS and H5N1), and the growing sensitivities and vulnerabilities of several national societies because of rapid globalization.

20th Century Pandemics and the Global Public Health System

A pandemic is defined as “an epidemic occurring worldwide, or over a wide area, crossing international boundaries, and usually affecting a large number of people.”³⁶ Throughout history, pandemics have not only threatened human existence but also stoked fear into the hearts of people. The Plague of Justinian, which ravaged the Byzantine Empire from sixth to the eighth century AD., was considered as a classic national security issue because it weakened the empire leaving its eastern territories vulnerable for conquest by a new emerging power —Islam.³⁷ The Black Death of the 14th century claimed more lives in five years than any military conflict before or since, while the great influenza pandemic of 1918-1920 killed far more humans than the First World War (1914-1918) that preceded it.³⁸ It was also estimated that it infected some 500 million people worldwide with tens of millions of deaths, and triggered a global over-reaction to a milder, less severe outbreak of the influenza virus.³⁹ A 1927 study claimed that the 1918-1920 influenza pandemic killed 20 million people, more than the human deaths during the First World War, which took about 15 million lives world-wide.⁴⁰ However, the death figure from the Spanish Flu is now estimated to be around 50 million, making it the deadliest pandemic in human history.⁴¹

Prior to the 19th century, addressing pandemics was limited to state-centered interventions aimed primarily to limit the spread and impact of contagions focused mostly on isolated epidemic outbreaks, as the case of with quarantining of people and goods suspected of harboring infectious disease.⁴² The mid-19th century marked the emergence of a recognition that since disease is an enemy of humanity, threats posed by pandemics are transnational in nature and represent a security challenge that cannot be addressed by humanity divided into independent, though not totally separate and impervious, territorial nation-states.

The International Sanitary Conference held in early 1851 is considered to be the starting point for international cooperation in public health. The primary focus then was on harmonizing quarantine requirements among the European colonial powers, which made the conference a crucial step toward international health security concerns.⁴³ The conference was followed by several negotiations aimed to address the cholera pandemic. This culminated into international acceptance of the International Sanitary Regulations of 1903, which was later renamed the International Health Regulations (IHR). In 1907, the Office of International Public Hygiene was created with a Paris-based headquarters, a permanent staff, and a decision-making body made up of representatives of over 50 governments and colonial administrators. This international body was tasked to disseminate medical information as well as codifying quarantine agreements and expanding the scope of the International Sanitary Convention.⁴⁴

The creation of the World Health Organization (WHO) in 1948, under the auspices of the United Nations (UN), marked the establishment of the key institution for the creation and the management of the global public health system. As the directing and

coordinating authority on international health within the UN system, the WHO has the specific tasks relating to epidemic control.⁴⁵ From a purely legal or governance perspective, the WHO's creation marked a radical departure from the so-called Westphalian system of inter-state relations and health governance, based around and solely harnessing independent and sovereign states into collaboration and cooperation based on international treaties and agreements.⁴⁶ Under the WHO's leadership, global public health system was focused on measures to prevent and treat infectious tropical disease in the developing world, to improve hygiene and water supply, and to promote child and maternal health.⁴⁷

The WHO's most notable achievement during this period was the global eradication of smallpox in 1978 after a massive and sustained immunization campaign. Its other successful accomplishments under this mandate included reducing the impact of Onchocerciasis (river blindness) through pesticide sprayings of the larvae of the Simulium black fly, and the development of the drug Ivermectin, and bringing yaws and Poliomyelitis close to eradication through antibiotics and vaccination campaigns.⁴⁸ In the late 1960s, the developed countries predicted that advances in vaccines and antimicrobials would soon eradicate infectious tropical diseases from the face of the world. For the developed world, the 1950s and 1960s were a period of tremendous optimism as nearly every week, the medical established declared another "miracle breakthrough" in humanity's long and protracted war against infectious diseases.⁴⁹

The optimism that infectious disease could be eradicated in the near future led to a change in the WHO's mandate from eradicating infectious tropical disease to pandemic preparedness. This represented a new form of public health governance in which interventions

shift away from targeting and eliminating known diseases to those projected to occur at some future time.⁵⁰ This global public health system is focused on both existing and novel sources of threats, and is organized in relation to the potential inherent in the biological latency of disease, a latency that is also social, political, and economic.⁵¹ This is based on the biological truism that pathogens' ability to change and adapt poses a major health crisis; while resistant microorganisms can withstand attack by antimicrobial medications, so that standard treatments becomes ineffective, thereby increasing the risk of human-to-human transmission of drug-resistant strains. At the same time, globalization has transformed the global society as this process has increased and intensified the links and networks between territorial nation-states and diseases making them globalized and networked.⁵² This, in turn, has required new surveillance programs at the global and national levels to facilitate sharing information about possible diseases that could trigger the outbreaks of pandemics.

The Securitization of Pandemics

The securitization of pandemics generates a “new normal,” which imagines the world as newly insecure because of human diseases, with the consequences for seeking ways of imagining and responding to this new security threat.⁵³ Securitization involves the following processes:⁵⁴ 1) an actor (usually a state) identifies an issue as an existential threat; 2) the larger audience (the civil society or the larger population) accepts that the threat is indeed existential; and 3) emergency measures are put in place to address the threat, whereby policy, efforts, and resources are allocated to address the threat.

The securitization of pandemic empowers a certain actor or group of actors who will focus on this issue, along with the recognition and acceptance that security and public health are no longer separate public goods.⁵⁵ The current objective is to formulate joint or combined policy to achieve and realize these public goods. This resulted to considerable international planning and financial investments toward pandemic preparedness and the mitigation of the social, economic, and political impact of 21st century pandemics.

The WHO's role in establishing and managing the global public health system to anticipate and prepare for future pandemics was greatly facilitated by the securitization of diseases in the late 20th and early 21st century. The securitization of human disease and pandemics was a result of three developments: 1) emergence and outbreaks of Emerging Infectious Diseases (EIDs); 2) the end of the Cold War and the broadening of the concept of security; and c) the designation of the WHO as the primary international organization tasked to manage the Global public health system's pandemic preparedness.

In the 1980s, the medical community's optimism regarding humanity's ability to defeat its worst enemy—infectious diseases—was shattered by EIDs. EIDs are broadly defined as infections that have appeared in a population or have existed but are rapidly increasing in incidence or geographic range.⁵⁶ In the last forty years, EIDs that have been identified range from Ebola and Marburg hemorrhagic fever, to Acquired Immunity Syndrome (AIDS), Severe Acute Respiratory Syndrome (SARS), Influenza a H5N1, etc.⁵⁷ EIDs have triggered pandemic outbreaks that have caught the global community off-balance, revealing the limitations at all levels of the global public health system. Since the 1980s, pandemics have taken several human lives, and have shattered health, and economic productivity on scale

comparable to the adverse consequences of wars, natural disasters, and economic meltdowns. It was also apparent that pandemics pose significant risk to security and economic development. They can also cause political and social upheavals.

In May 1980, the WHO proudly announced to the world that humanity has won its long and protracted war against smallpox. However, a year later, the Centers for Disease Control and Prevention in Atlanta (CDC) observed a rare form of deadly pneumonia called *Pneumocystis carinii* pneumonia (PCP) infecting patients who homosexuals were suggesting an association between some aspect of homosexual lifestyle or disease acquired through sexual contacts.⁵⁸ In 1984, this new disease would be called Acquired Immune Deficiency Syndrome (AIDS) and was linked to the Human Immunodeficiency virus, or HIV, a retrovirus that attacks the human immune system, rendering normally routine diseases suddenly fatal.⁵⁹ Since its discovery in the mid-1980s, HIV/AIDS has infected more 35 million worldwide. Furthermore, the sudden outbreak of the AIDS pandemic in the 1980s ushered the succession of life-threatening scenarios caused by the spread of “killer viruses” and other pandemics that had been considered eradicated or at least controlled in many developed countries.⁶⁰

From early 1960s to the 1990s, medical scientists have listed 24 EIDs while many old and unyielding infectious diseases such as cholera, diphtheria, malaria, tuberculosis, and polio have made their comebacks.⁶¹ The WHO warned that the seven most infectious (HIV, TB, Malaria, Hepatitis B and C, Influenza, Diarrhoeal Diseases, and Measles) that caused the highest number of deaths at the beginning of the 20th century will remain serious threats for the coming decades of the 21st century.⁶² In the first two decades of the 21st century, the WHO has declared a series of global public health crises ranging from

the SARS, the Middle East Respiratory Syndrome (MERS) to highly pathogenic human influenza A (H1N1), and Ebola virus disease.⁶³

The end of the Cold War in the early 1990s resulted to the broadening of the concept of security from military and diplomatic to non-traditional security in terms of health, food, water, environment, climate change, transnational crimes, and terrorism. The concept of security has expanded beyond the traditional military dimension to a list of non-strategic threats that drove security debates more intensely and longer.⁶⁴ This led to the widening of the scope of security from narrow/traditional state-centric focus to a broader/contemporary human security approach. The human security approach argues that militarized interstate conflicts are no longer necessarily happening among countries. Rather, for most people in the world, the sense of insecurity arises from many non-traditional threats such as diseases, hunger, unemployment, transnational crimes, terrorism, and environmental degradation.

An off shot of human security, health security emphasizes on the need to take preventive measures to protect people from infectious diseases, distress of insufficient health care, and poor public infrastructure.⁶⁵ Health security became one of the most important areas of foreign, development and security policy in the past three decades as security is frequently encountered as contextual framework in several countries' political health and foreign policy documents.⁶⁶ This in turn, led to the securitization of pandemics as a key feature of the global public health system. Consequently, from the end of the Cold War in 1992 to the terrorist attacks on the U.S. in 2001, several U.N agencies as well as member-states of the G-8 accepted the interesting marriage between the traditional/strategic thinking of security and the more contemporary/wider human security perspective.⁶⁷ Consequently, the war on terror and

the war on HIV/AIDS were seen as two sides of the same coin; both have been constructed by the State and Defense Department, as well by the Central Intelligence Agency (CIA), as security threats that required rapid mobilization of resources and requiring U.S. leadership and international collaboration.⁶⁸ Following the terrorist attacks in the U.S. on September 11, 2001, the European Union (EU) has also adopted a series of sectoral policy that recognized the links and interactions between public health and security.⁶⁹

The global public health system's goal in the late 20th and early 21st century is geared toward pandemic preparedness through health surveillance, along with emergence intervention to control epidemic outbreaks. This required the move away from a state-centric to a supranational level of global public health system to address what are, in essence, health issues that transcend national borders.⁷⁰ Pandemic preparedness 'embodies a preemptive approach to the regulation and control of emerging infectious disease that involves generating responses to predictions concerning a future event that is both exceptional and highly uncertain.'⁷¹ This requires developing the means to detect, investigate, isolate, and prevent the transnational transmission of the virus or bacteria.⁷² If pandemics breakout, they are immediately considered worldwide Public Health Emergencies of International Concerns (PHEICs) as no single nation-state has the resource capacity to contain its spread.⁷³

The WHO spearheaded the program of preparedness, as a security paradigm, in order to secure the global community against potentially catastrophic global pandemics. The WHO has been particularly influential in setting planning priorities for countries and regions that oriented toward preparedness. Preparedness emphasizes institutional readiness and emergency management, treating a variety of potential

catastrophic threats—terrorist attacks, hurricanes, and pandemics—under the same category and rubric. From 1999 to 2009, the WHO published four key planning documents that articulate the rationale for pandemic influenza preparedness and various models of pandemic phases. The WHO model requires member-states ceding a considerable part of their respective sovereignty in national health policy to the international community. This in turn, expanded the scope of individual member-states to manage pandemic crises more flexibly than was possible previously under the more rigid linkage to internationally promulgated phases.⁷⁴

The Global Public Health System

The WHO-led global public health system introduced three innovations in the global society:⁷⁵ 1) the extension of public health activities beyond the nation-state; 2) the shift of surveillance at the level of the individuals from the level of the population; and 3) the expansion of surveillance to encompass the communication of information and data about the outbreaks of pandemics. The system, however, does not operate through international law, meaning states are not legally bound to observe its rules and directives. Instead, it relies on soft law that represents non-binding but a normative obligation to cooperate with other member-states and the WHO in connection with EIDs surveillance and response to pandemic outbreaks.⁷⁶

The nation-states constitute the foundation of the global public health system. The International Health Regulation Treaty (IHRT) of 2005 figures as the most significant legal instruments that states have

signed on global public health system. Its purpose is to prevent, protect, against, control and provide a public health response to the international spread of disease.⁷⁷ Its particular importance is that member-states have undertaken to notify the WHO of events that may constitute a PHEIC. The 2005 IHRT requires all state parties to develop core health system capacities, and to prevent the international spread of disease with robust surveillance and response obligations.⁷⁸ Under the WHO Constitution, the IHR is binding to all WHO member-states. They are required to meet a set of standards, known as “minimum one core capacity requirements” aimed at averting and responding to PHEIC.⁷⁹ They must develop their minimum core capacities through national legislation, policy and financing to develop the capabilities for surveillance, response, preparedness and risk capabilities in responding to zoonotic, food, safety, chemical, and radio nuclear crises.⁸⁰

State parties are also expected to establish a “National Focal Point” in charge of monitoring regular communications with the WHO. This requires notifying WHO of potential PHEIC.⁸¹ In turn, the WHO, occupies the central role in summoning states to increase their preparedness in order to fulfill their obligations within a global system that has come to be defined by mutual vulnerability through discursive constructions of viral uncertainty and circulation.⁸² The WHO’s mandate and capabilities for an effective system of pandemic preparedness, however, would be severely challenged by the 2003 SARS and the 2020 COVID-pandemics.

The system operates on a simple and common clinical practice that isolated infectious disease outbreaks begin and could end at the local community level, the same as pandemic outbreaks begin and end. This process involves means to detect, investigate, isolate, and

prevent the transmission of the virus and bacteria outside of the local community. Every virus's weakness is that once human-to-human transmission is prevented and contained, it will be eradicated. This, in turn, will end the epidemic outbreak. The process of merging a customary clinical practice with global public health principles and the local culture defines what is referred to as "operational public health skill set." This is recognized as the WHO's core competencies.⁸³ It should be pointed out, however, that while the biology of infectious disease control is universal, the politics surrounding its containment and eradication differ greatly in every nation-state.⁸⁴ In several instances of epidemic and pandemic outbreaks, many states have intentionally refused to disclose information or failed to do so in a timely manner, resulting to the public being misinformed or even fed with false expectations.

The WHO publishes interim guidelines on pandemic risk management that describes pandemic phases along a continuum according to global average cases over time. However, individual member-states still retained responsibility and flexibility for their own national risk management plan.⁸⁵ The WHO depends on national health official for information, information these officials were under no obligation to provide and which they only receive from regional officials who in turn received it from local officials. The WHO is not directly involved in gathering local, regional, or national data.⁸⁶ Whether or not a member state will share information with WHO to contain an EID outbreak depends on two factors:⁸⁷ a) the country's self-interest; and b) the WHO's ability to construct a framework for international cooperation on infectious diseases that may withstand the expanding global threats posed by lethal pathogens.

China Undermines the Global Public Health System

In the past decade, there have been cases when tension broke out between states and the WHO over maximum cooperation and transparency as the formers' economic, commercial, political, and diplomatic interests have adversely infringed on global pandemic preparedness.⁸⁸ As a case in point, the 2005 IHR requires all WHO member-states to notify the organization "within 24 hours of assessment of public health information, of all events which may constitute a PHEIC within its territory as well as any health measure implemented in response to this event." However, for a number of reasons, there are cases when member-states withheld information to the WHO.

During the Ebola pandemic in West Africa, the world was caught off guard by the outbreak because national disease surveillance was poor, and local health systems were overwhelmed.⁸⁹ During the SARS outbreak in Canada in 2003, the Canadian federal government was not able to provide timely information because the Province of Ontario was handicapped in data gathering due to its dependence on voluntary transfer of information crucial to the WHO decision-makers.⁹⁰ From 2006-07, Indonesia refused to share samples of Influenza H5N1 isolates to the WHO in direct protest to what it alleged as inequitable sharing of virus samples and vaccine development technology.⁹¹

In the case of China, the Chinese Communist Party (CCP) has inadvertently facilitated the outbreaks and spread of two EIDs by taking steps to prevent the early detection and investigation of EIDS by concealing its existence.⁹² This lack of transparency is an attribute rather than a bug (or a flaw) in China's system of governance.⁹³ An Australian analyst insightfully describes it: "The entire system, beset with fear, uncertainty, cover-ups, bad faith, and indecision at multiple

levels, misfired until the top tier finally realized the gravity of the situation. This resulted to the virus spreading beyond a locality, into the rest of the country, and then to the world.”⁹⁴ This was apparent during the SARS outbreak from 2003-2004, and later with catastrophic consequences, during the COVID-19 pandemic in 2020.

The SARS outbreak was first detected on November 16, 2002 when a man with flu-like symptoms visited a hospital in Foshan in Guangdong province.⁹⁵ Doctors in the hospital were puzzled by the man’s illness but he did not die and eventually was discharged. Then, in January 2003, a seafood merchant from the provincial capital of Guangzhou was admitted in a local hospital and in the process, infected staff in three hospitals. He also infected a professor who went to Hong Kong. While in Hong Kong, the professor stayed in Hotel Metropole where he infected guests who then flew abroad to Vietnam, Canada, Taiwan, and Singapore carrying with them the SARS virus. The WHO was alerted about this new EID in late February by an Italian doctor who reported to Geneva that the new disease produced flu-like symptoms before developing into pneumonia.⁹⁶ The WHO coordinated an international team of experts to study the new disease, which was named SARS.

During the height of the SARS epidemic, the WHO representative to China complained that Chinese officials refused to give “straight answers” to multiple queries about the rapidly spreading SARS outbreak.⁹⁷ Accordingly, case reports from Chinese physicians were passed to local health departments and then forwarded to municipal and provincial authorities, but it took a month before they finally reached government officials in Beijing.⁹⁸ China’s incompetent and state-controlled surveillance and control system led to the spread of SARS from Southern China to 37 countries in 10 weeks.⁹⁹ This outbreak became the world’s first “multi-country events” that took the

lives of 774 people and infected more than 8,000 individuals. Its eight month-outbreak resulted to the loss of more than US\$40 billion.¹⁰⁰ In retrospect, the SARS outbreak from 2003 to 2004 exposed not only the individual nation-state public health's inadequacies in addressing an EID but also the limitations and vulnerabilities within the global public health system of an unprecedented scale. Unfortunately, this would only be the beginning.

The SAR-CoV-2 the virus that causes the COVID-19 pandemic—was first detected in Wuhan City, the capital of China's Hubei Province. The first human infection is thought to have been registered in November or December 2019, pursuant to which the virus spread locally through human-to-human transmission. Clinically, COVID-19 virus and its transmission have a unique feature that presents a particular challenge for disease prevention and control—COVID-19 can be infectious among humans without symptoms and through aerosol transmission paths, and that incubation period could be as long as 24 days.¹⁰¹ Epidemiologically, it would be first 21st century global pandemic of an EID affecting the respiratory tract that illustrated the complex interaction between animal and human hosts, the microorganism, and the environmental factors that affect exposure or transmission.¹⁰²

On December 31, 2019, the WHO was informed of “cases of pneumonia of unknown etiology (unknown cause)” detected in Wuhan City in the Hubei Province of China. In the first half of January 2020, cases of COVID-19 were registered in Thailand and Japan, signalling the beginning of the disease's very rapid spread on a global scale.¹⁰³ On January 30, 2020, the WHO president announced the outbreak of COVID-19 to be a PHEIC—reflecting the fact that the epidemic had escalated rapidly around the world, despite the Chinese government's emergency efforts since January 20 to mobilize and centralize resources



CHINA

SOUTH KOREA

Wuhan

THAILAND

CAMBODIA

VIETNAM

to control the epidemic's outbreak and global spread.¹⁰⁴ This allowed WHO to issue so-called "temporary recommendations" such as specific health measures to be implemented by the state of states where the disease has already broken out.¹⁰⁵ By this time, however, South Korea and Taiwan have already taken significant measures to contain the outbreak of the disease. By contrast, COVID-19 spread dramatically and rapidly to other countries such as Iran, Italy, and Spain. In retrospect, it is important to re-examine what transpired between late November 2019, when the first cases of COVID-19 were detected and January 20, 2020, the first day when a Chinese national health expert officially admitted that the COVID-19 has human-to-human transmission mechanism.

On the morning of December 26, 2019, Mr. Jixian Zhang, the director of respiratory medicine of Hubei Provincial Hospital of Integrated Chinese and Western Medicine in Wuhan found four abnormal cases of pneumonia and he reported this Wuhan Center for Disease Control (CDCP) the following day. On January 5, 2020, the Wuhan Health Commission (HC) confirmed that there were 50 patients with an unexplained pneumonia diagnosed in Wuhan. On January 9, 2020, Chinese authorities officially established the novel corona virus as the pathogen of what was then called "Wuhan pneumonia." In the early stage of the COVID-19 epidemic in Wuhan City, the Chinese government adopted information blockades and controls to prevent public panic, which resulted in most people unprepared for COVID-19.¹⁰⁶ An Australian think-tank observing the local government's knee-jerk reaction to the outbreak of the epidemic, comments: "the party-state soon managed to regain control of the narrative, at least at home. The media was reined in. Critical bloggers were silenced. Some critics disappeared altogether, into detention."¹⁰⁷

Strict government control over information about the emerging disease was seen as the main reason for the news blackout, which caused people to be unaware and unprepared for the outbreak of COVID-19 in Wuhan.¹⁰⁸ It was observed that local government officials habitually underreported bad news (like an outbreak of an infectious disease) for fear of economic losses or criticism from upper level officials, which would impact their personal political ambitions.¹⁰⁹ Oblivious to the spread COVID-19 in the city, the Baiting Community hosted a banquet for more than 40,000 families on January 18, 2020. At the same time, people were still visiting popular places in Wuhan such as shopping malls, supermarkets, and entertainment places in large number until January 20, 2020. These events accelerated the rapid spread of COVID-19 among the population.¹¹⁰

Doctors in Wuhan who first detected the appearance of the virus were subjected to reprimands and other punishments.¹¹¹ Some medical workers who warned their colleagues about the outbreak were silenced and admonished by the local authorities. On December 30, 2019, Dr. Li Wenliang posted a message to a social media chat group, which included other medical doctors, about patients showing symptoms of a new disease no different from the SARS. Instead of heeding his warning about an EID, Dr. Wenliang was detained for spreading false rumours and was forced to sign a police document admitting that he had seriously disrupted social order.¹¹² Another medical doctor, Dr. Ai Fen reported to a hospital's public health department that she had seen a test sheet mentioning to health department and infection department about SARS symptoms among patients.¹¹³ Instead of reporting it to higher medical authorities, hospitals differed to local health authorities about reporting infections, apparently to avoid surprising and embarrassing local official.¹¹⁴ On January 1 and January 2, rather than

responding factually to these online claims about the outbreak, the Wuhan municipal government and China Central Television (CCTV) announced that these eight medical personnel were spreading rumors and had been threatened by the local police.¹¹⁵

Aside from imposing an information blockade about the outbreak, local and national officials were far from transparent about the nature of COVID-19 infection. As late as January 15, the Wuhan Municipal Commission claimed that they found no evidence of human-to-human transmission, and while they cannot rule out the possibility of human-to-human transmission the risk of continuous human-to-human transmission is relatively low.¹¹⁶ This was despite the fact that human-to-human transmission was apparent in the light of medical professionals becoming infected by the virus.¹¹⁷ The Chinese National Center for Disease Control (CNCDC) did not explicitly admit that COVID-19 could transmit from human-to-human until January 20, 2020. However, Chinese academics writing in two Western academic medical journals—The New England Journal of Medicine and The Lancet—described in detail family cluster transmission, and the infection of seven medical staff from January 1 to January 11, 2020, all proving that COVID-19 is transmitted from human-to-human.¹¹⁸

On January 10, the second delegation from the CNCDC sent to Wuhan claimed that “the epidemic can be controlled and preventable, while the Wuhan municipal government health commission stated that it had not found newly infected patients from January 11 to 16.¹¹⁹ This was because authorities ordered a freeze in testing between January 6th and 14th, leaving the official figure of cases at 41 even as foreign authorities suspected that hundred cases had already developed.¹²⁰ This led the delegation to declare that the “epidemic can be controlled and preventable since the Wuhan municipal government health

commission had “not found newly infected person on the said dates.”¹²¹

As early as January 1, 2020, medical practitioners in Wuhan had discovered an unknown type of pneumonia based on medical testing reports. Local and national health experts and officials who visited Wuhan from December 31 to January 15, 2020 have already sensed the potential danger of human-to-human transmission given their years of experience and expertise plus the fact that all confirmed patients were already isolated by December 30.¹²² Nevertheless, health professionals and officials knew very well that they could only provide technical support intended to provide guidance to higher officials and party members who made the final decisions.¹²³ At the onset of epidemic in Wuhan, doctors and other medical officials successfully collected early data about the outbreak, but these efforts were crushed by the CCP and agencies under its control.¹²⁴ Instead of initiating efforts to prevent the spread of COVID-19, the Wuhan local government accused these medical professionals of spreading rumours and were admonished by the police. In contrast, from January 3 and 4 respectively, Singapore, Hong Kong, and Taiwan immediately implemented quarantine measures on those travelling to and from China.

The party’s and the local government’s massive efforts in concealing the extend of the outbreak were driven by the Chinese government’s apprehension that its population was resentful on how the top leadership mishandled the public health crisis by suppressing information regarding the epidemic.¹²⁵ Municipal and provincial party leaders in Wuhan City and Hubei Province tried to deflect the central government’s wrath and minimized the adverse effects of the raging public health crisis.¹²⁶ When the extent of the epidemic outbreak became apparent, however, the central leadership behaved like any

authoritarian regime would react by: blaming local officials; ramping up domestic censorship; arresting or silencing whistle-blowers; and withholding information about the brewing public health crisis while at the same time refusing American offer of assistance.¹²⁷ The central government castigated the local government for delays in reporting new cases of the epidemic. It sacked two senior officials—the party secretaries of Wuhan and Hubei province—over their roles in allowing the spread of COVID-19 in Wuhan City, in the surrounding areas around the city, and eventually, all over China.¹²⁸

On January 23, 2020, the Wuhan Municipal government eventually imposed a lock down on the city. However, by this time, 400,000 people left Wuhan moving to Guangdong Province, 120,000 to Shanghai, 120,000 to Beijing, and 680,000 to the provinces, and municipalities around Hubei provinces. This massive movement of people out of Wuhan meant the spread of the COVID-19 all over China. Consequently, health commissions in each province, municipality, and autonomous region outside the Hubei province concealed the epidemic's extent, while the Chinese central government launched an unprecedented national campaign to contain the spread COVID-19 in the country.¹²⁹

China did not only impose strict government control over information on the outbreak by silencing the media and punishing medical practitioners and researchers who warned the people about the spread this EID, which left the international community to be unprepared for the COVID-19 pandemic. China successfully enlisted the WHO in its cover up of the pandemic. China's early suppression of the public sector information and reporting chain generated a much larger and more serious national and medical crisis.¹³⁰ Intriguingly, WHO Director-General Ghebreyesus, formerly Ethiopia's health and

foreign minister, even thanked China for its transparency over the spread of COVID-19 (despite the month-long delay in responding, and the cover up that included the punishments of whistle-blower doctors) and heaped praises on Xi after their meeting in Beijing's Great Hall of the People on January 28, 2020.¹³¹ Worse, the WHO also officially adopted the Chinese government's claim that there is no clear evidence of human-to-human transmission of the novel coronavirus identified in Wuhan. This was despite evidences of medical practitioners being infected by their patients and its receipt of the 31st of December letter from Taiwan informing the WHO about COVID-19's ability to spread through human-to-human transmission.¹³² This was seen as the WHO's uncritical reiteration of Beijing's untruthful claim about human transmission that betrayed the organization's efforts to prevent other states from hitting China with travel restrictions.¹³³

When Australia and several countries imposed a travel ban on China, Mr. Ghebreyesus indirectly censured these countries by stating that "there is no reason for measures that unnecessarily interfere with international travel and trade. We call on all countries to implement decisions that are evidence-based and consistent."¹³⁴ On February 16-17, 2020, the WHO released a "Report of the WHO-China Joint Mission on Coronavirus Disease 2019," that singularly praised China's response as the best source of medical technology to deal with the pandemic.¹³⁵ The WHO also withheld declaring the PHIE in China as a pandemic until March 11, 2020, despite the fact that several countries around the world have already reported widespread cases of COVID-19 human-to-human transmissions in their respective populations. German news organization, Der Spiegel, reported that Mr. Tedros held off issuing a global warning about the pandemic due to direct pressure from Chinese President Xi Jinping.¹³⁶ It has



also been observed, that in difference to China, the WHO ignored Taiwan health officials' December 31, 2020 medical findings on human-to-human transmission and their offer of a valuable model of best practice in pandemic response and control.¹³⁷ Consequently, ever since the WHO first announced the presence of clusters of unknown pneumonia on December 31, 2019, an alarming concern has surfaced that this international body has become beholden to influential countries for funding support, giving wealthy UN member-states, especially China, support and influence both before and during the coronavirus outbreak.¹³⁸

The CCP's efforts to control information during the epidemic's outbreak, the central government's massive and well-oiled national campaign to control the spread of the virus, and its knack to sway the WHO to its side enabled China to win a decisive battle against this EID. The rest of the world, however, is left fighting a losing battle in containing the global spread of the COVID-19 pandemic.

Pandemic and Fear Amidst the U.S.-China Strategic Competition

From mid-January to mid-March 2020, China's political leadership single-mindedly focused on containing a deadly coronavirus epidemic that began in the central Chinese city of Wuhan.¹³⁹ The central government's focused and resource-intensive campaign to contain the spread of COVID-19 in China, however, was not about ensuring health security for the Chinese nation. For the CPP, like everything, it was and remains primarily a contest of politics, in which the party-state benchmarks itself against other governing systems, especially

the world most powerful democracy and its great power competitor, the U.S.¹⁴⁰ This has become more intense because even before the outbreak of the novel coronavirus in Wuhan China in December 2019, the U.S. and China were already engaged in a strategic competition.

Since 2011, U.S. and Chinese interests in East Asia have become less aligned as the two powers began competing for influence.¹⁴¹ On the one hand, Beijing has become more vocal against the U.S. alliance system, arguing that it reflects Cold War thinking and encourages America's Asian allies to challenge China's primacy in East Asia. On the other hand, the Obama Administration's rebalancing strategy to Asia-Pacific and heightened U.S. regional cooperation with its allies have stoked the CCP's fear of American geostrategic encirclement of China. Since coming to office in 2017, President Donald Trump made the strategic competition with China as the centrepiece of his administration's foreign policy. This geo-strategic contest is characterized by U.S. forceful pushbacks and initiatives against what the Trump Administration claimed as unfair Chinese trade practices, cyberespionage, unlawful maritime expansion, military intimidation of American allies and security partners in East Asia, and global propaganda campaigns directed against the Western Alliance.¹⁴²

As the level of domestic infection started to decline, Beijing activated its diplomatic network to announce and offer versions of China's solution to the COVID-19 pandemic.¹⁴³ China then launched a major diplomatic and humanitarian offensive aimed at assisting countries that are struggling against the raging pandemic.¹⁴⁴ In early March 2020, China deployed abroad medical experts, rapid diagnostic testing kits, and protective medical gears to the Philippines, Serbia, Spain, Iran, and Italy. From East Asia to the Middle East. China also provided or offered humanitarian and medical assistance in the form of medical expertise

and equipment. Exploring the motive behind China's generosity in donating medical equipment and gears to countries stricken by the COVID-19 pandemic, an American academic claims:

Propaganda efforts have also been taken a more positive tone, such as donations of medical equipment abroad. One advantage of keeping the extent of the outbreak secret was that this allowed China to obtain Personal Protective Equipment (PPE) at artificially low prices on international markets. In other instances, China was able to sell back PPEs that had initially been donated to fight the Wuhan epidemic to the countries that donated it—for example Italy or Mexico. Other PPEs were donated according to political calculation, making China appear benevolent and generous on the international stage.¹⁴⁵

China provided medical assistance to countries and cities around the world. In return, Chinese donors demanded that the benefactors should highlight their generosity.¹⁴⁶ Interestingly, when China was receiving international aid in the early part of the pandemic, it asked donor countries not to publicize their donations. Chinese officials are also claiming that COVID-19 pandemics should be viewed as an opportunity for international cooperation not competition. They also publicly flaunted the idea that China's national lockdown was a national sacrifice that decisively slowed down global spread of COVID-19.¹⁴⁷ China elicited and got the WHO's support to its claim that it is investing in "people's health outside its border" and its singular and spectacular success in controlling the pandemic should qualify China to take over the WHO.¹⁴⁸

China's triumph in containing the spread of the epidemic in the country, and its efforts in extending medical assistance to the global community emboldened Chinese officials and diplomats to conduct a propaganda campaign against the U.S. and its Western

European allies. In March 13, a Chinese Ministry of Foreign Affairs spokesperson accused the U.S. of spreading the virus to Wuhan City that was center of the country's coronavirus epidemic.¹⁴⁹ In his Twitter account, Chinese Foreign Minister Spokesperson Zhao Lijian claimed that the U.S. Army brought the virus to China during the Military World Games which held in Wuhan in October 2019.¹⁵⁰ Relying on a statement by the director of the U.S. Centers for Disease Control and Prevention (CDC) during a congressional hearing, Mr. Zhao inferred that the infection actually began in the U.S. and that American military personnel brought the virus to China during their participation in the 2019 Military World Games that was held in Wuhan in October 2019.¹⁵¹

This wild and unfounded accusation came on the heels of U.S. National Security Adviser Robert O'Brien's statement, during a U.S. congressional hearing, declaring Chinese cover up of the epidemic in Wuhan City, which cost the international community two months and led to the global outbreak of the COVID-19 pandemic.¹⁵² Interestingly, after criticizing American officials for politicizing the pandemic, Chinese officials and news outlets flouted unfounded theory that COVID-19 is actually an American disease that might have been introduced by members of the United States Army who visited Wuhan in October 2019.¹⁵³ 21st century Chinese allegations that the U.S. Army planted the virus in their country resurrected memories from the Cold War when the Soviet intelligence agency, the KGB, launched Operation Infektion.¹⁵⁴ This covert misinformation operation planted and propagated the myth that the U.S. created and spread the HIV/AIDS pandemic in the 1980s.¹⁵⁵

The coronavirus pandemic is testing American leadership in world affairs in terms of domestic governance, provision of global public goods, and ability and willingness to muster and coordinate

international response to address a global crisis—the COVID-19 pandemic.¹⁵⁶ The dramatic increase in COVID-19 cases among Americans, the Trump Administration's failure to implement with a nation-wide program against the pandemic, and inability to mobilize the global community in this time of crisis showed that the U.S. is failing its test of global leadership. As Washington falters, Beijing is moving quickly to take advantage of the political/diplomatic vacuum generated by the Trump Administration's missteps, filling the void to position itself as the global leader in the pandemic response.¹⁵⁷ In the face of sustained and well-funded and organized Chinese propaganda offensive against the U.S., the Trump Administration's policy toward China shifted away from a mix of competition and cooperation to outright confrontation.¹⁵⁸

In his March 23 speech in the White House, President Trump accused Beijing of concealing the outbreak first detected in Wuhan that eventually became a pandemic that paralyzed the U.S.¹⁵⁹ Trump Administration's health officials denounced China's resistance to share data about the virus and warned that it has the power to interfere with medical supply chains into the U.S.¹⁶⁰ The administration also entertained calls from several American commentators and legislators who were calling for businesses to domestically produce vital medicines and equipment to reduce the country's dependence on Chinese manufacturers and importers. It also raised questions on the degree of decoupling the U.S. and its allies need to undertake against the Chinese economy by diversifying their supply chain and being less dependent to manufacturing platforms based in China.¹⁶¹ Finally, key cabinet members called for a more confrontation posture toward this emergent power as they warned that a fast-growing China, under Mr. Xi's increasingly authoritarian rule, seeks military, economic, and



technological domination over the U.S. and its allies.

The Trump Administration also (correctly) claimed that China used the WHO to conceal the outbreak of COVID-19 in Wuhan, and to falsely report that there was no evidence of human-to-human transmission of the coronavirus. On April 15, 2020, despite criticisms from other world leaders, the Trump Administration decided to withhold funding to the WHO. The U.S. is the world's largest donor to the WHO with more than US\$400 million contribution in 2019, amounting to about 15% of the international body's budget. In his reaction to the Trump Administration's decision to withhold funding to the WHO at the time of the COVID-19 pandemic, United Nations Secretary-General Antonio Guterres decried that "cutting resources for WHO during a world crisis is counterproductive. Now is the time for unity and for the international community to work together in solidarity to stop the virus and its shattering consequences."¹⁶²

Conclusion and Recommendations

The COVID-19 pandemic is the first major biological upheaval that has rocked the 21st century global society. Prior to the 20th century, low population densities, infectious diseases, outbreaks of epidemics and pandemics were generally rare and were primarily driven by natural disasters, inter-state wars, revolutions, and other social upheavals. However, because human population has increased exponentially, the spread of numerous EIDS has accelerated because of economic globalization, massive urbanization, revolution in transportation and communication, decline in biodiversity, and climate change. The WHO is the most significant international

when it comes to managing the global public health system against the international spread of EIDs. Unfortunately, the WHO failed to prevent the global spread of COVID-19. This is because a powerful and wealthy member state, China, has undermined the WHO from fulfilling its essential role in mobilizing the global public health system against the spread of the pandemic.

The CCP and its local government official ordered a media blackout of the coronavirus outbreak in Wuhan. China also gave false statement to the WHO about the nature of the COVID-19 as it claimed that there was no clear evidence of human-to-human transmission. China's denial about the outbreak of the epidemic and the WHO's failure to investigate Chinese claim about the nature of the infection led to decisions that allowed hundreds of thousands of Chinese to travel abroad during the Lunar New Year. This prevented any meaningful measures to contain the virus inside China, and instead, allowed COVID-19 to ravage the global society. Interestingly, the WHO even praised China's response to coronavirus epidemic as the best source of medical technology in addressing the spread of the pandemic.

After China has managed to control the outbreak of COVID-19, it began a global campaign to portray Beijing as victorious in its fight against the coronavirus, and being altruistic in helping the world against the pandemic by donating medical supplies and sharing scientific knowledge to countries afflicted by disease. China then accused the U.S. of creating the disease and planting it in Wuhan City during the October 2019 Military World Games. These efforts aimed to project China's ability to lead the world in this time of crisis have poisoned its relations with the U.S., leading the only superpower in the world to adopt a policy of direct confrontation with this emergent power. Consequently, the Trump administration decided

to hold its financial contribution to the WHO at the time “that there is an urgent need for unity and for the international community to work together to stop the virus (or pandemic) and its shattering consequences.”¹⁶³ In the face of the COVID-19 crisis, the dangerous mix of the pandemic and geopolitics has exacerbated the raging U.S.-China strategic competition.

As a country geographically close to China and possessing one of the most fragile public health care systems in East Asia, the Philippines has vital interests in reforming the global public health system. The raging COVID-19 pandemic is an unmistakable writing on the wall that cannot be ignored. The current pandemic is a wake-up call for the Filipino nation to prepare against future EIDs that will hit and ravage the country in the 21st century. This will require developing its public health infrastructure and systems as critical strategic and security assets that require public attention, legislations, funding, and a whole-government approach. The Philippines must also ensure that the WHO should uphold its autonomy from influential and rich countries to make it better equipped in leading the global public health system against the future pandemics of the 21st century. To achieve these twin objectives, the Philippines must pursue the following measures:

1. *Incorporate Health Security in the National Security Strategy, the National Defense and Military Strategies, and in the National Economic Development and Authority’s (NEDA) Five-Year Development Plan*

As a concept, health security focuses on taking preventive measures to protect the nation from current and more importantly future

infectious disease, distress of insufficient health care, and inadequate public health infrastructure. Operationalization of health security in terms of policy will require the securitization of EIDS, and examining how the management of infectious diseases could converge with the broader configuration of, public administration, medical science, national security, and economic development.

2. Increase Investment in the Public Health Care System with the objective of finding the right balance between addressing chronic and endemic disease versus EIDS and the re-emergence of previously controlled diseases like tuberculosis, bubonic plagues, and even polio

It is known fact that the Philippines' public health system and infrastructures have been unattended and underfunded for decades. The government should increase the percentage of the national budget allocated to the public health system with an eye for determining the appropriate balance between managing chronic diseases and pandemic preparedness that will require prevention, preparedness, response, recovery, and rehabilitation from future pandemics of the 21st century.

3. Integrate Pandemic Preparedness in Philippine Diplomacy

The Philippines' Department of Health (DOH) should train and deploy epidemiologists to certain Philippine diplomatic posts to monitor EIDS that could emerge in certain parts of the worlds like China, Africa, and South America. These health attaches should be tasked to monitor possible outbreaks of EIDS in those parts of the world and alert the

DOH , the Department of Foreign Affairs (DFA), and the Bureau of Immigration (BOI) on the necessary measures to protect the country from the future pandemics of the 21st century.

4. Integrate Pandemic Preparedness in the Philippines alliance with the U.S. and security partnerships with Japan, South Korea, Australia, and India

The Philippines should tap into the capabilities and resources of its only formal treaty ally and security partners in preparing its overall capabilities not only for disaster but also pandemic preparedness. Pandemic preparedness should be included in the country's military exercises with the U.S., Japan, Australia, South Korea, and India.

5. Incorporate Pandemic Preparedness in its agenda in the Association of Southeast Asian Nations (ASEAN)

The Philippines should push the agenda of pandemic preparedness in all ASEAN-related activities. The Philippines should convince the regional organization's member states to include pandemic preparedness as one of the key functional areas of ASEAN cooperation.

6. Support Australia and other like-minded states in Pushing for an Investigation of the origin of the COVID-19 Outbreak and on the allegation that the WHO has become beholden to influential and affluent countries like China

Despite its close political and diplomatic ties with the China, this current administration should support Australia's call for an impartial investigation on the origin of the coronavirus outbreak. Given that the Filipino nation has been ravaged by this pandemic, it is only right and proper that China be held accountable for this epidemiological catastrophe that has killed thousands of people around the world, and caused the greatest economic meltdown in history since the Great Depression of the 1930s. The Philippines also has an interest on the WHO's being an autonomous and technical agency with a policy-making body free from excessive political intrusion by rich and powerful countries. An autonomous and science-driven WHO should be able to carry out of its technical work of pandemic preparedness with authority and credibility as the standard bearer of the global public health system.

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