

Coronavirus Politics

The Comparative
Politics and Policy
of COVID-19



EDITED BY

Scott L. Greer, Elizabeth J. King,
Elize Massard da Fonseca, and André Peralta-Santos

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Editors

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5 PUBLIC POLICY AND LEARNING FROM SARS

Explaining COVID-19 in Hong Kong

John P. Burns

Health outcomes in Hong Kong, a city of 7.3 million, are among the best in the world (Goodman, 2009; Kong et al., 2015). Life expectancy for men (82.2) and women (87.6) makes them the longest lived in the world (Food and Health Bureau, 2019). Infant mortality rates (1.5 per 1000 registered live births) are fourth lowest globally (Food and Health Bureau, 2019). All of this is achieved by spending just 6.2 percent of gross domestic product (GDP) on health care (Food and Health Bureau, 2019), compared to an average of 8.8 percent in Organization for Economic Cooperation and Development (OECD) countries, and 17.1 percent in the United States (OECD, 2020). This makes Hong Kong's healthcare system one of the most efficient (Miller & Lu, 2018). Yet, despite its experience of SARS in 2003 and community solidarity to implement measures to fight the virus, Hong Kong experienced uncontrolled community outbreak of COVID-19. Beginning January 23, 2020, for five months Hong Kong recorded only six deaths from COVID-19. However, by August 26, 2020, Hong Kong had recorded 4,736 confirmed/probable cases and 78 deaths in three waves of COVID-19 infection, each more severe than the previous one (The Government of Hong Kong Special Administrative Region, 2020). Hong Kong's third wave of contagion, beginning July 5, 2020, was so serious that for the first time since 1997, when China resumed sovereignty over Hong Kong, local authorities sought emergency help from the central government. What happened? Why was Hong Kong unable to cope?

Successive governments in Hong Kong established a dual-track public and private healthcare system. The public system, centered around the Hospital Authority (HA), provides about 90 percent of inpatient services, open to all residents of Hong Kong needing medical care at an "affordable" (nominal) price. The HA delivers these services through a network of forty-three hospitals, employing about 40 percent of local doctors (Hospital Authority, 2020). The private sector provides about 70 percent of all fee-for-service outpatient services (Our Hong Kong Foundation, 2018; Schoeb, 2016). The HA picks up the rest through its public outpatient clinics, again at a nominal charge. The HA system faces a chronic shortage of public health professionals, and patients face long delays for nonemergency services (Cheung & Tsang, 2019; Schoeb, 2016). The public system provides most services for Hong Kong's rapidly aging population. The government esti-

mates that from 2020 to 2066, the percentage of Hong Kong's population sixty-five years or older will grow from 18 percent to 33 percent (Hong Kong Special Administrative Region Census and Statistics Department, 2017b).

The Hong Kong colonial government long ago established a business-friendly low tax system (15 percent salaries tax; 17 percent business tax; and neither value-added tax (VAT), inheritance, nor capital gains taxes). Authorities chose to keep the tax base narrow, relying instead on land and property sales (stamp duty), and property taxes to help balance the budget (Poon, 2010). Only 40 percent of employed people pay any salaries tax, and only 10 percent of businesses pay business tax ("Hong Kong's Narrow Tax Base Is Storing Up Trouble for the Future," 2016). Neither employers nor employees in Hong Kong contribute to a mandatory health insurance scheme. Business-funded think tanks argue that the public health system, funded from annual government appropriations, is financially unsustainable at current levels of service, affordability, and revenue (Bauhinia Foundation Research Center Health Care Study Group, 2007; Hsiao & Yip, 1999; Our Hong Kong Foundation, 2018).

In 2003 the public health system was severely tested by the less infectious but more deadly SARS-1. Then Hong Kong recorded 1,775 cases of SARS-1, of which 299 people died (Legislative Council, 2004; SARS Expert Committee, 2003). Public inquiries into Hong Kong's handling of SARS-1 resulted in reform of Hong Kong's institutions for handling epidemics. Government set up the Center for Health Protection; introduced preparedness and control plans; established a command and control structure for epidemics; and facilitated cross-border public health experts' networks (see The Government of Hong Kong Special Administrative Region, 2014). The most senior government official responsible for Hong Kong's response to SARS-1 resigned to take responsibility for the government's performance (Lee & Benitez, 2004). SARS-1, however, impressed on the people of Hong Kong the importance of following medical advice (wearing masks; hand washing; social distancing), and the community overwhelmingly complied when COVID-19 struck.

Hong Kong's battle with COVID-19 came during a bitter political struggle over the future relationship of Hong Kong to the mainland. Beginning in June 2019 almost daily mass street protests, sometimes involving hundreds of thousands of people, increasingly violent, paralyzed Hong Kong, sank the economy, especially tourism on which Hong Kong depends, and by November, closed the entire school system. Civil servants and white-collar workers spent days working from home (Purbrick, 2019; "The Revolt of Hong Kong," 2019). In 2019 the economy contracted by 2.8 percent and 2.9 percent in the third and fourth quarters "as the local social incidents involving violence [anti-government protests] dealt a heavy blow to economic sentiment and consumption- and tourism-related activities," deepening Hong Kong's recession (The Government of Hong Kong Special Administrative Region, 2020a). Authorities in Beijing and Hong Kong fought back, relying on the police to suppress protest. By December 2019 protests waned.

During the pandemic, authorities imposed a new centrally drafted and draconian national security regime, removed opposition politicians from office, arrested

and jailed those who advocated independence for Hong Kong, and most recently postponed local elections to Hong Kong's legislature ("Hong Kong Postpones Legislative Election for a Year Citing COVID-19," 2020). Public trust in government fell from 30.6 percent in December 2018 before the protests to 17.8 percent by March 2020 after nearly a year of protest and two months of pandemic (Hong Kong Institute of Asia Pacific Studies, 2020).

In summary, the government has waged Hong Kong's battle with COVID-19 in an environment of low trust in government (Hartley & Jarvis, 2020). Yet, in the pandemic, the community pulled together (Wan et al., 2020). Public health has mostly not become a political issue.

Public Health Policy

Authorities recorded Hong Kong's first COVID-19 case on January 23, 2020. By that time the government, with more than three weeks' advance warning, was reasonably well prepared, within the limitations of its fragile public healthcare system and its experience of SARS-1. These limitations encouraged officials to take a high-risk, low-cost approach that by early July 2020 led to uncontrolled community spread. The government's strategy was to manage COVID-19 at a level that would not overwhelm Hong Kong's public healthcare system—not to suppress the virus to zero as was attempted on the mainland (Dharmangadan, 2020). By not sufficiently expanding testing, tracing, and isolation capacity, which saved resources in the short term, the government failed to prepare for the community spread that characterized the third wave. Hong Kong authorities relaxed suppression when they perceived that hospitals could cope, well above zero new cases.

At the time of this writing, Hong Kong had experienced three waves of infection. During the first two waves (January 23 to March 14, 2020, and March 15 to July 4, 2020) authorities succeeded in managing the virus, in cycles of "suppression and lift." As they lifted restrictions at the end of the second wave, however, the government implemented policies especially relaxing border control that allowed the infection to enter and spread in the community unchecked (third wave, July 5, 2020, to end of August 2020). Hong Kong found that, like water, the virus seeps through every crack. Local authorities, overwhelmed, requested central government help to ramp up Hong Kong's testing and isolation capacity to bring the virus under control.

Hong Kong acted swiftly to manage COVID-19 in early January, *not* waiting for official notification from the mainland government of the virus's infectiousness, which authorities there delayed (Associated Press, 2020; Da, 2020; Yang, 2020). On December 31, 2019, Hong Kong's infectious disease experts informed the Hong Kong government of what colleagues on the mainland told them had emerged in Wuhan (G. M. Leung, personal communication, June 12, 2020; K. Y. Yuen, personal communication, June 12, 2020). By January 15, 2020, Hong Kong authorities already knew that the virus could spread efficiently from person to person (Chan

et al., 2020; K. Y. Yuen, personal communication, June 12, 2020). Hong Kong public health authorities' action in early and mid-January was based on locally sourced expert information and preparations planned in the wake of the 2003 SARS-1 epidemic.

The health minister called the first of scores of meetings on the issue on December 31, 2019. On January 4, 2020, the Hong Kong government raised its official alert level to "serious" on a three-tier scale and promulgated the Preparedness and Response Plan for Novel Infectious Disease of Public Health Significance prepared in advance (Food and Health Bureau, Department of Health, Hospital Authority, 2020; The Government of Hong Kong Special Administrative Region, 2020k). The plan identified in detail the actions required at each response level, assigned responsibilities for each action, and laid down a command and coordination infrastructure, its leadership, membership, and responsibilities (Food and Health Bureau, Department of Health, Center for Health Protection, 2020). By January 14, 2020, nine days before the first recorded case in Hong Kong, because of its stepped-up surveillance of inbound travelers, the Hong Kong government had isolated sixty-eight people in the hospital for observation and put under surveillance 763 close contacts of those hospitalized ("HK Experts to Make Public Wuhan Trip," 2020, January 14). On January 25, 2020, the government raised the alert level to "emergency," and the Chief Executive took over chairing the steering committee and established a four-person advisory experts' group (Lam, 2020a).

Suppression of COVID-19 in Hong Kong included travel-based, community-based, and case-based measures (Cowling et al., 2020; Wu et al., 2020). Travel-based measures targeted travel restrictions, port control, and inbound traveler screening. Community-based measures included physical distancing (e.g., working from home; closure of schools, bars, nightclubs, fitness centers, and theaters; restrictions on dining-in at restaurants) and behavioral changes (e.g., masks, hand hygiene, social distancing) among the general population. Case identification and isolation, and quarantine of close contacts of confirmed cases made up case-based measures (classification of measures is based on Wu et al., 2020). The government used various combinations of these measures to suppress each of the three waves. After bringing the virus to manageable levels, authorities gradually lifted restrictions, attempting to return to some kind of normalcy.

Travel controls. The epidemic hit Hong Kong during the peak Chinese Lunar New Year holiday (January 25 to 28, 2020) travel period. From early February 2020 authorities suspended eleven of thirteen land border control points. At the airport, the government stepped up controls, eventually banning most non-Hong Kong residents, with some exemptions, from entering the territory on March 25, 2020. These measures cut the total number of inbound travelers from 162,000 on January 24, 2020, to about 20,000 by mid-February 2020 and to 1,200 by mid-April 2020, most of whom were Hong Kong residents (Hong Kong Immigration Department, 2020). From February 8, 2020, the government required all inbound travelers to be tested and then either isolated in hospital (all those with positive

test results) or quarantined for fourteen days. Wu et al. (2020, p. 4) estimate that the effective reproductive number from imported cases was mostly below one from mid-February¹ and that the fourteen-day mandatory quarantine for travelers was 95 percent effective up to early May.

With no new local infections reported from April 20, 2020, to May 12, 2020, authorities may have perceived that they had managed the second wave. Indeed, by June 25, 2020, the government reported that “people’s lives have generally returned to normal” (Lam, 2020d). As part of its measures to lift suppression, in May the government widened the scope of exemptions granted from the mandatory fourteen-day quarantine imposed on all inbound travelers. These included thirty-three categories of inbound travelers, such as essential business travelers, cross-border students, and cross-border truck drivers on whom Hong Kong depended for food and other supplies. By July 5, 2020, the number of confirmed cases began to creep up and then increased rapidly, with a reproductive rate of four. The virus spread quickly through Hong Kong’s high-density housing estates and elderly care homes, where visitors previously banned were once again allowed in (Lum et al., 2020). This time the virus infected taxi drivers, restaurant workers and customers, port workers, domestic helpers, hospital and clinic staff and patients, private medical practitioners, civil servants, and students and many other groups, their numerous close contacts mostly untraceable (Lam, 2020e).

It later emerged that authorities had exempted air and sea crews, and that Hong Kong had become a hub for crew changes for airlines, mostly cargo flights, and ships. According to one report, Hong Kong was the only place in southeast Asia that permitted unrestricted crew changes for shipping (Choy et al., 2020). Experts repeatedly pressed the government to close exempted traveler loopholes (J. Wong, 2020). Government resisted, arguing that Hong Kong depended on imports and should facilitate air and sea crew rotation for “humanitarian” reasons (The Government of Hong Kong Special Administrative Region, 2020f; “Up to 250 Crew Members a Day Arrive Without Quarantine,” 2020). Authorities eventually tightened the loopholes effective on July 29, 2020 (Siu et al., 2020), but only after it became known that from February to July 2020, the government had exempted from quarantine 290,000 inbound travelers (The Government of Hong Kong Special Administrative Region, 2020e; “Zhèngfǔ jìn yuè fā yú 29 wàn fèn yìxué jiānchá tōngzhī shū huòmiǎn qiángzhì jiǎnyì” [“The Government Issued More Than 290,000 Medical Surveillance Notices In Recent Months Exempted From Compulsory Quarantine”], 2020). Tests proved that many carried the virus (“Chén Zhàoshì: Dì Sān Bō Yìqíng Yuántóu Láizì Huòmiǎn Jiǎnyì Rénshì Yǒu Shízhèng Zhíchí Huì Yánsù Gēn Jīn,” [“Sophia Chan Siu-chee: The Source of the Third Wave of the Epidemic Comes From People Who Are Exempt from Quarantine”], 2020; Ho, 2020a). Asymptomatic, they moved around Hong Kong freely, spreading the disease. The need to obtain central government approval and the government’s reluctance to admit that it was wrong may account for the local authorities’ delay in tightening the loopholes.

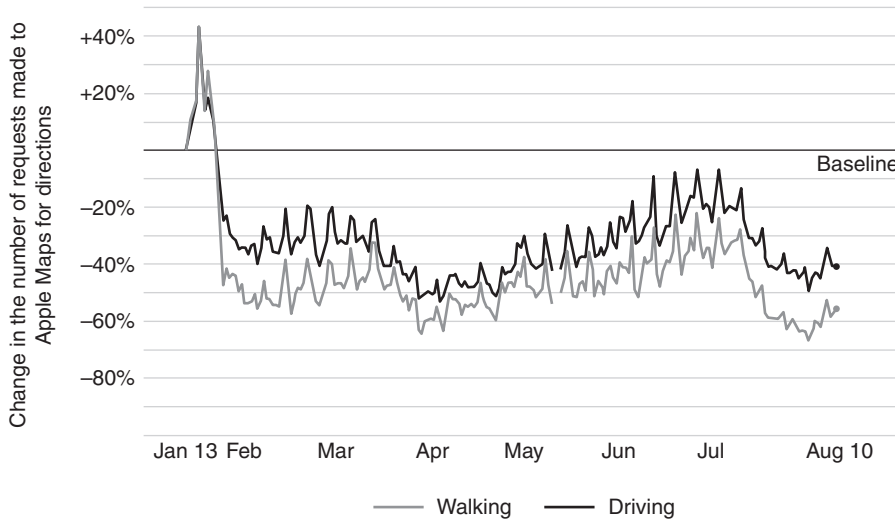


Figure 5.1. Apple mobility trends in Hong Kong, from January 13, 2020 to August 10, 2020.

Source: Apple Maps (2020).

Community measures. It is likely that before mandatory testing of all inbound travelers, asymptomatic carriers infected others in the community. As a result, local clusters of infection emerged in the community (in restaurants and bars and a place of prayer before the government-imposed controls). To suppress COVID-19, the government required civil servants to work from home in February 2020 to March 2, 2020; from March 21, 2020 to May 3, 2020; and from July 20, 2020 to August 24, 2020. About 40 percent of Hong Kong's more than 170,000 civil servants, because of the nature of their jobs, could manage this ("Forty Percent of Civil Servants to Work from Home Starting Tomorrow," 2020). Many businesses and non-government organizations followed. Authorities closed schools and universities from early February 2020 until late May, closing them again in July and August. These measures cut the mobility of the population dramatically (Figure 5.1; Apple Maps, 2020). Wu et al. (2020, pp. 4–5) estimate that working from home and reinstating working from home reduced the transmissibility to one,² and that the effectiveness of civil servants working from home was 67 percent.

Surveys confirm behavioral changes among Hong Kong residents. Respondents reported greater personal hygiene and, by mid-February 2020, the use of face masks in public exceeded 98 percent (Wu et al., 2020, p. 5). After first banning masks in October 2019 to help police identify antigovernment protesters who mostly wore masks (K. Cheng, 2019; The Government of Hong Kong Special Administrative Region, 2019) and then receiving conflicting advice from experts about the efficacy of masks in the fight against COVID-19 (K. Y. Yuen, personal communication, June 12, 2020), the Hong Kong government reversed its position on wearing masks by late February 2020. On July 22, 2020, faced with a third

wave of infection, authorities made wearing masks compulsory indoors in public places, and later, on public transport and in public areas (The Government of Hong Kong Special Administrative Region, 2020m).

At the end of each suppression cycle, authorities lifted restrictions, reopening closed businesses such as bars, karaoke lounges, entertainment venues, and theaters. In June 2020 they permitted groups of fifty to meet, up from four and then eight during suppression, for example, in restaurants. With the emergence of a third wave, authorities pointed to “pandemic fatigue”: less cautious residents ventured out in large groups, letting their social distancing guard down (Lam, 2020e). Still, the government used the pandemic restrictions to ban all antigovernment protests: when protesters continued to demonstrate in numbers allowed by the regulations, riot police still arrested protesters for violating the regulations (Lau et al., 2020).

Case measures. The Hong Kong government’s PCR (polymerase chain reaction) antigen test detects the sequence of the virus RNA (ribonucleic acid) and is generally considered the most accurate (Xia, 2020). Samples may be collected by nasal swab, deep throat saliva, or throat swab (Cheng, 2020). Authorities increased the number of tests from about six hundred per day in early February 2020 (first wave) to from two thousand to four thousand per day from late March 2020 until May (second wave) (Wu et al., 2020, p. 5). The government isolated all who tested positive in the hospital. The government reduced the time from symptom onset to isolation in hospital from ten days in late January 2020 to five days by late March 2020. Still 59 percent of the local cases in March 2020 took five days or longer to isolate (Wu et al., 2020, p. 5). The government published the street addresses of local residents who tested positive to encourage possible additional close contacts to come forward for testing and isolation or quarantine. Case-based quarantine arrangements varied from closed and guarded quarantine camps to less tightly managed quarantine housing estates and hotels, to self-supervised home quarantine for inbound travelers who tested negative, providing them with e-wrist bands that initially failed to allow effective monitoring. Government policy depended on the active cooperation of those quarantined. Authorities fined and jailed the relatively small number caught violating quarantine, five by mid-August (The Government of Hong Kong Special Administrative Region, 2020b, 2020i, 2020j).

By early May 2020 local authorities had tested 170,000 specimens, mostly from pneumonia inpatients and inbound travelers (Wu et al., 2020, p. 5). By July 2020, well into the third wave, demand for tests far exceeded local capacity of about 10,000 tests per day. Moreover, the close contacts of most local infected persons were untraceable, so widespread had the virus become. At the time of this writing, the central government had established temporary testing labs in Hong Kong with a reported target capacity of 500,000 tests per day, based on testing five samples at a time (V. Wong, 2020). The central government also planned to build two temporary emergency COVID-19 hospitals in Hong Kong, similar to those

built in Wuhan, to supplement local public hospitals and locally established temporary isolation units (e.g., at Asia World Expo, Lei Yue Mun, and other repurposed facilities) (The Government of Hong Kong Special Administrative Region, 2020h). Government also acted in anticipation of further outbreaks of COVID-19 during the peak winter flu season in the autumn and winter.

Economic and Social Policy

Hong Kong is characterized by high rates of inequality, densely packed and unaffordable housing, and a miserly social welfare net. In 2016 the Gini coefficient³ was 0.539, adjusted to 0.473 if benefits are included (Hong Kong Special Administrative Region Census and Statistics Department, 2017a). Thousands of poor families in Hong Kong who have yet to qualify for relatively scarce public housing live in subdivided flats, sharing bathrooms and kitchens, or, for elderly singles, in caged bunk spaces. Hong Kong's neoliberal economy provides neither a universal pension nor social security for the elderly (Poon & Wong, 2018). Social distancing measures have impacted the poor and elderly disproportionately. When government shut schools and demanded online learning, poor parents, many single, could hardly cope (Marques, 2020). These issues languished while the government fought COVID-19, trying to mitigate its impact on the economy.

In 2019 and 2020 Hong Kong's economy was hit by a triple whammy: the US-China trade war, six months of almost daily and increasingly violent antigovernment protests, and from late January 2020, COVID-19. As a result, Hong Kong's economy slipped into recession and months of economic contraction. From the second quarter of 2019 Hong Kong's economy contracted rapidly, so that by the first and second quarter 2020 real GDP fell by 9.1 percent and 9.0 percent, year-on-year, respectively ("2nd Tranche of Wage Subsidy Set," 2020; The Government of Hong Kong Special Administrative Region, 2020d). The government forecast a contraction of 6 to 8 percent for the year. Unemployment grew at seldom-seen rates of from about 2 to 3 percent in 2019 to 6.2 percent, the highest in more than fifteen years. Job losses rose by 10.7 percent in April to June 2020 in tourism-related retail, accommodation, and food and beverage, the biggest fall since SARS-1 in 2003. Among them restaurants recorded a 14.7 percent unemployment rate as government restrictions to fight COVID-19 kicked in (The Government of Hong Kong Special Administrative Region Census and Statistics Department, 2020).

A year earlier, months of antigovernment protest hammered these same sectors. In November 2019 alone, tourist arrivals fell by 56 percent, a steeper decline than even during SARS-1 when the WHO posted a travel advisory for Hong Kong and travelers stayed away (L. Cheng, 2019). Hong Kong provides no unemployment compensation, instead supporting the unemployed via a means-tested welfare benefit, set at near destitution levels (comprehensive social security assistance,

CSSA [Hong Kong Social Welfare Department, 2020]). In April and May 2020 the government reported a “sharp” increase in unemployment-related CSSA payments of 3,950 payments and 2,160 payments, respectively (“2nd Tranche of Wage Subsidy Set,” 2020). Yet the government’s own unemployment statistics indicate that at least 250,000 people lost their jobs during the pandemic (“Hong Kong Facts: Employment,” 2019). The government did distribute a one-time payment of HK\$10,000 (US\$1,282) to each resident.

At the time of this writing, the Hong Kong government had introduced three relatively large-subsidy, tax concession, and stimulus packages to cushion the economy (The Government of Hong Kong Special Administrative Region, 2020d), totaling HK\$280 billion (US\$36 billion), or 10 percent of the city’s GDP. The centerpiece was the Employment Support Scheme (ESS) designed to provide businesses with “time-limited subsidies” to reduce the need for employers to lay off their employees. The government’s stated goal was to protect employees and “guarantee employment.” On August 18, authorities announced that they had delivered HK\$44 billion (US\$5.7 billion) in the form of subsidies to 148,000 employers, mostly small and medium-sized enterprises employing fifty or fewer people (“2nd Tranche of Wage Subsidy Set,” 2020).

The government intended that 1.9 million workers would benefit from this scheme. Labor groups pointed out, however, that some employers accepted the subsidies and then forced their employees to take pay cuts, unpaid leave, or layoffs. Union representatives complained that ‘the scheme doesn’t require employers to disclose if they have received the subsidy, and called on employees to file a report if their employer has applied for the subsidy but either failed to pay it out or forced employees to take a reduced wage or unpaid leave’ (“Give Anti-Epidemic Funds Directly to Workers: Unions,” 2020). Labor groups demanded that the subsidies be paid directly to workers.

Some sectors have prospered during COVID-19, including supermarkets. Under the scheme authorities provided HK\$560 million (US\$72 million) to the owners of Hong Kong’s duopoly supermarket chains, run by two conglomerates, CK Hutchison Holdings (Li Kashing family, Hong Kong’s wealthiest) and Dairy Farm (Jardines) (“Hong Kong Subsidies Must End Up in Hands of Those Who Need Them Most,” 2020). Each engaged hundreds of thousands of employees. Anticipating criticism, on August 18, 2020, the government promised the conglomerates further subsidies only if they passed on benefits to their customers. How this would be monitored was unclear.

In addition to the ESS, the Hong Kong government subsidized job creation, job advancement, and specific sectors required to fully or partially close because of COVID-19. Authorities also announced a variety of other measures, such as government rent concessions, fee waivers, and deferral of loans. The Hong Kong Monetary Authority, the region’s central bank, increased its support for banks (cut reserve requirements, deferred new regulations, and increased bank liquidity), approved payment extensions from corporate customers, and granted other relief in total valued at about HK\$1.1 trillion (US\$142 billion) (Hong Kong Monetary

Authority, 2020). With help from the Hong Kong government, the local Airport Authority provided a HK\$2 trillion (US\$258 billion) relief package to the aviation sector. The Hong Kong government also invested HK\$30 billion (US\$3.9 billion) in Cathay Pacific Airlines, mostly grounded during the pandemic, taking a six percent stake, and \$5.4 billion (US\$700,000) in a local theme park, Ocean Park (The Government of Hong Kong Special Administrative Region, 2020g; Schofield, 2020; T. K. Wong, 2020).

Explanation

By late August 2020 Hong Kong had managed three waves of COVID-19 relatively successfully. This interim outcome was the result of learning from Hong Kong's experience of SARS-1, support from the central government, a relatively meritocratic bureaucracy, sufficient healthcare investment to support a fragile public health care system, and cross-border networks of infectious disease experts that enabled early detection.

First, Hong Kong is a local government of China, an authoritarian country ruled by the Chinese Communist Party (CCP). Hong Kong's authoritarianism is characterized by centralized political leadership (the CCP), local government that focuses on policy implementation, and a politically dependent and corporatized civil society, which privileges big business (Glasius, 2018; Ma, 2015; Purcell, 1973). This system is implemented via colonial-era political, bureaucratic, economic, and educational institutions, which transitioned mostly unchanged from British to Chinese sovereignty in 1997. The CCP provides political leadership in Hong Kong, guiding, supervising, and directing Hong Kong's civil service-led government. The party rules Hong Kong with the active and enthusiastic support of the united front, of which the Hong Kong government is a core member. Since 2006 but accelerated in 2019, the CCP has shifted Hong Kong's hybrid system of accountability (mixed external political and internal bureaucratic accountability) to one that is predominantly bureaucratic (internal), similar to the rest of China (Romzek & Dubnick, 1987). As of this writing, the party still permits a somewhat greater degree of autonomy for the internet, media, education, and legal/judicial institutions in Hong Kong than exists on the mainland (Basic Law, 1990).

The early post-1997 hybrid system allowed local authorities in Hong Kong to carry out relatively thorough, critical, and transparent investigations into the local government's mismanagement of SARS-1 when it hit Hong Kong in 2003 (Abraham, 2004; Davis & Siu, 2007; Lee & Yun, 2006; Legislative Council, 2004; Thomson & Yow, 2004). Authorities learned from this experience, better preparing Hong Kong for the outbreak of COVID-19 (see the forty-six recommendations in SARS Expert Committee, 2003). Crucially, authorities set up the Center for Health Protection in 2004 with specific responsibility, authority, and accountability for the prevention and control of communicable diseases (Recommendation

No. 2). Authorities improved coordination between the Hospital Authority, which has taken key responsibility for suppression in COVID-19, and the Department of Health (Recommendation No. 3). The government set up a new command structure, the “Steering Committee cum Command Centre,” chaired by the Hong Kong Special Administrative Region chief executive when the response level is “emergency,” as officials set it on January 25, 2020. Authorities prepared a pandemic management plan for Hong Kong, which they rolled out swiftly on January 4, 2020. They established regular official channels of information sharing with cross-border organizations in the Pearl River Delta and with the National Health Commission in Beijing. The government planned for epidemic surges and all that entails with the HA as the core (Recommendation No. 16). Authorities improved communications with the public, resulting in daily briefings delivered by Center for Health Protection experts, and the informative COVID-19 thematic website and dashboard (Recommendation No. 23) (Hong Kong Center for Health Protection, 2020b). Government increased support for research on newly emerging infectious diseases and university medical schools redirected research to this topic (Recommendation Nos. 35–40) (K. Y. Yuen, personal communications, June 12 and 14, 2020, and August 4 and 11, 2020; also see Wong et al., 2017). Officials have had less success, however, at improving coordination between the public and private healthcare systems. Public doctors continue to be attracted to lucrative private practice, which the medical profession is unwilling to touch.

Hong Kong’s experience of SARS prepared the people of Hong Kong for months of nearly universal mask wearing, stepped up personal hygiene, and social distancing that, although not completely locking down the territory, produced the economic dislocation discussed previously (Wan et al., 2020). Hong Kongers are pragmatic and seek to protect themselves and their families. They are also generally law abiding, and COVID-19 management rules were made law. Respect for experts and peer pressure also contributed to this result, largely unaffected by deep political divisions, months of antigovernment protest, and distrust of government.

Second, China is a unitary, not federal, system. Once the central government decided to suppress COVID-19, it did so very effectively, imposing tight border controls and complete lockdowns (see chapter 4). Hong Kong benefited from China’s unitary system. The central government provided border control, access to masks and personal protective equipment, improved testing and isolation capacity, and a postponed legislative election. From late June 2020 new tools were provided to suppress antigovernment protests (the national security law and its infrastructure). Further, Hong Kong could close its border with the mainland because the central government agreed to this move.

Third, the technical competence, professionalism, and reputation of the Hong Kong public healthcare system are relatively high (Goodman, 2009; Kong et al., 2015). In 1991 the government centralized management of all public hospitals in a hybrid organization, the HA, headed by a medical doctor. A board of directors governs the system, now employing 67,000 people. Authorities organized public

hospitals into seven regional clusters, each with a CEO to improve efficiency and service delivery. The system has allowed specialization across the territory. These moves better coordinated public health care and improved performance monitoring. The Secretary for Food and Health, traditionally a medical specialist, provides policy guidance to the HA (Gauld & Gould, 2002). Fourth, the government subsidizes the HA, amounting to about 14 percent of annual recurrent expenditure, third only to education (19 percent) and social welfare (14 percent) (Legislative Council, 2020). Substantial infrastructural and financial investments were made in pandemic preparations in the wake of SARS-1. Still, as we have seen, Hong Kong's public hospital-based healthcare system is fragile and financially unsustainable.

Finally, Hong Kong's infectious disease specialists have developed dense networks of professional collaboration with colleagues on the mainland and overseas. Hong Kong is a global hub for the study of coronaviruses and avian influenza, based on its location. Western specialists visit Hong Kong to study these diseases. Hong Kong epidemiologists and public health experts serve in senior positions in mainland hospitals (e.g., the University of Hong Kong-Shenzhen Hospital), giving them access to patients. The central government and the WHO invite Hong Kong's medical experts to join fact-finding missions to investigate novel coronaviruses. K. Y. Yuen, University of Hong Kong, joined the third National Health Commission mission to Wuhan in January 2020, which reported the infectiousness of COVID-19 at a Beijing press conference on 20 January. G. M. Leung, University of Hong Kong, joined the WHO mission to Wuhan in February 2020. Both Yuen and Leung, and undoubtedly others, received information on December 31, 2019, about the situation in Wuhan that the Hong Kong authorities acted on in early January 2020. As a result of these networks, Hong Kong could act early, and it did.

Conclusion

Hong Kong learned from its experience of SARS-1. Political leadership capable of learning is an asset. Still Hong Kong's preparations were incomplete. Prepared as they were by experts and bureaucrats, the plans assumed the continued existence of an unreformed colonial-era public finance system and a fragile, barely able to cope public health system. That was to be expected. Political leaders should consider the larger picture. Yet Hong Kong's political system has proven unable to produce political leaders up to the challenge.

Hong Kong's authoritarian political system, even though contested, has thus far prevented deep political divisions and distrust of government from fracturing the community's response to COVID-19. In Hong Kong, the community appears to have compartmentalized politics and its pandemic response. The lack of electoral politics during a pandemic and the relatively low stakes of elections in Hong Kong (voters do not elect the government) may account for this outcome.

Notes

1. This is the estimated number of people an infected person would infect. Authorities sought to reduce it to less than one.
2. This is the estimated number of people an infected person would infect. Authorities sought to reduce it to less than one.
3. The Gini coefficient is a measure of the distribution of income across a population used as a gauge of economic inequality. The coefficient ranges from 0 (or 0%) to 1 (or 100%), with 0 representing perfect equality and 1 representing perfect inequality.

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