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COVID-19 in different cultures

— East and West*

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China has one of the best track records worldwide in fighting COVID-19, while Germany is currently considering a third lockdown. On the whole, the East Asian countries have coped much better with the crisis than most Western countries. There are also some notable differences within East Asia: community-oriented societies have achieved better results than individually-oriented societies. This observation suggests that cultural and political differences may influence the success of health policies to address COVID-19.

Nature and culture are profoundly intertwined. However, cultural responses to natural challenges are decidedly distinct. Thus, to understand the varied responses to the public health threat of COVID-19, we must go beyond an epidemiological comparison. We use the virus and the response to this biological threat as an instrument of cultural analysis. It provides a perspective for analyzing a society's character, deeply rooted in its history and culture. Our question is: What do these different reactions mean for a country's culture, how did they arise historically, and why did they evolve?

In this paper, we provide an arguably preliminary answer to these cultural-comparative questions. After outlining the problem (Section 0), the natural agent is described in terms of the pathogen's biology (Section 1). We then cover the emergence of the COVID-19 pandemic, which necessitates a brief examination of the 2002/03 SARS epidemic (Section 2). In section 3, we present the reactions to COVID-19 in selected countries and regions: China, Taiwan, South Korea, and Japan in the East, and Germany, Sweden, and the USA in the West. Potential explanations for the observed differences are elaborated in Section 4: We base our analysis on new empirical studies and the cultural peculiarities of East Asia and Europe with respect to community- and individually-oriented societies. In section 5, varying approaches to government and governance in public health are explored in light of cultural and political differences. Finally, we draw conclusions about the differing results in the fight against COVID-19 and the selected cultural and political characteristics of East and West (Section 6).

Compared to Western countries, different forms of public health intervention used in East Asia have promoted success in fighting COVID-19. These differences are ostensibly determined by historically engrained cultural characteristics of community-oriented Eastern and individually-oriented Western societies. However, there are also noticeable differences within East Asia: the fundamental cultural characteristics and attitudes of 'guarded' societies such as China and Taiwan appear to be gradually supplanted by liberal state action and individualistic perspectives, as in South Korea and Japan. Mainland China and Taiwan have begun to differ in their community-oriented and more individually-oriented approaches. Hence, the comparison between East Asian countries is particularly interesting and informative. Continuing investigations in the direction proposed here appears to be a worthwhile task for the Society of Cultural Interaction in East Asia. There is abundant empirical material to support this endeavor.

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Keywords : Covid-19, SARS, public health strategies, governance, Asia, Europe, USA

0. A tiny virus controls the world: Introduction and outline

Coronavirus disease 2019 (COVID-19), caused by the Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2), has plunged the world into a state of emergency. At the time of writing, 123,632,487 people have been infected, and 2,724,461 people have died worldwide¹⁾. Considering the per capita impact, the differences in infection and death rates in different countries are striking.

As of 20 March 2021, the infection rates per 1 million inhabitants were as follows (table 1):²⁾

Table 1: COVID-19 cases per 1,000,000 people as of 20 March 2021

<i>Country</i>	<i>Population (million)</i>	<i>Infected (total)</i>	<i>Deaths (total)</i>	<i>Infected (per 1 million)</i>	<i>Deaths (per 1 million)</i>
China	1,440	90,099	4,636	63	3
Taiwan	24	1,006	10	42	0.4
South Korea	51	98,665	1,696	1,923	33
Japan	126	455,638	8,812	3,661	70
Germany	84	2,660,358	75,206	31,680	896
Sweden	10	744,272	14,007	73,368	1,307
United States	331	30,485,932	554,917	91,716	1,669

As of 20 August 2020, the fatality rates per 1 million inhabitants per country were as follows (table 2):³⁾

Table 2: COVID-19 fatalities per 1,000,000 people as of 20 August 2020

<i>Country</i>	<i>Population (million)</i>	<i>Infected (total)</i>	<i>Deaths (total)</i>	<i>Infected (per 1 million)</i>	<i>Deaths (per 1 million)</i>
China	1,440	89,594	4,709	62	3
Taiwan	24	486	7	20	0.2
South Korea	51	16,670	309	326	6
Japan	126	60,896	1,162	483	9
Germany	84	231,929	9,266	2,761	111
Sweden	10	86,068	5,810	8,606	582
United States	331	5,576,206	174,292	16,846	532

1) <https://www.worldometers.info/coronavirus/> (Queried on 03/21/2021).

2) <https://de.statista.com/statistik/daten/studie/1110467/umfrage/infektionsrate-beim-coronavirus-nach-laendern/> (Queried on 03/21/2021).

3) <https://de.statista.com/statistik/daten/studie/1111794/umfrage/todesfaelle-mit-coronavirus-covid-19-je-millionen-einwohner-in-ausgewaehlten-laendern/> (Queried on 08/21/2020).

At first glance, the tables clearly show divergent incidence and death rates in the selected East Asian and Western countries. Furthermore, if we compare the figures for March 2020 to August 2021, we learn that all European countries have seen massive increases in incidence and death rates. Additionally, the consistency in the figures for East Asia suggests that the measures taken there were not temporary but permanent. This points to a long-term and well-implemented strategy of disease prevention.

Generally speaking, if the reported figures are correct, China has one of the best track records in the fight against COVID-19, while Germany is going into a third lockdown at the end of March 2021. This comparison holds for almost all countries in East Asia and Europe, as well as the USA. East Asian countries coped much better with COVID-19 than the West. This applies first to China, where the epidemic started. Taiwan responded immediately at the end of December 2019 and saw one of the best results worldwide. South Korea reacted with interventions which largely spared public life after an initial severe incursion. Japan took the epidemiological approach of cluster tracking and initially achieved adequate results. Germany initially achieved exceptional results in Western Europe, only to drop off considerably in later stages. Sweden took an approach that spared public life as much as possible and failed to contain COVID-19. The USA was the world's example of a country where the epidemic was played down by the highest level of government, although some sensible decisions were made, for instance, on vaccination. Thus, each country exemplified a different approach to epidemic policy. The reactions to the virus reveal cultural differences, which we will focus on in this contribution.

Nature and culture are profoundly intertwined. However, cultural reactions to natural challenges vary considerably. What are these differences, how did they arise historically, and why? Just as experiencing a serious illness shows the character of a person and their relatives, an epidemic shows the character of a society and the quality of its representatives. Thus, the virus and the response to a biological threat can provide a lens for analyzing a society's character, deeply rooted in its history and culture. The different reactions to COVID-19 thus become an instrument of cultural analysis.

The basis for an integrative history of epidemics is the interrelation of nature and culture. From the conception of nature follow substantively different world views, which lead to different views of human beings and the organization of a society. Beyond nature and culture, approaches to public health need to be taken into consideration when comparing the outcome of measures to fight an epidemic disease. The question of a more authoritarian or more democratic approach to public health interventions can be refined by using the categories of government and governance approaches as an analytical tool. Governance approaches in the fight against epidemics in highly complex societies are essentially based on transparency, participation, and cooperation. The classic government approaches are based on a strong preponderance of state administrative structures.

This question of government vs. governance approaches does not just apply to the general comparison between East and West but also to certain comparisons within East Asia. Within the East Asian countries different political systems exist, ranging from the centrally managed Chinese people's republic to Western democratic states like South Korea. Both countries were more successful in coping with COVID-19 than the European states or the USA. Since Korea and China share some cultural roots, different forms of intervention in public health and their intertwinement with the cultural background must be considered. As an analytical tool, we will differentiate directive governmental orientations from participatory governance-oriented approaches. Historical experiences — especially the SARS epidemic of 2002/03 — must also be taken into account.

Thus, we attempt to consider a seamless web (Hughes 1986) of culture, political systems, and public health approaches to explain the different outcomes of interventions against SARS-CoV-2. Our preliminary analysis follows several steps. We first outline the problem (Section 0), describe the natural agent in terms of the pathogen's biology (Section 1). In Section 2, we introduce the emergence of the global pandemic, accompanied by an unavoidable albeit brief look at the 2002/03 SARS epidemic. The reactions of selected countries and regions to COVID-19 in East and West are presented in short vignettes, covering China, Taiwan, South Korea, and Japan for East Asia, and Germany, Sweden, and the USA for the Western world (Section 3). Section 4 elaborates on potential explanations for these glaring differences, based on new empirical studies and consideration of Eastern and Western cultural peculiarities with respect to collective vs. individualistic societal orientations. Accounting for cultural and political differences, the varying approaches to governance in public health are addressed in Section 5. Finally, we draw conclusions about the differing results in the fight against COVID-19 and the cultural and political characteristics of East and West (Section 6).

1. SARS-CoV-2 and COVID-19: Nature and biology

Countermeasures against the current pandemic are based on scientific evidence. Knowledge of the biology of the pathogen and its behavior unites the countries we compare in their reactions to the virus. What has been established is that a natural message — RNA, or ribonucleic acid, whose biological mass worldwide may be no more than half a glass of water — has urged humanity to act. In doing so, the virus transforms from a nameless natural substance into a socially relevant agent. Thus, biological details based on current scientific thinking play a crucial role in the spread of the virus and the reaction of individuals and societies. Given that the virus is a kind of animal and humans are animals — belonging to the family of dry-nosed apes (biological term: Haplorrhini) — the virus is just fighting with and against humans for survival by replication. Along the way, human

countermeasures select the virus from wild type to increasingly dangerous or infectious variants (e.g., VOC-202012/01 or the British variant of concern).

SARS-CoV-2 belongs to a larger family of coronaviruses. In the strict sense, the virus is only a single-stranded RNA that contains the genetic information for virus replication. The virus infiltrates a host cell, and the introduction of the virus's new genetic material stops the cell's normal tasks and sets in motion replication of the virus. Unlike the case of the influenza virus, the genetic information of coronaviruses is relatively stable. The case fatality rate of the SARS epidemic of 2003 was around 10%. The case fatality rate of the MERS-CoV epidemic (Middle East respiratory syndrome coronavirus) was between 30% and 40% by 2009. As there was no experience with the novel SARS-CoV-2, the analogies to the earlier SARS epidemics played and continue to play a major role.

COVID-19 seems to be a zoonosis, a disease that originates from animals. According to the current state of knowledge, its natural reservoir is a species of bat⁴). The original bat virus is not pathogenic to humans. The virus needs a second host, a so-called intermediate host, to transgress the species barrier between non-human animals and humans. These intermediate hosts serve as a kind of biological converter. Nevertheless, this exact scenario has not yet been verified. The context for biological conversion is determined by social institutions and behavior, such as rearing poultry and pigs together — as was the case with the so-called swine flu — or keeping different species quite closely in large live-animal stocks and markets. So, here, nature and society merge in producing novel pathogens.

COVID-19, the infectious disease itself, is not associated with unique symptoms, and its expression varies widely, from asymptomatic courses to severe pneumonia with lung failure and death. The report of the WHO-China Joint Mission on Coronavirus Disease 2019⁵) states that mild cases have a disease course of two weeks and severe cases of three to six weeks. Some people who become infected but have very mild symptoms might assume they have a simple cold. The non-specific clinical signs and the uncertainty around when an infected person is infectious to their environment are significant factors in the spread of the disease. According to the current state of knowledge, the virus spreads most readily before the infected person shows serious symptoms. Asymptomatic cases, especially among children, can act as 'silent spreaders' and play a crucial role in the undetected spread of the disease and persistence of the virus in a community. In addition to this, 'super spreaders' are important. These are individuals who infect numerous others far beyond the

4) For the state of knowledge in March 2020, see WHO/2019-nCoV/FAQ/Virus_origin/2020.1 (Queried on 03/21/2021).

5) <https://www.who.int/docs/default-source/coronaviruse/who-china-joint-mission-on-covid-19-final-report.pdf> (Queried on 03/21/2021)

usual infection rate, potentially leading to clusters in which the infections accumulate exponentially. If possible, one more line here or even better this word to last page, possibly by hyphens and make-up of lines before...

2. COVID-19: The rise of a pandemic

2.1 The first SARS epidemic in 2002/03 and its consequences

To understand China's health policy and its reaction against COVID-19, one must examine the SARS epidemic of 2002/03, its course, and its consequences (Kobler et al. 2004; Huang, 2004).

In November 2002, a particularly contagious type of pneumonia occurred in Guangdong Province in Southern China. It soon became clinically apparent that it was a highly infectious, severe acute respiratory illness, from which the name SARS derives (Severe Acute Respiratory Syndrome). The disease spread quickly via air travel, first in Southern China, then in Southern parts of East Asia — Hong Kong, Taiwan, and Singapore — before spreading worldwide, precipitating the first pandemic of the 21st century. The disease was spread primarily by super-spreaders; e.g., about 4,000 cases can be traced back to the first patient. Worldwide, 8,096 people were eventually infected, and 774 people died. The fatality rate was 9.6%. During the pandemic, no drugs or vaccines were developed against the pathogen SARS-CoV-1 RNA virus. Non-pharmaceutical measures, i.e., public health interventions, were implemented on a large scale in the affected regions: quarantine, closure of all educational institutions and entertainment venues, disinfection of entire streets and quarters, halting international air traffic, etc. The economic damage was considerable. In addition, the measures were perceived as excessive, contributing to discontent among the population. Finally, the provincial administration of Guangdong province had not reported the epidemic to Beijing, resulting in national level-measures being taken at a late stage. This delayed reaction discredited China in the eyes of the world.

Fortunately, the disease disappeared in the summer of 2003. This pandemic, however, seriously disturbed the world's sense of security. Significant reforms in public health security were carried out at the international and national levels. In Europe, for example, although it was not affected by the pandemic in the same way as China, the European Centre for Disease Control was established.

In China, the SARS-CoV-1 epidemic led to massive changes in public health. Unsparing failure analyses were carried out (Liu, 2004), and finally, the following measures were planned and implemented (Zhong & Zeng 2008, Zhang et al. 2013).⁶⁾

- Animal source containment: restricting wildlife marketing

6) For the „Communicable Disease Control Act” of 19 June, 2019, see <https://law.moj.gov.tw/ENG/LawClass/LawAll.aspx?pcode=L0050001> (Query on 03/21/2021).

- Early detection: monitoring systems for patients with pneumonia
- A Rapid information network for SARS: legislation on the surveillance, reporting, and pre-warning system for infectious diseases, mandating the periodic release of epidemics and preparedness for possible public health emergencies covering the economically developed, densely populated provinces and cities
- Health care training, education, and reinforcement
- Special care for human-to-human transmission in the community and hospitals
- Vaccine development

These measures have been implemented over the years and gained international recognition in 2010 while fighting H1N1 or the so-called Swine Flu (Hvistendahl, 2013). SARS research is concentrated in large research institutions in Beijing and Wuhan. The Chinese Centre of Disease Control and Prevention (CCDC) is led by internationally trained and experienced experts⁷⁾. All in all, China took the first SARS pandemic seriously and initiated massive improvements in health care with general and appropriate countermeasures for subsequent epidemics and pandemics (Bu, 2017; Wang et al., 2019)⁸⁾. This development may explain some of the observed differences in national and international reactions in late 2019 and early 2020 during the SARS-CoV-2 outbreak.

2.2 The emerging of the 2019 SARS epidemic

According to the state of knowledge at the end of March 2021, SARS-CoV-2 emerged in November 2019 in Wuhan and was passed on to humans⁹⁾. The virus began to spread in the city and region of Wuhan in late November and early December 2019. Based on the known factors for disease spreading, infections in the population must have progressed very slowly at first and then rapidly in the early stage of the as yet unidentified, even unnoticed, epidemic.

In China, hospitals are the first line of contact with the health care system for sick people. When several doctors in hospitals in and around Wuhan noticed, at the end of December 2019, that a SARS-like lung disease was on the rise, the virus and the disease must have already been widespread. By 30/31 December 2019, cases had multiplied and could no longer remain hidden. The Wuhan Municipal Health Commission issued a warning to all hospitals in and around Wuhan to be aware of a new SARS-like form of pneumonia and started an investigation into the causes of the

7) See <http://www.chinacdc.cn/en/> (Queried on 03/21/21). On the discussion of steadily improving public health protection against infectious diseases, see e.g. Li, Yu et al., 2019.

8) For the development of healthcare legislation, see <https://www.loc.gov/law/help/health-emergencies/china.php#Transparency>.

9) For the WHO-China Joint Mission on Coronavirus Disease 2019 report, see: <https://www.who.int/docs/default-source/coronaviruse/who-china-joint-mission-on-covid-19-final-report.pdf> (Queried on 03/28/21)

newly diagnosed disease following statutory reporting requirements. At the same time, information about the potential new disease was passed to the WHO country office in China. The Huanan live animal wholesale market in Wuhan was closed on 1 January 2020. On 9 January 2020, CCDC specialists classified a new coronavirus as the possible agent, and on 10 January 2020, the genome was sequenced, and the sequence was deposited in an international gene bank¹⁰.

There is an ongoing worldwide discussion that Chinese scientists and public health professionals wasted time in the initial phase of COVID-19. An international statement was issued against this allegation, signed by over 70 world-renowned public health experts, among which was the German Christian Drosten, a globally recognized expert on SARS viruses (Calisher et al., 2020).

It has been suggested that — semi-official or even private — reports by Ai Fan, a senior emergency doctor, Li Wenliang, an ophthalmologist, and other doctors, urging colleagues to protect themselves against an emerging pathogen, were suppressed by internet surveillance and law enforcement officers citing disruption of public order. If this kind of information were true, these warnings would have had a massive impact on public order, given the memory of the SARS epidemic of 2002/2003. A few days later, Li was forced to sign a statement that he had given false comments disturbing the social order. The internet messages were private communications outside of legal reporting channels for dangerous diseases — which also exist in other parts of the world. After heated public and legal debates on whether public order would be disturbed by such private reports, the reprimands were withdrawn, and Li Wenliang was reinstated.

An initially hesitant reaction to reports of an imminent epidemic is quite common, as history shows. The 1892 cholera epidemic in Hamburg became violent because the responsible doctors and administrators could neither agree on a medical level nor dared to pass on their forbidding diagnosis to the responsible authorities (Weisser, 1995). And when in early 1918 Loring Miner, a family doctor, announced an unusual heavy flu to the United States Public Health Department, no one took notice or provided any help or advice, yet this was the beginning of the deadly Spanish Flu. Notably, the disease did not emerge from Spain but probably from the USA (Barry, 2004, pp 92-95).

Later, the WHO referred to the virus as SARS-CoV-2 and the disease as COVID-19. Wuhan was locked down on 23 January 2020, and the entire province of Hubei placed under strict quarantine, the scale of which was unprecedented globally. WHO reports state that on 25 January 2020, 1,297 infections and 1,965 suspected cases were confirmed in China, and 41 patients died¹¹.

10) <https://virological.org/t/novel-2019-coronavirus-genome/319> (Queried on 03/28/ March 2021). For a precise timeline of the Covid-19 pandemic, see https://en.wikipedia.org/wiki/Timeline_of_the_COVID-19_pandemic (Queried on 03/28/ 2021).

11) https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200125-sitrep-5-2019-ncov.pdf?sfvrsn=429b143d_8 (Queried on 03/21/2021)

By 26 January 2020, control measures had been tightened considerably nationwide: all airports, train stations, bus stations, and ports were searched for suspected cases, which were immediately isolated in hospitals, sports halls, or similar mass accommodations. This early and rigorous isolation would later prove to be one of the most successful countermeasures against the virus's spread. Similar stringent measures were taken in the big cities, notably Beijing. The individual city districts, including university campuses, were closed. Public life was effectively shut down. By then, according to the local administration, at least 5 million people had left the Wuhan area. So, China faced many undetected cases (Li, Sen, et al., 2020), which allowed the virus to spread not only across the city of Wuhan, the province of Hubei, and throughout China (Guangdong, Henan, Zhejiang, Hunan, and many other provinces) but internationally. On 30 January 2020, the WHO announced an international health emergency. At that time, the number of infected people worldwide was reported as 10,000. On 28 February 2020, the WHO re-classified the risk from 'high' to 'very high'. In China, 79,000 people had fallen ill, and 2,790 had died. The fatality rate of 3.5% resulting from these figures suggests that the number of infected persons must have been considerably higher. Outside China, the numbers were 4,700 infected and 67 dead (fatality rate = 1.4%).

In China, Xi Jinping, the chairman of the Chinese Communist Party and President of the Republic, took responsibility for the fight against COVID-19 in a speech on 22 January 2020. The tradition of a guarded society (see below) that has characterized China for more than 2,500 years entails strong power of intervention of state organs into all areas of life. Familiar hierarchies, command, and obedience determine public administration. Close personal control is carried out by ordinarily friendly citizens' neighborhood committees — shequ juweihui (Heberer & Schubert, 2008) — but in this epidemic, they turned ruthless. If necessary, community police — shequ minjing — were called on to assist in restraining violators. Only against this background and in this way could strict curfews be implemented and upheld for eight weeks. On 10 March 2020, the president celebrated victory over COVID-19 with a public visit to Wuhan. The completely discontinued public life gradually began to reawaken under strict conditions. Early reporting, strict surveillance, isolation of infected people, tight control, and general quarantine for immigrants remain in place. Since the first emergence of the virus, China has experienced only isolated outbreaks spread across the vast country, often introduced from outside of the country. The public health security system has always reacted with massive interventions — from quarantine and mass testing to lockdowns of entire cities.

3. The path of SARS-CoV-2 through the world: Different responses from different societies

The course of COVID-19 across the world cannot be presented in detail here; it would be impossible even in the context of a more extensive project. Apart from that, the print media are at

an obvious disadvantage compared to electronic media: pictures, tables, and videos are excellent information carriers, and data can be kept permanently up-to-date. So, in this preliminary attempt, we will rely mainly on the ongoing reports that are freely accessible online and in medical journals retrieved through PubMed or Web of Science.

Outside China, the first confirmed COVID-19 case was reported on 13 January 2020 in Thailand, on 15 January 2020 in Japan, and on 20 January 2020 in the Republic of Korea. On 23 January 2020, the first COVID-19 case was reported in the US. On 2 February 2020, the first death outside China was reported in the Philippines. All identified cases had come from Wuhan. France reported its first death on 15 February 2020, followed by Italy on 23 February 2020. In Germany, the first case was reported on 28 January 2020 in Bavaria. These cases were also directly related to flights from China and particularly from Wuhan.

These developments drew attention from the genesis of the virus to its spread. The main means of the proliferation of the virus is international air traffic. On 24 July 2019, the highest number of flights worldwide was recorded: 225,000 — nearly 40,000 by global airlines¹²⁾. This figure is an indicator of the main distribution pathway of COVID-19, namely from China, especially from the air hub of Wuhan. WHO reports have stated that the virus spread worldwide within a short time, reaching Thailand, Cambodia, and Malaysia in Southeast Asia; Sri Lanka, India, and Nepal in South Asia; the United Arab Emirates in Central Asia; Russia, Italy, France, Germany, Great Britain, Belgium, Sweden and Finland in Europe; and finally to the US and Canada.

Notwithstanding the ongoing pandemic, from 25 January to 8 February 2020, travel for the Chinese spring festival could not be stopped entirely. The Chinese New Year is the most important festival in the Chinese calendar. Hundred millions of travellers visit their families, inadvertently providing the perfect environment for an epidemic to spread nationwide. A similar priority setting could be observed in Germany: although COVID-19 had come to authorities' attention in early January and the virus was obviously spreading worldwide, Germany publicly celebrated carnivals and skiing holidays in late February and early March — events that subsequently turned out to be regional (Heinsberg) or even national (Ischgl) spreading events.

These observations indicate that humanity does not only create the pathogen itself but is also responsible for its spread, resulting in epidemic and pandemic escalations. The pandemic of COVID-19 is therefore also human-made. However, this also means that it is in the hands of humanity to control both the emergence of pathogens and their spread.

12) <https://www.statista.com/statistics/564769/airline-industry-number-of-flights> (Queried on 03/21/2021)

Taiwanese health authorities¹³⁾ became aware of the developing coronavirus epidemic in Wuhan at an early stage, at the end of December 2019. In fact, it was due to the reporting by Li Wenliang, which also included lab results and lung computed tomography (CT) images¹⁴⁾. The trigger for Taiwan's fast and decisive reaction was the countries' adverse experience with the first SARS epidemic in 2002/03 (e.g., Twu et al., 2003; Hsie et al., 2005; Chen et al., 2005; Hsu et al., 2017). In response, Taiwan established the National Health Command Centre, a central facility for controlling the response to new disease outbreaks. On 31 December 2019, the Taiwanese Centre for Disease Control (CDC) notified the WHO of the cases of atypical pneumonia reported in Wuhan. Taiwan immediately introduced special health controls for all people arriving from Wuhan. On 21 January 2020, the first COVID-19 case was confirmed in Taiwan. By 24 February 2020, the National Health Command Centre had decided on multiple measures, including quarantine, proactive search for infected people, regulations for schools and educational institutions, and control of Taiwan's sea and air borders. The production of protective masks was increased with military assistance. The number of available isolation rooms with a negative pressure system was increased. Taiwan combined travel and health information with social security data to calculate individuals' exposure and send a real-time alarm to affected persons via the cellular network. If the data were inconsequential, the individual was allowed to partake in public life. When travel data raised suspicions, the individual was immediately placed in home quarantine for the incubation period. Quarantine compliance was monitored via mobile phone using the same program. Immigration control, strict quarantine rules, surveillance, internet-based monitoring, and, above all, transparent communication appear to be the main features of successful COVID-19 control. As a result, public life within Taiwan was and remains largely undisturbed.

South Korea was among the first countries to be affected by SARS-CoV-2 and COVID-19¹⁵⁾. This was not only due to the frequent exchange with China but to events within the country. A Christian sect had flouted all isolation rules, leading to mass infection in the city of Daegu. South Korea initially ranked second behind China in the number of new infections. South Korea eschewed

13) Because of the very different procedures of fighting Covid-19 in Taiwan and in mainland China, Taiwan is treated separately here. This does not imply any position on the international and national relation between Taiwan and China.

14) For a first glance, see: https://en.wikipedia.org/wiki/COVID-19_pandemic_in_Taiwan (Queried on 03/28/2021). For the vast literature on Taiwan and COVID-19, see e.g., Cheng, Li & Yang, 2020; Dai et al., 2020; Chiu, Laporte & Wu, 2020; Huang & Chen, 2020; Hsu et al., 2020; Lin et al., 2020.

15) For a first glance, see https://en.wikipedia.org/wiki/COVID-19_pandemic_in_South_Korea (Queried on 03/28/2021); among the vast literature on South-Korea, see e.g., Oh et al., 2020; Park, Park et al., 2020; Choi 2020; Shim et al., 2020

the drastic interventions in public and personal life enacted in China from the outset: no cities were cordoned off, and no curfews were imposed. The country's main strategy was quick mass testing, which is evident from the fact that South Korea achieved the highest test density worldwide. According to media reports, 400,000 people were tested daily in early April 2020, allowing rapid identification of infection foci and interruption of infection chains. While these are classic surveillance strategies, they were carried out with a high degree of organizational efficiency and appropriate equipment, from abundant test kits to protective clothing for medical personnel.

One unique feature was that South Korea relied on the internet for a permanent and open source of information on personal protective measures for the population. South Korea also combined testing with contact tracing to control infection foci and track interactions with known cases. Infected South Koreans are required to go into isolation, first in government shelters and later in their private homes. Their mobile phones and credit card data are used to trace their prior movements and locate their contacts. People who are determined to have been near the infected individual receive a phone alert. Data from a wide variety of sources — banking, mobile phone usage, surveillance cameras — are compiled in anonymous form into motion profiles and communicated to the infected and their environment. Apps and websites warn of locations visited by known cases. South Korean data protection legislation allows the government to track the telephone number of people infected with the virus and evaluate the GPS (Global Positioning System) data, and publish them anonymously. These practices, which can lead to individuals' private lives being exposed in public, were met with criticism. Infected people and their residential addresses are not named in the warning messages, but it was repeatedly found that individuals' identities could be uncovered based on the circumstances. As many new infections came from international travellers, all arrivals, regardless of nationality, were (and are) directed to monitored quarantine for 14 days.

Despite this clear structure of public health protection and the successful countermeasures, a second infection wave occurred in September and a third in December 2020. These outbreaks were linked to uncontrolled mass gatherings in religious communities and to hospitals, nursing homes, churches, prisons, and family gatherings during the holiday season. The third wave has been linked to the British variant of the virus, introduced into the country in late December 2020. Nevertheless, South Korea's public life remains largely open and undisturbed apart from mandatory face masks and social distancing.

In **Japan**, the government initially pursued a containment strategy¹⁶⁾. A prevention and treatment

16) For a first glance, see https://en.wikipedia.org/wiki/COVID-19_pandemic_in_Japan (Queried on 03/28/ March 2021). For further reading, see, e.g., Furuse et al., 2020; Iritani et al., 2020; Kwok et al., 2020; Oshitani 2020;

policy followed the outbreak on the Diamond Princess cruise ship, which was quarantined in the Yokohama harbour. A COVID-19 test system has been set up. The first strategy against infection clusters was contact tracing. On 27 February 2020, all Japanese elementary, middle, and high schools were closed until early April to contain the virus. The Japanese government also announced additional precautions on 10 March 2020: an entry ban was imposed on people who had previously been in certain provinces of South Korea, Italy, Iran, and Switzerland, for example. In addition, travellers from China, South Korea, and the Schengen area were quarantined for 14 days and banned from using public transport. Visas for citizens of these countries were invalidated, and visa exemptions for various states were revoked. Passenger ship and air traffic from China and South Korea was largely suspended. On 3 April 2020, the rules were tightened further with an entry ban on nationals from 73 countries. The quarantine regulations were extended to worldwide entries, and a COVID-19 test requirement was added. On 7 April 2020, the central government declared a state of emergency in seven prefectures, including Tokyo. This allows authorities of the respective prefectures to order citizens to stay in their homes and close schools and other facilities. On 16 April 2020, the state of emergency was extended to all prefectures.

By mid-April 2020, the Japanese system of tracking infection clusters individually and fighting them in a targeted manner had failed because the virus was spreading faster than the countermeasures could be implemented. Eventually, a policy of mitigation was adopted with the aim of flattening the infection curve. In mid-April, experts identified inadequate preparation of the health system for the virus as one of the causes of the more rapid increase in infections.

At the end of March 2020, there were various theories for the comparatively low number of cases in Japan at the time. For example, culturally determined social distancing and wearing face masks, which are considered normal, were proposed as possible reasons for the virus's slow spread. Critics noted that Japan's test capacity was not expanded and that many infections remained undetected. The estimated number of infected Japanese people could be 30 times higher than the reported number. The government's approach was also seen as an attempt to avoid cancelling the Summer Olympics, which were to commence in Tokyo in July 2020. Up to 70% of the Japanese population spoke out against the planned implementation of the Games. Despite the containment and mitigation measures, the improvement of medical care, especially intensive care, public information campaigns on health-related behavior, closing or banning of mass and sporting events, and travel restrictions, Japan was not spared a significant third wave of infections between December 2020 and February 2021.

Sawano et al., 2020.

Germany, the first case was confirmed in Bavaria on 27 January 2020¹⁷⁾. On 25 and 26 1 single line rather on following page February 2020, multiple cases related to the Italian outbreak were detected in Baden-Württemberg. A large cluster linked to a carnival event was formed in Heinsberg, North Rhine-Westphalia, with the first death reported on 9 March 2020. New clusters were introduced in other regions via Heinsberg and people arriving from China, Iran, and Italy. Non-Germans could arrive in the country by plane until 17/18 March 2020, when travel restrictions were expanded. The winter sports resort of Ischgl, Austria, played a significant role in the spread of the virus in March 2020, affecting not just Germany, but Europe more broadly. These imported infections led to the virus being distributed throughout the entire country.

German disease and epidemic control is advised by the “Robert-Koch-Institut” (RKI), a scientific organization subordinated to the German Ministry of Health. The outbreaks were first managed in a containment stage, which attempted to minimize cluster expansion. The German government and several health officials stated that the country was well-prepared and did not initially implement special measures to stockpile medical supplies or limit public freedoms. On 13 March 2020, epidemic management moved to the protection stage as indicated by the RKI plan, with German states mandating school and kindergarten closures, postponing academic semesters, and prohibiting visits to nursing homes to protect the elderly. Two days later, borders to Austria, Denmark, France, Luxembourg, and Switzerland were closed. By 22 March 2020, curfews were imposed in six German states, while other states prohibited physical contact with more than one person from outside the household. In due course, the measures started to reduce infections. Chancellor Angela Merkel spoke on 15 April 2020 of a fragile intermediate success. Gradually, and not always synchronously due to the federal system, the German states and the federal level eased restrictions and warnings, including on holiday travel to European countries that had likewise seen progress in fighting COVID-19. Germany’s comparatively low fatality rate relative to countries such as Italy and Spain has generated discussion and explanatory hypotheses that cite the country’s higher number of tests performed, availability of intensive care beds with respiratory support, and the proportion of positive cases among younger people.

Rising numbers of reported infections throughout the country in July and August 2020 prompted authorities and the RKI to urge the public to remain vigilant in an effort to ward off a possible second wave of infections. In October 2020, infection rates began to rise steadily. In late October, a fairly lax nationwide lockdown was enacted to stabilize infection rates. When infections, especially in

17) For a first glance, see https://en.wikipedia.org/wiki/COVID-19_pandemic_in_Germany (Queried on 03/28/2021).

For the early months, see more a detailed report from Heiner Fangerau & Alfons Labisch, 2020, *Pest und Corona*, Freiburg: Herder. The Chinese translation *Shuyi yu Xinguan*. Dongfang Chubanshe will be available shortly.

care homes for the elderly, could not be reduced, the lockdown was tightened ahead of the Christmas holidays. This still partial lockdown was extended to the end of January. At the time of writing, a third wave was on the rise, caused by the British variant.

Although Germany's situation is less severe compared to many other European countries, the morbidity and especially mortality rates of the second wave are alarmingly high compared to the first wave. This was linked to many older people dying in care homes (cf. Tab. 1 to 3). The first wave was probably managed well because many people behaved appropriately well before the strict March lockdown started. Since then, the political and public discussion has ranged from favoring a temporary total lockdown — recommended mainly by scientific experts — to a policy of opening up public life as much as possible, including education and culture — proposed mainly by politicians and administrators with regional and local responsibility. This debate represents a prototypical battle between a state-directive government approach and a governance approach based more on individual freedoms and responsibilities.

By comparison, the **Swedish** government is following a more restrained course of action against the virus¹⁸). Sweden has never imposed a lockdown or comparably strict measures. Instead, the country opted to keep public life as unchanged as possible. Most of the measures implemented to contain the epidemic in Sweden are voluntary. Prime Minister Stefan Löfven said at the end of March 2020: "It's about common sense. [...] We trust each other. We don't need bans". Anders Tegnell, the chief epidemiologist of the Swedish Public Health Authority (Folkhälsomyndigheten, FHM), stated: "We, who work with infectious diseases, know that this type of disease will continue to spread until we have achieved immunity in the population. [...] There is no other way to stop it." From the start, Sweden relied on voluntary discipline and limited prohibitions such as advice against unnecessary travel within Sweden. That restriction was lifted on 13 June 2020. Entry from outside the European free trade area was prohibited on 19 March 2020, and extended until 15 June 2020. For younger pupils, lessons were carried out as normal, but adolescent pupils were taught by distance learning. This was justified by scientific evidence that children do not represent a particular risk group or act as carriers of the virus. Visits to nursing and elderly care homes were banned from 1 April 2020. People over the age of 70 or those at specific risk were advised to stay home and reduce all social contact. Gastronomy, food and beverage industries, and other trades remained open, as did national borders. In bars, eating and drinking were allowed only while sitting at tables but not standing at counters. Universities switched to distance learning. On 27 March 2020, Sweden tightened its ban on public events of 50 or more people. From October 2020 to

18) For a first glance, see https://en.wikipedia.org/wiki/COVID-19_pandemic_in_Sweden (Queried on 03/28/2021). The verbatim quotes are from this text. See, additionally, Orłowski & Goldsmith, 2020; Irwin, 2020.

January 2021, Sweden experienced a massive second wave. The open policy has put enormous pressure on the healthcare system. In epidemiological terms, Sweden has performed poorly compared to other Northern European countries. Globally, Sweden ranks 17th on infections per capita and 26th on deaths per capita among 221 countries and regions. The approach has led to considerable debate in Sweden. King Carl Gustav opined in December 2020 that the Swedish COVID-19 strategy had failed.

In the **US**, the president was warned several times that an epidemic was spreading in China¹⁹. The first confirmed local transmission in the US was recorded on 21 January 2020, while the first known deaths were reported in February. By the end of March, cases were confirmed in all fifty US states, the District of Columbia, and all inhabited US territories except American Samoa. COVID-19 was officially declared a public health emergency on 31 January 2020, with restrictions placed on flights arriving from China. The initial response to the pandemic was otherwise slow, especially in terms of healthcare system preparedness, travel restrictions, and COVID-19 testing. On 13 March 2020, President Trump declared a national emergency. In early March, the Food and Drug Administration (FDA) had begun allowing public health agencies and private companies to develop and administer tests and lifted restrictions so anyone with a doctor's order could be tested.

In mid-March, large quantities of medical equipment were purchased. In late March, the administration used the Defense Production Act to direct industries to produce medical equipment. Federal health administrators who surveyed hospitals in late March found shortages of test supplies, personal protective equipment (PPE), and other resources due to extended patient stays while awaiting test results. By 11 April 2020, the federal government had approved disaster declarations for all states and inhabited territories except American Samoa. By early May, testing had increased, but experts indicated that this level of testing was still insufficient for containing the outbreak.

During this process, the president quite often publicly turned down his experts' advice, including his Secretary of Health and Human Services. The public health spokesperson for the president's office during the pandemic was Anthony Fauci, a globally recognized specialist in public health and disease control since the early days of AIDS research. In 2017, Fauci and others published a visionary work entitled "What recent history has taught us about responding to emerging infectious disease threats" (Paules et al., 2017). The high number of deaths relative to the officially reported infections suggests a significant underreporting of US cases. By mid-March, only a few hundred

19) For a first glance, see https://en.wikipedia.org/wiki/COVID-19_pandemic_in_the_United_States (Queried on 03/21/2021). In addition, see Berlanga-Acosta et al., 2020; Bui et al., 2020; Li, Zhang et al., 2020; Ngonghala, Iboi & Gumel, 2020; Oster et al., 2020; Shook et al., 2020.

tests were conducted daily. The real actors were the state governors and mayors. Given the lack of public social services, a capitalist healthcare system, and poorly equipped hospitals, many Americans are at risk of falling into poverty if they use the health care system. By Easter 2020, the US ranked first in global COVID-19 infections, responsible for a third of all infected people and 20% of all deaths worldwide. After a second wave, which peaked in July 2020, and a massive third wave from October 2020 to January 2021, the US currently ranks eighth in per capita infections and 14th in per capita deaths.

Finally, although federal power in public health is comparatively weak in the US, with states being responsible for public health, strong national leadership is also lacking. Nevertheless, President Trump offered massive support for the development and production of vaccines. As of 28 March 2021, 28% of the population had been administered at least one vaccine, putting the US in the top group of countries worldwide that have set a goal of vaccinating all their citizens against COVID-19. By comparison, as of 28 March 2021, in Germany 10,8% of the population had received one vaccination²⁰.

4. Nature and culture — theoretical, conceptual, and empirical questions

The foundation for an integrative history of epidemics is the interrelation of nature and culture (Fangerau & Labisch, 2021). Such a perspective reflects an interpretative concept of culture and nature, which does not conceive of culture as the counterpart of nature or vice versa. Instead, it focuses on the respective time-bound interpretation of what is understood as nature and culture. Included in such an understanding is the idea that people themselves are subjects of nature, but at the same time, nature confronts them as an object. People interpret this form of nature as ‘other’, not made by them. In doing so, people overlook the fact that they have already named this nature at the moment of contact, even from a distance, and have thus classified it and opened it up for the human sphere of action. In the act of naming, a purely natural entity emerges from the unnamed ‘bios’ — ancient Greek for ‘life’ — and becomes real in the human world as ‘bio-logy’. Culture and society affect the process of opening up, interpreting, and ultimately naming what people understand as illness. Charles Rosenberg proposed the term ‘framing’ for this process. From this perspective, diseases cannot be seen as purely biological, purely cultural, or purely social constructs. Rather, nature and culture intertwine in the process of interpreting and defining, of framing a particular name (Rosenberg, 1989; 1992). Cognition, emotions, body sensations, and collective cultural conventions interact to produce concepts of illness (Fangerau et al., 2009).

²⁰) <https://ourworldindata.org/covid-vaccinations> (Queried on 03/28/2021)

From this anthropological narrative follows that different cultures have developed quite different meanings of nature and disease over space and time. Considering the origins of thought in Europe and East Asia, a completely different worldview emerges. The Pre-Socratics — European philosophers who taught before Socrates — already proclaimed the recognizable world is separated from the recognizing subject. Their main endeavor was to recognize the ultimate from which all things can be explained. In contrast, the early East Asian sources — the Yi Jing and Tao Te Ching — offer a dynamic worldview in which things are constantly reshaping themselves in the eternal confrontation of different forces as phases — ‘wu-xing’. There is no need for a valid world outside the world, and the only constant is change (Porkert, 1974; Rappe, 1995).

In China, these different views of humanity — individual vs. collective — led to a life focused on community. Thus, a giant empire, whose history goes back to prehistoric times, is ruled without a state religion, without the obligatory concept of a single god. Only the idea of community, lived in fixed rites as taught by Kongzi, held this empire together in the face of natural disasters and historical turmoil. In Europe, a completely different society and culture, centred on the individual, emerged from the combination of Greek philosophy and Judeo-Christian religion. In the course of the Enlightenment, this path led to the secularised ideal of the bourgeois individual, whose government must be democratically legitimized. Of course, geographical and biological conditions as well as historically long-term developments also play a role in understanding nature and disease as well as in individual vs collective perspectives, and are the subject of historiography.

These coarse categorisations represent clichéd differences between East and West. In the context of fighting COVID-19, we can rely on recent conceptual and empirical studies on the impact of a more authoritarian regime in the East and a more democratic approach in the West. The research of Tianjian Shi, in particular, is a notable step forward toward the empirical application of cultural comparisons of East and West (Shi, 2015; Shi & Lu, 2010). Shi generally distinguishes between guarded forms of state and those oriented towards the free individual. In doing so, he returns to the elementary considerations of Robert A. Dahl — well known for his achievements in the political science of democracies (Dahl, 1989):

“According to Robert Dahl, the ‘perennial alternative to democracy is government by guardians’ (Dahl 1989, 52). Historically, the idea of guardianship has appealed to many different political thinkers and leaders around the world. If Plato provides the most familiar example, the practical ideal of Confucius, who was born more than a century before Plato, has had far more profound influence over many more people and persists to the present day (Dahl 1989, 54). Since 500 BCE, the theory of ‘minben’, or the Chinese concept of government by guardians, has profoundly influenced political thinking in China.” (Shi, 2015, p.197)

Shi argues that culture has an independent effect on political attitudes and political behavior. People under different cultural influences have distinct perceptions of democracy and government. People in Confucianism-influenced East Asia, such as mainland China and Taiwan, are more likely to perceive their government as a guardian. In contrast, people living in Western, individual-centered societies and cultures view government as an organization that experiences procedural justice before it has legitimacy and is instrumental in nature. Because of these different cognitive orientations, people may interpret the same event in fundamentally different ways. If the role of government is identified as guardianship, or ‘rule by elders’ — as the anthropologist Xiaotong Fei has put it (Fei, 1992, pp.114-119) — people are more willing to cooperate with government policies enacted to protect the collective interest. In China, for example, Confucianism has been practiced for millennia, enculturating its people and teaching them from experience that cooperation produces valued results. In contrast, Western populations, long imbued with a culture based on the combination of Greek philosophy and Judeo-Christian religion, a civic tradition, and the European Enlightenment, are more accustomed to criticizing and demanding transparency in the behavior of their governments. Moreover, the theory about the mechanisms by which two dimensions of culture — orientation toward authority and definition of self-interest — influences the behavior of individuals in real life. Shi notes that “a large number of people in East Asia still believe their relationship with authority should be hierarchical and that individuals are obligated to sacrifice their personal interests to collective ones. This means that their level of tolerance for the government could be higher than that in parts of the world where different norms prevail. They trust their government more and are less likely to withdraw political support at any given threshold of dissatisfaction.” (Shi, 2015, p. 145).

This concept provides us with a research approach that might explain some of the differences in public health approaches to COVID-19 between East and West and within East Asia.

5. ‘Government’ and ‘governance’ in public health²¹⁾

After this brief excursion into the cultural foundations of East and West, we can now move from the elementary findings on guarded vs. individually-oriented societies to examine basic models of public health interventions. It immediately becomes clear that there is an affinity between the form of society and the form of intervention.

In almost all societies, health is now considered one of the highest social goods. Social goods are

21) We recently published a separate paper on the question of governance vs. government in public health and new emerging diseases (Fang, Fangerau and Labisch, 2020). This JCIEA-paper has a different question and a different research approach.

bound to social values and convey social norms. Health is thus also a legitimate category for shaping public conditions and social behavior. In recent months, we have experienced this up close and worldwide in various forms. Values and norms are tied to a particular cultural context and are therefore always historically contingent. In reverse, this means that examining how health — as a social good — is implemented in any society enables an analysis of this society's elementary sub-areas. Health security thus becomes the focus of a historical and cultural investigation. (Labisch, 1992; 2018).

Health permeates all areas of policy. The political maxim of the WHO is, correspondingly, 'health in all policies'. The concepts of 'governance' and 'health system governance' are considered suitable tools to pursue this goal appropriately (Greer et al., 2019; Altgeld, 2017):

"Governance is the systematic, patterned way in which decisions are made and implemented. The governance of a health system, therefore, shapes its ability to respond to the various well-documented challenges that health systems face today, and its capacity to cope with both everyday challenges and new policies and problems." (Altgeld, 2017, p.937).

Health governance approaches in the fight against epidemics in highly complex societies are essentially based on transparency, accountability, participation, integrity, capacity, and cooperation.

Classic government approaches, in contrast, are based on a strong preponderance of state administrative structures in general and a particular emphasis on centralized decision-making and centrally controlled interventions. In this model, the possibilities for intervention by governmental policies are limited and are mainly implemented through administration, law, cash benefits, and educational services. Therefore, it is essential to ask how this approach can reach the living environment and thus the behavioral dimensions of public health security.

If this course-grained scenario is transferred to COVID-19, additional actors have to be identified. Science and individual scientists play a prominent role in both 'government' and 'governance' strategies for public health security. Scientists, on the one hand, and politicians or administrators as decision-makers on the other, are clearly separated in media representations of public health policy. But in both forms of action ('government' and 'governance'), scientific information is a significant part of the political and administrative decision-making processes.

The media play another major role. 'Governance' approaches rely on broad and open communication in the context of promoting transparency and participation. This also applies to the 'government' approach, which has to transmit appropriate information from the center of government to the periphery of the governed. In addition to internal communication, information about alternative forms of intervention or the political framing of health policies can also have a

significant impact. This has been illustrated by the politically offensive and incorrect use of the terms ‘Wuhan virus’ or ‘China virus’.

6. Cultural differences in fighting COVID-19: Some conclusions

What do these national histories and historical anecdotes mean? One possible decision criterion is the number of people infected and the number of people who have died from COVID-19. These numbers may be the acid test of the efficiency of a preventative public health strategy. Table 3 summarizes the infection and death rates per 1 million inhabitants per country, comparing August 2020 to March 2021.

Table 3: COVID-19 infection and mortality data from the selected countries as of 21 March 2021. Please note that this is the same data provided in footnotes 1 and 2.

<i>Country</i>	<i>Infected (per 1 million) August 2020</i>	<i>Infected (per 1 million) March 2021</i>	<i>Deaths (per 1 million) August 2020</i>	<i>Deaths (per 1 million) March 2021</i>
China	62	63	3	3
Taiwan	20	42	0.2	0.4
South Korea	326	1,923	6	33
Japan	483	3,661	9	70
Germany	2,761	31,680	111	896
Sweden	8,606	73,368	582	1,307
United States	16,846	91,716	532	1,669

The health care interventions and epidemiological outcomes are consistent with massive government interventions observed in China. However, this approach does not work without some aspects of governance, carried out by the ‘shequ juweihui’ in the cities and by the ‘cun wei hui’ in the countryside. In Taiwan, governance approaches are notably present, but they are backed by strict governmental interventions at the borders. Both countries are characterized by the most advantageous epidemiological outcomes. In all examples, government interventions became increasingly prominent as the disease spread. Thus, there is no clear distinction between government and governance. Rather, a wide range of different kinds of interventions can be assumed. The importance of strong government leadership at the national level can be seen in the example of the USA, where this was lacking, and the impact can be seen all the way through to January 2021. Sweden stands out as the main example of a governance-focused approach. The epidemiological outcomes of this strategy are questionable. Germany saw a mix of government and governance approaches. The epidemiological outcomes were favorable at first but are weakening now. The best epidemiological outcome among densely populated industrial societies, shaped as a Western-style democracy, can be found in South Korea. Its focus on mass testing and sophisticated

use of internet resources nevertheless came at the cost of loss of privacy and data protection.

The country vignettes and the epidemiological data offer room for further interpretations in light of the interdependence of nature and culture and the material and spiritual structure of societies. The data were not all collected in the same way, making it difficult to compare countries based on different measurements. Nevertheless, if we assume that the data are at least comparable to some degree, Tables 1-3 reveal very substantive differences between East Asia and the selected Western countries. It may justifiably be stated that the Western countries have paid a high price in disease and death for their liberal order. This is a statement, not a normative judgment. The observations within East Asia are even more striking, assuming that the selected East Asian states share a similar cultural background. The difference between East and West is certainly linked to the millennia-old tradition of the guarded state and the resulting community orientation in the East. This is well-established. However, within East Asia, a clear line can be drawn between the states that follow the guarded state model — China and Taiwan to some extent — and those that follow the liberal state model, such as South Korea and Japan. In the latter two countries, the liberal orientation and the resulting cautious interventions in public life have taken their toll. However, notably, the infection and death rates are still considerably lower than in Europe.

Taiwan is considered a Western-oriented country. Historically and culturally, it is closely linked to both Japan and China. The long-term effects of a community-oriented guarded state undoubtedly apply. Taiwan's interventions in public life are noteworthy, especially with respect to the rigorous protection of its external borders. However, Taiwan is a relatively small island and can, therefore, only serve as an international example to a limited extent. Nevertheless, public life inside the country was comparatively open and organized according to the liberal-state model. Despite this, Taiwan has achieved better epidemiological outcomes than mainland China.

Consequently, the notable differences within East Asia demand further attention. The basic cultural foundations and attitudes of guarded societies such as China and Taiwan appear to be gradually supplanted by liberal state action and a focus on individual behavior, as observed in South Korea and Japan. Mainland China and Taiwan are starting to differ in their more state-oriented vs. more community-oriented approaches. Further investigations along these lines appear to be a worthwhile endeavour, both for the present authors and the Society of Cultural Interaction in East Asia. The empirical material for such studies is abundant.

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