How to fight the pandemic? Notes on experiences in Asia and Europe

The history of any epidemic (and *a fortiori* any pandemic) combines many areas: biological and ecological, medical and scientific, political, social or cultural and so on. Hence it puts health systems (in the broad sense), solidarities (intergenerational, male-female, social and international), and states very much to the test.

When the conditions are right, an epidemic today internationalizes much faster than in the past as a result of capitalist globalization. The 1957 flu took 6 months to make Europe the heart of the pandemic, two months was enough for Covid-19. So, there was less time to prepare for its arrival, but there was still enough time to do so – it was lost, with the dramatic consequences that we all know. As we will see, this was not just a lack of responsiveness caused by bureaucratic dysfunctions. We don't have to deal with a simple lack of preparation in the temporal sense of the term. It has class (bourgeois) roots.

Not only was the Chinese warning ignored in January 2020, but the early experience of East Asia was not studied. However, it made it possible to anticipate events and to develop an appropriate health policy. On the scale of Johns Hopkins University – which only takes into account states or territories that have reported cases of Covid-19 – four of the five countries with the fewest deaths per 100,000 inhabitants are Asian: Taiwan, Vietnam, [Tanzania], Papua New Guinea (but here the social structure and density are extraordinarily different) and Thailand. A comparison: the death rate per 100,000 inhabitants in January 2021 was 113.46 in France against 0.03 in Taiwan!

Europe unprepared

Contrary to popular belief, “advanced”, but more “purely” capitalist, Europe, is less prepared to face epidemics than Asian countries where either community or bureaucratic structures, the distant legacy of revolutions, persist (even if they are fading) giving rise to a public health policy. The pandemic health preparedness index ranks Thailand sixth in the world and France eleventh.

On the strength of health advances (improved living conditions, antibiotics, vaccines), the Western world had proclaimed the “end of epidemics”, henceforth reserved for “underdeveloped”” countries. Health systems have focused on individual care, which yields the most profit, at the expense of prevention, of overall health. On the other hand, if Asia is also struck by the ills of the new capitalist world (explosion of diabetes, cancer and so on), contagious infectious diseases are still present there and are not understood only as individual pathologies.

The paradox is that, with overconfidence and neoliberal counter-reforms helping, the capitalist West has liquidated its anti-epidemic know-how (and the means that go with it) even as the epidemic risk worsened. Capitalist globalization, by dramatically accelerating the movement of goods and people, can change the nature of diseases: four dengue viruses had their own separate geographic areas. Their dense contact created a new form of dengue, haemorrhagic, which began in the 1950s in Asia (Thailand, Philippines), global warming facilitating its spread. Ailments caused by viruses transmitted by mosquitoes, ticks and other bloodsuckers (arboviruses) have succeeded one another: Zika, chikungunya, yellow fever.

An adaptive mutation related to the 2003 coronavirus, Sars-Cov-2 (remember that this is the name of the virus causing the disease) appears in a period of upheaval in the pathocenosis,

that is to say of rapid changes in the balance of human pathologies. Ecological upheavals, including deforestation, are changing the relationship between the animal world and human life, as well as factory farming: the H1N1 flu originated in Mexico (and not in Asia!) not far from the Smithfield pig factories. The development of gigantic megalopolises has constituted a privileged environment for the circulation of viruses. The food industry has imposed its dictates and so-called civilization pathologies are exploding (diabetes, hypertension). The population is getting older. These comorbidities are the bedrock of the new coronavirus. It is certainly less lethal than its predecessor, but it goes around the globe and therefore, ultimately, causes many more deaths. Covid-19 is a disease of capitalist globalization.

There is no universal recipe for tackling an infectious disease. An appropriate health policy depends in particular on the social structures and the environment specific to each country or region. The effectiveness of the choices made by the authorities is measured between close and comparable countries. However, there are a few simple considerations to start with.

The price of delay

Faced with a serious emerging epidemic, any delay in reaction from the authorities has a high price. This was dramatically confirmed in China in late 2019- early 2020. Once the Covid-19 disease had established itself, its rapid spread internationally was inevitable (especially since China is at the heart of trade). The question then was: would the same mistake be made in other countries? Several Asian countries reacted swiftly, but this was generally not the case in Europe, which as a result became a springboard from which the epidemic became a global pandemic.

Taiwan’s counterexample shows positively what a quick reaction allows. This country was particularly exposed, with hundreds

of thousands of Taiwanese working in China and multitudes of Chinese tourists visiting the island. A first imported case of Covid-19 was detected on 21 January 2020. The government immediately activated the disease control plan drawn up on the basis of the experience of the 2003 SARS epidemic, implementing around 100 measures. It never had to lock down the population. A year later, the country has only 8 dead (Taiwan has just recorded its first death since May 2020) and the number of positive cases is around 912.

Another counterexample, Vietnam, was also on the front line. As in Taiwan, the authorities reacted without delay. During the first wave of the epidemic, it had no deaths. After the second wave, the country recorded 35 deaths from the pandemic as a result of local community transmissions.

The price of Eurocentrism and foolish cultural nationalism

We did not know everything about the SARS-Cov-2 coronavirus in January 2020 – it is still a novelty and the more we learn about it, the more new questions arise. We knew, however, more than enough to act. Many articles were published in leading scientific journals and, in France, the health watch had done its job. The Asian experience, both early and varied, was instructive. Alas, European political circles are rarely used to learning from Asia. The metropolises of the late empires are struggling to shake off their arrogance – and blind Eurocentrism. Why be concerned with what is happening "over there" in the distance?

The refusal to learn from Asia involved its share of racist clichés and connotations, as if Asians (in this case from the Far East) were behaving like obedient robots, regardless of freedoms. Popular protest against the authorities is nevertheless evident in China (witness the number of administrative buildings set on fire). South Korean youth are

also claiming their right to enjoy themselves. The Japanese certainly greet each other without touching each other, but they are also people who like to live well, who regularly frequent tiny bars and traditional restaurants (high places of contamination, as we know) where the crowds are higher than here.

In France, we are smarter – how many times did Jérôme Salomon, the irremovable director of health, spell this out during the press conferences he held in February-March 2020. We do things our way, necessarily better. In France again, "we" foolishly laughed at the levity of the Italians, hit hard by the pandemic, shortly before us. Flattering the nationalist ego is a recipe so often used to divert attention from real issues and real responsibilities. This posture reveals a bewildering myopia even as Covid 19 accelerates the shift of the geopolitical centre of the world towards Asia and the Indo-Pacific region.

The price of lying

The Vietnamese government lied during the 2003 epidemic and it cost them dearly; it learned the lessons: in 2020, it spoke the truth, which is one of the factors that explain the success of its health policy during the first wave of Covid-19. The Chinese government lied, but the Taiwanese government told the truth. The French authorities dug into lies to hide their responsibilities in the then prevailing state of lack of equipment. In Vietnam, surgical masks were available over the counter at any drugstore. France was unable to produce them. Amazement in Vietnam to see the former colonial power so deindustrialized, become what can be called a dependent imperialism.

Since there were no masks, gel or gowns, French political and health authorities claimed that Covid-19 was not that dangerous and that masks were useless (or worse). Lying has become a policy. We are still paying the price today. Not only

have the authorities' words been discredited, but the door has been opened to the most dangerous health denials. It would have been healthier and easier to tell the truth: masks, hydro-alcoholic solutions, are important, but we don't have any, so we'll have to do without for a while.

Do not expect political and health authorities to admit having lied. Lawsuits are possible for endangering the lives of others. So, they claim that it was not known whether masks were effective against this coronavirus: was it spread by contact or by air? Note that the mask is useful in both cases, because it prevents us from touching our nose or mouth (which we do spontaneously). It should also be noted that masks are a standard measure in the event of epidemic contamination by the respiratory tract. Above all, countries have effectively reacted, in various ways, from January. Besides Taiwan and Vietnam, this was also the case for South Korea (after a brief delay), Thailand or the people of Hong Kong who masked themselves overnight without waiting for the authorities to recommend it.

The culprits are now relying on belated directives from the World Health Organization (WHO). Our leaders are, however, well placed to know that this body is subject to pressure from the main member states and that it is not (or no longer) free to talk. They brought under control an Organization which, in the 1970s, had shown itself to be too independent (which was a guarantee of its effectiveness). It is now subject to double pressure from governments (notably exerted by China in January 2020) and private donors. Plus, faced with a global shortage of masks, it (rightly) believed they should be reserved for healthcare workers. In times of scarcity, we must of course make choices, but in France we have experienced a genuine anti-mask campaign which has left deep traces.

Feedback of experiences

By opposing “liberal democracy” and “authoritarian regimes” (China, Vietnam) or “[East] Asian traditions” to “Western” concerns about individual freedoms, many French commentators are playing a dangerous game, suggesting that in the fight against an epidemic as formidable as Covid-19, a dictatorial order would be more effective than a “democratic” one.

China. The dictatorial order has meant in China that “whistle-blowers” have been brutally suppressed and that the first outbreaks detected were not nipped in the bud. Confronted by an epidemic that had grown out of control, Beijing imposed extremely violent lockdowns in the most affected cities – these lockdowns are by no means models (to put it mildly)! The Chinese experience, however, deserves to be studied. Xi Jinping has greatly strengthened the CCP’s single leadership and personal dictatorship, but Chinese society is complex and not just one political order. Power must also develop mechanisms ensuring popular support (great power nationalism being one). The experience of the pandemic is not uniform across this continent. In unaffected areas, local structures linked to the CCP (and usually monitoring the population) have established controls to prevent the arrival of potentially infectious people. The memory of the criminal mistakes, the suffering inflicted, and the lies will not disappear, but it is mingled with relief following the victories won and the hope that the state remains able to contain the danger of further contamination caused by the return to the country of Chinese residents or foreigners. Many questions therefore remain unanswered.

Hong Kong. During the first wave of January-February 2020, the response of the people of Hong Kong was remarkable. They saw the imminent danger. The territory was in direct contact with one of the most virulent Chinese epidemic centres. Population density is one of the highest in the world, and the structure

of urban housing makes it difficult to maintain physical distances within homes or buildings. However, on the strength of the SARS experience of 2003, the population spontaneously masked itself, while the authorities, under Beijing's influence, still advocated procrastination – a form of spontaneous self-organization.

Healthcare workers went on strike for five days in a row to demand that the border be closed and that sufficient resources be obtained, otherwise hospitals would be unable to cope; this mobilization was made possible by the creation in December, in this sector, of an activist trade union originating from the 2019 movement.

All this occurred during a genuine citizens' uprising to defend the legal and civic rights enjoyed by the population under the agreements reached at the time of the handover to China of the former British colony. Beijing had in fact decided to impose its direct hold on this "Special Administrative Region". The fight against the epidemic has been integrated into a comprehensive struggle, with remarkable health results.

The general climate has since changed. Not only hasCovid-19 been long-lasting, with the permanent danger of new surges fuelled by the return of residents to their homes (hence a policy of quarantine), but the battle to defend the autonomy of the territory has been lost. Fatigue is felt, following this defeat and the considerable toughening of the repression. At the end of January 2021, since the start of the epidemic, there had been 10,453 cases of contamination and 181 deaths linked to the coronavirus (the territory has 7.5 million inhabitants).

South Korea. South Korea was one of the countries most vulnerable to the pandemic in February 2020, after members of the Shincheonji Church of Jesus returned clandestinely from Wuhan. The government mobilized and reoriented the industrial

apparatus to produce what was necessary to fight the epidemic (nothing in common with Macron's "patriotic masks" supposed to bring relief to the French textile industry). It has deployed enormous resources to "test and trace" the chains of contamination and "isolate" those who are contagious. Initially, this last measure led to tragedies, the names of the patients having sometimes been revealed, subjecting them to the vindictiveness of those around them. This has been partially rectified (anonymity being better guaranteed by the medical teams and the data being stored independently of the state), but the government is today calling for denunciations of people who do not respect the measures of protection (with rewards) – a very dangerous slide towards the "surveillance society".

However, the South Korean experience shows how "test, trace, isolate" is one of the key elements of a health policy in the face of Covid-19. Without establishing lockdown, the contamination curve stabilized at around 8-9,000 cases. The country (more than 50 million inhabitants) had on 30 January recorded 1,425 deaths.

In Ile-de-France, it was only recently that the COVISAM teams began to operate effectively. Until now, hotels have remained desperately empty and the arrangement of the conditions of isolation at home very uncertain, because they were not part of a prevention policy, despite Macron's unkept promise of a home visit for each carrier of the virus. If the French authorities had wanted to learn from South Korea, they could have anticipated the implementation of a screening policy well in advance (also called for by many researchers).

Vietnam. Vietnam's success is linked to how it was able to mobilize the population by telling the truth about the situation and using social media to alert it – including showing a music video viewed 65 million times. Screening was set up, borders were closed, a strict quarantine policy was established regarding the return of nationals and the arrival

of experts, while hotels, barracks and hospitals were mobilised (up to 40,000 people were affected). All the mass organizations linked to the party (Women's Union and so on) were called upon to implement the health policy. Vietnam has only experienced two weeks of national lockdown and has 35 dead for a population of 97 million.

Political regimes and "social fabric"

Is there a simple relationship between political regime and health efficiency in the face of an epidemic? The answer is far from obvious.

Neoliberal hegemony is an almost universal rule. It dominates the regime's politics in Sri Lanka – but the free public hospital care system has yet to be dismantled; it was effectively put to work in relation to Covid-19. Is a federal plan a plus or a minus? It seems that the answer can only be "it depends". Angela Merkel had measures adopted more quickly and more effectively than in France during the first epidemic wave, with the agreement of the Länder; this was no longer the case in the autumn, which contributed to an epidemic outbreak (some Länder ministers admit this). Under Trump, Democratic-controlled states opposed his devastating madness; under Biden, Republican states have refused to implement the new health policy deployed at the federal level.

On the other hand, it is tempting to answer that the French system of hyper-centralization in the person of the president is a minus. The system is opaque, while transparency over time is a key factor for popular support. The vocabulary underlines it: the choices are made by the Defence Council whose meetings are subject to defence secrecy! The French Constitution, marked by the context of the time (an army in rebellion imposing the accession of De Gaulle to the presidency) is probably the least democratic in Western Europe (with, perhaps, the Spanish Constitution, in different ways). Macronism accentuates its original faults by making it even

more presidentialist in practice. Emmanuel Macron decides at the end of the day, according to his whim, and does not like strong personalities to act as a counterweight to his authority. However, the presidency is not organized to govern and anticipate the implementation of policies (in logistics, for example). As for Macron, his personal history has not prepared him to think of a health policy. The Merkels are scientists. Taiwanese Vice President Chen Chien-jen is a Johns Hopkins-trained epidemiologist and virus expert – it helps! Macron is formatted by the world of capital governance – it is disastrous.

There is a wealth of experience in France of mutual aid "on the ground" in the face of an epidemic. This was the case with helping AIDS patients, to break their isolation, to inform and popularize protection (condoms). It was again the case with Covid-19 during lockdown, often in collaboration with town halls, in particular in lower-income neighbourhoods: food distribution, location of isolated elderly people or populations not covered by official funding (including foreign and trans prostitutes who had lost all forms of resources), mobilization so that the homeless were urgently accommodated, action against domestic violence (against women and children) and so on. However, Macronism has always refused to associate the "ground" with the implementation of health policy (he even has difficulty "dialoguing" with elected officials). He is deeply authoritarian and verticalist. [1] Corollary: he has a narrow vision and, after having violently repressed the mobilizations of caregivers, he remains foreign to any notion of health democracy or community health. [2]

The more we dig, the more it becomes apparent that we must take into account actually existing society, as a whole and not stick to definitions that often only refer to state structures of domination. A comparison between Thailand and France (two countries comparable in terms of the number of inhabitants) is very instructive. In principle, the cost of

the epidemic should have been much higher in the Thai kingdom than in French “western democracy”: it is under military rule and the monarch is of dubious character. The reality is the opposite.

In Thailand, health authorities bypassed political (military) and royal authorities to mobilize pre-existing volunteer networks in villages and urban centres – which precisely has not been done in France. In January 2021, there were 77 dead in Thailand against 76,000 in France.

Solidarity, a factor of health efficiency and social justice

Immigrants have often been singled out and discriminated against during the pandemic; they are nevertheless its victims and have few resources to face the danger. Governments generally began to protect only their nationals, as in Thailand and Singapore, only to realize, at times, that by excluding migrants they were allowing the pandemic to continue. Of course, to include migrants in the health care system, undocumented migrants must be guaranteed that they will not be sanctioned or expelled, so that they do not avoid health checks.

Popular insecurity has reached new heights in the Philippines, subject to Duterte’s dictatorship, police impunity and death squad violence, widespread corruption, harsh lockdowns without effective social compensation and multiple military conflicts (in Mindanao in particular, in the south of the archipelago). Solidarity networks work in particularly difficult conditions to support the most marginalized populations.

For a long time, a particularly large part of the Filipino population has migrated to the West or the Middle East; the survival of families in this country depends on it. These emigrants can have secure jobs, but they are most often precarious (domestic service). Their insecurity has increased

with Covid.

Many nurses in British hospitals are Filipino. They can be subjected to an insidious hierarchy of roles, de facto racial discrimination, albeit invisible, being more often than others placed in risky situations, receiving less or later protective clothing. It should be noted, however, that all hospital staff in Britain paid an extremely high price for being unprepared for the epidemic and for the choices made by Boris Johnson's government (four times more infections than in the general population). It should be noted in passing that in some hospitals (regardless of the country?) the members of the administrative hierarchy have granted themselves the best protection even though they do not treat patients.

In Hong Kong, Chinese families have outright thrown Filipino and Indonesian servants onto the streets for fear they will infect them. Or, conversely, they have forbidden them to go out (which allows them to demand availability 24 hours a day, 7 days a week). However, the employer's family is not a place of socialization for a domestic worker, who is moreover confronted with racism. They are traditionally found in walking areas during their weekly leave where they must now keep their distance.

In general, the pandemic is testing social solidarity, within families, intergenerational or international. There is a search for scapegoats (foreigners, the elderly). This is favoured in the West by neoliberal individualism, a component of the dominant ideology, destructive of solidarities (but countered by currents of solidarity resistance). How less dominant is it in East Asia? The fight for solidarity is being waged on all fronts, including cultural ones.

Generally, we have to fight on two fronts at the same time. Against the "scientific" claims of the drug industry whose choices are dictated by financial considerations (including a very high rate of payment to shareholders) and against the

rise of increasingly disturbing irrationalism. A scene that one might have thought specific to the United States is also happening in France: an ordinary patient insulting nurses by claiming that “Covid does not exist” when he must be placed on respiratory assistance. That the 5G theory is spreading leaves us speechless. [3] Through their lies, the political authorities have opened a breach in which conspiracy theories are rampant, as well as being fanned by “populist” figures eager to build up a clientele.

The Asian experience confirms the obvious: people learn from experience (sometimes more than rulers). However, if irrationalism spreads, this progressive process can be fractured in a country like France. The issue is not marginal.

The policy of a state of health emergency gives a boost to an almost universal authoritarian drift of political regimes. Health democracy and community health thus become key components of the democratic struggle.

The same is true of the question of treatments and vaccines. Private firms have neither the will nor the means to produce them in sufficient quantity to meet the needs of a pandemic such as Covid-19. These drugs must fall within the public domain and the means should be provided to poor countries to develop production chains on their own territory.

The logic of the common good must decisively prevail against privatization via patents. Along with food security, the right to health is an obvious requirement. The arrival of vaccines (and hopefully also of treatments) and their shortage organized by the capitalist logic of profit underlines the burning actuality of the solidarity-based alternative, in a radical break with the dominant order.