

ORIGINAL RESEARCH

From SARS to Avian Influenza: The Role of International Factors in China's Approach to Infectious Disease Control



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Abstract

BACKGROUND Over the past decades global environmental change, globalization, urbanization, and the rise in movement of people have increased the risk for pandemic disease outbreaks. As environmental exposures do not respect state borders, a globalist concept of global health response has developed, which requires transparency and cooperation for coordinated responses to disease outbreaks. Countries that avoid cooperation on health issues for social or political reasons can endanger the global community.

OBJECTIVES The aim of this study was to examine the rapid change in China's infectious disease policy between 2000 and 2013, from actively rejecting the assistance of international health experts during the HIV/AIDS and severe acute respiratory syndrome crises to following best-practice disease response policies and cooperating with international health actors during the 2013 avian influenza outbreak.

METHODS Using international relations theory, I examined whether international political factors had a major influence on this change. Using the case studies of international reputation, socialization with international organizations, and the securitization of infectious disease, this study examined the influence of international and domestic pressures on Chinese infectious disease policy.

FINDINGS Although international relations theory, especially theories popular in global health diplomacy literature, provide valuable insight into the role of international factors and foreign policy interests in China's changing approach to infectious disease control, it cannot provide viable explanations without considering the domestic interests of the Chinese government.

CONCLUSION Analysis of state responses to infectious disease using international relations theories must consider domestic political factors.

KEY WORDS global health diplomacy, international relations, infectious disease, China, SARS, influenza, securitization

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Over the past decades global environmental change, globalization, urbanization, and the rise in movement of people have increased the risk for pandemic diseases. Health is no longer the sole responsibility of national governments and an

international health governance system has emerged, making transparency, cooperation, and coordinated multilateral responses the international norm. Traditional actors like states, the World Health Organization (WHO), and the World

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Organization for Animal Health, as well as new actors, practice information sharing through mechanisms like the Global Influenza Surveillance Network and the Global Outbreak Alert and response Network, required by the International Health Regulations (IHRs) since 2007.^{1,2} Yet, when confronted with severe acute respiratory syndrome (SARS) in 2002, an unknown and extremely virulent pathogen, the People's Republic of China (PRC; hereafter referred to as China), actively rejected the assistance of international health experts, resorting to obstructionism, secrecy, and isolationism. This caused the loss of many lives and facilitated the spread of SARS to 29 states on 5 continents.³ In 2013, 10 years after SARS, China responded to the emergence of the new avian influenza strain H7N9 in a manner conforming to international best-practice guidelines, earning praise from the international health community.^{4,5} Observers have provided many possible explanations for this rapid change, including the shock of the SARS crisis, a new national discourse about non-traditional security threats,^{6,7} the high cost of SARS to the Chinese economy,⁸ reforms to the domestic Chinese health system,⁶ and China's increasing relationship with international organizations.⁹ However, more in-depth analysis can add to the picture of the influence of international forces on China's response to infectious diseases.

The role of international political factors in motivating changes in domestic health policy was, until recently, largely neglected by international relations and political science academics. Academics in the field of global health diplomacy have begun asserting the importance of studying the relationships between health, international relations, and foreign policy and a significant body of research and theory has been developed.^{10–15} As has been previously suggested, the discipline of international relations has paid especially little attention to Chinese health policy, its foundations, or its value in understanding China's broader foreign policy.⁷ On the specific topic of Chinese infectious disease policy, a number of high-quality analyses of the relationships between international relations concepts and Chinese infectious disease policy have been published.^{6–9,16} Other authors have done similar analyses for other East and Southeast Asian states.^{1,17}

OBJECTIVES

The present study will answer the question, “How can international relations theories and concepts

add to our understanding of how and why China changed its infectious disease policy?” I argue that the international relations theories of socialization into international organizations and securitization can add valuable information on the following 2 case studies: China's engagement with intergovernmental organizations and the securitization of infectious disease in China. However, securitization and socialization theory are limited in the insight they can provide about domestic motivations for Chinese policy change. By combining public health and international relations approaches, we can develop a more complete picture of the forces that encourage states to support international health governance and evidence-based infectious disease policy, providing insights to better direct the work of public health actors and both broadening and setting boundaries for the usefulness of international relations theory. International relations theories can add nuance and show why some attempts to engage states like China in international health governance will be effective, whereas others will be ineffective.

METHODS

Using the International Relations theories of socialization into international organizations, securitization, and broader concepts from International Relations, Public Health, and Global Health Diplomacy literature, I examined the role of international and domestic factors on the changes in Chinese infectious disease policy between the HIV/AIDS and SARS outbreaks, and the H7N9 outbreak in 2013.

Due to space limitations and the opaque nature of Chinese policy decision making, this study did not attempt to analyze all international forces influencing Chinese health policy or determine the relative influences that individual forces have had on Chinese policymaking. Although this study has been constrained by the opaqueness of Chinese government decision making and the difficulty of accessing internal Chinese government documents, there is enough evidence published in English to develop a clear analysis.

CHINESE INFECTIOUS DISEASE CONTROL: 2000 TO 2013

One of the key assumptions of this work is that there was a dramatic change in China's infectious disease policy between 2000 and 2013. There is an academic consensus that China is now actively involved in developing effective infectious disease

response systems and wider health governance,⁷ although there are still local implementation issues.⁶ These developments have come after several shocks to the health care system, beginning with HIV/AIDS and SARS.

Although the first reported case of a Chinese national infected with HIV was in 1989, it was consistently labelled a “Western disease” and ignored by Chinese official media.⁹ Beijing prevented discussion of a HIV/AIDS disaster in China, covering up a local government-sanctioned paid blood donation scheme that reused needles and mixed blood donations, infecting thousands of people in several provinces, and the government was subsequently criticized.⁹ The central government did not acknowledge the crisis until June 2001, when it dramatically increased official figures on infection rates and presented an Action Plan on HIV/AIDS Prevention and Containment (2001–2005).⁹ Despite engaging more with international organizations and experts after June 2001, the government continued to control all reporting of infectious disease and did not significantly increase transparency.

The 2002 and 2003 SARS epidemic revealed the continued obstructiveness of the Chinese government to international health authorities and the weaknesses of the Chinese health care system. After being notified of an outbreak of atypical pneumonia in February 2003, the Chinese central government classified the information as top secret and prevented any domestic media reports on the virus.^{6,18,19} Local authorities did not notify Beijing of the emergence of the never before seen form of pneumonia until February 7 or 8, 2003, months after it first emerged.^{6,18} All information about the disease was classified as top secret, preventing state media from reporting on the virus, and the Chinese public were not informed of the outbreak.^{18–20} The crisis was not publicly announced until February 11, 2003.¹⁸ The Chinese Ministry of Health did not officially inform the WHO of the details of the outbreak until February 14, 2003, and continued to withhold information from international organizations until April.^{6,18,21} WHO assessment teams arrived in China on April 2, but were prevented from entering Guangdong Province for 8 days.¹⁸ A hierarchical Chinese decision-making system, a lack of effective communication mechanisms, and deliberate secrecy by rural and national Chinese officials forced the public, international organizations, and other state officials to rely on unofficial sources for updates on the unknown disease.¹⁸ As a result, Hong Kong was unprepared, and the virus spread rapidly. It was not

until after the official appointment of President Hu Jintao and Premier Wen Jiabao that official Chinese policy changed. Transparency and swift action were then emphasized and the national Minister of Health and the Mayor of Beijing were fired.²² Hu and the Chinese Communist Party (CCP) were widely commended for the new approach.²³ From its origin in southern China, SARS spread to Hong Kong and the rest of the world, causing 8096 confirmed infections and 774 deaths.²⁴ SARS was deadly evidence of the failures of the Chinese infectious disease response system.

Similar to the 2003 SARS outbreak, when enterovirus 71 (EV71) surfaced in Guangdong, Anhui, and Zhejiang provinces in 2008, it was not swiftly reported and was poorly managed on a technical level.⁹ The virus spread rapidly, killing 34 people and infecting 27,499 others.⁹ Although the government claimed that it had not purposefully concealed the virus, there was very little transparency and public reporting of the EV71 outbreak.⁹ The poor management of this outbreak suggests that substandard reporting and response systems were still in place in China in 2008.

The emergence of a new swine flu strain (H1N1/09) in 2009, which originated in North America, showed dramatic improvement in some areas of China’s infectious disease policy. The State Council, President Hu Jintao, and Premier Wen Jiabao labelled H1N1 as a “national priority,” initiating the National Pandemic Preparedness and Response Plan.^{19,25} A strict containment approach was implemented that involved scanning the temperatures of all passengers on board flights originating in countries with confirmed H1N1 infections; banning the importation of pork and pork products from Mexico, the United States, and Canada²⁶; and closing some schools.²⁷ China implemented stricter quarantine policies than any other state, quarantining all airplane passengers even if only 1 passenger exhibited flulike symptoms.²⁶ China was transparent about its epidemic response strategies²⁸ and was the first state to develop and distribute an H1N1 vaccine.²⁵ There was significant criticism of China’s containment approach, as H1N1 was found to be less virulent than expected,²⁶ the containment approach was less effective than WHO-supported mitigation strategies^{19,25} and aid was redirected from funds allocated for hand, foot, and mouth disease.²⁶ Despite the high economic cost and diplomatic issues caused by the quarantining of foreign citizens, the Chinese response proved partially effective and was tentatively praised by international analysts.^{26,27} Beijing’s response during the 2009 H1N1

epidemic did not follow evidence-based policy or all of the recommendations of international health organizations, but did show greater transparency and an aggressive commitment to controlling infectious disease.

China's central government acted swiftly, assertively, and transparently to contain the 2013 outbreak of avian influenza (H7N9), earning praise from the international community. The Chinese Center for Disease Prevention and Control sequenced the genes of the virus on March 19, soon after the first confirmed case; all Chinese citizens with suspected cases were diagnosed by March 30, and the WHO was informed of all Chinese cases on March 31, 2013.⁴ A new online disease reporting system was crucial to this response, incorporating >90% of rural hospitals and providing daily information on suspected and confirmed cases of 39 infectious diseases.⁴ Cooperation with the WHO facilitated the release of the virus sequences and samples by April 11, adhering to the WHO IHRs and the Pandemic Influenza Preparedness Framework.⁴ There appears to have been an increase in the use of evidence-based approaches in China between the 2009 H1N1 and 2013 H7N9 epidemics.⁴ The rapid reporting, development of diagnostic criteria, and treatment of patients during the 2013 H7N9 epidemic is evidence of the development of the Chinese infectious disease response program and a fundamental shift in official attitudes to infectious disease control.

FINDINGS

China is particularly valuable as a case study of infectious disease control. The Spanish influenza of 1918, the Asian influenza of 1956, the Hong Kong influenza of 1968, and SARS all emerged in east Asia and researchers have predicted many future varieties of seasonal influenza will emerge in the Asian region.⁹ The tropical climate has been given as the key supporting condition for emerging influenza outbreaks, but this is an insufficient explanation. China's huge population and increasing rural-urban migration creates good conditions for the spread of disease.²⁹ Poor air quality, water quality in some areas, and slow infrastructure development in rural areas also increase the risk for certain disease epidemics.²⁹ China is an important player in the east Asian region and internationally because of its size, economic growth, and increasing involvement in international governance. As seen during the SARS epidemic, China's nonparticipation in international disease

monitoring and response can have serious consequences for the world.

In addition to being a crucial actor in the region, Chinese foreign policy is shaped by many internal stakeholders and is difficult to analyze. In the diverse region of East Asia, traditional security issues like territorial integrity and protecting state sovereignty are still acknowledged as core to state decision making, but the threat of nontraditional security concerns like infectious disease, environmental pollution, organized crime, and terrorism have become a priority.^{1,17} After Hu Jintao's appointment as President of China, there appeared to be a shift in Chinese diplomacy and rhetoric, emphasizing China's role as a responsible international state. In April 2003, Premier Wen Jiabao explicitly linked China's newly aggressive response to SARS to China's reputation as a responsible state.³⁰ Since 2004, the ruling CCP has adopted a succession of terms to portray China as a responsible rising state, including Zheng Bijan's "peaceful rise" (*heping jueqi*) theory, later replaced by the softer "peaceful development."³¹ These terms were developed to counter the "China threat theory"^{9,31} and assuage fears of China becoming more aggressive as it gained economic resources and political power. The Chinese government's aim to project the image of a responsible state practicing good governance in health forms a part of a larger international strategy to develop an image of China as a peaceful great power. Despite this, China has continued to react aggressively to certain conflicts, particularly regional territorial disputes.³² There are many actors involved in Chinese foreign policy and health decision making and the Chinese government is notoriously opaque about its decision-making processes, the various agencies and actors involved in decision making, and the internal interest groups able to influence government policy.³³

SOCIALIZATION INTO INTERNATIONAL ORGANIZATIONS

China's socialization into the WHO is in a stage between social influence and persuasion. China follows the organization's rules and procedures and its attempts to gain influence within the organization suggest officials have internalized some of the norms of the WHO. Engagement with the WHO and other international health organizations has provided China with increased access to technical information on infectious disease management. The functionalist nature of health cooperation and

the positive goodwill it generates makes a constructive working relationship with the WHO a pragmatic policy decision.

Johnston's model of state socialization into international organizations is a respected measurement of China's participation in international organizations.³⁴ Johnston argued the socialization of states into international organizations can, in some cases, be viewed on a continuum, beginning with mimicking, which is when a state mimics the behavior of other actors before making concrete decisions about its commitment to the group, sometimes as a response to uncertainty.³⁴ During the next stage, social influence, a state ostensibly follows the prescriptions of the organization to gain approval from other actors and avoid censure but it is not clear if the rules and values of the institution have been internally accepted.³⁵ The final process is persuasion, where the state is internally convinced of the value of following the rules and prescriptions of an institution, requiring both private and public acceptance of the norms, values, and processes of the institution.³⁵ Although classical realist, neo-classical realist, and neorealist theories have used the concept of socialization, Johnston took a constructivist approach. This argument draws from the constructivist assumption that engagement with the international community can change the interests of actors, which can alter the norms of the international system itself.³⁵ Johnston's socialization approach has been effectively used to explain China's engagement with the World Trade Organization³⁶ and the International Monetary Fund.³⁴ As Ferdinand and Wang suggest, it goes beyond the debate between status quo and revisionist behavior,³⁴ but it only allows states to follow one path of socialization into international organizations.

Although the PRC became the official representative of China in the World Health Assembly (WHA) on May 12, 1972,³⁷ Chinese involvement with the WHO has increased significantly over the past 2 decades. The PRC has held many WHO meetings and conferences and >60 WHO collaborating centers are based in China.³⁷ The PRC has become more involved with the United Nations Children's Fund (UNICEF), the Joint United Nations Programme on HIV/AIDS, World Bank health projects, the Association of Southeast Asian Nations (ASEAN)'s health cooperation and other regional and international health organizations.³⁷ China has become actively involved in WHO management and activities, learning the principles and procedures of the organization.

China's support of Margaret Chan for the position of director-general of the WHO shows it has entered the social influence phase of socialization with the WHO. This is evidence of China attempting to follow the rules of the WHO, gain support from member states, and increase its position within the organization. China has become significantly more active within WHO since SARS, supporting the election of Chan, a Hong Kong resident, as director-general.³⁷ China's support of Chan for the position of director-general shows the government is trying to gain the public approval of other member states and accepts the value of the organization to CCP goals. Since the 1990s, there has been a rapid emergence of new health actors internationally in the form of civil-society groups, transnational companies, international foundations, and hybrid organizations.¹³ As suggested, this has altered the distribution of funding and influence within the international health community.¹³ China continues to show a clear preference for working with the WHO. The WHO state-centric decision-making model, which allows states to determine major policies, some program directions, and part of the organization's budget through the annual WHA, complements China's state-led view of governance. China appears to be actively trying to gain influence within the WHO, having accepted its value if not all of its mandates. To gain influence within the WHO, China must act responsibly and practice good health governance, increasing the opportunity costs of acting in a way conflicting with international best-practice disease control.

It does not appear that China has internalized all international health norms and entered the persuasion stage of socialization with the WHO. Although China has been influenced by WHO norms in the area of infectious disease policy, it continues to prioritize foreign policy goals over some health issues, in particular the position of Taiwan. Since the SARS crisis, China has supported a broader relationship between Taiwan and the WHO under strict conditions. After years of blocking Taiwanese applications for observer status in the WHA, Taiwan was granted observer status with China's support in April 2009⁹ on the condition it accept the "One China" policy.^{9,38,39} The date of Taiwanese accession to the WHA coincided with increased fear of a swine flu outbreak and a change in engagement strategy by recently elected Taiwanese President Ma Ying-jeou, who was more supportive of integration with China.³⁹ WHA observer status and the January 2009 decision to

allow Taiwan to become a participating party of the IHR³⁹ allowed Taiwanese health authorities direct access to WHO materials and advice, regular IHR updates, and access to the WHO Global Outbreak Alert and Response Network with real-time information about disease epidemics.³⁹ However, the Permanent Mission of the PRC to the UN in Geneva continues to carefully manage Taiwanese interaction with the WHO. As an example, Taiwanese experts are only permitted to attend WHO meetings and information-sharing groups with the permission of the PRC government.³⁹ Although the developments in the relationship between Taiwan and the WHO decrease the chance of cross-strait disease transmission and show China has been influenced by WHO norms of transparency and engagement, China still views the organization as a vehicle for other foreign policy goals, suggesting it has not been fully socialized.

Although China does appear to have passed the social influence phase of engagement with the WHO and embraced many of the organization's norms, socialization theory is unable to explain some of the motivations for China's improving infectious disease policy. Johnston's socialization theory is limited in 3 ways. First, it does not take into account the complexities of Chinese engagement with international actors and multilateral approach to a growing number of international issues. Since the 1996 adoption of a "new security concept" (*xin anquan guan*), China has approached many international issues multilaterally,⁹ although other conflicts like territorial disputes in south China see are still approached mostly bilaterally and sometimes aggressively.³² China's engagement with the WHO over the past 2 decades may be a part of the CCP's broader foreign policy strategies and unrelated to health policy. Second, although the concept of global health governance is increasingly influencing public health activities, China continues to support a state-centric approach to health.^{6,9} Beijing's attempts to balance the expectations of the global health movement and a state-centric approach to health can help explain why China has not accepted all of the values of the global health community. Finally, Johnston's socialization model is limited by its narrow view of engagement with international organizations as China's engagement with many international organizations has fallen outside of Johnston's model. China has used a maxi-mini approach to gain influence in some international organizations, which involves attempting to gain the most benefits for the least concessions. A state may completely avoid interacting with an institution by

creating alternative organizations as China has done with the Shanghai Cooperation Organization, an alternative to the North Atlantic Treaty Organization and the ASEAN or the Asian Infrastructure Investment Bank as an alternative to the World Bank. Although China's relationship with the WHO does fall within Johnston's continuum, the socialization model cannot be applied to all state relationships with international health organizations and does not explain the effects of broader multilateral policies.

Given China's emerging multilateral approach to global health issues, the state-centric WHO system, and the functionalist nature of the issue of infectious disease control, strong relations with the leading intergovernmental health organization are coherent with China's broader policies. The shock of SARS and the growing HIV/AIDS epidemic appears to have triggered greater Chinese engagement with the WHO and the process of socialization has allowed China to gain expertise in best-practice disease control.

SECURITIZATION OF INFECTIOUS DISEASE

Securitization theory can help explain the process through which the international securitization of infectious disease influenced discussion of infectious disease in Chinese policy circles, but it cannot fully explain domestic influences on this process. The Copenhagen School's securitization theory can be used to map how an issue that poses no threat to a state's security can be turned into a security concern. The securitization of an issue that poses no real threat to the security of a state is complete when the securitizing actor makes a securitizing move, usually a speech act, to convince an audience of the issue's credibility as a security threat.^{8,40} The securitization of a threat must be accepted by the audience to be considered successful.^{40,41} An actor may desecuritize a threat by moderating its language and characterizing it as a nonsecurity issue.⁸ Copenhagen School theorists often emphasize the use of language in the securitization process, although other actions are not specifically excluded.⁸ Williams⁴² argued that public actions and images can also be used as in nondemocratic states, the audience of securitization can be the elites in power rather than the public.⁴³ Securitization theory can be used to determine if and how a state or international actor has convinced its audience of the validity of a security threat, justifying an extreme response.

Using the cases of HIV/AIDS and SARS, there is significant evidence that infectious disease has been securitized at the international level. Securitization theorists, public health academics, and policymakers in international health and political communities have widely accepted that the securitization of infectious disease has occurred,^{44–46} labeling communicable disease a nontraditional security threat.¹ HIV securitization was initiated by Richard Holbrooke, the US ambassador to the UN, in December 1999, but the widely accepted date for the international securitization of HIV was July 2000 when the UN Security Council adopted Resolution 1308.^{41,47} In the case of SARS, a concrete securitizing move was made on May 28, 2003 when the WHA announced that SARS presented “a serious threat to global health security, the livelihood of populations, the functioning of health systems, and the stability and growth of economies.”⁴⁸ Various strains of influenza, including H1N1 and H7N9, have been labelled security threats.⁴⁴ Although it has been debated whether successful securitization has occurred and been sustained for particular epidemic diseases,⁴¹ the international community has embraced the general concept of health as a security issue.

Infectious disease was first securitized in China during the HIV/AIDS and SARS epidemics, and the securitization discourse has continued to inform Chinese health policy. Chan⁹ posited the Chinese government’s conception of disease as a security threat changed through interaction with the WHO during the HIV/AIDS crisis. Yet when SARS emerged, the first response of the Chinese government was to desecuritize SARS and minimize the perceived threat of an epidemic.⁸ The first securitizing steps were taken by the Chinese military doctor Jiang Yanyong who covertly distributed information about the government cover up and true scale of the pandemic, and then by the WHO, on March 12, 2003.¹⁶ Soon after, the Chinese government began to publicly respond to the crisis, making securitization moves with official and semiofficial speech acts.⁸ Beijing then used the Chinese media to gain public support for the SARS response, including posters and publications with the slogans “Declare War on SARS” and “Activate the whole Party, mobilize the entire populace, win the war of annihilation against SARS.”⁸ As suggested previously, the version of securitization theory described by Buzan, Wæver, and de Wilde, does not focus enough on methods of non-verbal and nonlinguistic communication with the

audience.¹ Because of the political system in China, the CCP’s control over the media and policies deterring criticism of the government, the people were primed to accept the government’s verbal and nonverbal securitizing moves. Despite some protests, the majority of the Chinese population supported the government efforts and rhetoric.⁸ Despite this, it has been argued that there was a move toward desecuritization after the pandemic with the arrest of Jiang Yanyong and a greater focus on preventative risk management.⁸ There has been an exponential increase in the use of the term *nontraditional security threat* by Chinese academics since the SARS crisis, mainly focused on health and infectious disease,⁶ indicating that Chinese conceptions of security have broadened. Since the SARS epidemic, the Chinese government has acknowledged the effects of infectious disease on security; every Chinese White Paper on National Defence has included the control of infectious disease since 2004.⁸ Some infectious diseases have been successfully securitized in China, partially as a result of exposure to the international securitization of disease.

Exposure to the international securitization of disease during and after the SARS crisis may have informed changes in China’s approach to the relationship between public health and security but it was not the primary influence. Two studies argued that international pressure and engagement with the UN played a key role in encouraging China to securitize SARS and avian influenza.^{7,8} However, when domestic interests are also analyzed, more authoritative explanations can be developed on the motivating factors behind China’s partial securitization of disease. One study suggested the HIV and SARS crises expanded the roles of the WHO and non-state actors, in relation to states, in managing infectious disease.⁴⁹ The securitization of communicable disease provides an opportunity for states to exert sovereignty over health concerns,^{49,50} something particularly attractive to the CCP. Another study⁴⁷ suggested linking health with security gives a state the opportunity to gain “security bonuses” of increased economic and political support.⁴⁷ The increase in financial support, both from within the state and from international sources, can be a key benefit of securitization.⁸ Chinese academics as a whole tend to argue that domestic reputation was a larger concern for Chinese officials during the SARS response than international reputation.⁸ Although the Chinese government has strict control over the media, it has been argued that officials still

have to gain public support for action to retain legitimacy and support for specific activities.⁴³ As the domestic support for the Chinese government was severely damaged by its response during the beginning of the SARS epidemic,¹⁶ the securitization of the threat was a powerful method of re-establishing CCP legitimacy. As the leading party in a one party state, the CCP is not dependent on re-election but still requires domestic legitimacy. Both domestic and international policy issues are directly linked to CCP legitimacy and have an impact on Chinese foreign policy.⁵¹ When communist ideology was no longer enough to sustain the legitimacy of the CCP, economic growth and increasing living standards became a form of “performance-based legitimacy.”¹⁹ This performance-based legitimacy was damaged by the original response to the SARS outbreak.¹⁹ The dramatic policy shift in relation to SARS, after the March 2003 leadership transition, increased the legitimacy of the CCP and President Hu Jintao.²³ As suggested, it was also an opportunity for Hu to consolidate his own position in the CCP and change the relationship with his predecessor, Jiang Zemin.²³ Domestic legitimacy appears to be one of the most important motivating factors for Chinese securitization of SARS and avian influenza outbreaks.

Securitization of infectious disease can increase the national interest calculations of governments.⁵² This is seen by some as a negative effect of securitization, but it supports the argument that understanding the domestic interests of the party in power in non-democratic states is crucial to understanding how a government will react to health crises.

Securitization theory can be used to determine the process through which infectious disease has been securitized internationally and within China but is limited in what it can add to our understanding of the domestic policy motivations of securitization. Many motivating factors may have led the government to securitize and desecuritize infectious disease outbreaks, including domestic legitimacy,

financial incentives, and a fear of domestic instability. Although securitization theory points us toward these motivations, it cannot be used to determine their relative importance, giving it less value as a tool to improve infectious disease management.

CONCLUSION

Although international relations theory, especially theories popular in global health diplomacy literature, provide valuable insight into the role of international factors and foreign policy interests in China’s changing approach to infectious disease control, the domestic interests of the Chinese government must also be considered. Evidence suggests China has been persuaded of the value of many of the rules and norms of the WHO but prefers to act through health organizations that support its state-centric approach to health decision-making. Engagement with the WHO has slightly altered China’s conception of sovereignty in infectious disease management but it continues to use health as a tool to achieve foreign policy goals. Analysis of the securitization of infectious disease in China and internationally explains how the government was able to effectively label HIV, SARS, and subsequent diseases as security threats, justifying large financial investment, but does not provide concrete insights into the specific domestic motivations for securitization.

China’s response to the HIV/AIDS and SARS crises were evidence of the dramatic harm states can do by resisting involvement in global health systems. The fields of international relations and public health should continue to constructively interact, providing valuable insights for both fields. In light of the danger posed by environmental exposures like infectious disease and the effects of globalization on health governance, it is important that research into the effects of international political factors on domestic health policy continue. Health decision making does not occur in a political vacuum.

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