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Unprecedented Challenges, Familiar Paradoxes: COVID-19 and Governance in a New Normal State of Risks

Abstract: This Viewpoint essay understands China’s COVID-19 responses through the lens of six paradoxes, focusing on normal and non-normal governance, competing values, expertise and politics, centralization and decentralization, public and private, and technology and institutions. Preliminary lessons are drawn regarding pandemic governance: embedding resilience into all aspects of governance; developing a public value framework for pandemic governance and improving individuals’ ethical capacity; institutionalizing policy capacity on pandemic governance and requiring expertise in relevant positions; balancing centralized coordination and decentralized responses with a stable and ready-to-work commanding center; enabling businesses and nonprofits for pandemic governance but regulating them appropriately; and enacting technologies to revolutionize pandemic governance with proper institutional safeguards.

At the beginning of May 2020, China had 84,385 COVID-19 cases and 4,643 deaths. Globally, the numbers were 3,257,996 and 233,429 respectively.1 The numbers are smaller than those of the 1918 Spanish influenza and the 1968 Hong Kong influenza, but COVID-19 is still evolving, and its shock is unprecedented in terms of its speed, scope, and intensity. What can we learn from this pandemic? It may be too early to compare countries’ strategies and performance before the pandemic halts completely, but it is never too early to learn. Reflections can be made on the policies countries have put in place and the problems they have encountered so far.

This essay adopts a paradox lens to make such a reflection, taking China as a primary example. A paradox is a “persistent contradiction between interdependent elements” (Schad et al. 2016, 6). It emphasizes the simultaneous existence of two contradictory but interrelated elements, the tension between which shapes the development of a management phenomenon (Poole and Van de Ven 1989). The contradictory elements can also be viewed as dilemmas or tough trade-offs (Bolman and Deal 2003), such as unity and diversity (Ospina and Dodge 2005), exploitation and exploration (March 1991), and planning and emergence (Mintzberg 1994). Increasingly, scholars believe they are not “either/or” choices but “both/and” configurations on a continuum (March 1991; Smith and Tracey 2016). From the viewpoint of the dialectical inquiry (Cosier 1981; Seo and Creed 2002), the solution is to create a synthesis by combining contradictions (thesis and antithesis).

Adopting a paradox lens helps place a particular country on a continuum where other countries can find their own place. A paradox, such as differentiation and integration, is a basic relationship that all organizations have to address. Focusing on the same paradox as an analytical dimension facilitates dialogue despite cultural and institutional differences among countries. After all, COVID-19 poses similar challenges to countries.2

Some caveats are in order. Given the time and space limit, I primarily use China as an example, with only occasional reference to the United States. Comprehensive describing China is beyond the scope of this essay, and attention is paid to the central government and the epidemic’s center—the city of Wuhan, Hubei Province. For the same reason, I discuss only six of many organizational paradoxes in a pandemic. This essay is not written as a research-based article, and it does not intend to explain China’s COVID-19 performance in causal language. More rigorous analysis awaits future studies.

Normal and Non-Normal

Frequently, normal and non-normal states of affairs are considered sequential: a normal stage followed by a non-normal one (e.g., pandemic) and then a normal one again. Alternatively, we should consider them a continuum, as accidents are “normal” (Perrow 1999). Their relationship is similar to that of “present” and “future”: they are embedded in each other. Nonemergency organizations (e.g., education agencies) have a role in pandemic preparation and response, while emergency organizations (e.g.,


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the Centers for Disease Control and Prevention (CDC) have nonemergency functions; the two types of organizations should maintain a seamless working relationship. Arrangements should be in place to coordinate all organizations in situations of various levels of uncertainty and scope. Moreover, leaders should balance their normal and non-normal roles, just as they should balance exploration and exploitation (March 1991).

Since SARS in 2003, China has established an all-phase, all-hazard emergency management (EM) system. It requires all governments to have an EM plan, an emergency legislation system, an emergency institutional system, and an emergency regulatory system. The EM system did not deliver timely and orderly responses at the beginning of this pandemic. When initial cases of SARS-like pneumonia surfaced, some hospitals activated EM plans and took preventative measures such as ordering and stocking medical devices, but others did not. After Wuhan was locked down, disarray and chaos ensued—medical beds, transportation, food, and even basic supplies for frontline health workers all became problems. The necessary capacity in a pandemic comes not only from EM organizations but also from non-EM organizations (e.g., transportation). Neither responded well. That EM plans did not work as expected is not surprising. The EM plans in many Chinese cities focused on emergency response upon an event, rather than preparedness and recovery. EM exercises were lacking, too.

The leaders of Hubei and Wuhan were unprepared and slow to act. The governor of Hebei did not know the production capacity of medical masks during a press conference. The Wuhan CDC was informed of the virus at the end of December 2019, but the city lockdown did not come until a month later. Despite the imminent risk, leaders greenlighted congress meetings of the local Chinese Communist Party (CCP) and community gatherings such as “hundred-family banquets.”

The virus was too new, and the local leaders were capable cadres otherwise—the province and the city (60 million and 10 million permanent residents, respectively) seemed well managed. Wuhan’s gross domestic product rank in the top 10 among Chinese cities. It was selected in 2019 as an exemplar for community governance by the CCP’s Central Political and Legal Affairs Commission.

The root problem seems to be institutional. Since 2013, President Xi Jinping has emphasized “bottom-line thinking” for government leaders, highlighting the importance of risk awareness and risk governance. Why was Hubei leaders’ bottom-line thinking not triggered? In the current CCP cadre evaluation system, performance ratings depend largely on economic and social indicators in normal situations. Protecting people’s health and safety in a pandemic is a basic government function—arguably more essential for government legitimacy than economic development, but institutionalizing it in the daily operations of governance is a challenge for all countries. Wuhan’s award-winning community governance was paralyzed in the initial stages of the pandemic, but that does not mean the award was wrong. Rather, it suggests that community governance must be reexamined and redesigned from the perspective of resilience and pandemic preparedness.

Wuhan is not alone. U.S. intelligence officials warned of the virus several months before a “national emergency” was declared.³ According to a New York Times report,⁴ throughout January 2020, many people inside the Donald Trump administration identified the COVID-19 threat, sounded alarms, and urged aggressive action, which did not happen until weeks later. If the time gap between “normal” and “non-normal” had been smaller, more lives could have been saved.

Maybe underestimating the COVID-19 threat is a high chance event. Human brains are prone to the optimism bias: overestimating the probability of positive future events and underestimating the probability of negative ones (Kahneman 2013; Sharot 2011). The remedy lies not at the individual level but at the organizational level: institutional and organizational arrangements should be designed to reduce the effects of the bias (Kahneman 2013). This requires embedding resilience in governance—including all governance aspects such as functions, processes, techniques, leadership, expertise, and resources. More often than not, normal and non-normal governance are separated by bureaucratic silos in governance planning. Risk governance is often treated as an add-on to a governing system. In the EM literature, Model R (Routine) and Model C (Crisis) are often treated as mutually exclusive (Leonard and Howitt 2008). Instead, they should be viewed as interwoven.

This is particularly relevant for pandemic governance. In the past 30 years, the occurrence of pandemics has become more frequent, leading people such as Bill Gates to forewarn of the inevitability of a massive pandemic.⁵ We may be entering a new historical stage when humans live with vital and highly contagious viruses. We live with normal accidents (Perrow 1999).

**Competing Values**

Policy makers must make trade-offs among competing values in a pandemic. For example, they need to balance health and safety and economic development, individual freedom and collective interest (e.g., forced quarantine decisions), transparency and privacy, rights and obligations, efficiency and equity, and free expression and preventing rumors and panic. Value trade-offs are present in almost any decision, but they are intensified during a pandemic because of uncertainty, high potential loss, and anxiety. The public value literature (Bryson, Crosby, and Bloomberg 2014; Yang 2016) and the administrative ethics literature (Cooper 2012) have offered recommendations on how to strike a balance.

COVID-19 manifested the pivotal role of public value governance. Balancing human life and economy is an example. In the early stages of the outbreak, concerns with costs, instability, panic, economy, and image were strong. This changed when President Xi mandated the prioritization of people’s lives. Under this mandate, forced and self-quarantines were enforced quickly and swiftly, effectively curbing the virus. Despite the mounting economic pressure, China decided to resume work and production in a slow and deliberate manner. This does not mean there were no dissenting voices regarding this in China. There were people who expressed doubts about social distancing and people who argued for reopening the economy sooner. China’s authoritarian nature made the value balancing seem easier, but the trade-off was inherent and present. In comparison, this trade-off has been a hot political issue in the United States. President Trump delayed shutting down the economy but hastily pushed for reopening, while there were warnings and
protests from disease control experts, Democrats, and even officials in his own administration.

Another tension occurred around equity issues such as resource allocation between COVID-19 patients and other patients, especially elderly people with severe or chronic diseases, as well as migrants living in “urban villages” (usually in city outskirts). In Wuhan and Hubei, the surge capacity of hospitals was soon overwhelmed, and many secondary and tertiary damages were reported. As drugstores were closed and hospitals became overcrowded and concentrated on COVID-19, many patients with chronic diseases could not get treatment. The equity issue manifested differently in the United States. For example, according to an analysis conducted in mid-April, African Americans account for 14.2 percent of the population covered by the analysis but 30 percent of the COVID-19 patients.8

After the quarantine mandate in China, reports surfaced in which local officials took “hardcore measures” to quarantine households that were suspected of infection or that had returned from Hubei. This tactic could be as extreme as installing a steel bar to block the door. In some local areas, roadblocks proliferated to protect local community, making it hard for ambulances and the critically ill to pass through. This occurred despite the central government having long explicitly prohibited it. The unclear boundary of state power in relation to individual liberty can also be seen in a notorious case regarding Li Wenliang, a Wuhan doctor who was summoned and admonished by local police for spreading rumors—sharing COVID-19 information in a WeChat group consisting of his medical school classmates before the government formally acknowledged the virus.7

The value conflicts were deeply rooted in society and among citizens. Hubei residents and automobile plates were discriminated against in some areas, prohibited from entering, passing, or checking into a hotel. A salient case involved Fang Fang, a famous writer living in Wuhan, who posted an online diary recording her thoughts and feelings during the lockdown. Some of the contents were about fears, horrors, angers, and disappointments, leading some people to criticize her for “looking only at the dark.” When the English version, “Wuhan Diary: Dispatches from a Quarantined City,” became available for presale on Amazon, intense debates erupted on social media. While some liberal intellectuals publicly supported Fang Fang, many people harshly blamed her for a lack of patriotism and selling materials that might be used by foreign enemies. In a similar way, xenophobia and anti-Asian racism was fueled by COVID-19 in the United States and worldwide.9

These events suggest a need for stronger ethical competency. For officials enforcing orders in a pandemic, having a heightened sense of moral agency and avoiding administrative evil seems important (see Adams and Balfour 1998). There should be an institutional framework to address value conflicts and enable different voices to be heard. Intensified value conflicts and ideological polarization are the reasons why public value governance emerged as a new research paradigm (Bryson, Crosby, and Bloomberg 2014). Governments also have a responsibility to strengthen citizenship,enculturating reasoned deliberation among citizens. In the Fang Fang case, many online comments were simply venting feelings and emotions or expressing moral rules such as narrow patriotism and “don’t air dirty linen outside the organization.” That is, many people’s ethical reflection is at the expressive level or the moral rules level, not the ethical analysis level or the postethical level (see Cooper 2012).

Expertise and Politics
This paradox relates to the “dichotomy” of politics and administration, or facts and values. Democratic governance requires both expertise and politics—even more so during a pandemic. Expertise is critical to understanding the virus, identifying effective interventions, finding a cure, and making reasoned, intuitive decisions when information is incomplete and risk is high; politics is essential for allocating resources and responding to competing demands and values. Expertise should be guided by democratic responsibility, while politics should be informed by scientific evidence.

Lack of expertise has been linked to some missteps in this pandemic. The early faults in Wuhan and Hubei demonstrated a competence problem. The Hubei health commissioner had no health-related background; the Commission’s CCP secretary had experience in administration work in universities and the Youth League. In Huanggang, a hard-hit city not far from Wuhan, the health commissioner was caught on camera completely ignorant of the city’s status in front of a central government team. This commissioner had no health-related background either. This problem is illustrated by a comparison of two hospitals in Wuhan.9 Wuhan Central Hospital had 299 staff infections and 5 died, while Central South Hospital had 88 staff infections and 0 died. Both the president and the CCP chairwoman of the former were political cadres, while both leaders of the latter were top-notch medical doctors. As the literature shows, professional accountability should be weighted more than political and hierarchical accountabilities in expertise-intensive agencies; otherwise, crises are inevitable—the Challenger tragedy is one example (Romzek and Dubnick 1987). In recent years, China has tried to increase political control of such organizations, but COVID-19 warns that a delicate balance must be made between political responsiveness and professional autonomy.

The lack of disease prevention and control expertise is a chronic problem in China. China has only 1.35 disease prevention and control workers per 10,000 population, lower than what is mandated by the State Commission Office for Public Sector Reform and lower than the United States (9.3) and Russia (13.8). Since SARS, the number of such workers has been reduced 10 percent.10 The lead scientist of the Chinese national CDC indicated in June 2019 that the agency had lost more than 100 young employees in the past three years.11 On average, disease prevention and control workers receive the lowest pay among all health workers in China. During the 2018–19 government reorganization, many local CDCs were downgraded or absorbed by other institutions.

The U.S. response has also seen tension between expertise and politics. Sometimes the president did not seem to make evidence-based decisions. Sometimes infectious disease experts were pushed out or silenced. In 2018, the administration abolished the Directorate for Global Health Security and Biothreats, a White House unit of the National Security Council created by the Barack Obama administration to fight Ebola. Timothy Ziemer, the director of the unit, was pushed out and the global health security team he
led was disbanded. In addition, President Trump has consistently pushed for budget cuts to agencies that battle infectious diseases such as the CDC and the National Institutes of Health. When asked about the cuts, the president’s response clearly illustrates a lack of appreciation for institutionalized expertise:

We can get money, we can increase staff—we know all the people. This is a question I asked the doctors before. Some of the people we cut, they haven’t used for many, many years, and if we have ever need them we can get them very, very quickly. And rather than spending the money—I’m a business person. I don’t like having thousands of people around when you don’t need them. When we need them, we can get them back very quickly. (Friedersdorf 2020)

Admittedly, the Chinese CDC does not have governmental authority, but scientists, regardless of where they work, have democratic responsibilities. Luckily, both China and the United States have benefited from professional experts who have great political acuteness. Dr. Zhong Nanshan, a fellow of China’s Academy of Engineering and director of the National Clinical Research Center for Respiratory Disease, was the first person to formally warn the country that the virus can spread between people. Dr. Anthony Fauci, director of the U.S. National Institute of Allergy and Infectious Diseases, offered candid professional judgments even when they were in disagreement with those of the president.

Centralization and Decentralization

Centralization and decentralization capture the division of decision authority—vertically between the central and local, and horizontally between the center and peripheral (Pollitt 2005). Both centralization and decentralization have pros and cons. Policy makers have to make a trade-off based on an organization’s environment, strategy, and technology. Kaufman (1969) sees a pendulum swinging back and forth between centralization and decentralization. Mintzberg (1979) sees a continuum of decision processes along which some steps are centralized and others are decentralized. In the New Public Management doctrine, targets are centralized and implementation is decentralized (Pollitt 2005). In a crisis, a pervasive notion is that decision-making should be centralized to ensure timely and coordinated responses (’t Hart, Rosenthal, and Kouzmin 1993). But structural contingency theory suggests that decentralization is preferable for a large organization facing an uncertain and tumultuous environment to ensure fast information gathering and agile local responsiveness (Donaldson 2001).

Vertically, the slow initial response in Hubei revealed a problem: pandemic-related authority is not clearly delineated between central and local governments. Confusion existed as whether Hubei or Wuhan had the authority to issue public warnings. In the Law on the Prevention and Treatment of Infectious Diseases (2004), only the health administration under the State Council or the provincial-level government it authorizes can issue epidemic warnings; in the Emergency Response Law (2007), counties or higher-level governments can issue public warnings when an epidemic is imminent or increasingly possible; in the State Council’s Regulations on Preparedness for and Response to Emergent Public Health Hazards (2011), all governments should proactively make available EM plans for public health hazards, surveillance information, and response status. The laws and regulations are not aligned, and no operational guideline was in place to help local governments decide.

In most EM areas, China has adopted the principle of “territorial management,” giving local governments the primary responsibility. However, responding to a pandemic is beyond the capability of any local jurisdiction and requires national intervention. After the central government stepped in to help Hubei, a centralized effort effectively restored order, confidence, and treatment in the epidemic center. About 346 medical teams of more than 42,600 doctors and nurses were assembled quickly nationwide and dispatched to Hubei.

The vertical problem arose in the United States, too. President Trump clashed with many state governors over issues such as when social distancing should be implemented, whether the federal government should coordinate the states’ purchasing of medical devices from abroad, and who has the authority to reopen the economy. Kettl (2020) has observed that “the federalism divide is shading government’s response to COVID-19.” While the United States has pandemic influenza plans outlining federal versus local responsibilities (e.g., DHHS 2017), COVID-19 suggests that adjustments and adaption are necessary in the event of an unprecedented shock.

Horizontally, the pandemic response power can be centralized in one agency or scattered across many, creating coordination problems. According to China’s 2018 reorganization, the Health Commission manages and coordinates health emergencies, the EM Ministry handles work safety and natural disasters, and the Ministry of Public Security addresses social incidents. The EM Ministry was responsible for directing other ministries and local governments to establish EM systems, develop EM plans, and conduct exercises. While the United States has rules regarding when the emergency response authority should be transferred from the Department of Health and Human Services (DHHS) to the Department of Homeland Security (DHS), where the Federal Emergency Management Agency is housed, China had not yet completed this mechanism design. Thus, the Chinese EM Ministry did not play a central role in this pandemic. To facilitate coordination, the Joint Prevention and Control Mechanism of the State Council led by the Health Commission was created on January 21, 2020. Four days later, the Central Leading Group on COVID-19 Response, chaired by Premier Keqiang Li, was established under the Politburo. The two arrangements have proven effective, but both are only
Lateral coordination in the United States suffered from a lack of stability and clarity at the center. As the DHS took over from the DHHS, the role of the DHHS became opaque—partly because of its failure to develop a reliable coronavirus test on time. The White House seemed to have three centers of authority: the president, the taskforce led by Vice President Mike Pence, and the group led by the president’s son-in-law, Jared Kushner. If we view federal actors involved in coronavirus response as part of a large and complex network, then a strong and stable center node is critical for the network performance (Milward and Provan 2003).

Public and Private

This paradox refers to the relationship between governmental and nongovernmental entities. It can be separated into two relationships: state-market and state-society. For our purposes and given the space limitations, this essay uses one concept instead and focuses on public-private partnerships (PPPs), which are essential for pandemic prevention and response (Abou-bakr 2013). “Private” does not mean the private or business sector but private agents as opposed to the government. PPPs “combine the resources of government with those of private agents (businesses or not-for-profit bodies) in order to deliver societal goals” (Skelcher 2005, 347). Any collaboration process should balance the autonomy and mutuality of the partners (Thomson and Perry 2006).

While China’s new governance philosophy emphasizes the market as the deciding factor in resource allocation, many people believe that government should control resource allocation during the pandemic. The government first mobilized nongovernmental organizations in the public sector to help. Many state-owned enterprises (SOEs) participated by donating money, making additional shifts to increase production, converting production lines to make emergency materials, and serving people in crisis. Two well-known projects in Wuhan, the construction of the new 1,000-bed Huoshenshan Hospital within 10 days and the new 1,600-bed Leishenshan Hospital within 14 days, were conducted by SOEs. Similarly, public hospitals played the major role in treating coronavirus patients and sending volunteer health workers to Hubei. 14

In contrast, the contribution of private businesses varied. In some areas, such as Hongzhou and Shenzhen, where the market economy is more advanced, companies such as Alibaba helped in many ways. However, in some places, there was illegal market behavior, such as price gouging and counterfeit products. The State Administration for Market Regulation had to issue a new guiding opinion on investigating and publishing such behaviors during the outbreak.

In the health care industry, although many large private hospitals were active in coronavirus response, the public seemed unaware. People expressed anger at the seeming indifference of the Putian System, a loosely affiliated network of private hospitals whose investors were mainly people from the City of Putian, Fujian Province. The Putian System developed a bad reputation in 2015 when a 22-year-old university student, Jiaxi Wei, died of mistreatment by an affiliated hospital. The real issue is not whether private hospitals participated in the pandemic response—many did; instead, it is the lack of regulatory framework to govern the inclusion and monitoring of private hospitals in pandemic prevention and response. It is not clear what power government has to force or empower private businesses to help, what mechanisms can be used, and under what circumstances.

Similarly, nonprofits played a significant role in China’s COVID-19 response, but regulatory and capacity problems came to the fore. For example, the way donations were initially handled in Wuhan ignited a nationwide outrage. The Hubei government initially mandated that all donations go through the local Red Cross. The provincial Red Cross had only about 20 staff and the city Red Cross had about 10 staff, supplemented by 30 or also Bureau of Statistics staff. These employees worked day and night, but they had no professional expertise in allocation and distribution, nor did they have a logistics network to work with. Thus, millions in donated funds went unused, and piles of donated materials sat in the warehouse while desperate health workers were waiting. 15

The Red Cross, one of China’s five state-run charities, has suffered from a series of scandals and reputation loss over the last decade. The lack of a network of nonprofits with trained volunteers ready for a pandemic was obvious in Hubei. The CCP’s 19th Congress plenary vowed to build a new model of community governance based on public consultation, broad participation, and the rule of law. But a well-functioning nonprofit sector seemed missing. As the Red Cross’s capacity and management woes backfired and led to criticisms of the government, people have called for re-regulating the sector to enhance its transparency, openness, and trustworthiness. In the meantime, the nonprofit sector should be deregulated so that nonprofits are in a better position to improve capacities. State-run charities should be de-bureaucratized to improve their professionalism.

Weaving market mechanisms and societal organizations into pandemic governance brings challenges. Even in the United States, where the private and nonprofit sectors are strong and active in coronavirus response (e.g., Google, Amazon, and the Gates Foundation), there were concerns. For example, in late February, the Trump administration requested $2.5 billion from the Congress, some of which would go to industries developing vaccines. In a congressional budget hearing, DHHS secretary Alex Azar said, “We would want to ensure that we work to make it affordable, but we can’t control that price, because we need the private sector to invest.” 16 This angered Democrats and the public. For another example, Jared Kushner led a team of government allies and private industry representatives working alongside the official coronavirus task force, which created confusion and led to criticisms. 17

Technology and Institutions

Technology shapes, and is shaped by, institutions. On one side, technology alone does not guarantee benefits; it is always enacted by institutions and actors (Fountain 2001; Yang 2003). Alice Stewart discovered in 1956 that fetal X-rays double a child’s risk of developing cancer, only to find the medical practice would not end until more than 20 years later (Greene 2001). Edward Jenner invented a smallpox vaccination...
China’s coronavirus response shows the impasse of technology determinism given the role of institutions and leadership. After SARS, the Chinese CDC developed an online infectious disease reporting system, which began to operate in 2004. It puts 39 legally defined infectious diseases and public health emergencies under real-time surveillance. The direct reporting system has been expanded to all disease prevention and control institutes, all medical institutions at and above the county level, and nearly all township clinics. However, the reporting system did not work at the beginning of this pandemic. After doctors in Wuhan began observing a mysterious pneumonia in December, local health officials asked hospitals to withhold information. The National Health Commission first learned of the outbreak not from the reporting system but after unknown whistle-blowers leaked two documents online. Even after the National Health Commission got involved, local officials still set narrow criteria for confirming cases and ordered hospitals to count only patients with a known connection to the alleged source of the outbreak, a seafood market.18

On the other hand, technology has played a significant role in China’s COVID-19 response. In Hangzhou, where Alibaba is located, a mobile system called Health Code was deployed on February 11, 2020, to track in real time every individual’s COVID-19 related status. The QR code can be accessed from Alipay (a third-party mobile and online payment platform that is widely used in China), popular social media apps such as WeChat and DingTalk, or the Hangzhou Resident app. People with a green code can travel in and out the city after showing the code to “gatekeepers”; people with a yellow code must quarantine (in a central place or at home) for seven days; and people with a red code must quarantine for 14 days before the code will turn green.

This essay has argued that what happened in Hubei and China reflects similar problems faced by all governments and familiar paradoxes that public administrationists have long been trying to resolve. Adopting a paradox lens, I discussed China’s coronavirus response across six dimensions.20 I intentionally use phrases such as “normal and non-normal” instead of “normal versus non-normal,” as I want to emphasize that these are not “either/or” choices (March 1991; Smith and Tracey 2016).

Some preliminary lessons can be drawn. First, we should avoid thinking that pandemic governance is a separate part of public governance. Recognizing that we are entering a new historical stage of risk, an era with a lasting threat of pandemic, we need to embed resilience in all aspects of governance. EM planning must be exercised and public leaders must be on permanent alert. Second, international and domestic efforts should be made to develop actionable guidelines to address the competing values in a pandemic. The guidelines should be based on a sound public value framework. Efforts should also be made to improve the ethical capacity of both public officials and citizens. Third, we should strengthen institutionalized policy capacity inside and outside government for pandemic responses. Relevant expertise should be required for positions responsible for infectious disease control. Experts should develop skills working with politicians and politics. Fourth, when a pandemic hits, there should be a balance between centralized coordination and decentralized responses, facilitated by new information technologies. A stable, clear, and ready-to-work command center is important and should be institutionalized. Fifth, businesses and nonprofits should be enabled to help with pandemic responses, but an appropriate regulatory framework must be established to ensure the boundaries and autonomy of the partners.

Public administration educators can play a major role in the pursuit of good governance in a new normal state of risks. In April,
the Chinese Ministry of Education selected 20 comprehensive universities to offer EM master’s and doctoral degrees under the discipline of public administration. Before this, the EM Ministry already supported 17 colleges, but they focus more on training frontline EM workers for technological expertise. The 20 new programs are expected to integrate governance, management, and technology, and a national “guideline” on program design and curriculum development has been suggested by the Education Ministry. The guideline emphasizes the purpose of the degrees is to improve students’ problem-solving capabilities. Dialogue and collaboration between those programs and similar NASPAA programs would be beneficial.

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Notes
1. These figures are from “Tracking Coronavirus’ Global Spread,” CNN, https://edition.cnn.com/interactive/2020/health/coronavirus-maps-and-cases/ (accessed May 1, 2020).
2. In addition to similarities among countries, the phrase “familiar paradoxes” in the title of this essay has another meaning, COVID-19 is unprecedented, and the problems it has brought differ from those of past pandemics, but the paradoxes are arguably similar.
3. Josh Margolin and James Meek, “Intelligence Report Warned of Coronavirus Crisis as Early as November,” ABC News, April 9, 2020, https://abcnews.go.com/Politics/intelligence-report-warned-coronavirus-crisis-early-november-sources/story?id=70031273 (accessed June 4, 2020).
4. Eric Lipton, David E. Sanger, Maggie Haberman, Michael D. Shear, Mark Mazzetti, and Julian E. Barnes, “He Could Have Seen What Was Coming: Inside Trump’s Failure on the Virus,” New York Times, April 11, 2020, https://www.nytimes.com/2020/04/11/us/politics/coronavirus-trump-response.html (accessed April 30, 2020).
5. See Bill Gates, “The Next Outbreak? We’re Not Ready,” March 2015, https://www.ted.com/talks/bill_gates_the_next_outbreak_we_re_not_ready/language=en (accessed April 20, 2020).
6. See Kat Stafford, Meghan Hoyer, and Aaron Morrison, “Racial Toll of Virus Grows Even Starker as More Data Emerges,” Associated Press, April 18, 2020, https://apnews.com/8a3430dd37c7c44290c76215fa96d6b (accessed April 30, 2020).
7. This is reminiscent of the firing of Captain Brett Crozier in response to his emails to U.S. Navy leaders detailing the COVID-19 outbreak on the Theodore Roosevelt submarine. See John Ismay, “Navy Captain Removed from Carrier Tests Positive for Covid-19,” New York Times, April 5, 2020, https://www.nytimes.com/2020/04/05/mazine/navy-captain-crozier-positive-coronavirus.html (accessed June 5, 2020).
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9. The comparison of the two hospitals appeared in a popular social media post, https://mp.weixin.qq.com/s/NQANnWRSCCLogMIH_ITtgg (accessed April 30, 2020).
10. The numbers are from the National Health Commission of China.
11. According to Dr. Guang Zeng’s speech at the Seminar on Ten-Year Health Care Reform in China, China Development Research Center, June 15, 2019, Beijing.
12. Lena Sun, “Top White House Official in Charge of Pandemic Response Exits Abruptly,” Washington Post, May 11, 2018, https://www.washingtonpost.com/news/to-your-health/wp/2018/05/10/top-white-house-official-in-charge-of-pandemic-response-exits-abruptly/ (accessed June 5, 2020).
13. Data are from the National Health Commission of China.
14. There are cultural differences here. Chinese SOEs participate in market competition and are subject to market mechanisms. Thus, China’s PPPs framework includes SOEs. Also, according to data from the National Health Commission of China, China had about 11,900 public hospitals and 23,200 private hospitals by the end of 2019, but public hospitals are dominant, as they treat about 85 percent percent of the patients. Public sector organizations in China can be more easily mobilized and monitored.
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20. There are many other relevant paradoxes, such as localism and globalization, modernism and postmodernism, and deliberate and emergent strategies. For example, China’s coronavirus response reflected both the deliberate strategy as developed in the EM plans and the emergent strategy from acting on suggestions from frontline workers and professional experts. In the pandemic, thousands of recommendations were made through official channels to the central government by researchers from universities and think tanks around the country. Many of them were adopted.
21. In 2011, China listed safety science and engineering as a first-tier discipline, which includes safety and emergency management. By now, 30 universities are authorized to offer doctoral degrees in safety science and engineering, and more than 40 universities offer master’s degrees. More than 170 universities and colleges offer undergraduate degrees in safety engineering.

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