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Why America's Response to the Covid-19 Pandemic Failed: Lessons From New Zealand's Success

Richard Parker

University of Connecticut School of Law

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WHY AMERICA’S RESPONSE TO THE COVID-19 PANDEMIC FAILED: LESSONS FROM NEW ZEALAND’S SUCCESS

RICHARD W. PARKER*

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ABSTRACT

Polls show that 48 percent of Americans think the United States has fared no worse in dealing with COVID-19 than most other countries and that COVID-19 posed an essentially impossible test. This article refutes that remarkable misperception. It shows that the U.S. COVID-19 mortality rate for 2020, adjusted for population, was more than twice as high as Canada’s and Germany’s; ten times higher than India’s; 29 times higher than Australia’s; 40 times higher than Japan’s; 59 times higher than South Korea’s, and 207 times higher than New Zealand’s mortality rate. In fact, U.S. performance at the level of South Korea, Australia, New Zealand, or Japan in containing the pandemic would have saved over 300,000 American lives in 2020 alone.

This Essay then offers a detailed comparison of the COVID-19 response of the Trump Administration to that of New Zealand, one of the few countries to succeed in virtually eliminating the virus within its borders. While some observers have dismissed New Zealand’s success as an artifact of good luck -- or of its geographic situation as a small,
rural, island state—this Essay offers evidence to suggest that these distinctions are of marginal importance compared to a more crucial distinction: New Zealand’s response followed the now-familiar pandemic containment “playbook” to the letter while the Trump Administration departed from that playbook at every turn. The weight of the evidence thus strongly suggests that the tragic disparity between America’s COVID-19 performance and New Zealand’s is primarily due—not to geography or happenstance—but to a stark contrast of messaging, policy and implementation in the pandemic response strategy adopted by New Zealand’s Prime Minister Jacinda Ardern compared to that of President Trump. Leadership matters.

**INTRODUCTION**

COVID-19 is the ultimate test of administrative law and governance. Faced with a global pandemic threat, every government on the planet faces essentially the same public health challenge: to protect its people from a deadly, contagious disease by regulating private and public conduct to minimize disease transmission—at a manageable cost to the economy. While government performance can be hard to measure in normal circumstances, performance in meeting the COVID-19 challenge is easily measured in brutally objective terms: cases of disease and death, lost jobs, lost income, and increased government borrowing and spending.

By virtually any measure, New Zealand’s government has passed its COVID-19 test with high honors, while the United States has failed by comparison. New Zealand, with a population of 5.1 million, experienced only about 2,000 cases with twenty-five total deaths from the onset of the crisis through December 31, 2020 (the equivalent in population percentage terms to roughly 127,000 American cases and 1,625 American deaths), with only three deaths from COVID-19 in New Zealand since June 2020.¹

¹ Professor of Law, University of Connecticut School of Law. Many thanks to Timothy Jablonsky, Libby Reinish, Demery Ormrod, Lauren Moscato, Matthew Hall, and the reference librarians of UCONN School of Law for valuable research assistance.

Economically, New Zealand has been hit hard by the loss of tourist revenues from pandemic-stricken countries around the world. Nonetheless, economic activity overall rebounded more quickly than expected after June 2020, with budget deficits lower than forecast, yielding a national debt equal to 30.5% of Gross Domestic Product (GDP) (compared to the 98.2% debt-GDP ratio forecast by the Congressional Budget Office for the United States by year-end 2020). Despite a minor outbreak in August of roughly a hundred cases in Auckland, New Zealand, life had returned to near-normal across most of New Zealand by July 2020, and it has done so safely with no additional loss of life from COVID-19.

The situation in the United States has been far different. By December 31, 2020, over 340,000 Americans had died from COVID-19. Over 20 million Americans had tested positive for the disease with over a quarter of the United States population.

Sept. 23, 2020. A straightforward method for crafting an apples-to-apples comparison of New Zealand and United States case/death counts, and the method employed in this essay, is simply to multiply New Zealand’s case/death count by a factor of 65. This is mathematically equivalent to calculating case and death counts on a “per 100,000 of population” or “per million of population” basis, the metrics commonly employed in news media accounts.


million new cases per day. Epidemiologists were forecasting a cumulative death toll from the disease of up to 500,000 by March 1, 2021, as the pandemic has spiraled out of control.

Figure 1 captures the bottom line through 2020. That contrast will only grow starker as COVID-19 deaths continue to pile up in the United States:

6. Id.

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**FIGURE 1**
Cumulative Deaths per 100,000 in the United States and New Zealand

Nor has the enormous U.S. death toll purchased economic relief. Over 67 million Americans filed for unemployment benefits between mid-March and December 2020. Overall, the U.S. GDP shrank by over $500 billion

8. COVID-19 Data Repository by the Center for Systems Science and Engineering (CSSE) at Johns Hopkins University, https://github.com/CSSEGISandData/COVID-19 [last visited January 2, 2021] [hereinafter CSSE]. Cumulative death totals were extracted from the JHU GitHub repository (https://raw.githubusercontent.com/CSSEGISandData/COVID-19/master/csse_covid_19_data/csse_covid_19_time_series/time_series_covid19_deaths_global.csv) for 12/31/2020 along with their total population in 2019 (the latest data available) from the World Bank (http://api.worldbank.org/v2/en/indicator/SP.POP.TOTL?downloadformat=csv). The total deaths per hundred thousand population was calculated by dividing the total population by 100,000, and then dividing the total deaths by the result.

(3.5%) in 2020 despite a stimulus bill that added over $2 trillion to the national debt by the end of September, with a massive new round of deficit spending (estimated at another $2 trillion) needed to avoid an economic precipice in the winter 2020-2021. It appears that the U.S. response managed to capture the worst of both worlds: an economic meltdown and a public health calamity.

Polls show that 48 percent of Americans think the United States is doing no worse in dealing with COVID-19 than most other countries and that COVID-19 posed an essentially impossible test. The response of President Trump and his political base is aptly summarized by Senator Ron Johnson (R-Wis.), who himself tested positive in early October, 2020: “Why do we think we actually can stop the progression of a contagious disease?”

This article refutes that remarkable misperception. Part I examines the relevance of New Zealand’s strategy to the U.S. experience, and argues that those who dismiss New Zealand’s experience as irrelevant to the United States were wrong.


States are indulging a politically convenient alibi at the expense of both theory and the weight of the evidence. Part II offers a detailed comparison of New Zealand’s pandemic response to that of the United States. It will be seen that New Zealand’s battle to contain the virus followed the classic pattern ordained by the science of virus transmission – the pandemic “playbook” if you will – while the United States deviated from that playbook or botched its implementation at every turn. The weight of the evidence thus suggests that COVID-19 posed a tough but not impossible challenge, and that the disparity between America’s COVID-19 performance and New Zealand’s is primarily due -- not to geography or happenstance – but to a stark contrast of policy and implementation.

I. THE RELEVANCE OF NEW ZEALAND’S EXPERIENCE

While some reputable observers have dismissed New Zealand’s success as the isolated achievement of a small, rural, island nation of little relevance to the United States, the evidence suggests otherwise. In fact, COVID-19 came to New Zealand shortly before February 2020, in the middle of its summer tourism season. With Chinese tourists traditionally accounting for a large share of New Zealand’s summer influx of visitors, COVID-19 could have spelled disaster for this island country. Once community transmission of the virus was established in New Zealand, as indeed occurred, epidemiological models suggested that an ineffective response might have produced upwards of 14,000 deaths from COVID-19 in New Zealand (equivalent as a percentage of national population to 910,000 American deaths). The actual number of deaths was twenty-five.

Was New Zealand’s response aided by its small size and island status? Only marginally. The novel coronavirus spread around the world largely by


15. Id.

air and sea travel, not land, initially, making New Zealand’s island status largely irrelevant to the comparison.\textsuperscript{17} In fact, the pandemic came to New Zealand in the peak of its summer tourist season and it established community transmission in New Zealand, as it did in the United States, before either country could seal its borders.\textsuperscript{18} While it is true that New Zealand is less densely populated than the United States, New Zealand does have large population centers, and epidemiological models forecast a death toll of over 14,000 in New Zealand from an ineffective pandemic response.\textsuperscript{19} In fact, the size and density distinctions between the two countries may cut the other way: the larger and more densely-packed population of the United States logically suggests that a strict, early, nationwide, and mandatory approach of the sort employed by New Zealand and reviewed below might have proved more critical to success in the United States than in New Zealand.

If any doubt remains about the primacy of strategy and implementation over situation and chance in explaining the disparate track records of New Zealand and the United States, that doubt should be removed by considering the fact that New Zealand is not alone in putting America’s pandemic-fighting performance to shame. As Figure 2 makes clear, U.S. covid-mortality performance through December 31, 2020 (though not the worst in the world) trailed not only New Zealand but many other countries. The U.S. COVID-19 mortality rate for 2020, adjusted for population, was more than twice as high as Canada’s and Germany’s; ten times higher than India’s; 29 times higher than Australia’s; 40 times higher than Japan’s; 59 times higher than South Korea’s, and 207 times higher than New Zealand’s mortality rate. Many of the countries that turned in much stronger pandemic responses are populous countries that would have been decimated but for an effective response. And they are not autocracies like China.

\textsuperscript{19} Baker &Wilson, supra note 16.
There is a grimmer, but equally valid, way to look at these same numbers: ask how many Americans who died from COVID-19 in 2020 would still be alive today if the Trump Administration had done as well as other countries in preventing deaths from COVID-19. The answer: If the Trump Administration had done as well as Germany or Canada, over 210,000 Americans now dead would still be alive today. Performance at the level of South Korea, Australia, New Zealand, or Japan in containing the pandemic would have saved over 300,000 American lives.\footnote{These figures are calculated by simply multiplying the benchmark-country COVID-19 death rate per hundred thousand, as listed in Figure 2, by 10 to yield a death rate per million. Then multiply that figure by the US population (measured in millions) to yield a number of lives that would have been lost had the benchmark-nation death rate been achieved in the United States. Subtracting that number from the actual US death count as if December 31, 2020 yields the number of lives that would have been saved by US achievement of the benchmark nation COVID-19 mortality rate.}

Moreover, while national situations and responses vary and a detailed

\textbf{Figure 2}

Cumulative Deaths from COVID-19 (per 100,000 of population)\textsuperscript{20}
multinational comparison of pandemic response strategies is beyond the scope of this Essay, it would appear that (with the somewhat “mysterious” exception of Japan) the most successful pandemic responders (such as Vietnam, China, New Zealand, Australia, Taiwan, Malaysia and South Korea) generally employed an aggressive, centrally-coordinated response that incorporates the now-familiar elements of the pandemic response “playbook”: travel restrictions, testing, tracing, mass deployment of personal protective equipment (PPE), and isolation and treatment of infected patients. That approach, this Essay will show, contrasts starkly with the slow, uneven, de-centralized and largely voluntary approach adopted in the United States through 2020. Again, the weight of the evidence thus strongly suggests that the principal factors explaining the differential between the mortality rate New Zealand and other countries and the U.S rate are not differences of size, geographic situation, or luck. They are differences of

II. A COMPARISON OF NEW ZEALAND AND U.S. CORONAVIRUS RESPONSES

Readers of this Essay are doubtless familiar by now with the classic playbook of pandemic response ordained by the science of virus transmission from foreign sources. While there are variations on the theme, this playbook entails prompt government action to: stop the influx of the virus from arriving travelers; procure and deploy PPE to protect essential workers; test, contact trace and isolate those who test positive; and, most of all, mobilize the public in affected regions (or nationwide if necessary) to socially distance completely enough for long enough to break the chain of virus transmission.

This Part will show that after initially failing to move quickly enough to impose travel restrictions, New Zealand’s response followed this playbook to the letter, while the U.S. response departed from it at every turn. Because the virus originated in China and spread around the world initially via air travel, our account begins with travel restrictions used to curb the initial inflow of contagion from inbound air travelers.

A. Contrasting Approaches to Travel Restrictions

On February 2, 2020, two days after the World Health Organization (WHO) declared the novel coronavirus originating in Wuhan, China a “Public Health Emergency of International Concern,” 23 New Zealand responded by banning the entry of airline passengers who had originated or traveled through China during a 14-day period prior to arrival. 24 Inbound flights were allowed to continue from everywhere else, however, allowing both New Zealand residents and travelers from other countries to enter

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provided only that they agreed to self-isolate for fourteen days.25 Not until April 9 did the New Zealand Minister of Health issue an order requiring all airline or marine passengers entering New Zealand from overseas to undergo medical testing and to quarantine in a supervised facility.26 With that step, the government effectively stopped the foreign influx of the virus into New Zealand. But by then, officials had confirmed more than 1,200 cases in New Zealand and community transmission had been established.27

The United States followed a similarly halting initial trajectory with its travel restrictions from China, but without New Zealand’s follow-through.28 On February 2, the Trump Administration banned direct flights from China, without, however, preventing entry of passengers who had been in China and traveled elsewhere first.29 The first U.S. travel restriction came after forty-five other countries had restricted travel from China.30 Moreover, unlike New Zealand, the United States has never implemented a comprehensive ban or supervised quarantine requirement on inbound travelers from overseas.31 President Trump boasted throughout the 2020 election that he saved “millions” of lives with his travel ban on China.32 The truth is that President Trump’s much-ballyhooed travel restrictions came too late – and were far too porous – to do the job.

27. Gunia, supra note 13.
30. Id.
B. Contrasting PPE Procurement policies

The second element in the pandemic playbook is ensuring that citizens have the essential protective gear needed to keep themselves and others safe, and that health care providers have the tools needed to treat infected patients safely. So, when the COVID-19 threat materialized in New Zealand, Prime Minister (PM) Jacinda Ardern promptly created a national register to identify Kiwi manufacturers that could assist in the fight against COVID-19 by manufacturing all types of PPE equipment.33 Local businesses responded by ramping up domestic production or working with affiliates in China to source large, additional purchases of masks, sterilized gowns, hand sanitizer, and face shields.34 These efforts to augment supplies succeeded in fully meeting the demand for PPE—aided by the success of New Zealand’s early intervention—that kept case counts, hospitalization rates, and associated demand for PPE relatively low.35

The Trump Administration created no comparable register to mobilize voluntary production of either PPE or COVID-19 test kits.36 It also made no effort in the early stages to procure PPE on the world market or even to preserve domestic supplies for domestic use. In fact, on February 7, 2020, Secretary Pompeo announced that the United States had donated nearly eighteen tons of medical supplies—“including masks, gowns, gauze, [and] respirators”—to China.37

President Trump also initially resisted using the considerable powers conferred on him by the Defense Production Act (DPA) to expand production of PPE and test kits—citing a preference for relying on market forces.38 But manufacturers reported a reluctance to invest in re-tooling factories to make PPE in the absence of any assurance of a market after the pandemic receded, so market forces did not yield the hoped-for surge in

35. Infra, Part 2.a (describing New Zealand’s early nationwide lockdown after first community transmission was known).
37. Id.
When President Trump finally did invoke the DPA for the first time, the order applied only to ventilators used by hospitals for patients on death’s door. In late spring 2020, the U.S. Department of Defense signed contracts for production of N95 masks, but these orders took substantial time to fill.

Meanwhile, the message from President Trump to governors was “for respirators, ventilators, all of the equipment—try getting it yourselves.” What followed was a “free-for-all” [for supplies] in which medical providers and states competed not only against each other but against the federal government, which on one occasion seized three million N95 masks ordered by the State of Massachusetts. The consequences of PPE procurement competition and chaos were felt nationwide in the form of critical shortages. The Associated Press reported that even in September 2020 there were not enough N95 masks and test kits to support health care workers, much less the millions of frontline workers in essential businesses who needed them.

**C. Contrasting Testing Performance**

Rapid testing and contact tracing are critical elements in the pandemic response playbook and speed is essential. Here, too, New Zealand’s and the United States’ governments chose starkly different approaches. New Zealand’s government quickly organized a public–private consortium to procure test kits and reagents from other suppliers in a global scramble for scarce supplies. By mid-May, New Zealand had obtained and administered more than 100,000 coronavirus tests, yielding a rate of about

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41. *Id.*

42. *Id.*

43. Mendoza, supra note 39 (“Pressure on the medical supply chain continues today, and in ‘many ways things have only gotten worse,’ the American Medical Association’s president, Dr. Susan Bailey, said in a recent statement.”)

2,200 tests per 100,000 people—a much higher testing rate than the United States achieved over the same period.\textsuperscript{15}

The United States, by contrast, decided to go it alone in procuring test kits. For a full month after the WHO declaration of an international emergency on January 30, 2020, the U.S. Food and Drug Administration (FDA) refused to authorize use of any coronavirus test kit other than the one designed by the Centers for Disease Control (CDC), which did not work.\textsuperscript{46} Not until February 29, 2020 did the FDA grant a general Emergency Use Authorization for kits developed by private labs.\textsuperscript{47} By then, the disease had been spreading unchecked in the United States for over a month and the WHO had already delivered more than a quarter million test kits to labs around the world—with no request for assistance from the United States.\textsuperscript{48} By March 18, 2020, South Korea had conducted 400 tests per hundred thousand of population, while the United States had tested only 2.6 per hundred thousand.\textsuperscript{49}

Even after the FDA logjam was broken, testing continued to be hampered by a shortage of swabs and re-agents, maldistribution of kits, and slow test result response times resulting from lab shortages.\textsuperscript{50} By year’s end testing was occurring on a massive scale in the United States—with over 1.2 million reported tests per day.\textsuperscript{51} But the adequacy of tests depends heavily on the


\textsuperscript{47} Id.

\textsuperscript{48} Id.


\textsuperscript{51} US Daily Tests, COVID TRACKING PROJECT AT THE ATLANTIC, https://covidtracking.com/data/charts/us-daily-tests (last updated Dec. 29, 2020) (providing the total number of reported COVID-19 tests in the United States, as well as a 7-day average).
background level of infection, which by then exceeded 19 million in the United States. Moreover, experts were warning that the numbers may be inflated by errors in state reporting that confuse patients tested with tests administered, and that conflate antibody tests and infection tests.

D. Contrasting Performance in Contact Tracing

Once a patient has tested positive, standard COVID-19 pandemic protocols require a concerted effort to identify and test all the persons with whom that patient has had close contact over the past fourteen days. New Zealand accomplished this rapidly and efficiently through both low-tech and high-tech methods. The primary tracing tool was the Ministry of Health’s low-tech method, whereby government officials interviewed each patient who tested positive for the virus to determine whom they had interacted with in the past fourteen days. The national government later created a COVID-19 tracing cell phone application, which individuals may download on a voluntary basis to help them retrace their steps if and when a human tracer contacts them after learning that they have the virus or may have been exposed to someone with the virus. Participation in the program was strong, with 2,139,000 registered users by early September, nearly half of New Zealand’s population.


By contrast, the United States never established a federal contact tracing system, preferring once again to leave it to the states, who were quickly overwhelmed by a lack of tools, training, tracers, resources, as well as slow test result reporting (which exponentially increased the difficulty of tracing) and the absence of any federal coordination. As Dr. Luciana Borio, a former director of medical and biodefense preparedness at the National Security Council, put it: “We need federal leadership for standards and privacy safeguards [for contract tracing], and I don’t see that happening.” The CDC issued guidelines for state contact tracing programs, and it sent about $11 billion to states and localities for expanding testing and tracing. But this appropriation yielded only about a third of the recommended number of tracers, and the Trump Administration reportedly opposed an additional $25 billion appropriation for state contact tracing in July on grounds that it was not needed. Ultimately, hopes for effective tracing were dashed by the tidal wave of cases: tracing is manageable and highly effective when case counts are low, but it becomes-logically difficult, if not impossible, on a system-wide basis when cases number in the millions.

E. Contrasting Approaches to Stopping the Spread of the Virus

While early testing and tracing are important tools in the pandemic response “playbook,” they are effective in containing the spread of disease only if they produce the isolation of the virus. This challenge of

61. Steinhauer & Goodnough, supra note 59.
62. Aschwanden, supra note 55.
63. Steinhauer & Goodnough, supra note 59.
64. Aschwanden, supra note 58.
containment, to which we now turn, is by far the most difficult element of the COVID-19 challenge, and the one that most dramatically separates New Zealand’s approach from that of the United States.

Effective containment strategy has three distinct elements: (1) effective communication to set the stage for the behavior changes that will be sought; (2) a strategy for isolating the virus to break its chain of transmission; and (3) a plan for re-opening the economy while keeping the virus isolated. The containment strategies of New Zealand and the United States offer a study in contrasts on all three fronts.

1. Contrasting Communication Strategies

The communication element is often overlooked in analyses of administrative performance, but it is a vital component of any strategy aimed at persuading a population to change its behavior rapidly and drastically in response to a pandemic threat. Social scientists have demonstrated the power of government and party leaders to influence and even change the views of their followers across a broad range of policy issues.\(^{65}\) Both Trump and Ardern are brilliant communicators, but they used their talents to convey vastly different messages about the pandemic risk and the proper response.

Ardern sounded the alarm early:

“Like the rest of the world, we are facing the potential for devastating impacts from this virus . . . We currently have 102 cases. But so did Italy once . . . The situation here is moving at pace, and so must we . . . If community transmission takes off in New Zealand the number of cases will double every five days. If that happens unchecked, our health system will be inundated, and tens of thousands of New Zealanders will die . . . .”\(^{66}\)

She then proposed a clear and unified national response in the form of a rapidly escalating series of restrictions culminating in a nationwide lockdown: “[W]e are all now preparing to go into self-isolation as a nation.”\(^{67}\) Most important, she offered both a clear sense of purpose and a short (four-week)


\(^{67}\) *Id.*
time limit to the personal sacrifices that her strategy would require:

Everything you will all give up for the next few weeks, all of the lost contact with others, all of the isolation, and difficult time entertaining children—it will literally save lives. Thousands of lives... If we after those four weeks have been successful, we will be able to ease up on restrictions. If we haven’t, we’ll find ourselves living with them for longer. That’s why sticking to the rules matters. If we don’t—if you hang out with that friend at a park or see that family member for lunch, you risk spreading COVID-19 and extending everyone’s time in Level 4 [lockdown].

Such was the compact PM Ardern offered her people: accept stringent restrictions now in exchange for (hopefully) freedom with safety in a month. It was a bold and politically risky covenant for PM Ardern to offer her nation but, as will be discussed, it worked.

President Trump chose a different rhetorical path. From March to November 2020—a period in which 9.5 million Americans contracted the virus and over 225,000 Americans died from it—President Trump issued more than two hundred tweets or other statements downplaying the severity of COVID-19, treating the risk as already under control, or denying the need for an aggressive federal government response. Moreover, Trump announced that he planned to leave states primarily responsible for deciding for themselves whether and when to announce various restrictions, and whether or when to enforce them. This policy stance profoundly affected the messaging options of governors in dealing with their state populations. It meant that no state could offer its residents a clear end date for restrictions—since success in managing the pandemic overall depended on the actions of other states whose actions could not be controlled or even foreseen. As a result, the American people, unlike their Kiwi counterparts, were asked by their respective states to accept stringent restrictions on their mobility along with enormous economic sacrifices, with no clear end date and no clear purpose. Seen from this perspective, it is perhaps less surprising that increasing numbers of Americans have rebelled against arduous restrictions with no

68. Id.
Having refused responsibility for organizing a national response, President Trump then undermined state efforts to manage the pandemic themselves by frequently sharing his view that a rapid re-opening of the economy is at least as important as responding to the COVID-19 crisis; and by consistently framing mandatory social distancing measures as alternatives to economic re-opening rather than as essential steps on the critical path to early re-opening (the way PM Ardern framed the issue to her followers). Given the tendency documented above for constituents to follow their leader, it seems likely that Trump’s messaging strategy fueled popular resistance to state restrictions; undermined the ability of states to manage the crisis on their own; and thus prolonged the crisis.

Ultimately, one cannot understand the communications policies of Prime Minister Ardern and President Trump by comparing them on the same criterion. Ardern’s communication strategy was tailored to addressing the pandemic risk. Trump’s communication strategy is harder to fathom, but seems to have been more closely tailored to honoring what might be deemed an implicit covenant with his political base: that he will “make America great again” without ever formally asking its citizens to accept personal sacrifices for a common purpose.


72. See Blake & Rieger, supra note 69 (Quoting President Trump as follows: “Our Economy is roaring back and will NOT be shut down. . . . You’re going to lose a number of people to the flu. But you’re going to lose more people by putting the country into a massive recession or depression.”).

73. Agadjanian, supra note 65.
2. **Contrasting Approaches to Lockdowns**

Perhaps the most difficult challenge for a government responding to a novel pandemic threat is that of mobilizing the population to take the threat seriously and change its normal behavior, drastically and immediately, to break the chain of virus transmission. This is the step at which New Zealand’s government has made history, by adopting very strong commerce and mobility restrictions very early in an effort to **eliminate**, not just mitigate, community transmission of the virus.74

a. **New Zealand’s Strict and Centrally-Directed Lockdown**

On March 25, 2020, New Zealand implemented a nationwide lockdown, just two days after officials first confirmed community transmission in New Zealand, with only 102 cases on the books.75 Moreover, New Zealand’s lockdown was strict—one of the strictest in the world.76 The government ordered all schools, public venues, and non-essential businesses—including restaurants and carry-out services—to close.77 The government prohibited public and private gatherings outside the residential bubble and instructed residents to stay at home, with an exception for “essential personal movement,” such as buying groceries or essential medicines.78 Government restrictions also prohibited residents from engaging in recreational activities outside the home except in isolation or with others in one’s own residential “bubble.”79

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New Zealanders were moving “into self-isolation as a nation.”\footnote{Ardern, supra note 77.} Although the lockdown was draconian, the Prime Minister offered her citizens the hope, if not the promise, that the lockdown also would be short — approximately four weeks — if they complied with the strictures; longer if they failed to comply.\footnote{Id.}


b. The Partial, Piecemeal and Unenforced U.S. “Lockdown”

Unlike his New Zealand counterpart, President Trump elected to delegate primary responsibility for imposing social distancing disciplines entirely to
the states. He departed from this script only briefly on two occasions: once when he tweeted that he was considering imposing a quarantine or strong travel advisory on New York City after a major outbreak there, and again a few days later when he asserted “absolute authority” to order states to re-open their economies despite the pandemic risk in order to limit the economic fallout. In both cases, however, he quickly backed down in response to vehement opposition from states and reverted to his script of state primacy in responding to the pandemic.

In the absence of federal coordination, the states responded, as one might expect, in a piecemeal and uncoordinated fashion: issuing stay-at-home orders that started on different dates from late March through April; employing different lists of “essential” businesses allowed to remain open during lockdown; and imposing different safety requirements on these essential businesses.

Several states with Republican governors did not


impose mask mandates on their citizens until November, 2020, when skyrocketing case counts forced their hand.\textsuperscript{91} Unlike New Zealand, the Trump Administration has not collected information on state and local enforcement of the various stay-at-home orders, but anecdotal accounts suggest that even states that issued lockdowns and mask mandates deployed civil and criminal enforcement sanctions only sporadically and as a last resort.\textsuperscript{92} National news media during this period captured numerous flagrant breaches of social distancing norms, led by (but certainly not limited to) massive and boozy Spring Break gatherings on Florida beaches.\textsuperscript{93}

These media accounts comport with the hard data revealed by Google tracking. Google Mobility Data anonymously collects and aggregates location data from people’s cell phones for periods before and after social distancing orders in countries around the world. Table 1 captures the reports of visits to public gathering sites for two sample dates (April 15 and April 18), occurring in the middle of the overlapping U.S. and New Zealand lockdown periods, as compared to the pre-COVID-19 baseline.

\textbf{Table 1:}

\textbf{Visits to Public Gathering Sites during Lockdown in the United States}


and New Zealand (compared to baseline visits)94

<table>
<thead>
<tr>
<th>Country/Date</th>
<th>Retail and recreation percent change from baseline</th>
<th>Grocery and pharmacy percent change from baseline</th>
<th>Parks percent change from baseline</th>
<th>Transit stations percent change from baseline</th>
<th>Workplaces percent change from baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Zealand- April 15</td>
<td>-88%</td>
<td>-36%</td>
<td>-76%</td>
<td>-86%</td>
<td>-73%</td>
</tr>
<tr>
<td>United States- April 15</td>
<td>-36%</td>
<td>-13%</td>
<td>-16%</td>
<td>-49%</td>
<td>-49%</td>
</tr>
<tr>
<td>New Zealand- April 18</td>
<td>-91%</td>
<td>-45%</td>
<td>-77%</td>
<td>-84%</td>
<td>-57%</td>
</tr>
<tr>
<td>United States- April 18</td>
<td>-45%</td>
<td>-15%</td>
<td>-20%</td>
<td>-47%</td>
<td>-33%</td>
</tr>
</tbody>
</table>

Clearly, New Zealand’s restrictions produced a much larger change in the movement patterns of the citizenry on these sample dates95 than the various states in the United States have achieved by their piecemeal Strictures.96

While mobility data are revealing, the ultimate evidence of contrast is found in the results. As discussed below, New Zealand’s strict, mandatory, and centralized lockdown virtually eliminated the virus, paving the way for a safe re-opening within a few weeks, while the disorganized U.S. approach failed to contain the virus.

3. Contrasting approaches to re-opening the economy

New Zealand’s lockdown decision came at a time when new case counts were doubling daily in New Zealand but with only about a hundred confirmed cases.97 Prime Minister Ardern, as we have seen, offered her country the hope that a strong, early, and nationwide response would enable the lockdown to be short (about a month).98 Subsequent events confirmed the wisdom of her decision. After continuing to rise for twelve more days after the lockdown, New Zealand’s new case count began to drop


95. Wilson, supra note 86.


97. History of the COVID-19 Alert System, supra note 78 (indicating the dates of each alert stage).

98. Ardern, supra note 77.
precipitously, from eighty-nine cases per day on April 5, 2020 (equivalent in percentage of population terms to 6,100 new U.S. cases per day) to only nine per day on April 19. On April 27, the government began to ease the lockdown, albeit with significant distancing restrictions kept in place. Officials further reduced restrictions on May 13, when the new case count reached zero, and lifted them entirely on June 8 with the recovery of the last known COVID-19 patient in New Zealand. All told, New Zealand’s nationwide lockdown lasted twenty-six days for the severe phase and fifty-one days for the severe and moderate phases combined.

In the United States, the piecemeal state-by-state approach to lockdowns in the spring did “flatten the curve” temporarily, reducing new case counts in May from highs reached in April. But the required business closures came at an enormous cost to the economy and to jobs, while the disjointed and half-hearted implementation of the lockdown failed to stop the virus or clear the way for an early or safe re-opening. As a result, states began to re-open their economies in May, against medical advice, more out of fatigue with the lockdown than in response to progress achieved. Moreover, the re-opening over the summer was even more piecemeal than the lockdown, with different states re-opening various sectors on different dates and to different degrees, without ever achieving the level of pandemic control that would warrant re-opening.


102. Id.


105. Consider, as just one example, the illustrative case of restaurants in Connecticut and Florida. Both closed for indoor dining on March 20 in response to orders from their respective
The well-known result is that new cases spiked again, then gradually declined to the level of about 40,000 new cases per day before the surge to over 80,000 new cases per day by November 1,106 with more than 9.5 million cumulative cases overall. This is seventy-four times higher than New Zealand’s total on population-adjusted basis, a ratio that continues to climb. The United States appears to have captured the worst of both worlds: a “lockdown” intrusive enough to have caused massive dislocation and job loss, but not planned or implemented well enough to stop the spread of the virus and enable safe re-opening nationwide. This outcome is entirely foreseeable when one considers the nature of the novel coronavirus. The SARS-coV-2 virus spreads freely wherever it is not blocked by surface cleaning and vapor barriers or social distancing.107 It may infect people other than the carrier, in many cases causing harm to those people that is far worse than the consequence to the carrier. In short, it is a classic example of an “externality” that can only be cured by effective mandatory regulation.108 Because Americans are free to travel nationwide, the overall effectiveness of the nation’s response is only as great as that of the governors. But Florida re-opened its restaurants to indoor dining on May 4, Fla. Exec. Order No. 20-112 (May 4, 2020), https://www.flgov.com/wp-content/uploads/orders/2020/EO_20-112.pdf, a full month before Connecticut did so, Conn. Exec. Order No. 7PP (May 18, 2020), https://portal.ct.gov/-/media/Office-of-the-Governor/Executive-Orders/Lamont-Executive-Orders/Executive-Order-No-7PP.pdf?la=en, with looser requirements on re-opened restaurants. Florida’s rush to re-open its restaurants and other establishments would produce a spike in cases that forced Miami-Dade County to re-close restaurants on July 8, while many other restaurants closed voluntarily. See Nicholas Reimann, Miami is Closing Its Restaurants Again, As Florida’s Coronavirus Crisis Continues, FORBES (July 6, 2020, 12:27 PM), https://www.forbes.com/sites/nicholasreimann/2020/07/06/miami-is-closing-its-restaurants-again-as-floridas-coronavirus-crisis-continues/#4cc9e2747487; see also Helen Freund, Some Tampa Bay Restaurants Choosing to Close Amid Safety Concerns and Dwindling Sales, TAMPA BAY TIMES (July 7, 2020), https://www.tampabay.com/life/culture/food/2020/07/07/some-tampa-bay-restaurants-choosing-to-close-amid-safety-concerns-and-dwindling-sales/. 106. United States, supra note 1. 107. Frequently Asked Questions, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/coronavirus/2019-ncov/faq.html (Dec. 11, 2020). 108. See generally Zachary Bethun & Anton Korinek, Covid-19 Infection Externalities: Herd Immunity Versus Containment Strategies, VoxEU.ORG (May 3, 2020) https://voxeu.org/article/covid-19-infection-externalities-herd-immunity-versus-containment-strategies (exploring the severity of COVID-19 as an externality).
least-effective jurisdiction within it: like the proverbial chain that is only as strong as its weakest link.\textsuperscript{109} To be effective in containing the virus, mandatory rules are needed and they need to be largely uniform, or at least effective, nationwide.

For a clear illustration of the need for nationwide and mandatory norms, consider the illustrative case of the motorcycle rally in Sturgis, South Dakota in August 2020. Up to that point, South Dakota, a mostly rural state, had been relatively free of COVID-19. But the influx of nearly 500,000 motorcycle enthusiasts from all over the country for a week of partying left the county (and America) with a massive spike in COVID-19 cases and hospitalizations that produced, according to one study, an estimated $12 billion in COVID-19-related medical costs in the aftermath of the rally.\textsuperscript{110} Yet even in November, weeks after South Dakota had become a national hotspot of covid disease and death, the governor of the state refused to adopt a mask mandate, its residents remained free to travel about the country, and the state continued to serve (along with numerous other recalcitrant states) as an incubator of contagion regionally and nationwide.\textsuperscript{111} This spectacle would be repeated over and over nationwide as one jurisdiction after another rapidly traveled the path from (a) relatively few cases and risk denial to (b) overflowing hospitals. Such was the fate of America’s piecemeal lockdown and helter-skelter re-opening in the face of a pandemic that knows no legal boundaries.

\textsuperscript{109} Linda Hasco, Second Wave of Coronavirus Hits Florida, Texas, Arizona After Reopenings, Penn. Real-Time News [June 11, 2020], https://www.pennlive.com/news/2020/06/second-wave-of-coronavirus-hits-florida-texas-arizona-after-reopenings.html (reporting that states, such as Florida, who have failed to take adequate precautions with regard to the coronavirus are experiencing second waves and are preventing the entire country from recovering as a result).


CONCLUSION

This essay has documented the stark contrast between the New Zealand and U.S. pandemic responses. New Zealand sealed its borders early and effectively, the United States did not. New Zealand moved quickly to deploy rapid testing and tracing on a mass scale: the United States did not. New Zealand ramped up domestic production and overseas procurement rapidly to ensure adequate supplies of all necessary PPE; the United States failed to do the same. New Zealand’s Prime Minister clearly and unequivocally conveyed the seriousness of the threat and encouraged cooperation with restrictions and controls, while the U.S. President repeatedly denied the seriousness of the threat and encouraged resistance to protective measures. New Zealand implemented a comprehensive and centrally-coordinated nationwide lockdown with widespread voluntary compliance but enforced by police where necessary. The United States, by contrast, relied on an uncoordinated, piecemeal patchwork of barely-enforced (or unenforced) state by state restrictions. As a result, New Zealand successfully broke the chain of community transmission in New Zealand; the United States failed to do likewise.

The consequence: twenty-five COVID-19 deaths in New Zealand (equivalent in population percentage terms to 1,625 American deaths) with the virus now virtually eliminated nationwide, compared to nearly 350,000 COVID-19 deaths in America as of December 31, 2020, with the virus spreading out of control. Nor is New Zealand unique. At least thirty-five other countries have out-performed the United States in containing the virus. Had the United States matched the COVID-19 death rate of any of the top Asia-Pacific countries over 300,000 Americans who are now dead from COVID-19 would still be alive today.112

The success of New Zealand and other Asia-Pacific responders in containing the virus in 2020 did not just prove the effectiveness of the playbook in controlling cases and saving lives. It also proved that strong responses to contain the virus are also the most effective strategies for saving the economy. While the United States faced, on New Year’s Day 2021, a dismal winter of renewed COVID-19 mobility restrictions and deprivations for its citizens, with another $2 trillion in government spending required to keep the economy afloat for a few more months, the successful Asian-Pacific countries such as New Zealand, Australia, Taiwan, Vietnam and China were

112. See note 21 supra.
well on their way to returning to a pre-COVID way of life.\footnote{113} By the end of 2020, these economies were normalizing,\footnote{114} people were confident enough to enter malls and bars,\footnote{115} and some were even back to hosting concerts.\footnote{116} Even in the less successful countries where temporary lockdowns have been re-imposed, the baseline of COVID-19 deaths was orders of magnitude below that of the United States.

New Zealand’s experience confirms that an airborne pandemic elimination strategy can succeed if it is communicated well to the public and backed by effective testing and contact tracing practices in support of strict mobility restrictions implemented with sufficient geographic scope to contain the virus. Equally important, it confirms that mobility restrictions can be short-lived if they are imposed quickly, with resolve, and in tandem with other protective measures. New Zealand’s experience viewed in context thus serves as both an indictment of the Trump Administration’s mismanagement of the crisis and a source of important lessons for future pandemic response planning in the United States and around the world.

\footnote{113} Albeck-Ripka, \textit{supra} note 4.
\footnote{115} Javier C. Hernández, \textit{U.S. Says Virus Can’t Be Controlled. China Aims To Prove It Wrong.}, N.Y. TIMES, https://www.nytimes.com/2020/10/30/world/asia/china-covid-coronavirus.html (Nov. 17, 2020) (“Residents are once again flocking into malls, bars, concert halls and hair salons, while schools, subways and offices are crowded.”).