Critical Public Health volume 32 (2022) issue 1. pp. 44-47
https://doi.org/10.1080/09581596.2022.2029195

Pandemics, infection control and social justice: challenges for policy evaluation

Ewen Speed (School of Health and Social Care, University of Essex)
Simon Carter (Department of Sociology, the Open University)
Judith Green (Wellcome Centre for Cultures & Environments of Health, University of Exeter)

The COVID-19 pandemic has been a global threat, but one primarily managed by nation-states. Across the world, national public health responses have provided a grim comparative natural experiment in infectious disease control policy, as governments have implemented a range of border controls, masking mandates, contact tracing, economic support and communication strategies. It may be premature to assess the effectiveness of these strategies for protecting health and wellbeing. However, what is clear from the papers gathered in this Special Section, is that future evaluation will have to take into account the wider political contexts of public health action in determining which count as policy successes and which count as policy failures. The content of policy matters; but so does the context in which it is implemented. In a companion Special Section, Marelli et al. (2022) introduce three papers on solidarity in pandemic times, flagging how issues such as trust in government shape responses to contact tracing, for instance. What is also abundantly clear is that evaluation will need to focus not just on COVID-19 infection and mortality outcomes, but also on broader impacts on health, social justice, and equity.

The burden of pandemic effects has not been borne equally. This is partly because the resources to cope with illness, economic disruption and stress are unequally distributed. The most marginalised – such as indigenous populations (Singh et al., 2022), migrants, those living in poverty – are often most at risk from both infectious disease and the consequences of pandemic control measures. But beyond these issues of unequal capacity to withstand shocks, policy responses to COVID-19 across the world have actively exacerbated social divisions and undermined social justice, as studies in this Special Section illustrate. Kajeepeta et al. (2022), for instance, document how criminalisation, as a public health strategy in New York, USA, has reinscribed spatial and racialized discrimation; likely to have not only exacerbated infection spread disproportionately in Black communities, but also to have had wide ranging collatorial unequal impacts on health. Kapilashrami et al. (2022) document the ethnic inequalities in exposure to risk among health workers in the UK's NHS, in which those from minority communities are more likely to be exposed to infection as front line workers. Gaspar et al. (2022) note that the histories of public health show that conflation of infection and moral risk have long-held risks for sexual minorities.

Evaluating the wider impacts of infectious disease mitigation strategies will not be straightforward. The lack of good quality evaluations of public health measures has been widely noted, most recently in the context of a systematic review that found only one RCT of mask-wearing (Glasziou et al., 2021). More trial evidence is unlikely to help much: complex packages of interventions are likely to be variable in their effects, interacting with contexts in dynamic ways over time, as behavioural

responses change in response to both pandemic waves and public policies. Assessing success or failure in the absence of counterfactuals is challenging. However, initial assessments certainly suggest that the UK has furnished a raft of example policy measures that appear to have been associated with increases, rather than decreases, in morbidity and mortality. For example, the so-called 'Eat Out to Help Out' initiative provided subsidies for restaurants to encourage people to dine out. This, it was thought, would increase economic activity but was associated with a subsequent spike in COVID-19 infections and deaths. Fetzer (2021) estimates the policy accounted for between 8–17% of all new local infection clusters during its operational period. With the concomitant increase in cases, we could regard this as a public health policy failure. Other UK policy failures can be described as downstream public health interventions that sought to responsibilise individual citizens to reduce COVID-19 transmission at a population level. Mandatory mask-wearing was lifted in England on 19 July 2021. This date was labelled 'Freedom Day', where the Government lifted many of the legal restrictions concerning COVID-19, in England, including those related to mask-wearing in public places. Whilst the evidence for mask-wearing initially was less firm than some had claimed (Martin et al., 2020), both contemporary scientific consensus and the precautionary principle would suggest continuing mandated mask-wearing to be an evidence-informed decision. More recent evidence is broadly supportive of public health measures; for example, Talic et al. (2021) found a 53% reduction in COVID-19 incidence from mask wearing in a recent systematic review. Indeed, mandated mask-wearing legislation remained in place in much of Europe after England's 'Freedom Day'. Patterson (2021) has criticised the mixed public health messages from the UK Government, which sought to minimise public perception of COVID-19 risk, but also to impress upon people the need to get vaccinated and adopt behaviours to reduce transmission; one message confounds and contradicts the other. Infection rates in the UK certainly far outstrip other European countries, suggesting these mixed messages directly and negatively impact population health. As of December 2021, data from European Centre for Disease Prevention and Control suggested that the UK has the highest rates of COVID-19 infection the Europe. As Leach et al. (2022) note in this issue, the UK's limited incorporation of uncertainties in pandemic planning has meant that overall outcomes to date have been 'devastating and discriminatory'.

What nation-states do, then, still matters: national public health policies affect infection spread and can exacerbate or mitigate the unequal impacts of pandemics. National public health policy also signals, more broadly, how far a government cares for the health and wellbeing of its citizens. However, the scope of national governments is increasingly circumscribed by global economics, with international corporations' interests potentially trumping those of sovereign nations. In the most recent pandemic, attention has been focused on the global inequalities of vaccine access, with notable disparity across low middle and high-income countries regarding vaccine access (Figueroa et al., 2021). Light and Lexchin (2021) ask several pertinent questions about the pricing structure of COVID-19 vaccines. While their analysis is based on minimal available data, they demonstrate projected actual costs (and projected profits) for the manufacture of vaccines across the leading producers and ask whether profiteering on COVID-19 vaccine manufacture represents 'crimes against humanity'. This profiteering can be characterised as a policy failure of global pharmaceutical governance, where primacy (again) is given to economic rather than public health.

In this Special Section, two papers explore less obvious corporate influences on national public health policy. Focusing on the role of technology companies in contact tracing, French et al. (2022) point to their potential 'to de-centre the power of public health authorities'. Even those designed by non-profits, or commissioned by public bodies, rely on vast telecommunications and digital infrastructures to operate. Governments become reliant on the innovations of commercial actors, yet the networks that enable them (including the algorithms that embed inequality) are black-boxed. Again, policy solutions (the promise of efficient tracing) are folded in with risks to social justice, as tracing technologies can be used for surveillance and control. Lindsay et al. (2022) explore a digital mental health app, privately operated, but funded for the New Zealand public by the government to support mental wellbeing. This, argue Lindsay et al, is a form of 'neuroliberalism', part of an ideological response to the pandemic that reinforcing individualising solutions and responsibisation of citizens for maintaining health through the pandemic.

Policies do not simply succeed or fail: their public health effects are inevitably multiple. For example, local action can mitigate the effects of national policy making, as Loblay et al. (2022) demonstrate, in their study of the multiple ways that local organisations in Tasmania, Australia, adapted their chronic disease support work in a lockdown. Here were examples of reorienting work to provide direct support to communities, repurposing funding, and expanding their roles. Yet these responses also had costs, in the additional burden of care on often already over-stretched providers. The question of success or failure is also a question of 'success for whom?', and of when, given the long timescales of effects into the future. As Leach et al. (2022) argue, pandemic planning needs to account for the complex and contingent ways in which policy initiatives unfold in time. They call for a 'new ethics of preparedness needs to acknowledge histories, political economies, unequal relationships and everyday injustices'. Any future evaluation of contemporary pandemic policies will need to ask not just whether they reduced infection, but whether they fostered health equity and social justice. On current evidence, however limited, many national responses will be found wanting.

References

1. Alexander, C. (2021). Why 'freedom day' is the latest example of COVID propaganda. (The Conversation 17 November). https://theconversation.com/why-freedom-day-is-the-latest-example-of-covid-propaganda-164521

2. Fetzer, T. (2021). Subsidising the spread of COVID-19: Evidence from the UK'S eat-out-to-help-out scheme. The Economic Journal, (ueab074). https://doi.org/10.1093/ej/ueab074

3. Figueroa, J. P., Bottazzi, M. E., Hotez, P., Batista, C., Ergonul, O., Gilbert, S., Gursel, M., Hassanain, M., Kim, J. H., Lall, B., Larson, H., Naniche, D., Sheahan, T., Shoham, S., Wilder-Smith, A., Strub-Wourgaft, N., Yadav, P., & Kang, G. (2021). Urgent needs of low-income and middle-income countries for COVID-19 vaccines and therapeutics. The Lancet, 397(10274), 562–564. https://doi.org/10.1016/S0140-6736(21)00242-7

4. French, M., Guta, A., Gagnon, M., Mykhalovskiy, E., Roberts, S. L., Goh, S., McClelland, A., & McKelvey, F. (2022). Corporate contact tracing as a pandemic response. Critical Public Health, 32(1). https://doi.org/10.1080/09581596.2020.1829549

5. Gaspar, M., Grey, C., Wells, A., Hull, M., Tan, D. H. S., Lachowsky, N., & Grace, D. (2022). Public health morality, sex, and COVID-19: Sexual minority men's HIV pre-exposure

prophylaxis (PrEP) decision-making during Ontario's first COVID-19 lockdown. Critical Public Health, 32(1). https://doi.org/10.1080/09581596.2021.1970720

6. Glasziou, P., Michie, S., & Fretheim, A. (2021). Public health measures for covid-19 lack of good research is a pandemic tragedy. British Medical Journal, 375, n2729. https://doi.org/10.1136/bmj.n2729

7. Kajeepeta, S., Bruzelius, E., Ho, J., & Prins, S. (2022). Policing the pandemic: Estimating spatial and racialised inequities in New York City police enforcement of COVID-19 mandates. Critical Public Health, 32(1). https://doi.org/10.1080/09581596.2021.1987387

8. Kapilashrami, A., Otis, M., Omodara, D., Nandi, A., Vats, A., Adeniyi, O., Speed, E., Potter, J. L., Eder, B., Pareek, M., & Bhui, K., Intersectional view of Covid-19 Protections & Experiences (I-COPE) Consortium. (2022). Ethnic disparities in health & social care workers' exposure, protection, and clinical management of the COVID-19 pandemic in the UK. Critical Public Health, 32(1). https://doi.org/10.1080/09581596.2021.1959020.

9. Leach, M., MacGregor, H., Ripoll, S., Scoones, I., & Wilkinson, I. (2022). Rethinking disease preparedness: Incertitude and the politics of knowledge. Critical Public Health, 32(1). https://doi.org/10.1080/09581596.2021.1885628

10. Light, D. W., & Lexchin, J. (2021). The costs of coronavirus vaccines and their pricing. Journal of the Royal Society of Medicine, 114(11), 502–504.

11. Lindsay, N., Baker, T., & Calder-Dawe, O. (2022). Mental coaching through crisis: Digital technologies and psychological governance during COVID-19. Critical Public Health, 32(1). https://doi.org/10.1080/09581596.2021.1965543

12. Loblay, V., Garvey, K., Shiell, A., Kavanagh, S., & Hawe, P. (2022). Can adaptation to 'extraordinary' times teach us about ways to strengthen community-based chronic disease prevention? Insights from the COVID-19 pandemic. Critical Public Health, 32(1). https://doi.org/10.1080/09581596.2021.2006147

13. Marelli, L., Kieslich, K., & Geiger, S. (2022). COVID-19 and techno-solutionism: Responsibilization without contextualization? Critical Public Health, 32(1).

14. Martin, G. P., Hanna, E., McCartney, M., & Dingwall, R. (2020). Science, society, and policy in the face of uncertainty: Reflections on the debate around face coverings for the public during COVID-19. Critical Public Health, 30(5), 501–508. https://doi.org/10.1080/09581596.2020.1797997

15. Patterson, L. (2021). Encouraging covid vaccine uptake and safe behaviours—an uphill struggle against government complacency. BMJ, 375, n2773. https://doi.org/10.1136/bmj.n2773

16. Singh, T. P., de Schweinitz, P. A., Khanna, I., & Norbu, C. (2022). Buddhist Monks as community organisers: An indigenous response to COVID-19 in the Spiti Valley of Northern India. Critical Public Health, 32(1). https://doi.org/10.1080/09581596.2021.1931662

17. Talic, S., Shah, S., Wild, H., Gasevic, D., Maharaj, A., Ademi, Z., Li, X., Xu, W., Mesa-Eguiagaray, I., Rostron, J., Theodoratou, E., Zhang, X., Motee, A., Liew, D., Ilic, D. (2021). Effectiveness of public health measures in reducing the incidence of covid-19, SARS-CoV-2 transmission, and covid-19 mortality: Systematic review and meta-analysis. British Medical Journal, 375, e068302. https://doi.org/10.1136/bmj-2021-068302