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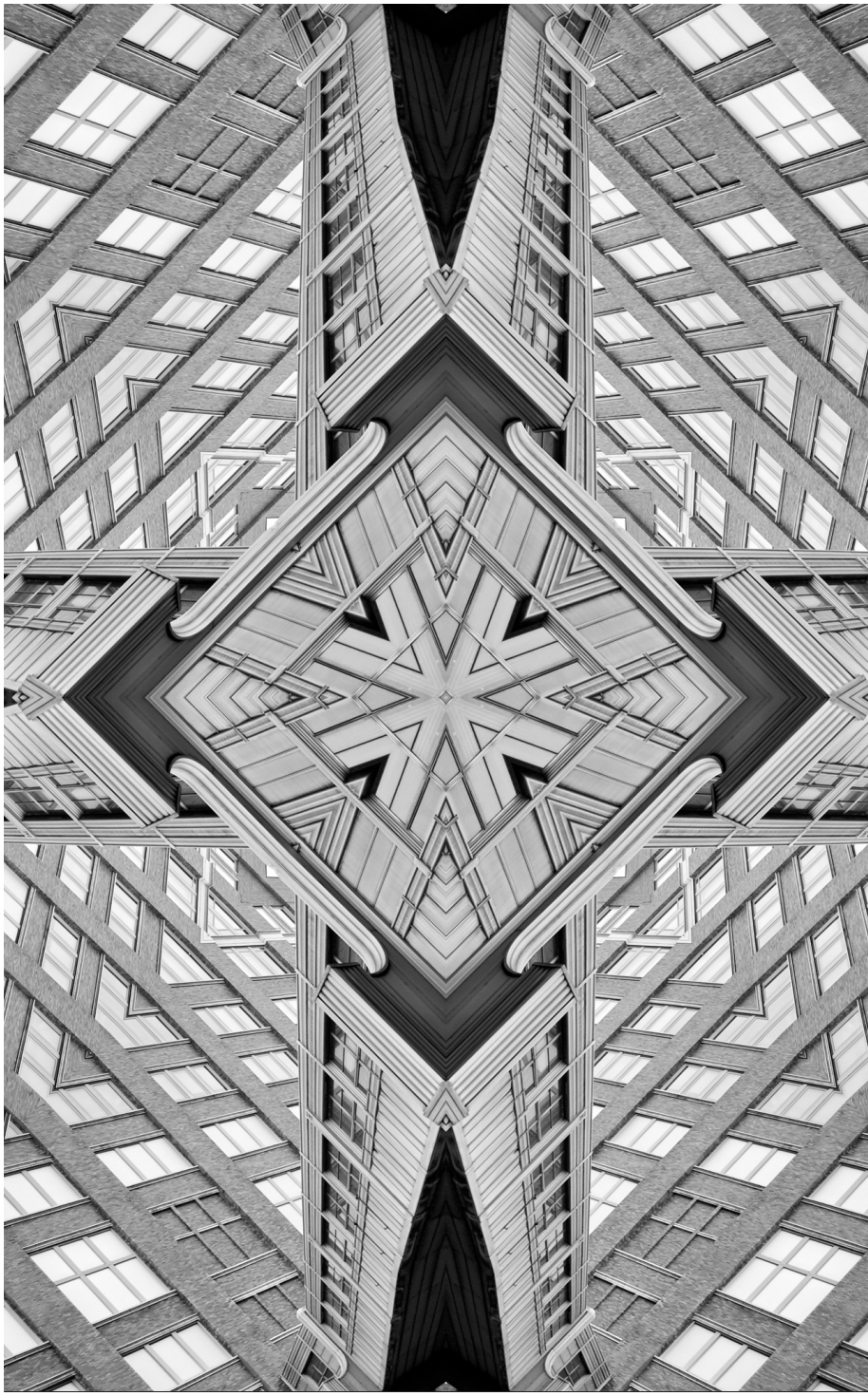

The Pandemic at 24 Months: An Assessment

Sridhar Venkatapuram

Abstract

Two years since the start of the COVID-19 pandemic, an estimated 14-24 million people have died worldwide due to the coronavirus or the chaos of lockdowns and other impacts. To a great extent, much of this current state of the world is due to human health being profoundly misunderstood and neglected in international relations and national politics. This brief discusses two principles that can help understand why this pandemic is not at an end despite the boon of vaccines, and why humankind is unprepared for the next pandemic.

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Introduction

On 11 March 2020, the World Health Organization (WHO) declared the novel coronavirus (COVID-19) outbreak, which originated in Wuhan, China, a global pandemic. In the two years since, no country has been able to hold off the virus at its national borders. And no country—or its people—has been able to avoid the impact of responses to contain the pandemic, from local to global. It has indeed been a modern global event. Every single person has been harmed by the pandemic in some way, not least by the addition of a new threat to their health and wellbeing. Nearly 24 million people are estimated to have died so far due to the virus and pandemic responses, which is four times more than the official COVID-19 death statistics. The number of deaths continues to rise daily, now largely in low and middle-income countries.[1] Beyond deaths, the long-term health harms from infections ('long-COVID') and mental health impacts are still unclear, but certain. The knock-on effects in terms of social, political, economic, and other harms will be felt for years to come, particularly by the worse-off and vulnerable within and across countries.

As the world marked two years since the pandemic was announced, China, once again, implemented an enormous lockdown in Changchun—a city of over nine million people—to stave off rising infections.[2] This drastic approach was repeated despite the advent of vaccines, mass testing, and lower fatalities because people are still spreading infections, and also to prevent further damage to the country's global standing from another wave or variant originating within its borders. At the same time, a new wave of infections and hospitalisations in Europe and the US appeared to have begun, following on from their removal of all disease control restrictions to return to normalcy.[3]

Additionally, a few days before the two-year anniversary, Russia invaded Ukraine, further exacerbating a refugee crisis and raising the possibility of a protracted war in Europe, or worse. The invasion destabilises the world order as Russia's status—as of one of the big geopolitical powers—is now in play as the entire country and its oligarchs are being isolated, domestic dissent is now visible and increasing, and its threat to countries beyond Ukraine will not go unchecked. It would require wilful blindness to not see the timing of Russia's invasion of Ukraine as being linked to how the global handling of the pandemic has produced disarray in geopolitics, marginalised the United Nations (UN) and other international organisations, and worsened the divisive domestic politics inside the G7 and broader G20 countries.

Introduction

To a great extent, much of this current state of the world is due to human health being profoundly misunderstood and neglected in international relations and national politics. For decades, the focus has largely been on economics (growth, trade, finance), security, and culture wars/populism. For example, Dani Rodrik, a leading economist and analyst of the problems of 'hyper-globalisation', only began to appreciate and engage with the concept of public health (as something distinct from healthcare) in 2020.[4] Beyond academia, even senior statespersons such as Mikhail Gorbachev,[5] Madeleine Albright,[6] and Henry Kissinger[7] were taken aback by an infectious disease being a threat to domestic stability, multilateralism, and the liberal world order.

How most countries, international organisations, including UN agencies, corporations, international NGOs, and some billionaire 'super-citizens' responded to the pandemic over the past two years can best be described in terms of failure. Despite political leaders and major actors in the global COVID-19 response putting a positive spin on their efforts, the reality shows otherwise. The rapid development of COVID-19 vaccines is showcased as an epic success of government-supported global science and cooperation. But it has also exacerbated global tensions between the G7 and the poorest countries, bringing back the concept of racism in international relations. There is little assurance that the pharmaceutical success will adequately translate to ending the pandemic harms anytime soon—except, perhaps, for the wealthiest people and countries, barring new variants. It would require some magical thinking to conclude that, despite the profound failures and current disarray, the world is on a path to being better prepared for the next pandemic or epidemic.

Two principles can help explain why this pandemic is not at an end despite the boon in vaccines, and why humankind is unprepared for the next pandemic:

1. Infectious disease emergence and spread, and health issues—whether at the individual, national, regional, or global levels—are generally simply biological events requiring just a biomedical solution;

2. Pandemic (or outbreak and epidemic) preparedness cannot be adequately achieved in isolation from improving the health of populations, particularly the most deprived.

Biomedical Fetishism and Incompleteness

In early 2020, the world's attention was focused on the biological and epidemiological aspects of the novel virus. What kind of a virus is it? How does it get transmitted? How fatal is it? How transmissible is it? Answers to such questions are crucial to responding effectively to any outbreak. But what is astounding—especially in light of enormous learning from recent global experience with outbreaks of AIDS, Ebola, Tuberculosis, Zika, and so forth—is that there was utter lack of attempts to understand and integrate how human diversity and social forces at various levels drive the spread of infections across and within countries. To put it simply, the dominant and narrow perspective that the pandemic was a biological problem requiring biomedical solutions at the individual level has been catastrophic. Vaccine inequity is only a symptom of this fundamental fixation with the narrow biomedical perspective.

Infectious diseases are social phenomena; infections are transmitted from person to person through social interactions, profoundly determined by people's biological diversity (age, sex, morbidities, pregnancy, reasoning capacity, etc) as well as their behaviours that are, in turn, shaped by social and natural environments. We learned this from decades of dealing with other infectious disease outbreaks and pandemics. Focusing exclusively on the biology of the virus and viewing people as individual, passive biological units, produces incomplete explanations about causes beyond individual bodies, blinds us to social distribution patterns of disease (inequalities), and results in misdirected or inadequate responses. Three key moments—where this narrow perspective dominated and human diversity and social analysis were excluded—include the initial lockdowns in China, the early disease modelling in the UK, and WHO's advice to countries with the mantra of "test-trace-isolate".

The Chinese government implementing lockdowns on cities with millions of people was not only unprecedented in terms of scale, but also scientifically unknown and unproven. Historically, infectious disease outbreaks have been dealt with through a 'contain and control' approach. Those who are infected or thought to be infected are separated from the not-infected to contain spread. In a small, localised outbreak, it can be effective to quickly apply this approach as it involves few people. Immediately after an outbreak, quickly identifying and isolating human bodies with the virus can effectively contain it from spreading. But the greater the spread of infections across people, time, and geography, the cause of infections is no longer just the harmful organism.

Biomedical Fetishism and Incompleteness

Human behaviours—affected by social factors (cultural, legal, economic, political, etc.)—start to profoundly impact the spread of infections. It becomes more necessary to identify how human diversity and social forces (from local to global) are impacting the scale of the spread and population distribution of the infections, and then integrate that evolving knowledge into the containment response. The response entails addressing both the biological and social factors driving spread of infections; and it requires social cooperation, as infections spread from one person to another.

China's approach of locking down cities—well after infections were spreading widely—reflects the absolute denial of the importance of human diversity and social factors affecting behaviours driving the spread. Officials thought that what could be done to a few individuals in a small outbreak, could be done to millions of people, expecting the same results. However, this is where the biomedical perspective fails profoundly. While the quarantines may have curtailed infections to some extent, they also spread infections outward to other countries as hundreds, perhaps thousands, of infected people fled the country.

The second key moment was also in early 2020 when mathematical modellers of infectious diseases at London's Imperial College predicted large scale deaths in the UK and the US.[8] Drawing on initial biological information about the virus and patients in Wuhan, the modellers aimed to identify the epidemiological dynamics of COVID-19 in the UK and the US, without and with interventions. The modellers, however, used assumptions that all people would have equal risk of exposures, of infections taking root, of proceeding to serious disease, and of death. The modelling did not include any human diversity or differences in how different social contexts will affect individuals' and groups' vulnerability to infection and death. The frightening numbers of predicted deaths (500,000 in the UK, 2 million in the US)—following on from China's large-scale city quarantines—motivated national lockdowns in the UK, the US, and then quickly around the world.

The models also presented the picture—which was repeated by politicians and news headlines—that anyone could die from the disease. Any experienced infectious disease expert would have known in early 2020 that the coronavirus is not one of the most dangerous viruses that will kill anyone who is exposed. We know from history and from recent experiences with other epidemics and pandemics that infectious diseases will affect those who are biologically and behaviourally least able to protect themselves.

Biomedical Fetishism and Incompleteness

The third key moment occurred at the global level when WHO began to daily broadcast around the world the mantra of "test-trace-isolate" (and later "support"). The basis of this mantra was the familiar 'contain and control' approach to small outbreaks. It may have made sense to think that an initial small number of infected people entering countries is similar to a localised outbreak—officials could quickly identify and isolate the individuals at the borders. There is also the powerful idea that biological science and natural science is generalisable and applicable to all humans and all places. For example, results from medical research on people in one part of the world are often applied to people in other parts; and the laws of physics in one part of the world are the same in other parts. As the 'contain and control' approach is based on scientific reasoning, it seems plausible to think it can be applied anywhere in the world.

But what WHO's mantra obfuscated or elided was that the pandemic was not spontaneous and random little outbreaks in separate national-units. In our hyper-globalised world, all countries are inter-connected, and the infections were spreading because of the trans-national social connections and contexts we have created. By just focusing on the actions governments can take at the level of individuals within the country, the mantra took attention off the dynamics occurring and actions needed at the transnational and global level. For example, thousands of people carrying the virus were travelling on major airplane routes from China to global metropolitan cities, and these infections would then cascade to smaller cities and less connected countries. The role of these transportation routes are examples of significant international legal, economic, political, and other factors that were driving the spread of infections across countries. And the mantra repeats the error of thinking that what may be done to a few individuals can be done at ever increasing scale with the same results.

This inadequacy of the test-trace-isolate mantra—in the face of non-biological drivers of infections—raises the important issue of whether WHO is capable or allowed to identify health threats and analyses that are beyond individual level biomedical factors. The mantra also did not help highlight the fact that some individuals in every country would be more vulnerable to becoming infected because of their diversity in biology and abilities to protect themselves. That is, the mantra neither addressed the global social factors driving the spread of infections across countries, nor did it go beyond the biomedical focus on individuals.

Biomedical Fetishism and Incompleteness

The initial China lockdowns, early disease modelling, and WHO's contain and control mantra, all focused narrowly on the biology of the viruses and individual human bodies, which contributed to the rapid lockdowns of entire countries across the world. The hard lockdowns in the beginning of the pandemic, like in China, were all the scaling up of the "contain and control" approach to entire populations without precedent and were scientifically unproven. The three events also contributed to the focus on individual-level biomedical interventions (vaccines) and other commodities such as tests, personal protective equipment (PPE), masks, and medical treatments. To be absolutely clear, all these biomedical interventions are hugely important in addressing the pandemic, but they are only part of the solution. Richer analysis of human diversity and social drivers of the global and local spread of infections, and good modelling of social distribution patterns could have informed much better lockdown policies and highlighted the importance of social cooperation. In particular, governments could have been compelled more to protect the most vulnerable (older people, biologically and psychologically impaired, social excluded groups, etc), rather than largely focusing on policies protecting the average healthy citizen.

To put it another way, had some of the earlier affected countries known that infections would largely lead to the deaths of older people—and those biologically and socially vulnerable—would they have implemented the lockdowns, or implemented them in the way they did? The individual level biomedical reasoning behind the contain and control approach cannot be applied to entire populations, and it does not inform us about social distribution patterns or the causes for such patterns.

> "Focusing exclusively on the biology of the virus and viewing people as individual, passive biological units produces incomplete explanations about causes beyond individual bodies, blinds us to social distribution patterns of disease (inequalities), and results in misdirected or inadequate responses."

Conclusion

The vaccine inequity and the persistence of pandemic deaths that are now being witnessed are not just about pharmaceutical greed, the dysfunction of UN organisations such as the World Trade Organization, or capitalism gone amok. The fixation on a biomedical intervention—a vaccine—as the best or ideal solution motivated some national leaders to see the development and procuring of vaccines as a competition. Even before the pandemic, former US President Donald Trump and his administration had established that US national interests would always prevail. And in early 2020, Trump's behaviour towards even the US's closest allies—by commandeering global supplies of masks, ventilators, and PPEs—cast doubt that the US was going to share any knowledge or actual vaccines. The UK found itself in the difficult position of neither being able to rely on the US nor on the European Union because of the acrimonious exit from the union. So, the narrow biomedical perspective, which points to individual-level biomedical interventions and fierce mistrust and competition even among the G7 countries, produced a race in the development and domestic manufacturing of vaccines. Billions of public dollars, pounds, and euros were put into vaccine development and purchasing various kinds of vaccines. While discovering effective vaccines in a short time is an astonishing achievement, the biomedical perspective does not provide much insight into how to ensure access to biomedical solutions for those who need them.

Despite the current situation, there is little indication that those who seek to prepare the world for the next pandemic are not still trapped in the biomedical perspective. For example, the Coalition for Epidemic Preparedness Innovations raised US$1.5 billion in March 2022 from various governments and funders to ensure that they will have safe and effective vaccines within 100 days of the next pandemic or epidemic.[9] As vital as these vaccines may be, the effort does not even try to address the root causes of the next pandemic. It just aims to provide the biomedical solution to (only) the next pandemic or epidemic. Preparedness in this form is only a partial answer.

Conclusion

The emergence of a novel virus and subsequent outbreak in Wuhan was not a natural, random, or purely biological event. The virus emerged as a result of various policy choices and neglect regarding sites of human-animal interactions ("wet markets"), and the infections spread in a social context where the free flow of information, particularly regarding harms under the domains of government agencies, is suppressed. In turn, the central government's approach to containing infections after it was widespread was by isolating millions of bodies through brute force, which pushed the infections outward toward other countries. The viruses were then carried across major international flight routes to major metropolitan cities, where they spread to smaller cities, as well as to major cities in smaller countries.

Within countries—especially in the earliest affected large countries such as the US, the UK, and Italy—the quality of government, public finances, public institutions, and federalist structures profoundly affected the spread of infections and the policies implemented in response. The subsequent deaths of older people, the physically vulnerable, and the socially marginalised can be described as disproportionate only if it was not known how infectious diseases impact societies. Infectious diseases spread in concert with individual biological diversity and socially created differences in the ability to control one's body and behaviours. The more biologically vulnerable and the more social factors constrain one's ability to protect oneself, the more likely one is at risk of becoming infected and suffering. Preventing the next epidemic or pandemic entails improving those biological vulnerabilities, the social environments that constrain people from being able to protect themselves, and addressing the biosocial drivers of behaviours that spread infections across countries. This will involve both biomedical interventions, such as ensuring wider access to healthcare, as well as addressing the important social factors that impact health, such as good governance from the local to the global levels. Perhaps, most of all, it will require elevating health to be a central concern of national governments and the international order.

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Endnotes

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