Each One Counts: Pathogen and Policies in the COVID-19 Pandemic

Kirk C. Allison
College of Saint Scholastica Program in Health Humanities

From the outset, policy response to COVID-19 treated pathogen casualties as somehow more significant than policy casualties (collateral damage, for example from social isolation). The burden of policy interventions, including extended lockdowns and work restrictions, despite 'all in this together' rhetoric, was borne unevenly along lines of function and vulnerability. In developing countries starvation risk increased significantly. In evaluating policy outcomes, 'each one counts' more adequately reflects the burdens of disease and of policy interventions under a holistic understanding of health (e.g. domains in the WHO definition), and offers a more adequate consideration of risk, burdens, and ordering of social goods.

Keywords: COVID-19, policy casualties, pathogen casualties, counting, vulnerable people, vulnerable populations

INTRODUCTION

Statements like 'a virus know no politics, no borders' express and encourage local and international solidarity. Yet epidemics are not purely biological events but are also social (often in transmission) and political (in responses). Responses to COVID-19 have ranged from broad economic shutdowns excepting 'essential services' (most countries) to relative economic and social openness to minimize economic dislocation and associated suffering (Sweden, Japan). Limiting death and illness is a morally laudable goal. The central prudential question is, what policy marks the best path? And what unintended consequences and burdens does a policy generate? This chapter invites reflection on policy responses and health after COVID-19 spread worldwide from Wuhan, Hubei Province, China.[1]

There is a 'fog of war' and a 'fog of contagion': Early reports are imprecise; early predictions and models are far off the mark. While some issues are "academic," in a pandemic, each person is an expert: You experience and observe direct and indirect impacts of the virus and policies in your life, immediate family, and community opposite the previous 'normal.' Especially aware are poorer people whose pay has been eliminated, those unable to work at home or through a computer, a person fighting addiction unable to reach a support group. Being 'all in this together' is not bearing burdens and deaths equally. *Do not each of us need the other to think about this together?*

THE ETHICS OF NAMING, DESCRIPTIVE ACCURACY, AND STIGMATIZATION

After the Ebola virus outbreak of December 2013, the World Health Organization issued new guidance in 2015 for naming infectious diseases due to stigma (Ebola River) and historical misnomers (Spanish flu originating elsewhere). The guidelines call for 1) generic descriptive terms, 2) specific plain nontechnical

terms, 3) pathogen names, 4) short & pronounceable, 5) consider acronyms if long, and 6) following the International Classification of Diseases (ICD). Excluded are locations; personal names; animal or food references (swine flu); cultural, population, industry, or occupation references; and terms inciting undue fear (WHO, 2015). Guidelines exclude *Chinese coronavirus*, *Hunan coronavirus*, and *CCP virus.*[2] *How does one discuss origins while avoiding stigmatizing the innocent?*

WHO'S HEALTH? WHOSE CONSEQUENCES?

As a starting point for reflection, the World Health Organization's definition of health, unchanged since 1946, is helpful:

> Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. (WHO, 1947)

The definition of health is comprehensive, unattainable, but understandable. It identifies multiple dimensions and determinants of well-being beyond "merely the absence of disease or infirmity."

A question for the pandemic is *which elements are promoted and which are demoted in response to COVID-19*. Medical professionals, infectious disease epidemiologists, and politicians concentrating on death by the virus may simply discount or not recognize secondary impacts on health and well-being, including additional deaths and suffering, from well-intended strategies.

COUNTING THE COST OF POLICIES IN THE CONTEXT OF COVID-19[3]

Public health is a coercive entity within the state, and this intends to be a benevolent coercion, promoting population health and well-being. *If viewed as the greatest good, if left unchecked, might not pursuing population health result in sacrificing the individual and related rights and goods? If losing sight of health beyond physiology, might policy generate injury in other dimensions (psychological, social, even spiritual)?*

Public Health Powers

Under the Constitution's 10th Amendment of the USA, responsibility for health, welfare, and morals belongs primarily to individual states (California, Kansas, Florida, …), not the national government. This includes public health. It explains why there are diverse approaches to the pandemic state-by-state - which looks chaotic from the outside (and sometimes from the inside) - despite a declared *national* emergency. State-level health powers were clarified by the US Supreme Court in *Jacobson vs. Massachusetts* (1905), affirming a unique vaccination requirement for smallpox. But later, Justice Oliver Wendell Holmes, Jr. cited this case in *Buck vs. Bell* (1927) to uphold Virginia's specific coercive eugenic sterilization law, while other states had other criteria or rejected it entirely.

A Key Question for a Community and Culture: How Are Complementary or Competing Goods and Rights Ordered in Ordinary and Extraordinary Times Such as a Pandemic?

A protracted emergency, such as a pandemic, clarifies this ordering. With social and economic restrictions, there is a collision between public health goals and freedoms common in free democracies: free exercise of religion, freedom of assembly, freedom of speech, freedom to contract labor, and to earn a livelihood, to name a few. *How do we choose which is given priority – or – what criteria are currently used with what data and what is being sacrificed?*

What Is the Nature of the Pathogen and Vulnerability?

With a new pathogen, much is unknown: rate of transmission (Ro), pathways of transmission (animal, human, insect, …), who is vulnerable, health impacts, rate of immunity built-in community, and resources

needed to care for the sick at peak infection rates. Early in a pandemic, *a maximal public health approach is understandable, but its validity may be temporary*.

It was clear early that COVID-19 vulnerability increases significantly for individuals with severe underlying medical conditions at any age, but especially with increasing age (60+). The graphed mortality curve is like a field hockey stick opposite age, not a U (most flu) or W (the 1918 flu pandemic that killed many between 18 and 40). Given COVID-19's mortality pattern, does a universal shutdown make sense? Good policy is based on the general trend rather than the exceptional tragedy (a young, healthy person dying).

Might country age structure (e.g., Italy) and household patterns are given culture or economics present different risk profiles and inform variation in prudent responses? (Colombia has more multigenerational households than the lonelier United States. Does that impact thinking about transmission risk?)

What Is the Goal of the Intervention?

In Minnesota, where I live, the governor declared a public health state of emergency. The two goals first articulated were 1) limiting illness and death by limiting transmission and 2) not overwhelming critical medical resources needed to treat the infected. The first goal leads to an economic shutdown of all but 'essential' services. The second led to state management of critical health supplies and companies' creative production of more face masks and ventilators (also justifying businesses staying open as essential).

For a time, the discussion turned to maintain the economic shutdown until there was a treatment or a vaccine - a very different goal with no end in sight - while economic desperation increased for many 'nonessential' workers.

People in Minnesota generally stayed at home except to buy food or walk the dog or run – that is until the police killing of George Floyd on 25 May 2020, at which point more urgent concerns than the pandemic filled the streets of Minneapolis, Saint Paul, and the world, increasing exposure to COVID-19, but likely also increasing herd immunity. *Even during a pandemic, what other social concerns may overturn immediate public health control and perhaps result in a more balanced recognition of burdens and response?*

Pathogen Morbidity and Mortality vs. Policy Morbidity and Mortality

At what point does policy generate more significant damage than the pathogen? Recall the WHO definition of health ("a state of complete physical, mental, and social well-being, and not merely the absence of disease and infirmity"): Closing schools and businesses, isolating human beings, even language chosen for noble ends have profound health implications beyond the infectious condition.

Ironically, medical staff have been let go due to elective procedures being cancelled, leading to greater morbidity downstream and at times greater near-term mortality. Epidemiologists and politicians, intent on controlling viral spread and hospital deaths, often discount and underestimate the dangerous side effects of policies. Several types arise:

- **The unforced policy error (100% preventable):** In the name of egalitarian 'non-discrimination' several US governors (New York, Michigan, …) signed executive orders requiring nursing homes without *any* COVID+ cases to accept still-contagious patients from hospitals: a vector directly into the most vulnerable populations. This led, not surprisingly, to many 'excess deaths' (Lahut, 2020). The rational solution would be a transitional facility dedicated to recovery.
- **The false dichotomy. Lives vs. livelihoods.** In poor moments of public debate, a false choice has been presented between lives and livelihoods. Critics accuse advocates of opening up the economy and society to prioritize money over lives. Countries have pursued various models with varying degrees of social and economic disruption. Sweden has had perhaps the most open society and economy, with moderately higher mortality rates but less economic disruption (Our World in Data, 2020). Actual irreversible costs mediated through high unemployment include increased suicides. Calls to a federal mental health crisis line in the USA increased 1000% (10x) in April 2020. In the "great recession" of 2007-2009, for every 1% increase in

unemployment, the rate of suicide increased by 1.6% extending impacts beyond the immediate worker (May 2020).

- **The poor suffer more.** This is true in countries rich or poor. On the one hand, susceptibility to infection is patterned on underlying conditions, and such conditions are more prevalent among poorer people due to multiple pathways. This may also be stacked with other factors of marginalization. The professional class can often (though not always) work via computer or at a distance. Per the World Food Program, an additional 130,000,000 million people could be pushed to the brink of starvation by the end of 2020 (Beasley, 2020). For perspective, through June 13, 2020, reported total COVID-19 deaths *worldwide* at 425,931 (European Centre for Disease Prevention and Control, 2020). Starvation risk is thus stated by the WFP to be 32 times the current COVID-19 mortality to date.

  Against the imposed deprivations of forced unemployment, many workers, deemed nonessential, express exasperation and desperation: 'Feeding my children is an essential service.' Some resort to crime, lacking other resources. *Why are suicides or death by starvation of less import in policy discussions than infectious disease deaths?*
- **Opioid behavioral epidemic: COVID19 vs. Overdose Deaths.** For many who are sober or struggling against addiction, meeting places for daily support and accountability were labeled 'nonessential' services. Meetings on Zoom or phone require internet access. Many very poor or homeless rely on computers in the public library: the libraries are closed. Cook County, the home of Chicago, Illinois, has seen a doubling of opioid deaths through May (924 compared to 461 last year): "If you're alone, there's nobody to give you the Narcan," said one coroner (Sanchez & Eldaib, 2020). Cook County COVID-19 deaths through 7 June numbered 4005 (Sun Times Media Wire, 2020).
- **Social well-being: Social distancing vs. Physical distancing.** Language carries technical and popular meanings. The US Centers for Disease Control adopted the term "social distancing" instead of "physical distancing" as its primary technical term (CDC, 2020) (as have other countries such as Colombia). By 8 June 2020, for each use of "physical distancing" on the internet, there were 76 uses of "social distancing" – over a billion and a half times.[4] The appeal to social distance has led to unnecessary isolation, then pleas to stay socially connected. 'Social distancing' can lead to social isolation in an atomized society but may be less of an issue in contexts with integral multigenerational families.

For Ethics and Life Together

How should we weigh the costs and benefits of interventions in the present pandemic? Why not give equal weight to each death, to each person's suffering, whether from a pathogen (infection) or from policy? Might giving equal weight more effectively consider the multiple dimensions of health and well-being as reflected in the WHO definition of health help us choose more prudent courses of action and perhaps better embody the spiritual call to bear one another's burdens?

ACKNOWLEDGEMENT

This was originally published in Spanish as: Allison, Kirk C. (2020). Cada uno cuenta: Patógenos y políticas en la pandemia de COVID-19. In X. Castro Sardi; D. Cagüeñas Rozo; D.P. Quintero Mosquera; J.J. Fernández Dusso; R. Silva Vega (comps.), Ensayos sobre la pandemia (pp. 259-268). Cali: Editorial Universidad Icesi. DOI: https://doi.org/10.18046/EUI/vc.4.2020.

ENDNOTES

1. Consideration of the political context and transition of COVID-19 from the Middle Kingdom into the world is a separate reflection.
2. CCP = Chinese Communist Party, which has been responsible for more deaths in China in a shorter amount of time than any virus.
3. In part developed in Tilburt, J & Allison, K (6 April 2020) "Pandemic ethics and Christian ethics," Anselm House, Saint Paul, MN. https://www.youtube.com/watch?v=5vy0RkXouks.
4. Per Google "social distancing" appeared on Internet "about 1,570,000,000" times compared to "about 20,600,000" times for "physical distancing". Google search by author on 8 June 2020.

REFERENCES

Beasley, D. (2020, April 21). *WFP Chief warns of hunger pandemic as COVID19 spreads (Statement to UN Security Council)*. World Food Program. Retrieved from https://bit.ly/2YDGr58

Centers for Disease Control. (2020, April 4). *Social distancing*. Retrieved from https://bit.ly/30jDwRh

European Centre for Disease Prevention and Control. (2020, June 13). *COVID-19 situation update worldwide, as of 13 June 2020*. Retrieved from https://bit.ly/2C5qxc0

Lahut, J. (2020, May 22). NY Gov. Cuomo reportedly ordered over 4,300 recovering COVID19 patients to be sent to nursing homes. *Business Insider*. Retrieved form https://bit.ly/30BhHNr

Mathieu, E. (2020, March 5). *Coronavirus Pandemic (COVID-19)*. Our World in Data. Retrieved from https://bit.ly/30DQsSg

May, W. (2020, May 4). The coronavirus pandemic is pushing America into a mental health crisis. *Washington Post*. Retrieved from https://wapo.st/3fpPVrp

Sanchez, M., & Eldaib, D. (2020, May 30). Overdose deaths have skyrocketed in Chicago, and the coronavirus pandemic may be making it worse. *Pro Publica*. Retrieved from https://bit.ly/2UXD2gv

Sun Times Media Wire. (2020, June 7). Coronavirus Illinois: Cook County passes 4,000 COVID-19 deaths, medical examiner says. abc7 Eyewitness News. Retrieved from https://abc7.ws/2N1ItWZ

WHO. (1947). *Official Records of WHO*, 2, p.100. retrieved from https://apps.who.int/iris/bitstream/handle/10665/85573/Official_record2_eng.pdf

WHO. (2015). *World Health Organization Best Practices for Naming of New Human Infectious Diseases*. Retrieved from https://bit.ly/2MXj0hG