Covid-19: Not A Surprise, So Why Did We Act Like It?

The start of the new decade withered under the emergence of Covid-19. A new viral respiratory syndrome that originated in Wuhan, China. The disease is the third coronavirus that has appeared in the millennium. Its preceded by outbreaks of Severe Acute Respiratory Syndrome (SARS) from 2002-2004 and Middle East Respiratory Syndrome (MERS) in 2012. The appearance of another viral disease that could inflict global harm was actually not surprising. As humans become further integrated in a globalized world with each other, and the environment (including wild animals) there was bound to an emerging disease. However, even with the knowledge that a deadly pandemic may arise—and as it did, the U.S. government's response and in turn its public health community's response was woefully inadequate. Subsequently, unnecessary and horrible deaths were inflicted on the American public as U.S. leaders failed to coordinate an effective response to the pandemic. This includes actively contradicting and even working against public health leaders that attempted to guide the U.S. public to safe actions in response to the Pandemic. Instead, a fragmented response occurred between all levels of U.S. government and sectors. In comparison several countries—although different demographically, like New Zealand, took aggressive measures that in the end have preserved the New Zealand population from undue health burden. The early policy actions of the New Zealand government included: early and aggressive social distancing restrictions, wage supplementation, and transparent and coordinated government communication. All moves that the U.S. should have emulated or led in as the sickness emerged.

What Is Covid-19? And How Does It Differ From SARS-CoV-1 and Influenza

SARS-CoV-2 that caused the outbreak of Covid-19 is genetically similar to SARS-CoV-1 which is another respiratory tract infection. The similarities don't end there with these coronaviruses;

SARS-CoV-1 was first identified in February 2003 in China, Covid-19 also emerged in China first, and were likely both spread from animal hosts (most likely bats) (Caladaria, Conforit, DiMeo, et al., 2020). Both viruses are airborne viruses and can be spread through small droplets of saliva—similar to influenza (WHO.int, 2021). Coronaviruses such as SARS-CoV-1 and -2 are difficult to identify because they are so similar in terms of symptomology as compared to influenza. These symptoms can include headache, feelings of discomfort, aches and chills, sore throat, cough, pneumonia, difficulty breathing, hypoxia and in small cases diarrhea (CDC.gov, 2021). However, Covid-19 succeeds SARS-CoV-1 in that people may remain asymptomatic for two day or even up to two weeks. In severe juxtaposition, the Center for Disease Control and Prevention reports that, "no cases of SARS have been reported among persons who were exposed to a SARS patient before the onset of the patient's symptoms" (2004).

A comparison of these coronaviruses would be remiss without noting the fatality rate and what demographics are impacted by the subsequent diseases. The outbreak of SARS from 2002 to mid-2003 killed far less people than Covid-19 has the past year and a half. SARS had around 8,000 cases and 774 deaths globally (CDC.gov, 2004) As compared to 121 million cases and 2.68 million deaths (nytimes.com, 2021). In terms of necessity for persons to be hospitalized, and mortality rate, the viruses are pretty similar. An estimated 20 percent of with Covid-19 will be hospitalized for treatment (WHO.int, 2020). Whereas SARS 20-30% of patients had to be put on mechanical ventilation (Fauci, Marston, Paules; 2020). The mortality rate of both viruses is similar. Covid-19 mortality rate—depending on country can waver between 1-9% (coronavirus.jhu.edu, 2021). Whereas the Mortality rate of SARS was 10% (Fauci, Marston, Paules; 2020). What doesn't differ however, is that both viruses are most severe for people aged

60 and older, as well as people with underlying medical problems like high blood pressure, heart and lung problems, diabetes, obesity, or cancer (WHO.int, 2020).

As discussed before, influenza and coronaviruses are difficult to diagnose apart from each other. Similar symptomology might have been a part of early public rhetoric that claimed that Covid-19 was "just another flu" thereby contributing to some country's reluctance to address the emerging disease in the early days of the pandemic. However, Covid-19 and SARS differ quiet considerably from the flu and influenza viruses. Covid-19, in comparison to the flu spreads more easily, and it causes more serious illnesses in some people. And, as I have discussed before, it can take longer for people to show symptoms and people can be contagious for longer (CDC.gov, 2021). As the pandemic goes on, the data over post-sickness is more severe than survivors of the flu. Covid-19 survivors have reported lingering symptoms such as weakness, shortness of breath, trouble focusing, and in some cases, kidney and heart problems (jhsph.edu, 2020). Another significant difference is that influenza (flu) viruses occur every year and are responsible for flu epidemics every year. Because the flu season is just that—an annual season, epidemiologists are well versed in understanding how viruses work. Particularly in the knowledge that influenza viruses make only small shifts from one season to another ("antigenic drifts"). Because these changes are so small and closely related to one another, experts are able to more succinctly predict what flu vaccines will be most effective in the upcoming year (CDC.gov, 2019). Such a deadly virus such as Covid-19 is so deadly precisely because it does not belong to the same virus family as "the flu," therefore it emerged as a new sickness. A sickness that in its most recent likeness hadn't been seen since almost two decades prior.

The Global Response: Special Focus on the U.S. and New Zealand

Global Response and The International Health Regulations

The International Health Regulations (IHR), most recently revised in 2005, developed by the World Health Organization (WHO) is an internationally agreed-upon set of regulations. The purpose of these regulations is to ensure public health events in any of these states are reported to the WHO for assessment. The results of said assessment then aims to then create some sort of prevention and mitigation, detection and containment of the health risk in order the health risk not to spread. Notification of such health events are broadly defined as,

> …all "events that may constitute a public health emergency of international concern". In this regard, the broad new definitions of "event", "disease" and "public health risk" in the IHR are the building blocks of the surveillance obligations for States Parties and WHO. "Disease" means "an illness or medical condition, irrespective of origin or source, that presents or could present significant harm to humans". The term "event" is broadly defined as "a manifestation of disease or an occurrence that creates a potential for disease". "Public health risk" refers to "a likelihood of an event that may affect adversely the health of human populations, with an emphasis on one which may spread internationally or may present a serious and direct danger". A public health emergency of international concern (PHEIC) is defined as "an extraordinary event which is determined to constitute a public health risk to other States through the international spread of disease and to potentially require a coordinated international response" (WHO.int, 2014).

Drawing upon these definitions, China (the state where Covid-19) did notify the WHO and the WHO acted accordingly in releasing information to inquiring states and continually investigated the emerging sickness cases. However, there is significant evidence that China put off sharing information on the emerging coronavirus. The Associated Press reported that while the WHO praised China was its apparent transparency and immediacy in reporting on the burgeoning (what was then) “pneumonia cases,” in all actuality, “China in fact sat on releasing the genetic map, or genome, of the virus for more than a week after three different government labs had fully decoded the information… China stalled for at least two weeks more on providing WHO with detailed data on patients and cases” (apnews.com, 2020). Undoubtedly, this stalling of overturning information goes against the WHO regulations set forth. Particularly because these

regulations call for supreme immediacy in overturning information on part of the reporting states. However, it's notable that several states exceeded WHO guidelines in response to the rapidly advancing sickness. From January 2020 into the end of April 2020 the WHO meeting under the IHR (2005) did not recommend and travel or trade restrictions against China or anywhere else. It wasn't until the end of April that they recommended, "appropriate travel measures" and states should "review travel and trade measures based on regular risk assessments, transmission patterns at origin and destination, cost-benefit analysis, evolution of the pandemic, and new knowledge of Covid-19" (Tigerstrom, Wilson; 2020). Against these recommendations most countries—whether member states or not, implemented "some type of mandatory restrictions on international travel" as well as some restrictions against China in January. These restrictions were in line with potentially mitigating the threat a public health event. However, the restrictions may have gone against regulations by not reporting the denial of an entry or exit into states for more than 24 hours. The significance of lack of reporting from states to the WHO of course undercuts states' sworn obligation to transparency and reporting. Which in turn undermines the WHO's power, subsequently weakening the efficacy of international cooperation (Tigerstrom, Wilson; 2020).

The U.S.: What Not to Do

It is fair to critique that in the previous section I may have lauded the states' general action to take early travel restrictions as more effective than they really were. This is particularly true as we discuss the U.S.' early actions in response to Covid-19. The first U.S. travel ban occurred on February 2nd, and only barred foreign nationals who had visited China in the last 14 days. Then it wasn't until February 28th that Trump expanded travel restrictions to Iran, then to European countries on March 12th. Although, by that time it was a little too late—on March 17th the official

U.S. death toll surpassed 100 and was quickly approaching 2,000 confirmed cases (washingtonpost.com, 2020, 2021). The situation only worsened as the federal government and Trump clashed over recommendations for the public. Most Americans by April 2nd were living under state-mandated stay-at-home orders. And in a reversal the federal government recommended that people wear mask in public, while President Trump said that, "I don't think I'm going to be doing it." Underscoring the lack of Federal response to shut-down public life, comes on April 11th with the U.S.' coronavirus death toll surpassing Italy as the highest in the world. What followed was a series of chaotic events in part due to the lack of a strong and coherent federal response. And, because of the rhetoric of Trump and his unwillingness to support state guidelines that seeked to limit the spread of Covid-19. Across the country people protested state-mandated shutdowns and social distancing orders. A flashpoint for this increasingly violent rhetoric occurred at the Michigan State Capitol when protesters stormed its steps after Governor Whitmer instituted shutdown and social distancing orders (washingtonpost.com, 2021).

The U.S.' response to the pandemic only exacerbated the social, political and economic sectors of American life. In horrifying numbers, the pandemic has exposed the shameful social and economic inequalities of the U.S. And, in consequence to U.S. leaders' divided response to pandemic measures, issues surrounding the pandemic were politicized—thereby further polarizing the country. The social inequalities that Covid-19 has burdened the U.S. with have only illuminated and widened the inequalities that already existed for ethnic minority groups and for women. The CDC, in a recent report summarizes these increased risks as: discrimination, healthcare access and utilization, occupation, educational, income, and wealth gaps, and housing.

> Discrimination: Unfortunately, discrimination exists in systems meant to protect well-being or health…Occupation: People from some racial and ethnic minority groups are disproportionately represented in essential work settings such as healthcare facilities, farms, factories, grocery stores, and public transportation…Educational, income, and wealth gaps: Inequities in access to high-quality education for some racial and ethnic minority groups can lead to lower high school completion rates and barriers to college entrance…Housing: Some people from racial and ethnic minority groups live in crowded conditions that make it more challenging to follow prevention strategies. In some cultures, it is common for family members of many generations to live in one household…(2021)

In addition, to these factors, minorities suffer from higher rates of some medical conditions—including chronic conditions that put them more at risk for contracting Covid-19. And, without government assistant such as income assistant (like stimulus checks), or without federally implemented or regulated shutdown orders people must make the decision to either lose wages or risk their lives. For women, unless they're minorities they are not exactly at more risk to contract Covid-19—in all actuality men are more vulnerable to contract Covid-19 (Bwire, 2020), but they are bearing more of the domestic burden of Covid-19. That is, women are more likely—if they weren't already, to have to take care of the children and do more domestic chores due to Covid-19 closures. Before the pandemic, women were doing about three quarters of the 16 billion hours of unpaid work done each day globally (bbc.com, 2020). This number invariably has increased as women have had to drop out of the work force. Just in the U.S. for example, in September 2020 alone, 865,000 women, compared to 200,000 men were pushed out of the work force.

Another significant factor in the U.S. response to the pandemic, on an individual level is due to the partisan media coverage of the pandemic. One study by the Brookings Institute claims that state responses to the pandemic were largely based on partisan politics. The study also discusses how news programs impacted—or are at least highly related to individual behavior in response to the pandemic. For example,

> When the pandemic started, two of the most popular news programs—both on Fox—covered it very differently. Tucker Carlson emphasized the disease's severity while Sean Hannity downplayed it…In survey data, they find that Hannity's viewers waited longer before significantly changing their behavior compared to Carlson viewers, who were otherwise demographically similar. More Hannity viewers predicted more infections at the county level. The "Hannity Effect" illustrates a much larger pattern: Access to information is heavily distorted by our media diet, and that has real consequences for attitudes and behavior (2020).

The mixture of deep social, economic, and medical inequalities as well as divisive partisan politics quickly overcame the U.S.' medical defenses. The inadequacy of the U.S. response has led the country to outrank other nations in case count and deaths considerably. At the time of this paper being written the U.S. had garnered just under 30,000,000 cases and almost 600,000 deaths (CNN.com, 2021).

New Zealand: The Model for Pandemic Response?

As of March 2021, the World Health Organization reported that from January 3rd 2020 to the 10th of March 10th, 2021, New Zealand only had around 2,000 cases and 26 deaths due to Covid-19. Of course, New Zealand's population is considerably smaller than the U.S, which some critics may seem made it easier for New Zealand to institute measures. That claim is tenuous however, as we consider the policies and leadership that the U.S. could have emulated as a developed state with equal (if not more) resources than New Zealand.

New Zealand's response is exceptionally striking juxtaposed to the U.S. in the aggressive measures it took early on (and is still taking) in order to eliminate the virus. On February 2nd, a man in the Philippines became the first person outside of China to die of Covid-19. While New Zealand had not reported a single case, nevertheless they began banning entry to any foreigner coming from or through China—any New Zealander returning from China would isolate for 14

days. The U.S. on the same day only prohibited the entry of foreign nationals—not so different from New Zealand, how the U.S. had already recorded local transmissions. Thereby making the U.S.' actions far from the necessary restrictions U.S. leaders should have made at that point. By late March, New Zealand had introduced a four-stage alert system to notify the public on necessary social distancing measures. Once it reached level four, the nation went into full lockdown (BBC.com, 2020). By the end of March 2020, the U.S. had recorded it's 1,000th official coronavirus death. Only three days earlier Trump announces that he's considering eliminating social distancing guidelines all together (washingtonpost.com, 2021). By mid-May, the New Zealand government announces that they eliminated community spread of the virus, reopening the country on June 9th.

This quick eradication of the spread was undoubtedly due the New Zealand governments strong "all-of-government" approach. That is, the nation's Ministry of Health, and all government ministries and agencies coordinated in response. They coordinated in government rhetoric and address to the public, in economic subsidies, business closures, trade, foreign relations, disease treatment, etc. Admittedly, New Zealand's aggression did come with a cost; due to "shutting down" New Zealand's economy and the global economic slowdown, its economy suffered. In the second quarter of 2020 its GDP declined by 12.2 percent and New Zealand is slouching through its first recession since 2008. That being said, the U.S. economy is objectively stronger due to its diversity and overall breadth. Meaning, if the U.S. had employed economic measures as quickly as New Zealand (was subsidy, eased loan terms business development services, infrastructure investments support for workers), so people could safely make the choice to social distance, lives would have been saved (brookings.edu, 2021). Still New Zealand's aggressive

measures have prevented undue social and medical burden on New Zealanders—thus preventing untold loss of life.

What Could We Have Done Better? (If It Isn't Obvious)

Following the previous discussion's appraisal of the New Zealand response to Covid-19, I'll once again affirm that the policy response of that government was strikingly superior to the U.S.' Quite honestly it's difficult to overstate how dangerous and inept the U.S.' Covid-19 response has been for the majority of the pandemic. Perhaps one could argue that a lack of unified government response let more "freedom" for local state leaders to decide what particular measures best fit their states. However, needed measures actually didn't need be differentiated, and because they were unnecessary lives were lost, as well as the burden to society only increased. Starting with the Biden Administration though, U.S. has turned a corner in terms of aggressive action to combat the pandemic. The administration has pushed through a more thorough economic stimulus package as well as more aggressive testing, and generally more transparent communication with the public over measures, including vaccination (joebiden.com, 2021).

Led by the Trump Administration, the U.S.' Covid-19 response could have been unduly more effective. The Administration could have started with restricting travel in mid to late February. This would have decreased the number of foreign nationals and domestic travels come from and via China by a significant amount. Next, the administration should have coordinated all government sectors—health, trade, economy, federal, state, local etc. to transparently communicate and enforce social distancing guidelines. Similar to New Zealand, the U.S. should have also instituted a system that communicated the severity of the pandemic at any given time.

This would have also helped eliminate the contradictory rhetoric between the Trump Administration, health officials and state officials. The current response by the U.S. government, while attempting to be effective with reliably transparent communication and recommendations, they cannot be fully. Pandora's Box has been opened, so to speak, in terms of states opting to follow Covid-19 restrictions. As the vaccine rollout started, Republican-led states such as Texas started announcing that they would nix virus restrictions. Texas governor Greg Abbott's decision to do so then led other Republican states like Mississippi and South Carolina to do the same thing (nytimes.com, 2021). Lastly, the Biden Administration has recently announced that they plan on having enough vaccine to inoculate ever U.S, adult by the end of May (cnbc.com, 2021), hopefully, distribution will outpace lax measures.

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