RESPONDING TO THE COVID-19 PANDEMIC IN EUROPE: TOWARDS STRONGER POLICY THAT INCORPORATES THE IMPACT OF SOCIAL DISPARITIES

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Summary: The impact of the COVID-19 pandemic on countries in the European Region has been devastating with substantial morbidity and mortality and broader societal and economic effects. This in part reflects poor public health leadership and politicised responses but more importantly, a failure to account for social disparities. The stop-start pattern of Public Health and Social Measures further exacerbates the disproportionate impact on those most vulnerable. A Health in All Policies lens offers an indication of the type of coherent multisectoral thinking needed to address these social disparities in the COVID-19 context as well as in pandemic planning measures going forwards.

Keywords: Pandemic Preparedness, Governance, Health Inequalities, COVID-19

Introduction

Hindsight suggests that no country in the world was adequately prepared for a pandemic on the scale of COVID-19. Yet, at a press conference in late February 2020, the then President of the United States (US) touted America’s readiness, brandishing a 300-page report which he said proved it. The 2019 ‘Global Health Security Index’ (GHSI) was the first comprehensive assessment and benchmarking of health security and related capabilities across the 195 countries that are States Parties to the International Health Regulations (IHR [2005]). It ranked the US first. What the President did not mention, however, were the US flaws identified in the report – such as low hospital beds per capita and poor access to health care, which have proven especially damaging in the current pandemic – nor its overall finding that “No country is fully prepared for epidemics or pandemics. Collectively, international preparedness is weak”.

Turning to Europe, while the GHSI covered more than pandemic preparedness, it suggested that the United Kingdom (UK) (ranked second) was better prepared than Germany (ranked fourteenth); while Sweden placed seventh and Spain fifteenth. The GHSI report is based on data that a country has published itself or which it had reported to an international entity, such as the World
Health Organization (WHO) – and the UK (not to mention the US) had a well-formulated pandemic preparedness plan before COVID-19. But what we know now about the pandemic in these countries suggests that the GHSI ranking was not an accurate predictor of response success. The UK has the third most deaths per million population in the WHO European Region and, at the time of writing, the highest number of new weekly cases per million. Spain suffered heavily during the first wave in particular, and has seen some of the most stringent application of Public Health and Social Measures (PHSM) globally. Germany has, by many accounts, handled things fairly well, while Sweden has been an outlier in allowing the virus to circulate without the widespread application of restrictions, and has suffered higher death rates than its Scandinavian neighbours.

In view of the above, it can be asked why there has been so little correlation between the assessment of countries' readiness plans and actual outcomes? And given the harsh and inequitable impact of COVID-19 on those most vulnerable, have decision-makers pursued appropriate response strategies? The second question is the focus of this article. Without reviewing each country's pandemic plan and response, we provide a high-level discussion of the types of strategy adopted across the European Region and the leadership priorities behind them. We then apply a Health in All Policies (HiAP) lens, arguing that a failure to recognise and act on social disparities pre-COVID-19, as well as during the course of the pandemic itself, has worsened both the health and social impacts. By way of conclusion, we suggest that building an understanding of social disparities into future pandemic preparedness plans – and ongoing COVID-19 responses towards ‘building back fairer’ – is a must.

**Strategies to prevent pathogen spread**

Across Europe, countries have pursued different strategies for tackling the pandemic. As the pandemic unfolded and more clarity emerged around the epidemiological characteristics of SARS-CoV-2, the virus that causes COVID-19 disease, strategies were necessarily adjusted. But they were adjusted not only to stop the spread of the virus. The wider impacts of the pandemic on society, and particularly the economy, were necessarily also taken into account. Despite differences in approach and the communication and messaging about this not having always been clear, most countries in Europe have sought to achieve a balance between the two.

In respect of COVID-19, response strategies have translated into discussions about eradication, elimination, suppression and mitigation. Eradication involves eliminating occurrence of the disease (which may or may not mean extinction of the pathogen even in a laboratory setting). Elimination focuses on eliminating occurrence of the disease in a given geographical area. Suppression, by contrast, is a ‘control’ approach. It is aimed at reducing mortality and morbidity through interventions that are acceptable to the public, but without looking to stop community transmission completely. Finally, mitigation, also a control mechanism, is primarily concerned with protecting the health system rather than preventing transmission. The latter two often go together as “the response is typically to increase stringency as the pandemic progresses and for more disruptive interventions, such as school closures, to be held in reserve to flatten the peak”.

Given that COVID-19 is also caused by a coronavirus, much comparison has been made with countries’ responses to the 2002–04 Severe Acute Respiratory Syndrome (SARS) outbreak which ultimately resulted in the eradication of the disease. But SARS was eradicated because countries focused on breaking the chains of human-to-human transmission from the outset, which involved following a clear set of measures: a stated commitment to eradication; robust syndromic surveillance; enforced isolation (of patients) and quarantine (of contacts) policies, including at community-level in some cases; and all supported by clear communication and messaging to the public. COVID-19 did not see the same level of initial commitment to tackle the virus, at least not in Europe, and many would argue still not. Despite warnings from the scientific and public health community, many policymakers seemed unwilling to countenance an epidemic in Europe; many felt they were in any event prepared – recall the earlier-mentioned GHSI report – and, after all, SARS itself had been eradicated. Additionally, there was still much we were not aware of regarding both the SARS-CoV-2 virus itself and COVID-19 disease, with some continuing to compare it with the flu.

The result was that as early as March 2020, less than two months after WHO declared a Public Health Emergency of International Concern (its highest warning-level), scientists were suggesting that COVID-19 was already past the possibility of eradication. This on account of the high transmissibility of the virus, the fact that mild infection meant that cases would be missed (we have subsequently understood that asymptomatic transmission occurs as well), and an overall slow global response.

Europe's focus on mitigation and suppression ahead of elimination

Responses in the European Region focused initially on mitigation i.e., ‘flattening the curve’ to prevent hospitals from being overwhelmed, rather than breaking the chains of transmission. On the one hand this is understandable as hospitals were quickly filling up with COVID-19 patients. On the other, there were early projections suggesting that “even optimal mitigative strategies would lead to substantial excess mortality and exceedance of health care capacity.” Yet, tackling clusters and treating COVID-19...
patients remained the initial priorities. But this was often undertaken at the local level, sometimes resulting in the diversion of key health resources away from one part of the country in favour of another, thereby raising the risk of continued transmission and undermining the overall response. By contrast, in other regions of the world where countries adopted both mitigation and suppression measures simultaneously from the start, while case numbers have risen overall, they have been more gradual and controlled.

With the development of highly-effective vaccines, most European countries have since moved towards suppression, with Sweden an outlier (see Box 1). This involves all the control measures that public health experts have been advocating throughout the pandemic, and which have now become part of the common lexicon i.e., (rapid) identification and isolation of infected persons; effective contact-tracing, testing and quarantine of individuals following contact with a potential case; and the application of PHSM such as: physical distancing requirements, the banning of mass gatherings involving a defined number of individuals, and imposition of wider societal lockdowns as appropriate. The use of non-pharmaceutical interventions at the personal level e.g., hand-hygiene, minimising personal contacts, and use of facemasks are also fundamental. The application of travel restrictions to prevent the importation of cases is associated primarily with elimination but can be central to suppression as well. And the degree of strictness around the application of these measures, in particular their scope and duration (including border controls), is what differentiates suppression from eradication.

A pattern of stop-start measures and a disproportionate impact on those most vulnerable

In focusing on mitigation and suppression because of concerns about the wider societal and economic impacts of an elimination approach, the result in much of the European Region has been the ‘stop-start’ application of PHSM mandates. While comparing across countries and regions is fraught, evidence suggests that this stop-start pattern has resulted in higher levels of morbidity and mortality in Europe versus those countries in other regions, such as Australia, Japan, Republic of Korea and New Zealand, which implemented an elimination strategy from the get-go.

Box 1: The Swedish ‘outlier’ case

Sweden has been something of an outlier in its response. By shunning restrictive measures and issuing voluntary recommendations to its population, the policy of allowing the virus to circulate was viewed as an attempt to achieve ‘herd immunity’ by infection.

While Sweden has not altered course towards suppression as is the case in other countries, the authorities have at times been forced to impose certain restrictions, especially in cities when case numbers were putting a strain on the health system.

There have been a high number of deaths, in particular of older persons, and while some of these excess deaths were amongst individuals who were at risk of death anyway (the so-called ‘dry tinder effect’), this appears marginal. At the same time, Sweden’s economy has not suffered to the same degree as its neighbours.

It is noteworthy that, in comparison to many other countries, the national public health agency (Folkhälsomyndigheten) has been very much central in the response.

We see that stop-start measures have had further deleterious impacts, and again with an inequitable impact. Evidence suggests that they are harmful for economic growth in the longer-term. According to one study of OECD countries, “GDP growth returned to pre-pandemic levels in early 2021 in the five countries that opted for elimination, whereas growth is still negative for the other 32”. From Europe, only Iceland features in the top five. The same is true at the micro-level as companies seek to develop a buffer in anticipation of the next lockdown rather than investing for the future; this is also in respect of turning to short-term staff rather than investing in longer-term skills and training. As many who are already socially-disadvantaged are dependent on lower-wage jobs, often in the informal sector, or are self-employed without social safety net support, government policy responses to the pandemic have exacerbated their vulnerability and widened inequalities; pushing them...
further into precarity and worsening the pandemic’s impact overall. This underscores the false dichotomy between health and the economy. For we have known for decades that investing in health, which in turn demands action on health inequalities and inequities, is investing in economic development both at an individual and societal level; yet this appears not to have been part of the COVID-19 response thinking in most countries.

In view of suppression and mitigation having so far not allowed us to get a real grasp on the virus – in turn potentially undermining the effectiveness of existing vaccines vis-à-vis the emergence of variants such as B.1.1.7 (Alpha) and B.1.617.2 (Delta) which are more transmissible than the original strain and affect younger age-groups – nor escaping the stop-start pattern, calls have grown for a so-called ‘Zero-Covid’ strategy across Europe. Proponents contend that countries have to abandon suppression and push for elimination, at least until populations have been fully vaccinated. And while a ‘Zero-Covid’ strategy is not feasible for all countries in the European Region, not least on account of shared borders, it is argued that pursuit of the goal is more important than actually achieving it – the gains to be made in controlling the virus and breaking transmission are more substantial than continuing with current stop-start PHSM and suppression efforts. Additional evidence from OECD countries suggests that those which pursued swift lockdown measures as part of a clear elimination approach in fact saw lockdowns that were less strict and of shorter duration. Going in the opposite direction now, the UK appears to be eschewing suppression in a similar vein to the Swedish approach despite very different case numbers, leading to some accusations of the government “embarking on a dangerous and unethical experiment”. Box 2 also notes ‘exclusion’ as falling under a ‘Zero-Covid’ / elimination strategy.

With SARS-CoV-2 so transmissible and so much unknown at the outset of the pandemic, it remains unclear from a public health perspective as to why suppression rather than elimination was initially seen as the way forward in Europe, and especially in view of the more decisive action taken in countries in South East Asia. Moreover, with each ‘wave’ revealing the need to focus first on breaking the chains of transmission to the extent possible before resuming social and economic activities, it seems baffling that decision-makers did not learn. Despite continued warnings from the public health community on the need to stop transmission and develop an integrated health promotion approach, this reflects a reactionary health protection approach to the pandemic, and an overarching concern with the economic and societal impacts. As the stop-start suppression pattern has been especially harmful to those most vulnerable, this raises questions about a lack of foresight, learning and health leadership (see Nathan et al. in this issue).

Box 2: An ‘exclusion’ strategy

Some Pacific Island and Caribbean countries and territories, which are especially vulnerable to COVID-19 on account of population health characteristics and fragile single-sector economies, have been able to pursue a so-called ‘exclusion’ strategy. That is ensuring, by way of suspending all incoming travel, that the virus would not re-enter the country.

In the European Region, a number of smaller Greek islands have been able to do this. But on account of economies that are almost wholly dependent on tourism, they are now touting their COVID-free status and in some cases fully vaccinated local populations in order to attract visitors.

The Faroe Islands first declared COVID-19-free status on 26 February 2021 (following detection of the first cases in July 2020). This lapsed on 13 April 2021 and, since then, they have declared COVID-19-free status on three further occasions only for this to not hold. Each time new cases were detected they were traced to arrivals either by air or sea. The same can be observed for example in New Zealand where the initial elimination strategy was followed by exclusion, but with cases flaring up once border controls were eased.

Adapting responses to account for social disparities in the context of COVID-19

We understood early on that severity of COVID-19 disease was correlated with age and a number of underlying health conditions resulting in higher death-rates. We saw outbreaks and widespread deaths in long-term care facilities across the European Region; which remains a major stain on our collective conscience. Also, we have subsequently seen the significant role played by social and economic determinants in exacerbating the effects of the pandemic in those already disadvantaged and vulnerable.

But did we really need to wait for such tragic real-world results from COVID-19 to understand the importance of social disparities? Whether it was the Spanish Flu of 1918–20 when the poor, the unemployed, and those living in cramped accommodation in poorer parts of cities were most affected, or the West African Ebola outbreak of 2014–16 when socio-economic factors were shown to be a driver of the disease, we know that susceptibility to disease outbreaks can be significantly reduced by addressing the social determinants of health. Already in 1996 Paul Farmer showed the link between social inequalities and infectious diseases specifically. And we also see this in practice every year with seasonal influenza; yet public health experts continue to lament the lack of explicit recognition of social disparities in influenza preparedness plans. In this regard, the COVID-19 pandemic has amplified the need to take action on the social and economic determinants of health. The response across Europe has in the main been reactionary – hence stop-start – when it needed to reflect a concerted and multisector health protection and promotion approach.
In asking to what extent governments have adjusted their responses accordingly, one lens we can turn to is HiAP. HiAP is an approach which focuses on health equity and demands concerted multisectoral actions to ensure that all public policies are geared towards protecting and promoting health (see Box 3). It applies not just in terms of routine policy, but clearly has relevance to pandemic planning and response as well.

We are not proposing HiAP as the answer, but the application of a HiAP lens to Europe’s overall COVID-19 response reveals that this dual health promotion and protection role does not appear a discernible feature of most countries’ responses, neither initially nor later. This is reflected in how European countries prioritised hospital-based care over the continuity of essential services as part of initial response measures. Noncommunicable diseases (NCDs) provide a case-in-point. A rapid review of the impact of COVID-19 on the provision of NCD services showed many national health departments and agencies having postponed their NCD health improvement services, focusing instead on health protection. As the pandemic has evolved and NCD patients continue to struggle, this has led some to refer to a syndemic, and even to suggestions that COVID-19 is not the real pandemic. Focusing on protection is perhaps understandable early in the pandemic, but as it has to go hand-in-hand with promotion, responses ought to have been adjusted accordingly.

Moreover, stop-start by its nature reflects a lack of the joined-up multisectoral thinking central to HiAP.

Examples of health promotion and multisectoral actions in response to COVID-19 can be found at local level. Towns and cities across Europe are developing (post-) COVID-19 recovery strategies that seek to link policy action in areas such as housing, ‘green’ policies, healthy environments and transport. In many cases these have been achieved despite a lack of support from national governments.

Overall, therefore, the focus on suppression (and mitigation) across Europe, and the resulting stop-start pattern of PHSM application we have highlighted, suggest that decision-makers have not sufficiently adapted their COVID-19 responses to reflect the inherent social disparity issues which are driving the worst impacts of the pandemic. If a pandemic preparedness plan is to ensure protection of those most vulnerable, in both health and non-health terms, then addressing the root causes from the outset must be a given. Moreover, a coherent response demands every part of government work together. While we have seen examples at the local level, HiAP-type thinking has not necessarily been part of the overall planning nor the practice at national level. The question going forwards therefore is whether COVID-19 can precipitate the necessary change in thinking.

**Final remarks**

Just over a month after the US President cited the GHSI report as showing the US to be prepared for COVID-19, another ranking, this time covering 150 countries and entitled the ‘COVID-19 Safety, Risk and Treatment Efficiency framework and indices’ (CSRTE), was released. Drawn up by a consortium of for- and not-for-profit organisations called the Deep Knowledge Group, their indices did not correlate with the GHSI ranking – neither the US nor the UK made the top-40. Germany ranked second and Israel – fifty-fourth according to the GHSI – was top. The CSRTE was undertaken with the pandemic already underway.

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* For a summary of Health in All Policies as a framework and approach in practice, see: [https://www.euro.who.int/__data/assets/pdf_file/0007/188809/Health-in-All-Policies-final.pdf](https://www.euro.who.int/__data/assets/pdf_file/0007/188809/Health-in-All-Policies-final.pdf)

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**Box 3: WHO Helsinki Statement on Health in All Policies**

*Health in All Policies* is an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity. It improves accountability of policymakers for health impacts at all levels of policy-making. It includes an emphasis on the consequences of public policies on health systems, determinants of health and well-being.

We recognize that governments have a range of priorities in which health and equity do not automatically gain precedence over other policy objectives. We call on them to ensure that health considerations are transparently taken into account in policy-making, and to open up opportunities for co-benefits across sectors and society at large.

Policies designed to enable people to lead healthy lives face opposition from many sides. Often they are challenged by the interests of powerful economic forces that resist regulation. Business interests and market power can affect the ability of governments and health systems to promote and protect health and respond to health needs. Health in All Policies is a practical response to these challenges. It can provide a framework for regulation and practical tools that combine health, social and equity goals with economic development, and manage conflicts of interest transparently. These can support relationships with all sectors, including the private sector, to contribute positively to public health outcomes.

Source: Taken from [24]
and is regularly updated (now covering countries and regions), so the two are not directly comparable. But as the CSRTI includes parameters such as: ‘literacy rate’, ‘percentage of population with tertiary education’, ‘poverty rate’, ‘incidence of diabetes, cancer and obesity’, ‘size of elderly population’, ‘economic support for quarantined citizens’, and ‘unemployment rate due to COVID-19’, it reveals a more sensitive and nuanced view of pandemic preparedness – one that touches on the social determinant issues which have driven the worst impacts of COVID-19.

Recalling the first of our opening questions – namely, why have most European countries’ pandemic preparedness plans not stood up to COVID-19 – two related responses are therefore clear. First, it appears that initial plans have failed to sufficiently account for social disparities. Moreover, foresight and forecasts visible on paper were not acted upon in a timely nor determined manner (it is not clear, for example, that either the UK or US kept to their pandemic ‘playbook’). Second, despite some countries introducing specific policies to protect those most vulnerable, a more forward-looking health promotion approach involving a coherent multisectoral understanding appears in the main absent. Current recovery strategies and future preparedness plans need to account for social inequalities from the outset, and here health leadership will need to come to the fore much more than it has done so far. And while this article has not been about HiAP per se, the lens it provides offers a potential perspective on the type of decision-making and leadership required in both a pandemic and non-emergency context.

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