Letter to the Editor

Recommendations for 'responsible behaviour' is not a sufficient policy tool in public health emergencies

In response to the ongoing coronavirus disease 2019 (COVID-19) pandemic, several countries including the USA, the UK, and Sweden initially relied on recommendations for 'responsible behaviour' of their citizens in reducing the spread of infection. Among simple things such as increased handwashing, these recommendations suggested a few unusual and inconvenient behaviours, collectively termed 'social distancing'. That meant no more handshakes, embraces, parties and even conversations among friends, neighbours, colleagues and acquaintances in close physical proximity. For these social distancing recommendations to make an impact on the COVID-19 spread rate, they had to be adhered to by the absolute majority—as much as 90%—of the population.[1]

Most countries (e.g., Italy, France, Denmark, Lithuania and so on) deemed unrealistic that the required majority of the population will be responsible enough to adhere to such recommendations voluntarily and imposed enforced restrictions of movement, including large fines for violation of social distancing regimes. Such measures have been shown to be effective in reducing the spread of a pandemic in China[2] and reducing deaths by as many as 3.7 times in Italy.[3] Some countries, such as the USA and the UK, were quite late to do that, which led to detrimental effects in terms of thousands of extra deaths. At the time of writing, some countries, such as Sweden and Belorussia, still rely on responsible behaviour instead of mandatory orders.

At the time of writing, COVID-19 deaths per million of the population in Sweden stood at 132, which is very unfavourable when compared with the neighbouring countries, which initiated population lockdowns—55 in Denmark, 28 in Norway and 14 in Finland.[4] As these mortality comparisons suggest, recommendations for responsible behaviour alone is not a viable policy tool in public health emergencies such as pandemics of highly contagious and deadly diseases such as COVID-19. For responsible behaviour to be effective, it should be practiced voluntarily by the absolute majority of the population. This is unrealistic, given that current social distancing recommendations are both unusual and inconvenient, i.e., they contradict both prevailing social customs and personal habits. Psychological research has shown that it takes at least 18 days to develop a new habit, but the average time is about 2 months.[5] Making responsible decisions concerning daily behaviours involves conscious choices with the regard to behaviours, which used to be automatic. This also requires a personal reflection on causes of behaviour, which is additionally inconvenient and may even be anxiety arousing for many. Furthermore, about half of the people fail to adhere to inconvenient health recommendations.[6] Conscious choices in favour of inconvenient behaviour tend to require significant amount of knowledge and understanding concerning the reasons for such behaviour change. Alternatively, people may switch to inconvenient, but adaptive, behaviour if they have very high trust in the source of such recommendations. Although approval ratings for Stefan Löfven, the Prime Minister of Sweden, almost doubled since the beginning of the COVID-19 crisis, at the time of writing, they were at about 50%, which was not enough to expect sufficiently high adherence to inconvenient social distancing recommendations. Thus, in emergency situations involving large populations, implementation of enforced restrictions is unavoidable.

References

1. Martìn-Calvo D, Aleta A, Pentland A, Moreno Y, Moro E. *Effectiveness of social distancing strategies for protecting a community from a pandemic with a data driven contact network based on census and real-world mobility data*. Working paper, https://covid-19-sds.github.io, 2020. [Accessed 15 April 2020].
2. WHO. *Coronavirus disease 2019 (COVID-19) situation report-44*. https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200304-sitrep-44-covid-19.pdf?sfvrsn=783b4c9d_2, March 4, 2020. [Accessed 15 April 2020].
3. Flaxman S, Mishra S, Gandy A, Unway H, Coupland H, Mellan T, et al. *Estimating the number of infections and the impact of non- pharmaceutical interventions on COVID-19 in 11 European countries*. Technical Report. Imperial College London; 2020. https://spiral.imperial.ac.uk/handle/10044/1/77731. [Accessed 15 April 2020].
4. *Worldometers*. https://www.worldometers.info/coronavirus/. [Accessed 17 April 2020].
5. Lally P, van Jaarsveld CHM, Potts HWW, Wardle J. How are habits formed: modelling habit formation in the real world. *Eur J Soc Psychol* 2010;**40**: 998—1009.
6. Incorvaia C, Mauro M, Ridolo E, Puccinelli P, Liuzzo M, Scurati S, et al. Patient's compliance with allergen immunotherapy. *Patient Prefer Adherence* 2008;**2**: 247—51.

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