Practicing Corona – Towards a research agenda of health policies

Roland Bal*, Bert de Graaff, Hester van de Bovenkamp, Iris Wallenburg

Erasmus School of Health Policy and Management, Erasmus University Rotterdam, the Netherlands

ARTICLE INFO

ABSTRACT

As Corona virus is putting a huge stress on healthcare systems around the world, analysts of health policy will have to respond with starting up research on the consequences of current policies. In this paper, we propose an agenda for research of health policy from a governance perspective, focussing on the consequences of decision-making structures and practices, the mediatisation of the pandemic, the organisation of healthcare systems and the role of expertise.

1. Introduction

Corona virus is putting an enormous stress on the world, and on healthcare systems in particular. Massive efforts are being taken as to the prevention of further outbreaks, the treatment of patients, and the training and protection of health professionals. Healthcare providers around the world are either overwhelmed by patients, making plans for new waves of the virus, or anticipating waves of delayed care. Calls for the production and distribution of personal protective equipment (PPE), drugs and intensive care technology are loud. At the same time, many countries are in lockdown, with economies slowly coming to a halt and only vital services (e.g. healthcare, police) operational and others (e.g. education) moving into the virtual world.

Research can and should help in dealing with this crisis. Whilst much research efforts are currently and understandably undertaken *for* policy (e.g. predicting the spread of infection, course of disease and planning capacity) the study *of* preventive and care policies with regard to epidemic crises (e.g. how policies come about, how they are implemented and to what effects and for whom) is equally important. Corona is here to stay for a while—as a virus and as an issue on the political agenda—and researchers of health policy should start doing research on how our policymakers and institutions deal with this crisis and to what consequences.

In this short paper we therefore suggest an agenda for policy research. We do this largely from our background in healthcare governance, realizing that other fields and disciplines will have other themes and valuable contributions to make. Health planning studies on how to calculate necessary capacities [1]; economic studies on the cost-benefits of specific strategies towards early warning [2] and remediation strategies, social psychology studies on risk perspectives and communications [3]—those will all be necessary, but lie outside the scope of this agenda. Here we focus mainly on decision-making structures and practices, the organization of healthcare and welfare systems and their underlying values, mediatization and the importance of language, and the role of expertise.

2. Decision-making structures and practices

One of the questions that will no doubt figure prominently in the evaluation of the Corona crisis is if 'we' were prepared. This will have at least two components; capacity and decision-making. Whilst this will take different forms in different countries, all of them now have to deal with scarcity; e.g. with regards to PPEs, beds, professionals, and medication. The crisis makes clear how dependent the functioning of our health systems has become on global trade and that for example production capacity in Europe is very limited. Protective masks and raw materials for drugs have to be shipped in from China, lung-machines from the US. Given the global and political character of the crisis, production and distribution lines have come under stress. Discussions will no doubt rise on becoming less dependent, but it would also be interesting to analyze the different ways in which countries—policymakers, healthcare providers, professionals—deal with scarcity and what this means for the resilience of our health-

care systems. On a global scale this will lead to discussions about protective measures versus international solidarity, and the functioning of international organizations. But also within countries, distribution and rationing will become important themes. The extent to which 'scaling up' (of production, training) can occur, and how innovation (e.g. in sterilization of protective masks) is stimulated will become important questions, as will questions about rationing. Who is to get PPEs, who is tested, which patients are allowed into the hospital and the ICU? Countries will differ in the answers to these questions and it will be necessary to compare differences as they will have large consequences for healthcare systems.

The ways in which decision-making about prevention and care are structured also seems to be of crucial importance to the development of the crisis. Within the public health literature, there are some voices saying autocratic regimes fair 'better' as they can more easily take directive measures and scale up [4]. How such systems work out is not predetermined though. The Chinese reaction is a case in point: the authoritarian regime was able to take fierce measures, but only after weeks of denial and scapegoating that might have contributed to the global spread of the virus. Decentralized systems, like most Western European countries, might have a harder time to design and implement protective measures. However, they may also give more room for actors at the sharp end to act on emerging issues and experimentally learn what works. Also, previous experiences with infectious outbreaks might be of importance—e.g. the experience of Asian countries with SARS or of African countries with Ebola. At least the strategies of intensive testing combined with immediate containment versus controlled scaling up towards 'lockdown' might be explained by those experiences.

Institutionalized responses can also be seen in the ways in which public health services are organized across countries and how they relate to healthcare services. Many healthcare systems have decentralized—'market-based'—structures that are at least partly sidelined in crisis decision-making. This raises the question how 'normal' and 'crisis' governance and management relate and under what conditions centralization or decentralization occurs, a question that is especially pertinent now Corona virus will likely be among us for some years to come. These questions include issues of financing healthcare and preparing for (new waves of) the epidemic.

Moreover, structures only tell us so much; it is the ways in which they are practiced that makes the difference. Data collection should therefore not only focus on the formal organization of decision-making structures, but also on how these are used (or not), bypassed, reinvented, etc. To what extent do such structures and practices help in making countries more resilient and 'manage the unexpected' [5]?

3. Healthcare systems and values

One thing that the Corona crisis makes clear is the different ways we have organized our healthcare systems. Take for example the relative amount of ICU beds: whereas the European mean is 11 ICU beds per 100,000 inhabitants, differences are huge, with the Netherlands at 6,4 and Germany at almost 30 (source: https://www.covid-19.no/critical-care-bed-numbers-in-europe, visited 4 May 2020). Some countries have invested more in primary care than others. These differences reflect underlying choices and values in the organization of care. The Dutch, for example, have a longer tradition of preventing unnecessary and burdening clinical treatment, and a likewise longer tradition of palliative care than the Germans, but as a consequence faced a need to at least double ICU capacity in a matter of weeks. Likewise, differences exist in the

organization (and quality) of the long-term care sector that matter greatly for the protection of vulnerable populations in times of pandemic threat.

The organization of healthcare and the principles and values that guide the ways in which historical choices have become institutionalized influence the resilience of healthcare systems in times of a pandemic threat. This is not only the case for hospital care, but also for elderly care facilities, home care and care for vulnerable groups such as the homeless and mental health patients. How are trade-offs made between freedom and safety, between health and well-being, at different levels of the healthcare system, and how do these work out in practice? Such questions include the distribution of PPEs that in most countries have favored hospitals over say elderly care. No doubt, these issues will all be on political agendas for the years to come and researching the consequences of the organization of healthcare for dealing with such values will be crucial for the quality of future debates.

4. Mediatization and the importance of language

Corona-disease is the first pandemic in times of social media. Whilst mediatization has been important in earlier crises, the enormous flow of information by news media, on twitter and other platforms is unprecedented. No doubt we have all noticed the horrid images from Italy with pilled-up coffins and doctors and nurses speaking about the painful choices they had to make in daily care. Such powerful images have a huge impact on people—and on politics. In the Netherlands, every day at 2 pm we get an update on the number of people that have died from or hospitalized with Corona disease (175 and 722 respectively at the time of writing the first version of this paper, 26 and 42 while revising it). There is no escaping the dreadful news that comes in everyday from all over the world. How is media reporting influencing the decisions that people on the streets (or rather: in their homes) make, and how does it influence politics?

Framing [6] plays a crucial role in pandemic decision-making, both in relation to measures taken and to the issues at hand. Whether the Corona crisis is depicted as a public health, an economic or a social crisis has huge implications, not only in terms of decisions to scale-up protective measures, but also in the focus of policies. I.e. whilst the media is full with ICU beds, there is very little attention for primary care. Also, the framing of behavior is crucial. In his speech introducing the 'intelligent' lockdown in the Netherlands, Prime Minister Rutte referred to people going to the beach as 'anti-social'. Such framings legitimize more far-reaching policy measures and delineate the experience of the problem at hand. Framings can also backfire, however. Earlier references by Boris Johnson to build up 'herd immunity' by preventing a lockdown back-fired under media and expert criticism.

What kinds of metaphors are used to describe the disease or preventive measures also matters. Susan Sontag already pointed at the endemic use of war-talk in relation to infectious diseases [7], with 'foreign' bodies 'invading' our own, thus eliciting militaristic reactions. Whilst such metaphors might be helpful in developing specific responses, they are also highly problematic. For example, the metaphor of the 'lockdown' might seem to make sense, but what about populations that can hardly be 'locked down' (e.g. slums in South-Africa, or the impoverished communities in Syria) or for whom lockdown might actually be bad, such as the homeless or refugees, or children in problem families? There is a need to study the ways in which policy measures are framed and to what consequences. Again, differences between countries are interesting to study to understand such consequences.

5. Organizing expertise in times of crises

Every public crisis is also a crisis of expertise. As experts are necessarily drawn in to advice politics, expertise also becomes politicized [8]. Not only is this visible in the huge amount of misinformation—there is a whole infodemiology of Corona out there—but legitimate experts themselves disagree on key issues whilst research is being executed and published at record-speeds, making it more difficult to value. Disciplinary backgrounds of course matter—virologists will have a different take on things that say sociologists or economists. The pressures put on experts also enlarges differences within disciplinary circles. Discussions that are usually played out 'behind the scenes' of scientific committees [9] now come out into the open as experts are all over the place in the media, and differences are exposed and magnified. Calls for trust in 'the experts' then become somewhat empty as the question is rather whom will be granted the position of expert. The role that can be played by certified expert bodies—in Sweden for example the Public Health Agency—then becomes dependent on the ways in which other experts are given a stage in the media.

Again, there are differences between countries, both in the voicing of expert opinions and in the stage experts get at the political level. Clearly, this is also influenced by the media, but the institutionalization of expertise probably also matters. Countries with a strong tradition of certified expert bodies probably do different than countries that have a more fragmented organization of expertise. The recent rise of 'fact free politics' in some countries of course also influences the ways in which experts can now set the agenda. What experts get a voice and how they can influence pandemic decision-making is clearly a matter that needs scholarly attention.

6. Conclusion

The Corona crisis calls for research by and insights from health policy analysts, to deal with the (unfolding) crisis now but also to learn for future crises. Handling this crisis will take considerable time, and we can anticipate many evaluations of current policies.

The issues mentioned above are only a few of possible important ones. They are all issues that we can (and should) start collecting data on now, by observing decision-making in action, by analyzing policy documents and (social) media and by interviewing key actors. Comparative research between countries and regions will be particularly helpful in evaluating the effects of different prevention policies and practices. At the moment, both national and international (i.e. EU) calls for research are being issued and allow for opportunities to actually start doing comparative research. We look forward for you to join in this effort.

Declaration of Competing Interest

There are no competing interests to declare. Nobody has paid for or ordered this publication in any way except for the authors.

References

[1] Ramanathan K, Antognini D, Combes A, Paden M, Zakhary B, Ogino M, et al. Planning and provision of ECMO services for severe ARDS during the COVID-19 pandemic and other outbreaks of emerging infectious diseases. The Lancet Respiratory Medicine 2020, http://dx.doi.org/10.1016/S2213-2600(20)30121-1.

[2] Himmler S, van Exel J, Perry-Duxbury M, Brouwer W. Willingness to pay for an early warning system for infectious diseases. The European Journal of Health Economics 2020, http://dx.doi.org/10.1007/s10198-020-01171-2.

[3] Husnayain A, Fuad A, Su EC-Y. Applications of google search trends for risk communication in infectious disease management: a case study of COVID-19 outbreak in Taiwan. International Journal of Infectious Diseases 2020, http://dx.doi.org/10.1016/j.ijid.2020.03.021.

[4] De Ceukelaire W, Bodini C. We need strong public health care to contain the global corona pandemic. International Journal of Health Services 2020, http://dx.doi.org/10.1177/0020731420916725.

[5] Weick KE, Sutcliffe KM. Managing the unexpected. Assuring high performance in an age of complexity. San Fransisco: Jossey-Bass; 2001.

[6] Schön DA, Rein M. Frame reflection: toward the resolution of intractable policy controversies. New York: Basic Books; 1994.

[7] Sontag S. Illness as metaphor. New York: Farrar, Straus & Giroux; 1978.

[8] Weingart P. Scientific expertise and political accountability: paradoxes of science in politics. Science and Public Policy 1999;26(3):151–61.

[9] Bijker WE, Bal R, Hendriks R. Paradox of scientific authority. The role of scientific advice in democracies. Boston: MIT Press; 2009.