

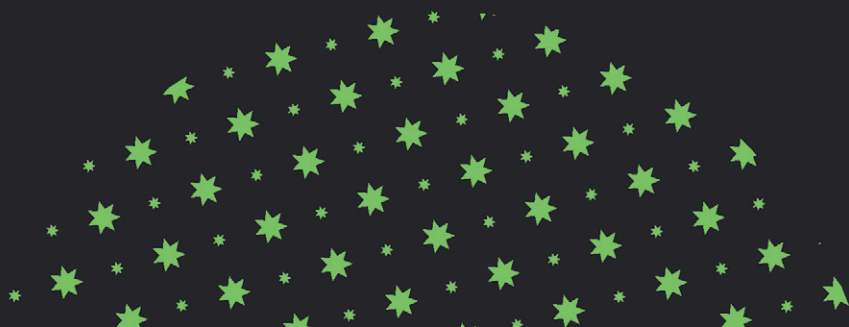


EMERALD POINTS

POWER, POLICY AND THE PANDEMIC

A Sociological Analysis of COVID-19
Policy in England

**MICHAEL CALNAN
TOM DOUGLASS**



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A Sociological Analysis of
COVID-19 Policy in England

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INVESTOR IN PEOPLE

We dedicate this book to all those who have died from COVID-19 and the families that mourn their loss.

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LIST OF ABBREVIATIONS

CMA	Conditional marketing authorisation
COVAX	COVID-19 Vaccines Global Access
DHSC	Department of Health and Social Care
EMA	European Medicines Agency
JCVI	Joint Committee on Vaccination and Immunisation
MHRA	Medicines and Healthcare products Regulatory Agency
ONS	Office for National Statistics
PPE	Personal protective equipment
SAGE	Scientific Advisory Group for Emergencies
VTF	Vaccine Taskforce
WHO	World Health Organisation

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CONTRIBUTIONS

The original concept for this book arose from Michael Calnan's sociological analysis of health policy. Both authors contributed equally to the development of the central ideas and the analysis of documentary material comprising this book. Chapters One and Four were co-authored. Michael Calnan led the analysis and writing for Chapter Two. Tom Douglass led the analysis and writing for Chapter Three. Author order is alphabetical.

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SITUATING AND CONCEPTUALISING PANDEMICS AND POWER

As Dingwall, Hoffman, and Staniland (2013, p. 167) suggest, infectious diseases may not immediately seem like the typical terrain of the sociologist, seeming rather to be a topic of study more suited to the scholar of public health, the virologist or the microbiologist – but infectious disease epidemics and pandemics are inherently social phenomena. The emergence, extent and impact of an epidemic or pandemic reflect the existing social and political structures of and inequalities in society (Dingwall et al., 2013; Lupton, 2021; Lupton & Willis, 2021). In other words, epidemics and pandemics are shaped by and reflective of the distribution of power in society. This book contributes to knowledge about the interplay between power, policy and pandemics by sociologically analysing the COVID-19 pandemic in England. Our specific focus is on the policy response to the pandemic which takes influence from the sociology of health policy developed by Calnan (2020a, 2020b).

Sociological insights have largely been missing from analysis of the policy response to the COVID-19 pandemic thus far and this book fills this lacuna placing analytical emphasis on the interplay between powerful structural interests and influence on the development, implementation and outcomes of COVID-19 policy. Put differently, we offer a sociological analysis of COVID-19 health policy-making and of the policy arena of health and healthcare which we view as containing a range of powerful groups with specific interests. This includes not only the government, medical/scientific experts, the medical profession, social care professionals and public health professionals but also supranational organisations, the pharmaceutical industry and other private sector and commercial actors, the media and the public. Building directly or indirectly on a range of our previous work (Calnan, 2020a, 2020b; Calnan & Douglass, 2020; Douglass & Calnan, 2020; see also Douglass & Calnan, 2016;

Calnan & Douglass, 2017), we look across these actors, their specific interests and relationships with one another, with the overall aim of identifying the key sociological aspects that have shaped and influenced, facilitated or challenged COVID-19 policy in England and its successes and failings.

TRACING THE ORIGINS AND ONSET OF THE COVID-19 PANDEMIC

It is evident that with improvements in public health and the development of vaccines, serious illness and death caused by infectious diseases, such as influenza, plague, smallpox and yellow fever, have greatly diminished. Between 1960 and 2004, it is also true that there were 335 emerging human diseases (many with origins in animals) (Snowden, 2020). Snowden (2020, pp. x–xi) notes that between the years of ‘2003 and 2016, these included outbreaks of avian flu, SARS (severe acute respiratory syndrome), MERS (Middle East respiratory syndrome), Marburg and Ebola’. These emerging infectious diseases have had notable impacts on human health (Lupton, 2021, pp. 15–17). For example, over 11,000 died in the West African Ebola outbreak, which began in 2013 (Calnan, Gadsby, Kondé, Diallo, & Rossman, 2018; Kelly, 2018). Lupton (2021, p. 15) states that when observing and responding

...to [such] outbreaks, several commentators and organisations had begun to warn of the inevitability that an even more serious new pandemic was waiting in the wings, and that all nations should be preparing for it.

This pandemic was ultimately the COVID-19 pandemic – which has without doubt become the most momentous of the emerging infectious diseases in the late twentieth and early twenty-first centuries and has been the most consequential pandemic since the Spanish influenza pandemic of 1918–1920. By October 2021, COVID-19 has killed over 4.5 million people globally, caused vast economic downturn and substantially disrupted social life. As Lupton and Willis (2021, p. 4) state, the ‘COVID pandemic is far more than a massive global health problem – it is a crisis on every level: social, cultural, environmental and economic’.

What is known about the origin of SARS-CoV-2 (the virus causing the disease known as COVID-19), the initial spread and its arrival in England? We turn in the next two chapters to articulate and analyse the specifics of the spread of SARS-CoV-2 and the policy response over the months between

March 2020 and October 2021. However, for those unfamiliar, it is worth here briefly outlining the origin of the pandemic. In early January 2020, the World Health Organisation (WHO) alerted the world to a cluster of apparent pneumonia cases of mysterious origin in Wuhan in Hubei Province, China, seemingly linked to a wet market selling live animals in the city.¹ A few days into the New Year, on 7 January, Chinese scientists had isolated and identified the pathogen causing the infections. This was a new type of coronavirus (similar to SARS), and the disease that it causes would later come to be known as COVID-19.

The exact origin of the virus is, at the time of writing, contested. One theory is of zoonotic transmission from bats spilling over to humans, likely via an intermediary species. This, it has been argued, is linked broadly to destruction of vegetation and wildlife, thus meaning that viruses require new hosts (McKie, 2021). Another theory is that the origin of the virus might be traced to a lab accident at the Wuhan Institute of Virology where researchers work with coronaviruses (Calvert & Arbuthnott, 2021). The lab leak theory was initially dismissed as coincidence, conspiracy theory and politically motivated, but the claim was reignited under the Biden administration in the United States and the medical science and national security communities are split over the issue (BBC News, 2021c; Maxmen & Mallapaty, 2021).² The main evidence for this latter theory, however, seems to be the inability of scientists so far to pinpoint the animal that passed it to humans (McKie, 2021).

The first death was confirmed in China on 11 January, with the first case outside of China, in Thailand, confirmed on 13 January (Ashton, 2020, p. 50). On 21 January, China's health ministry stated that the virus could be transmitted from person to person and on 23 January Wuhan went into lockdown. Meanwhile, on 24 January, a concerning paper was published in *The Lancet* suggesting that as many as a third of people infected required intensive care admission (Huang et al., 2020; Sinclair & Read, 2020). Latter data ultimately suggested that less than 10% of patients with COVID-19 required admission to hospital (Roberts, 2021a).

With borders remaining open, by the end of January, the first cases in the United Kingdom were officially recorded – a Chinese student and relative in York. In early February, the first British national to have caught the disease

1 The first confirmed case of COVID-19 was on 1 December 2019.

2 US intelligence indicates that three members of staff at the Institute were hospitalised in the weeks before the virus was officially detected.

was identified (with this person also demonstrating the dangers of asymptomatic transmission). However, it is now certain that the virus had been in Europe, and in the United Kingdom, for much longer (Calvert & Arbuthnott, 2021). Indeed, the first UK COVID-19 death is now known to have occurred on 30 January 2020, although this was not officially discovered until half a year later (Robinson, 2021). The same day, the WHO declared a Public Health Emergency of International Concern (PHEIC), which denotes an extraordinary event constituting a public health crisis for countries internationally and is the most serious level of alert (essentially a call to action for WHO member states) and indicates the need for a coordinated global response (Ashton, 2020, pp. 105–106; Pieri, 2021, pp. 8–9). By the beginning of March, there had been more than 88,000 COVID-19 cases globally and more than 3,000 people had lost their lives (Yeung, 2020).

On 11 March, the WHO officially declared a pandemic (Sinclair & Read, 2020). The WHO have been criticised in the past for both being too alarmist when declaring Swine Flu a pandemic in 2009 and for being too slow to alert the world to the West African Ebola crisis in 2014 (Pieri, 2021, p. 37). Certainly, declaring a pandemic is a politically and economically contentious decision. The basis for such a declaration is a six-phase schema which charts the spread of an epidemic before and then with animal to human infection and then the incidence of human-to-human spread locally, regionally and internationally (see Ashton, 2020, p. 107).

Before turning in the following chapters to analyse the policy response specifically in England from the time shortly before the WHO's declaration of a pandemic onwards, it is necessary to set out the conceptual framework that guides our analysis across the following chapters.

CONCEPTUAL FRAMEWORK

Our approach in this book is to take a sociological perspective on or approach to health policy making and we approach the policy arena of health and healthcare specifically through the lens of the theory of countervailing powers. In its medical sociological application, the theory suggests that the sphere contains several powerful interest groups that contend for power, legitimacy and resources to fulfil their vision of health and healthcare (Gabe et al., 2012; see also Light, 1991, 1995, 1997; Mulinari & Vilhelmsson, 2020). Put differently, as Gabe et al. (2012) highlight, the use of the theory in medical

sociology has been in scholarship concerned with the balance of power in the health policy arena and if and how it changes or is challenged as a range of groups assert their own priorities. Actors have distinct interests, objectives and values which may be in tension resulting in challenges to the power of the dominant actors. Groups may act in loose and potentially temporary coalitions/allegiances established in relation to a specific issue. Gabe et al. (2012) also show how *within* different groups there may be factions and opposition. In this regard, the theory of countervailing powers has been refined by medical sociologists to show that actors have fluid and complex positionings within the healthcare arena that vary over time and issue. Overall, the theory suggests that actors may work to reshape, constrain, challenge or reject policy and policy decision-making, to counter the power of the dominant actors, although actors may also collaborate or develop alliances and allegiances that support and facilitate the power of dominant actors (Gabe et al., 2012).

In the context of pandemic policy overall, we approach our analysis with the government positioned as the central and most powerful actor. As noted earlier, however, there are other important actors which includes regulators, medical scientific experts and the medical profession, social care professionals, public health professionals, the pharmaceutical industry (and other private sector and commercial actors), the media and the public (see Gabe et al., 2012). It is necessary in the context of a global pandemic to consider the role too of supranational organisations, such as the WHO, the EU and other nations competing for resources and charitable and non-profit organisations. Looking across these actors, their specific interests and relationships with one another, the approach adopted in this book is one that looks beyond direct inclusion or exclusion in policy decision-making considering influences, interests and strategies that shape policy decision-making and policy outcomes. The theory of countervailing powers suggests that there will be evidence of actors countering or challenging the power of the government, potentially leading to shifts in policy and the balance of power. However, it is also sociologically salient to examine evidence of the reverse where actors facilitate or support government policy and power.

This provides a general framework to inform sociological analysis of health policy. However, a pandemic is a rare health and social emergency. Are there specific aspects or dimensions unique to such emergency situations that might influence or be reflected in the action, behaviours, values, relationships or

interests of relevant groups as they shape or react to decision-making and policy in a pandemic? In existing analysis of how society responds to pandemics, policies and the associated surveillance systems set up to monitor developments are portrayed as means of society showing it can manage the uncertainties and associated panic and fear using science (Dingwall et al., 2013). In relation to this, Mansnerus (2013) has highlighted the rise of quantification in the form of modelling which provides the basis or platform for control policies. Despite considerable uncertainties, once models provide results, they become authoritative and useful evidence for policy-making. As such, one key theme in the analysis presented in the later analytical chapters of this book will consider if and how far science, modelling and associated experts have played a role in shaping the policy response to COVID-19. The presence and importance of competing scientific and medical interpretations will also be considered.

The roles and performance of and the nature of the relationship between the state or the public sector and the private sector are also of potential significance. Existing analysis has focussed on the collaboration between the two sectors in the preparation for a major flu epidemic in France in 2009 and showed how problematic it was setting up such partnerships not least because of different cultures and modes of operation with each actor retreating to familiar modes of practice such as regulation and contractual allocation of responsibilities (Steyer & Gilbert, 2013). This said, in the years immediately before the pandemic, recent UK governments have emphasised the need for a partnership with the private sector in healthcare and other sectors. Unsurprisingly then, as Calnan (2020a, 2020b) shows, there is evidence of increasing marketisation and creeping privatisation in the NHS over the last two decades which has been accelerating in recent years. This is illustrated by the spending on independent sector providers which amounted to 3% of NHS spending in 2006 rising to 8% in 2017. However, overall NHS expenditure on private services is claimed to be much higher at 18%, which includes consultancies, support and outsourcing. This is coupled with the chronic underfunding of the NHS over the last decade or so exemplified by the lowest rate of growth in total healthcare spending, 1.3% per year between 2009 and 2013, being recorded since 1955. Public health services were transferred to local authority services and, along with social care services, experienced even more severe financial cuts during this period. This, overall, suggests that a close relationship with the private sector is to be expected in the policy response to the pandemic.

Vaccines are considered one of medicine's finest achievements having eliminated or substantially reduced the threat of a range of dangerous and debilitating infectious diseases (see Calnan & Douglass, 2020). Almost immediately after the beginning of the COVID-19 pandemic, governments around the world positioned vaccines as the way to control and end the COVID-19 crisis. Other actors are involved in the development of vaccines, however, and, in this regard, it is necessary to analyse the public-private relationship between the pharmaceutical industry and the government and the broader social and political conditions in which vaccine development, manufacture and regulation occur. Importantly, both the pharmaceutical industry and the government, as well as the public, have their own interests in the development and regulation of vaccines. Analysis of the pharmaceutical industry and regulation of health technology generally suggests that public health interests and commercial interests are not necessarily compatible and may in fact be biased in favour of commercial interests (Abraham, 1995, 2008). If and how the interests of government, the pharmaceutical industry and the public are served respectively by vaccine development and rollout is, as such, a central issue.

Medical sociological work has established the importance of the practices and values underpinning traditional media's framing of matters of health and illness (Seale, 2002) and the negotiated nature of newsworthiness which simultaneously draws on and shapes public opinion (Conrad, 2001; Howarth, 2013). Framing is a central organising idea which promotes the importance of some topics and information and neglects others at a given time. In the crisis circumstances of an epidemic or pandemic, traditional media's framing can influence the policy response, what the issues are and if/how they are attended to, as well as the prioritisation of interventions (Pieri, 2018, 2021, p. 83). Traditional media have the potential then to challenge government policy and power (Gabe et al., 2012). Pieri (2021, pp. 63–69) discusses how social media facilitates the uncontrolled spread of vast amounts of information and misinformation about an emerging infectious disease known as an infodemic. It provides space for the proliferation of myths, negative attitudes and even stigmatisation or discrimination against certain groups of people held, for example, as responsible for spread of the disease (Parmet & Sinha, 2017; Pieri, 2021, pp. 68–78). This might, as such, be used to challenge or reject government policy and encourage other users to do the same. The nature of government communication and messaging to the public (potentially using traditional and/or social media) is also significant in terms of fostering public

support. Good communication in a pandemic arguably embraces uncertainty and involves the public as a stakeholder in two-way dialogue (Pieri, 2021, pp. 87–92).

Trust (or the lack of it) between actors is also of consequence in the development and success of the policy response to pandemics. But what is trust? Trust is a multi-layered concept which consists of a ‘cognitive element (grounded in rational and instrumental judgements) and an affective dimension (grounded in relationships and affective bonds) generated through interaction, empathy and identification with others’ (Calnan & Rowe, 2008, p. 6). Trust is used, along with other concepts such as hope, as a strategy for managing uncertainty which is a key characteristic in the context of illness and healthcare generally and during a pandemic particularly. In terms of its dimensions and dynamics, trust has been characterised by one party, the trustor, having positive expectations regarding the competence, knowledge and skills of the other party, the trustee, to do a good job (competence trust) and to be able to work in their best interests (intentional trust) with beneficence, fairness and integrity (Calnan & Rowe, 2008). Public and patient trust matters because it is a precursor to social action such as consulting a clinician or adherence to public health policy. Public trust is necessary to support and legitimise the position, reputation and policies of institutions and administrations. Low levels of trust or distrust may mean the public or sections of the public attempt to challenge, reshape or resist government pandemic policy. In this book we analyse if and how (dis)trust has been and is playing out in the COVID-19 pandemic. There is also need for analysis where relevant trust by the public in actors other than the government and also between the other actors involved in or related to the development, dissemination or implementation of policy (e.g., scientists or the pharmaceutical industry) (see Douglass & Calnan, 2016).

Trust is also important in public vaccine uptake – but there are other dimensions that must be considered too. Vaccine coverage varies over time, place and in relation to disease, and some people are vaccine hesitant, and others reject vaccination. Vaccine hesitancy and rejection are important problems which threaten community immunity and leave those unable to be vaccinated vulnerable to infection. Yaqub, Castle-Clarke, Sevdalis, and Chataway (2014) define vaccine hesitancy as harbouring doubts about the safety of vaccines and questioning of benefit and necessity. Decision-making about vaccines both for oneself and on behalf of children reflects a sophisticated decision-making process that takes into consideration past vaccine and