



PUBLIC HEALTH POLICY (BMHP5013)

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INTRODUCTION

This comparative report discusses and analyses in-depth the impact, legislation and strategies employed by the governments of the UK and Spain on the monitoring and control of the incidence of COVID-19.

BACKGROUND OF COVID-19

COVID-19 belongs to a kind of coronavirus known as SARS-CoV-2, it was named after its likeness to the virus SARS. The virus is called coronavirus because it is covered by club-shaped structures that give the virus a corona-like appearance on electron micrographs. The SARS-CoV-2 virus is part of a family of organisms known to infect mammals and birds. The Coronaviridae family consists of a positive-sense single-stranded RNA wholly wrapped in a complex protein and a bilipid layer (Gaglioti, 2020).

The first coronaviruses were discovered in the mid- 1960s and didn't spark a great research interest as they were considered a nuisance rather than a public health danger. These viruses caused typical cold symptoms and were very common. Their past reputation shifted with the SARS outbreak, which killed 10 per cent of infected people. Of the several strains known to humans, only seven are known to affect us. However, SARS, MERS and COVID-19 originated in animals and jumped to humans. Despite the fatality rate of the SARS outbreak in 2002, the warning was widely ignored (Williams, 2020).

In December 2019, pneumonia caused by an unknown virus was identified in the now well-known Chinese city of Wuhan. Shortly after, it would be named SARS-CoV-2, although it would be known in the coming months simply as coronavirus, the infectious agent that would radically change life throughout the planet or as covid to the disease it causes in those infected. The coronavirus pandemic began as a local epidemic, which forced China to take extreme measures, similar to those that had served the Asian giant to control the SARS outbreak eight years earlier. For this reason, at first, most countries in the world did not react strongly, and the coronavirus began to spread uncontrollably from China to the whole world. It reached Europe for the first time through France. Italy first suffered a major outbreak in the Lombardy province, which became the pandemic's epicentre and led it to take measures as drastic as those in China. Unprecedented measures for Western powers would soon be standard in most countries. Among them are the United Kingdom and Spain. Confinement, de-escalation, the types of protective masks, the gauges, the time slots. Concepts that sounded like improbable times had crept into normality (BBC, 2020).

MEASURE, CONTROL AND MONITORING STRATEGIES IN THE UK

In the outbreak's early stages in the UK, the Government suggested that at least 60% of the population should get infected to build the so-called "herd immunity" and become resistant to the illness. This strategy was promptly abandoned after the Government's scientific advisors warned against it, arguing that this model would put the NHS under severe strain. The country was instead moved into a national lockdown (Calnan, 2020).

A second strategy carried out was the test and trace contact application. This application was launched in September 2020 after many setbacks. The app determines if contact with a person that tested positive happened using Bluetooth. This app will subsequently send an alert in the event of contact with a positive for more than 15 minutes. The difference with this model as opposed to other countries is that it is voluntary. Also, as it is decentralised, the information is stored entirely on the device, making it impossible to identify the person and the advice given legally unenforceable. Thus, it relies on the user to obey the advice to avoid infecting others. The app is also used to check into venues via a QR code that is scanned upon entry as required as opposed to leaving personal details. This means that if an outbreak happens in a particular venue, the user can be notified immediately (GOV.UK, 2022).

Concerns about data usage and privacy were taken into account as it is not compulsory to enter a name, and there is no way of tracking location or monitoring whether the advice is being followed.

A study published in April concluded that if 80% of smartphone users- 56% of the population- actively used the app and followed the advice, it would be enough to suppress the pandemic on its own (Fraser, 2020).

More than 100,000 people in the UK have died from a virus that, a year ago, appeared to be nothing more than a distant external threat (BBC News, 2021).

To summarise, the containment response was implemented in three phases: containment (via contact tracing), delay (by flattening the peak of the outbreak to allow time for vaccine development), and mitigation (consisting in the idea of herd immunity, where the population is allowed to be exposed to the virus to build resistance to it).

According to Calnan (2020), the Government's response to date can be described as reactive and slower than other countries, characterised by a lack of consistent strategies and communication.

MEASURE, CONTROL AND MONITORING STRATEGIES IN SPAIN

In Spain, the first imported case (a tourist in La Gomera who had been infected in Germany) was known on January 31, but it was not until almost a month later, on February 26, when the

first local infection was confirmed. He was a 62-year-old man in Seville. From that moment, the cases began to grow exponentially, from 73 on March 1 to 589 a week later and 5,753 infections on the day the Government announced home confinement. The peak of infections was reached at the end of March and that of deaths in the first days of April. In just 24 hours, on April 1, Spain registered 950 deaths. The peak in the third wave has been half, 488 deaths (Redacción Médica, 2020).

On June 21, Spain emerged, three months later, from the State of Alarm. The so-called de-escalation process - the progressive withdrawal of confinement measures and restrictions on mobility - had begun in early May. On June 21, when all of Spain entered the "new normal", the cumulative incidence at 14 days was eight cases per 100,000 inhabitants (RTVE.es, 2021).

From December 27 to March 11, in Spain, more than three and a half million people have already received a dose of the vaccine, and for just a few days, that number is greater than the registered infected.

PUBLIC HEALTH POLICIES

UK and Spain share comparatively vastly underfunded and understaffed public health systems. Decades of right-wing policies implemented by governments that create inequality and continuous underfunding of the public health system are primarily to blame for the inability of the health systems of both countries to cope during a pandemic.

Although heralds had announced their arrival, containment against SARS-CoV-2 was not possible. In the autonomous communities with the largest population, the available epidemiology resources were not enough to identify and control a few cases or fully follow up their contacts. In a short time, they went from containment to mitigation, that is, to rearm the health service and adopt population quarantine measures of extraordinary magnitude. This tenuous epidemiological barrier faithfully illustrates the current state of both Spanish and British public health and is only the most visible of a neglected system, if not abandoned for decades (La Voz de Galicia, 2021).

It should be emphasised, however, that assuming that with better public health, we would have done better is a more or less plausible working hypothesis as it is not known how the present situation will end. However, there are components of the response given in terms of prior planning, strategic reserves of resources, management, leadership, and communication. That has been improvable, and that at least could have increased the population's confidence. On the other hand, better public health that stimulates and implements cost-effective health policies is very likely socially beneficial.

HEALTH AND BEHAVIOUR MODELS AND THEORIES

Each historical era corresponds to a unique structure of power, techniques, ideas, values, customs, beliefs and norms, in which the conception of being human within the complex integration of these factors seeks to generate actions aimed at improving the conditions of the health-disease process; It is essential to recognize them to generate strategies that lead to effective health care and translate into the improvement of the quality-of-life conditions of the population (Tones and Tilford, 1995).

The foregoing is exemplified by comparing epidemiological profiles of countries that have different levels of development of productive forces and social relations of production, or in the fact that the different social classes of the same society get sick and die differently; This is why the health-disease process is considered a social construction (Seedhouse, 2004).

Rates of poor health and life expectancy have always been worse in the most impoverished areas, but the pandemic appears to have further exacerbated this difference.

Data from the UK Office for National Statistics show that death rates are twice as high in disadvantaged areas than in wealthy areas. The Health Foundation conducts its research on the subject, arguing that the death rate from covid-19 must be viewed through the "lens" of inequality to understand it fully (The Health Foundation, 2021).

It is something that Professor Michael Marmot (2020), one of the country's leading experts on health inequality issues, also addresses. "The dismal UK record is telling us something important about our society."

IMPACT OF LEGISLATION AND POLICIES

There are significant differences in how policies, guidance and public surveillance is implemented between the UK and Spain. Public Health surveillance in the UK considers the data protection of its population and is not imposed as harshly as it is done in Spain. The population of Spain are used to impositions and does not question their implications. This stems from a cultural legacy of past oppression. Democracy in Spain was only implemented 40 years ago when dictator Franco died. Even so, it was a sort of placebo transition to democracy that did not purge the system. It is still compulsory in Spain to carry a National Identity card at all times to be produced on command as requested by police, no reason necessary.

The difference in the way both countries implemented lockdowns is also noteworthy. In Spain, people were not allowed to leave the house unless strictly necessary, and this was monitored by the police, that patrolled the cities and fined people that did not carry a permit from their

employer. The UK is noticeably more lenient on restrictions and tends to give advice and warnings rather than physical reprimands in the shape of fines.

The question with mandatory policies is whether they are enforced for the well-being of the population based on protection and the ethical implications and moral questions these raise. Nevertheless, policies that mandate actions or behaviour interfere with individual autonomy and liberty and raise concerns on the population that affect their ability to trust the systems' safeguarding of their citizens.

ETHICAL CONSIDERATIONS

When epidemics have occurred throughout history of humanity, they have invariably generated a climate of uncertainty, commonly accompanied by panic generalized, mainly motivated by common situations to almost all pandemics: they are usually unpredictable, because there is no immediate cure or vaccine and because it cannot be controlled in the beginning by health institutions. The result can be the death of many human beings and changes in the basic socioeconomic situation of many societies. In the presence of an epidemic, uncertainty and social confusion develop parallel, something that must be tackled, initially, with an adequate communication strategy from the health institutions, both at the particular level of each country, and globally, and thus generate a current of trust in the population (Gamboa-Antiñolo, 2021).

We face problems that concern ethics, since they compromise values that, in one way or another, come into conflict when personal conduct is assumed, and actions are proposed that seek general solutions. In other words, a conflict is created between the individual good and the common good.

In personal responses to an epidemic or pandemic risk, individual rights to freedom, health and the right to life come into play. However, individual rights face the needs of other members of the society in which we live (Bastidas-Pacheco, 2022).

The experience of the current crisis allows mentioning situations and conflicts that collide with ethics such as:

- The conflict between individual rights versus the protection of collective health: for example, the home isolation of cases and contacts, the interruption of activities that are not considered a priority or the closure of shops, schools and public spaces are possible decisions in which creates a challenge between different rights levels.
- In pandemic situations in the face of an unknown virus, the uncertainty of medical treatment is generated and one may fall into the temptation of starting procedures that have not yet been duly tested, when starting research protocols that do not meet all the requirements that from

the point of view from an ethical point of view are required, sometimes pressured by the urgency of the situation, obviously lacking principles such as non-maleficence.

-Vaccines against an unknown virus take time to produce, and the possibility is created that the contracts for their acquisition will be made when there is still not enough knowledge about the possible evolution of the pandemic and about the safety of these vaccines. The health authorities of the different countries bear great pressure, since most members of society wish to be included in the groups likely to be vaccinated. Initially, the production capacity of vaccines is often limited, but there is also the possibility that there are countries that see their ability to acquire them reduced, because their economic situation has been affected by all the expenses inherent to a pandemic.

-The need to prioritize the type of patients who receive specialized treatments with limited availability, as seen in various parts of the world and our own, (for example, beds in Intensive Care Units (ICU) or ventilators).

In the public decisions made by the health authorities to face the seriousness of an epidemic and the risk of a pandemic, values are compromised that, according to how they are ranked, will determine the convenience of these decisions. We must always assume that the main value in this situation is, obviously, the protection of the population's health, through effective measures based on the best existing scientific evidence. The bioethical principle of justice is the primary foundation in public health decisions. Justice must include, of course, the distribution of existing resources with equity criteria, allocating them according to the needs and urgencies regardless of the economic resources of the different groups or parts of a society to which they are intended (Esquivel-Guadarrama, 2020).

RECOMMENDATIONS

The development of an organisational design for Public Health that, for example, would reinforce its core structure in the autonomous communities, enable a robust network of rapid-action epidemiology services and analysis capacity, or reinforce the community strategy for the promotion and protection of collective health, helping to foster interactions with social and institutional agents committed to improving the health of the population; that it be closely coordinated with non-specialised care, helping to create primary and effective community care, which is the fundamental basis of any national health system.

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