

COVID-19: Politics, Inequalities, and Pandemic Democracy, Capacity, and Coercion in Pandemic Response: COVID-19 in Comparative Political Perspective

Matthew M. Kavanagh
Renu Singh
Georgetown University

Abstract The COVID-19 pandemic has challenged governments around the world. It also has challenged conventional wisdom and empirical understandings in the comparative politics and policy of health. Three major questions present themselves: First, some of the countries considered to be most prepared—having the greatest capacity for outbreak response—have failed to respond effectively to the pandemic. How should our understanding of capacity shift in light of COVID-19, and how can we incorporate political capacity into thinking about pandemic preparedness? Second, several of the mechanisms through which democracy has been shown to be beneficial for health have not traveled well to explain the performance of governments in this pandemic. Is there an authoritarian advantage in disease response? Third, after decades in which coercive public health measures have increasingly been considered counterproductive, COVID-19 has inspired widespread embrace of rigid lockdowns, isolation, and quarantine enforced by police. Will these measures prove effective in the long run and reshape public health thinking? This article explores some of these questions with emerging examples, even amid the pandemic, when it is too soon to draw conclusions.

Keywords COVID-19, global health, comparative politics

The COVID-19 outbreak has challenged governments. It also is challenging conventional thinking in comparative public health law and policy on at least three fronts. First, some of the governments assessed to be most prepared by public health experts—with the greatest capacity for outbreak response—have failed to respond effectively to the pandemic. We suggest the neglect of political factors in these assessments may explain this disconnect. Second, the pandemic has shown the limits of the long-running

debates on democracy and health. Several of the mechanisms theorized and empirically supported in the literature have not operated as expected in the context of this pandemic, offering the opportunity for deeper complexity in future analyses. Third, the pandemic has raised new questions about public health opinion that suggests coercive policy responses are ill-advised because they are resisted and ultimately counterproductive. With COVID-19, governments have been praised for enacting rigid lockdowns that would not have been seen as ethical in other contexts, opening a rich field of inquiry about the outcomes of coercive responses as they unfold over the months and years to come. This article explores key questions raised amid the COVID-19 pandemic about how we think about preparedness, capacity, democracy, and coercive public health policies. We explore emerging examples that both complicate prior thinking and suggest caution about simple conclusions, even as the outbreak continues and it is far too soon to draw conclusions.

Which Countries Have the Greatest Capacity to Respond to a Pandemic?

Public health and social science have offered clear answers to this question—but the actual performance of states and governments around the world in COVID-19 has scrambled much of this thinking. A new conceptualization of political capacity for disease response capacity is needed.

A pandemic similar to COVID-19 has been predicted for years—by everyone from the World Health Organization (WHO) to the US National Academy of Medicines to Bill Gates (Ghebreyesus 2018; National Academy of Medicine 2016). Following the SARS outbreak in 2003, UN member states revised the International Health Regulations (IHRs) in numerous ways, including a commitment by all to strengthen eight core public health and disease response capacities (WHO 2008). This began a paradigm of “global health security,” which focused on how weakness in one country could quickly threaten the health and economic well-being of people around the world—a paradigm driven largely by wealthy countries and only deepened after the 2014 Ebola outbreak in West Africa (Davies, Kamradt-Scott, and Rushton 2015; Gostin and Katz 2016).

These commitments have led to extensive efforts to understand which countries are the most and least prepared to respond to infectious disease outbreaks. Joint External Evaluations (JEEs) have been officially conducted under the IHRs (Abimbola et al. 2017), the WHO has conducted various assessments (WHO 2020a), and perhaps the most robust effort

was mounted by an academic-think-tank collaboration titled the Global Health Security (GHS) Index, designed to “assess a country’s capability to prevent and mitigate epidemics and pandemics” (Cameron, Nuzzo, and Bell 2019: 7). This index is based on measuring a range of capabilities from laboratory capacity and health workforce to compliance with international norms, planning capacity, and political stability (i.e., level of social unrest and orderly transfer of power).

This conceptualization of pandemic preparedness turns out to align closely with the broader concept of state capacity—how effectively the state is able to conduct policy making and provide public goods such as security, health care, and physical infrastructure. As shown in the online appendix to this article, preparedness measures align closely with the World Bank’s measure of state capacity/government effectiveness. Thailand, for example, is the only country in the GHS Index category of “most prepared” that is not also in the top quartile in state capacity. The US is ranked first on the GHS Index, the UK second. China is ranked 51 and South Africa 34, while most other African countries are near the bottom. These measures have been critiqued as incomplete and biased toward wealthy countries (Langbein and Knack 2010; Razavi, Erondy, and Okereke 2020). For example, they award higher scores when countries spend money in ways that may not reflect good prioritization in resource-limited settings, thus sometimes measuring relative wealth instead of the quality of decision making. These measures nonetheless reflect a dominant concept of what *capacity* means.

COVID-19 should cause us to reflect on the limitations of this conceptualization and, relatedly, the degree to which high “capacity” has been associated with an effective response. Figure 1 shows the top-ranked 35 countries according to the GHS Index—all considered among the most prepared compared to the rest of the world—alongside the absolute number of COVID-19 cases and the deaths per 100,000 population as of May 1, 2020. These similarly “capable” countries have had very different outcomes to this point. South Korea, the US, and the UK, for example, all saw a handful of reported cases by mid-February, which spread into significant outbreaks in major cities. But by the beginning of May, South Korea had (at least temporary) control of the epidemic—with total cases of just 10% of those in the UK and 1% of those in the US as of May 1st. South Korea had seen fewer than 1 COVID-19 death per 100,000 people while the US and the UK saw 19 and 40 respectively. The scale of these differences provides a snapshot of significant variation between countries—even as they are, of course, imperfect ways to compare countries’ disease response

COVID-19 Cases and Deaths Among the Most “Prepared” Countries As of May 1, 2020

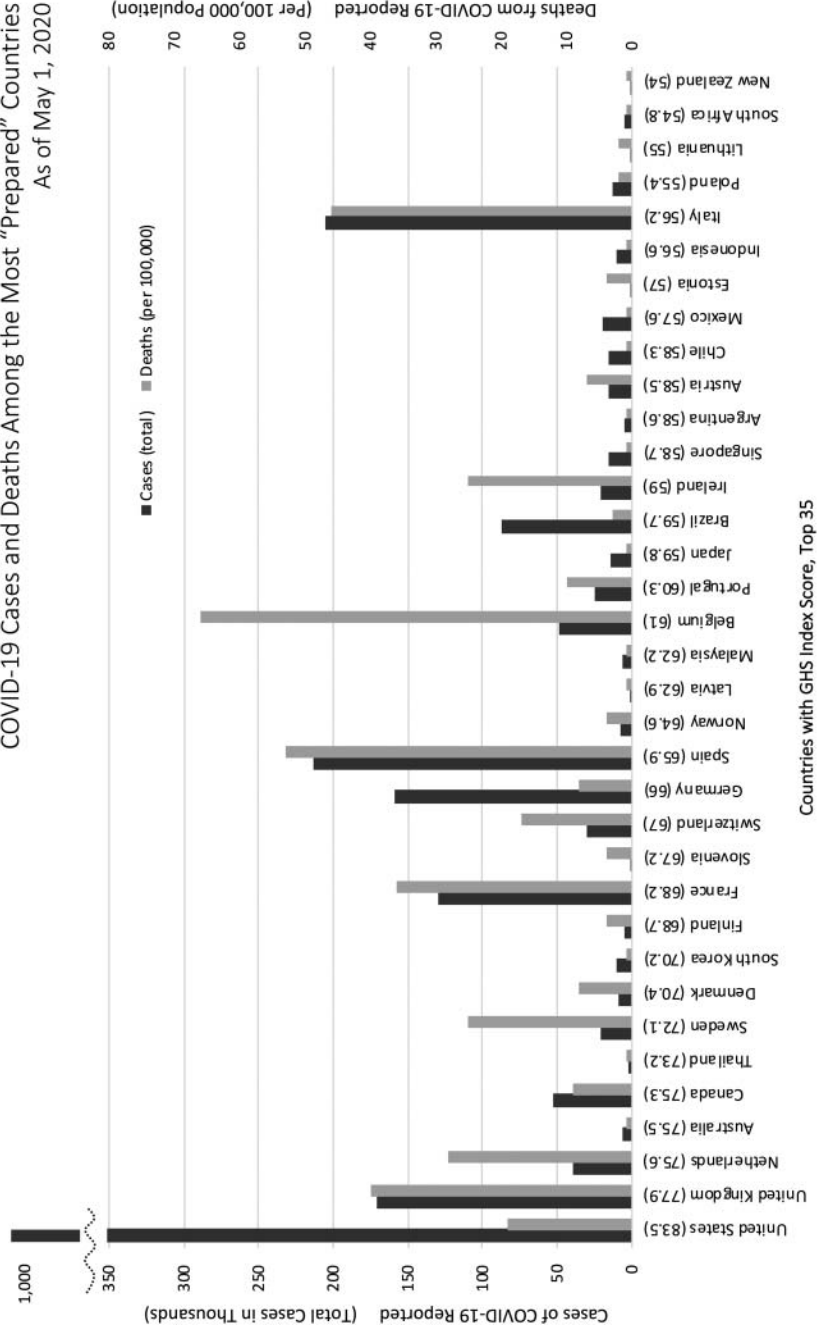


Figure 1 COVID-19 cases and deaths among the most “prepared” countries as of May 1, 2020.
Source: Johns Hopkins University and the *New York Times*.

given complex epidemics and variation in case-counting methods and saturation of testing. These trends could, of course, still reverse themselves, but they certainly suggest that these countries were *not* similarly prepared for a pandemic.

The variation shown across the supposedly most-prepared countries raises the question of how we might better reflect *political* capacity to respond to epidemics. Strong infrastructure and “stability” are clearly not sufficient. The state, in all its capacity, must be mobilized through political processes. From federalism and polarization to the ideological priors of ruling parties and relative dynamism and competence of leaders, differences between countries on these factors are clearly driving how capacity in public health can and will be harnessed. South Korea’s President Moon Jae-In, for example, came to politics as a pro-democracy campaigner and to the presidency following the peaceful ouster of his predecessor. His government seems to exemplify a common thread running through tentative successes in Germany, New Zealand, Vietnam, Singapore, and South Africa of leadership that took the threat seriously, listened to experts, and was able to quickly and effectively implement policies. Evaluating how and why might help us understand what political capacity looks like. Prior experience and political learning, for example, might turn out to be decisive in pandemic response (Bennett and Howlett 1992). Moon watched his predecessor fail to respond as a ferry boat accident turned into a national tragedy—then campaigned as a more responsive and transparent politician. He also lived through the SARS epidemic. In South Africa, the government is responding to COVID-19 in ways that reflect the recent experience of the AIDS pandemic—both the Mbeki government’s failure that cost hundreds of thousands of lives and the recent success it has experienced building the largest HIV treatment program in the world (Mbali 2013). This is just one of a host of other political factors that can and should help us understand capacity in a new way after COVID-19.

Is Democracy Good or Bad for Health during a Pandemic?

In general, social scientists have tended to agree, albeit with caveats, that democracy is beneficial for public health. COVID-19 is raising important questions about this contention as high-profile cases show authoritarian countries winning praise for their response while leading democracies have struggled to respond. This complicates, perhaps in helpful ways, the exploration of health and of democracy.

A wide literature has long debated the value of democracy for health. Electoral pressures and political freedoms of democratic regimes, it is argued, contribute to improved health and longer lives (Ruger 2005; Sen 1999). These claims have empirical support in political science (Gerring, Thacker, and Alfaro 2012; McGuire 2010; Przeworski et al. 2000; Wigley and Akkoyunlu-Wigley 2017), economics (Kudamatsu 2012), and public health (Bollyky et al. 2019)—though not without challenge, as some have shown weak or no connection (Ross 2006). A range of mechanisms have been proposed and tested for how democracy improves health, including *incentives*—median voters desire redistribution, and a norm of equality increases support for accessible health services; *information*—open media and opposition ensure that information both flows to the public about health and from the public to government about how to calibrate policy; *accountability*—enabling voters can punish leaders who fail; and *association*—enabling knowledge networks and interest groups to drive good policy.

The narrative of Chinese success and US failure has led to concern that COVID-19 represents bad news about the value, and future, of democratic governance (Diamond 2020). Initial studies have already been conducted showing a correlation between democracy and worse outbreaks as well as less effective policy responses (Cepaluni, Dorsch, and Branyiczki 2020).

Pandemic response is different from much of population health—with effective responses requiring the ability to act quickly, implement effectively, and gain public compliance. With the exception of HIV (see Lieberman 2009), disease outbreaks and political institutions have been understudied in comparative politics—with much of the literature focused on infant mortality or life expectancy, long-running trends that have far different mechanisms from a pandemic. Here, the accountability mechanisms that help democracies perform better may not be as beneficial. Political leaders with short time horizons may have relatively weak incentives to invest in pandemic preparedness and response (Dionne 2010; Healy and Malhotra 2009). And some of the benefits of associational networks and civil society can be shut down in the face of an emergency—facing, for example, stay-at-home orders. Democracies also have the added challenge of managing competing political factions and institutions, some of whom may have political incentives to undermine response. Once the outbreak broke into the public and Beijing was moved to act, China was able to quickly shut down the Wuhan market, shut down the movement of tens of millions of people, screen and isolate the sick, and even build two hospitals in a matter of days. Singapore is another autocracy that has gained praise

for its quick response. The United States, on the other hand, has struggled to respond. The Trump administration focused on travel bans to keep the “foreign” virus out rather than on mobilizing public health capacities to detect and respond—a message that aligns with the Trump administration’s election-year anti-immigrant and anti-China political frame. The president’s incentive structure has been clear, as his administration has tried to label COVID-19 the “Wuhan Virus,” continuing a trade war with China, the largest producer of medical goods needed by the United States. Perhaps these incentives were clearest in early March when Trump resisted allowing a cruise ship with COVID-19 cases to dock because “I don’t need to have the numbers double because of one ship” (White House 2020).

While it can be tempting to use high-profile examples and correlations to draw rapid conclusions, more time and analytic complexity are required. South Korea, for example, offers a very different example. Open media report widely, elections are highly competitive, and the previous president was removed after massive street protests. The main opposition party has been active in criticizing the government response to coronavirus in the lead-up to the next elections, including pushing back against lockdowns of the city of Daegu (Sang-Hun 2020). In this context, incentives seem to have aligned with a rapid response, as the political leadership has put transparency at the center of its approach and mounted one of the most effective responses to a major outbreak in the world. The Chinese and Singaporean examples also offer a complicated story. While China’s response has been praised, authoritarian information politics arguably enabled the disease to break out in the first place (Kavanagh 2020). An epidemic was becoming clear in December (Huang et al. 2020), but information with which the public might have taken preventive measures was suppressed, physicians posting accurate reports were threatened, and social media was censored until the government changed its official stance (*SINA* 2020). Without open media and opposition check on bureaucratic hierarchy, knowledge from the front lines of the epidemic did not reach Beijing to alert senior officials to the growing threat. Meanwhile, in Singapore, an initially effective response has been undermined by the government’s marginalization of migrant workers, who are given few rights and were invisible to the government’s early response given what the national development minister, who chairs the COVID-19 Task Force, has called “two separate infections” (Ministry of Communications and Information 2020). Democracy, accountability, and openness are playing a complex role in COVID-19.

Rather than give conclusions, then, we might ask a series of questions that will likely take years to untangle. Heading the call to consider

“democracy with adjectives” (Collier and Levitsky 1997), how might we categorize democratic or authoritarian governance that helps or hinders pandemic response? What is salient about the democracies of South Korea and Germany, for example, compared to the US and the UK? Are certain regime types more likely to defer to science? Does the *direction* of regime trends matter, and might “democratic declines” play a role in why some countries have responded poorly (Marsh and Miller 2012)? While a robust literature has considered the drivers of democratization and democratic breakdown, these trends themselves might provide causal power. In addition to studying how regime type matters in a global public health emergency, it could be fruitful to consider how this crisis will affect regimes in return. Will the pandemic lead to greater polarization in democracies? And to what extent will the scientific community be subject to such polarization? Already in the United States it has become clear that Americans are dividing along party lines in terms of their reaction to COVID-19. Will the pandemic advance authoritarianism? In Hungary, for instance, the Orban government has seized emergency powers well beyond what would be needed to respond to the virus. Meanwhile, in Egypt, President El-Sisi has acquired new emergency powers that may win him praise in the short term but could expose him to greater public anger if the government’s response to the economic consequences of COVID-19 ultimately prove inadequate (Singh and Williamson 2020).

There are also important methodological considerations that must be addressed before causal claims can be made. What does *better* look like? At this point, case counts are attributable not just to government response but also to luck and geography. Most importantly for questions of democracy, there is a problem of endogeneity—few reported cases could reflect reality or a lack of transparency linked to regime type. As the pandemic progresses, there will be a need for creative research designs to work around this problem.

Are Coercive Measures Desirable Policy Responses in the 21st Century?

COVID-19 is also raising important, potentially norm-shifting questions about the deployment of coercive measures to control the outbreak.

Since the 14th century and the time of the Black Death, coercive measures including forced screening, quarantine, isolation, sanitary cordons, and bills of health have been used and enshrined in law (Tognotti 2013). The goal is reducing contact between those sick with, or potentially exposed

to, infectious disease and those who are susceptible to the disease. With the dramatic decline in infectious disease in recent decades, and particularly following the AIDS crisis, there has been a broad shift away from forced measures. They came to be seen as ineffective and counterproductive in most cases, undermining trust, alienating communities, and driving people away from care (Gostin and Hodge 2020; National Academy of Medicine et al. 2007; WHO 2016). Long-term effects including individual trauma and public resistance to public health authorities amplify these concerns (Greenough 1995; Pellecchia et al. 2015). A growing, but imperfect, international consensus supported keeping police out of public health enforcement and making measures voluntary to the fullest extent possible.

But under COVID-19 much of this consensus has gone by the wayside and coercive measures have reigned. The Chinese imposed an unprecedented *cordon sanitaire* restricting the movement of more than 50 million people across Hubei province (Kavanagh 2020), and more than 80 cities enforced lockdown policies where, in many places, just one person in each household was allowed to leave every other day (Fang, Wang, and Yang 2020). Rather than cautioning against overly coercive measures, World Health Organization director-general Tedros Adhanom Ghebreyesus praised China as “actually setting a new standard for outbreak response” (WHO 2020b). This led to some handwringing about whether other, more open societies can address COVID-19 without China’s capacity for social control. Countries throughout the world, however, have followed suit, with the degree of coercion imposed not neatly aligning with regime type. Italy followed with some of the most restrictive policies in the world—enforcing lockdown measures with huge fines and the use of drones by police (Duncan 2020). In Spain, thousands of soldiers have been deployed to quarantined cities to patrol the streets and enforce lockdowns (*Economist* 2020).

Understanding and evaluating this shift will take years to unravel, particularly as the pandemic is still unfolding. From one perspective this might be an anomaly, with measures in response to COVID-19 best seen as idiosyncratic and isolated responses to the unprecedented threat of a novel, deadly, fast-spreading virus in this era of globalized interconnectedness. Indeed it is not even clear how to classify the lockdowns imposed in many countries. Quarantines generally refer to isolating asymptomatic individuals who are thought to be incubating a disease. Sanitary cordons take quarantine to a wider geographic area. Individuals are regularly quarantined throughout the world when exposed to drug-resistant tuberculosis or Ebola, for example, while neighborhood and citywide cordons were imposed in China and Canada during the 2003 SARS outbreak and in

Liberia in the 2014 Ebola outbreak. But in COVID-19, entire countries and states or provinces have been given orders to stay home—in part because insufficient testing meant there was little information about who might have been exposed. The purpose was not to separate those exposed from those likely not exposed but instead to reduce movement overall to shut down transmission outside small household units. Given the wide variation in implementation, enforcement, and meaning of stay-at-home orders, work will be needed to understand and classify these uses of state power. In some ways, they are closer to the exercise of martial law than to traditional quarantine powers, and perhaps post-COVID-19 they will not be relevant.

On the other hand, these responses can be seen in the light of broader questions about the exercise of power, coercion, and control by the state as threats are likely to continue to rise. We know that policy choices have long-run consequences (Pierson 2004). So what might come from these policies?

We might find that they work—challenging public health thinking. Preliminary evidence from a variety of countries has suggested that social distancing has been an important piece of the puzzle in “flattening the curve” (Fang, Wang, and Yang 2020; Harris 2020). Others have suggested that some particular measures may be doing more to delay rather than to prevent infections (Chinazzi et al. 2020). What is not yet clear is the role of coercion and enforcement. If China’s success is genuine and sustains, it certainly suggests an intuitive benefit in tight social control and rigid enforcement. Will we find that other countries that more tightly enforced social distancing did better, after accounting for other factors? Or will we find that coercion was not necessary? South Korea has focused heavily on combining public health measures with voluntary measures and behavioral nudges over coercive measures and is doing far better than many countries that called out the army. Untangling the causal chain, however, will be complicated.

We might find that coercion works initially but that it reduces trust, undermining the response in the medium term. Early polling has shown support for enforced distancing. In the United States, 80% of Americans said strict shelter-in-place orders are worth it; polls in Italy, Spain, and France each found more than an 85% approval rating for lockdown measures; and in South Africa the vast majority in an online poll supported a “total lockdown” (Dickson 2020; Ipsos 2020; Kirzinger et al. 2020). Yet there is reasonable concern that widespread use of coercive measures might spur backlash. We have seen this, for example, in South Africa, where

forcing people with drug-resistant tuberculosis into isolation has triggered protests, breakouts, and refusal to seek care (Baleta 2007). Barring a major scientific breakthrough, most public health authorities are describing the need to maintain social distancing for months to come—which will require a high level of compliance with public health orders, even as some restrictions are lifted. In addition, there are economic costs associated with pursuing social distancing measures and a risk of further backlash to the heavy economic price being paid to comply with such measures. In India, hundreds of thousands reportedly defied public health advice and fled the big cities for rural areas when the lockdown was announced, potentially spreading the virus throughout the country (Mehta 2020). Protests have sprung up from Michigan in the United States to Mumbai, Beirut, and Baghdad—not only creating moments in which the disease may spread but also suggesting the potential for wider-spread backlash (Sly 2020).

Given the scale of the coercive power seized by states throughout the world during COVID-19, we may find that some of the coercive policies are hard to undo after the outbreak abates. This ratchet effect is well documented in policy making in times of crisis (Posner and Vermeule 2003). Emergency powers after terrorist attacks, originally described as temporary, have been made permanent—from the US Patriot Act to surveillance powers enacted in France after the 2015 Paris attacks. Responding to the coronavirus, Belgium has set up police checkpoints on streets to augment the monitoring of people's compliance with stay-at-home orders, augmenting cellphone location tracking. In Chile and Hong Kong, bans on public gatherings have effectively enabled governments to shut down protests. Surveillance during the pandemic increasingly involves partnerships with private companies to track individual movements and contagion outbreaks in the name of public health. Will leaders and private entities, having reached for remarkably sweeping power to control movements, refrain from using those powers in reaction to future health and non-health crises inevitably to come?

While it might reflect a singular moment and one-time aberration, it seems likely to us that this move to embrace coercive public health measures on an unprecedented scale will have wider and more long-lasting implications.

Conclusion

COVID-19 has challenged core understandings in the comparative politics and policy of public health. Much of what seemed settled in the

definition of public health preparedness and capacity, the impact of democracy on population health, and the acceptability of widespread use of coercive public health measures appears unsettled. This presents an important and unique moment in comparative political study—where the tools of social science will be much needed in the years to come to help us make sense of COVID-19. It is far too soon, in the midst of a pandemic, to draw conclusions, but we have sought here to raise questions that might set out a reordering of assumptions and a research agenda for the years ahead.

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Matthew M. Kavanagh is assistant professor of global health and visiting professor of law at Georgetown University, where he directs the Global Health Policy and Politics Initiative at the O'Neill Institute for National and Global Health Law. A political scientist by training, with extensive experience in global health policy work outside the academy, he also is cochair of the UNAIDS Advisory Group. He received his PhD from the University of Pennsylvania and his master's from Harvard University. matthew.kavanagh@georgetown.edu

Renu Singh is a fellow at the O'Neill Institute for National and Global Health Law at the Georgetown University Law Center. Her research focuses on science policy and health policy, and she has conducted research as a political scientist and epidemiologist in Germany while on fellowships from the Fulbright program and the DAAD. She received her PhD from Georgetown University, her MS from the London School of Economics, and her BA and BS from the University of Massachusetts Amherst.

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