Prosperity and the New Normal: Social Distancing and the Exit from Lockdown

Abstract

The rapid policy response to quash the spread of the Covid-19 virus has been social distancing and lockdown. But these immediate policy goals cannot be maintained in the long-term management of the virus and for economic and societal wellbeing. Social distancing and lockdown policy have already proved to have disastrous impacts not only on the economy, but on inequality, poverty, housing, access to care and food and education – exposing how precarious people's livelihoods are. This paper aims to start a critical discussion on how to develop innovative social mechanisms for supressing the spread of Covid-19 and whether there might be alternative solutions to long-term social distancing. It has been to the detriment of the UK and the USA that they have not viewed the Covid-19 pandemic as a humanitarian crisis as countries in Africa have. We argue that any solution to manage the virus, society and the economy must be locally informed and led. This requires progressive localism and universal public service delivery, enhancing the capacities and capabilities of local communities who are already responding to the virus.

Key words: prosperity; social distancing; Covid-19; social innovation; public policy; localism

1. Introduction

"Society is largely based on trust when you get right down to it, and without that there's an alienation that works its way through the fabric of society," (Barry, 2004).

The world went into lockdown to save lives, but what does the world look like as we begin to emerge? Few would have offered the prediction that exiting lockdown would be harder than going in, but so it is proving to be. Governments responded to the Covid-19 outbreak in a panic, implementing lockdown policies in the absence of clear data (as opposed to predictive medical modelling) and without any clear plan as to what would actually be involved. From the beginning of the pandemic, it was clear that a few basic measures – washing hands and sneezing into your elbow and wearing a mask – helped to slow down the chain of infection. Social distancing rapidly evolved and lockdown was the logical extension. What no one had quite bargained for is that lockdown would end, but social distancing would remain, and, worse, governments would be once again without a plan to manage both the negative effects of longer-term social distancing and the inevitable surges in infection that follow lifting lockdown.

By locating the current pandemic globally and historically it is important to recognise two things. Firstly, isolation and lockdowns have been central practices to epidemics throughout history and have always been controversial (Tognotti, 2013). Secondly, Asia has more recent experience with epidemics and pandemics and generally has been more prepared than the West (Lee et al., 2020; Lewis & Yap, 2020; Martin & Yoon, 2020; Peckham, 2020). In many ways, Covid-19 has caught the West by surprise after 100 years of relative protection and the ability to respond using medical models and means. The HIV/AIDS epidemic is the exception, however, initially ignored by political elite. Against the West's self-perception, the Covid-19 crisis needs to be recognised as what it is - a humanitarian crisis, not just a medical

one. Following from the traditions of harm reduction research and public messages from HIV/AIDS, we ask - what will be the equivalent of safe sex in Covid-19 times?

If the predictions are true, the world will be dealing with the Covid-19 virus until at least 2022, unless a viable vaccine becomes available (Roy, 2020). The world will get through this pandemic, but there will be another. Although pandemics have occurred throughout human history, they are on the rise. Roughly every three years there is a declaration of a Public Health Emergency of International Concern by the World Health Organisation (Ducharme, 2020). Consequently, policy needs to be based on something more than the assumption that social distancing will remain until the virus goes away. This paper aims to start a critical discussion on how it might be possible to develop innovative social mechanisms for supressing the spread of Covid-19 and whether there might be alternative solutions to long-term social distancing, by looking to what local communities have done in past epidemics and how they are responding to Covid-19.

2. Social distancing and lockdown: a long-term perspective

The Covid-19 crisis was universally presented as an unprecedented event, with unprecedented consequences. The result was a demand for renewal from several quarters; new national innovation plans, new green deals, a great reset of our relations with the planet, a new economy, a host of better futures, but all without any real public debate about the alternatives to social distancing and lockdown, no sustained thought as to the social innovations that would be necessary to secure our futures. It is as if imagining alternative futures has cut off the oxygen for debate about the immediate challenges we face.

Over time it has become clear that the most distressing features of the virus's impact are not new. Going into the crisis, a decade of benefit cuts, caps and limits in the UK had decoupled welfare benefits from people's needs (Moore & Woodcraft, 2019; Wallace-Stephens, 2019); a large fraction of households have low-savings and high-debt (ONS, 2020c); variation in mortality, infections and outcomes reflect pre-existing inequalities and social structures. The long-term effects of social distancing and lockdown differ across ethnicity (Siddique, 2020; Southall, 2020; C. White & Vahé, 2020), education (Deaton, 2020; Gustafsson & Mccurdy, 2020), gender (Vassilev & Williams, 2020), age (Ageing Better, 2020), disability (ONS, 2020a), employment type (Chiou & Tucker, 2020) and place (Green, 2020). The lockdown and social isolation have laid bare the flaws in the current social contract.

The pandemic seized on existing structural fragilities and inequities, and amplified them, creating fissures in the social, economic, cultural and political fabric of societies. What began as a medical crisis, quickly became a set of financial, employment, housing, education and political crises. Across the world, systemic inequalities meant that the people most vulnerable to the risks of Covid-19 were less able to reduce their risk through measures such as social distancing and lockdown. The terrifying images of Indian day labourers walking for days without food and shelter to get home made it immediately apparent that such measures are not viable options long-term for the global South who rely heavily on their informal economies. Social distancing is impossible in refugee camps (Subbaraman, 2020). International agencies repeatedly warned that that the virus was pushing millions across the world into poverty and hunger (Oxfam, 2020). Even in the UK many vulnerable people were forced to work during lockdown and continued to transmit the virus because of poor working conditions, such as garment factory workers in Leicester (LBL, 2020). The costs of lockdown

were greatest for Black, Asian, minority ethnic, and low-wage workers, women and single parents (ONS, 2020b).

Governments and agencies around the world recognise these consequences, and yet most are still not driving the social innovations needed to develop alternative measures. The longer the delay, the greater the scarring on human and physical capital and the productive potential of the economy (Haldane, 2020). Nearly 50 percent of Black and minority ethnic households in the UK live in poverty, and those in poverty are disproportionately vulnerable to job losses and pay cuts which are the result of the pandemic, increasing the severity and persistence of poverty going forward (SMC, 2020). In the USA, children in around 16 percent of households were food short in June 2020, and Black and Hispanic children are experiencing even higher rates of food insecurity. Some 50 percent of the respondents whose children did not have enough to eat were working, but their earnings were insufficient for household needs (Bauer, 2020; Sanchez et al, 2020). High levels of unemployment and poverty post Covid-19 will see many struggling to put food on the table, with particular psychological and physical effects on young people as they develop. Diet is a key determinant of life chances; lack of nutrition causes health problems in later life and undermines social equality (Gundersen & Ziliak, 2015; NFS, 2020).

School closures in 188 countries have affected 1.5 billion children, leaving them vulnerable to hunger, child labour, forced marriage, teenage pregnancy and domestic violence (KidsRights Foundation, 2020). School closures are an obvious and easily enforced intervention, but research suggests that they are surprisingly ineffective at reducing deaths from coronaviruses (Viner et al., 2020). Education under lockdown reflected social, class and racial inequalities (Green, 2020; NFER, 2020), with pupil engagement lower in schools with higher deprivation, and evidence of a strong correlation between income, home internet access and ability to self-isolate (Chiou & Tucker, 2020). The most immediate effect of the school lockdown was to widen educational disadvantage for poorer children with consequences potentially cascading into the future for educational achievement and employment (Bivand, 2012). Education is the surest path out of poverty, and the World Bank estimates that five months of school closures would cut lifetime earnings for the children who are affected by $10 trillion, equivalent to 7 percent of current annual GDP (Azevedo et al., 2020).

The virus brought with it a global epidemic of domestic violence (Bradbury-Jones & Isham, 2020; Mccrary et al., 2020; Mlambo-Ngcuka, 2020; Perez-Vincent et al., 2020), with devastating long term consequences for women and child health. In the UK, as elsewhere, women were disproportionately affected by the crisis as they are more likely to work in shutdown sectors (Adams-Prassl et al., 2020) and bear the burden of care (ONS, 2020a; Vassilev & Williams, 2020). The number of carers reporting poor mental health has increased, with one in three carers reporting poor mental health (ONS, 2020a).

The impact of social distancing on health is increasingly becoming a global concern (Galea et al., 2020). Research before the Covid-19 pandemic found that social distancing and strict quarantine policies decrease social welfare (Brooks et al., 2020; Fenichel, 2013; Fenichel et al., 2011; Keogh-Brown et al., 2010; Mesnard & Seabright, 2009). In terms of physical health, situations involving social isolation and exclusion can provoke neural-immune reactivity in a way that is adaptive and beneficial to health in the short-term, but in the long-term can lead to mental and physical health problems. Social isolation influences the brain and immune system to increase individuals' risk for inflammation-related health issues and

viral infections (Slavich, 2020), while frequent physical contact can reduce anxiety, sleep issues, depression and improve immune response (Frijters, 2020).

In terms of mental health in the UK, a third of adults have reported high anxiety (ONS, 2020b). Increased feelings of loneliness and isolation can greatly influence mental health and exacerbate inequalities. In the UK higher levels of anxiety and depression symptoms were markedly higher than pre-Covid, particularly for those who had to self-isolate (White & Van Der Boor, 2020). For people with pre-existing mental health concerns, social distancing presents severe problems and can exacerbate anxiety and anger (Goodman et al., 2001; Jeong et al., 2016). Suicide, post-traumatic stress, depressive disorders, sleep disorders and emotional disturbances are likely to become pressing concerns as a long-term consequence of lockdown and isolation causing a 'parallel pandemic' (Mucci et al., 2020).

Social distancing measures are impacting trust as seen in the rise of violence and negative rhetoric towards 'others.' Populism feeds on tensions between international initiatives and national preferences. The concept of 'my country first' sees the USA buying all the stocks of remdesivir the drug which aids in Covid-19 recovery, leaving none for the rest of the world, and blocking other medical goods made in the USA from being sent abroad (Boseley, 2020). The shutting of borders and the promotion of the idea that others are contagious creates divisions of 'them' versus 'us' (Graham-McLay, 2020). Research shows how people are more confident that they are six feet away from a friend than a stranger, and that they are more likely to blame people of another race for standing too close (Norton et al., 2006). Social fraying of society happened during the 1918 influenza epidemic because people became afraid of one another (Hall, 1980; Kim, 2020). In the UK relationships between family and co-workers worsened over the lockdown (Fancourt et al., 2020).

Diverse life opportunities mean that some people are more likely to 'break the rules' than others. In the pandemic it is easy to focus on the people who appear to be 'making bad choices,' by breaking the rules and not adhering to physical distancing than to recognise that some individuals have to make 'bad choices,' and they are responding to institutional and governmental failures, rather than personal choice (Wilkinson-Ryan, 2020). 'Even when shamers have the risk calculus right, social distancing shaming is useless or even harmful to society. Each judgement is a chance not just to get the math wrong, but to let indignation outstrip empathy,' (Wilkinson-Ryan, 2020).

Childhood and adolescence are important life stages where stigmatising attitudes can solidify and often continue into adulthood (Hinshaw & Stier, 2008). If such attitudes are not modified, they may develop into prejudices and discriminatory behaviour (Adlaf et al., 2009; Faulkner et al., 2010). By telling young people that others are contagious, in a time ripe with polarising politics, it could create a generation of young people who are fearful of others, rather than accepting and empathetic. Exposure to difference has a strong effect on attitudes and reduces prejudice (Turner & Crisp, 2010), highlighted by the fact that anti-immigrant sentiment is higher in less diverse places (Evans & Menon, 2017). Frayed societies will not be mended while social distancing policy is a reality. Innovative, local and citizen-led solutions are required to build back better.

3. What are the next steps?

Most governments are concentrating on economic policies and how to get things back on track. Covid-19 is a disease of social intimacy – infection spreads through social pathways

(Richards et al., 2015) – and consequently new ideas about social behaviour and social institutions, with associated practices and policies, will be required to tackle it. However, without working through the challenges and problems associated with social distancing societies will be less resilient, rather than more, when it comes to the next pandemic. Long-term resilience requires a series of social innovations designed both to address the negative effects of social distancing and lockdown, and also to strengthen the ability to respond to future pandemics, as well as the challenges of climate change, livelihood insecurity, and intergenerational injustice.

The communities that survive and rebuild best after disasters are those with strong social networks, and those that fare worse are vulnerable populations with weak social connections (Aldrich et al., 2018; Ye & Aldrich, 2019). Strong social ties require a connection to place, and a series of networks and resources, underpinned by respect and trust. Creative policies to address pandemics need to be based on local people coming together with the right resources, knowledge and power to develop solutions for the places they live in. Such policies also need to be based not on current models of economic success, but on citizen-led understandings of what it means to live a good life (Moore, 2015; Moore & Woodcraft, 2019). Although, community-led support initiatives sprang up in the UK during the crisis, as they did in countries across the world, there was little attempt in the global North to turn to communities for solutions and to make those the basis of local responses to the crisis. While regional responses are currently being advocated in the current situation of localised spikes, the overall approach is still based on national decision making.

This perhaps explains why government responses did not look to successful examples of pandemic management from other parts of the world, coupled with the inevitable hubris – evident in the early days of the crisis – that the most developed countries in the world would somehow be spared. For example, in Senegal, forty years of responding to the HIV/AIDS pandemic led the country to focus on the importance of a human rights-based approach, while concentrating on developing communication materials adapted to specific communities and involving affected communities in the definition, implementation and follow up for Covid-19 control. A key feature was helping communities to develop their own responses. The Senegalese economic and social resilience programme encouraged community actors to innovate and become providers of essential services. Networks of people living with HIV/AIDS were also quick to mobilise to distribute resources, share accurate information and combat stigma associated with Covid-19 learnt from their experiences with HIV/AIDS and discrimination (Avafia et al., 2020; Somse & Eba, 2020; UNAIDS, 2020a, 2020b; UNCDF, 2020).

Sierra Leone drew on its experience of Ebola[1] utilising an approach that viewed Covid-19 not simply as a medical emergency, but rather a humanitarian crisis, with wider implications for food security, livelihoods and education (Maxmen, 2020). Contract tracing was essential to ending the 2014-2016 Ebola outbreak in Sierra Leone and is being used across the country during Covid-19. Over a thousand contact tracers have been employed and trained for each of the country's 16 districts. Community health workers are perfectly placed to share information tailored to each community as well as to link people to resources needed to effectively quarantine. This is especially relevant for higher risk populations living on borders, coastlines and in informal settlements. Active community engagement, accurate

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[1] This is not to say Sierra Leone is without its own difficulties in the Covid-19 pandemic which is exacerbating healthcare challenges and poverty that existed pre-Covid-19. A lack of resources hampers government and community efforts.

information spreading, contact tracing, digital health tools, policy known as 'less touching,' temperature checks at borders, selective quarantine, isolation facilities and periodic, short national lockdowns are all policy, action and insights stemming from experience with Ebola and are crucial in a context where social distancing is impossible (IOM, 2020; Lolleh, 2020; PIH, 2020).

Other West African countries are also drawing on their experiences with Ebola. Liberia was one of the first countries to introduce Covid-19 testing at airports after the outbreak in China and handwashing facilities were appearing outside of shops as early as January (Rouse, 2020). Senegal set up emergency operations centre after the Ebola epidemic to manage public health crises – which is seeing some Covid-19 tests results coming back within 24 hours. Here, every patient with Covid-19 is given a bed at a hospital or health care facility (Attiah, 2020). Senegal, with a population of 16 million, has had only 312 Covid-19 deaths at the beginning of October 2020 (Johns Hopkins, 2020). Insights from Ebola are particularly important as it has not had a vaccine developed for it and, despite best efforts, an effective Covid-19 vaccine may not be developed either.

A wider humanitarian approach would have seen the crisis characterised quite differently in the UK, where the differential impact of Covid-19 and its magnification of existing frailties seemed quite absent from the government formulated response. The medical modelling that so strongly advocated social distancing and lockdown was devoid of any assessment of the social, economic and political responses to these actions, even suggesting that lockdowns should continue until a vaccine might be available 18 months hence (Ferguson et al., 2020). The self-image of governments in the global North likely mitigates against characterising the pandemic as a humanitarian crisis, but this is exactly what it has turned out to be. The wealthy, white west seems to be largely blind to successful mitigation of Covid-19 in many African countries that are building responses from their experience with Ebola and HIV/AIDS. Long-term humanitarian crises cannot be solved by social distancing[2].

We can see this by reflecting on how an initial focus in the early days of the HIV/AIDS pandemic on sexual abstinence (unsustainable) was replaced by the practice of safer sex (sustainable) as responses evolved and matured. The world cannot abstain from social interaction and physical closeness long-term (Kutscher & Greene, 2020; Lally et al., 2010) we need physical intimacy to manage the diverse interactions of populous cities and run essential public services, such as transport systems. In the 2014 Ebola outbreak in Liberia, the initial public policy response was to encourage people not to touch each other, but in a cultural context that lays particular value on care giving, this appeared inhumane to local people (Abramowitz et al., 2015) who responded by developing community-led systems for the surveillance and treatment of Ebola. Innovative community response proved vital for containing the virus, highlighting that sustainable policy to manage crises must build capacities and capabilities through placed-based practices, addressing local needs and maximising local knowledge.

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[2] Interestingly, Massachusetts did draw on African humanitarian experiences to tackle Covid-19 because the organisation Partners in Health (PIH), which is based in Massachusetts, had lengthy experience working in Sierra Leone and with the Ebola outbreak. Partnering with PIH, the state established the Massachusetts Community Tracing Collaborative (CTC) which was the first large-scale Covid-19 contact tracing programme in the USA. PIH hired and trained 1900 people to support the state in contact tracing – essential for placing equity at the centre of an pandemic response by directly engaging with community in response efforts and making sure people can quarantine safely (Commonwealth of Massachusetts, 2020; PIH, 2020).

Further potential learning from the HIV pandemic involves thinking in terms of harm reduction, focusing on behaviour that makes individuals and communities safer, rather than basing advice and practices on a notion of absolute safety (Holmes, 2020; Kutscher & Greene, 2020). Harm reduction gives people the information necessary to protect their health, instead of making survival contingent on perfect behaviour, and it starts from the presumption that inequality, poverty, racism, disability, homelessness, civic status make people both more vulnerable to certain risks and less able to manage or reduce them. The approach emphasises engaging in lower-risk activities, discussing safety protocols before you meet someone, and dating based on risk communication. A safer way of socialising would involve such techniques supported through public messaging, recognising that all-or-nothing, when it comes to social distancing, is not an option. A harm reduction approach would see people going places, with substantial space and good ventilation, as well as improved and frequent hygiene routines. People who show symptoms or have been exposed must isolate themselves and be supported by local communities to do so. The aim would be to provide support networks around exposure and potential infection and move away from highly individualised responses based on the entrepreneurialism of 'stay alert'. This is crucial because, while young people may be less at risk of the virus, they can cause significant illness in others as recent spikes in infection have revealed. The world is different post-Covid, we need both to shift power and resources to people affected by structural violence and vulnerability (Homes, 2020; Kutscher and Greene, 2020), and to inhabit a new normal that allows us to evolve social behaviours based both on data and local experience (Goldman, 2020)[3].

Measures are needed now to prevent a long-term mental health crisis stemming from isolation, fear of others and loneliness. Research into the mental health status of people who isolated due to the Middle East Respiratory Syndrome found that providing mental health support to individuals vulnerable to mental health problems, accurate information and appropriate resources to assist with isolation (food, clothes, accommodation) could prevent mental health problems after isolation ends (Jeong et al., 2016). The crisis of unemployment that the UK will face can be remedied in one part through re-training people to provide emotional and social support to local people suffering from the long-term physical and mental impacts of Covid-19 and social distancing.

Some of the fundamentals for further innovation are already in place. For example, in England, local authorities are responsible for public health in their area and they work with a variety of partners to deliver key services such as housing, business support and social care. They can support local communities to tailor hygiene advice to local language needs, work with business organisations to deliver PPE equipment, distribute hand sanitisers to shops and care homes, manage a lockdown, work with local universities and businesses to produce locally relevant predictive models, and organise test, trace and isolate procedures. Networks like ODI Leeds OpenDataSavesLives are prototyping data sharing and building tools for local places (ODI Leeds, 2020). The key is local citizens generating and managing tailored and responsible data for local benefit which then builds trust and compliance. Covid-19 Mutual Aid UK helped communities during the pandemic to pull together resources to reach vulnerable and marginalised groups most at risk and to provide community care. These

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[3] Looking at alternatives to mandatory social distancing Goldman (2020) argues for voluntary social distancing informed by an 'infection load index' to be used in the long-term management of outbreaks of the virus. Such an index could be created by random sampling of a population and would be used to monitor outbreaks.

initiatives should be the backbone of response during the current Covid-19 spikes, and when the next pandemic comes around.

Policy and resourcing must recognise that pandemics are best controlled at the local level, and local authorities need enhanced capacities to facilitate, encourage and support community responses. Such an approach to resilience would involve a new localism (Moore & Collins, 2020b) and a new social contract between government and citizens. In the UK, Covid-19 has revealed just how much we have paid, and are paying, for low wages, zero-hours contracts, social inequality, poor housing, systemic racism, emaciated social care system and a weakened NHS. Basic public services need to be strengthened, revised and reinvigorated urgently – extending to transport, digital connection, housing, and food – supported by a new social contract based on secure livelihoods and a commitment to quality of life for all (Coote & Percy, 2020; IGP, 2017, 2019; Moore & Collins, 2020a). Public services need to be redesigned for the 21st century to build individual and community capacities and capabilities and strengthening livelihoods, health and social and environmental assets and resilience. Universal Basic Services (UBS) are something we all have in common; they can unite us in times of populist division because they are about finding collective strategies for collective needs. Without a renewal of individual capacities and capabilities, the next pandemic will likely prove more deadly, feeding off the fragilities Covid-19 has amplified.

4. Conclusion

Coming out of lockdown is anxiety ridden, involving a series of incomprehensible judgement calls, compromised intimacy, fear of strangers and social ambivalence. Large numbers of people around the world do not want to send their children to school, go back to work or even go out to meet friends. Meeting friends and family while staying a safe distance from them is producing not relief, but a strange kind of prohibition on social life itself, on touch, communication, trust and solidarity. Highly unequal societies, with high levels of mistrust and anxiety, are not resilient or high performing, nor do they produce the conditions for quality of life. In this paper, we have argued that we need social innovation to tackle Covid-19, and not just a vaccine or medical innovation.

Managing the current Covid-19 spikes and the many challenges that will follow, including future pandemics, will of course involve mass testing, meticulous contact tracing and some isolation. Lives must be saved, but we cannot sleepwalk into the next phase of the Covid-19 pandemic through a reliance on the current forms of social distancing and lockdown. They are blunt instruments, causing extreme damage to social, economic and political life. We urgently need new concepts, framing devices, narratives, forms of governance and social practices. What is the equivalent of safe sex in Covid-19 times? How can communities manage the landscape of infections - the clear pathways between hospitals, care homes, offices and households - better through more data and better resources? Answers to these questions, and others, will involve social innovation. Amongst these innovations will be a reworking of the notion of public health, who is responsible for it, how it can be delivered and who pays for it. We will not exit this pandemic well nor manage future ones through policies that: do not involve people locally; have no evidential or conceptual underpinning; and involve social prohibitions that have to stay in place until the virus is under control. All of that will be much too late.

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