# Communicable Disease Outbreak Preparation

A Topic Proposal for the National Federation of High Schools Topic Selection Committee

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# Introduction

*"Public Health is a powerful tool to level that playing field, to bend the arc of our country away from distrust and disparities and back towards equity and justice."*

*- Leana S. Wen.*

It does not take a trained medical professional to ascertain that the state of public health within the United States has reached a fever pitch. Individuals are constantly reminded of their health; often in the context of the neglect thereof. From fad diets to over-priced medications, consumers are bombarded with an overwhelming number of prescriptions aimed at protecting their well-being. And yet, with such an emphasis placed on health, the United States has proven that it is not prepared to handle an unprecedented disease outbreak. If the COVID-19 pandemic was not a wake-up call to the American public, it should be. This begs the question: with such an emphasis placed on public health, why does the United States fare poorly when it comes to its preparation for communicable diseases outbreaks? And why is this the case when the United States is the number one high-income country that spends more per person on health care than any other? These questions demand a closer look at public health policies within the US and what is being done to rectify this dilemma.

With the COVID-19 pandemic in the rearview mirror for many Americans, the threat of another pandemic may seem far-fetched. However, this is a topic that has been at the forefront of scientific research. Karen Feldscher, Associate Director for News in the Office of Communications at the Harvard T.H. Chan School of Public Health wrote in September of last year that "The pandemic also shined a light on vast health inequities, led to economic disruption, and spawned vitriolic politics on everything from masks to vaccines to school closures (Feldscher, 2024)." After such a traumatic event, it's no wonder that many individuals want to put the pandemic behind them. Feldscher asks researchers to "share their perspectives on recognizing, preparing for, and managing future outbreaks." She asks Yonathan Grad, a professor of immunology and infectious diseases, "Is there another pandemic coming?" to which Grad replies, "Yes. When? Which pathogen? How severe will it be? No one can say for sure. But the big demographic changes that are coming, due to climate change as well as economic and other factors, will alter the landscape and create new risks, both for new pathogens to emerge and for known pathogens to re-emerge (Feldscher, 2024)." This line of thought is far from localized. There is a litany of research that confirms that another outbreak is imminent. In 2023, the London-based disease forecasting company, Airfinity, utilized risk modeling to suggest that there is a 27.5% chance that a pandemic as deadly as COVID-19 could occur by 2033 (Airfinity, 2023). Airfinity's research posits that viruses are emerging more frequently due to a combination of factors such as increasing international travel and populations, climate change, and an "increasing threat posed by zoonotic diseases." The H5 Bird Flu outbreak in the United States should serve as an indicator that Airfinity's predictions were not unfounded. Thus, this topic IS uniquely relevant and WILL remain relevant to our lives and to the lives of the students who will be debating on the best course of action for preparing to combat another communicable disease outbreak.

A particularly troubling question that remains unanswered is 'How will the current administration alter disease readiness in the next two years?' In January, PBS News published an article explaining how "Trump and his team plan to slash government spending, and Trump has endorsed prominent vaccine detractors for top government health posts. During the campaign last year, Trump told Time magazine that he would disband the White House office focused on pandemic preparedness, calling it 'a very expensive solution to something that won't work (Stobbe 25).'" Additionally, Trump's move to withdraw from the World Health Organization further supports the prediction that he will not plan to further strengthen domestic public health policy.

While unfortunate, this does make it highly unlikely that federal policymakers will pass legislation that will make this topic a nonstarter.

The scope of a topic centered on disease preparedness presents an interesting nexus aimed at assisting novice debaters while simultaneously engaging more experienced competitors. This point of intersection is achieved by selecting a topic that is relevant to the lives of students. In this way, students will be able to use their own personal experiences as a baseline when attempting to understand their research. In 2024, the American Journal of Infection Control explained that the COVID pandemic impacted approximately 1.5 billion students in primary and secondary education (Mody, 2024). This makes the proposed topic one that is pertinent to students and it is one that even novice debaters will be able to wrap their proverbial heads around. What many students may not be aware of is the impact that the pandemic had on the lives that they lead as many students that will be debating this potential topic were relatively young at the height of the pandemic. As such, even experienced debaters will engage in eye-opening investigations as they begin to unpack the implications of their lived experiences. The aforementioned article goes on to explain that "Educational disruptions led to decreased academic performance, engagement, and test scores. The pandemic significantly influenced students' physical, social, and mental health. Furthermore, many students lost access to school-provided benefits, including subsidized lunches, after-school activities, and access to role models. The pandemic concurrently exacerbated pre-existing educational and economic disparities. Therefore, it is critical to identify strategies to reduce the impact of this pandemic and future public health crises on primary and secondary students." It is because of the relevance that this topic holds within the lives of individuals across the nation that students as well as coaches will be interested in deepening their understanding of communicable disease preparedness.

As for the quality of debates that may occur under one of the following proposed resolutions, we anticipate that these debates will be fresh and interesting year-round. Not only are the research materials widely diverse in terms of source, ranging from news articles to medical journals, but they are diverse in terms of content as well. A 2025 study published in the BMC Medical Journal put it best, "...the diversity in research prioritization practice in the context of high-consequence pathogens (Antonia et al 25)" means that there will never be a drought of research material for students and coaches to uncover. Due to the range of impact, application, and health standards within the US, researchers may prioritize different aspects of the topic. As such, a diverse research pool prevents debates from becoming stale as the year progresses.

Finally, the proposed topic provides a sufficient balance of ground to be shared between Affirmative and Negative teams. Affirmative cases may concern vaccine distribution or mandates, medical supply production, disease tracking and surveillance, disease-resistant gene editing, and research capacities just to name a few. The topic would allow Aff teams sufficient ground to get creative with their case writing and explore options within the boundaries of the topic without overtly reducing negative ground. Conversely, negative teams would have access to classic arguments such as the medical mistrust, politics, and federalism disadvantages; international actor counterplans like the World Health Organization or NATO, and public-private partnerships, as well as the capitalism and identity based kritiks. But their ground does not stop there. The negative would also have the freedom to draft more creative arguments specific to affirmative cases such as the gentrification/development disadvantage, deregulatory action, and state cooperation counter plans. Kritikal ground specific to the topic is vast and will cover a range of identity and structural-based arguments. Specifically, debates center around how healthcare programs address social elements of health, as well as the government's structural control over their citizens' bodies. And of course, there will always be room for topicality debates. Primary topicality arguments will center around the creation of programs focused on disease prevention versus reaction to outbreaks.

Additionally, the promotion of existing programs and the creation of new initiatives. Furthermore, as government sponsorship for private company developments grows, topicality debates will be had about the possessive nature of affirmative mandates. Thus, one side will not have a tremendous advantage over the other due to an inequitable distribution of ground.

It is because this topic sufficiently meets the criteria outlined in the NFHS guidelines, that we submit this topic paper for consideration. It is our prediction that a resolution centered on communicable disease preparedness will train young minds across the nation and sow the seeds necessary to change how public health is viewed and talked about in modern-day pedagogy.

# Potential Resolutions + Definitions

**Disclaimer:** *All resolutions elect to use the term "communicable diseases" rather than "infectious diseases" because all communicable diseases are infectious, but not all infectious diseases are communicable. Communicable disease requires human-to-human transmission and focuses debates on the external aspects of the disease.*

**Resolved: The United States federal government should significantly expand communicable disease outbreak preparedness programs in the United States in one of the following areas: Disease Surveillance, Medical Supplies, or Research Capacity.**

*"One of the following areas" topics are very good for narrowing the debate down to a few key areas that provide the best in-depth debates and have the most literature available. These 3 areas are what our research indicates provide the best balance between limits and innovation.*

**Resolved: The United States federal government should establish a comprehensive strategic plan for communicable disease outbreak preparedness in the United States.**

*A "comprehensive strategic plan" forces affirmative cases to blend substantial portions of pandemic preparedness. This avoids the risk that affirmatives will do tiny preparation actions.*

**Resolved: The United States federal government should substantially increase its regulatory incentives for communicable disease preparedness programs.**

*The primary term of art used here is "regulatory incentives". Through our research, we have found these to be regulations and legal restrictions that are implemented to induce a desired behavior. This term would most likely promote debates about government encouragement of private actions like subsidies, and bans on products or production methods. This resolution is lower in priority, however, because this term may open up affs to get really specific with diseases and spawning points. The term preparedness is quite interesting as it prompts affirmative to take actions that will be deployed post-outbreak rather than preventing the outbreak itself. Actions like response plans, lockdown mandates, and supply chain securitization would be topical.*

**Resolved: The United States federal government should substantially increase its support for communicable disease response measures in the United States.**

**"Communicable Disease" -**

**Edemekong and Huang 22.** Edemekong, Peter F, and Ben Huang. "Epidemiology of Prevention of Communicable Diseases." National Library of Medicine, 24 Oct. 2022, www.ncbi.nlm.nih.gov/books/NBK470303/.

**Communicable diseases are illnesses caused by viruses or bacteria that people spread to one another through contact with contaminated surfaces, bodily fluids, blood products, insect bites, or through the**

air. There are many examples of communicable diseases, some of which require reporting to appropriate health departments or government agencies in the locality of the outbreak. Some examples of the communicable disease include HIV, hepatitis A, B and C, measles, salmonella, measles, and blood-borne illnesses. Most common forms of spread include fecal-oral, food, sexual intercourse, insect bites, contact with contaminated fomites, droplets, or skin contact. This activity reviews the epidemiology of communicable diseases and discusses the role of the interprofessional team in preventing communicable diseases and educating patients on techniques to avoid the transmission of communicable diseases.

**Kandola, 2020,** Kandola, Aaron. "Communicable Diseases: Definition, Symptoms, Prevention." Medical News Today, 17 June 2020, www.medicalnewstoday.com/articles/communicable-diseases.
**A communicable disease** is one that **spreads from one person or animal to another or from a surface to a person.** They are **the result of pathogens, such as viruses and bacteria. Communicable diseases include colds and flu.**

**"Communicable disease preparedness"-**

**City of New York, No date.** "Infectious Disease Readiness - NYC Health." Www.nyc.gov, City of New York, www.nyc.gov/site/doh/providers/emergency-prep/communicable-disease-preparedness.page.
The NYC Department of Health's **Communicable Disease Preparedness Program works to ensure** citywide **readiness for** Ebola virus disease and other special **pathogens transmissible from person to person**. New York City is an international crossroads and disease outbreaks anywhere in the world can make their way here. **Health care facilities and emergency medical services must be ready to prevent, detect and respond to dangerous pathogens**. The tools and guidance documents found on this page are designed to help health care systems prepare to safely and successfully identify, isolate, assess, transport and treat patients with a suspected or confirmed special pathogen.

**"Comprehensive Strategic Plan" -**

**Medhi and Manshadi, 2015,** Mehdi HAGHI, and Mehdi GHARASI MANSHADI. "The Necessity of Strategic Plan for Preparedness and Response in Iran's Hospital System." Iranian Journal of Public Health, vol. 44, no. 7, July 2015, p. 1029, pmc.ncbi.nlm.nih.gov/articles/PMC4645758/. Accessed 25 June 2025.
**To reduce the human and economic losses, hospitals are required to design and implement a comprehensive strategic plan for disaster management** more than ever. Having s**uch plan can reduce significantly financial and physical loses and lead to a better and more responsiveness to events**.
Finally, it should be noted that considering a single and similar program for all hospitals in the country (due to different environmental conditions) cannot be helpful, and every hospital based on the specific situation of their own, must consider design and implementation of a unique disaster management master plan.

**"Disease Outbreak" -**

**WHO, 2024** "WHO EMRO | Disease Outbreaks | Health Topics." World Health Organization - Regional Office for the Eastern Mediterranean, 2024, www.emro.who.int/health-topics/disease-outbreaks/index.html.
Disease outbreaks - **A disease outbreak is the occurrence of cases of disease in excess of what would normally be expected in a defined community, geographical area or season**. Outbreaks are **maintained**

**by infectious agents that spread directly from person to person, from exposure to an animal reservoir or other environmental source, or via an insect or animal vector.** Human behaviours nearly always contribute to such spread. Early detection and reporting of such events is crucial in minimizing their negative social and economic impact. Epidemic-prone diseases, including emerging and re-emerging diseases constitute the greatest threat to public health security and the disruption of social and economic developments of the countries of the Eastern Mediterranean Region. In the past 20 years, the Region has witnessed a marked increase in the number of outbreaks and pandemics caused by emerging and re-emerging diseases, such as Alkhurma haemorrhagic fever, chikungunya, cholera, dengue, A/H5N1 influenza, pandemic A/H1N1 (2009) and Rift Valley fever, among others. This situation has been exacerbated by acute and chronic humanitarian crisis in many countries of the Region.

**"Disease surveillance" -**

**CDC, 2001,** Centers for Disease Control and Prevention. Updated guidelines for evaluating public health surveillance systems: recommendations from the Guidelines Working Group. MMWR Morb Mortal Wkly Rep. 2001;50(RR-13): 1-35.
**Disease surveillance is an ongoing process that involves the systematic collection, analysis, interpretation, and dissemination of information regarding the occurrence of diseases in defined populations for public health action to reduce morbidity and mortality.**

**WHO, 2024,** World Health Organization. "Surveillance." Www.who.int, 2024, www.who.int/westernpacific/emergencies/surveillance.
Surveillance in emergencies - The Western Pacific Region, being the most diverse region in the World, is beset by unique public health challenges and is considered a hotspot for outbreaks and emerging and re-emerging infectious diseases, such as SARS, MERS, avian influenza, Zika and dengue. Currently there are 3 global emergencies affecting the Region:
COVID-19 (Grade 3 protracted emergency;
Mpox (Grade 2 protracted emergency) and
The global dengue situation (Grade 3 emergency).
Public health surveillance is the continuous, systematic collection, analysis and interpretation of health-related data for action. **Disease surveillance data serves as the basis for the detection of potential outbreaks for an early warning system to prevent what could become public health emergencies**. It enables monitoring and evaluation of the impact of an intervention, helps track progress towards specified goals and clarifies the epidemiology of health issues. Humanitarian emergencies increase the risk of transmission of infectious diseases and other health conditions, such as severe malnutrition. An **effective disease surveillance system is essential to detect disease outbreaks quickly before they spread, cost lives and become difficult to control.** Effective surveillance can improve disease outbreak detection in emergency settings, such as in countries in conflict or following a natural disaster.

**"Establish" -**

**Merriam-Webster, no date,** "Definition of ESTABLISH." Www.merriam-Webster.com, www.merriam-webster.com/dictionary/establish.
**establish**
verb
es·tab·lish i-ˈsta-blish
established; establishing; establishes
Synonyms of establish

transitive verb
**to institute (something, such as a law) permanently by enactment or agreement**

**“Expand” -**

**Cambridge Dictionary, 2024**, Cambridge Dictionary. “Expand.” @CambridgeWords, 9 Oct. 2024, dictionary.cambridge.org/us/dictionary/english/expand#google_vignette.
**expand**
verb [ I or T ]
us /ɪkˈspænd/ uk /ɪkˈspænd/
**to increase in size, number, or importance, or to make something increase in this way**:

**“Increase” -**

**Merriam-Webster,** No date, “Definition of INCREASE.” Www.merriam-Webster.com, Merriam-Webster, www.merriam-webster.com/dictionary/increase.
increase
verb
in·crease in-ˈkrēs ˈin-ˌkrēs
increased; increasing
Synonyms of increase
intransitive verb
: **to become progressively greater (as in size, amount, number, or intensity)**

**National Academies of Sciences, Engineering and Medicine, 2012,** National Academies of Sciences, Engineering, and Medicine. 2012. Disaster Resilience: A National Imperative. Washington, DC: The National Academies Press. https://doi.org/10.17226/13457.
THE NATIONAL IMPERATIVE TO INCREASE RESILIENCE
Decisions by communities, states, regions, and the nation regarding whether to invest in building resilience are difficult. If building the culture and practice of disaster resilience were simple and inexpensive, the nation would likely have taken steps to become more resilient already. **Making the choice either to proceed with the status quo—where concerted investments and planning do not take place throughout the country to increase disaster resilience—or to make conscious decisions and investments to build more resilient communities is weighted** by a few central points:

**“Medical supplies” -**

**Law Insider, 2015,** “Medical Supplies Definition: 228 Samples.” Law Insider, 15 Oct. 2015, www.lawinsider.com/dictionary/medical-supplies.
**"Medical supplies" means items for medical use that are suitable for use in a health care facility or in the home and that are disposable or semi-disposable and are non-reusable.**

**Northside Medical Supply, 2023,** “What Is an Example of a Medical Supply or Equipment?” Northside Medical Supply, 1 Feb. 2023**,** northsidemedicalsupply.com/blog/what-is-an-example-of-a-medical-supply-or-equipment/.
Understanding **Medical Supplies** - When described **in simple terms**, medical supplies **include surgical or medical items that are expandable, consumable, disposable, or non-durable, which might be used for the diagnosis or treatment of a specific illness, condition, or injury of the patient**. Medical devices are **considered essential to provide** compassionate, **comprehensive care.** Medical supplies can **help diagnose, prevent, treat and rehabilitate illness in a safe and effective manner.** There are

now a lot of manufacturers and companies that are working hard to come up with all the essentials that are required by patients. So when you visit Northside Medical Supply, you will be able to find both online and offline platforms that will help you to get the right products. Medical tools are generally items that aim to provide in-home care, but they can be quite expensive. In some situations, hospitals can consider sending some supplies besides staffing to guarantee the patient receives the proper attention and care they deserve. Hospitals and other facilities can also directly negotiate with the seller for the purchase of the supplies through a group purchasing organization. Having an idea about the essentials becomes extremely important when you have a loved one who requires at-home medical care. This will guarantee that you are able to find the right website for placing your order at an affordable cost.

**"Preparedness" -**

**Merriam-Webster, 2020,** Merriam-Webster. "Definition of PREPARATION." Merriam-Webster.com, 2020, www.merriam-webster.com/dictionary/preparation.
preparation
noun
prep·a·ra·tion ˌpre-pə-ˈrā-shən
Synonyms of preparation
**the action or process of making something ready for use or service or of getting ready for some occasion, test, or duty**

**UNDRR, 2017,** UNDRR. "Preparedness." Www.undrr.org, 2017, www.undrr.org/terminology/preparedness.
Definition: **Preparedness**
**The knowledge and capacities developed by governments, response and recovery organizations, communities and individuals to effectively anticipate, respond to and recover from the impacts of likely, imminent or current disasters.** Annotation: Preparedness action is carried out within the context of disaster risk management and aims to build the capacities needed to efficiently manage all types of emergencies and achieve orderly transitions from response to sustained recovery. Preparedness is based on a sound analysis of disaster risks and good linkages with early warning systems, and includes such activities as contingency planning, the stockpiling of equipment and supplies, the development of arrangements for coordination, evacuation and public information, and associated training and field exercises. These must be supported by formal institutional, legal and budgetary capacities. The related term "readiness" describes the ability to quickly and appropriately respond when required. A preparedness plan establishes arrangements in advance to enable timely, effective and appropriate responses to specific potential hazardous events or emerging disaster situations that might threaten society or the environment.

**"Promotion" -**

**The Economic Times, no date,** "What Is Promotions? Definition of Promotions, Promotions Meaning." The Economic Times, Bennett, Coleman & Co. Ltd, economictimes.indiatimes.com/definition/promotions?from=mdr.
What is 'Promotions' - Definition: **Promotions refer to the entire set of activities, which communicate the product, brand or service to the user. The idea is to make people aware, attract and induce to buy the product, in preference over others**. Description: There are several types of promotions. Above the line promotions include advertising, press releases, consumer promotions (schemes, discounts, contests), while below the line include trade discounts, freebies, incentive trips, awards and so on. Sales promotion is a part of the overall promotion effort.

**Law Insider, 2017** "Promote Definition: 873 Samples | Law Insider." Law Insider, 22 Oct. 2017, www.lawinsider.com/dictionary/promote. Accessed 25 June 2025.
1.235**"Promotion" means** those **activities**, including, without limitation, **normally undertaken by a pharmaceutical company's sales force** to implement marketing plans and strategies **aimed at encouraging the appropriate use of a particular Licensed Product in a specific indication.** When used as a verb, "Promote" shall mean to engage in such activities.

**"Regulatory Incentives" -**

**Trémolet and Binder 10.** Trémolet , Sophie, and Diane Binder. "Promoting Investments – How Can Regulatory Incentives Be Introduced to Promote Investment?" Regulationbodyofknowledge.org, The University of Florida, Nov. 2010, regulationbodyofknowledge.org/faq/price-level-and-tariff-design/promoting-investments-how-can-regulatory-incentives-be-introduced-to-promote-investment/. Accessed 25 June 2025.
Promoting investments – How can **regulatory incentives** be introduced to **promote investment**?
You're in the section: Frequently Asked Questions -> Price Level and Tariff Design -> Promoting investments – How can regulatory incentives be introduced to promote investment?
[Response by Sophie Trémolet and Diane Binder, November 2010] **The overall regulatory framework** within which a company operates **plays a large role in determining this company's incentives for investment.** The sunk nature of many investments by utilities means that investors are vulnerable to governments or regulators changing the rules of the game. **Regulators should therefore strive to develop a stable environment and can adopt specific approaches to incentivize utilities to invest sufficiently to expand the network while promoting efficiency and equity[**1]. In developing countries specifically, the need for new infrastructure development is vast and regulators, while encouraging investments, must not encourage gold-plating [2]and inefficiencies. Regulatory decisions that can promote (or discourage) investments include setting the allowed return on capital, the definition of the asset base and the link between cost allocation and tariff structures. These elements are examined below.

**"Research Capacity" -**

**Bilardi et al, 2021,** Bilardi D, Rapa E, Bernays S, et al Measuring research capacity development in healthcare workers: a systematic reviewBMJ Open 2021;11:e046796. doi: 10.1136/bmjopen-2020-046796
The process of progressive empowerment is usually referred to as capacity development.8 This term has been used in multiple areas and applied in different sectors to develop new or existing competencies, skills and strategies at a macro or individual level.9 **In the field of health, research capacity development should support healthcare workers in generating local evidence-based results to inform policy and improve population health**. The three health-related Millennium Development Goals, and more recently the targets 'B' and 'C' of the Sustainable Development Goals, all support the adoption of new strategies to strengthen the capacity of healthcare workers in all countries in performing their job and engaging in research.10–12 One of the critical barriers in supporting HRCD is the lack of empirical measurement of competencies in relation to the performance of research activities. Existing frameworks and tools have been developed for a particular purpose in a particular context.13 14 Others have identified barriers that healthcare workers encounter in engaging in research or have monitored and evaluated targeted training activities.15 **This systematic review aims to identify tools to measure individual healthcare workers' capacities to conduct research.**

**Matus & Mickan, 2018,** Matus, J., Walker, A. & Mickan, S. Research capacity building frameworks for allied health professionals – a systematic review. BMC Health Serv Res 18, 716 (2018). https://doi.org/10.1186/s12913-018-3518-7
**There is a burgeoning interest in strategies to enhance research capacity building for healthcare professionals.** The recent Strategic Review of Health and Medical Research in Australia (2013) recommended that research should be fundamentally embedded in the health system, and that the healthcare workforce should be involved in research to drive continuous improvement [1]. **Research capacity building has been defined as "a process of developing sustainable abilities and skills enabling individuals and organisations to perform high quality research"** [2], or **"a process of individual and institutional development which leads to higher levels of skills and greater ability to perform useful research"** [3].

**"Response measures" -**

**Law Insider, no date,** "Response Measures Definition | Law Insider." Law Insider, 2025, www.lawinsider.com/dictionary/response-measures. Accessed 25 June 2025.
Response measures means **any reasonable measures taken** by any person, including public authorities, following an industrial accident, **to prevent, minimize or mitigate possible loss or damage** or to arrange for environmental clean-up. Domestic law may indicate who will be entitled to take such measures.

**"Substantially" -**

**Cambridge, 2025,** Cambridge Dictionary. "Substantially." *@CambridgeWords*, 5 Mar. 2025, dictionary.cambridge.org/us/dictionary/english/substantially#google_vignette.
substantially
adverb
us /səbˈstæn.ʃəl.i/ uk /səbˈstæn.ʃəl.i/
substantially adverb (LARGE)
**to a large degree**:
The new rules will substantially change how we do things.

**Arush et al 22.** Pandemic preparedness and response: exploring the role of universal health coverage within the global health security architecture Lal, Arush et al. The Lancet Global Health, Volume 10, Issue 11, e1675 - e1683
Fostering global solidarity, such as by funding the common goods for health, is an overlooked role of global health security financing. Common goods are interventions that require **collective financing and** include **investing in essential public health functions**, building local health systems, and incetivising UHC.64 To ensure the provision of common goods for health, WHO member states need to support **proposals for a substantial increase (at least 50%) in assessed contributions to WHO**, and **provide the organisation with** non-earmarked **funding, as proposed by the Working Group on Sustainable Financing**.65 All efforts should be made to ensure that these funds come from equitable contributions of high-income countries, donors, and private sector partners, and that clear enforceability mechanisms exist for all participating stakeholders.

**FEMA, 2018,** Homeland Security. Threat and Hazard Identification and Risk Assessment (THIRA) and Stakeholder Preparedness Review (SPR) Guide Comprehensive Preparedness Guide (CPG) 201 3rd Edition. FEMA, May 2018.

The **projected impacts of threats** and hazards **determine the level of capability that a community will need to address those impacts**. To understand their risks effectively, communities should identify and select threats and hazards that have impacts that most challenge their communities, and therefore their capabilities. **When assessing impact,** it is important to consider that different incidents present different types of challenges. In some cases, **the sheer magnitude of the incident may be substantial**. In other cases, there may be operational or coordination complexities or economic and social challenges.

## Affirmative Ground

This topic paper has been written with the ideal that affirmative teams will focus solely on actions that are meant to be deployed in the event of a major communicable disease outbreak. Most cases would defend that another pandemic is not a question of IF it is coming but when and how big will it be? This means that affirmatives would be barred from taking action geared towards preventing the next pandemic from starting. With the astronomically unpredictable nature of communicable diseases we will defend the impossibility of not only expecting affirmatives to reach solvency on the question of pandemic prevention but negative teams predicting what that might look like as well.

The first instinct of a topic surrounding pandemic preparedness is to focus your affirmative case solely on the lives lost during such an outbreak and finding creative ways to mitigate the toll. While this is a focus area affirmative teams will take on a communicable disease preparedness topic, a significant amount of affirmative ground and creativity can be generated from the process of establishing such initiatives. We believe this is where most of our argument innovation will lie. Primary areas of argument innovation that we have identified are both structural and existential in nature, providing debaters the opportunity to explore big stick and proximal areas of research. Discussion of the key affirmative topic areas is below:

### Disease Data / Surveillance

A very large part of preparing for any nationwide disaster is establishing a network for communication as well as data collection and sharing. We anticipate creating surveillance and data systems specifically tailored towards communicable disease tracking will be at the core of this topic. Affirmatives that wish to go down this route will have access to a litany of advantage scenarios and solvency mechanisms. First in the realm of solvency advocates, Federally sponsored data collection, interstate medical data sharing agreements, and self reporting mandates are examples of surveillance the federal government can create on this topic. Advantage opportunities are plentiful as well. International alignment based on domestic data collection can promote cooperation with foreign entities and international organizations. Data collection and analysis supports an increasingly vital part of the American technology economy as we anticipate affirmatives contracting to private companies for such actions. Additionally, there is significant research that indicates a shared collective engaging in disease tracking promotes social cohesion and reduces the stigma surrounding our personal medical information.

### Medical Supplies Production

If COVID did one thing, it exposed our complete insufficiency in the realm of medical supplies. From masks all the way to hospital ventilators, production was not able to keep up with demand in real time. Affirmative cases in this realm would explore the efficacy of US manufacturing and innovation in the medical supplies sector. Solvency mechanisms can include but are not limited to;

PPE stockpiling, distribution schematics, rationing plans, and potentially government subsidies for new innovative technology, topicality debates permitting. Additionally, our research indicates that vaccines and pharmaceutical treatments do qualify as a "medical supply". This opens the topic to discussing the role the pharmaceutical industry plays in communicable disease preparedness and response measures. Advantages associated include the economic effects of manufacturing, artificial government pricing controls on medicinal products, as well as aforementioned international implications of trade and cooperation.

### Research Capacity

Research capacity allows the federal government to expand grants and/or funding to ensure that appropriate research is being done to respond to a potential outbreak. Laboratory and research capabilities, when properly supported pre outbreak, are better equipped to respond to such a disaster. Direct, government investment in this sector would include research grants, university sponsorships, and exploring the role government regulation plays on actions research can take in such a scenario. Significant research exists on the role government red tape plays in hindering our research response measures in the event of a communicable disease outbreak (Varma, 2023). Affirmatives can choose to take deregulatory action that speeds up those response measures. Advantages of this topic area could include the multifunction goals that some laboratories serve, looking towards spillover from communicable disease research efficacy to other scientific sectors as well. Additionally, increasing diagnostic availability nationwide by setting minimum research capacity measures per capita across the US can open affirmatives to inequality based impact scenarios.

### Urban/Rural Preparedness

Every good policy debate topic needs to provide debaters the opportunity to defend socially significant impact scenarios, while also defending federal government action. Communicable diseases do not discriminate in who they choose to attack. However, there is a large disparity in response priorities between social classes in the United States. Debaters would have the choice of exploring how disease disaster response is unequally created in rural versus urban communities. During COVID, we learned that even though the pandemic was slower to reach rural areas, once it did it was much more deadly because those areas were forgotten in disease preparedness initiatives. Much of those discrepancies in response is what informs most rural populations distrust for government medical initiatives and recommendations. Affirmatives can take action to alleviate those gaps in preparedness and ease much of the medical mistrust that exist in those communities.

## Negative Ground

### Case Debate

Each topic area discussed in the affirmative ground section boasts significant opportunity for negative teams to generate robust case debates. A lot of that debate stems from analyzing past preparedness initiatives and comparing those to the affirmative proposed changes. Additionally, negative teams will find arguments in the scope of preparing for a pandemic without addressing underlying health problems in the US that exacerbate those outbreaks first. Surveillance and data collections call into question the ethicality of invading American's privacy for the sake of tracking. Medical supplies production arguments will introduce the negative effects of the government

artificially increasing demand in the industry, causing short term economic shocks. The overarching case debate will be about the federal government trying to solve a problem that either many Americans don't believe exist, or think bureaucratic governance caused more harm than good the last time we had a communicable disease outbreak. There is a lot of research to suggest that under the current administration, programs deployed by the affirmative will get tampered with to the point of disaster (Slavitt, 2021)

## Disadvantages

Anytime the federal government begins proactively preparing for an oncoming disaster, considerations must be made for the potential negative effects; not only at the end point but during the process as well. Competition based disadvantages can be created not only from international relations scenarios but also in domestic markets as well. There are significant hegemonic implications to medical readiness, with countries like China priding themselves on their ability to respond and provide logistical support to other nations during COVID pandemic. Additionally, government involvement in sectors like surveillance and manufacturing calls into question how federal policy can shape the private sector and its competitive nature. Medical mistrust is a big part of this topic area. During COVID we saw how government actions towards what people deemed a personal issue can affect government trust and involvement. Finally, the politicization of preparing for a potential disaster, especially one that is medical related, is quite large. COVID proved that taking actions on disease can cause quite the political firestorm, simply because a significant portion of the country doesn't believe pandemics are real.

## Counterplans

Actor counterplans are going to be at the core of the negative team's advocacy tool box. Communicable disease preparedness requires a significant amount of cooperation between governments, as well as private companies. Counterplan debate on this topic would utilize the efficacy of international organizations such as the WHO, NATO, or the International Pandemic Preparedness Secretariat (IPPS) to bolster that international solvency. Furthermore, private actor counterplans that promote business coalitions or individual companies to sponsor manufacturing or data collection could grant negative solvency while avoiding the damages of federal government intervention. Finally, the beauty of counterplans is that they don't have to be topical (pending cp theory). This means that counterplans can take a litany of proactive measures to try and prevent the next pandemic from breaking out at all. Shoring up America's medical security pre breakout is a great opportunity for negative flexibility.

## Kritiks

The final area of negative argument innovation will lie in the Kritikal world. There is much debate to be had about the philosophical implications of health policy, especially pandemic preparedness. A healthy portion of our responses to previous communicable diseases are framed by social and class relations. For example, racial tensions due to the rumored origins of the COVID pandemic were talked about frequently. Debates about how medical treatments and preexisting conditions are shaped by our racial, gender, or class identities are plentiful. Past pandemics have seen decisions made for vaccine rollouts, PPE distribution, and hospital prioritization made along capitalist and racial lines (Stevano, 2021). A very large part of kritikal literature can be found about the government control over bodily decisions and personal medical information. Additionally, research finds that past pandemic response has been significantly informed by biopolitical social expectations (Espina & Nurruhn, 2021).

# Appendix

## Topic Synopsis

Historical responses to public health emergencies in this country have been incredibly reaction based. Seldom have these issues arisen with ample preparedness and response measures in place. On the sunset of one of the most impactful pandemics in American history, it is imperative that our government adopt policies to prepare us for future health issues. This topic proposes that the United States federal government expand its communicable disease outbreak preparedness programs. While COVID proved that the United States is not adequately prepared to handle a mass outbreak, our lens of viewing this potential topic should not stop there. Considering that current federal policies aim at eroding public health measures within the US, from President Donald Trump's decision to cut health spending, withdraw from the World Health Organization, and appoint Robert F. Kennedy Jr. (a known vaccine denier), to the Department of Health and Human Services, our topic proposal couldn't come at a better time. This topic will pave the way for a balanced debate that is supported by a litany of information for both affirmative and negative teams. Allowing students to engage in high-level debates about communicable disease prevention will produce invaluable education for students. Affirmative cases may garner advantages from innovations in the medical industry, domestic and global health security, as well as international modeling. Negative arguments may include classic disadvantages that interrogate jurisdictional questions like federalism, while also offering unique disadvantages involving mistrust from rural communities and the political ramifications of healthcare policy. Alternative advocacy options include private solutions, international cooperation, and reactionary measures versus prevention. The effect that recent health crises have had on students who will be debating this topic allows students to draft solutions as they reflect on the impact communicable diseases have had on their lives.

## Timeliness

As outlined above, current federal policies are directly impacting public health measures within the US. We are seeing the first hand effects of the current administration's policymaking.
The U.S. is currently experiencing one of its largest measles outbreaks in decades, with cases reported in multiple states. The CDC has confirmed cases across 37 jurisdictions as of June 24, 2025. Additionally, the CDC is also actively monitoring the H5 bird flu outbreak which is widespread in wild birds worldwide and is causing outbreaks in poultry and U.S. dairy cows with several recent human cases. While the CDC has currently labeled this outbreak a low risk to public health, the situation is being carefully monitored. These are just a few examples that illustrate the timeliness of this particular topic.

## Scope/Range/Quality/Material

As mentioned in the introduction, the scope of the topic is relevant to the lives of all students regardless of geographical location due to the sheer magnitude of the COVID-19 pandemic. The solutions to mitigate potential disease outbreaks will likely encourage affirmative debaters to compare the response measures of their state and local governments with that of the requirements outlined by the federal government; thus, developing an understanding of how the federal government's policies influence things such as medical supply innovation and distribution, vaccine

research, and disease surveillance. Due to the scope of the topic, we believe that this will make the topic highly accessible to novice debaters without boring those who are more experienced. As for the quality of debates that may occur under one of the following proposed resolutions, we anticipate that these debates will be fresh and interesting year-round. Debates will not merely devolve into affirmative teams arguing, "the next pandemic is inevitable so we must be prepared," and negative teams responding with generic disadvantages. It is likely that the wording of the resolutions presented will encourage competitors to explore logical link chains and impact scenarios, interrogate which communities are likely to receive aid in the event of an outbreak, and uncover the implications that implementation of various communicable disease response programs will have on the country writ large. As for negative teams, yes, the Fifty States counterplan and Federalism disadvantage will likely be arguments that novice debaters will explore. However, those are by far the only arguments that negative teams will have access to. Disadvantages that hinge on medical mistrust, rural-access tradeoffs, and other affirmative-specific aspects will supercharge the vast litany of counterplan ground that negative teams will enjoy, allowing for greater negative flexibility.

## Interest & Balance

It has been previously mentioned how many do not wish to return to the days of the pandemic. This may be true to an extent, but that does not close the door on these discussions outright. It is our belief that the wealth of research available will keep students interested throughout the year. This is reflected in the research used in this paper that ranges from pre covid analysis to solutions proposed this year. Researchers are constantly searching for new ways to prepare for the next pandemic and their counterparts are continuously finding issues with their proposed solutions. This would be a stark difference from topics in previous years in which the arguments read at the end of the year were the same arguments that were read at the beginning of the year. Thus, students will not become bored with the materials available to them or the arguments that they hear in-rounds.

## Solvency Advocates for Various Affirmative Cases

### Several Proposals for Communicable Disease Preparedness

**Daschle**, Tom , **et al**. "Positioning America's Public Health System for the next Pandemic." Bipartisanpolicy.org, Bipartisan Policy Center, June **2021**, bipartisanpolicy.org/download/?file=/wp-content/uploads/2021/06/Public-Health-Report_RV2.pdf.

The COVID-19 pandemic has made clear that the nation's **safety, health, and economic prosperity are dependent on a robust public health system. Federal public health agencies** and state and local public health departments **have long been severely underfunded. They have lacked the workforce and modern data systems to support surveillance, contact tracing, testing, guidance on mitigation measures, administration of vaccines, and clear communication that is needed to stop** infectious **diseases from spreading** across the country. In the beginning of the current pandemic, the federal government did not provide effective testing kits or clear and timely guidance to states, localities, tribes, and territories on COVID-19 mitigation measures, resulting in a delayed and fragmented national response. **In addition, many Americans have chronic underlying health conditions such as obesity and heart disease, leaving them more likely to develop severe illness** from the virus that causes COVID-19. Public health agencies and departments lack the resources to support prevention programs that might have reduced the prevalence of these conditions. **Further, there are long-standing racial and socioeconomic inequities with respect to health and health care access.** Had these shortcomings not existed, the United States death toll might have been smaller. It is also true that if vaccine development had been delayed further, the death toll would have been higher. As of the end of May 2021, the U.S. has the highest mortality numbers in the world, with more than 592,000 deaths from COVID-19.1 Communities of color disproportionately represent these deaths. Tens of thousands more Americans are living with the persistent and debilitating symptoms from COVID-19, including brain fog, headaches, and shortness of breath. Halfway into 2021, the United States is on better footing. There has been a whole-of-government response to the pandemic along with clearer federal guidance issued to public health departments. Congress has

appropriated additional resources to the public health sector, which is engaged in a historic national vaccination effort. As of the end of May, more than half of adults received at least one dose of a COVID-19 vaccine and deaths are at the lowest level in 11 months. **The economy is recovering, and Americans are expecting a return to a more normal life. But even as the pandemic is easing, the United States must prepare for possible additional waves of disease from this pandemic, potentially caused by new virus variants, as well as plan for future public health emergencies.** Executive Summary 7 The nation remains vulnerable to myriad threats, including from another dangerous infectious disease, a widespread natural disaster, or a potential bioterrorist attack, each of which could impact almost every sector of the economy, disrupt social connections, and have significant long-lasting health impacts. **Equipping the public health system with an adequate and prepared workforce, data systems, and medical countermeasures will enable the country to better withstand not only a pandemic, but any number of other public health emergencies.** Shoring up the system will take years of consistent effort by public health officials and policymakers. In the past 20 years, the nation has responded to every public health crisis with temporary funding measures that have not provided state and local public health departments with the people and the information technology tools needed to build enduring programs which address Americans' poor health and adequately prepare for a future emergency. This moment must be different. There is heightened appreciation for the critical role of public health. A May 2021 survey from the Harvard Opinion Research Program and the Robert Wood Johnson Foundation found that over 70% of adults "favor substantially increasing federal spending on improving the nation's public health programs," and the same proportion believe public health agency activities are very or extremely important to the nation's health.2 Since August 2020, the Bipartisan Policy Center's Future of Health Care Initiative leaders have been developing and supporting recommendations to improve the resilience of the nation's health care and public health systems to address the threat of COVID-19 and beyond. In January 2021, the Future of Health Care leaders released a report outlining high-priority immediate actions that the administration and Congress should take in combating COVID-19. In this report, the leaders have developed additional recommendations to ensure that the public health system, specifically, not only continues to respond to COVID-19, but that it is well-prepared to respond to and mitigate the consequences of a future pandemic. **Our recommendations focus on three areas: 1) creating clarity and accountability in federal leadership and operations during a pandemic; 2) improving public health information technology and data systems; and 3) committing the United States to more and consistent funding of public health to prepare for inevitable public health crises.** There are **10 overarching recommendations in this report: 1. Clarify and strengthen federal operational roles and responsibilities during a federal response to a pandemic. To improve the nation's federal response to emergency events** such as a pandemic, the White House and Congress should clearly define roles, responsibilities, and authorities for all relevant governmental entities. Because 8 only the White House has the authority to direct federal departments to work with one another and coordinate their efforts, the president should appoint a White House Deputy National Security Advisor for Pandemic and Biothreats Preparedness to provide leadership to prepare and respond to national public health emergencies and conduct joint pandemic planning efforts including exercises to refine roles and responsibilities. **White House leadership and coordination of agency preparedness should be supplemented by congressional evaluations of roles and responsibilities** to ensure federal entities have the necessary authorities and resources to execute emergency pandemic response efforts. **2. Incentivize states to participate in a coordinated response to national public health threats. The patchwork of state responses to COVID-19 raises salient concerns about barriers to a coordinated national response during public health emergencies.** States and localities have the flexibility to appropriately tailor public health activities to their community needs. However, **it is still vital for states and localities to follow federal evidence-based guidelines for disease mitigation during a pandemic. Congress and the executive branch should create incentives to encourage states and localities to follow these guidelines and best practices.** These incentives could involve additional financial resources beyond core funding, such as providing supplemental public health funds, to enhance a state's pandemic response. **3. Establish a National Board on Pandemic Preparedness to provide oversight and ensure the United States is equipped to respond to future public health threats. There is no congressionally chartered oversight mechanism for evaluating the state of America's pandemic preparedness system**, which is reliant on the capacity, capabilities, and coordination of federal, state, and local agencies. This lack of oversight leaves the nation vulnerable to a suboptimal response to public health emergencies and future pandemics. To ensure the United States is equipped to respond, Congress should create an independent National Board on Pandemic Preparedness that will establish a set of metrics and benchmarks for evaluation of federal and state pandemic preparedness capacity and capability; gauge how the nation is faring against these metrics; and develop an annual report to Congress on the state of pandemic preparedness with specific recommendations. The Board will be supported by independent career staff in a new Office of Pandemic Preparedness located in the executive branch. 9 **4. Establish federal data collection and reporting standards to improve consistent collection of core public health data across data systems, with a prioritized focus on race and ethnicity data. The Office of the National Coordinator for Health Information Technology (ONC)** recently established a Public Health Data Systems Task Force that **should consider defining a "core public health dataset," developing additional standards for data collection, and developing a plan for implementing those standards, including linking them to funding mechanisms.** Core public health data should include information for public health surveillance and response, such as demographic information, electronic laboratory data, travel health data, genomic sequencing data, and electronic vital records data. The health disparities in the COVID-19 pandemic have revealed the urgent need to set standards around race, ethnicity, and other demographic data, and should be treated as a priority. To ensure accountability, Congress should require the Department of Health and Human Services (HHS) to submit a report on current streams of funding, activities, and program requirements related to data collection and standardization. **5. Improve data sharing and interoperability by establishing integrated platforms for detection and surveillance of public health**

**threats, clarifying privacy standards during public health emergencies, and encouraging data exchange between clinical and public health organizations. The U.S. public health system relies on an outdated, patchwork data system that does not allow data to flow freely between public health, clinical and other entities. To improve early detection of public health threats, the CDC should establish an integrated infectious disease surveillance system that would strengthen surveillance efforts currently conducted by multiple data systems and agencies.** This system could be modeled like the CDC's existing influenza surveillance system and be expanded to detect other novel pathogens. To improve situational awareness during public health emergencies, Congress should direct the HHS secretary to ask the National Academy of Medicine (NAM) to propose a design for a national interoperable data platform to improve access to health data and other relevant data needs during ongoing public health emergencies. Considering the volume and type of data sharing required during public health emergencies, patient privacy and security must be prioritized. Finally, as the United States updates electronic health record (EHR) standards, a priority should be made to include public health data, and to facilitate data sharing between health systems and public health officials. 10 **6. Build upon data collection and sharing efforts during COVID-19 to strengthen vaccination data systems for use during future infectious disease pandemics. The CDC recently issued guidance that fully vaccinated individuals can resume certain activities, but—despite demand from private businesses—there is not currently a reliable system in place to identify who has been fully vaccinated.** Several private companies are working on platforms that an individual could use to digitally access their vaccination information. **The federal government has a key role to play in promoting the development of a vaccination credential system by ensuring that credentials protect privacy and are synchronized, secure, and high quality.** In addition, HHS should build on technology it is using to collect states' COVID-19 immunization tracking data to inform national response efforts and improve interoperability between states and enhance states' collection of demographic data, such as race and ethnicity. **7. Assess existing federal funding of pandemic preparedness and response activities for opportunities to increase coordination and efficiency and improve equity. For programs deemed highest priority to prevent, detect, and address infectious disease threats, create a permanent budget designation named Biodefense Interagency Operations outside annual 302(a) allocations, and should they be established by future legislation, outside overall budget limitations.** Congress should form a Joint Select Committee including members representing the relevant authorizing and appropriating committees to evaluate existing federal funding, identify mission-critical investments, and produce legislative recommendations with stakeholder feedback on how interagency funding can be better coordinated and optimized. Those programs deemed mission critical would receive a Biodefense Interagency Operations (BIO) exemption, allowing them to be exempt from budget caps, including any future discretionary spending limits set after the expiration of Budget Control Act of 2011 limits in fiscal year 2021, and federal departments and agencies should be allowed to independently request the BIO exemption for their programs to ensure the country remains vigilant and primed for pandemic threats. **8. Allocate funding to the Public Health Emergency Fund for use immediately following a Public Health Emergency declaration and use it as the primary vehicle for supplemental appropriations funding.** To enable the federal government to rapidly deploy funding as a stopgap measure in a public health emergency until Congress can pass emergency supplemental appropriations, **Congress should add funding to the Public Health Emergency Fund and consider passing future supplemental appropriations through the fund in future emergencies.** When the pandemic began, there were 11 zero dollars in the fund, requiring the HHS secretary to draw upon the transfer of funds from other executive programs to pay for emergency response, arguably adding to the initially disorganized response to COVID-19. **9. Allocate $4.5 billion in permanent annual mandatory funding to a new Public Health Infrastructure Account to support state, local, tribal, and territorial foundational public health capabilities. To enable state and local health departments to develop the minimal, cross-cutting capabilities that are needed to support their delivery of public health programs, the federal government should build on investments made by the administration through the American Rescue Plan.** Congressional appropriations committees would still appropriate this money annually, but the money would not be subject to Committee 302(b) allocations. The HHS secretary would award the appropriated money in grants to accredited jurisdictions based on population size, level of health disparities, level of health risk and chronic disease burden in the community, and public health governance structure to bolster foundational public health programs. Part of the funding would be tied to the set of metrics and benchmarks created by the National Board on Pandemic Preparedness for evaluation of federal, state, and local pandemic preparedness capacity and capability. **10. Reform and increase annual funding to the existing Prevention and Public Health Fund from its current level of about $900 million to $4 billion to bolster inadequately supported public health programs and meet local needs.** Congress should direct funds from the Prevention and Public Health Fund, created under the Affordable Care Act, to state and local health departments to support public health programs, and the Preventive Health and Health Services Block Grants that gives health departments "the flexibility to solve problems unique to their residents, while still being held accountable for demonstrating the local, state and national impact of the investments." Public health programs include chronic disease prevention and communicable disease control programs that aim to improve community health.3 Statutory language should be added to the law to prevent Congress from using the Prevention Fund to offset other activities as Congress has done since 2014. Research shows investment in prevention reduces long-term illnesses in a population. With a healthier population, the United States will be less vulnerable to an infectious disease outbreak, and individuals will live longer with a higher quality of life. **The $7.6 billion called for in Recommendation Nos. 9 and 10 would be funded by a public health excise tax.**

# Disease Surveillance / Data Collection

## A coordinated, uniform health data & surveillance state is key to communicable disease preparedness

**Lipsitch et. al. 2024** Marc Lipsitch is a researcher at the Center for Forecasting and Outbreak Analytics, US Centers for Disease Control and Prevention, Atlanta, GA, United States. "Infectious disease surveillance needs for the United States: lessons from Covid-19" https://pmc.ncbi.nlm.nih.gov/articles/PMC11285106/

Administrative and reporting preparedness **The response to COVID-19 required collaborations across sectors–public, private, and academic–but these collaborations were often forced to work through administrative frameworks that were not designed with speed and flexibility in mind.** In turn, such mis-specified frameworks ultimately slowed or limited some critical public health projects and prevented others from being undertaken entirely. To address this class of problem, we propose six ideas below that would update, recast, or create key frameworks that establish links across sectors and that facilitate the urgent work of pandemics, while maintaining safeguards and oversight. **Emergency data use agreements and formats. Data use agreements (DUAs) are core elements to collaborative work across institutions,** but they pose two types of challenges. First, the process for negotiating an agreement acceptable to the institutions providing and receiving the data is often slow. The staff on each side tasked with reviewing and signing off on these agreements may have many competing priorities or be overwhelmed as an outbreak or pandemic may dramatically increase the volume of DUAs. Work on a sensitive or high-profile project, such as associated with an outbreak of infectious disease or a pandemic, generates additional scrutiny and often further lengthens the review process. Second, **conflicting limitations can stall progress or even undermine a project before it starts.** For example, in a partnership between academics and government public health institutions, academic institutions may deem the freedom to publish without interference to be non-negotiable. Public health institutions, however, may require veto power over what, if anything, is published, due to the sensitivity of the institution's data and ownership thereof. To address these problems, **one solution is to establish Emergency Use Data Authorizations (EUDAs) for public health data with a standing framework vetted and updated regularly** (e.g., annually), perhaps at the individual state level. Such **EUDAs would catalyze collaborations and enable investigators at both institutions to shift the balance of effort up front from administrative to research tasks.** As these are put in place, discussions about data formats can take place, ideally also in advance, to ensure that when data are delivered they are as ready-to-use as possible. **Surveillance versus research**: updating the Common Rule. Projects designated as human subjects research require institutional review board (IRB) review, whereas those designated as public health surveillance are deemed not to be research, and thus do not require IRB review. T**his surveillance-research dichotomy has substantial implications for timeliness and speed of work, because writing, reviewing, and adjudicating IRB reviews–while vitally important for protecting the rights, welfare, and well-being of human subjects–may take days to weeks. The boundaries between surveillance and research are governed by the Common Rule, which states that public health surveillance activities "include those associated with providing timely situational awareness and priority setting during the course of an event or crisis that threatens public health (including natural or man-made disasters)"** [45 CFR 46.102(l)(2)] (70). Unfortunately, these boundaries lacked clarity and standardization as questions arose during the COVID-19 pandemic. For example, while case monitoring is clearly surveillance and a routine public health activity, one could make a strong argument that "situational awareness and priority setting" includes assessing vaccine effectiveness and disease severity for new variants. However, analysis of variants requires pathogen genome sequencing, which is viewed by some as constituting research, as is evaluation of vaccine effectiveness, another critical public health function which is not exclusively a research objective. Modifying the text of the Common Rule to explicitly include examples such as these or providing an interpretation of the surveillance/situational awareness exemption that includes these activities would considerably improve the ability for public health agencies to maintain situational awareness and set priorities, quite in line with the spirit of the exemption. Streamlined IRBs. Where projects fall under human subjects research designation and require IRB review, **generic, pathogen-agnostic study protocols for specific populations would accelerate research by decreasing the time to first data. Preapproval of a range of well-defined studies targeted at emergency response and using specific data sets would retain critical protections for human subjects,** while allowing high-urgency protocols to be "on the shelf" and ready for fast rollout. As an additional feature, such preapproved protocols would also free up valuable researcher and IRB reviewer time, having converted per-submission efforts during a pandemic into fixed-cost efforts ahead of time. Moreover, designing consent processes for normal "peacetime" studies to allow use of data and specimens in public health emergencies could avoid some of the delays experienced during COVID-19 with, for example, use of the Seattle Flu Study's specimens to understand early transmission of the virus in the United States (12). **Case reporting standardization.** Tracking and understanding outbreaks, particularly at their beginnings, rely on case reporting. Ideally, public health efforts would follow case trends over time and across regions, compare and monitor clinical features including disease progression, resolution, and response to interventions, and track demographics of infected individuals. But **lack of standardization of case report protocols, parallel or overlapping surveillance systems that result in duplication** (often with varyingly completed fields for the same case), **and inadequate systems for incorporating updates as further information about a case accumulates after the initial report,** among other issues, result in case report data that require much time and effort to sort through. Worse, these issues may render some fraction of case reports unreliable. Improving national surveillance systems to be more uniform, timely, and flexible could serve both local and national surveillance needs would help address these issues

(60). **Dataset accessibility.** In the absence of a United States national healthcare system, research into the distribution and burden of clinical conditions depends on academic or private data streams, **including surveys and surveillance systems constructed to address specific questions,** and databases of insurance claims which represent utilization of the healthcare system. Insurance claims datasets include those from (i) employer-based insurance companies (e.g., MarketScan) (ii) all-payer claims databases available in some states (which, since a 2016 Supreme Court decision (71), are no longer necessarily 'all payers'), (iii) Medicare for individuals over 65 years of age, (iv) Medicaid, which provides coverage to over 18% of the United States; and (v) data bases for other specific populations, such as those of the Veterans Affairs Health System, the Indian Health Service, and the Department of Defense. While these datasets can provide an important window into healthcare use across demographics and geography, **access to these datasets can be expensive and time and labor intensive.** Gaining access to Medicaid data, for example, presents a substantial burden, since this has to be acquired on a state-by-state basis. Establishing standing flexible DUAs for these datasets, with a single agreement across states for Medicaid and other state-controlled data, could enable both routine surveillance-type analysis to identify trends (such as disease outbreaks or patterns of disease spread) and to evaluate the impact of clinical and public health interventions. Public health-health care partnerships: While **the United States** does not have a national health system for all, it **has a wealth of data in the health care sector that can inform public health decision making.** Multiple studies at **the Centers for Disease Control and Prevention (CDC)** and other institutions **harnessed such data** to provide estimates of key quantities **such as vaccine effectiveness (72, 73), variant severity (74), and antiviral effectiveness (75), as well as for surveillance of disease burden and its correlates (76).** Building public health partnerships with the health care sector in advance to set in place the administrative, information technology, and financial arrangements to make possible high-quality analyses of this sort rapidly (and automated where possible) would greatly increase the timeliness and value of such efforts (77).

## Disease Surveillance and Data Dissemination is key to pandemic response

**Meierkord et. al. 2024** Anne Meierkord is a researcher at the Robert Koch Institute, Centre for International Health Protection, Nordufer 20, 13353 Berlin, Germany. "Strengthening disease surveillance capacity at national level across five countries: a qualitative study" https://www.sciencedirect.com/science/article/pii/S0033350624001872

**Disease surveillance is an 'early warning system for impending outbreaks that could become public health emergencies'1 and therefore key to protect the health of populations globally.** Public health surveillance is defined as 'the ongoing, systematic collection, analysis and interpretation of health-related data with the a priori purpose of preventing or controlling disease or injury and identifying unusual events of public health importance, followed by the dissemination and use of such information for public health action'.2 **The World Health Organization (WHO) detects over 7000 public health threat signals every month** of which 0.5% result in a field investigation and risk assessment.3 Public health events of international concern that occurred in recent years, such as the Ebola epidemic in West Africa 2014–2016, the **COVID-19** pandemic or the recent spread of Mpox have **emphasized the importance for countries** to collaborate at global level for early detection of emerging infectious diseases and strengthen their **national disease surveillance capacities to respond adequately.**4, 5, 6 To achieve this, the International Health Regulations (IHR) framework (2005) 'obligates State Parties to develop national capacity for the detection, investigation and reporting through WHO of potential public health emergencies of international concern'.7 National Public Health Institutes (NPHIs) defined as "government agency, or closely networked group of agencies, that provides science-based leadership, expertise, and coordination for a country's public health activities"8 are an important part of countries' public health systems' and commonly a countries' disease surveillance activities fall within their mandate.9 **Strengthening** NPHIs in their **efforts to establish and maintain efficient surveillance systems is an opportunity to ensure future outbreak preparedness and response.**10 Globally, **a variety of different disease surveillance systems exist** and challenges and opportunities of their effective operationalisation are context specific. The Integrated Disease Surveillance and Response approach is one of the strategies promoted to African countries by the World Health Organization.11,12 However, **multiple challenges regarding its implementation, such as limited resources, a lack of coordination between those who collect data and a variety of surveillance systems, have been documented and identified.**13 Sharing data between different disease surveillance systems and across borders is crucial to recognise signals, respond where required and prevent outbreaks from spreading further and developing into a pandemic. Yet, obstacles exist such as a variety of legal frameworks that can significantly impede the integration of different data sources. This can be the case within countries, for example in federalised systems where states struggle to integrate data at national level or also between countries.11 One area where the COVID-19 pandemic made the challenges to data sharing between countries visible was in the field of genomics and the use of genomic data in surveillance, as countries were tracking the emergence of new variants of the SARS-COV2 virus. WHO's Global genomic surveillance strategy for pathogens with pandemic and epidemic potential 2022–203214 highlights the need to harmonize across systems and countries to be able to use and compare the data effectively. **The COVID-19 pandemic overall brought the challenges and limitation in infectious disease surveillance at national level into stark focus.** It revealed the need to better understand these in order to strengthen public health systems at national level around the world. To better understand these challenges, including the 'messy realities' of how systems' work in practice, this qualitative case study examined national level disease surveillance in five countries, focusing on how data was collected, analysed and where possible shared, and how it did (or did not) enable decision-making. Specific attention was on the role of National Public Health Institutes as central actors within this system, on genomic surveillance, and on how to strengthen capacities including through training.

# Medical Supplies

## Medical Supplies availability is key to solving the effects of pandemics. Stockpiles are sufficient for short term coverage but production reform is needed to ensure long term stability.

**Zhang, Li, & Zhao 2023** Yuwei Zhang, Zhenping Li, and Yuwei Zhao are research at the School of Information, Beijing Wuzi University, Beijing, China and the School of Economics and Management, Beijing University of Chemical Technology, Beijing, China. "Multi-mitigation strategies in medical supplies for epidemic outbreaks" June 2023.

Medical Supplies **Medical supplies, including drugs and medical protective equipment, play a crucial role in decreasing morbidity and mortality during pandemics. Inadequate preparations may severely delay epidemic control and entail irreparable life losses.** The attack of the Coronavirus disease 2019 (COVID-19) in Wuhan, China, showed this characteristic. The **production comes to an abrupt halt** around the Spring Festival, and i**nsufficient stored medical materials put lives at risk from the new coronavirus. As a result of inadequate preparations, medical supplies were scarce in the early stage of the COVID-19 epidemic, leading to the continuous strikes of the subsequent crisis.** The media reported that several hospitals even appealed donations of protective equipment for frontline workers fighting COVID-19 since the regular inventory of strategic locations (i.e., reserves) had exhausted rapidly. Coincidentally, when the first wave was tapering, the government of India had not planned for a second wave and assumed the worst in advance: oxygen, antiviral drugs and other medical supplies stockpiled were not sufficient and manufacturing capacity failed to ramp up. Then India became the worst COVID-19 surge in the world [1]. **Surge demand caused by epidemics has a lower arrival rate but higher demand volume per arrival [2], even lasting for a long time. It seems to be not enough to rely solely on the inventory of reserves.** On the other hand, the potential disadvantages of maintaining adequate items at reserves are considerable inventory-related costs [3], and even substantial waste in the absence of an outbreak, as the emergency has low-frequency characteristics. Due to their fixed use-by date, especially perishable products (even masks and gloves), **expiration problems make stockpilers challenging.** For example, Australia dumped expired materials worth $200 million into landfills [4]. Clearly, unpredicted demand leads to a high degree of uncertainty. Thereby, an effective inventory strategy for medical supplies is concerned. **If the supply chain of medical resources is broken, insufficient materials may accelerate the spread of the epidemic and lead to irreparable losses**. It highlights the importance of resilience in the medical resources supply chain. In this regard, a key issue is to increase the resilience of the medical supply chain and balance appropriateness against the adequacy of medical supplies. Determining prepositioning strategy to satisfy surgent demand while avoiding inventory surplus as much as possible is the motivation of this work. Efforts to seek the balance should not only rely on prepositioning supplies at reserves, but integrate various sources of relief materials as well. Unpredicted demand for medical supplies leads to a high degree of uncertainty. This paper introduces several supply strategies to mitigate or deal with uncertainty. Specifically, t**he supply strategies include materials prepositioned in reserves, backups served by reserving suppliers, and medical commodities produced by manufacturing suppliers.** We denote these various supply channels as multi-mitigation strategies. In terms of prepositioning in reserves, we explicitly consider materials stored in municipal (local) and regional reserves for emergencies, which involve location problems and stocking levels. Apart from locations and sizes, administrative duties are fundamental differences between municipal reserves and regional reserves. **Each municipal reserve covers a subset of hospitals assigned to it in advance,** whereas regional reserves cover all hospitals. Typically, municipal reserves improve the quick response, especially in metropolitan areas. **Contract suppliers in multi-mitigation strategies play a critical role in simultaneously ensuring uninterrupted supply and maintaining relatively lower inventory levels.** More specifically, there are two typical store options except for prepositioning in reserves: one is backups from the reserving supplier (RS), and the other is medical commodities provided by the manufacturing supplier (MS). The former is undertaken by some pharmaceutical companies with a regular and high stocking level, and they prioritize medical supplies to hospitals as soon as an emergency occurs. And the latter is being conducted by enterprises with government approval, which are able to make the rapid adjustment to their facilities and turn to produce masks, protective suits, and other products for the fight against the pandemic. Whether prepositioning physical supplies (end products) is the fundamental difference between MSs and RSs. Typically, MSs keep production capacity and stock semi-finished products, while RSs store finished products. The two-type suppliers are responsive to surging demand after epidemic strikes, whereas both needs to be paid subsidies for potential public service in advance. In addition, China's emergency supplies reserve system involves physical supplies offered by both strategic reserves and RSs, and production capacity provided by MSs. Multi-mitigation strategies align with the emergency supplies reserve system of China. Unlike most rescue supplies for natural disasters, such as tents, medical supplies tend to have a short shelf life and are mostly disposable. Some of them have higher requirements for storage environments. It indicates mass storage is not economical. **The perishability of medical supplies and the uncertain duration of a health disaster highlights the necessity of considering production capacity** in epidemic outbreaks. Procurement from RSs and stocked commodities in reserves are near-term channels since it gets finished products immediately, compared with the production of MS. Whereas the production of MS is resilient against long-term needs. Different from short-duration emergencies such as natural disasters, health disasters such as epidemic outbreaks are of uncertain duration. If the duration is short, the physical reserves from near-term channels are sufficient. If the duration is long, only considering near-term supply channels suggests that a large number of medical materials need to be stocked in advance to cope with the surge in demand. It is not economical for the strategic reserve and RS, and there is a risk of overdue waste. It highlights the necessity of production provided by MS, which can alleviate the risk of excess medical materials on the one hand and improve the capacity for securing the supply on the other. Furthermore, COVID-19 brings challenges in raw materials procurement and logistics, which lead to production limitations ("Securing critical raw materials supply is key to the response to COVID-19 | [5]. We incorporate a real-life issue: MS's

production may be disrupted since the pandemic acts as a trigger for the lack of raw materials. In this paper, raw materials refer to the components required to further process semi-finished products, such as melt-blown fabric for surgical masks. One of our contributions is regarding MS's production as one of the various sources to powerfully mitigate the high uncertainty in demand and increase the resilience of medical supply. In this study, we formulate the problem as a two-stage stochastic mixed integer program, and propose an exact algorithm based on the classical Benders decomposition (BD) method incorporating a branch-and-cut framework, namely branch-and-Benders-cut (B&BC). This solution approach builds a single search tree and generates valid cuts for the integer solutions encountered inside the tree, attaining the same optimal solution as BD [6]. The classical BD solves a master problem to integer optimality multiple times, whereas the B&BC method only once. In summary, our research contributes to the existing literature in the following ways. (1) We propose multi-mitigation strategies in medical supplies involving two-type contract suppliers, namely MS and RS. **Multi-mitigation strategies ensure uninterrupted supply and significant savings in terms of unfulfilled demand penalty cost and handling cost associated with the expiration problem.** We explicitly take raw materials available for MS into account. A two-stage stochastic mixed integer program is formulated to determine prepositioning strategy, including the selection of two-type suppliers and post-event allocation of multiple sources. (2) We develop an exact algorithm, the B&BC method, for solving this problem and compare its performance with the classical BD and Gurobi. We observe that the B&BC method significantly outperforms both the classical BD and Gurobi in the solution time, which is somehow more robust against input data and occupies less memory.(3) We design numerical experiments based on a realistic and typical case study in Wuhan, China, to demonstrate the effectiveness of multi-mitigation strategies and the proposed model. In the remainder of this paper, Section 2 reviews the relevant literature, with an emphasis on the location and allocation problem, and then Section 3 formally describes a two-stage stochastic mixed integer program for the problem and discusses its various versions. Section 4 develops the B&BC solution approach for solving the problem. We test the formulation and the solution approach for application using a realistic and typical case study in Wuhan in Section 5. Finally, this paper's conclusions and managerial implications and suggestions for future research are summarized in Section 6.

# Rural Preparedness

## National Level Disease Preparedness leaves rural areas behind, only establishing a less rigid response plan can grant adaptability needed for local implementation.

**Dudley et. al. 2023** Lilian Dudley is a researcher at the Division of Health Systems and Public Health, Department of Global Health, Stellenbosch University, Cape Town, South Africa. “COVID-19 preparedness and response in rural and remote areas: A scoping review” https://pmc.ncbi.nlm.nih.gov/articles/PMC10651055/ Nov. 15, 2023.

Coordination, planning, financing and monitoring **The 32 studies** in this SPRP pillar dealing with overarching governance issues, **described coordination, planning, financing and monitoring at various levels** from communities, to local, state, national and international levels. The main subthemes which emerged were:- i) Inclusion of rural and remote areas in policies; ii) Coordination between national policies and rural responses; iii) Operational readiness in rural areas, iv) Factors which enhanced local coordination of preparedness and response; and v) Financing. Inclusion of rural and remote areas in policies. **The review identified few policies and guidelines which specifically included an approach to rural or remote areas,** or provided information on COVID-19 preparedness and response in rural populations. At the level of regional guidance to support national COVID-19 responses, the PAHO guidance on strengthening the first level of care had an explicit embedded focus on rural and remote areas to promote targeted planning at that level [15]. In HICs, the USA National COVID-19 Preparedness Plan of 2022, [16] was an example of a policy which provided detailed guidance for rural and remote areas, and identified rural challenges. In some LMIC countries with large rural populations, **national policies identified through the review appeared not to differentiate between rural and urban areas** [17, 18]. Examples of challenges were described in reviews of India’s national policies in which authors identified overall health policy and system inadequacies that could hinder an effective COVID-19 response, but also highlighted the capacity for successful responses in states with large rural populations such as Uttar Pradesh and Rajasthan [19, 20]. Coordination between national policies and rural responses. A **few studies reported tensions between national policy and local responses** where authors reported that top down, **hierarchical national responses did not provide adequate space for local innovation and adaption** [21, 22]. In some settings this was resolved to create a balance between top down and bottom-up responses, but in others, **a rigid national approach and extreme border controls impacted negatively on rural and remote communities. Local autonomy was also impeded by structural factors such as workforce turnover, limited funding, medicolegal concerns, and a lack of access to information.** Operational readiness in rural areas. **In the USA,** operational readiness assessments at various levels found that **rural areas had fewer health professionals, hospitals and intensive care units (ICU), despite having more vulnerable populations and reporting more deaths per population than urban areas** [23–25]. **Rural health services** including Emergency Medical Services (EMS), community pharmacists and home health agencies **were less prepared**, and facilities were predicted to reach maximum capacity faster than in urban areas [26, 27]. Factors which enhanced local coordination of preparedness and response. Despite the tensions and local constraints, studies suggested that a balance between top down and bottom up responses can be achieved by building on well-established social structures, and a strong sense of social solidarity [21, 28]. **Good relationships**

**between government services and local leaders were critical in influencing attitudes and behaviours of rural populations** [21, 28]. **Planning** and implementation **by local multisectoral committees also ensured appropriateness of strategies, and collaborative leadership enhanced collective action in community governance and effective responses** [29]. Rural COVID-19 responses relied heavily on local level institutions whose effectiveness and efficiency depended on the nature of those institutions, and their capacity, legitimacy and a history of policy interventions [30]. Important organisational attributes that enabled appropriate COVID-19 responses included strong leadership, effective communication, and multi-disciplinary collaboration, as well as operational elements such as a well-functioning incident command system with clear roles and responsibilities, and regular communication with health service employees. Good responses were based on well-defined and well implemented plans, included expanding intensive care capacity; provision of COVID-19 information, screening, testing and follow up services for geographically dispersed populations; coordination across large diverse organisations; and the integration of community-based responses. **A strong degree of trust and collaboration between local government and communities facilitated more appropriate responses to the pandemic** [30]. Studies in indigenous communities found that structural conditions limited local adaptive capacity to COVID-19, with high dependence of communities on public transfer payments as illustrated in a study on Torres Strait Islanders [31]. Lessons learnt were to ensure the participation of indigenous peoples as partners in decision-making regarding the planning, development, and implementation of programmes and in the development of preventive measures against COVID-19 [31]. Financing. Of the limited studies addressing health financing, and within that, financial protection, an important finding of a study in China was that **health insurance did not adequately cover the costs of COVID-19 hospital care for rural households, who were at risk of catastrophic expenditures [32]. Health services in rural areas in USA were also affected financially through loss of revenue** [16, 27].

## Links for Disadvantages

### Making Preparations for an unseen pandemic creates mass hysteria that balloons medical mistrust

**Ojikutu et al 2022** Bisola Ojikutu is with Brigham and Women's Hospital, Massachusetts General Hospital, Harvard Medical School, Boston, MA. Laura M. Bogart and Lulu Dong are with RAND Corporation, Santa Monica, CA. "Mistrust, Empowerment, and Structural Change: Lessons We Should Be Learning From COVID-19" March 11, 2022. https://pmc.ncbi.nlm.nih.gov/articles/PMC8887168/

**Within the COVID-19 pandemic, public mistrust has been cast in the pivotal role of antagonist. From lack of acceptance of preventive measures,** to online misinformation and disinformation, to low vaccination rates, "**the epidemic of mistrust" has been characterized as a thwarter of public health mitigation efforts**. However, among Black/African American individuals in the United States who remain twice as likely to die1 yet significantly less likely to be vaccinated against COVID-192 versus White Americans, mistrust is not the primary etiology of racial and ethnic inequities. Instead, mistrust is a manifestation of the pervasive pathologies of structural racism and White supremacy.3 Historical awareness of and contemporary exposure to structural racism—the system of hierarchy, privilege, and power that largely benefits White individuals—has resulted in **mistrust as a rational, adaptive response to an adversarial environment.** Furthermore, White supremacy, the belief that White people are superior to people of other racial backgrounds, sustains structural racism and, thus, is a fundamental driver of mistrust among people of color.4,5 **A specific form of mistrust, medical mistrust, centers on the belief that health care providers, the health care system, the pharmaceutical industry, academic institutions, or the government as a steward of public health are acting against one's best interest or well-being**.6 As a multidimensional belief system, medical mistrust likely exists on a spectrum from skepticism, to active suspicion, to belief in conspiracy theories or secret plots concerning perpetrators, motivations, and modi operandi that are not necessarily apocryphal.7 Typically, medical mistrust has been viewed through a deficit lens. This is unsurprising; negative characterizations of health beliefs espoused by people of color that diverge from those expressed by the dominant culture are a normative feature of race-based science. This is particularly true regarding mistrust beliefs. Individuals who express medical or research mistrust are frequently characterized as irrational, less well-educated, or possessing lower literacy.8 Among Black/African American individuals, medical mistrust has been associated with suboptimal health behaviors, such as nonadherence to antiretroviral therapy among people living with HIV, poor engagement in care, and decreased uptake of preventive behaviors, including vaccines.8,9 Unfortunately, a surfeit of attention within public discourse on combating the negative impacts of medical mistrust, particularly in regards to COVID-19 vaccine "hesitancy," has obscured the need to correct deficiencies and disparities in health care perpetuated by structural racism, White supremacy, and inequitable power structures in the United States. Specific historical and recent events have oftentimes been cited as the root cause of medical mistrust. As such, **medical mistrust has been framed as a reaction to instances of medical, research, or public health malfeasance.** For example, the Tuskegee Syphilis Study, during which Black men were enrolled without informed consent and observed for 40 years with no offer of treatment, is frequently cited as the exemplar of this unethical behavior.10,11 Another frequently cited example is compulsory and coercive sterilization dating back to the early 20th century, which disproportionately impacted Black/African American, Indigenous, and Latinx women.12 Most recently, in 2020, unnecessary gynecological procedures were performed on women of color, many of whom were non–English speaking, held at Immigration and Customs Enforcement detention centers in the United States. Following an investigation, the Department of Homeland Security closed the facilities where the procedures were performed.13 These specific events are important to note. However, understood within a psychological and sociopolitical context, medical mistrust is an adaptive response to chronic, not episodic, inequity experienced by Black, Latinx, Indigenous, and some Asian American Pacific Islander communities. As an adaptive response to repeated exposures, medical mistrust can be protective and potentially promote resilience to discrimination and maltreatment experienced directly or indirectly within one's social network, family, or community.14 Given the persistence of COVID-19 inequities, **a critical analysis of medical mistrust as an adaptive response** that may promote individual-level resilience, community-level empowerment, and structural change **is warranted.**

UNDERSTANDING MISTRUST Psychological literature, which is often deficient in racial diversity of both authorship and research participants, has contributed to pathologized views of mistrust.15 A substantial portion of this research has focused on the more extreme end of the mistrust spectrum, exploring "conspiracy beliefs" as a reflection of individuals' psychological disposition. This research suggests that individuals who express "conspiracy beliefs" have low self-esteem, are paranoid, or are delusional.7,16 Individual-level perspectives such as these delegitimize rational belief systems and ignore the origins of mistrust among people of color. Other **research has contributed to a broader understanding of medical mistrust as a protective coping mechanism.** An epistemic rationale for belief in conspiracy theories posits that they arise in the face of persistent threat. In such instances, conspiracy theories provide causal explanation and render order in the place of uncertainty and injustice.8 For example, racial and ethnic disparities in HIV incidence and mortality have been a persistent feature of the epidemic in the United States since its inception 40 years ago. In response, HIV-related conspiracy theories, such as HIV is a man-made virus or AIDS was created by the US government to control the Black population, have developed as common beliefs within the Black/African American community.17 Within health care settings, **medical mistrust can develop as a response to inequitable or hostile situations.** In a study to determine psychosocial factors associated with medical mistrust among Black/African American men, the author found that perceived racism in health care was the strongest correlate of mistrust and often resulted in lack of follow-up.18 Thus, **when faced with antagonistic circumstances** such as racism, **individuals may develop mistrust and disengage from care to minimize psychological harm and restore a sense of control.** As a protective response, medical mistrust may also manifest as caution or self-preservation in light of adverse exposures both within and external to the health care system.19 From a sociopolitical perspective, the interplay among physical, social, and political environments may contribute to stronger mistrust beliefs among individuals living in neighborhoods with higher concentrations of social vulnerability.8,20 Medical mistrust may also be a learned attitudinal response that is transmitted among members of the same group or community with shared identity and cultural experience.14

## Public Health initiatives like pandemic preparedness are extremely politically divisive. Even if the plan is not immediately struck down, it causes major fighting.

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The evolving COVID-19 crisis is shattering social precedents. Individuals are quarantining and most business is anything but usual. Amid the instructions for the public, social media posts have bubbled to the surface imploring us to "not make this political." Why should we be surprised **COVID-19 appears to be the most politically divisive disease outbreak in U.S. history**? Well, **public health is always political. Even though** federal funding for **U.S. agencies charged with protecting the nation's health enjoys broad bipartisan support, many specific public health initiatives do not.** There are many recent examples in the United States that are highly divisive—soda taxes, needle exchanges, and universal health coverage to name just a few. Activists and advocates for funding disease-specific programs targeting breast cancer, autism, and HIV/AIDS actively seek to thrust their causes into the political sphere—as do fringe groups who advocate against vaccines or for alternative therapies. So why should we be surprised when in 2020, in the middle of the most widespread infectious public health threat this country has seen in a century, **the COVID-19 pandemic appears to be the most politically divisive disease outbreak in U.S. history**? Protecting the public's health requires the elevation of evidence-based forecasting in order to anticipate nationwide resource needs before a disaster demands them. **The only entity with the capacity to mount a sufficiently sizable response when a large population is endangered is the government. But between major emergencies, when social conditions feel stable and risks do not appear imminent, convincing our leaders to invest in preparedness may be difficult.** The U.S. public health response system (however strong or weak) has gradually been steered into its current position by elected officials, yet our health system is not set up to succeed in preventing threats to a population's health. **The Centers for Disease Control and Prevention (CDC), the federal body tasked with responding to outbreaks and supporting state and local public health departments, reportedly has hundreds of vacant positions, some even eliminated in the months leading up to this pandemic, while facing annual budget cut proposals by the current administration.** In 2018, the Donald J. Trump administration decided to downsize the global health security directorate on the National Security Council, potentially leaving us less prepared for COVID-19. Infectious agents anywhere can impact Americans at home President Trump has now floated a plan to eliminate funding to the World Health Organization (WHO), an entity that convenes member states and coordinates international responses to infectious diseases, among other tasks, and is already massively underfunded. Infectious agents anywhere can impact Americans at home. Contagions cross borders with ease, so investing in efforts to extinguish outbreaks in other countries protects the homeland. Proposed funding cuts for global health security initiatives abroad could leave other countries' citizens vulnerable to outbreaks, weaken U.S. moral and diplomatic authority, and squander opportunities to squash potential epidemics at their source for a fraction of the cost of a full-blown pandemic response. The U.S. Congress has mounted a bipartisan defense over the last couple of years to prevent these requested reductions from becoming a reality, but the priorities of an administration nevertheless influence political will to cultivate (or weaken) such international efforts. **Finally, when Americans require treatment for such a disease, they are coming into contact with a domestic health-care financing and delivery system operating in a regulatory landscape that reflects the priorities of their elected representatives.** The United States lacks universal health coverage, despite spending more per capita on health care than any other country on the planet, forcing ill-timed confusing discussions surrounding individual coverage of COVID-19 testing and treatment nationwide. An understaffed CDC and hamstrung global health security efforts leave the country exposed to many a menace that do not recognize international borders or discriminate between those with insurance and those without. 53 Percent Some 53 percent of eligible voters cast a vote in the 2018 midterm elections—a four-decade high **The U.S. health system is a quilted composite of patchy**

**political decisions and compromises over competing priorities.** Those compromises reflect a winner-take-all political landscape in a country where one of the most protected rights is the freedom to vote—and have that vote counted fairly—as protected as anywhere in the world. However, only 55.7 percent of eligible voters voted in the 2016 presidential contest. Some 53 percent of eligible voters cast a vote in the 2018 midterm elections, which was a four-decade high for midterms. This trails behind most other high-income countries, while those in some low-income countries have to fight for their vote to actually be counted and not diluted with ballots stuffed in boxes by the cronies of an incumbent autocrat. **Responding to public health threats requires political prioritization and bold action before infections hit our shores.** The time to act is before the Ebola virus lands in Dallas, before measles infiltrates Disneyland, or before COVID-19 comes ashore on the Pacific coast. The United States had more than two months after China's first reported coronavirus case to ensure we had testing capacity, personal protective equipment for health workers, and a plan in place to identify and isolate cases as they appeared. But the horse is well out of the barn as the U.S. government is racing to shut the barn door. **It is hard to imagine how public health preparedness could be anything but political. The desire to avoid politics in the pandemic response is understandable.** The top priorities today center on safety and reopening the economy—goals we can all agree on. In some ways the disease itself has reminded us of our commonalities even while highlighting our disparities, at least as they pertain to health. We are all under its threat—and therefore we are all in this together. However, **pandemic responses in any country are fundamental human endeavors led by governments put in place by the people through a political process**. It is hard to imagine how public health preparedness could be anything but political.

## Traditional interpretations of federalism make pandemic preparedness a cooperative issue. Unilateral federal action wrecks that norm

**Birkland et al 2021** Thomas A. Birkland is a researcher at North Carolina State University. "Governing in a Polarized Era: Federalism and the Response of U.S. State and Federal Governments to the COVID-19 Pandemic" https://pmc.ncbi.nlm.nih.gov/articles/PMC8385820/

**Public health is grounded in the most basic function of government**: to promote public health, safety, and welfare (Hodge 1997a, 1997b). **Disease preparedness and response is an inherently intergovernmental activity. Under our constitutional order, the federal government plays an important role in this system, in particular by supporting state and local efforts** to promote and maintain public health. But **the federal government does not act alone,** and effective public health preparedness and response requires cooperation among the federal, state, and local governments. The idea that the states should take primary responsibility for public health is rooted in notions of "dual federalism," in which the federal government and state governments' responsibilities are distinct from each other (Kincaid 2017, 159). **The protection of public health and safety is part of the states' "police power" retained under the Tenth Amendment** (DeLeo 2010; Gostin 2001). The positive rationale for this arrangement is that the states closely reflect the culture and desires of the people in the states. Dual federalism does not equate to a strict division of labor between the federal and state governments in public health. **The literature on public health acknowledges that public health policies ideally fall under the rubric of "marble cake" or "cooperative federalism,**" in which the federal government and the states work together to address problems of mutual concern (Hills 1998; Kincaid 1990). Cooperative arrangements between states and the federal government to provide for public health through sanitation and other means require cooperative federal–state relationships (Williams 2001; Doremus and Hanemann 2008; Burleson 2012). Public health preparedness is "the capability of the public health and health care systems, communities, and individuals, to prevent, protect against, quickly respond to, and recover from health emergencies, particularly those whose scale, timing, or unpredictability threatens to overwhelm routine capabilities" (Nelson et al. 2007, S9). Within the context of public health emergencies, such as disease outbreaks, terrorist attacks, or large-scale natural disasters, public health preparedness encompasses everything from hazard or disease surveillance and prevention to developing greater operational capacity through the creation of emergency plans, stockpiling of certain types of critical supplies, and critical infrastructure development. The preparedness system reflects key features of cooperative federalism and fiscal federalism. The federal government, because of its ability to engage in deficit spending to a far greater extent than the states, is able to bring resources to bear to address problems that challenge state and local governments and can also grow into much more serious national problems (Kincaid 1990). Clearly, disease outbreaks qualify as the sort of national problems to which the federal government should be most attentive (Foreman 1994; Garrett 2000). Particularly in the wake of the September 11, 2001 terrorist attacks, the federal government redoubled its efforts to bolster the nation's preparedness capability, investing billions of dollars into a host of federal–state cooperative programs aimed at enhancing the nation's readiness for "all hazards," including public health emergencies stemming from bioterrorism or pandemics. **At the root of the preparedness system is the idea that the federal government, state governments, and private and nonprofit organizations share an interest in promoting public health.** As Altman and Morgan (1983, 7) noted, the design of the public health system is a classic example of "marble cake federalism" in which the roles of the federal and state government are intertwined. The federal government employs thousands of scientists in agencies such as the Centers for Disease Control and Prevention, the National Institutes of Health, and the Public Health Service, all under the U.S. Department of Health and Human Services. These agencies undertake research, gather data, share good practices with states and local governments, and develop ideas and recommendations for health interventions. The federal government also has considerable fiscal power to induce states to adopt particular public health policies (DeLeo 2010). Global disease surveillance is a responsibility of the federal government, led by the Centers for Disease Control and Prevention. The public health literature calls the CDC the "sentinel" for American public health (DeLeo 2014; Etheridge 1992), because it is responsible for identifying and tracking outbreaks of threatening infectious diseases before they make their way to the U.S. In the current COVID-pandemic, the CDC established an Incident Management Structure to begin U.S. response operations on January 7, 2020. **Despite these features of the design of the public health system, observers of the post-9/11 public health preparedness regime have similarly**

**lamented the lack of clarity around public health emergency preparedness,** noting "despite anecdotal reports suggesting that progress has been made, it is unclear whether these investments have left the nation better prepared to respond to a bioterrorist attack, pandemic influenza, or any other large-scale public health emergency" (Nelson et al. 2007). As part of CDC's disease surveillance mission, the agency collects and publishes indicators of public health in its Morbidity and Mortality Weekly Report or MMWR. The dissemination of information on novel viruses in the MMWR is central to the national system of disease surveillance. Novel viruses are particularly concerning because the human population has no experience with such viruses, so there is no human immunity, and the disease can spread rapidly. This surveillance function of the CDC relies on scientific excellence for the gathering and dissemination of credible information vital to the public health system.

## Counterplan Solvency

### The USFG should rejoin the World Health Organization (WHO) - health access is a key internal link to diplomatic conflict resolution

**Walson, Judd 1-30-2025** Judd Walson MD is the host of the Public Health On Call Podcast with Johns Hopkin's Bloomberg School of Public Health. "The U.S. and the WHO: An Imperfect but Essential Relationship"
https://publichealth.jhu.edu/2025/the-consequences-of-the-us-withdrawal-from-the-who

What is the U.S.'s relationship with the WHO? How do we benefit as a member and what do we lose by leaving? **Without the U.S., there will be important impacts to WHO both in terms of the funding we provide and the broader impacts. From a financial standpoint, we are the largest contributor to the WHO—somewhere between 12%–15% in 2022–2023. The WHO is already struggling financially, and the U.S.'s withdrawal will likely lead to a loss of jobs, reduction of work, and less ability to do the functions we just talked about.** But if we think it's expensive to be part of the WHO, just wait until we aren't part of the WHO. That's where we're going to see the true costs. This withdrawal will be incredibly costly for both the American people and the global community, and not just in the pure economic terms of our contributions to WHO. Since World War II the U.S. has developed a reputation around the world as a country that supports others, and that has important consequences for global diplomacy. We are known in the health space as a country that provides assistance to many countries. In fact, many **countries with whom we have very poor diplomatic relations, and that we don't see eye-to-eye with politically, still reach out to us for support around health. Health provides an entryway for us to engage with countries, many of whom we may not agree with, and to have diplomatic conversations and other conversations.** If that is lost, it will have tremendous consequences for the U.S.'s security and long-term economic and political outlook. The Trump administration cites the WHO's response to COVID as a reason for the U.S.'s withdrawal. What role did the WHO play in response to the COVID pandemic? The COVID response globally can be classified in some ways as a technical success. We had many technical breakthroughs, including the development of vaccines at a pace that had never been seen before, the deployment of drugs and vaccines to places that previously were hard to access, and in some circumstances very quickly. If we think it's expensive to be part of the WHO, just wait until we aren't part of the WHO. That's where we're going to see the true costs. Early on, there was some consensus around how to approach the problem globally, but it was a tremendous diplomatic failure. We saw that with the hoarding of vaccines by some countries and not delivering to other countries. We saw it with failure to access data from China and other places around the origin of the virus. Now, those diplomatic failures were not only at WHO; they were broader. But there are valid concerns about the way that WHO operates when handling large crises. There are also concerns about the failure to reform and concerns about lack of independence from political pressures. The WHO is a consortium of many member states, all of whom have a voice, and managing that is challenging. Lastly, there's a feeling that there's a disproportionate level of investment by the U.S. It's important to acknowledge that those are all real problems that need to be resolved. But **rarely does walking away from a problem fix the problem. We should work to resolve them so that these functions can be performed**. How will the U.S.'s withdrawal from the WHO impact the health of people globally and in the U.S.? **It is likely to cause enormous strain on the global community. Ultimately the global community, including Americans, will suffer and have poorer health.** Take, for example, my colleagues around the world, including people at the WHO, working to reduce childhood deaths. That's important for people living in low-income settings, but it's important here, too. Many of us have relatives or friends who have had a baby born premature—that's a high risk period for a baby. Where do the guidelines come from [for premature births]? How do we know what the best interventions are for preterm babies? That comes from **data collected from around the world and interventions that have been tried to improve survival or reduce the level of morbidity in children who do survive. We benefit in real ways here at home from the work of the WHO.** This is not only about what we do for others; it's also about what we do for ourselves.

### The North Atlantic Treaty Organization should increase its investment in field laboratory response measures

### NATO field lab research point towards large scale feasibility - solves research response with international cooperation

**Wellington et al 6-9-2025** Trevor Wellington works for the Department of Medicine, Uniformed Services University of the Health Sciences, Bethesda, MD 20814, United States "Deploy to Diagnose: Enhancing Pandemic Preparedness With NATO Field Lab Capabilities" https://academic.oup.com/milmed/advance-article-abstract/doi/10.1093/milmed/usaf231/8159027?redirectedFrom=fulltext&login=true

Introduction **Laboratory testing capabilities are critical for pandemic preparedness and response.** However, **deployable laboratory assets are not typically designed for the high-throughput demands of large-scale disease outbreaks.** Validating such capabilities in field conditions requires deliberate planning and execution. Here, we outline the setup, execution, challenges, and lessons learned from the multinational Task Force Lab at Clean Care 2024 (CC24), a live **NATO (North Atlantic Treaty Organization) training exercise** in Hungary. Materials and Methods During CC24, an outbreak of a morbilliform virus, with pre-prepared nasopharyngeal swab samples, **was simulated** during the exercise. **Task Force Lab received and processed samples to assess accuracy and turnaround times,** while endemic disease surveillance and foodborne outbreak testing were also performed. Statistical analysis included daily performance updates and composite accuracy assessment, using a sample key maintained by a trusted agent within Task Force Lab. Results Over the course of the exercise, 4 microbiology laboratories processed 891 samples. Two partner laboratories (Germany and Hungary) simultaneously handled 825 samples from the simulated outbreak with a 98% overall testing accuracy. Additional laboratories focused on endemic disease surveillance (Italy) and foodborne enteric disease outbreak testing (Romania). The 1st Area Medical Laboratory (United States) provided a command-and-control function, directed sample distribution, and results reporting. Key challenges included lack of standardized form usage and variability in laboratory capabilities. Conclusions **Task Force Lab demonstrated the feasibility of conducting high throughput microbiological testing in a deployed setting, providing a framework for future exercises and real-world operations.**

## Links for Kritiks

## Communicable Disease Preparedness is controlled by a system of Biopower

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Structural racism and COVID-19 via biopower **Biopower is inextricably related to intersections of identity such as race and citizenship. When disparate incidences of COVID-19 began to manifest in the early days of the pandemic, many called COVID-19 an equal opportunity disease.** Much like the refrain that "white lives matter too" in response to the Black Lives Matter movement, **the idea of COVID-19 "leveling the playing field" misses powerful structural factors that shape health outcomes.** Certainly, white lives matter and COVID-19 affects white people. We do not argue these facts. Rather, **we call attention to the disproportionate COVID rates** affecting Black, Indigenous, and people of color **due to structurally embedded systems that are designed to dehumanize and judge the worth of racialized and disenfranchised people**.20,21 Structural racism is defined as "the ways in which societies foster discrimination through mutually reinforcing inequitable systems."21(p77[1]) People who benefit from existing systems (eg, education, financial, employment, housing) are more likely to be white. Their access to life-sustaining resources enables them with the choice to follow governmental mandates for safety such as social distancing and quarantine or isolation. People who are made zoe (usually the minoritized and racialized) have less access to resources and choice to decrease their risk of contracting COVID-19. Health care as an apparatus of biopower **Biomedical criteria applied to homo sacer at the point of triage and treatment serve as gatekeepers to their chances of surviving COVID-19.** These criteria guide resource allocation such as testing and treatment like ventilators. A recent systematic review found wide variation in ventilator allocation guidelines during COVID-19 among 26 US states. Some states' guidelines listed prioritized categories of people such as pregnant patients, those of younger age, and health care workers. **Some guidelines recommended de-prioritizing patients who have a lower life expectancy due to underlying comorbidities.**22 Communities with higher risk for chronic comorbidities and contracting COVID-19 are influenced by multiple social determinants of health such as race, employment, citizenship status, food and housing security, and socioeconomic status. Communities of color living in crowded housing, high poverty, and little access to health care have higher COVID-19 infection rates.23 People who are zoe are more likely to be essential and low-wage workers with little to no access to benefits such as paid sick leave or health insurance and more likely to lack access to personal protective equipment. Low-wage earners who contract COVID are faced with the decision to isolate often in a multigenerational household or earn money to provide for their family's basic needs. For those without rights (zoe), care in a hospital intensive care unit for assisted ventilation is simply out of reach. Much less, those who are zoe often cannot enter through the doors of the clinic to receive initial testing for COVID-19, thereby deterring any chance of ventilator eligibility. **Health care is not considered a right but a privilege in the United States. Those who are zoe suffer the structural violence of lacking health care access, coupled with the systemic and structural violence that predisposes them to increased risk for chronic comorbidities, placing them at a higher mortality risk from COVID-19.** Biomedical criteria fall short of accounting for health inequities shaped by social determinants; these criteria perpetuate the idea that homo sacer can be denied resources, enacting biopower by killing them slowly with impunity. Essential workers as bare life **Through biopower, the nation-state controls all aspects of bare life (zoe).** Agamben's zoe—or bare life—also extends to manual and domestic labor,17 and **"essential workers" such as grocery store staff, health care workers, migrant workers, and first responders are placed at a highest risk for exposure to**

**COVID-19.** COVID-19 is a state of exception, and essential workers who are zoe risk their lives to maintain the survival of those who are bios. **The use of biopower can be seen in both policies and actions of the nation-state regarding the status of zoe and bios and the changed decision-making processes based on the zoe and bios distinction. Examples of a state of exception include lockdowns, social distancing guidelines, and travel restrictions.** For example, several governors in southern states in the United States pushed for early reopening of businesses,24 impacting essential workers who are most often from marginalized, poorer communities of color (zoe).21 COVID mortality rates by race can be examined within and across these states. Alabama, for instance, reported race data for 60% of their cases as of early September 2020. Of those cases, 42% of those deaths were among Black or African American people, even though Black and African American people comprise 27% of the population, indicating a racial disparity.25 Biopower becomes sanctioned and normalized at a policy level. While we concur from a scientific public health perspective that public health strategies such as masks, social distancing, and quarantine and isolation to contain the virus are necessary, we have c**oncerns about possible enactments of state-sanctioned biopower that serve to consolidate power rather than serve the common good.** Detaining asylees and prisoners, increasing the use of martial law, and rationing resources such as ventilators are acts based on the perceived worth of categories of people such as the elderly, the imprisoned, and the detained. **Decisions of people's hierarchical worth are enacted in an autocratic process, which is manifested in the deliberation of the worth of some people (zoe) and their access to safety and lifesaving resources**. The dual pandemics of COVID-19 and racism have revealed that not all communities have access to rights. Biopower, racism, and the criminal justice system/police brutality The second pandemic of police brutality is also an outcome of biopower and the perceived worth of racialized people. Racism and police brutality have been denounced by national professional associations such as the American Nurses Association and the American Academy of Nursing,8 the American Public Health Association,1,2 and the American Medical Association.26 These professional organizations urge for the cessation of police brutality and racism. Police brutality is a symptom of a racist criminal justice system institutionalized by biopower. For example, in the school-to-prison pipeline, Black people are incarcerated at disproportionately higher rates with loss of voting rights and life opportunities and disenfranchisement in a relegation to a permanent second-class status.27 In the current nation-state "we have rights, but not rights to rights."17 These "rights" can be taken away in a moment's notice or, more accurately, in a heartbeat. The COVID-19 pandemic has illuminated how those who are incarcerated have little to no access to health care and environmental living spaces for proper social distancing and ventilation,28 let alone personal protective equipment.29 Detainees in U.S. Immigration and Customs Enforcement (ICE) detention centers have little recourse to legal representation30 or health care while being exposed to COVID-19. Basic survival is constructed both explicitly in resource allocation algorithms and implicitly in the constant struggle for health care, resources, and safety. Those in the contested and constant struggle for rights are homo sacer. Brutality includes not only physical violence but also emotional, psychological, and sexual violence. Alang et al31 argue that police brutality is more than police misconduct; it is the deep mistrust and psychological toll among communities and victims who have been historically targeted and dehumanized even without conscious intent by state agents or perpetrators. These insidious effects of physiological responses of increased morbidity, the continued witnessing of racist reactions to brutality, and the legal and medical financial strains of exposure to blatant violence contribute to the cumulative allostatic load. **Dehumanization is equated with Agamben's zoe and homo sacer—or those who can be killed with impunity. The chronic denial of testing, triage, and treatment for COVID-1921—essentially, access to life and breath**—parallels the acute, increasingly publicized death by asphyxiation of Black people at the hands of state-sanctioned police, **namely, biopower.**

## Pandemic preparedness and response is controlled by a system of unstable capitalism that leaves behind the ones who need its help the most.

**Stevano et al 21** Sara Stevano is a professor in the Department of Economic at the University of London. "COVID-19 and crises of capitalism: intensifying inequalities and global responses" https://www.tandfonline.com/doi/full/10.1080/02255189.2021.1892606#abstract

Through the COVID-19 magnifying glass As the pandemic was declared by the World Health Organisation (WHO) on 11 March 2020, governments across the world successively crafted more or less apt responses, including declarations of nationwide lockdowns. In this context, **COVID-19 has amplified pre-existing inequalities and created some odd juxtapositions.** We list a few. First, **many so-called "advanced economies", despite having the strongest health security capabilities, as captured by the Global Health Security (GHS) index,Footnote3 were unable, or unwilling, to protect their citizens while various countries in the Global South seem to have been more successful at managing the pandemic.** The United States as the richest country in the world, for instance, commanding one of the highest concentration of scientific skill and ranking first globally according to the GHS, registered more US Americans dying in the first three months of the US outbreak than during the entire Vietnam war (Horton Citation2020a, 47). At the same time, Vietnam, now a lower middle-income country with just short of 100 million people, recorded a total of 35 deaths as of December 2020, while deaths in the United States reach top 300,000. Across the world, more than 103 million people have been infected by COVID-19 and over 2.2 million have died at the time of writing.Footnote4 Despite only making up around a sixth of the world population, countries of the Global North have so-far accounted for nearly half of the deaths. On the other hand, some countries in the Global South, including Vietnam, Rwanda, Sri Lanka, Mali, Laos, Cambodia, and Cuba have been more effective at containing the spread of the virus. In a recent study of the impacts of the COVID-19 pandemic on global income inequality, Deaton (Citation2021) finds that income inequality between countries has decreased because national per capita income has fallen more rapidly in high-income countries than in poor countries, unless income inequality is weighted by population.Footnote5 In addition, **the presumed trade-off between protecting health and the economy is not supported by the data, which shows that countries with higher deaths per million are also those with lower predicted income per capita growth** (ibid.). Second, pre-existing inequalities of class, race and gender within countries have been laid bare dramatically. When national lockdowns started to be enforced across most countries in the world, people were told not to step out of their homes except for a limited set of activities. Entire sectors came to a standstill and mobility − within and across countries − all but ceased. Initial studies demonstrate that lockdown policies had direct adverse effects on all economies across the globe (e.g.

Jackson et al. Citation2020). **Lower socio-economic groups have been more likely to bear the brunt of the negative economic fallouts, apart from often being disproportionately represented in the fatality rate.** Alston (Citation2020, paragraph 34) insists that: **The public health community's mantra for coping with COVID-19 encapsulates the systemic neglect of those living in poverty.** The pithy advice to "stay home, socially distance, wash hands, and see a doctor in case of fever" highlights the plight of the vast numbers who can do none of these things. They have no home in which to shelter, no food stockpiles, live in crowded and unsanitary conditions, and have no access to clean water or affordable medical care. Far from being the "great leveler," **COVID-19 is a pandemic of poverty, exposing the perilous state of social safety nets for those on lower incomes or in poverty around the world. The class impacts of coronavirus are shaped by the unequal ability of different socio-economic groups to follow social distancing measures as well as their uneven underlying health and housing conditions** (Reeves and Rothwell 2020). A key factor is employment. Depending on job type, the pandemic has differentiated effects on workers' earnings, the likelihood of becoming unemployed, ability to work from home and exposure to the disease, with those in informal, precarious and front-line work most severely affected (Adams-Prassl et al. Citation2020; ILO 2020a). With labour markets in the Global South marked by a high degree of informality, job vulnerability during the COVID-19 crisis is particularly high. **There are** also **significant intersections across class**, race, gender and migrant **status**, with racial disparities underpinning the disproportionate effects of the pandemic on ethnic minorities in various countries including Brazil, the United Kingdom and the United States (Tai et al. Citation2020). Young workers, women, migrants, racialised minorities who are overrepresented in services and informal occupations are more likely to lose their jobs and not receive a replacement income. Those who had to continue working, including workers who have been deemed essential, face increased health risks (ILO 2020b). **In addition to labour markets reproducing inequalities through the internal segmentation that exposes specific social groups to super-exploitation** (see Elson Citation1999; Elson and Pearson Citation1981), **the patterns of exclusion, marginalisation and expulsion from regular employment underpin processes of racialisation that are integral to the functioning of global capitalism** (Bhattacharyya Citation2018). COVID-19 has illuminated how multiple inequalities are formed and re-constituted through divides of work/non-work, productive/reproductive work that fragment the global working classes and those expelled from them. A gender lens reveals the complex ways in which inequalities filter the impacts of the pandemic, with women at a lower risk of mortality than men but, at the same time, disproportionately impacted through their concentration in jobs exposed to the disease, increased care needs, unemployment and domestic violence (Hawkes and Buse Citation2020 this issue; ILO Citation2020b; Wenham, Smith, and Morgan Citation2020). Third, aside from increasing intersecting inequalities within countries, **the uneven power dynamics of capitalism manifest themselves in the perpetuation of the divide between Global South and North. The COVID-19 crisis reminds us of the stark topography of the unlevelled playing field of global capitalism, particularly through dynamics of production, reproduction and finance, in spite of the differential effectiveness of governments' responses to the COVID-19 pandemic that escape South–North divides and new data analysis showing a decrease of global between-country income inequality** (see Deaton Citation2021). The subordinate position of the Global South in the global economy exposes specific vulnerabilities, not just at the level of the nation but more structurally with regard to the organisation of the global economy as a whole. **Relations of dependence, structured by re-iterations of colonial configurations of production, reproduction and exchange, continue to shape processes of development in the Global South.** For instance, the growth underpinning the "Africa rise" phenomenon has been mostly jobless but was accompanied by a significant increase in the income payments made by African economies to the rest of the world in the form of primary income on foreign direct investment (Sylla Citation2014). Furthermore**, the participation of Global South firms in global supply chains enables new forms of economic imperialism.** In her study of imperialist practices, Suwandi (Citation2019), for example, finds that Indonesian suppliers−pressured by Multinational Corporations (MNCs) to adapt to flexible production regimes−transfer unreasonable demands onto workers through various forms of control of the labour process (see also Mezzadri Citation2016). What are the structural conditions of the South–North divide that are relevant to understand the unequal impacts of the COVID-19 crisis on a global scale? The integration of countries of the Global South at the lower end of global value chains generates three distinct forms of vulnerabilities. First, the export-oriented growth model focussing on primary commodity extraction and labour-intensive manufacturing exposes countries directly to international price volatility and demand shocks (Blattman Citation2007; Nissanke and Thorbecke Citation2007). Whilst this is a recognised long-standing issue, the COVID-19 pandemic has had additional effects on export logistics, commodity prices, labour markets and demand composition (OECD Citation2020). The drastic drop in global demand, the dramatic fall in exports, and the sudden stop (and reversal) of capital inflows will have long-run ramifications for the sustainability of commodity exporting economic models (Asante-Poku and van Huellen Citation2021 this issue; Franz Citation2020 this issue; Hanieh Citation2020 this issue; UNCTAD Citation2020). Second, the unequal distribution of power in global supply chains has meant that Global North corporations have been able to transfer costs and risks down the chain, with severe implications for firms and especially workers at the bottom (Anner Citation2020). Again, the mechanism is not new, but the magnitude of the effects is. As a result of the informality of work arrangements, the lack of social protection and job security, the workforce in the Global South is in an overall position of structural vulnerability, both within and without global supply chains (ILO Citation2020c). This is another key dimension of how the pandemic is disproportionately affecting economies and workers in the Global South. Finally, the subordinate position of the Global South in the global financial architecture underpins the responses to the COVID-19 crisis that we have seen enacted so far (see section 3). However, before we reflect on whether (and if so how) policies implemented so far are likely to lead to any reconfiguration of global power dynamics, we want to point to a further dimension of inequality that is likely to play an important role in the COVID-19 recovery. As we write this article, the rollout of the COVID-19 vaccine is underway in many countries, with Israel, the United Arab Emirates, the United Kingdom and the United States spearheading the rollout. Whilst the timeframes of this unprecedented global immunisation campaign are not fully determined yet, it is clear that countries have widely different abilities to secure a vaccine for their citizens. The wrangling over the waiver request by South Africa and India to the World Trade Organisation to suspend intellectual property rights related to COVID-19 serves as a sobering reminder of the stark South–North divide (Aryeetey et al. Citation2021; Usher Citation2020). The ramifications of inequalities in vaccine distribution are likely to be multiple and long-lasting. Protecting the status quo? Before the COVID-19 outbreak, the dominant austerity narrative dismissed calls for more spending to address urgent environmental and inequality issues. We were repeatedly told that "there is no magic money tree". However, with the COVID-19 outbreak, such a botanical species was suddenly (re)discovered and it was found to bear fruit quite vigorously. **The imposition of national lockdowns triggered a series of connected and mutually**

**reinforcing supply and demand shocks, heavily disrupting production and transportation of commodities and causing a massive fall in private consumption and investment.** This created an urgent need for government and central bank interventions, which led to unprecedented increases in public spending and expansion of central bank balance sheets in certain parts of the world. As of early September 2020, global pandemic-related fiscal measures are estimated by the IMF (Citation2020) to be close to 12 per cent of global GDP. But while the magic money tree flourishes in countries of the Global North, producing a lot of money for financial markets and particular segments of society, it is a rare species in the Global South. **High-income countries have been in a position to conduct large fiscal expansionary programmes because they are at the top of the global currency hierarchy,** their favourable credit ratings allow them to borrow money at low interest rates and their central banks can conduct massive purchases of government bonds. In middle-income countries, the capacity to spend has been much lower, given the low demand for short-term local currency debt and less favourable credit ratings internationally. In **low-income countries, this capacity has been minimal.** The IMF (Citation2020, 8), for example, notes that some countries, like Sudan and Zambia, might in effect see a reduction of their government deficits in 2020 compared to 2019, as a result of a decrease in their primary public expenditures. These differences in the capacity to conduct fiscal policy are a reflection of political and institutional processes, including financialisation, that have taken place over the last decades and have deepened the peripheral position of the Global South (see Bonizzi, Kaltenbrunner, and Powell Citation2019). They are also the result of the subordinate position of Global South countries in the global value chains and their subjugation to the modalities of transnational capital (see OECD Citation2020; UNCTAD Citation2020). Measures seeking to attenuate this unevenness in fiscal space have been very limited. The grants that have been provided to some countries via the IMF's Catastrophe Containment and Relief Trust have been extremely small (Stubbs et al. Citation2021). The World Bank has provided support primarily through its private financial arm without changing its private finance-oriented approach that serves the interests of foreign investors and private financial institutions (Dimakou, Romero, and Van Waeyenberge Citation2020 this issue). Additionally, the pandemic puts strains on the financial systems in emerging market economies that rely significantly on dollar-denominated borrowing. In March 2020, the US Federal Reserve Bank (Fed) (which prior to the pandemic had standing swap arrangements with only 5 central banks) created new swap lines with 9 countries, but only 3 of them (Brazil, Mexico and Korea) were not high-income ones (Bahaj and Reis Citation2020). Finally, the G20's Debt Service Suspension Initiative only sought to provide temporary relief on debt service rather than alleviate structurally high debt burdens, failing to produce any substantial relaxation of the fiscal space necessary to support essential service provision (see Laskaridis Citationforthcoming this issue). Crucially, fear of sovereigns losing market access (to commercial lenders) in case they participate in the scheme has limited the number of countries applying.Footnote6 Overall, despite the unprecedented economic and social consequences of the pandemic, the status quo that is reflected in the global financial architecture, and puts the Global South in a subordinated position, has not been challenged (let alone changed). **Furthermore, the magic money tree, where it grows, has not been used by the governments to protect effectively the most vulnerable.** Although "essential workers" were praised for their invaluable contribution to the tackling of the health crisis, this has not translated into wage increases or a substantial increase in spending on health and social care; in fact, essential work legislations have been used by governments across the world in politicised ways that escape universally intuitive understandings of "essentiality" and have often resulted in making essential workers more disposable (see Ghosh Citation2020; Stevano, Ali, and Jamieson Citation2020 this issue; The Lancet Citation2020). At the same time, many big corporations were bailed out without any environmental or social conditionalities. **The reinforcement of uneven relations and inequalities within and across countries is estimated to push between 80 and 115 million people into extreme poverty,** measured using the $1.90/day international poverty line. The projections become even gloomier if indicators of moderate poverty are used (Sumner, Hoy, and Ortiz-Juarez Citation2020; The World Bank Citation2020). Although the positive narrative about income poverty falling since 1990 can be challenged (see Hickel Citation2016), the COVID-19 crisis is creating a consensus that poverty is set to increase substantially, regardless of the methodological approaches taken to measure it.

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