6

The Social Contract and Responses to COVID-19

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As the COVID-19 pandemic steamrolls through a third year, it has become increasingly evident that there will be several long- and short-term health, socio-economic, and political ramifications. This is not the first global or even global health crisis, and yet, with every new ordeal society learns to reassess, readjust, and redevelop as needed. On the one hand, SARS-CoV-2 had brought a number of age-old concerns and practices about sanitation, isolation, and public health more generally, back to the surface of public debate and political discourse. On the other, such concerns in the context of a much more globalised and interconnected world have posed new challenges, specifically about what the respective roles, responsibilities, and limitations of government and individuals in a given society should be. For example, both China and Italy have implemented some of the most stringent travel restrictions at different points in the pandemic—a policy echoed in the unprecedented introduction of border controls in the Schengen zone, which historically has allowed for free movement across the European Union starting in 2020. However, once implemented, Europe lifted such border controls much more quickly than China and several other countries that have maintained a zero-COVID policy—a policy also implemented for varying amounts of time and at varying levels of risk to public health. This shift towards increasingly stringent policies is also reflected in many of the COVID-19 public health measures across these contexts with the lockdowns, quarantines, and other policies put in place. Meanwhile, countries including the United States, Sweden, and the United Kingdom, while also reconsidering how stringent their public health and travel measures should be since the beginning of the pandemic, have fallen on the other side of the spectrum. In part, these differences reflect the public's reactions to these policies, with people holding different opinions about how much their governments should be involved in managing the risks of the pandemic and how much personal freedoms should be limited as a result.

All of these public health concerns allude to a theory as old as philosophy itself, describing an agreement—hypothetical or actual—among individuals about their rights and duties to each other and in the context of some form of government. This

'social contract' defines the moral and political obligations that the public and government have to themselves and each other, and in so doing provides the basic framework underlying how a society conducts itself. COVID-19 clearly illustrated the extent to which countries have very different social contracts based on their own contexts, histories, and public psyches. Faced with the same deadly threat of the coronavirus, countries have responded in very different ways over the last few years. Stringencies of policies and the relative prioritisation of health, trade, and economic policy by governments have varied. Likewise, what the public expects the role of their government to be in this crisis has also differed. Should governments mandate vaccines? How much of a priority is vaccine equity and how is it defined? For how long should mask mandates be in place or reinstated, if at all? Should there be quarantines? And if so, for how long and for whom? These questions are some of the most essential and controversial in the COVID-19 response and in defining the new norm in countries' social contracts going forward.

This chapter unpacks the idea of the social contract and applies it in the context of health policy and the world's response to the COVID-19 pandemic.

The Social Contract: An Introduction

The social contract provides a foundation of understanding upon which societies are built. This foundation of understanding requires that individuals have certain obligations to themselves and each other and where they voluntarily agree to either a tacit or explicit agreement based on their own self-interest and rationality. Social contract theory can trace its roots to Socrates's *Crito*, where he explains that he must remain imprisoned and face the death penalty in order to honour the very system of laws and norms in Athens that allowed for his existence and life. The laws and norms allowed for his parents and him to live the life they had led until the point in time of his imprisonment and execution, and in return, it was his obligation to uphold certain duties and responsibilities to the city and society of Athens.[1]

Social contract theory centres on the established expectation about what governments can and cannot do and what individual freedoms and responsibilities exist in any given society. The aim of the theory then, is to show why individuals in a given society endorse and comply with the formal and informal institutions (i.e., values, laws, etc.) in place, as with Socrates choosing to remain imprisoned and subjected to the other laws in Athens. However, there is no one theory for how this relationship between individuals and society should operate.

Modern social contract theory was developed by the British and French philosophers Thomas Hobbes, John Locke, and Jean-Jacques Rousseau. The basic premise

1. Plato, *Crito*, Internet Classics Archive, accessed 13 September 2022, http://classics.mit.edu/Plato/crito.html; Internet Encyclopedia of Philosophy 'Social Contract Theory', accessed 13 September 2022, https://iep.utm.edu/soc-cont.

behind each of their conceptions is that rational, free, equal-status individuals are in a State of Nature, and that the establishment of some type of a social contract via a government entity develops among these self-interested and rational individuals, forming a civil society that imposes rules and limitations to protect all. However, for Hobbes this State of Nature is comparable to a state of war, without morality and politics, where everyone is for themselves. As such, individuals choose to live under a sovereign with absolute authority in order to have a social contract that protects them.[2] Locke, on the other hand, views the State of Nature as a place where free, equal individuals do as they see fit to be their best selves while respecting the life, health, liberty, and possessions of others.[3] In this context, individuals accept a social contract in order to protect themselves against any transgressions by having a representative government. Finally, for Rousseau, the State of Nature also involves free individuals, but they succumb to dependencies, inequalities, and comparisons among themselves and need a social contract to break free from them and still be able to live together as a society.[4] The variation in these philosophers' ideas highlights how people can arrive at very different conclusions about what the social contract should look like and the problems it is meant to solve for society. These differences have implications for how individuals and societies address major governance issues, including health broadly but also emergencies like the COVID-19 pandemic.

The Social Contract and Health

Each theory of social contracts offers a justification for what a government provides the public and what the public is allowed to do. This can be applied to any sector in which the government is involved, and health is no exception. This balance of individual and societal needs, capacities, and responsibilities is central to both healthcare and public health policy. All healthcare systems have a social contract with the public emphasising the need to provide accessible, equitable, effective, and efficient care to whatever level they deem legitimate.[5] A classic tension also exists between growing demand for healthcare and public health services and declining economic means by which to do so.

As such, discourse on the role of government and individuals in healthcare and public health policy centres around questions of distributive justice, individuals' rights, and state and individuals' responsibilities. How accountable is the state for ensuring that conditions promote and even secure individual health? And to what extent are

2. Thomas Hobbes, *Leviathan* (Cambridge, MA: Hackett Publishing Company, 1994).
3. John Locke, *Locke: Two Treatises of Government*, ed. Peter Laslett (Cambridge: Cambridge University Press, 1988).
4. David Lay Williams, 'Book I', in *Rousseau's Social Contract: An Introduction* (Cambridge: Cambridge University Press, 2014), 26–63; Internet Encyclopedia of Philosophy, 'Social Contract Theory'.
5. Kumaran Senthil, Evan Russell, and Hannah Lantos, 'Preserving the Social Contract of Health Care—A Call to Action', *American Journal of Public Health* 105, no. 12 (December 2015): 2404, https://doi.org/10.2105/AJPH.2015.302898.

individuals, in turn, to be responsible for maintaining their own health and, further, to be held accountable for unhealthy behaviour—if at all?[6]

The development and reform of different welfare state systems is a testament to the fact that there is no single social contract around individual and community health. Countries approach it differently among themselves and also within their own contexts overtime. For example, the United Kingdom's National Health Service is one of the most socialised forms of medicine, providing free public healthcare to all permanent residents at the point of need, paid for by taxes. It was established to guarantee that everyone in the United Kingdom could seek healthcare when they need it, and yet it has also been criticised for being too all-encompassing and even intrusive as a 'nanny state', with too much influence on individuals' lives. In the context of these debates, the system has gone back and forth on how much spending and responsibility it has for the public's health.[7] At the other end of the spectrum, the United States does not provide universal coverage through the government, with Americans predominantly covered by private insurance through their workplace, and the right to healthcare being a less central tenet of the social contract. Publicly financed Medicare for the elderly, Medicaid for those with limited income and resources, and Tricare for military service members all exist, but private health insurance coverage is still predominant, with 67 percent of the population utilising this form.[8]

Of course, welfare states span several policy areas ranging from education, unemployment, and social security to healthcare, parental leave, and mortgage interest deductions. And policies, especially social security, unemployment, and mortgage interest deductions, show how all groups in society and not just those with low incomes, benefit from them. Thus, welfare policies and the welfare states that implement them reflect the social values and economic priorities of a country and the social contract that its government has with its people in light of such values and priorities.

The Social Contract and COVID-19

The COVID-19 pandemic has put each and every country's social contract on healthcare and public health to the test. A public health emergency in the form of a global pandemic immediately brought up questions of what public health measures should be in place and for how long, but also more fundamental questions of what the default state of health will be going forward and how much to prioritise prevention versus treatment.

6. T. Patrick Hill, 'Health Care: A Social Contract in Transition', *Social Science & Medicine*, XIVth International Conference on the Social Sciences and Medicine, 43, no. 5 (1 September 1996): 783–789, https://doi.org/10.1016/0277-9536(96)00123-2.
7. Nanny State Index, 'The Best and Worst Countries to Eat, Drink, Smoke & Vape in the EU', 2022, http://nannystateindex.org/.
8. US Census Bureau, 'Health Insurance Coverage in the United States: 2020', Census.gov, accessed 26 May 2022, https://www.census.gov/library/publications/2021/demo/p60-274.html.

The very definition of what it means to be healthy has been questioned and changed since the first cases of COVID-19 appeared. When the pandemic started, a number of countries decided to prioritise a zero-COVID policy. All COVID-19 measures put in place by these governments, ranging from travel bans and quarantines to mask mandates and social distancing measures, aimed to bring the public back to a world where the coronavirus did not exist. Being healthy meant not getting COVID-19 and not having the virus in the community at all, ideally. Zero-COVID countries predominantly located in the Asia-Pacific were touted for their success in preventing COVID-19 cases and deaths before vaccinations were available and were thought of as representations of what the future would look like post–COVID-19.[9] However, as the virus became increasingly endemic around the world and vaccinations became more available, a new norm has been established—one of being healthy but 'living with COVID'. Countries still vary on where they stand on this idea of what being a healthy society means, and their social contracts have adjusted accordingly.[10]

One area has been the overall prioritisation of prevention versus treatment. As a public health issue, COVID-19 has underscored the importance of prevention in the form of better preparedness for the next virus and of public health measures (e.g., masks, social distancing, etc.) to address the current one. And yet, there has been much controversy and public discourse about what measures are truly necessary when also balancing the need for individual freedoms and for how long measures should be mandatory. The use of coercive policies in public health has been controversial. Consensus of where this balance lies has been especially difficult to reach as initial risk assessments began to change with the development and distribution of new vaccines and other treatment mechanisms.

Further, the discourse about the public health measures has been twofold. On the one hand, the focus has been on individual freedoms and whether or not the COVID-19 policies have been too coercive. On the other hand, there is also the issue of individual responsibility, centring on how much the interests of the collective should supersede that of the individual. This ties into the Rawlsian idea of impartiality being key to a social contract. The American moral and political philosopher John Rawls puts forward that establishing a fair and just society requires making decisions as if one were behind a 'Veil of Ignorance', where an individual is unaware of their particular hereditary, socio-economic, political, or other circumstances. In this 'Original Position', any rational individual should choose to distribute civil liberties and social and economic goods as widely as possible, having no bias from knowing the advantages or disadvantages of their own condition.[11] In the context of COVID-19, this would be the equivalent of any given individual making a decision on mask or vaccine mandates, the distribution of

9. Jay Patel and Devi Sridhar, 'We Should Learn from the Asia-Pacific Responses to COVID-19', *The Lancet Regional Health—Western Pacific* 5 (1 December 2020), https://doi.org/10.1016/j.lanwpc.2020.100062.
10. Darren Dodd, 'Living with Covid vs Zero Covid', *Financial Times*, 18 February 2022, https://www.ft.com/content/1c85e715-9a57-45af-8c47-ca652efef050.
11. Internet Encyclopedia of Philosophy, 'Social Contract Theory'.

vaccinations, social distancing measures, and other such policies without knowing their race, socio-economic status, nationality, medical history, and health status. However, even in an ideal world where individuals form opinions about the pandemic response through this approach, they will still hold differing opinions about the relative importance of health and economic outcomes for the government's policy decisions. Thus, both individuals and their societies could arrive at different conclusions about how the social contract should be formed in the pandemic.

Conclusion

In conclusion, the social contract is a fundamental institution in any society, demarcating what roles the government plays for the public, and what individual responsibilities and freedoms the public has to each other and for themselves. This theory has been a central tenet in every society that also adapts and adjustments overtime. While the social contract applies to all policy areas, this chapter focuses on its application to health, healthcare, and specifically COVID-19.

The roles and responsibilities of a government and the public to each other are reflected in healthcare policies answering questions ranging from what kind of welfare state exists, if any, to how much of a balance there is between public versus private expenditures on health and public health. There are a variety of welfare states and ratios of public-to-private expenditures on health, with countries like the United States on the more capitalist and economically liberal side of the spectrum, the United Kingdom on the other end with its system of more socialised medicine, and most other countries somewhere in between. At the core of the health policy debate in every country context is a divided perception of what the healthcare and public health systems represent—one centred on the idea that healthcare is about individuals' right to health and the other on how it is a government obligation to provide this as a public service. This divide and overall debate ultimately shape the social contract on this issue.

COVID-19 has been the most recent crisis to spark a reassessment of social contracts between governments, health systems, and the public worldwide. SARS-CoV-2 has brought forth an public health crisis that is unprecedented in living memory. Not since the 1918 flu has the world experienced such a dramatic loss of life due to a pandemic. As of July 2022, there were over 570 million COVID-19 cases and over 6.4 million deaths worldwide.[12] Thus, it certainly is not surprising that governments responded very differently to the threat posed by the novel coronavirus.

Without a clear playbook for how to deal with the virus, and with decisions needing to be made very quickly early in the pandemic, governments pursued varying approaches that were not always predictable based on pre-existing measures of health

12. Center for Systems Science and Engineering, 'COVID-19 Dashboard', Johns Hopkins University, accessed 13 September 2022, https://coronavirus.jhu.edu/map.html.

and overall state capacity.[13] However, as highlighted in some of the chapters of this book, a country's social contract generally, and in the sphere of health in particular, played an important role in influencing national level pandemic responses.

At the same time, the social contract in many countries has also been influenced by the disruptions emanating from the pandemic. After decades of experience and research indicating that coercive public health measures are largely counterproductive in efforts to mitigate disease, COVID-19 brought about a new norm. There has been a global shift towards greater acceptance of strict lockdowns, police-enforced social distancing and quarantines, tracking of movement for contract tracing purposes, and other coercive public health policies. The question then becomes, will these policies be effective enough to change perceptions and norms for the long term? Or are these policies merely a direct response to a particular public health and political problem that will peter out with time and with increasing pandemic fatigue, vaccine uptake, and biotechnological advances? Further, what will be the resulting, if any, amendments to the nature of healthcare? Will this have enduring effects on how people relate to their government in many countries as a consequence of the pandemic? It is too soon to know, but clearly a topic worth serious consideration in the future.

13. Matthew M. Kavanagh and Renu Singh, 'Democracy, Capacity, and Coercion in Pandemic Response: COVID-19 in Comparative Political Perspective', *Journal of Health Politics, Policy and Law* 45, no. 6 (December 2020): 997–1012.