Competition During Covid-19

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Ranking failed during Covid-19. Autumn 2019 saw the release of the first World Health Preparedness Report, accompanied predictably with a Global Health Security Index (Global Health Security Index 2019). Compiled by the Johns Hopkins University's Bloomberg School of Public Policy, the Nuclear Threat Initiative, and the Economist Intelligence Unit, the Global Health Security Index offers a classic example of a ranking produced by "rationalised third-parties" (Werron 2015), which collect information and collate it into a plausible index. Like most indices, it created numerical values for multiple parameters and combined them to rank nation-states on their preparedness to address an epidemic. The report ran over 300 pages and contained more than 50 pages detailing its methodology.

The Global Health Security Index has now become infamous for having no predictive power whatsoever. The index had ranked the United States and the United Kingdom as the first and second most prepared countries for a pandemic. When one economist compared the index with fatalities per capita in January 2021 (Milanovic 2021), he found that there was no correlation between a country's rank on the index and its performance during Covid-19. As of January 2021, the United States' fatality rate was 145th out of 153 countries, while the UK was in 149th place. One of the most striking aspects of this crisis is how ranking discourse so poorly anticipated nations' performance during the crisis. The Index had done what rankings are supposed to do: "To aggregate a variety of dimensions into one ranking position, rankings translate qualities into quantities" (Brankovic et al. 2018: 274f.). And yet those quantifications bore no resemblance to the reality that unfolded mere months later.

While commentators have lambasted the Index for its poor choice of measurements, the report's subtitle highlights the paradoxical nature of such indices: "Building Collective Action and Accountability." An index that created national competition through ranking was supposed to generate collabora-

tion. And yet, during this crisis, national comparison and competition have dominated, much to the detriment of most of the world's population.

This volume asks when competition becomes "a globally relevant political category" (Russ/Stafford this volume). The Covid-19 pandemic offers a telling and tragic example of how competition can exacerbate systemic risks and ultimately undermine recovery. Competition has remained all too relevant, whether through statistics around cases and deaths or, more recently, vaccines. Even more strikingly, Covid-19 follows an older pattern where the nation-state is used as the default unit of "competitive comparisons" (Steinmetz 2019). The chapters in this volume highlight other crucial questions—what is the political power behind units of comparison? What do comparisons of deaths or cases of Covid omit? What is the development against which countries are measured and how does that translate into political or economic power? Finally, what historical developments have fostered a world where national competition comes before collective action, even for obviously global problems like pandemics? Even supposedly non-violent competition may have violent consequences.

The Covid crisis has been full of competition. Many countries report their health statistics on a more granular, sub-national level: provinces in Canada, individual states or even counties in the US and Germany. Yet, national statistics have dominated in the global discourse. Perhaps to many readers of the *Financial Times*, it seemed natural to play around with graphs and compare Sweden to Switzerland to Senegal. This edited volume, though, highlights the complex competition that lies behind such purportedly "natural" units of comparison. Ramy Youssef reminds us that status competition is "a historically contingent social form." It is not a natural phenomenon that millions of people should pore obsessively over data dashboards and graphs showing the success of one country over another. The power of the frame of competition requires explanation. Indeed, the richest analysis of such phenomena arises from interdisciplinary engagement. So too, we can best understand how Covid-19 statistics have spurred national competition and, at times, obscured much more important effects by turning to history, epidemiology, sociology, and international relations.

There is a long history of why statistical representations of disease became the main mode of measuring disease and of making disease comparable across borders. Many scholars (Porter 1995; Speich Chassé 2013; Speich Chassé 2016; Jerven 2018) have examined the growing importance of numbers and statistics in modern economics and international institutions, while

Wernimont (2019) has explored the feminist media history of quantification, including mortality statistics. While health statistics had been gathered for centuries, the movement to standardize epidemiology accelerated in the interwar period under aegis of the League of Nations Health Office (LNHO). The epidemiologists and medical officials at the LNHO believed in collating, collecting, and communicating standardized statistics as the most effective method to prevent another pandemic like the Spanish flu. They thought that swiftly-delivered statistics of infectious diseases could enable public health officials to act more quickly to enact quarantines or other measures to prevent an epidemic. Although the LNHO also created medical exchanges and national health systems, its main focus lay on generating comparable statistical information. The LNHO formed the first international epidemiological intelligence system by pushing nations, empires, and territories to submit their data in standardized numerical formats that enabled comparison. By the late 1920s, the League's system encompassed two-thirds of the world's population.

The LNHO disseminated weekly bulletins of smallpox, cholera, and plague cases around the world. Such diseases were not necessarily the deadliest during that period. But they were the highest priority for empires that wished to smooth imperial trade and avoid the spread of disease from colonies back to Europe. The most powerful members within the League of Nations shaped how diseases should be understood—as individual cases counted by statistics—and they also decided which diseases would matter. The statistical mode took the focus away from examining how political, economic, and social conditions could exacerbate disease. This focus continued into the World Health Organization (Tworek 2019).

While much has changed in global public health since the 1920s, the focus on statistics has become even more pronounced. During Covid, it has been accompanied by an increasing reliance on comparative and competitive models. A ranking mania has pervaded much of the discourse around Covid. The US magazine *Foreign Policy* had created an index of Covid-19 performance by autumn 2020. In the Canadian province of British Columbia, public health officials created their original models around Covid-19 in March and April 2020 based upon comparison with a worst-case scenario (Italy) and best-case scenario (South Korea). It was seen as a moment of triumph when models no longer had to compare to any scenarios elsewhere, because the case count in British Columbia was so low. Declaring the end of competitive comparisons in modelling implied that British Columbia had outperformed any compar-

isons, possibly creating a complacency that contributed to an autumn surge of cases (though this was a very small surge compared to the rest of Europe and North America).

The case of British Columbia leads into broader questions about the competitive nature of comparisons. Such implicit and explicit comparison often made little sense on an empirical level. First, countries have classified cases in different ways. China does not count asymptomatic cases in its case count, even though these account for up to forty percent of all cases. Second, the United Kingdom only counts as Covid deaths those that occur within 28 days of a Covid-19 diagnosis. Such a decision would make little sense for many other diseases, such as cancer. It makes even less sense as some studies start to show that some Covid patients are re-admitted into hospital and may pass away after being readmitted. Third, some countries have later revised their statistics, which many speculated were manipulated from the start for political reasons. Russia was the most obvious example, adding hundreds of thousands of cases in late 2020. This indeed seemed a classic case of the suppressive impulse of statistical comparison: Russian officials wanted to highlight the swift development of their vaccine, Sputnik V, and to downplay the terrible conditions in Russian hospitals, rather than appear high in 'league tables' of Covid cases.

In other cases, a denial of international comparison offered a route to hold off the spotlight on poor policies. The rejection of comparisons also became a way of rejecting criticism. Many European governments dismissed New Zealand as an example of the successful suppression of Covid because it is an island nation. But Great Britain is an island too. Governance matters more than geography. In May 2020, as the UK's Covid deaths per capita seemed to be rising above other European countries, the UK government claimed that the country's statistics were not comparable with any other nation. To justify this assertion, politicians pointed to a *Guardian* article by statistician David Spiegelhalter. Yet Spiegelhalter had actually traced the complexities behind comparing international death statistics for technical reasons, including some that I have mentioned above. Spiegelhalter had to plead for the UK government to stop misinterpreting his article and weaponizing his explanations to cover for political errors (Taylor 2020).

Another obvious question of competitive comparison was to whom a nation compared itself. New Zealand has garnered enormous English-language media attention, as has Australia. So too has Taiwan, though sometimes less for its actual policies and preparedness than as a geopolitical anti-China

stance. Alex Azar, Health and Human Services Secretary under former President Donald Trump, sought to increase cooperation with Taiwan over health but appeared not to promote any of the Taiwanese policies that had led to such impressive results, whether masks or significant public health institutional capacity. One group has used comparison with Taiwan, New Zealand, and Australia to advocate for a Zero Covid strategy in Canada (Global Canada 2020). Meanwhile, other effective responses have garnered significantly less media and scholarly attention, including Senegal and Uruguay. Suppression strategies that did not involve significantly increasing funding for public health or introducing paid sick leave have garnered far more attention than community-led or equity-driven strategies. Few in Europe or North America looked to Vietnam or Cuba for lessons, perhaps because these were not countries that they expected to manage the crisis effectively. Even non-comparison is politicized in the age of competitive ranking.

A further problem emerged from a focus on national-level statistics that obscured the differential and increasingly inequitable impact of Covid-19. In the United States, for example, policies exacerbated inequalities by failing to improve workplace safety for those who could not work from home such as people in meatpacking plants or Amazon warehouses (Okonkwo et al. 2020). Countries like Germany and provinces like Ontario did not make any effort to collect race-based data. In Toronto, civil society groups filled the gap. Racialized people comprised 79 percent of all Covid-19 cases up to November 30, 2020, although they only make up 52 percent of the city's population. The differences were even starker for some groups. South Asian or Indo-Caribbean residents of Toronto made up 27 percent of all Covid-19 cases, though they comprise just 13 percent of the population. Such data have emerged mainly because doctors and civil society have pushed for collecting more granular data. Only once such patterns emerge can public health act to prevent infection where it is actually spreading. Broad statistics and national comparisons could lead astray from the real problems at hand, which require "equity-driven policy" (Dosani 2021).

Statistical competition between nations has focused many Euro-American politicians on absolute numbers and pushed them towards more blanket measures, such as school closures or lockdowns. As one set of mathematicians and epidemiologists put it: "Focusing on high-level, broad policy decisions as singular causal determinants belies a complexity and heterogeneity of transmission dynamics to be considered if we are to move from 'flattening the curve' to turning it downward" (Baral et al. 2020). Without attention to smaller units of

analysis, however, politicians cannot address the underlying structural conditions that facilitate the spread of Covid-19, such as homelessness, multi-generational households with no room for anyone to self-isolate, and precarious work conditions. Rather than one pandemic, as implied by national statistics, Covid-19 is actually "many microepidemics" with highly heterogenous effects that require much more specific interventions wherever possible (Mishra et al. 2020).

Such problems were compounded by data disappearance and the non-collection of certain types of data. The United States government under the Trump administration so abdicated its responsibility to collect basic statistics that *The Atlantic* magazine led a group of citizens to track the number of Covid tests and cases in the Covid-19 Tracking Project (2021). As Samanth Subramanian, one of the writers of a major project on data disappearance in the United States, put it (Huffington Post 2020), "precise, transparent data is crucial in the fight against a pandemic—yet through a combination of ineptness and active manipulation, the government has depleted and corrupted the key statistics that public health officials rely on to protect us." But problems with data collection are not unique to the United States. Many other countries, from Brazil to Tanzania, have seen politicians find ways to deny the state of the pandemic in their nation because they themselves had failed to create the testing infrastructure to understand the pandemic on the ground. Tanzania has not provided statistics on Covid-19 cases since April 2020. The politics behind such data collection long hid those really bearing the burden of the pandemic.

More broadly, these fights over statistics amongst epidemiologists, biostatisticians, journalists, politicians, and much of the public have obscured the qualitative aspects of this crisis. It is striking how few stories we know of the over two million individuals who have died. Even the incoming Biden administration's memorial service on January 19, 2021 featured forty illuminated columns in Washington, DC, each column representing 1,000 of the 400,000 Americans who had died at the time; the service did not mention any person by name nor tell their story. The lack of public mourning is a profound contrast to the many memorials to fallen soldiers, as well as the ritual of returning coffins in the United States. Civilian engagement with and understanding of deaths and violence during war has changed profoundly over time (Dudziak 2018). Perhaps the concealment of Covid-19 deaths dovetails with the now dehumanized drone warfare that has killed so many thousands. But the lack of stories remains a phenomenon to be explained. Some news

organizations have filled that gap, including the *Guardian*, which has traced the deaths of over 1,300 healthcare workers in the United States. The Canadian Broadcasting Corporation (CBC) too has sometimes featured stories of those who have passed, often because the family wanted others to know the person's story. In the long run, though, the statistical mode inherited from the League of Nations has rendered other forms of suffering invisible.

Statistics have desensitized, making the pandemic more about a competition over cases than about mourning those who have passed away and finding public health solutions to prevent further cases. As Caroline Chen (Jaffe 2021), a ProPublica reporter put it,

> Sometimes when I'm looking at the charts, I have to remind myself what the numbers mean. It's become so easy after months and months of this to become numb. For example, even though the case count is finally starting to go down in Los Angeles County, and that *is* good news, it's not just a trend line. […] Each person […] was somebody's everything. I have to remember that, so I don't ever treat the numbers like just numbers in my reporting.

The absence of stories of suffering individuals further acts to obscure the disproportionate toll of the pandemic on racialized minorities in many European and American nations. Without stories to mobilize action, the statistics seem often to lead politicians away from the most effective solutions, including paid sick leave, rapid testing, and improved workplace safety for essential workers.

Ignoring stories has also had detrimental consequences for those who have suffered from what is currently colloquially called "Long Covid." Long Covid seems to compromise a wide range of symptoms from persistent fever to fatigue to skin issues to myocarditis. Yet, for many months, the individual stories of people who were suffering seemed to spread mainly on social media. The statistical focus on cases and deaths created a narrative binary of death and recovery. This binary elided the long-term effects of Covid-19. One UK doctor, Nisreen A. Alwan, suffered from fatigue and chest pain for months after Covid-19 symptoms (though she was never tested because there were so few tests in March 2020 when she developed symptoms). Like many others, her case was described as "mild," yet she continued to struggle with the post-viral aftermath. Thousands of people took to social media and formed support groups to document confounding, incapacitating, and long-lasting effects. "We are the unrecorded," lamented Alwan in July 2020. She pushed for more precise and nuanced definitions of Covid that do not simply divide between death, hospitalization, and mild cases before assuming a recovery

within a few weeks. "Death is not the only thing to count in this pandemic, we must count lives changed," she pleaded (Alwan 2020). Nation competition has effaced a commitment to quality of life and to preventing chronic illness.

Perhaps ironically, many of the countries that have most effectively combatted the pandemic are those that spent least time obsessing over statistics. Instead, leaders spent more time creating rapport with their populations and conveying messages around civic responsibility and solidarity. In summer 2020, I worked with an interdisciplinary team to explore how nine jurisdictions (South Korea, Taiwan, Germany, Canada, Senegal, New Zealand, Norway, Sweden, Denmark) and two Canadian provinces (British Columbia and Ontario) had communicated around Covid-19 (Tworek et al. 2020). Amongst other findings, we point to the importance of values, emotions, and stories alongside scientific facts. We also show the culturally-situated ways of conveying values and emotions that have frequently resulted in much greater compliance with public health guidelines.

Examples were highly contextual and indeed, we pushed back against the idea that our report might pit countries against one another. Instead, we derived principles of effective communications that were implemented quite differently in different jurisdictions. In Taiwan, physical distancing was portrayed as an act of civic love. "The deeper the love," went one key government slogan, "the greater the distance you keep." The Health and Welfare Minister, Chen Shih-chung, has called for journalists and citizens alike to have empathy for other Taiwanese residents. "Have a heart!" Chen often urged the public. In British Columbia, meanwhile, chief medical officer Dr. Bonnie Henry conveyed statistics but has never given specific numbers as a guide for certain actions. Her mottos focused not on specific statistical values (like getting below 50 cases per 100,000 residents, as in Germany), but rather on asking people to work together, use layers of protection, be humble, and not shame those who did not seem to be following the rules. Henry frequently calls for empathy, noting that "we don't know everyone's story… we are all working hard to stay safe" (citations in Tworek et al. 2020).

Finally, vaccine delivery has become a new form of nation ranking and a serious source of competition. Media outlets like Bloomberg have created maps showing how many tens of millions have been vaccinated. Israel became the envy of much of the world for vaccinating its population so quickly, though most reports omitted that Palestinians have yet to benefit. Such fierce competition has consequences: in early January 2021, around 25 vaccines had been administered in low-income countries, while over 25 million people had

received at least the first vaccine jab in high-income nations. Tobias Werron and Johannes Nagel's historical examination of "scarcity nationalism" could not be more apt for thinking about debates over vaccine deliveries in Europe and North America. Though writing about US ideologies of economic and naval power in the nineteenth century, so too in the twenty-first century has scarcity discourse become "a discursive mechanism, which links notions of scarcity to the imagining of competition." Rather than global collaboration under the World Health Organization's Covax scheme to deliver vaccines to the most vulnerable around the world, high-income countries compete to vaccinate their entire populations. Nation rankings and competition can cost lives.

Looking at Covid through the dynamics of competition illustrated in this volume can conceptualize our current crisis in new, interdisciplinary ways. While denaturalizing competition shows the strange cruelty of national comparison, other chapters also offer important reflections on who might use competition to frame economic recovery. Dieter Plehwe's chapter examines how "Economic Freedom Indices" created by the Canadian Fraser Institute and American Heritage Foundation became a "neoliberal policy tool." Such efforts and mindsets may shape the recovery to come. Plehwe's work alerts scholars and policymakers to be more critical of the "agenda-setting capacity of neoliberal think tanks."

Competition, particularly in rankings, seems here to stay. But scholars can offer vital interdisciplinary reflections on how and why competition emerged as well as how it affects diverse populations around the world. This volume poses vital questions: who is competing and for what? What discursive power does competition exert and how does that discursive power translate into policy? We might also end by asking: who is left out of competition, and whom does competition harm? These questions are all too real in times of Covid.

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