We need hands-on public health expertise to tackle COVID-19

22 March 2020

The government has released its scientific evidence, which sheds light on the fiasco and the catastrophe that is unfolding economically, socially, and health wise. It also highlights the lack of public health input and the decimation of the speciality and expertise in communicable disease control prior to and after the Health & Social Care Act 2012. There appears to be no public health evidence from experienced physicians in communicable disease control and their teams.

Last week the New England Complex Systems Institute presented a critique of the Ferguson paper (Imperial College) which the government used to justify its volte face – on the basis of its truly apocalyptic figures. The NECSI academics' critique highlighted the deep flaws in the modelling in the Imperial paper, and crucially how the model failed to take account of the impact of contact tracing and testing, isolation, and quarantine. These are classic public health measures. The government's evidence includes an

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important paper by Keeling et al on the impact of contact tracing on disease containment. This shows how, if basic public health measures are implemented, the transmission of the disease can be markedly reduced and the disease contained, without the draconian measures we are currently being subject to.

It is not too late to do this and it must happen especially in areas within Scotland and the North East where the number of cases are still low.

Blanket school closures across the whole country do not make sense. They should be proportionate to the situation in each local area with appropriate risk assessment and to the effectiveness of contact tracing, cordon sanitaire, etc, on containment. For example, Gateshead, Sunderland, and Northumberland have very few cases, so vigorous contact tracing of cases could be done. During the H1N1 flu epidemic only some schools were closed and then for short periods depending on the local information and risk assessment.

This useful map shows the distribution of cases and deaths in different parts of the UK for COVID-19 and also the opportunity for rapid and intensive contact tracing and local intervention and risk assessment depending on the number of cases.

Children appear to not be at high risk of COVID-19 infection and there is no strong evidence to suggest they are vectors; indeed, the Chinese evidence suggests the contrary. Those interviewed could recall no cases of child to adult transmission.

It seems our government and its task force has failed to read and above all to learn from and apply the meticulous lessons of the China WHO report.

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"Much of the global community is not yet ready, in mindset and materially, to implement the measures that have been employed to contain COVID-19 in China. These are the only measures that are currently proven to interrupt or minimize transmission chains in humans. **Fundamental to these measures is extremely proactive surveillance to immediately detect cases, very rapid diagnosis and immediate case isolation, rigorous tracking and quarantine of close contacts**, and an exceptionally high degree of population understanding and acceptance of these measures." [*My emphasis*]

"China has a policy of meticulous case and contact identification for COVID-19. For example, **in Wuhan more than 1800 teams of epidemiologists, with a minimum of 5 people/team, are tracing tens of thousands of contacts a day. Contact follow up is painstaking, with a high percentage of identified close contacts completing medical observation**. Between 1% and 5% of contacts were subsequently laboratory confirmed cases of COVID-19, depending on location." [*My emphasis*]

In Singapore the army was brought in to help with contact tracing.

One of the major differences in this outbreak is that the outbreak is being centrally *managed* rather than being centrally *coordinated*, with insufficient foot soldiers on the ground. In England local authorities and directors of public health cannot tailor responses to the local situation and are subject to central policy decisions. My colleagues in public health in local authorities say they have received very little information. This, combined with the devastating cuts to community-based communicable disease control and the changes wrought by the Health & Social Care Act 2012, which carved out public health from health services in

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England and then further fragmented communicable disease control by removing it to Public Health England, have created a perfect storm. National and local expertise has been lost and many of my colleagues in communicable disease control were made redundant. The government has not applied the lessons from the H1N1 epidemic, specifically ensuring the advice of operational public health experts was incorporated alongside that of modellers (para 4.43).

- Is the indefinite closure of all schools, colleges, and universities a proportionate measure?
- Was the decision to close schools taken area by area having considered the risks in each area and only after all other exhaustion of all other public health measures including contact tracing, testing, travel restrictions, and cordon sanitaire?
- How extensive is contact tracing? Chris Whitty appeared to imply on 19 March that the government was not doing much contact tracing currently. (I know that testing has been restricted to those presenting in hospitals, with patients in community settings being told to stay at home!)
- Why is the government not seeking to contain the disease by properly applying the basic public health measures in every local authority area – instituting a massive centrally-coordinated, locally-based contact tracing and testing programme with large teams of foot soldiers?

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