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COVID-19 Recovery:  
Building Future Pandemic  
Preparedness and  
Understanding Citizen  
Engagement in the G7

# Adapting to the ‘New Normal’: Implications for Post-COVID-19 Health Communication and Education

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### **About COVID-19 Recovery: Building Future Pandemic Preparedness and Understanding Citizen Engagement in the G7**

The programme aims to facilitate global and interconnected learning about the contexts, causes and factors leading to vaccine engagement. Through the programme, the Academy has awarded funding to seven research projects exploring vaccine engagement in Canada, France, Germany, Italy, Japan and the UK. The programme, which was funded by the UK's Department for Business, Energy and Industrial Strategy, builds on a series of statements developed in partnership with humanities and social sciences bodies across G7 countries. The Academy has supported another series of projects focused on the USA and UK.

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# Executive summary

## **COVID-19 public health and safety measures – putting population preference in policy**

In October 2021, the British Academy granted seven awards for projects focusing on 'vaccine engagement' across G7 group of nations. It is important to note that at the point of this award, the world had been well into about 18-months of the pandemic and mass vaccination campaigns were already underway across G7 nations. It is of even greater importance to note that during the last six months of designing this study and completing data collection (October 2021 – March 2022) the ebbs and flows of new variants, coupled with fluctuating activity levels of different public measures and a plunge into debates about vaccination campaigns versus natural immunity as the Omicron variant quickly spread across the globe cast a small glint of hope for the end of the pandemic, or at the very least consideration of us entering a COVID-19 endemic state. Even as some countries begin to phase into an endemic status, it is unlikely that they can do so consistently, even within their own jurisdictions. This is especially true for federal nations, which can adopt different stances to public health measures internally. And in centralised administrations, 'soft' measures like the need to have temperature checks before entering private premises can be applied without the need for legislative backing.

In this project, when we think about 'vaccine engagement' we do not think of trying to establish causality of the public's hesitancy to be vaccinated, but we think of where and how vaccination is situated alongside other COVID-19 safety measures that have been activated worldwide to help control the spread of this disease. Secondly, we operated on a hypothesis that given the current lack of information on general issues like vaccine integrity or the virulence of the disease to create future (perhaps more dangerous) variants, that countries around the world might consider the 'lessons learned' from the pandemic in terms of creating an action plan for how societies might act if given another shock in the future. This raises a question of:

- would our 'new normal' feature policies which promote public health to prevent the spread of diseases like COVID-19 and which can have beneficial side effects like reducing the spread of seasonal influenza?
- if we were to consider the long-term inclusion of public health and safety measures (PHSM) then what information can policy makers rely on to understand the burden this shift in our habits might cost the population?
- how do we know the populations' willingness to adapt to or take on board these safety protocols to try and prevent another global pandemic in the future?

We considered whether if we were able to answer these questions and provide policy makers with a means to understand and interpret their populations' cost-benefit profile when thinking of incorporating PHSMs (albeit seasonal or permanent) in

the future – would this be enough of a contribution given all we have learnt about COVID-19 across the G7? The team conducted a micro-study with teachers and pupils in primary and secondary schools to understand how the lessons learnt from COVID-19 could be factored into primary and secondary school curricula, so that habit formation and health education can be targeted and tailored for our younger populations, which is also a means for preparing the future generation to be more resilient against global shocks like future pandemics. Being able to connect the cost-benefit profile of the adult population and use these as projected pathways for younger generations can help the Ministry of Education develop curricula which helps shape the habit-forming mindset of the next generation.

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**How does this study help policymakers think about country-specific policy?**

- Provides a framework for how COVID-19 policies can include the public's voice in its design and implementation
- Gives evidence for why the public's voice should be considered when designing long-term plans for PHSMs to help prepare for future shocks
- Provides recommendations for Education Ministers to design COVID-19 specific curricula that can help educate the younger generation on how to translate the lessons learnt from the pandemic into more lifelong transformative messages

# Across the G7 countries: Why compare the UK and Japan?

The pandemic has certainly taught us there is no one-size fits all policy, even if all countries want the same outcome. In the case of the pandemic, this was to stop or slow the spread of disease and death without burdening health resources. It is interesting to compare the health and political responses from the UK and Japan to activate PHSMs, given they are both high-income island countries. The UK has been criticised for being slow in its initial response to the pandemic, but then enacted very strict policies (e.g., quick to national lockdown), whereas Japan has been less severe when enacting sanctions on PHSMs. For instance, declaring a national emergency or closing domestic borders between prefectures but no national lockdowns despite having close to double the size of the UK's population. It is interesting to note that while there have been media reports, commentaries, and anecdotes across G7 countries about the measures in place to control both the spread of the infection and limit the death rates, there have been limited quantitative and qualitative data to actively explain the public's understanding of how these sanctions or public measures were decided. This comparative study steps outside of the country-specific bubble to try and ascertain how cost-benefit profiles might differ across populations, for instance we understand the challenges, physically, financially, and emotionally, that members of the public have had to endure over the course of the pandemic but are there any country specific trends that tell us a different narrative?

## **How does this study help policymakers think about comparative policies across the G7?**

- Provides the public's willingness to comply with PHSMs across the G7, in preparation for the next possible emerging disease (e.g., consistent guidance across the G7 for wearing mask on all public transport across the G7) which strengthens disease containment across borders
- Deepens understanding of culturally specific traits of populations as displaying homogenous behaviours which can help with the curation of messages in terms of knowing when and how to approach the public about changes to policies
- Provides recommendations for Education Ministers to design COVID-19 specific curricula that can help educate the younger generation on how to relate to the lessons learnt from the pandemic into more lifelong transformative messages

# What have we done?

This study focuses on the idea that vaccine engagement will be the central theme as countries attempt to move toward endemic status with respect to COVID-19. We expect the findings and recommendations from our extended report will supplement formal impact assessments frameworks that account for economic and social wellbeing effects of COVID-19 policy changes. The key assumptions driving this study are:

1. The less virulent Omicron variant gives hope for endemic equilibrium, but we will exist in a period of transition while we seek more understanding of waning immunity profiles and the potential for more virulent strains to emerge. This period marks the beginning of the 'new normal'.
2. Although many G7 governments are now limiting their severity, contagion controls in the form of PHSMs will continue to be relevant and relied upon during this period, given the risks above.
3. It is likely that PHSMs will evolve and be adapted in the future, particularly those which become more cost-effective and less intrusive as investment is made in R&D, including new drugs for treatment and contact tracing apps.
4. The concept of vaccine hesitancy will become more complex, as we begin to understand the correlations of patterns of infection between COVID-19 and influenza.
5. Governments will still rely on health experts and scientific advisors to shape policymaking options, but public sentiment will play a much larger role in the effectiveness of centralised policymaking than it did at the beginning of the pandemic.

Against these background assumptions, this study reconceptualises the relationship between vaccination policies and other PHSMs as the main driver of public vaccine engagement. We propose that this relationship is predicated on individual, utilitarian, and political positioning of the costs, benefits, and risks associated with policy responses to COVID-19.

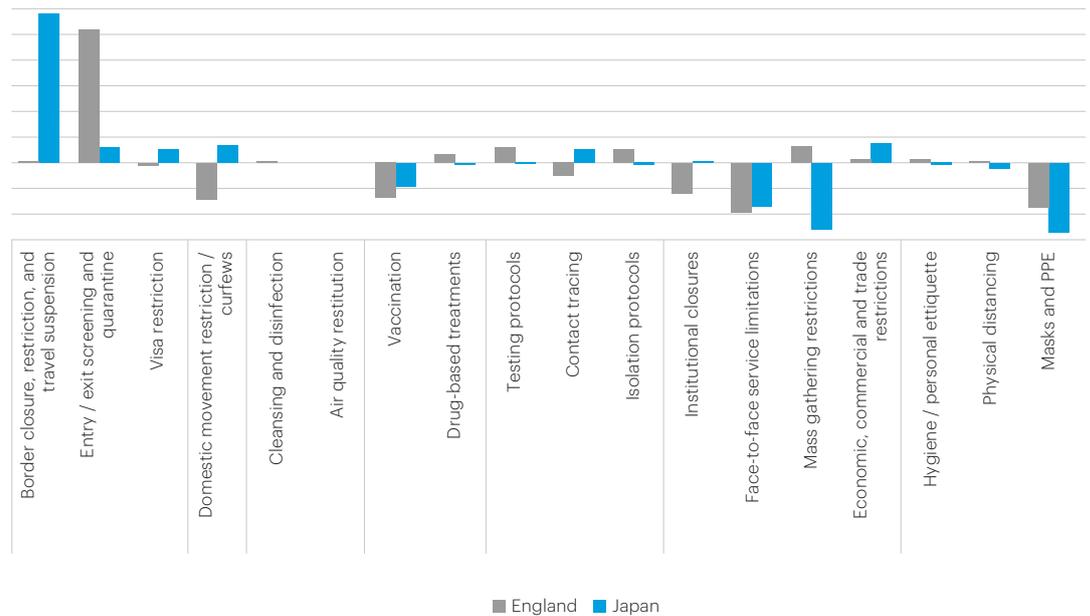
# How did we collect the data?

We focus comparatively on England and Japan as these G7 countries had large pockets of unvaccinated or partially vaccinated communities prior to the Omicron wave. While it is recognised that logistics and vaccine availability may have had a role to play, understanding the profile of vaccine engagement in such communities, whether positive or negative, may have significant bearings on wider G7 policy action.

There were three main stages of data collection and analysis:

1. A review of PSHM activity in England, Japan, and the wider G7

**Figure 1: PSHM Activities across Japan and England (relative to the G7, excluding the US)**



2. A survey comprising questions related to:
  - a. Vaccine hesitancy
  - b. General state of anxiety
  - c. General inclination or propensity to take risks
  - d. Ranked preferences of a shortlist of PHSMs
  - e. A discrete choice experiment (DCE) which attempts to identify respondents' trade offs between PHSMs

**Figure 2: Sample of discrete choice experiment used in survey data collection**

Question	Situation A	Situation B
<b>Current levels of COVID-19 cases and deaths</b>		
Deaths per month compared to normal	25% more	Normal death rate
New cases per million people every week	300	3,800
Hospital admissions 2-week trend	Falling	Falling
<b>Proposed measures (given levels above)</b>		
Domestic movement restrictions	Overnight curfews (stay indoors 9pm to 6am)	Daytime commuting limited to local town or prefecture
Working/teaching hours for business and schools	Regular (maintains economy)	Minimal (relieves health services)
Face covering rules in public spaces	Recommended only not enforced	Mandatory fines for non-compliance

3. Focus groups which supplemented the survey to provide deeper insights into individuals' assessment of costs, benefits, and risks within COVID-19 vaccination policies, alongside other PHSMs.

# Guidance for creating COVID-19 policy in the 'new normal'

Key to effective policymaking in this transitory 'new normal' is a robust planning framework. Some basic elements of such a framework are outlined below.

## 1. Pay close attention to the science

The momentum of the medical and scientific community in unlocking the mechanisms of infection and immunity to COVID-19 has been unprecedented so far. While they have charted the frontier for hope, it is also important to temper this with the accepted limitations to progress. In a recent report issued by the World Health Organization (WHO) on 28 January 2022, Chair of WHO COVID Vaccines Research Expert Group, Phil Krause, expressed that while there is a possibility for an endemic COVID-19, we cannot discount the risks which are posed along this journey. The chief concerns are that future variants (beyond Omicron) may be more transmissible, virulent, and evasive of current immunity.<sup>1</sup>

## 2. Monitor the repertoire of contagion controls

In the first instance, public health measures that attempt to limit transmissibility of COVID-19 have been crucial factors in inhibiting the spread of COVID-19. While the particular selection of measures used varies by country, understanding their relative effectiveness and potential for uptake has been necessary for epidemiological modelling of infection rates, and will still be important in the 'new normal'. Monitoring this repertoire of measures relies on acknowledging when measures have outlived their usefulness, anticipating when to trigger and release extant measures, and operationalising a robust impact assessment framework. Such impact assessments should reflect high-stakes, non-economic domains including crime, education, wellbeing, and civic engagement.

## 3. Improve public confidence in vaccines

It is widely accepted that vaccine confidence is vital to immunisation programmes in general. For COVID-19, vaccines stand apart, as they do not offer contagion control in the typical sense (they do not significantly reduce one's chance of becoming infected), but they are efficacious against the severity of the disease. This is important for two reasons. Firstly, the general upper limits of disease severity will affect public perceptions of progress towards endemic status, which in turn may affect their willingness to adapt to lessening or strengthening of contagion controls on an ongoing basis. And secondly, the effective severity will affect actual rates of hospitalisation, which will be one of the key indicators of the progression of the pandemic.

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<sup>1</sup> World Health Organization (2022). Why do we need a pan-sarbecovirus vaccine? World Health Organization, R&D Blueprint

#### **4. Have a clear threshold for endemic status**

The requirements for endemic status are not strictly defined, but it broadly captures the idea that the disease has become relatively predictable in its emergence and epidemiology, and that societies are prepared to accept the levels of mortality and other accompanying losses. When this happens and how this translates into mortality and morbidity metrics will vary from country to country. For many Western countries, the benchmark metrics which are regularly cited are those relevant for influenza, which has its own relatively stable pattern of occurrence annually. This is largely because there is some correspondence in respiratory symptoms between COVID-19 and the flu, and also perhaps it is more palatable to express the correlated risk of dying from either disease. Nevertheless, other headline metrics are still salient in public minds, including hospitalisation rates, new daily or weekly infections, rates of recovery, and even rates of absence from work. In adapting to the 'new normal' it will be necessary to achieve some notional convergence in perceptions of these metrics, so that we can better quantify the impact of adverse situations like waning immunity, or new, clinically significant variants.

#### **5. Contingency plans for 'special populations'**

Despite the hopefulness of moving toward endemic status for the majority of society, policymakers must remain sensitised to the fact that not everyone will benefit equally from learning to live with COVID-19. Extra care and investment must be made for groups with special needs or limitations, including those who are immunocompromised, shielding, elderly, afflicted with comorbidities, socioeconomically deprived, and even vaccine hesitant. This final point will be the hallmark of whether we have truly moved forward, beyond the pandemic.

# Why should the population's voice be included in public policy?

One consistent finding that emerged in the process of conducting this research, with approximately 3,000 participants (inclusive of both countries), was how little the public generally knew about how decisions were made by government. For instance, for some of the data collection members of the public were asked to step into the shoes of policy makers to complete the activities and arrive at group-based solutions. A large majority, if not all, of the participants (in both countries) provided feedback that they felt empathy for their Government Ministers, politicians, and policy makers after completing the exercise. This sets the precedence for considering whether the public should be more involved in terms of understanding how decisions are made in their best interest, and will this form of understanding help build public trust and reduce general anxieties about potential health related shocks in the future?

The following summaries some key policy recommendations for consideration based on the methods employed in our data collection process:

## **From policy borrowing to co-production**

- Countries across the G7 should take joint accountability for monitoring the crisis and converging to endemic status.
- Co-create an action plan for cumulative lessons learned (perhaps employing a multiple criteria decision analysis (MCDA) method) to support other nations.
- Understand how G7 approach to creation of policy measures might differ from other nations especially those of neighbouring countries.
- Monitor local application of 'soft' policy measures in the event it creates social inequalities.

## **Terminology and treatments**

- The pandemic has linguistically associated new meanings to terminology and this raises a need to capture risks when communicating with the public. Seeking to build a common bank of translatable phrases will help for clearer communication across the G7.
- More training for mental health and wellbeing within local organisations and those in community service or working with vulnerable individuals and streamlining the language of illness associated with COVID-19.

### **Creating new metrics for disease control**

- Using information like excess mortality, hospitalisation trends and infection rates to create a clear set of metrics to help define an acceptable equilibrium of COVID-19 that is compatible with 'endemic status' and applicable to other nations.
- Pay close attention to situations where the public accepts certain levels of PHSM sanctions, especially where there might sensitivities to sudden shifts or changes in demographics.
- Consider the relative acceptability of mandatory vaccines, compared to other PHSM options. This will give insights into how easy it is for the public to accept triggering of more sanctions in the emergence of a new or more dangerous COVID-19 variant.

### **Reframing messages to the general public**

- Consider posing issues of public contention with certain measures in terms of bounded rationalities, where limitations are given in the amount of available information and the public is requested to share their responses to what they have, not what they think they need to know. This activity will help further frame and anticipate public reactions to changes in policy.
- Encourage the use of occupational health platforms which provide adaptive information about COVID-19 which is culturally sensitive and mitigates cognitive biases the public might have when developing individual cost-benefit-risk analyses.

### **Teaching about COVID-19 in school curricula**

- **Social wellbeing** – it is believed that vaccine status will be a longstanding consideration going into the future years. Therefore, from a sociological viewpoint, it is important to consider how we manage the hidden inequalities or discrimination that can result from one's vaccination status.
- **Personal hygiene** – lifelong lessons on maintaining health in public spaces including the consideration of public measures that were used during the pandemic. Important to educate children on how conventions of mask wearing when unwell, or frequent habits of hand-washing and bodily fluid etiquette can become habitual to prevent the spread of disease (including good practice for influenza).
- **Mental wellbeing** – addressing current anxieties or emerging concerns from COVID-19 and vaccination. Of particular focus is the 'grieving generation' of children across the world who have lost loved ones, friends and even teachers. This common grief needs to be addressed in a module that talks about mental wellbeing and coping with human loss from a shared illness or disease. Concerns behind vaccination should also be approached with care due to worries that some might express (e.g. potential side effects and adverse events following immunization, effectiveness of the vaccine).
- **Health complications** – learning about Covid in relation to more common health concerns (e.g. asthma). This is to address the needs of vulnerable populations and children who live with particular underlying health conditions. It is important to learn about one's vulnerabilities and assessing risk-taking behaviours.

- **Resources** – how to be critical of content read in the media, heard from peers or seen in news especially critical thinking and a general awareness of cognitive and information bias. Using COVID-19 as a stimulus of content will be a good way to help children think through the complexities of seeking a reasonable response even in current times where there are no certain answers to questions they might have.

# Concluding with a few key findings: Living with COVID-19

While we offer several recommendations for policy makers, derived from an intensive six-month dive into 'vaccine engagement' about the consideration of public voices when thinking of PHSMs and as we move into our third year of living through the pandemic, we are aware there is still a long way to go before anything about COVID-19 becomes 'normal' again. While we have a rich resource of analysis, we would like to share how our approach shed light on the collation of the following points:

- **PSHM Policy burden on public engagement:** The patterns we found for England demonstrates that when policy change burden is high for the public, focusing on vaccination policy may be the most effective line of action. However, if incremental policy changes are not onerous, then it may be more pragmatic to position face coverings and testing guidance as the most important measures before invoking vaccination policy changes. Conversely, in Japan, face covering guidance is most likely to be influential within PHSM directives, and vaccination policy may be less influential than guidance around testing and international travel when there is lesser public burden for policy change.
- **Preferences of PSHM given the spread of disease:** Testing stands out as a measure that both countries are prepared to activate as the primary choice of PHSM, regardless of whether the underlying infection/death circumstances have improved or deteriorated. Furthermore, the approach to vaccination appears to be different between the countries. Participants in England appeared to be ready to adjust vaccination policy as being of lesser importance regardless of the situational change. However, Japanese participants escalated the importance of vaccination policy in the case of worsening death rates or improvement in the number of cases. This preference structure is consistent with the rationales presented by the Japanese participants that the primary aim of the vaccine is to reduce transmissibility as well as the severity of the disease. By comparison, the participants in England were more likely to be skeptical of the vaccine efficacy, especially given that they did not decouple the elements of transmissibility from the virulence of COVID-19. This is because several participants had either been infected multiple times despite being vaccinated or had known someone familiar to them experience multiple infections. This led to a more natural disbelief in the overall efficacy of the vaccines, which helped us explain the trends we observed.
- **General anxiety and risk-taking public behaviours in relation to COVID-19 and vaccinations:** For Japan, an increase in risk-taking propensity universally has a positive impact on the relative probability of taking the vaccine, and the opposite is true for an increase in generalised anxiety. This suggests that at a foundational level, the Japanese sample is more innately risk-averse and uneasy about vaccination, independent of the indicators for vaccine hesitancy. The England sample paints a different picture, as individuals who are unemployed as

well as those in secondary front-facing professions (like office workers) decrease their likeliness of taking the vaccine with higher risk-taking propensity.

As society continues to evolve and adapt to a 'new normal' of unresolved COVID-19 infection rates. For instance, at the close of this study we have seen the evolution of 'Omicron stealth' and the UK hitting over a million cases in one week having been one of the first countries, at an early stage, to make bold strides in relaxing all PHSMs. Through this study we have found that the inclusion of public voice for on-going policy implementation, coupled with more robust public education about living with infectious diseases, is an essential step to help prevent the spread of infection.

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