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Towards Sustained and Sustainable Management of COVID-19: An Alternative to the Simplified Return to Pre-Pandemic “Normality”

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Abstract: The article is focusing on current processes, models, and possible consequences of the easing or cancelling of measures to contain the COVID-19 pandemic that we have seen by the end of July 2022. This is observed in the broader context of selected European countries, allowing us to detect differences, similarities, and, especially, the different ways in which these processes have been legitimized by politicians (governments) and experts. The authors agree with a group of biomedical and other experts, scientists, who consider the rapid abolishment of epidemiological measures as a strategy that is considered a too-simplified solution, so are searching for a more sustainable way of managing the pandemic and also “pandemic fatigue”. In the text, the authors advocate a strategy, based on the principles of calibration, combination, and continuity of measures, which is compatible with the sustainable organization of the healthcare system. However, the implementation must be viable and long-term oriented.

Keywords: COVID-19; Omicron variant; risk society; pandemic preparedness; biomedical experts; sustainable management; second-order observation; meta-analysis; social epidemiology; Coronavirus Worldometer



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1. Introduction

1.1. Definition of the Problem and Conceptual Starting Points

The COVID-19 pandemic has seen the intersecting of nature and culture, a natural disaster and inadequate societal preparedness to face it, external dangers, and risks arising from poor human decisions, erratic/unpredictable natural processes, and contradictions in social relations. These antinomies are especially visible in the fifth wave, starting in the winter of 2021/2022 and continuing through spring and summer 2022, when Omicron and its many subvariants established itself as the dominant variant of the SARS-CoV-2 virus. Many scientists have talked about the onset of the endemic period (no longer an epidemic) [1–3], and several politicians believe the time has come to remove all of the epidemiological restrictions. Both are mistaken, although one may argue that in view of the new variants and stronger natural immunity or presence of antibodies in the population, any summer and autumn outbreaks of infection are unlikely to be as fatal as with other variants (such as Delta) of the virus. However, many scientists [4,5] warn that, even if the virus has been deemed endemic, that does not mean it is becoming harmless, since it will still continue to exist and cause serious illness and death [6]. Nevertheless, without the reconsideration and application of social preventive measures, it is possible that we will be unable to contain and control the virus.

In expert circles and (biomedical) science as well, we can find opinions that are divided into ones closer to ‘nature’ and others closer to ‘society/culture’ and social decisions (measures). The former bet on herd immunity (spontaneous infection of population) and on the premise that the virus, especially now, when Omicron is predominant, will exhaust itself in its aggressive search for a host, lose its living space, and, thus, exterminate itself, as

Slovenian immunologist Ihan recently pointed out [7]. The latter emphasize precautionary and preventive measures on the personal and societal level, while warning of the severe consequences the virus can hold for individual and public health. This opinion split was very evident in 2020, when in reaction to the Great Barrington declaration (that stresses herd immunity for most of the population except the elderly), the John Snow memorandum was created, viewing herd immunity as an unethical and risky approach and advocating tough lockdown measures and the wearing of masks. At the time, most people in science supported the Snow memorandum, especially due to the lack of knowledge about the virus and its severity at the time. Today, this differentiation seems to be re-emerging in light of the dominant Omicron variant. As we describe in chapters 3 and 4, the Great Barrington declaration is being revived in Denmark, as well as most recently seemingly in Austria, in its purest (but not explicit) form.

This leads us to the question of how the pandemic could be designed and managed from the viewpoints of sustainability and preparedness for any new (possible) outbreaks and crises [8,9]. Namely, the simple cancelling of epidemiological measures visible in several EU countries accompanied by some kind of amnesia is probably not the right way to protect ourselves from COVID-19 and prevent major outbreaks and the pandemic from continuing. Defining the principle of sustainability is most easily done per negationem. It is opposed to the short-sighted focus and orientation towards short-term benefits and profits [10,11]. Moreover, it is a principle that requires persistence, long-term planning, strategic discourse, and a comprehensive reflection on the consequences and risks of decisions [12–14].

Despite all the shortcomings of the work of experts and science, experiences have accumulated following earlier epidemics (e.g., SARS in 2002). We know that, as much as the general public, governments are sensitive to pandemic fatigue too—which is already turning into organized resistance to all epidemiological measures—especially due to economic interests and pressures. However, we do not propose a return to rigorous and complete lockdown measures, such as the closing of schools and service activities. We advocate less invasive, flexible, and selective pandemic management that is compatible with the principles of sustainable organization of the healthcare system, though they must be implemented systematically and consistently. The principles by which the measures should be designed are calibration (measures are adapted to a certain part of the population), a combination or an integral approach (a set of several different measures), and the continuity or readiness to continue (replicate) certain measures (such as wearing face masks or working from a home office).

1.2. Methodological Starting Points and (Hypo)theses

The article considers current processes, models, and possible consequences of the easing or cancelling of measures to contain the COVID-19 pandemic that we have seen in the first half of 2022. This is observed in the broader context of selected European countries, allowing us to detect differences and similarities and especially the different ways in which these processes have been legitimized by politicians (governments) and experts. We not only observe the short-term impacts of such actions, as reflected in epidemiological indicators such as the number of infections and deaths, but possible long-term consequences as well.

We are proceeding from our sociological/social-epidemiological observation of how biomedical experts on the one side, and politicians on the other side, observe/interpret an epidemiological situation and how they respond to it, by referring to the notion of observation of observation or the second order observation (observing observers) (we are referring here to Luhmann's theory of social systems [15]). To put in more concrete terms, we make use of qualitative meta-analysis in the sense of the in-depth reconsideration of different data sets and documents. We mostly refer to the following datasets: Coronavirus Worldometer, ECDC—European Centre for Disease Prevention and Control, different calculations of excess deaths (WHO, The Economist), Our World in Data, and, for Slovenia,

we also use datasets created by NIJZ—National Institute for Public Health. We also take into account public opinion surveys (Eurobarometer and SJM—Slovenian public opinion, for the case of Slovenia). In addition, we take into consideration several European printed and online media, as well as other documents, such as a German evaluation study, using comparative (cross-national) methodology.

In the methodological sense, we are leaning on our empirical research/publications, especially the chapter National and Regional Innovation Capacity through the Lens of Social Capital: A Qualitative Meta-Analysis of Recent Empirical Studies [16] and the chapter Methodological and Epistemic Framework: From Positivism to Post-positivism [17]. From the point of view of cross-national comparative studies, we can refer to [18,19].

In the tradition of the qualitative approach, this methodology is connected with multiple case studies. Put differently, this kind of research is rather case-based (contextual or holistic) and not variable-based [20]; in our investigation, the basic units (case) are the individual countries (two plus eight cases). The main point is the comparison between cases in order to detect the similarities and differences between them. Our intention was to find out the patterns and tendencies regarding the management of pandemics and abolishment of epidemiological measures in these countries. It should be stressed that such an approach is more in line with the type of exploratory research—and less with the explanatory/conclusive/confirmatory methodological/epistemic model. This means that the former does not provide conclusive evidence but helps us to better understand the research problem, so it is helpful for theorizing empirical material at an early stage [21]. Proceeding from the methodological frame of reference, the article considers the following tentative (hypo)theses:

1. Omicron and its various subtypes cannot be considered to be a priori a non-dangerous variant of the coronavirus, and the rapid and total abolition of epidemiological measures is, thus, inappropriate.
2. The rapid and uncompromising abolition of the epidemiological measures and restrictions is not in line with a sustainable strategy for managing the COVID-19 pandemic and solving social crises generally. In particular, the vulnerable and elderly population continue to be underprotected.
3. Such rapid abolition of the measures signals to the population—already grown tired of the pandemic—that a return to the old normality is possible; this leads to amnesia and an unwillingness to accept restrictions, should the epidemiological picture worsens in the coming autumn and winter months.
4. Among biomedical experts, there are different opinions about the abandonment of measures and the danger of Omicron and about the possibility of the end or continuation of the pandemic. However, it seems that many of them do not advocate the radical abolishment of all measures. On the other side, governments often only consider short-term calculations, where economic and financial interests prevail (more on the socio-economic impacts of the pandemic in [22]).
5. An alternative view of realistic sustainable epidemic management includes the principles of calibration, combination, and continuity. This arises from what we have learned from the measures and restrictions used so far. These principles represent a compromise between an invasive and general lockdown and the more flexible yet strategically oriented management of an epidemiological/health crisis.

2. Unusual Behavior of Omicron and the Responses of Different Countries

In 2022, the dominant variant of the SARS-CoV-2 virus is the Omicron variant (and several subvariants), which is considered to be more contagious and more resistant to both vaccine and natural immunity, but less dangerous with regard to serious illness or death [23–25]. A number of theories have surfaced about the Omicron variant's transformation into an endemic form, whereby we can live alongside and survive it without rigorous lockdown and self-protection measures [2,26].

Hospitals, particularly intensive care units, have become emptier. Together with ‘pandemic fatigue’, which in some cases has developed due to aversion and amnesia, and the relatively high vaccination rates, this led governments and some experts to embark on a generally radical lifting of the epidemiological measures in February 2022, even though in some areas the conditions for this may not have then existed and not all circumstances were taken into account [27].

However, the fifth wave of the pandemic has also brought some surprises and paradoxes. Certain connections that were visible and could be proven in 2020 and 2021 are no longer valid. For example, the correlation between preventive (compulsory or self-protective) measures or vaccination on one hand, and minor pandemic consequences in terms of number of infections, hospitalizations, and deaths, on the other. In the fifth wave, this connection is no longer as strong or must be re-interpreted with respect to immediate and latent factors. In this regard, we selected EU member states (Denmark, Finland, Sweden, Greece, Portugal, Germany, Slovenia, Croatia, and Austria, plus the United Kingdom as a non-EU country) for analysis. As is shown, the premature lifting of all COVID-19 measures, reliance only on vaccination or immunity from previous infection without selective and targeted (calibrated) protection measures (notably face masks) and, above all, inadequate risk protection, particularly for vulnerable parts of the population (elderly, chronic patients, and others) are the factors that can help explain the unexpected relatively high mortality in certain countries.

3. Were the Epidemiological Measures Lifted Too Early?

We first focus on Denmark, where it has been demonstrated that it is not true that Omicron is not responsible for high mortality. Yet, paradoxically, that has not been an obstacle in its complete removal of all measures known in the pandemic management strategy context. Then, to further complicate matters: a higher or lower mortality is not a *facta bruta*, it is also a subject of (re)interpretations and ‘negotiations’ concerning what those numbers mean. Also, attitudes to those numbers seem to change. The British-Croatian epidemiologist I. Rudan mentioned the Italian tragedy in a medicine journal already in June 2020 (which he said could have been prevented with timely measures of quarantine and lockdown that would have reduced mortality by 80%) [28,29]. At the time (the first wave), the country lost 9000 lives. Today, the number is over 168,000.

As we further describe later, we are following the debate on deaths *from* COVID-19 and deaths *with* COVID-19. The ‘ageism’ context is only shown here implicitly, but sufficiently clearly for anyone who knows about social conflicts. Already at the start of the pandemic, experts warned that the discourse on the COVID-19 pandemic “*misrepresents and devalues older adults*” and gives the impression that the pandemic “*is an older person problem*” [30]. Here, we encounter another paradox that is most evident in what are supposedly the most socially oriented countries in the world.

3.1. About the Danish Experiment

Just one day after Denmark announced the lifting of its epidemiological measures with the beginning of February [31], the country recorded over 50,000 new cases of coronavirus, according to Worldometer data. Although the whole Danish pandemic management strategy is based on the assumption that Omicron is much milder, the epidemiological data, especially mortality rates, in the ensuing weeks were worrying. Between 1 January 2022 and the end of June 2022, over 3200 COVID-19 patients died in Denmark, namely, as many as from the start of the pandemic until the end of 2021. The country also registers the highest number of cases per population, not just in Europe, but in the entire world (followed by Portugal and Slovenia). Less than 3 months after the epidemiological measures were lifted, we, thus, cannot ignore the question of whether the Danish strategy or the logic underlying it were questionable, if not simply wrong. The situation, therefore, needs to be analysed in greater depth—especially in terms of the involvement of experts in the making of such decisions.

It is known that, in February 2022, it was not the first time Denmark had decided to lift all preventive and protective measures. This had already occurred in early September 2021 [32]. Still, following concerning trends and an increase in infections it reintroduced certain measures in November and December 2021, notably the need to wear masks and show a COVID-19 certificate upon entering some public places [33]. A small number of experts (mostly living outside Denmark, see [34]) contend that this approach is dangerous in several respects. The possibility of new strains, long COVID-19, and the need to protect the most vulnerable are particularly problematic. Some (such as the American epidemiologist Duncan) note that the rapid release of all measures is often the result of economic and political pressure on decision-making and pandemic fatigue in public, while others (such as the Danish infectiologist K. Andersen) also believe the number of deaths was still too high to accept it as something we can live with. Further, with the decision to declare an end to the pandemic, certain data stopped being collected, making it harder to react in the event of changes. Above all, such experts point out the notable absence of a discussion on how to improve the situation in the future [34].

On the other hand, the Danish authorities claim the only relevant indicator is the number of people in intensive care, and that figures are showing COVID-19 deaths as less relevant because the distinction must be made between people who died ‘with’ COVID-19 and people who died ‘because’ of COVID-19. While in Denmark, the authorities are portraying that there are actually fewer COVID-19 deaths than the figures reveal, there are several assessments that, based on excess deaths, the real death toll of the COVID-19 pandemic is much higher. While the official number of global COVID-19-related deaths is around 6.4 million, the World Health Organization estimates a total of 14.9 million excess deaths globally in 2020 and 2021. The Economist estimates this may be even higher, at around 18.2 million, while the Institute for Health Metrics and Evaluation estimates a total of 17.7 million deaths globally [35,36].

Decisions on epidemiological measures fall wholly within the domain of the Danish government. They are based on the idea that such measures entail a serious breach of human rights and democracy, so must only be exceptional, short-lived, and justifiable. In February 2022, the government had to decide whether to prolong the measures and determined that the low number of hospitalizations meant COVID-19 no longer posed enough of a threat to justify the strong interference in public life (the Social Democratic Prime Minister has also convinced the public about this).

Still, one cannot say this was a purely political decision. While the government had not established a special pandemic advisory group, they did rely on expert advice from the Danish Health Authority (DHA), which played the leading role in coordinating the health crisis, and the Statens Serum Institut, which is in charge of the epidemiological tracking, analysis, and modelling. Both support the radical lifting of measures and add legitimacy to the government’s decision. The Statens Serum Institut created a tab on its website entitled “typical misinformation regarding the Danish COVID numbers”, where it explains the need to distinguish between deaths with and because of COVID-19. It describes warnings of a high number of deaths as misinformation. However, such explanations can be problematic. In March, one of the main Danish newspapers, Berlingske, noted that 1000 people had died because of COVID-19 in less than 3 months. A representative of the Statens Serum Institut confirms in that article that some lives could have been saved but that that would have required action at the general level of society [37].

At the same time, they themselves publicly state that the high number of deaths is not a problem and that COVID-19 is no longer something needing to be dealt with (or, as put by the Statens Serum Institut: “COVID-19’ is no longer considered an infection critical to society” [36]). The radically altered testing regime is testimony to this. From the beginning of March, COVID-19 testing is only recommended for symptomatic individuals at risk of severe illness. Further, the instructions make it clear that “The Danish Health Authority does not recommend that you get tested unless there is a health professional reason to do so”, adding that “if you experience mild symptoms/ . . . /you do not need to stay home or be tested” [38]. It

is noted that the latest information (early July 2022) indicates that the Danish authorities plan a new—fourth—vaccination campaign in autumn, and 60% of the population is to be invited to participate. Such preparations are also visible in some other countries.

3.2. United Kingdom

Like Denmark, the United Kingdom is a country that was very quick and thorough in renewing the cancellation of all measures, especially in England. Prime Minister Johnson stated in January 2022 that the Omicron variant is extremely mild, so strict measures were not needed. Although the fifth wave (until the end of June 2022) in the United Kingdom has seen a total of around 30,000 deaths of COVID-19 patients, which is 440/million or 17% of the whole pandemic death toll (according to Worldometer), the UK government announced at the start of February that it would abandon all its measures. The scientific background for the UK government's decisions is provided by SAGE (Scientific Advisory Group for Emergencies). During the pandemic, SAGE also formed several subgroups in the fields of modelling, behavior, social work, health work, and the like. At the time of the coronavirus, committee meetings were also attended by some politicians, which was often criticized. Further, the committee repeatedly faced allegations of operating non-transparently [39].

On 22 February, the government presented the comprehensive document *Living with COVID-19*, which does away with the measures and retains only some recommendations, while, for individuals infected with COVID-19, it does not require any isolation and changes the system of testing to primarily target the elderly and the most vulnerable population. The new strategy is based on vaccination as the key measure, despite the proportion of vaccinated being lower than in Denmark.

More experts in the UK than in Denmark are (or were) raising concerns with the general relaxation of the measures [27,40]. On one hand, for example, the British virologist Muge Cevik believes that because of the high immunity level, numerous interventions to curb infections are pointless, so instead of preventing the infections, one should focus on solely preventing major disease outbreaks. On the other hand, we find the epidemiologist Deepti Gurdanasi from Queen Mary University of London, an initiator of the John Snow Memorandum, being critical from the start of the total relaxation of the measures. They warn that deaths due to COVID-19 are still present, and the relaxation of some measures means others should replace them (e.g., with the cancellation of the need to wear face masks, more attention should be placed on the ventilation of spaces) and warns of the great danger of long COVID-19 being overlooked in the current strategy [41]. Several experts (e.g., the epidemiologist Mark Woolhouse and virologist Lawrence Young) already advised in February 2022 that it was still possible for a new, more dangerous variation of the virus to emerge and that abandoning all the measures and controls was dangerous [42].

Even more warnings pertain to the repeal of the rules on isolation and the smaller amount of testing. An open letter was signed by 3360 scientists in February 2022. Their concern was the measures in the event of a possible new strains of the virus with no guarantee that they would be milder than those hitherto known. Abolishing testing and the non-isolation of cases make it impossible to control the virus' spread.

Indeed, a new wave of infections followed in March in the United Kingdom, which is now slightly easing, although the numbers of deaths are still not down to the level of December 2021, let alone of May last year. It has been reported that over 2 million people suffer from long COVID-19 [43]. Moreover, over 800,000 cases of reinfection with COVID-19 were recorded [44] and COVID-19 continues to disrupt daily life in the UK. At the beginning of April, new warnings from certain hospitals emerged (e.g., Bristol and Weston) of the appearance of a new major number of incidents, exceeding the level in January; due to the number of sick leaves, certain airlines needed to cancel numerous flights [45]. At a similar time, the British government—paradoxically or not—abolished the financing of some research programmes related to COVID-19 (e.g., the ZOE Study) and some independent public studies for researching the preparedness and response of the UK to the COVID-19 pandemic.

3.3. Comment

Together with Sweden and Norway, Denmark is the first in the EU to abolish its regime of preventive epidemiological measures. Simultaneously, and just as radically, this happened in the UK. In both cases, it was a politically motivated decision, yet in Denmark it was also supported by expert groups located in state institutions. In the UK, unlike Denmark, experts are quite divided, and criticism of opening up too quickly and doing away with all the restrictions seems to prevail.

In Denmark, despite the high vaccination rates (82% of the population, over 60% with a booster shot), the consequences of such decisions have been negative, or the price to pay for this radical abandoning of the epidemiological measures is extremely high (although the government and most experts suggest otherwise). Why? First, it has been shown that one measure alone, even vaccination, is insufficient to control the COVID-19 pandemic [46]. It is a necessary but not sufficient factor (condition) for containing or eliminating the pandemic. As is known, the vaccine (mRNA) only has a level of 30–40% protection against infection with Omicron (or a little higher with a booster), though it effectively protects the vulnerable from severe disease. Many people who were vaccinated or recovered from the disease saw a drop in the number of antibodies, if they did not renew the vaccination. Denmark's decisions, in fact, therefore, give support to the argument of anti-vaxxers and COVID-19 sceptics that vaccination is not worthwhile or ineffective.

Still, increased mortality is portrayed in the public as a characteristic only of the older population, which has no connection with most of the population (or is not “critical to society” [36]. Here, we can talk about implicit ‘ageism’. It is clear, however, that decision-makers should at least consider the risk groups and find some solutions for them, at least recommending avoiding being crowded in closed spaces or wearing masks in that event. They did not do that. We can observe the same in Slovenia and in its neighbour Croatia.

The decision to not require COVID-19-positive patients to self-isolate is the one that implies that we are dealing with a revival of the idea of herd immunity. As shown later, not all countries have followed that example. Even in the United Kingdom, experts warned that such a decision is unwise [47]. Lately, a leading Slovenian infectiologist, M. Jereb, stated that the decision to do away with obligatory self-isolation might be economically efficient, but is in no way “*medically acceptable*”.

In Slovenia, ZZZS (the Health Insurance Institute of Slovenia, a public institute in charge of providing compulsory health insurance), recently recommended ending the obligatory self-isolation for COVID-19-positive individuals because of the costs of that measure, noting that by 1 July 2022 people in Slovenia had used a total of 1,248,369 days of sick leave, over twice the level for the same time in 2021. This amounts to more than EUR 107 million in reimbursement costs [48]. While Omicron is considered to be less dangerous for serious illness and death, being infected by it still represents a considerable risk to an individual's health. Research shows that 10–30% of individuals are suffering from *long COVID-19* [49], and the virus can cause worrying neurological, dermatological, cardiological, and other consequences [23].

There is also a serious danger that people in those countries will see the rapid and uncompromising lifting of the epidemiological restrictions and precautionary measures as a sign to stop dealing with COVID-19; in a sense, meaning the end of the pandemic saga and that we might all return to 2019: ‘go back to normal’. It is an appeal to amnesia, as if the pandemic never happened and probably will not re-occur. How to persuade social groups to abandon certain consumption habits in the face of the climate change remains completely unclear, if we cannot persuade them to wear face masks from time to time. These are serious ethical questions and issues of social responsibility that will confront us in the ensuing years, even if the pandemic becomes an endemic or is no longer a threat to society.

4. Fifth Wave—Evidence from Finland, Sweden, Slovenia, Portugal, Greece, Germany, Croatia, and Austria

As the above description of Denmark shows, the epidemiological situation (number of infected and dead) has worsened considerably in the fifth wave or during the time of predominance of the Omicron variant (and its subvariants).

Finland is a similar and even more profound example of this. Together with Cyprus, this country is generally the most successful among the EU countries regarding management of the epidemic (850 deaths per million—on average, the figure for the EU is 2598 at the end of June 2022), however this year's level of mortality has reached exceptional dimensions. Since March 2020 until the end of June, 5074 people have died from COVID-19, with over 3300 in the last 6 months alone, which represents 65% of all deaths. If we consider a different indicator, namely, the number of deaths in the fifth wave per million inhabitants, we are talking about 550 deaths.

On 10 February 2022, Finland adopted a 'hybrid strategy' for managing COVID-19. The strategy's goals are: to stabilize society so that it remains as open as possible, support post-crisis management and reconstruction, and prepare for the ongoing global pandemic and possible new outbreaks/variants. The measure is focused on encouraging people to protect themselves (mainly through vaccination and testing at home). The testing regime is similar to Denmark, but there is still a requirement for people who test positive for the coronavirus to self-isolate.

On that date, the country stopped enforcing measures on the national level, instead transferring this to the local authorities, who can prescribe measures in the event of outbreaks. Yet, these measures should be as short as possible, the least disruptive to society, and only adopted if truly necessary. In practice, the measures in the region around Helsinki, where most of the population lives, are currently primarily concentrated on recommendations (wearing masks in closed spaces containing many people, especially for people at risk and those who suspect they may have COVID-19 or make visits to and work in hospitals; working from home). Certain recommendations about restrictions on the organization of recreational and other activities (e.g., ensuring as little contact as possible between different groups, maintaining a distance between people, etc.) and the need for a COVID-19 certificate to enter the country were only lifted on 30 June 2022.

Articles have occasionally appeared in the Finnish media that question the large number of deaths [50]. Representatives of the Finnish Institute for Health and Welfare responded that most deaths have been among patients older than 80 years, and almost all had associated diseases and were patients who could have died from any infection. As they stated, these were chiefly patients with cancer, heart disease, and serious forms of dementia or diabetes, and in several hundred cases COVID-19 was not the primary cause of death, so the number of deaths has primarily been attributed to the large number of infections. They added that not much could have been done to prevent these COVID-19-related deaths. Such relativization of deaths is similar to that seen in Denmark.

Finland's neighbour, **Sweden**, is considered an enigmatic country when it comes to managing the pandemic. Even though it issued occasional obligatory measures, the strategy was mostly based on recommendations. From February 2022 on, there are no preventive measures or recommendations in place (according to information in June, there is a recommendation to wear face masks in crowded public spaces and in transportation). A rise in infections and deaths from Omicron is also visible, particularly in February and March, yet this did not prevent the government from lifting the measures and declaring an end to the pandemic. However, Sweden is recording the highest number of deaths in the region, but that is still below the EU average (2598 deaths per million inhabitants at the end of June 2022). (If we take just the old members of the EU into account, the average number is 1967 deaths per million of inhabitants. In the whole pandemic period, Swedish data show a higher level of mortality (1900 deaths per million of inhabitants). In the fifth wave (1 January 2022 to the end of June 2022), 3744 people died, accounting for 374 per

million, less than in its neighbouring countries and more than in Germany. Nevertheless, Sweden has a very high level of vaccination.

It is quite unusual that the wearing of face masks was never made mandatory, in sharp contrast to every other country as well as the instructions of the WHO and ECDC. In the media and in scientific journals, one can find many analyses critical of the official policy, albeit these largely refer to the epidemiological situation in 2020 and not later. Most recently, an article by a Swedish author has been published, where analysis includes the two-year period until the end of 2021. The author point out that Swedish lax COVID-19 management was successful, however, conclusions based on intransparent calculation of the excess mortality (see our footnote on page 5, where we mention different assessments of excess mortality) [51,52].

While many believe the Omicron variant has not caused any major problems in **Slovenia**, it has a relatively high mortality rate—around 1680 deaths in the fifth wave, or 21% of all deaths from the start of the epidemic until the end of June 2022 (in Worldometer, the number is lower, at 1062). At the same time, the total number of deaths in Slovenia, around 7800 (3760 per million—again, according to NIJZ—National Institute of Public Health data) is the fourth-highest in the EU (it is only higher in Bulgaria, Hungary, and Croatia). The main cause of the discrepancy in data in different databases is a different methodology for counting deaths (some databases count total deaths as a sum of daily deaths, which are incomplete. NIJZ counts all deaths occurring 28 days after the positive COVID-19 test, but with a week or more delay). Some international databases show the first number, while others show the second number. The ECDC even shows both. This is not the sole observable difference in the data, as can be similarly observed in Sweden where the number in Worldometer is higher than in the ECDC.

Slovenia had quite strict measures in place, but the main issue was the relatively low level of compliance or high level of defection or non-compliance/non-implementation of measures [53]. This is evident in a Eurobarometer survey showing attitudes to vaccination and satisfaction with the government's measures. The level of vaccination in Slovenia is generally lower (58% of the population) than in the mentioned Nordic countries or old members of the EU. Further, according to the latest surveys, the Slovenian population is among the most skeptical or disapproving of vaccination, this being a continuation of a trend already observed in an international survey in 2016 [54]. The new (left/liberal-wing) government that commenced office on 1 June is actually pursuing a short-term strategy of 'muddling through'.

As concerns the severity of the fifth wave's impact, **Greece** stands out with 830 deaths per million, or 35% of all deaths over the course of more than 2 years. Generally speaking, the level of mortality is lower than in Slovenia, and the vaccination rate is a little higher (65% of the whole population vs. 58% in Slovenia). Some epidemiological measures in the country remain in place and are relatively strict. The country has a big proportion of elderly (the life expectancy is among the highest in the EU) and a poorly organized health system on all levels that became overburdened during the fifth wave, making access to intensive care difficult [55]. The great majority (91%) of all deaths have occurred in the age group of above 60 years.

Although **Portugal** is one of most vaccinated countries in the EU (87% of the population), it experienced a surge in the fifth wave of the pandemic. Between 1 January and 30 June 2022, 5176 people died, and many were infected. This amounts to one-third of all deaths or 500 per million inhabitants. Otherwise, the death toll for the whole pandemic was 2300 deaths per million, still below the EU average (and similar to Spain and France).

According to available information, the most dangerous sub-variant of Omicron, B.A.5, is dominant in the country. There was no radical lifting of restrictions, but, in early April, when the infection incidence (temporarily) decreased, the lifting of the need to wear face masks (which only remains in public transport and in health and nursing institutions) was perhaps a premature step.

One should mention **Germany**, where the mortality rate in the fifth wave is the lowest among the analysed countries (330/million or over 28,000 in total). Overall, the German model of epidemic management is slightly more successful than, for example, the Swedish one (considering either the fifth wave or complete numbers). Measures and restrictions were, compared to Denmark and Slovenia, relaxed gradually, beginning on 20 March and then in April [56].

Based on the latest information, while masks are obligatory on public transport, the type of mask prescribed varies among the *Länder*. Some of them require FFP2 masks, although in most a surgical mask is sufficient. Minister of Health Karl Lauterbach, who is coming from the scientific sphere, also recommends masks be worn in all closed spaces, especially for those groups most at risk. Further, he has declared in the media that people should be prepared for an autumn outbreak of a more contagious version of Omicron: B.A.5 [57,58].

Other important information is that the Ministry of Health has completed an evaluation study. The study is based on an analysis performed by a special commission composed of lawyers, two social sciences experts, representatives of biomedicine, and experts in data processing and modelling. The study is entitled *Evaluation der Rechtsgrundlagen und Maßnahmen der Pandemiepolitik (first draft)*. As we see in one of the footnotes in the study, the authors did not agree on all aspects. It also seems that the study is editorially not finished and is a first version of the text.

Croatia belongs to the group of countries most affected by the pandemic in the EU and in the world, based on the number of deaths (over 4000 deaths per million inhabitants). Even in the fifth wave, there have been many infections and deaths. Currently (beginning of August 2022), according to Worldometer data, Croatia is the country in Europe with the most deaths per million inhabitants. Despite this, almost all epidemiological measures and restrictions have been lifted since February (like in the neighbouring Slovenia). This certainly affects the current poor epidemiological picture. In particular, the role of mass tourism and related activities in the hotel and hospitality industry should be emphasized. This country is very dependent on the inflows generated by foreign tourism, especially in the resorts along the narrow strip beside the Adriatic Sea and the islands. For this connection, we are not talking about a direct impact on the epidemiological picture, although it certainly has an indirect one. In addition, what we must highlight is the unsustainable nature of tourism, not only in this country, but more broadly in the EU (and the world). The fact that a country with a little more than 4 million inhabitants has in the high season a daily influx of another 1 million tourists or visitors from other countries (mainly Germany, Italy, Austria, and Slovenia) leads to the question of how we will reach a consensus on sustainable tourism in the EU and when it will happen.

Austria is a very interesting case, as it had quite a few epidemiological measures in place until 1 August 2022. After that date, however, the government (together with the country's expert group) literally removed all of the restrictions. Even the measures of self-isolation and quarantine no longer apply. The infected can work and are allowed all types of public engagement. They just have to wear a mask, or it is recommended that they do. How this is controlled is another matter. Here, too, we can mention the impact of tourism and the lack of the labour force in various service branches. The data on the incidence of infected people and deaths are not alarming, but they are not negligible either. What is particularly interesting from a 'theoretical' point of view is the way of justifying the elimination of measures. In addition to referring to some countries that have done the same, especially Denmark, the Austrian Minister of Health (from the Green Alternative party) stated that none of the measures help anyway, saying: "*Wir koennen die Pandemie nicht wegimpfen, nicht wegtesten, nicht wegabsondern*" (Frankfurter Allgemeine Zeitung dated 26.7.). According to media reports, some experts are against such a quick lifting of the measures; the German Minister of Health Lauterbach was also critical of it, as well as some experts from Slovenia.

Comment

The question remains whether Finland should have had more restrictive measures in place based on the severity of its outbreak. It is important to note that the political and health authorities there did not opt for a rapid and radical release of all of its epidemiological measures, like in Denmark and Sweden. The country has taken a more selective approach, which seems to be a good strategy (measures are limited to some regions, especially the Helsinki region, and certain population groups). However, the country has been shaken by the demonstrations against the vaccination and pandemic measures since the New Year. The case of Greece potentially shows that it should more consistently persist with some measures and ‘calibrate’ them, as in making them selective and more differentiated. This is especially important for older generations and the groups most at risk, who should be treated separately with specific measures.

In Slovenia, it is certainly true that the preventive measures were released too quickly, partly because of the considerable resistance of quite well-organized groups of anti-vaxxers and COVID-19 sceptics. Moreover, parliamentary elections were just around the corner.

Regarding Sweden, an enigma remains regarding the mask-wearing mandate. It is the only member of the EU not to have prescribed or ordered the general wearing of face masks, which were only recommended in a certain period.

For now, it seems that among the mentioned countries only Germany—thanks to its Minister of Health—is thinking about preparations for an autumn outbreak of the pandemic and publicly speaking about this. Still, even within this country, one can find many opposing views about the past restrictions and how to act in the near future. This is seen in the mentioned evaluation report, which appears to be rather a work in progress and not a well-elaborated or coordinated text.

5. Additional Report on Omicron—Why a Pandemic in the Global Sense Is Far from Over

In order to present more evidence regarding the possible consequences of the Omicron strain, the situation in some non-European parts of the world should be mentioned.

While European countries were lifting their measures and declaring an end to the pandemic in the first four months of 2022, many East Asian and South-East Asian countries as well as Australia and New Zealand were experiencing their worst COVID-19 outbreaks, with record high numbers of infections and deaths and imposing strict lockdowns following the ‘zero COVID-19 strategy’. The first example of this was Hong Kong, which was practically COVID-19-free until the emergence of Omicron. Hong Kong reported a total of 213 deaths from the start of the pandemic until the end of 2021. Yet, at the end of June 2022, the figure had grown to over 9400, or more than 1200 per million inhabitants. A huge increase in new cases and deaths is also seen in Taiwan.

Similarly, the South Korean death toll rose from 5563 at the end of 2021 to over 24,000 at the end of May 2022 (Worldometer data). Even China (first in Shanghai then also in Beijing), which allegedly did not have any COVID-19-related deaths between April 2020 and April 2022, saw a surge in deaths during April and May 2022. These numbers occurred despite the strict lockdown measures or zero COVID-19 strategy.

Among the most common explanations for this surge are the less effective vaccines for elderly people—especially in Hong Kong, where many of the elderly were not vaccinated at all or used the Chinese-made vaccine Sinovac, which reportedly is less efficient [59–61]. Despite the present drop in the number of cases and deaths in most Asian countries, some areas remain under a strict lockdown, showing that in a global sense the pandemic is far from over. While the main surge seems to be over in the mentioned countries, it is still problematic in Taiwan, which was also a COVID-19-free country until March 2022, but relatively high numbers of COVID-19-related deaths have been registered daily. Similarly, Australia recorded its highest number of daily COVID-19 deaths in July 2022 (Worldometer data). However, in these Asian and Oceanic countries, we are dealing with a huge and

short-term increase from a very small starting base. All of these countries, except for Hong Kong, would in Europe be classified as having the lowest death tolls.

6. Discussion

From this overview of the approaches used in 2022 in the process of easing or abolishing the preventive epidemiological measures, we must learn some things regarding the future planning and establishing of measures and restrictions and how to successfully lift them.

First, we have to strive for a combination of measures and restrictions. We cannot rely on a single measure, not even vaccination, which several studies confirm [46,62]. Vaccination must be supported by the wearing of face masks (which in the above-mentioned German evaluation report are also described as the only preventive measure proven to be effective—next to vaccination, which the report does not look at in detail due to its ‘complexity’), especially in closed spaces, and the ventilation of spaces and other restrictions concerning social distancing and avoiding large concentrations of people, even in open spaces. However, it is not necessary for such restrictions to concern the general population or entire national territory. At the moment, the epidemiological situation needs to be monitored along with the trends in neighbouring regions and countries. At the forefront, the older population and other risk groups (those with weaker immunity) must be targeted. Practically all of the countries we mentioned are reporting that victims of Omicron are mostly older people (in some places older than 60, in others older than 80). Still, most of those countries did not do enough to protect this segment of the population. They should consider this group and protect it from infection through recommendations and obligatory measures (if recommendations are not enough). This also means that a stepping away, from adopting measures purely based on the pressure on hospitals, is needed. Governments should take account of the number of infections and the spread of the virus among the general population as well, as it is impossible to completely isolate groups at risk when the prevalence of the virus in society is high.

Second, it is important that when lifting the measures, we do not signal that the pandemic is over and does not need to be dealt with anymore. Lorenzo-Redondo (2022) [63] warns that early reports suggesting the lower mortality of Omicron were “*broadcast with limited emphasis on the underlying uncertainty*” and that effective communication is essential for both individual risk assessment and the public health response. These signals influence the amnesia of many people, including decision-makers, and adds to the influence of the already well-organized groups of COVID-19 sceptics and anti-vaxxers.

A central question is whether the easing/abandoning of the epidemiological measures and restrictions means a simple return to the pre-pandemic ‘normal’ or the transition to a more complex frame of reference in which greater reflection and awareness is sought regarding social risks on the system level and (micro) life-worlds. The quick lifting of measures (like in Denmark) gives the impression of a greater probability of ‘going back to normal’. This would, however, be a grave mistake, as noted in the editorial introduction in the biomedicine journal *The Lancet* [64].

We are presently (July 2022) dealing with an interregnum: we know that the pandemic is not over, but the seasonal factor, at least temporarily, is reducing the number of infections (new cases), hospitalizations, and mortality. Now is the time for an independent evaluation of approaches to solving the health or epidemiological crisis taken so far, with a view of learning and searching for new solutions. Staying passive today would mean, as the Independent Panel for Pandemic Preparedness and Response warns, “laying the groundwork for another pandemic” [65]. Not only for future pandemics, but preparedness and action are also needed for other risks and crises that may await us, for example, fighting climate change and dealing with the altered security and energy circumstances in the EU. Those will all require long-term strategic approach and a systematic cooperation between governments, experts, and wider society.

The current situation, especially in Europe, suggests a strong impulse towards ‘going back to normal’, without much consideration of the long-term consequences such an approach may bring. This impulse is seen in the public discourse, political decision-making, and parts of scientific and expert communities. Yet, there are many warnings about how that approach could become dangerous. Not only in the short term, where we risk the emergence of new variants and are ignoring the problem of long-COVID-19, but also in the long run, in the case of new outbreaks of this or any other infectious disease. Moreover, we would be missing the chance to learn and adapt our system for other crises that may yet come. Referring back to the introduction, this kind of approach cannot be deemed as sustainable.

Concluding Remarks

It is important to understand that there are not only two possible scenarios—severe lockdown or total abolishment of all measures. It is important to search for sustainable and effective solutions. Based on the past experience with management of the pandemic, we should learn to use three principles, both when adopting and releasing epidemiological measures: **calibration**, **combination**, and **continuity**. The first one refers to the targeting, selectivity, proportionality, and time sensibility (if they are adopted at the right time, they can be shorter in duration) of preventive measures (including lockdowns). The second principle refers to the smart combination of different measures, as was pointed out, we cannot rely on one measure alone, not even vaccination. This is a necessary but not sufficient factor in pandemic management: other precaution measures (such as wearing masks) are needed as well.

Last but not least, continuity means that certain measures and limitations are constantly present, though not necessarily for the entire population. They should certainly relate to the groups most at risk (for example, wearing masks indoors). Here, we also include ventilation in schools and apartments, the requirement to disinfect hands for all the population, etc. In other words: in the current situation (July and August 2022), health authorities should recommend (and in some cases make it mandatory) for the groups most at risk to wear masks (FFP2). This applies not only for public transport, but for all closed spaces, especially where crowds are present, and for health institutions. Moreover, visitors and personnel of care homes should wear masks.

Finally, experts and scientists from various disciplines should be involved in the activities and acceleration of learning and developing new, long-term strategies for dealing with the pandemic. More interdisciplinary dialogue is needed; in fact, greater harmonization and consensus in terms of the convergence of views is required. We can only accomplish this—if there is the will—through discursive-cognitive methods of “consensual conference” and “adversarial collaboration” [66]. The approach called citizen science would also be beneficial as an alternative to populist conspiracy theories. It is not necessary for science to achieve total unanimity, but it would be useful to disclose the reasons for divergence and disagreement. In this context, future studies should lean more on cross-national research and comparative methods, namely on comparative social (science) epidemiology research.

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