



A DCI Deliberation Guide

Lessons Learned from COVID-19:

How should we prepare for the next pandemic, if at all?

Format for Deliberation

Before the Deliberation

- I. Read this Deliberation Guide (required)

During the Deliberation

- I. Setting Expectations (5 min.)
- II. Getting to Know Each Other (10 min.)
- III. Understanding the Impacts of COVID-19 (15 min.)
- IV. Assessing the Responses to the COVID-19 Pandemic (30 min.)
 - A. Containment and Closures (15 min.)
 - B. Behavioral Modifications, Economic Stimulus Payments, and Investments (15 min.)
- V. Break (5 min.)
- VI. Considering the Pandemic's Ethical and Political Challenges (15 min.)
- VII. Deliberating on Future Government and Policy Responses (30 min.)
 - A. Lessons Learned from the COVID-19 Pandemic (15 min.)
 - B. Recommendations for Preparing for the Next Pandemic (15 min.)
- VIII. Reflections (10 min.)

Background

Introduction

Coronavirus disease (COVID-19) is an infectious disease caused by the SARS-CoV-2 virus. Cases of the 2019 “novel coronavirus” were first detected in China in December 2019, with the virus spreading rapidly to other countries. In COVID-19, ‘CO’ stands for ‘corona,’ ‘VI’ for ‘virus,’ and ‘D’ for disease—with 19 representing the first year a case was detected.

It is generally accepted by scientists that COVID-19 likely originated in an animal population and crossed over to humans - a process called zoonotic transmission.¹ Consequently, it was the first time human immune systems were exposed to the virus.² The human body had not developed immunity to COVID-19, and an infection that began as a mild to moderate respiratory illness could rapidly lead to hospitalization and death. On March 3, 2020, the World Health

Organization (WHO) reported that 3.4% of reported COVID-19 cases had died compared to the seasonal flu killing “far fewer than 1% of those infected.”³ Also in March 2020, An Imperial College London study estimated that 2.2 million Americans would die from COVID if drastic actions were not taken.⁴ On March 11, 2020, the WHO characterized the outbreak as a pandemic,⁵ which is defined as a state where a disease evolves quickly, affects a significant proportion of the population, and spreads across geographic boundaries to afflict more than one continent.⁶

COVID-19 posed a heightened risk to older people and those with underlying medical conditions such as cardiovascular disease, diabetes, chronic respiratory disease, or cancer, but the WHO warned that anyone can get sick with COVID-19 and become seriously ill or die at any age.⁷ Some people also experienced “Long COVID,” which is referred to as the wide range of ongoing symptoms and conditions that can last weeks, months, or even years after the initial COVID-19 illness.⁸

By June 2022, the U.S. had recorded over 80 million COVID-19 infections and more than 1 million deaths from the virus.⁹ As of August 2022, Black and Hispanic people experienced higher rates of infection and deaths than Asian and White people after adjusting for differences in age.¹⁰ As of February 2025, there have been 7.1 million reported COVID-19-related deaths worldwide and 1.2 million in the U.S.¹¹ *The Economist* estimates that COVID infections resulted in 27 million excess deaths by August 2024.¹² At the height of the pandemic in January 2022, nearly 150,000 people (or 442 people per million) were hospitalized in the US due to COVID.¹³ Efforts to control the pandemic included widespread testing, quarantine measures, vaccination campaigns, and public health guidelines such as social distancing and mask-wearing.

The pandemic highlighted the importance of global cooperation in responding to health crises and emphasized the need for continued research, preparedness, and resilience in the face of future outbreaks.

Origins and Initial Responses to the COVID-19 Pandemic

Origins

To this day, the origins of the SARS-CoV-2 virus remain unconfirmed. While there is a consensus that Wuhan, China, was the place of origin, the etiology (i.e., how the pandemic was caused) remains in contention. Two hypotheses have gained the most attention and are recognized to have the highest levels of credibility: exposure to an infected animal (natural origin) or a laboratory leak (research-related origin).¹⁴ A recent CIA report favors the lab leak hypothesis—positing that the virus most likely originated at The Wuhan Institute of Virology (WIV), which has been studying coronavirus in bats for more than a decade—but the agency admits to having a low level of confidence in this assessment.¹⁵ The continued search for definitive evidence has been hampered by the fragile relationship between U.S. intelligence agencies and Chinese government officials.¹⁶ In the absence of such evidence, the CIA’s conclusion was based on information regarding the virus’s spread and on-the-ground research about the work conditions and health standards of China’s virology labs.¹⁷

China vehemently denies this hypothesis and believes that a natural origin, likely through Wuhan's Huanan Seafood Market, is far more plausible. This theory has been supported by WHO, the Defense Intelligence Agency, and the National Intelligence Council.¹⁸ Other theories, including one that claims China intentionally unleashed the virus as a biological weapon, are largely unsubstantiated and are not viewed as legitimate hypotheses by the U.S. and the global scientific community.¹⁹

Containment

Following the initial human infection, the virus spread rapidly in Wuhan and the surrounding areas. On January 23rd, 2020, China's President Xi Jinping placed an unprecedented **quarantine** on the city for 3 months. However, it was too late to prevent the virus from escaping Wuhan, and indeed even China. By late January, cases were appearing in Korea, Japan, and Thailand.²⁰ Just a few days later, the first confirmed case appeared in the U.S., and by the end of January the Centers for Disease Control and Prevention (CDC) had recorded seven cases nationally, as well as the first instance of person-to-person spread in the U.S.²¹

In the ensuing weeks, governments worldwide grappled with a nearly unprecedented challenge: they had to respond to the virus's rapid spread and the immense uncertainty it created, all within the context of our highly interconnected modern world. On March 13th, President Donald Trump issued a **travel ban** on non-U.S. citizens traveling from 26 European countries.²² This was in addition to earlier restrictions on travelers from China. While Trump touted these bans as effective measures to stop the pandemic, some have argued that he did not act swiftly or comprehensively enough. By February 2nd, when the U.S. implemented a travel ban on China, more than 430,000 travelers from China had entered the U.S. since the initial outbreak in December 2019. Despite Trump's claims that he cut travel from Europe pre-emptively, there had been more than 2.6 million entries between the initial positive case on the continent and his March ban.²³

Some commentators asserted that "the government should have known how ineffective travel restrictions would be at protecting the country."²⁴ According to a Cato Institute analysis, travel bans do little to stop a rapidly spreading virus. The authors argue that such measures create a false sense of security and can disrupt vital supply chains, hamper global cooperation efforts, and distract from more effective efforts within each country.²⁵ A 2022 study found that implementation of international travel controls before a country experienced its first COVID case delayed the first epidemic peak by approximately five weeks, concluding that these controls "bought valuable time for local health systems and governments to prepare to respond to local transmission."²⁶

Once it was clear that the virus was going to spread within the U.S.'s borders, the administration declared a national emergency and introduced the "15 Days to Slow the Spread" guidelines, advising social distancing, limits on large gatherings, and the closure of schools and certain businesses.²⁷ In April, those guidelines were extended, and efforts shifted to ramping up testing capacity, securing personal protective equipment (PPE), and encouraging states to adopt stay-at-home orders, though specific measures varied widely by state.²⁸ The following sections of

this guide are devoted to exploring these strategies and their effectiveness—as well as their costs and consequences—with an eye toward how the U.S. and other nations can be better prepared for a future pandemic.

Closures: Schools and Other Institutions

Since COVID-19 has a far greater propensity to spread in crowded indoor environments, officials justified closures of schools, religious buildings, businesses, and other gathering places as life-saving public health measures.²⁹ These shutdowns were met with mixed reactions, featuring critiques in the name of individual freedom, religious liberty, economic prosperity, and educational goals.

School Closures

Perhaps the most salient pandemic-era closure controversy was the closures of public K-12 schools.³⁰ Directly following the outbreak of the pandemic in March 2020, schools across the country—in red and blue states alike—implemented full closures en masse, fully pausing in-person instruction.³¹ However, as the pandemic grew more political and less universally feared in the year that followed, policymakers came to different conclusions. While states like Florida mandated reopening to begin the 2020-21 school year,³² students in other states like California had minimal in-person instruction until the spring of 2021.³³ It's worth underscoring that though school closures remained a salient political issue on state and national stages, most states left their reopening policies up to individual school districts to decide.³⁴

To evaluate the empirical success of school closures, competing policymaking priorities should be considered. On one hand, these closures are associated with clear reductions in both COVID cases and deaths, thus aligning with 2020 public health policy goals.³⁵ However, these public health benefits appear to have had a cost in educational outcomes, as students' chronic absenteeism and mental health problems increased while their test scores declined during virtual learning.³⁶ Notably, this "learning loss" was particularly pronounced in low-income school districts.³⁷

Even from a straightforward perspective of lives saved, the debate is more complex, as some contend that the effects of learning loss on educational attainment may ultimately be correlated with reduced life expectancies, given that people with a college education live a decade longer on average than those with only a high school education.³⁸ A 2024 study found that while high school graduation rates increased during the pandemic, enrolment in two-year colleges declined by 21%, with larger declines in Black and Hispanic-majority colleges (four-year institutions witnessed an initial 6% drop followed by a 4% rebound).³⁹ Weighing in on the school closure debate thus requires consideration of both sets of values—safety and public health versus liberty and prosperity—and the conflict between short and long-term concerns.

Other Closures

However, schools were not the only venue for disagreement on the pandemic-related closure debate. Many other institutions, such as religious institutions and businesses, found themselves the subject of these debates.

Closures of places of worship provide an intriguing starting point. Ostensibly due to concerns about violating the First Amendment's protection of the free exercise of religion, 12 of the 39 states with stay-at-home orders in the early weeks of the pandemic implemented partial or full exemptions for religious services and houses of worship.⁴⁰ Legal scholars had mixed interpretations of the First Amendment in a unique moment like the pandemic. Because quarantine orders did not favor certain religious institutions over one another, the American Constitution Society contended that exempting religious institutions from quarantine orders was "a misreading of the Constitution as well as awful public policy."⁴¹ On the other hand, the conservative legal advocacy group Alliance Defending Freedom concluded that "the First Amendment cannot be suspended because of a pandemic" as it worked to overturn restrictions on religious institutions.⁴²

Houses of worship were not the only private institutions that found themselves the subject of public debate. Businesses across the country found their doors closed by lockdown policies. For better and worse, these closures had significant impacts. A working paper published by the National Bureau of Economic Research estimated that these shutdown policies saved approximately 15,000 lives.⁴³ Conversely, these closures were linked to an estimated 26% decline in US gross domestic product in the first half of 2020, creating an historic economic downturn.⁴⁴ A cost-benefit analysis published in *PLOS One* concluded that lockdowns in the US saved 866,350–1,711,150 lives while "mortality attributable to the economic downturn was 57,922–245,055 lives." Another study found that government restrictions likely played a limited role in the economic contraction; legal restrictions only explain 7% of the 60% reduction in consumer traffic, which began to decline before legal restrictions were put in place. The authors conclude that "individual choices were far more important and seem tied to fears of infection," as they were highly associated with the number of nearby COVID deaths.⁴⁵

Naturally, even among Americans who agreed with these facts, disagreement persists on which to prioritize. In May 2020, 59% of Americans disagreed and 35% agreed with the sentiment that closures had been too severe.⁴⁶ However, in October 2024's retrospective view, 44% believed restrictions on public activity were about right, 38% thought there should have been fewer restrictions, and 18% felt like there should be more.⁴⁷

Once again in these examples, value trade-offs are an important component of these debates. The lives saved by lockdowns speak for themselves, fueling support for these closures by a majority of the American populace (a March 2024 poll found that 63% and 56% believed that dining closures and school closures, respectively, were "generally a good idea").⁴⁸ However, for staunch critics of these closures, the loss of individual freedoms (Supreme Court Justice Neil Gorsuch deemed it "the greatest intrusion on civil liberties in the peacetime history of this country") and the economic cost suffered by Americans nullifies their merits.⁴⁹

Behavioral Modifications: Masks, Social Distancing, and Vaccinations

On November 28, 2020, 35 states issued emergency orders for **statewide mandatory mask requirements**.⁵⁰ Several studies have demonstrated that face masks decreased the spread of the virus.⁵¹ The primary objective of these measures is to provide “source control” of infected individuals, and face coverings block a large proportion of the person’s respiratory secretions during talking, deep exhalation, singing, and similar actions. Face masks can decrease the number of expelled large droplets and aerosols, the concentration of virus-laden droplets, and the distance that secretions travel from the source person.⁵²

In April 2020, the CDC recommended that everyone wear masks when outside the home, and on January 30, 2021, CDC required masks to be worn “by all travelers while on public transportation and inside transportation hubs.”⁵³ On July 8, 2022, the New York Department of Health recommended that “all people should wear N95, KN95, or KF94 masks in all public indoor settings and when in crowded outdoor areas.”⁵⁴ States, school districts, and institutions nationwide enforced indoor masking to varying degrees.⁵⁵ State-issued mask mandates included requirements for persons to wear a mask 1) anywhere outside their home and/or 2) in retail businesses and in restaurants or food establishments.⁵⁶ A *Journal of Health Economics* article found that state mask mandates significantly reduced COVID weekly cases, hospital admissions, and deaths; through December 19, 2020, they likely saved 87,000 lives, and another 57,000 lives would have been saved by a national mandate.⁵⁷

While mask mandates were widely implemented and associated with reduced transmission rates, mask efficacy varied depending on mask type, compliance, and setting.⁵⁸ Some sources discuss how mandates were difficult to enforce;⁵⁹ reasons for people’s resistance to wearing masks included physical discomfort and other negative effects, perceived lack of effectiveness, and “being unnecessary or inappropriate for certain people or under certain circumstances.”⁶⁰

Scientists and pharmaceutical companies worked at an unprecedented pace to develop vaccines, with several becoming available within a year of the outbreak. **Mass vaccinations** first began towards the end of 2020. Within Biden’s first 100 days of office, 200 million doses of the vaccine had been administered.⁶¹ However, some people were hesitant about getting the vaccine; reasons included concerns about side effects, an emphasis on individual liberties, and a belief that the vaccine would cause more harm than good (“it hasn’t been around long enough”).⁶² As the pandemic continued and vaccines became more available, a variety of state governments, federal agencies, private firms, and higher ed institutions began issuing vaccine mandates.⁶³ All federal vaccination mandates for international travelers, government employees and contractors were lifted when the national emergency was declared to have ended in May 2023.⁶⁴

The COVID-19 vaccine is very effective at preventing serious illness, hospitalization, and death.⁶⁵ Vaccinations are estimated to have saved between 14.4 and 19.8 million lives during the first year of their availability.⁶⁶ A meta-analysis of seven studies covering 22 million COVID patients found that unvaccinated patients were 2.45 times more likely to die from COVID-19.⁶⁷ Because the virus that causes COVID-19 continues to change, vaccines are updated periodically to help

maintain protection against severe disease, hospitalization, and death.⁶⁸ Vaccination, however, did not completely eliminate the risk of death from COVID-19 as the virus evolved and the pandemic continued to take lives.⁶⁹

Masking and vaccinations were accompanied by **social distancing** that aimed to slow the spread of COVID-19 by stopping chains of person-to-person transmission of the disease and preventing new cases from occurring.⁷⁰ While the WHO argued that social distancing ought to be at a minimum of 3 feet,⁷¹ the CDC recommended individuals keep at least 6 feet of distance from others.⁷² In contrast, scientists in a recent study contend that these droplets travel much farther than six feet — sometimes as far as 27 feet, although they are much less concentrated.⁷³

Social distancing mandated at the institutional level came with its own challenges. Teachers often said they couldn't enforce social distancing because they had too many students in class to separate them by either the 3-foot or 6-foot marks.⁷⁴ Different populations may be more or less able or willing to comply with these social distancing mandates. One study found that Hispanic adults in New York City faced numerous obstacles to social distancing and quarantining, such as living in crowded, multi-generational households, working as essential workers, and providing unpaid care to family members.⁷⁵ Another study revealed that counties with higher proportions of essential workers and people living in poverty had lower levels of social distancing, while counties with higher population densities and larger Black populations had higher rates of social distancing.⁷⁶

Overall, these policy interventions taken together have been found to have a significant positive effect on health outcomes of the pandemic. A 2024 study published in the Journal of the American Medical Association (JAMA) concluded that 118,000 and 248,000 more Americans would have survived the pandemic if all states had followed the restrictions practiced in the ten most restrictive states.⁷⁷ Conversely, 13-17% more people would have died if all states had followed the restrictions in the 10 least restrictive states. At the extreme, five times more people died in Mississippi, the least restrictive state, than in Massachusetts, the most restrictive state.⁷⁸

The pandemic can be characterized as a time of intense political disagreement, with some making the argument that mandated masking or vaccinations takes away their individual freedom or civil liberty. As Steven Cohen writes in an article on vaccination, freedom, and responsibility, "The exercise of government authority to require vaccination should be viewed as an infringement of personal freedom in the interest of collective security." Acknowledging and resolving such tradeoffs is not a new problem for policymakers and the public, and mandatory vaccination, moreover, was not a new policy unique to the COVID pandemic.⁷⁹ In more than 100 countries there has already existed some version of mandatory vaccination of school children for a range of diseases, including measles, mumps, rubella, tetanus, and polio.⁸⁰

Economic Stimulus and Investments in Vaccine Development and Infrastructure

Faced with widespread business closures, job losses, and strained healthcare systems, governments introduced emergency funding, stimulus packages, and public health investments

to stabilize economies and protect citizens. The U.S. unemployment rate rose as high as 14.7% in April 2020, the highest since the Great Depression.⁸¹

The Coronavirus Aid, Relief, and Economic Security Act, also known as the CARES Act, was a \$2.2 trillion **economic stimulus bill** signed by Donald Trump on March 7, 2020. The spending primarily included \$300 billion in one-time cash payments to anyone who submitted a tax return.⁸² The CARES Act provided Economic Impact Payments of up to \$1,200 per adult for eligible individuals and \$500 for each qualifying child under age 17.⁸³ However, unlike the federal government, states cannot run operating budget deficits. Consequently, welfare payments and expenditures tended to be more modest at the state level.⁸⁴ During the pandemic, the U.S. economy saw a 15%-23% loss in Real GDP (leading to a decrease in government revenue) as well as a large increase in welfare payments and benefits payouts (leading to an increase in government budget deficits). Finally, decreased spending at the state level was accompanied by mass layoffs.⁸⁵

Across the Atlantic, the recovery plan **NextGenerationEU (NGEU)** allocated a total of €1.8 trillion to help rebuild a post-COVID-19 Europe.⁸⁶ Towards the beginning of the pandemic In June of 2020, European Investment Bank signed a €100 million loan which helped to finance the research, development, and advanced manufacturing facilities of BioNTech's COVID-19 vaccine.⁸⁷ Similar pre- and post-pandemic investment initiatives were implemented in various parts of the world—at national and micro scales. The **Rebuild India Fund**, for example, was launched as a relief initiative at the height of the COVID-19 pandemic in India in April 2021. The initiative focuses on building and fostering India's vulnerable communities by providing \$13,500 annually to individual NGOs.⁸⁸

Despite incomes decreasing for the average American, taxpayer dollars continued to fund **research and development (R&D) for a COVID-19 vaccine**. Over \$18 billion of US public funds were invested in six vaccine candidates⁸⁹ (while some sources cite a higher number of \$30 billion).⁹⁰ While costly, this investment averted many illness-related deaths and costs, as the data cited above indicates.⁹¹

Other kinds of investments during the pandemic came in the form of infrastructure upgrades including but not limited to: **plexiglass installations in classrooms, HVAC (Heating, Ventilation, and Air Conditioning) systems, and outdoor alternatives**. These measures were implemented in many hospitals, schools, offices, and public buildings to minimize airborne transmission. For example, institutions invested in portable air purifiers with HEPA (High-Efficiency Particulate Air) filters to enhance air filtration.⁹²

In Horry County, South Carolina, for example, **plexiglass installations** in schools cost \$5 million – an investment that some parents called a waste.⁹³ In real-world settings, plexiglass barriers vary widely in effectiveness in reducing staff exposure to aerosols, and some barriers may increase the risk for exposure if not positioned correctly.⁹⁴ For example, airflow studies have shown that poorly placed barriers can create stagnant air pockets where airborne particles accumulate instead of being carried away by ventilation.⁹⁵ If the virus is present in these pockets, the risk of

inhalation increases for those within the enclosed space. This can further disrupt airflow and reduce the efficiency of HEPA systems designed to filter and remove airborne particles.⁹⁶

When the pandemic hit, outdoor learning went from an occasional activity to a common occurrence. Many schools received funding from government relief packages such as the Elementary and Secondary School Emergency Relief (ESSER) Fund in the U.S. to cover the costs of transitioning to an outdoor learning environment. Basic outdoor classroom setups included tents, seating, weather protection, and more permanent outdoor learning spaces included pavilions, outdoor heating, and improved landscaping.⁹⁷ At Suntree Elementary School in Melbourne, Florida, transitioning to outdoor classrooms cost \$15,000.⁹⁸

Similarly, for the food and beverage industry, there was no option but to create alternatives to indoor dining. This entailed converting parking spaces to dining patios, rerouting traffic and closing off a downtown block to vehicles and setting up picnic tables instead, and creating enclosed outdoor dining booths separated by curtain walls or distance.⁹⁹ In the colder months, this outdoor seating became an even bigger challenge.

Setting Expectations (5 min.)

In this section, we will review the “Expected Outcomes,” Deliberative Dispositions,” and “Conversation Agreements” below.

Expected Outcomes of the Conversation

The purpose of this deliberation is to constructively discuss the national and global response to the COVID-19 pandemic, including how we might best prepare for a hypothetical future pandemic. Over the course of the deliberation, we will have the opportunity to listen to the perspectives of our fellow deliberators as well as share our own thoughts about the topic. Finally, we will have reflected on our conversation, our areas of agreement and disagreement, and what we have learned from our time together.

Deliberative Dispositions

The DCI has identified several “deliberative dispositions” as critical to the success of deliberative enterprises. When participants adopt these dispositions, they are much more likely to feel their deliberations are meaningful, respectful, and productive. Several of the Conversation Agreements recommended below directly reflect and reinforce these dispositions, which include a commitment to egalitarianism, open mindedness, empathy, charity, attentiveness, and anticipation, among others. A full list and description of these dispositions is available at <https://deliberativecitizenship.org/deliberative-dispositions/>.

Conversation Agreements

In entering into this discussion, to the best of our ability, we each agree to:

1. Be authentic and respectful
2. Be an attentive and active listener
3. Be a purposeful and concise speaker
4. Approach fellow deliberators' stories, experiences, and arguments with curiosity, not hostility
5. Assume the best - and not the worst - about the intentions and values of others, and avoid snap judgements
6. Demonstrate intellectual humility, recognizing that no one has all the answers, by asking questions and making space for others to do the same
7. Critique the idea we disagree with, not the person expressing it, and remember to practice empathy
8. Note areas of both agreement and disagreement
9. Respect the confidentiality of the discussion
10. Avoid speaking in absolutes (e.g., "All people think this," or "No educated people hold that view")

Getting to Know Each Other (10 min.)

In this section, we will take less than a minute to once again share our names, where we are currently located, and answer the two questions below.

1. What is one skill that you can teach others?
2. What is one skill that you would like to learn?

Understanding the Impacts of COVID-19 (15 min.)

In this section, we will reflect on their personal experiences while linking them to broader societal patterns. Participants should feel free to ground their responses in their personal experience/perspective or answer from a more general perspective. We will each take 1-2 minutes to answer one of the three following questions, without interruption or crosstalk.

1. What aspect of the pandemic had the biggest impact on your daily life (e.g., health, employment, education, social interactions, mental well-being)?
2. How did different populations experience the pandemic differently (e.g., age, income level, occupation, access to healthcare)?
3. What was the most surprising or unexpected outcome of the pandemic for you (e.g., vaccine development speed, misinformation spread, economic shifts)?

After everyone has spoken once, the group is welcome to continue discussing these questions as time allows. Participants are encouraged to ask clarifying and follow-up questions.

Assessing the Responses to the COVID-19 Pandemic (30 min.)

In this section, we will discuss the myriad strategies employed by federal, state, and local governments, as well as the private sector and local communities, in response to the COVID-19 pandemic. The first set of questions relate to containment and closures, while the second set focus on behavioral modifications, economic stimulus payments, and investments in vaccine development and infrastructure. We will each take 1-2 minutes to answer one of the two following questions, without interruption or crosstalk.

Containment and Closures (15 min.)

1. What were the primary benefits and costs of quarantines and travel restrictions, and how should we weigh them?
2. What were the primary benefits and costs of closing schools, public facilities, businesses, and places of worship, and how should we weigh them?

After everyone has spoken once, the group is welcome to continue discussing these questions as time allows. Participants are encouraged to ask clarifying and follow-up questions.

Behavioral Modifications, Economic Stimulus Payments, and Investments (15 min.)

1. What were the primary benefits and costs of policies that required masking, social distancing, and vaccinations, and how should we weigh them?
2. What were the primary benefits and costs of economic stimulus payments, vaccine research investments, and infrastructure investments (plexiglass installations in classrooms, improved Heating, Ventilation, and Air Conditioning systems, and outdoor alternatives), and how should we weigh them?

For the second question, participants are encouraged to avoid a technical macroeconomic discussion and instead focus on the short-term vs. long-term tradeoffs associated with specific pandemic-related fiscal policy choices.

After everyone has spoken once, the group is welcome to continue discussing these questions as time allows. Participants are encouraged to ask clarifying and follow-up questions.

Break (5 min.)

Considering the Pandemic's Ethical and Political Challenges (15 min.)

In this section, we will discuss some of the ethical and political challenges that the pandemic introduced. We will each take 1-2 minutes to answer one of the following questions, without interruption or crosstalk.

1. To what extent did governments overreach in their pandemic restrictions? To what extent were the measures necessary and appropriate? What ethical and political considerations should we prioritize in answering these questions?
2. To what extent did governments respond to misinformation about COVID-19 and potential treatments appropriately? To what extent did they violate free speech protections? What ethical and political considerations should we prioritize in answering these questions?

After everyone has spoken once, the group is welcome to continue discussing these questions as time allows. Participants are encouraged to ask clarifying and follow-up questions.

Deliberating on Future Government and Policy Responses (30 min.)

Together, we will now focus on how the global community (including the US government, international governments, and other institutions) can best prepare in the event of a future pandemic. The first set of questions below focus on the key lessons learned from the COVID-19 pandemic, while the second set asks us to identify specific recommendations for preparing for the next pandemic. We will each take 1-2 minutes to answer 1-2 of the following questions, without interruption or crosstalk.

Lessons Learned from the COVID-19 Pandemic (15 minutes)

1. Which pandemic responses were most and least effective?
2. What roles did governments, private businesses, communities, and individuals play most and least effectively in responding to the pandemic?
3. Did any countries have a better response than others? If so, why do you believe it was better?
4. What is the most important lesson governments and the public should take from the COVID-19 pandemic?

After everyone has spoken once, the group is welcome to continue discussing these questions as time allows. Participants are encouraged to ask clarifying and follow-up questions.

Recommendations for Preparing for the Next Pandemic (15 minutes)

We will each take 1-2 minutes to answer 1-2 of the following questions, without interruption or crosstalk.

1. What explicit steps, if any, should be taken to prevent and better prepare for future pandemics?
2. What role should the federal government play in combating future pandemics? What about state and local governments?
3. How should countries cooperate, if at all, in addressing future pandemics? What role should national and international agencies (such as the CDC and WHO) play in this process?
4. In the next pandemic, what should be left to individual choice, and what should be mandated?

After everyone has spoken once, the group is welcome to continue discussing these questions as time allows. Participants are encouraged to ask clarifying and follow-up questions.

Reflections (10 min.)

While today's conversation is an important step in the journey, effectively learning from the COVID-19 pandemic and preparing for the future is necessarily an ongoing effort. Please reflect on the insights from your discussion with your fellow participants today, and then answer one of the questions below without interruption or crosstalk. After everyone has answered, the group is welcome to continue exploring additional questions as time allows.

1. What was most meaningful or valuable to you during this deliberation?
2. Where are the areas of both agreement and disagreement in your group?
3. Have any new ways to think about this issue occurred to you as we have talked today? Any new ideas that might transcend our current way of conceiving of the problems and potential solutions?
4. Was there anything that was said or left out from the discussion that you think should be addressed with the group? Are there any perspectives missing from this conversation that you feel would be important to hear?
5. What did you hear that gives you hope for the future of conversations about global pandemics?
6. Is there a next step you would like to take based upon the deliberation you just had?

About This Guide

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The Deliberative Citizenship Initiative

The Deliberative Citizenship Initiative (DCI) is dedicated to the creation of opportunities for Davidson students, faculty, staff, alumni, and members of the wider community to productively engage with one another on difficult and contentious issues facing our community and society. The DCI regularly hosts facilitated deliberations on a wide range of topics and organizes training workshops for deliberation facilitators. To learn more about these opportunities, visit www.deliberativecitizenship.org.

DCI Deliberation Guides

The DCI has launched this series of Deliberation Guides as a foundation for such conversations. They provide both important background information on the topics in question and a specific framework for engaging with these topics. The Guides are designed to be informative without being overwhelming and structured without being inflexible. They cover a range of topics and come in a variety of formats but share several common elements, including opportunities to commit to a shared set of Conversation Agreements, learn about diverse perspectives, and reflect together on the conversation and its yield. The DCI encourages conversations based on these guides to be moderated by a trained facilitator. After each conversation, the DCI also suggests that its associated Pathways Guide be distributed to the conversation's participants.

DCI Pathways Guides

For every Deliberation Guide, the DCI has also developed an associated Pathways Guide, which outlines opportunities for action that participants can consider that are related to the covered topic. These Pathways Guides reinforce the DCI's commitment to an action orientation, a key deliberative disposition. While dialogue and deliberation are themselves important contributors to a healthy democracy, they become even more valuable when they lead to individual or collective action on the key issues facing society. Such action can come in a range of forms and should be broadly understood. It might involve developing a better understanding of a topic, connecting with relevant local or national organizations, generating new approaches to an issue, or deciding to support a particular policy.

If you make use of this guide in a deliberation, please provide attribution to the Deliberative Citizenship Initiative and email dc@deliberativecitizenship.org to tell us about your event. To access more of our growing library of Deliberation Guides, Pathways Guides and other resources, visit www.deliberativecitizenship.org/readings-and-resources.

Notes

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