Paying for the Consequences. How Privatization and Austerity Disabled Infection Protection Law

By *Helena Alviar García* and *Günter Frankenberg*[*]

Abstract: The authors argue that the privatization of health care not only privileges profitable health provision and loses sight especially of community services and basic medical treatment but also tends to imply a crippling change of the legal tools available to face a pandemic. Privatization, flanked by austerity programs, disempowers public health institutions and authorities as well as disables the regular legal regimes covering public health. When confronted by a pandemic, they hold, privatized systems lay bare the limitations of healthcare understood as a business and framed within insurance contracts, not universal rights. After introducing the core elements of neoliberalism and the tailor-made reduction of law's vertical, regulatory power the authors discuss in which respects public health systems are privatized how deregulation, austerity and reduced welfare are essential to privatization. They show how the law of danger prevention is replaced by a legal regime of market transactions, focusing on the liberalized elements of healthcare and some of the crucial legal instruments in various socio-economic and political contexts. In the final section follows an analysis of various legal strategies in a few selected countries that illustrates how privatization disabled regular infection protection law and as a consequence favored authoritarian responses to the pandemic.

***

A. The Argument

Contagious diseases, first and foremost epidemics and pandemics can hardly be negotiated within the legal framework of contractual relations and market transactions. Because of their diffusion, health damages have widely dispersing and often lethal effects. As a consequence, they need to be coped with and contained by instruments of public law designed to protect universal health and to avert wide-ranging dangers. Public law structures the relationship between the state and its citizens, therefore it is particularly suited to trace chains

* We thank Michael Blecher and the anonymous reviewer for their very helpful comments on the original version of this article. Helena Alviar García, Professor of Law at Sciences Po, Paris (France) - helena.alviar@sciencespo.fr. - Günter Frankenberg, Professor of Public Law, Philosophy of Law and Comparative Law at Goethe University in Frankfurt am Main (Germany) - frankenberg @jur.uni-frankfurt.de.

of infection and authoritatively regulate behavior (personal hygiene, social distancing and wearing masks) so as to prevent contagion and administer vaccinations, to treat those who are critically ill, and dispose of bodies. The urgency and scale of these tasks usually qualify them not as matters of free choice and negotiated agreement but of command and control, notwithstanding the authoritarian risks these types of measures entail. Granted, the success of top-down orders also depends on the interaction with, and the responsible practice of, individuals and groups. During past and recent pandemics, most societies passed infection protection acts, pandemic plans and special branches of their regimes of police or security law were in charge of the prevention of dangers. In general, they are measures intended to isolate those who are infected or under suspicion of being carriers of the virus, to provide for mechanisms of surveillance and punishment, and a security apparatus that registers statistically the number of 'cases', the infection curve, the rate of transmission, the immunity model, and the mortality rate.[1] As a rule, constitutions (or extraconstitutional habits and traditions) come to the aid of statutory infection law with a state of exception or emergency law to be formally declared and applied if necessity or urgency so requires.

The relationship between 'normal law' and the state of exception is always strained and ambiguous; and its dynamic in severe crises when 'necessity knows no law'[2] is hard to predict. More specifically, we want to show that the privatization of health care not only privileges profitable health provision and loses sight especially of community services and basic medical treatment but also tends to imply a crippling effect of the regular legal tools available to face the crisis. By definition, privatization, flanked by austerity programs, disempowers public health institutions and authorities. It is less obvious that it also disables the regular legal regimes covering public health. When confronted by a pandemic, we try to show, privatized systems lay bare the limitations of healthcare understood as a business and framed within a sometimes-costly insurance contract,[3] not a universal right. These limitations make it difficult to activate the first medical lines of defense against infection, such as family doctors, community health clinics, etc. Instead, privatization and underfunding of public health promote a corporate model that privileges drug research and specialized hospital services, and makes sure that medical procedures and products are evaluated according to cost efficiency and profit maximizing, while relinquishing the capacity of the state to ex-

1 Compare the legal responses, say of Germany (Infection Protection Act), Italy (Testo Unico delle Leggi Sanitarie) and South Korea (Infectious Diseases Control and Prevention Act, Act No. 9847, Dec. 29, 2009, amended by Act No. 17067), with *Michel Foucault's* security modalities in his first lecture in id., Security Territory Population – Lectures at the Collège de France 1977-1978, London 2007.

2 *G. Frankenberg*, Comparative Constitutional Studies – Between Magic and Deceit, Cheltenham 2018, p. 261 ff.; *A. Harel* and *A. Sharon*, "Necessity Knows No Law": On Extreme Cases and Uncodifiable Necessities, University of Toronto Law Journal 61 (2011), p. 845 ff.

3 In the United States, health insurance for a family of four – including all extra-payments and retentions – may amount to 25.000 USD per year, not counting prescription drugs and extended hospital stays. Which means that diseases are unaffordable for the not so well-to-do, see *C. Hulverscheidt*, Hegemon auf Talfahrt, Süddeutsche Zeitung 2. October 2020.

peditiously and effectively implement anti-pandemic plans. It can be observed that governments in countries with highly privatized healthcare systems, if deprived of the standard public law instruments, responded to the threat of the pandemic by more readily accessing the legal armory of extraordinary measures catered by emergency law or a (normalized) state of exception.[4] So, the broader the space for contractual relations covered by private law (patients, hospitals, and insurance companies), the less a state can rely on public health law to provide the necessary health services and needs to resort to authoritarian measures to keep people in quarantine and this way avoid that they flock to an unprepared hospital system, notably put a strain on the intensive care units.

One may argue that epidemics have a tendency to generate authoritarian responses, however, we want to discuss a different aspect of such authoritarianism. During the last year many autocrats exploited COVID-19 for Machiavellian moves to bolster their powers.[5] Others downplayed the crisis with an economic subtext: the economy should not be burdened with lockdowns, shutdowns and other harsh interventions.

After briefly introducing the core elements of neoliberalism and the tailor-made reduction of law's vertical, regulatory power (B.) we show in which respects public health systems are privatized (C.) how deregulation, austerity and reduced welfare are essential to privatization. In addition, we want to show how the law of danger prevention is replaced by a legal regime of market transactions (D.). We focus on the liberalized elements of healthcare, in particular the cover narratives justifying privatization, and some of the crucial legal instruments in various socio-economic and political contexts. (E.), we analyze various legal strategies – short scenarios rather than case studies or 'thick accounts' – in a few selected[6] countries in order to illustrate how privatization disabled regular infection protection law and as a consequence favored authoritarian responses to the pandemic.

B. A Note on Neoliberalism

Neoliberalism, a contested concept and political-economic agenda, revamped 19th century's ideas of *laissez-faire* liberalism, capitalism and a corresponding governance regime. Despite differences in detail, most defenders and critics agree that the combination of policies of privatization, globalization, and free trade fairly neatly captures the essence of ne-

4 However, Corona does not generate simply one authoritarian legal response but a variety characterized by different institutional arrangements and governance styles, see, e.g. Brazil, Chile, Colombia, Ecuador, Hungary, Italy, India, Turkey, and the United States.

5 E.g., again having the differences in view, displayed by Lukashenka in Belarus, Bolsonaro in Brazil, Modi in India, Johnson in the United Kingdom, and Trump in the United States.

6 From the countries under review here, we focused on privatized, non-privatized and hybrid regimes. Rather than attempting a systematic comparison, we had to settle for exemplary studies hoping that some of our readers will be tempted to pursue systematic investigations.

oliberalism.[7] Whatever definition or perspective chosen, the concept of *privatization* is usually paired with *austerity* and invariably comes with demands for *deregulation.*[8] Deregulation implies the reduction of regulatory governmental interventions and controls endorsed by law, to allow for more competition and corporate leeway in decision-making, and to reduce regulatory and transaction costs. In general, privatization changed the register from the regulatory (legal) power of government to business self-regulation and, in consequence, from administrative law to the legal regime of price and profit oriented market transactions, especially contract and property law, complemented by what is celebrated as 'voluntary self-restraint'.

A further aspect of the basic strategy to be pursued by market societies, according to the widely shared neo-liberal credo, is to drastically reduce government spending in order to increase the role of the private sector. *Austerity* includes budget cuts and as a result underfunding to pave the road for the turnover of public goods and services into private commodities. Not surprisingly, deregulation and austerity help orchestrate and legitimize the takings of capitalism: its advance into non-economic domains where private enterprises produce public goods, such as education, security, incarceration, and as will be shown below, health services. Thus, capitalist cannibalism devours what once were and now should again be commons[9], like water supply, the rain forest, natural energy and a society's wellbeing.

C. Deregulating and Underfunding Public Health

In the domain of healthcare, neoliberal strategies usually limit state interventions and regulatory legal forays and instead favor the private production of medical and care services, notably the specialized and therefore profitable treatment in hospitals. In this way public policy and law crafted to plan and design the adequate and universal provision of a fundamental right is replaced with private law, property rights, and corporate governance. By the same token, the World Bank, the IMF and many national governments helped dismantle the institutions allocating public health: they fragmented or took over local health systems, reduced government health spending, undermined national and local control of health programs, and encouraged or tolerated demoralizing working conditions in the health sector.

7 Regarding the history, ideologies and varieties of neo-liberalism see: *Friedrich von Hayek*, The Road to Serfdom, Chicago 1944; *Milton Friedman*, The Social Responsibility of Business is to Increase Its Profits, The New York Times Magazine 1970, pp. 32 ff. and 122 ff.; *D. Leshem*, *The Origins of Neoliberalism: Modeling the Economy from Jesus to Foucault,* New York 2017; and *Q. Slobodian*, Globalists: The End of Empire and the Birth of Neoliberalism, Cambridge 2018; *T. Biebricher*, Die politische Theorie des Neoliberalismus, Frankfurt 2021.

8 See *G. Stigler*, The Citizen and the State: Essays on Regulation, Chicago 1975; *Paul Krugman,* Laissez Not Fair', The New York Times December 11 2001.

9 See *D. Feeney* et al., The Tragedy of the Commons: Twenty-Two Years Later, Human Ecology 18 (1990), No. 1.

I. Privatization as Austerity

Hence, it does not come as a surprise that since the 1970s the public health systems of many countries were stripped of their welfare underpinnings and forced to go through the acid bath of austerity. Catchwords were 'adjustment' or 'restructuring'.[10] During the 1980s, most of Latin America was subject to Structural Adjustment Programs, led by the IMF and the World Bank.[11] In the 1990s, the former Soviet Union and the states of Central and Eastern Europe underwent similar restructuring 'therapies'.[12] When the 2008 financial crisis brought the global economy to its knees, it only briefly shook the faith in the capitalist system and its neoliberal narratives. Rather than giving rise to a more progressive capitalism, the crisis boosted, in many countries, the ascendance of austerity politics and the re-construction of yet another version of capital-centric, shrunken welfare state and public health models as well as loosely regulated regimes.[13]

Aside from prevention, health budget cuts in OECD countries affected inpatient and outpatient care, pharmaceuticals, and public health coverage. Controlling and reducing spending were blended with the practices of co-payments and user charging.[14] Austerity measures in the wake of the 2008 financial crisis affected, for example, Greece more than any other European country.[15] In particular, the budget of the Greek Organization Against Drugs (OKANA) was cut by more than a half. Preventive medical and psychological services, concerning drug abuse, suicide, HIV infections, etc., were dialed down considerably in a number of European countries.[16] Similarly, several European countries privatized health care financing, health care provision, health care management and operations and, finally, health care investment.[17] Spain, for instance, moved its health system from univer-

10 *K. Rittich*, Recharacterizing Restructuring, Law, Distribution, and Gender in Market Reform, New York 2002.

11 Ibid.; *C. Mesa-Lago*, Social welfare reform in the context of economic-political liberalization: Latin American cases, World Development 25 (1997), p. 497 ff.

12 *S. Johnson and G. Loveman*, Starting Over in Eastern Europe, Cambridge 1995.

13 *D. Stuckler* and *S. Baru*, The International Monetary Fund's Effects on Global Health: Before and After the 2008 Financial Crisis, International Journal of Health Services 39 (2009), p. 771 ff.

14 *G. Quaglio* et al., Austerity and health in Europe, Health Policy 113 (2013), p. 1 ff.; *V. Gool* and *M. Rearson*, Health, Austerity and Economic Crisis: Assessing the Short-term Impact in OECD Countries, OECD Health Working Papers 76 (2014).

15 OECD (2016), Health Policy in Greece, OECD Health Policy Overview, http://www.oecd.org/greece/Health-Policy-in-Greece-January-2016 (accessed 10 July 2020); *A.A. Ifanti* et al., Financial crisis and austerity measures in Greece: Their impact on health promotion policies and public health care, Health Policy 113 (2013), p. 8 ff.

16 *M. Karanikolos* et al., Financial crisis, austerity, and health in Europe, Lancet 281 (2013), p. 1323 ff.; *D. Stuckler* et al., The public health effect of economic crises and alternative policy responses in Europe: an empirical analysis, The Lancet 374 2009, p. 315 ff.; *B. Franklin* et al., Public Health in Europe During the Austerity Years – a Research Report, ILC-UK 2017.

17 *H. Maarse*, The Privatization of Health Care: An Eight-Country Analysis, Journal of Health Politics, Policy and Law 31(5) (2006), p. 981 ff. with further references.

sal coverage, paid for by general taxation, to a contribution-based system, revoking part of the population's entitlements to healthcare. Likewise, health policy in Ireland placed more emphasis on payment by individuals rather than the state, largely through raising the eligibility thresholds or increasing existing charges for inpatient care, prescriptions, and accident and emergency charges.[18] In the United Kingdom, the effects of austerity policies were less palpable as public health spending was devolved from central to local government in 2013. Initially the direct grants from the Department of Health to fund public health programs increased by 5% each year, however, in 2015 the grant was cut by £200 million. In consequence, the combination of reducing grants and placing more responsibilities, such as children's health services, on local shoulders caused a budgetary decline in real terms. Local authorities responded by restricting or stopping public health services.[19]

II. Privatization as "Reponsible Spending"

Privatization of the National Health Service has been a controversial issue in the United Kingdom for quite some time. Thatcherism combined the radical critique of social-democracy (labor) with the adoption of key neoliberal strategies, in particular the government's public sector reforms applied business principles to the welfare state and prepared the National Health Service for subsequent privatization.[20] Thatcherism introduced the 'responsible spending' cover story that was later picked up by 'New Labor' and the May and Johnson Governments. The ensuing disparity between public and private interests, social inequality, and the damages to the health and wellbeing in Britain have been actively ignored by prime ministers since Margaret Thatcher who did not want 'the nanny state' to tamper with people's private health decisions. Despite introducing entrepreneurial public health management, she backed off plans to completely replace the National Health Service by a health insurance system.

Neoliberals, supporting Thatcherism and 'New Labor', never got tired to indicate, for instance, that rates of successful cancer treatment are lower in the UK's government run hospitals compared to their privatized counterparts in the Netherlands or their mixed public-private counterparts in Germany. They argued that by allowing elements of the NHS to be privatized these services might better be performed by corporations seeking to maximize profits, and that competition would provide fast-track and higher quality treatment.[21]

18 *S. Thomas* et al., The Irish health-care system and austerity: sharing the pain, The Lancet 383 (2014), p. 1545 f.

19 *B. Franklin* et al., Public Health in Europe During the Austerity Years, ILC UK November 2017, p. 37; and *Maarse*, fn. 17.

20 *A. Scott-Samuel* et al., The impact of Thatcherism on health and wellbeing in Britain, International Journal of Health Services 44 (2014), p. 53 ff. with further references.

21 *C. Poling*, Privatizing Britain's NHS, Georgia Political Review, 30 June 2018; *H. Buckingham* and *M. Dayan*, Privatisation in the English NHS: Fact or Fiction, <https://www.nuffieldtrust.org.uk/news-item/privatisation-in-the-english-nhs-fact-or-fiction/ (accessed 18 February 2021).

Whereas most British citizens abhor privatization – based on their experience with privatized railroads –, the May Government followed its predecessors, including 'New Labor', and continued the process of reducing the public sector and making room for the profit motive in public (health) services. Justifying austerity as 'responsible spending,' the May Government slashed funding for the NHS, forcing nurses to work longer hours for significantly less pay – or else leave their job and migrate to private companies that offer better salaries, thus creating further inefficiencies in treatment time and public healthcare quality. Similar to the railroads, a once united system was being partly dismantled and handed over to business entities. Rather than coordinate their policies, they are likely to pursue their own strategy and perhaps even actively sabotage each other if profit so requires. During the last decade, the gulf between the resources allocated to services and the resources needed to provide adequate care has increased considerably and private healthcare providers in direct competition with the NHS have grown steadily. Vast portions of the NHS are already in the hands of private sector entities. In 2017–18, £8.8 billion of the health service budget went to 'independent sector' providers—a 50 percent increase compared with 2009-10.[22] The 'Responsible Spending' strategy was aptly described as a toxic combination of underfunding and stealth privatization.[23] As a result of 'responsible spending' £ 700 million in real terms were cut between 2015/16 and 2029/29.[24]

C. Narratives of Deregulated Healthcare

Privatization has repeatedly raised concerns over efficiency and coordination, lack of capacity and expertise. Negative repercussions of privatization are particularly touchy issues in the sensitive field of a society's health and wellbeing and call for narratives of justification. Some of the more common problems and 'cover narratives' are briefly discussed here. They range from invoking necessity (to balance the books) to ideological convenience (search for comparative advantages). As the examples illustrate they tend to be justified as better meeting consumer demands and making more efficient use of resources.[25]

I. Privatization as Necessity

In a number of countries, like Brazil, Italy and the United States, private agencies have increasingly performed public health functions, such as primary care services and chronic disease testing and treatment, whereas public health agencies have sought to balance the per-

22 *Poling*, fn. 21.

23 By *N.H. Zapala*, How to Destroy a National Health Service, https://www.thenation.com/article/world/destroy-britain-nhs-privatization/ (accessed 18 February 2021).

24 https://www.local.gov.uk/parliament/briefings-and-responses/health-and-local-public-health-cuts-house-commons-14-may-2019/ (accessed 18 February 2021).

25 See *S. Villa* and *N. Kanes*, Assessing the Impact of Privatizing Public Hospitals in Three American States, Value in Health 16 (2013), p. 524 ff.

sonal health and population health services they can provide.[26] Critics considered, for example, the United States' public health system in absolutely urgent need of organization because of the inefficient division of labor between the national government, the states and local institutions that resulted in unclear accountability within a fragmented authority structure. Moreover, the system was marked by underfunding and quality problems, disparities across socioeconomic groups, and a racist bias. During the 1990s and the first decade of the 21st century, local health departments in the US have contracted out for primary care services, communicable disease control services, chronic disease testing and treatment, personal health services laboratory work, home health care, substance abuse services, health education, and environmental health services.[27] While public hospitals used to represent a significant share of the providers and, in particular, also served as community hospitals for lower-income neighborhoods and were specialty providers for publicly-funded patients, quite a few states of the U.S. have privatized them and thus destroyed or weakened this 'safety-net' for the uninsured.[28] Private hospitals cut outpatient services, trauma centers, psychiatric emergences services and community services. Budget cuts and the outsourcing of health services were usually legitimized as necessary to reduce social spending, including expenditures for public health and health care delivery, in order to balance the budget. In the back looms the argument that universal access to public health services is simply too costly.

Brazil used to have a comprehensive Unified Health System that provided nearly universal access to health care services, since 1988 underscored by a constitutional guarantee.[29] Starting under the military regime and supported by the World Bank, the health care system was 'reformed' over the years, which is to say, step-by-step dismantled and partly privatized as well as rendered anaemic by budget freezes and cuts to health services.[30] The reforms were 'sold' to the general public as inevitable austerity measures within the larger national scheme to reduce public expenditures.[31]

26 Critical *D. Beauchamp*, Public health, privatization, and market populism: a time for reflection, Quality Management in Health Care 5 (1997), p.73 ff.; *Committee on Public Health Strategies to Improve Health - Institute of Medicine*, For the Public's Health: Investing in a Healthier Future, Washington (DC) 2012.

27 *C. Keane* et al., Services privatized in local health departments: a national survey of practices and perspectives, American Journal of Public Health 92 (2002), p. 1250 ff.

28 *S. Villa* and *S. Kane*, fn. 25.

29 See Art. 6, 196-198 Constitution of Brazil (1988, rev. 2017).

30 *F. Ortega* and *M. Orsini*, Governing COVID-19 without government in Brazil: Ignorance, neoliberal authoritarianism, and the collapse of public health leadership, Global Public Health 15 (2020), p. 1257 ff. with further references.

31 *L. Montenegro* et al., Public Health, HIV Care and Prevention, Human Rights and Democracy at a Crossroad in Brazil, AIDS Behavior 24 (2020), p. 1 ff.

II. Privatization and Subsidiarity

In the 1990s steady increases in health-care costs and perceived inefficiency in Italy created political pressure to increase the role of the private sector in provision and decentralization of health policy responsibilities.[32] During the corona crisis, especially the first and the second 'wave' in the Spring and Fall of 2020, the structural problems of the Italian healthcare system emerged dramatically. While the structure consists of a strong private component and a series of large, modern and efficient hospitals, which some argue have been an effective barrier to the COVID-19 disease, others focus on a variety of problematic aspects that explain, at least in part, why the crisis shook the Lombardy region to the core.[33] According to the critics, privatization of health services in Lombardy had two striking features: First, Roberto Formigoni, the president of the region from 1995 – 2013, combined a neoliberal strategy with the Catholic doctrine of subsidiarity.[34] The doctrine that central authorities should have a subsidiary function contributed to the already weakened (national) public health service and claimed to create a system centered on the citizen's freedom to choose whether to be treated by the public or private health service rather than on municipal provision of health services. His concept was facilitated by national healthcare reforms that had been transforming Italian hospitals increasingly to companies, with autonomous budgets and managerial administration. The reforms in question also granted the regional governments – responsible for healthcare, pursuant to the Constitution – the autonomy to organize the services as they saw fit.

Second, about half of the healthcare sector in Lombardy had been in private hands, yet it supplied only one quarter of the intensive care beds.[35] Since private companies work in the healthcare sector to make profit, they focus on the type of services that is profitable, especially examinations, complex surgical operations and specialist visits. Other services that happen to be crucial to cope with a pandemic, like prevention, care of the elderly, and intensive care treatment of rare diseases, are generally considered unprofitable and, for this reason, as far as possible left to public hospitals. Moreover, and due to the progressing pri-

32 *C. Quercioli* et al., The effect of healthcare delivery privatisation on avoidable mortality: Longitudinal cross-regional results from Italy, 1993-2003, Journal of Epidemiology and Community Health 67 (2012), p. 1 ff.; *M. Ferrera*, The rise and fall of democratic universalism: health care reform in Italy, 1978-1994,Journal of Health Politics, Policy and Law 20 (1995), p. 201 ff.

33 See *D. Tega* and *M. Massa*, Fighting COVID 19 – Legal Powers and Risks: Italy,https://verfassungsblog.de/fighting-covid-19-legal-powers-and-risks-italy/ (accessed 17 February 2021); *D.M. De Luca* et al., Two months that shook Lombardy, il post, 7 May 2020 - <https://www.ilpost.it/2020/05/07/two-months-that-shook-lombardy-to-the-core-coronavirus/> (accessed 11 July 2020).

34 Pope Pius's Encyclical *Quadragesimo anno*, promulgated in 1931, responded to Fascist and Soviet centralism, and to capitalist individualism, by propagating subsidiarity as the doctrine that central authorities should have a subsidiary function, performing only those tasks that cannot be discharged effectively at a more immediate or local level.

35 *De Luca* et al., fn. 33; and id., Why Lombardy was hit harder than Italy's other regions - <https://www.theguardian.com/world/2020/may/29/why-was-lombardy-hit-harder-covid-19-than-italys-other-regions/> (accessed 15 October 2020).

vatization, community health services provided by general practitioners, out-of-hour services, and local clinics were often neglected during the corona crisis. Privatized care had shifted the focus on hospital treatment (also for the common flu) and undermined the role of the family doctor and community care.

Despite its critics, the Lombardy region was considered by many observers, including their governor, the WHO and the IMF[36] to be capable of dealing with an epidemic caused by an unknown virus, thanks to its healthcare system that is – at least was – regarded as one of best in Italy and Europe. However, during the pandemic the structural problems of the Italian healthcare system began to emerge with a vengeance. When Corona struck the region, it had a shortage of 600 general practitioners and over forty-thousand hours of healthcare support.[37] Privatization had seriously weakened the first line of defense after the outbreak of the pandemic: general practitioners, also referred to as family doctors, who cater to initial treatment and prevent patients from going to hospitals where they risk being infected or transmitting the contagion. What is more, general practitioners were neglected, whereas hospitals received preferential (political) treatment. Consequently, family doctors were basically left to their own devices and had to work in the shadow of the renowned hospitals with neither protective gear nor official guidelines. In return, they had to pay a high price.[38]

III. Privatization as Development

Latin American countries were told again and again, by neoliberal academics and policy makers, that a minimal state would be the key to economic development. This critique of the state was set forth, among others, by P.T. Bauer who famously stated: 'Nations are not poor because they are poor, that is, because of vicious circles; rather they are poor because of too much government interference.'[39] The dismantling of government interference was justified by the basic ideas we described above and crystallized in the elimination of welfare style policies, the privatization of social service provision and the reduction of state investment in certain areas of the economy. With very few exceptions (notably Cuba among them), from the late 1980s through the late 1990s many worker's benefits were eliminated and direct state investment in health and education was diminished. Along with the high levels of inequality that the dismantling of state intervention in health provision brought (as will be described below), private health companies were structured around a business mod-

36 *International Monetary Fund*, A Crisis like No Other' – An Uncertain Recovery, World Economic Outlook Update, June 2020.

37 For a critical assessment see *G. Remuzzi*, La salute (non) è in vendita, Rome 2018.

38 In Italy 151 medical doctors had died of COVID-19 by the end of April 2020, s. aerzteblatt.de, 28. April 2020 - https://www.aerzteblatt.de/nachrichten/112379/151-Aerzte-in-Italien-an-COVID-19-gestorben/ (accessed 09 August 2020).

39 P.T. Bauer, quoted by *J.M. Cypher* and *J.L. Dietz*, The Process of Economic Development, London 1997; see also *P.T. Bauer*, Equality, the Third World, and Economic Delusion, Cambridge 1981.

el that didn't allow them to easily or profitably shift to facing the challenges of the pandemic.

In Chile, for example, the Pinochet regime implemented a market-oriented health reform to lower the fiscal deficit by reducing social expenditure and privatizing the social security system. Regulatory power over private insurers was scarce. In this context, Pinochet's health policy created what was called a 'dual system': public insurance through the National Health Fund (Fondo Nacional de Salud, FONASA), and private insurance through different health insurance institutions (Instituciones de Salud Provisional, ISAPRES). One of the most significant characteristics of this remodeling: it established the stratification of health care. People with higher incomes would select their insurance from what the market offered, people with middle-income would benefit from the FONASA with co-payments depending on their incomes, and the rest would have access to healthcare from state services, if they previously passed the means test (poverty). In line with what would be signaled a few years later by the World Bank as adequate policies in healthcare, Chile also decentralized its publicly supplied services, establishing twenty-nine zones[40] in order to cover thirteen different administrative regions.

The development of a private insurance system and the privatization of services in Chile increased the levels of inequality regarding coverage and access[41]. In consequence, the ISAPRES targeted the rich, impoverished the rest of the social security system and differentiated the quality of care each citizen received according to how much money they earned – and in the Fall of 2020 fueled sustained protests against the government.[42]

Colombia followed a similar privatization path, with some particularities, though. In 1993, under a government influenced by neoliberal policies and World Bank recommendations[43], Colombia launched a market-oriented reform. The government wanted to reach two goals that seem contradictory: diminish state spending in health and provide universal access.[44] The way to do this, according to the advice of the World Bank, was to promote competition between public and private sectors, creating a double tier system similar to the

40 *World Bank* ed., World Bank Development Report of 1993 - Investing in Health, June 1993, 128; *Decreto Ley* 2763 de 1979, articulo 16: "Créanse los siguientes Servicios de Salud, en adelante los Servicios, que coordinadamente tendrán a su cargo la ejecución de las acciones integradas de fomento, protección y recuperación de la salud y rehabilitación de las personas enfermas [...]".

41 *L. Giovanella* and *M. Faria*, Health Policy Reform in South America, in: E. Kuhlmann et al. (eds), The Palgrave International Handbook of Healthcare Policy and Governance, London, 2015, 209.

42 "Workers who opted for enrolment in a private insurance institution (ISAPRE) no longer contribute to public insurance, thus preventing redistribution between lower and higher income workers." Ibid.

43 *R. J.F. Esteves*, The Quest for Equity in Latin America: A Comparative Analysis of the Health Care Reforms In Brazil And Colombia, International Journal For Equity In Health 11, p. 6.

44 *A.V. Bustamante* and *C. A. Mendez*, Health Care Privatization in Latin America: Comparing Divergent Privatization Approaches in Chile, Colombia, And Mexico, Journal Of Health Politics, Policy and Law 39 (2014), pp. 841 ff., 854.

Chilean one.[45] The system consists of a contributory (private providers) and a subsidized regime (which included public resources for health offered by private providers). The contributory regime includes all formal and independent workers who can pay 12% of their salary as a contribution. The subsidized regime targets the poorest members of society by subsidizing their insurance with resources from the contributory regime along with public contributions. As was the case in Chile, decentralization was also an important element of the reform, regulation and supervision was handed over to a weakly funded institution. Importantly, the provision of healthcare services and responsibility for their provision was transferred mostly to private institutions.[46]

This privatization and market-based transformation, far from solving the problems it aimed to solve was translated into very low levels of equality, an inefficient system with scarce quality, and, given the combination of public and private resources managed by insurance companies, opened the door for high levels of corruption.[47] Competition is scarce and provision is concentrated among very few private providers, the oversight is weak and because of the system's complexity the administrative costs of health plans were extremely high. The following quote shows the chaos that characterizes the Colombian system:

> *More than 50 percent of administrative costs are spent on supporting daily operations (financial, personnel, and information management) and enrollment processes. Little is spent on risk management and quality assurance. Delays in the flow of funds from the government to health plans and from health plans to providers are a serious problem…All actors contribute to the problem: providers are slow in charging health plans, health plans spend much time auditing claims, and local governments delay payment to health plans to obtain interest on insurance funds. This constrains providers' capacity to invest in technology and infrastructure and, in general, increases the financial risk of operating their services.*[48]

Another difficulty comes with the fact that in the face of private insurers refusing to offer services they were supposed to provide, citizens crowded in the courts and demanded their right to health. In a vast number of cases, healthcare providers denied services, treatments and medications, forcing people to fight for their right to health. From 1999 to 2012, the judicial system received more than one million *tutelas* (a tool for the protection of constitutional rights —such as the right to health— when they are being violated).[49]

45 *Giovanella* and *Faria*, fn. 41, p. 210.

46 *Esteves*, fn. 43, p. 7.

47 *C. E. Abadía-Barrero*, Neoliberal Justice and The Transformation of the Moral: The Privatization of The Right To Health Care In Colombia, Medical Anthropology Quarterly 30 (2015), pp. 62 ff., 63.

48 *D. Pinto* and *W.C. Hsiao*, Colombia: Social Health Insurance with Managed Competition to Improve Health Care Delivery, Social Health Insurance for Developing Nations, Washington DC 2007.

49 *Abadía-Barrero*, fn. 47.

D. Containing Corona: Patterns and Problems of Legal Regulation

From a not very recent report of the World Health Organization one may infer that adequate legal responses to an influenza pandemic presuppose strong health and social (welfare) systems, and a comprehensive strategy.[50] Under the impression of the corona-virus, the WHO urged to include the tracing of infection chains, quarantine, and attending to those who have developed COVID-19.[51] Accordingly, infection protection laws in countries like Germany, Japan, New Zealand, Singapore, South Korea, and Taiwan that more or less followed the WHO course could rather successfully contain the pandemic, especially because they also rested on efficient public medical and social services. In the following, we discuss various legal-political constellations where the privatization of health services and the commercialization of medicine frustrated comparable efforts.

I. Emergency Rule 'with Chinese Characteristics' - a Digression?

Whoever wants to talk about corona and law, with the neoliberal framing presented above, cannot remain silent about China. While China, at first glance, does not qualify as a site of neoliberalism or privatization, we argue that, on closer scrutiny, the oxymoron can be deconstructed and, hence invite China into the circle of neoliberal economy:

> *China's relation with neoliberalism as a mode of economic governance is contested and contradictory. Scholars and activists on the left criticize China for its neoliberal authoritarianism. Neoliberals celebrate China's growth success as a result of market reforms, yet they attack China for its incomplete reforms, its interventionist state, and a lack of compliance with the liberal international order. At the same time, development economists with an industrial policy mission see China's developmentalist state as a challenge to the quintessentially neoliberal Washington Consensus.*[52]

The 'socialist market economy with Chinese characteristics'[53] combines features of the old-style socialist command regime with traits of a quite modern version of capitalism: a market economy without universal private property, monitored by a government that reserves its rights to exercise control of the economy and society. Despite party-supervision, social scoring and state interventions, Chinese-style capitalism is driven very much like its

50 *WHO Interim Protocol*, Rapid operations to contain the initial emergence of pandemic influenzas, Geneva October 2007 - https://www.who.int/influenza/resources/documents/RapidContProtOct15.pdf/> (accessed 10 February 2021).

51 *WHO*, Infection prevention and control during health care when novel coronavirus (nCoV) infection is suspected. Interim guidance, Geneva 2020.

52 *I. Weber*, Origins of China's Contested Relation with Neoliberalism: Economics, the World Bank, and Milton Friedman at the Dawn of Reform, *Global Perspectives* 1 (2020), p. 12271. For a skeptical view see *R.D. Atkinson*, "Chinese Capitalism" is an Oxymoron, National Review, 20 May 2019.

53 Article 11 Constitution of the People's Republic of China (PRCC).

Hayekian siblings by the imperative of growth and profit, as well as propelled by private enterprises. Market-based transactions are considered to be the key to prosperity by this imitated, centralist and authoritarian version of neoliberalism with Chinese characteristics.[54]

Corona hit the city of Wuhan and the surrounding Hubei province first, arguably it originated there - somewhere.[55] The national and local authorities demonstrated to the world, after first misconstruing Corona as a flu, how cope with the new s*evere acute respiratory syndrome-related coronavirus*, and thus became the example, for better or for worse, that would instruct the political-legal approaches of other governments. Wuhan, like megacities everywhere, drives capitalist production and urbanization onto the ecological balance at the expense of the natural lifeworld.[56] China appears to have become aware of the possible, ecological dimension of an infectious disease that is, yet again, transferred from 'wildlife' to humans, and which arguably has the potential to supersede the difference between neo-Keynesian, neoliberal and other economic strategies (as long as they are based on lifeworld takings). From today's perspective, capitalist expansion is firmly entrenched in Chinese-style authoritarian neoliberalism. Perfidiously, the 'Law on the Prevention and Treatment of Infectious Diseases' (1989) regulates:

> *Article 19. Before a large construction project is started in an area, which is a natural infection focus or a possible natural infection focus, the construction unit shall apply to the local anti-epidemic agency for a sanitary investigation of the construction environment and take necessary anti-epidemic measures according to the requirements of the anti-epidemic agency.*[57]

To contain the COVID-19 contagion, the Standing Committee of the National People's Congress, in one of its early decisions, which set aside the statutory provisions, banned the 'Illegal Wild Life Trade' and abolished the 'Bad Habit of Excessive Eating of Wild Animals' on 24 February to effectively protect 'People's Lives, Health and Safety'.[58]

After China's initial misreading of the Corona-outbreak in Wuhan as a common flu or pneumonia[59], then like a new version of SARS (Severe Acute Respiratory Syndrome), the

54 Oxymoronic or not, Chinese capitalism has proven to be quite successful.

55 After a recent mission of the WHO the origin of the pandemic is still unclear. See *Science*, 14 February 2021 - https://www.sciencemag.org/news/2021/02/politics-was-always-room-who-mission-chief-reflects-china-trip-seeking-covid-19-s/ (accessed 18 February 2021).

56 To explain at least tentatively the varying patterns of epidemic/pandemic disease circulation that have "affected human affairs in ancient as well as in modern times", we take some - at this point still very tentative - cues from the studies of *W.H. McNeill*, Plagues and Peoples, Garden City 1976, p. 4 f.; *D. Crawford*, Deadly Companions. How Microbes Shaped our History, Oxford 2007; and *J.C. Scott*, Against the Grain, New Haven/London 2017.

57 Ministry of Commerce - http://english.mofcom.gov.cn/article/lawsdata/chineselaw/200211/20021100050619.shtml/> (accessed 24 August 2020).

58 China's Fight against COVID-19, China Daily, 19 April 2020. See also *U. Mattei* et al., The Chinese Advantage in Emergency Law, *Global Jurist*, August 2020.

59 The first Corona case was *officially* identified in China on 7 January 2020.

rule of law 'with Chinese characteristics',[60] that is a layered regime of emergency regulations,[61] was brought to bear against what rapidly developed into a regional epidemic and supplanted the regime of horizontal provisions in the market-oriented sectors.[62]

The Asian flu 1957 with 1.1 million deaths, the Hong Kong flu (1968), the Bird Flu A (H5N1) in 1997 and especially the SARS 2003 epidemic should have prepared the Chinese Government for another epidemic. Still, it took a while for the central working group to mobilize national and local authorities to implement the 'Master State Plan for Rapid Response to Public Emergencies' (2006), and the 'Law of the People's Republic of China on Responses to Emergencies' (2007). To avoid a country-wide lockdown and shutdown of the dynamic economy, the national government and local teams ordered drastic emergency measures, in particular shutting down life and business in Wuhan, closing the borders of the province, suspending public commuter and mainline systems, tracing contacts, self-isolation, banning assemblies on public places for entertainments, political gatherings and markets, and keeping schools closed. At the same time, the workgroups focused on supplying medical equipment, protective gear and providing hospital treatment.

Before long, China fought a centrally monitored 'people's war of disease prevention' in Hubei province and Wuhan, with central and local authorities implementing extremely strict emergency laws, based on the 'four earlys': early prevention, early detection, early diagnosis, and early quarantine. This campaign was supported by peoples' discipline and compliance but had all the features of a straightforward state of exception – unimpeded by privatized institutions or services, rule of law concerns or plans to educate the public about the epidemic. Since transparency is not exactly a virtue of the government, but still an experiment, and after the initial gag orders, cover-ups and ignored help offers from overseas, China's official corona statistics can hardly be trusted.[63]

60 For a somewhat apologetic description of the emergency regime and practice, with Xi Jinping omnipresent as something like Little Red Riding Hood, see *U. Mattei* et al., fn. 58.

61 *M. Tao*, Emergency Laws in China: Their Formation, Present Situation and Future, Social Sciences in China 32 (2011), pp. 124 ff. and 222 ff.

62 Regarding the shifts between market-orientation and reinstating the government's role: *W. Yip* and *W. Hsiao*, Harnessing the privatization of China's fragmented health-care delivery, The Lancet 384 (2014), p. 805 ff.

63 See, however, *J.P. Horsley*, The Chinese Communist Party's Experiment with Transparency, The Diplomat, 02 February 2018. Regarding the corona statistics: *S.N. Romaniuk* and *T. Burgers*, Can China's COVID-19 Statistics Be Trusted?, The Diplomat, 26 March 2020; *J. Wallace*, Numbers Aren't Reality But You Can't Govern Without Them, Foreign Policy, 01 December 2020.

II. State of Exception with Italian Characteristics

'In terms of the next pandemic, in recent years there have been I don't know how many conferences, meetings, study groups, awareness campaigns, European Commission meetings and World Health Organization alerts'.[64]

Italy's time of distress began on 20 February 2020 when the Corona 'paziente zero', who had flown in from Wuhan, was identified in the town of Codogno (Lombardy). This happened three weeks after the WHO had officially acknowledged Corona to be a 'public health emergency of international concern'.[65] The next day, the Italian Council of Ministers declared a six-month state of emergency for the national territory and, among other measures, banned air traffic from and to China.[66] However, as the pandemic developed into a catastrophe, the regionalization of health care and the dismantling and privatization of Italy's national health care service impeded the coordination of adequate collective responses and delayed the implementation of a package of coherent legal measures.[67] It soon turned out that the regions of Lombardy and to a lesser degree Veneto, the industrial, wealthy capitalist north of the country, were most severely affected by COVID-19. Early on, the regional authorities, most of them radically authoritarian 'populists' (to be precise: xenophobic nationalists with a libertarian agenda), trivialized the crisis and claimed to defend 'constitutional liberties' against the authoritarian decree laws (*decreti legge*). On February 25, the Governor of Lombardy and a member of the right wing *Lega*, suggested 'to play it down'. 'This is undoubtedly a difficult situation, but it is not dangerous.' In the same vein, the Governor of Veneto described the virus outbreak as a 'media pandemic' or 'international psychosis' and claimed the press had amplified the seriousness of the situation.[68] The Secretary of the *Lega*, Matteo Salvini, found it politically advantageous to oppose the national government. He urged the Lombards not to stop their activities and encouraged the regional government to 'open everything'.[69] While the city of Milan had been spared from the 'Black Death' in 1348, arguably because of strict quarantine measures, and

64 *R. Villa*, member of the Italian Government's COVID-19 task force, quoted by *De Luca* et al., fn. 33.

65 WHO publications are available at https://www.who.int/> (accessed 08 August 2020). China's apparent accomplishment, regardless of the initial misjudgment and the social and psychological costs (quarantine in sealed apartments!), may have suggested to follow its lead.

66 *Mattei* et al., fn. 58 for further references; *A. Simoni*, Limiting Freedom during the Covid-19 Emergency in Italy: Short Note on the New "Populist Rule of Law", Global Jurist 20 (2020), p. 1 ff.

67 See *V. Navarro*, The Consequences of Neoliberalism in the Current Pandemic, International Journal of Health Services 50 (2020).

68 As quoted by *F. Nicola*, Exporting the Italian Model to Fight COVID-19, The Regulatory Review, 23 April 2020.

69 *De Luca* et al., fn. 33. Salvini, the former Minister of the Interior, is one of the leaders against the 'capitulation' of the government to corona, see *RND* 2 June 2020 - https://www.rnd.de/politik/salvini-und-italiens-rechte-demos-gegen-corona-kapitulation-N6JYDKENFDK2KPVIA57CHDOVR4.html/ (accessed 09 August 2020).

was ravaged in 1630 by the last outbreak of the plague, the mayor seemed to selectively repeat history by denying the seriousness of the Corona pandemic.[70] Under pressure from the association of entrepreneurs, the mayor of Bergamo, Gori, a democrat, opposed a strict containment policy and, for instance, the demarcation of 'red zones' and a lockdown.[71]

Hence, during the first phase after the outbreak, cooperation between the national government and the regional authorities were anything but smooth and hardly coordinated like a comprehensive strategy. When finally severe restrictions set in and draconic measures originally prescribed only for the 'red areas' were extended to the national territory, Italy was already well on its way to a national catastrophe – dramatically symbolized by military convoys transporting bodies out of the region of Bergamo to be cremated – with a COVID-19 death toll that soon exceeded China by far.[72]

Italy's legal regime was no match for the pandemic. Though the national government had adopted a first pandemic plan in 2006 and the regions, including Lombardy and Veneto, had done so shortly afterwards, these plans were never pursued coherently and the emergence of the economic crisis and the budget cuts that followed dealt the final blow. Under the auspices of austerity, the plans developed for the 2009 H1N1-Pandemic (Swine Flu)[73] were no longer updated, stocks of medical supplies were not replenished, and medical services were privatized. Hence, the 2009 pandemic was comparable to 'a dress rehearsal generously given to mankind that ended up being wasted'.[74] The country seemed to rely on the Consolidated Health Laws and, for situations of a health emergency, on the somewhat ambiguous Article 77 of the Constitution to legitimize law-decrees and decree-laws passed under the supervision of the Prime Minister.

As was mentioned above, the Lombard health system had been basically remodeled, according to the logic of privatization and the Catholic doctrine of subsidiarity. The decentralized system was to give citizens the choice whether to be treated by the public or private health service.[75] In consequence, privatization 'reforms' disabled the health system to provide the kind of services COVID-19 required. The well-reputed, highly specialized hospi-

70 *M.M. Ciulla*, History repeating. The plague of 1630 in Milan and the COVID-19 pandemia, Acta Biomedica 91 (2020).

71 See *Alzano/Nembro*, Il sindaco Gori - https://video.corriere.it/cronaca/alzano-nembro-sindaco-gori-mai-ricevuto-pressioni-evitare-l-istituzione-zona-rossa/9f487c4e-af48-11ea-a957-8b82646448cc/> (accessed 17 February 2021).

72 On August 8 2020 the WHO reported 84.528 COVID-19 cases, 4.634 deaths and 79.057 cured patients for China and 248.803 cases, 35.181 deaths and 200.976 cured for Italy. Source: CDC of the WHO - https://www.who.int/emergencies/diseases/novel-coronavirus-2019/ (last accessed 08 August 2020).

73 https://www.cdc.gov/flu/pandemic-resources/2009-h1n1-pandemic.html/> (accessed 19 February 2021). The Italian National Pandemic Plan for Preparedness and Response was developed in 2003 and subsequently updated in 2006 according to the 2005 recommendations of the WHO.

74 See *Villa* and *Kanes,* fn. 25.

75 Formigoni was convicted for corruption and spent six months in prison. His successors – Roberto Maroni and Attilio Fontana of the Northern League – have maintained the same approach.

tals were not prepared for a pandemic, and neither the family doctors nor the community health centers were robust enough to step in and take the necessary protective measures, provide assistance, mandatory medical treatment and disinfection. In default of a viable preventative system, Italy, notably Lombardy was literally overrun by the pandemic.[76] In consequence, the national government, actually of a classical social-democratic brand, and the authoritarian, right-wing public health authorities in the regions resorted to emergency law provisions in the tradition of a decree law regime with scant constitutional basis (see Art. 21 and 77 Italian Constitution), that covered the country with a meshwork of decrees, law-decrees and regulations of administrative law. They drastically curtailed the freedom of movement and assembly, ordered shutdowns, banned travel and restricted other civil liberties because there seemed to be little else for them to do. Liberal critics of Italy's corona response, especially of the restrictions of personal freedoms, took stock and criticized them as a singular event in the history of the Italian Republic rather than recognizing the inherent authoritarianism of liberal constitutionalism[77] that manifested itself during the 'phase 1' in Italy and many other liberal democracies. Other critics advanced the thesis that law seemed to have lost its power as an instrument of social organization,[78] some attributing this failure to a conspiracy of (global) political and economic actors, others claiming to observe a general 'falling down' of law.[79]

Both camps of critics may claim that the prerogative operated top-down with an imperative legal style in the name of public health and safety over and above Italy's Consolidated Health Laws.[80] Indeed, the national response more or less disregarded the Consolidated Health Laws (CHL)[81] and the standard measures these laws hold in store, and invoked the state of emergency. The CHL establish a system of reporting and provide for preventative measures, necessary assistance, mandatory medical treatment and disinfection interventions. They authorize the minister of health to issue special orders for the inspection and disinfection of premises, the organization of special services and medical assistance, and the adoption of protective measures against the spread of such diseases. Even though the CHL can be said to normalize the state of exception (see below), during epidemics or pandemics, infection protection is shifted from the level of CHL to the more drastic emergency

76 See *N. Dentico* and *E.R. Fletcher*, World Health Organization's Censorship Of Report On Italy's Pandemic Response Sets Dangerous International Precedent – Critics Say, Health Policy Watch 15. December 2020.

77 The inherent authoritarianism, informed by the prerogative and its offsprings, is elaborated in *G. Frankenberg*, Authoritarianism – Constitutional Perspectives, Cheltenham 2020, Ch. 3.

78 *Mattei* et al., fn. 58, p. 39.

79 Regarding the presumed decay or dereliction of law and democracy see (from the recent literature cultivating an apocalyptic tone) *T. Ginsburg* and *A. H. Hug*, How to Save a Constitutional Democracy, Chicago 2018; *S. Levitsky* and *D. Ziblatt*, How Democracies Die, New York 2018.

80 See the report, Italy: Legal Responses to Health Emergencies, www.loc.gov/law/help/health-emergencies/italy.php/> (last accessed 30 May 2020).

81 *M. Di Paolo* et al., A Review and analysis of new Italian Law 219/2017, BMC Medical Ethics 20 (2019).

decrees and decree-laws to coordinate intervention of national and local/regional authorities in case the first line of public health law defence is weakened or disabled by privatization.

III. Emergency Law in Support of Autocracy

1. Privileging Power

While China had, as some claim, the 'advantage' to implement a straightforward emergency rule, autocrats who in some way or other have been democratically elected, either used the pandemic as a Machiavellian moment to consolidate or extend their powers or to protect the economy.

First, the regimes in Bangladesh, Thailand, Hungary and Venezuela used corona as a convenient pretext to silence critics and further discipline the media.[82] Likewise, Rodrigo Duterte awarded himself additional emergency powers, Vladimir Putin banned demonstrations and Xi Jinping had the digital surveillance intensified. During 2020, autocrats around the world have passed emergency decrees and legislation not only or not at all to cope with the pandemic, instead they used the opportunity to expand their reach during the crisis.[83] Accordingly, they have attempted to control every aspect of the pandemic through whatever emergency 'law' they had at their disposal to exude an aura of total control over an inherently chaotic situation.[84] While Viktor Orbán did not waste time to add new legal instruments to the always already heterogeneous ensemble of authoritarianism in Hungary,[85] he also took a significant, rather conventional step on 30 March to consolidate his autocracy by removing parliamentary control of his decrees. After two and a half months and more than 100 decrees, which are not unlikely to remain in effect for the time being, Orbán's parliamentary majority suspended the emergency law – but passed a new law that authorized the prime minister to 'declare a medical crisis emergency'.[86] Indian PM, Nahendra Modi sent his government down the path of *executive emergency*, bypassing parliament with no

82 See *K. Roth*, How Authoritarians Are Exploiting the COVID-19 Crisis to Grab Power, The New York Review of Books, 03 April 2020, also regarding the following. See also *Politico*, 14 May 2020, about Hungary's controversial corona law.

83 *S. Gebrekidan*, For Autocrats and Others: Corona is a Chance to Grab more Power, The New York Times, 30 March 2020 - https://www.nytimes.com/2020/03/30/world/europe/coronavirus-governments-power.html/
(accessed 26 February 2021).

84 *D. Walsh*, Autocrats' Quandary: You Can't Arrest a Virus, The New York Times, 06 April 2020 - https://www.nytimes.com/2020/04/06/world/middleeast/coronavirus-autocrats.html/ (last accessed 31 August 2020).

85 *G. Frankenberg*, Authoritarianism – Constitutional Perspectives, Cheltenham 2020.

86 *E. Zerofsky*, How Viktor Orbán Used the Coronavirus to Seize More Power, The New Yorker, 09 April 2020.

constitutional and a questionable statutory backing.[87] In default of a constitutional basis for a public health emergency, the government launched its expanded rule by decree with reference to the National Disaster Management Act, the Epidemic Diseases Act of 1897 (!) authorizing state governments, and the Criminal Procedure Act implemented by the local police to justify its nationwide lockdown and brutal crackdown on the population. Likewise, Israel's regime activated measures of counterterrorism and ordered its internal security agency to track citizens using a secret trove of cellphone data developed for the 'war on terror'. Moreover, unrelated to the pandemic, PM Netanjahu decreed the closing of the nation's courts to suspend, at least delay his corruption trial.[88]

Second, autocrats used the crisis to create a perverted Hobbesian moment by denying that that there was a threat to public safety and health, claiming implicitly that everything was well under control. US President Donald Trump initially called the coronavirus a "hoax." Brazilian President Jair Bolsonaro called the virus a "fantasy" and preventive measures "hysterical." Before belatedly telling people to stay home, Mexican President Andrés Manuel López Obrador ostentatiously held rallies, and hugged, kissed, and shook hands with supporters.'[89]

Denialism and ignorance usually come with official statements that are to certify the innocuous nature of the virus. Thus, Tanzania's President John Magufuli championed steam-inhalation and drinking a tonic from the Artemisia plant and believed that prayers would end corona in his country. Further pursuing this idiocy, he refused COVID-10 vaccines for Tanzania.[90] In March 2021 he died after alleged COVID-19 treatment. Likewise, Jair Bolsonaro dismissed corona as a 'small flu', praised a chloroquine-based therapy and called for 'a day of fast and prayer'.[91] Turkmenistan's dictator, Gurbanguly Berdymukhamedov, promoted his book on medicinal plants as a possible solution to corona. (Widespread resistance against his policy suggest, however, that he overestimated his hand at anti-COVID-19 cards.) Belarusian dictator Alexander Lukashenka recommended the 'tractor therapy' against the virus: stay in a good mood, drink vodka and work in the countryside.[92] After the headlines from China, the pictures from Bergamo, and the infection curve in the United States, the population turned a deaf ear to their president's advice and entered the people's

87 See the incisive analysis by *G. Bhatia*, An Executive Emergency: India's Response to Covid-19, https://verfassungsblog.de/an-executive-emergency-indias-response-to-covid-19/ (last accessed 27 August 2020).

88 *Gebrekidan*, fn. 83.

89 *Roth*, fn. 82.

90 *BBC News* 17 June 2020 - https://www.bbc.com/news/world-africa-52983563/ last accessed 31 August 2020; *Munyaradzi Makoni*, Tanzania refuses COVID-19 vaccines, The Lancet, 13 February 2021.

91 *J. Nunes* et al., Brazil: Jair Bolsonaro's strategy of chaos hinders coronavirus response, in: The Conversation, 23 April 2020 - https://theconversation.com/brazil-jair-bolsonaros-strategy-of-chaos-hinders-coronavirus-response-136590/> (accessed 09 September 2020).

92 The Times, 29 March 2020 - https://www.thetimes.co.uk/article/tractors-and-vodka-will-cure-belarus-of-the-coronavirus-says-leader-t6b9xvc55/> (last accessed 27 August 2020).

quarantine on their own initiative, though. India's Hindu-nationalist PM, Nahendra Modi, initially recommended Ayurveda to boost immunity against the virus infection and set up a task force to scientifically validate Ayurveda for use in COVID-19 treatment.[93] US President Trump advised corona could be treated with household detergents.

2. Privileging the Economy

At times, denialism was boosted by strong economic motives that displaced public health concerns. Thus, Turkish authorities took their time before finally admitting that one case had been identified, fortuitously a day after the IMF had announced it would make money available for countries hit by corona. While the pandemic had affected 119 countries, Turkish health authorities and media continued to cover up the infection, most likely for the benefit of tourism.[94] More obviously, the national government of Brazil negated that the pandemic called for governmental intervention. Under the Temer and the Bolsonaro regimes privatization was accelerated at the expense of primary health care, mental health, Indigenous health, and HIV prevention programs. President Bolsonaro first refuted that Brazil had a Coronavirus problem. Then he berated social isolation measures for destroying jobs, as late as the end of July, with over 2 million cases and more than 90,000 deaths in the country.[95] He downplayed the pandemic claiming that 'other ills such as hunger, misery and depression, kill more than the virus' and had the nerve to join protests against 'dictatorial' lockdowns.[96] He even participated in a demonstration during which opposition to regional lockdown measures came forward with calls for a military intervention. His governing COVID-19 stands out for its stunning lack of regard for public health.[97]

Likewise, former US President Trump's health regime bespoke a trend that had been set in motion by some of his predecessors – to expand the commercialization of medicine and with it the private sector in health care, alongside policies of social austerity, legitimized by the hegemonic ideology of neoliberalism.[98] In consequence, most workers in the United States and large parts of the population living under precarious conditions still have defi-

93 The Economic Times, 18 August 2020 - https://health.economictimes.indiatimes.com/news/diagnostics/pm-modi-sets-up-task-force-for-scientific-validation-of-ayurveda-for-treatment-of-coronavirus-says-shripad-naik/75104160. Meanwhile, the WHO registers 1.967,038 cases; 40, 798 deaths; and 1.329,202 cured in India (08 August 2020).

94 Turkey's media ownership structure prevented citizens from receiving reliable information on the coronavirus. Also, as the world's biggest jailer of professional journalists, the Turkish government continued to censor social media. See *E. Kocyildirim*, Only 1 Case? Turkey's Coronavirus Coverup Is A Disaster Waiting To Happen, The National Interest, 11 March 2020.

95 As of 08 April 2021, Brazil registered 13.286,324 cases and 345,287 deaths. https://www.worldometers.info/coronavirus/?utm_campaign=homeAdUOA?Si#countries/> (access 09 March 2021).

96 Coronavirus: Brazil's Bolsonaro joins anti-lockdown protests, BBC News, 20 April 2020; *M. Farmbauer,* Die Wut auf Bolsonaro wächst, t-online, 02 June 2020.

97 *Ortega* and *Orsini*, fn. 30.

98 *Navarro*, fn. 67.

cient social protection and dramatically insufficient insurance coverage.[99] They do not benefit from the contractual coverage of health care. Regulating COVID-19 without the national government also characterizes the Trump administration's approach to the pandemic. Contrary to better knowledge, Trump (supported by some of the Republican governors) combined consistent denialism of scientific evidence with strategic ignorance[100] to keep the economy 'running'. Trump, one of the brashest liars of all autocrats, first denied there was a pandemic problem[101] and called it 'a passing moment in time' that would 'miraculously disappear'.[102] In July 2020 he insisted in the face of a soaring infection rate that 'it was getting under control', that most warnings were 'fake news', and that '99% of COVID-19 cases are totally harmless.' Repeatedly he referred to corona as the 'foreign' or 'Chinese virus' blaming preferably China, but also Mexico or Europe. His repeated 'denial of unsettling facts' corroborates his 'realisation that knowing the least amount possible is often the most indispensable tool for managing risks and exonerating oneself from blame in the aftermath of catastrophic events'.[103] In default of a collective legal or constitutional commitment (under public law) against a common threat or a comprehensive, private law strategy to face the pandemic, the Trump administration declared a 'public health emergency' at the end of January 2020 that had no consequences. It meant that plasma treatment could be used in emergency cases,[104] which observers said did only incrementally change the U.S. Government's position on corona: inaction, lies, and lack of a consistent response.

3. Shooting the Messenger

Most everyone would agree that exceptional situations, like pandemics, call for exceptional measures and legal tools. Two autocratic moments have to be distinguished, though, for they have little if anything to do with containing the contagion. Autocrats like to bring to bear the repressive apparatus, in particular emergency law and criminal law, against whoever issues a warning or sows the seeds of doubt about the official information concerning a pandemic and the efficiency of the measures taken by the government. Rather than concentrate on coping with COVID-19 they focus on suppressing information and public debate.

99 According to the official Health Report almost 29 million people were without insurance coverage in 2019, https://www.census.gov/library/publications/2019/demo/p60-267.html (accessed 15 October 2020).

100 See *S. Lukes*, Power. A Radical View, Cheltenham 2005.

101 *K. Brinkbäumer,* Der paranoide Präsident, Die Zeit 12 March 2020 - https://www.zeit.de/politik/ausland/2020-03/coronavirus-usa-donald-trump-pandemie/> (last accessed 27 August 2020).

102 *C. Paz*, All the President's Lies about the Coronavirus, The Atlantic, 17 August 2020. - 28.526,673 corona cases; 505,326 deaths were registered in the US as of 18 February 2021 - https://www.worldometers.info/coronavirus/?utm_campaign=homeAdUOA?Si#countries/> (access 19 February 2021).

103 *L. McGoey*, Strategic unknowns: Towards a sociology of ignorance, Economy and Society 41 (2012), p. 3; and id., The Unknowers: How Strategic Ignorance Rules the World, London2019.

104 *A. Smith*, NBC NEWS, 24 August 2020.

As of the end of March, more than 400 people were arrested in Turkey for their social media posts about Corona for 'attempting to stir unrest' and almost a dozen journalists were interrogated for their COVID-19 reporting. Likewise, in Hungary, Viktor Orbán turned criminal law against the opposition with a statute that imposes a prison sentence of up to five years for spreading 'false information'[105] that 'obstructs or prevents the successful protection' against the coronavirus.[106] Tanzania's President censored critics of his 'therapeutic' advice. Jordan's government promised to 'deal firmly' with anyone who spreads 'rumors, fabrications and false news that sows panic'. Other autocrats[107] repeated the pattern of shooting the messenger, blaming the bearer of bad news, who might reveal that the autocrat did not measure up to Hobbes' 'mortal God'.

IV. Normalizing the State of Exception

Some countries were able to avoid Machiavellian or Hobbesian moments, among them are Germany and South Korea. While their anti-corona responses are anything but fairy tales, they at least avoided declaring a straightforward state of exception to suspend citizens' rights. And what is more, their containment strategies have been fairly successful during the first phase of the pandemic. They were marked by a constellation of moderate neoliberalism combined with normalized emergency[108] regulations.

On 20 January South Korea registered the first Corona patient: a Chinese national who had flown in from Wuhan. When in February the numbers skyrocketed in particular in the city of Daegu, the government ordered the highest alert level, demarcated special control zones, and soon began to launch a strategy of testing, treating and tracking, which included strictly monitored social distancing within a Foucauldian surveillance scheme. South Korea could draw on its experience with the SARS and MERS[109] epidemics and thus succeeded in

105 *E. Zerofsky*, fn. 86.

106 Hungary: Law to fight coronavirus creates "uncertainty" for journalists, Deutsche Welle, www.dw.com/en/hungary-law-to-fight-coronavirus-creates-uncertainty-for-journalists/a-53027631/> (last accessed 30 March 2020).

107 President J. Magufuli cracked down on critics of his statement that prayers ended corona in Tanzania and his recommendation of a traditional medicine therapy. He died in 2021, allegedly after COVID-19 treatment - https://www.bbc.com/news/world-africa-56437852 (accessed 29 April 2021).

108 The concept of and criteria for normalizing the state of exception are discussed in depth in *G. Frankenberg*, Political Technology and the Erosion of the Rule of Law – Normalizing the State of Exception, Cheltenham 2014, Ch. 1.

109 The Middle East Respiratory Syndrome (MERS) is a viral respiratory illness that is new to humans. It was first reported in Saudi Arabia in 2012 and has since recurrently returned and spread to several other countries; the largest known outbreak was in 2015 in South Korea. Most people infected with MERS-CoV developed severe respiratory illness, including fever, cough, and shortness of breath. Many of them have died.

flattening the infection curve and keeping the death rate very low.[110] The Infectious Diseases Control and Prevention Act, enacted in 2009, complemented by the Quarantine Act, confers upon the Minister of Health and Welfare various powers and obligations, some of them extraordinary, notably to develop a mast plan and to set up a surveillance regime.

Combining neoliberal rationality and a developmental state's governmentality[111] gave South Korea the profile of a unique public-private regime distinguished by a well-funded and efficient system of delivering public services (especially health, energy and public transportation), a single-payer healthcare system ranked the first among the OECD countries, the absence of a welfare regime, and an initially aggressive legal response to the pandemic that was supported by a disciplined and cooperative citizenry.[112] Hospitals are privately run, 97% of the population are covered by the compulsory national health insurance scheme. South Korea seems to be only country where a moderate neoliberalism had the paradoxical effect of strengthening the national government's control over economic policies, which may be due to the fact that neoliberal policies weakened the historically very powerful family-owned conglomerates.[113] What is more, they were popular to the extent that they and sustained the high quality of the public services, including health care, for which the citizens tend to hold the state to account.[114]

In contrast to China's straightforward emergency rule, South Korea's blend of democracy, normalized emergency (surveillance, tracking) and an active civil society seems to have so far succeeded against the virus with a strategy that connected strict governmental measures with citizens' initiatives and, for the most part, favored transparency, openness and public education. The country went from having the highest number of confirmed COVID-19 cases outside China in February to single-digit increases in new cases by mid-April. By November, South Korea registered roughly 30.000 cases and 300 COVID-19 deaths. This success, if it can be trusted, is always threatened, however, by Evangelical sects that deny the existence of a virus, purposely violate the official rules (distancing, self-quarantine) and disable the work of the public health institutions.

South Korea's legal response to the corona crisis combines *detecting* by large-scale testing in special screening clinics set up outside hospitals and special phone-booth style screen

110 On 18 February 2021 South Korea registered a total of 86,128 corona cases, and 1,550 deaths (population over 51 million) - https://www.worldometers.info/coronavirus/?utm_campaign=homeAdUOA?Si#countries/ (accessed 19 February 2021).

111 *T.Y. Kong*, Neoliberal Restructuring in South Korea before and after the Crisis, in: C. Kyung-Sup, B. Fine and L. Weiss (eds), Developmental Politics in Transition. International Political Economy Series, London 2012.

112 See *June-Ho Kim* et al., Emerging COVID-19 success story: South Korea learned the lessons of MERS, Our World in Data, 30 June 2020 - https://ourworldindata.org/covid-exemplar-south-korea/> (accessed 09 September 2020).

113 *D. Hundt*, Neoliberalism, the developmental state and civil society in Korea, Asian Studies Review 39 (2015), p. 466 ff.

114 *T. Hoon Kim*, Why is South Korea beating the coronavirus? Its citizens holding the state to account, The Guardian, 11 April, 2020.

centers, *containing* by isolation and quarantine, *contact tracing* by the Epidemic Intelligence Service with access to personal data, and *treatment* according to a triage system to classify patients' illness. The South Korean legal infection control and prevention regime is marked by provisions (testing and contact tracing; prohibiting high-transmission events; prioritizing mask distribution) that qualify as normalized extraordinary disciplinary regulations and bio-politics relying on statistical covering and surveilling the population. This strategy also allows for innovation and learning 'on the job' and obviously garners popular support because drastic lockdowns and shutdowns have so far been limited or even avoided to keep the economy afloat.

Whereas the experience from MERS, as well as the SARS outbreak in early 2000s taught the Korean Government an important lesson, Corona apparently took German governments on the national and state level by surprise. Contrary to original plans, they had stored neither face-masks[115] nor protective gear for hospitals, let alone test kits. A Chinese citizen had transmitted the infection to a colleague in a Bavarian company and the first patient was identified in Germany on 28 January.[116] What followed during the next year still looks like a not very streamlined but rather successful attempt to contain the pandemic without resorting to the state of exception despite the not always smoothly concerted efforts of the federal and state authorities, but to rely on social distancing, quarantine, personal hygiene and, if need be, also lockdown, shutdown, curfew and closed borders.

The German Infection Protection Act (IPA) provides a danger prevention scheme for the national and regional authorities that resembles the Italian Consolidated Health Laws. On closer scrutiny, the IPA, especially after its revisions in Spring 2020 and in early 2021, empowers the Federal Minister of Health and the regional public health authorities to take emergency measures that are treated as the standard *modus operandi* of infection control. The IPA, one could argue, normalizes the state of exception by introducing, in response to the pandemic, extraordinary executive measures in the guise of ordinary regulations: The Federal Minister of Health is entitled to sidestep regular legal procedures and rule by decree once the Federal Diet has declared an 'epidemic situation of national importance' (§ 5(2) IPA), thus invoking the infamous emergency ordinances which contributed to the decline of the Weimar Republic and the erosion of its Constitution.[117] Furthermore, the IPA contains a rather generous framework to be filled out by decrees and ordinances of the *Länder* (the member states of the Federal Republic), authorizing all 'necessary protective measures' 'to the extent and for as long as necessary to prevent the spread of communicable diseases'. Accordingly, the IPA gave the green light for reporting obligations, bans on public activities

115 As long as masks were not available their protective value was played down by the same health authorities who never saw a contradiction in their ordering that masks must be worn in shops and public transportation etc., once they were at hand.

116 As of 18 February 2021 Germany registered 2.372,521 corona cases and 67, 559 deaths (population close to 84 million). https://www.worldometers.info/coronavirus/?utm_campaign=homeAdUOA?Si#countries/ (access 19 February 2021).

117 See Article 48, sec. 2 of the Weimar Constitution (1919).

and private gatherings, the closure of communal facilities, business and school shutdowns and a national lockdown – in short: for measures that elsewhere come under emergency law, sometimes preceded by the declaration of the state of exception. The emergency character is echoed by draconian sanctions for any violation.[118]

The IPA regime certainly qualifies as a security law with 'tightened measures' straining the corset of the principle of proportionality. However, they were implemented in a public health and public law setting with several lines of defence against a pandemic, despite budget cuts in the health sector and the privatization of hospitals.[119] In a Foucauldian perspective, one might say that during the first phase the accent had been placed – despite the lockdown – not so much on repression and sanctions, but more on 'voluntary' self-discipline, statistical predictions, calculations of risks and costs, etc., which put science (epidemiology and virology) rather than law in the driver's seat. From the beginning, the national government tried to tone down the safety measures as 'recommendations' and 'principles of behaviour' so as to ascertain people's compliance and responsible behaviour.[120] Only during the 'third wave' the Federal Government applied the "emergency brake" and shifted significant powers to the national level after the cooperative management of the pandemic, debated by the conference of the Chancellor and the Prime Ministers of the states, failed to warrant a consistent execution of the anti-corona measures taken.

During the 'second wave', beginning in the fall of 2020, the IPS was revised by the 'Population Protection Act' which was meant - but did not succeed - to provide a solid parliamentary backing for the anti-corona measures for the sake of avoiding another total shutdown of the economy and protecting the intensive care facilities from overload. Wearing face-masks, social distancing and other regulations morphed from recommendations to specified, enforceable legal duties. With over 20 000 infections per day in November 2020 (and still about 10 000 in February 2021), the vast majority of the population complies with the stricter measures.[121] However, private gatherings remain drivers of the pandemic and a significant cohort continues to protest against the 'Corona dictatorship' that is governmental interferences with their liberties. 'Lateral thinkers', as they call themselves, composed of fundamental opponents of vaccination, people haunted by conspiracy theories, and 'concerned citizens' that are hijacked by right-wing extremists refuse to comply with even

118 See §§ 28–30 IPA.

119 *T. Schulten*, Liberalisation, privatisation and regulation in the German health care sector/hospitals, November 2006 - https://www.boeckler.de/pdf/wsi_pj_piq_sekkrankh.pdf/ (accessed 19 February 2021); *R. Busse* and *M. Blümel*, Germany. Health system review, Health Systems in Transition 16 (2014).

120 *G. Frankenberg*, COVID-19 und der juristische Umgang mit Ungewissheit,https://verfassungsblog.de/covid-19-und-der-juristische-umgang-mit-ungewissheit/, (accessed 19 February 2021).

121 See Coronavirus in Deutschland, NZZ 22 November 2000; *L. von Hammerstein*, Germany's coronavirus skeptics: Tactics from the Middle Ages, Deutsche Welle, 03 October 2020 (retrieved 3 December 2020).

wearing masks and social distancing.[122] One would assume but cannot be sure that vaccination - due to the bureaucratic and halting organization of the process - will put an end to this spook.

E. Epilog

Will a crisis of the magnitude we have experienced and are still experiencing with COVID-19 lead nations to rethink public health: its important role in society; who delivers it; under what legal conditions and with what funds? We would hope so but fear that *corporatocracy* is likely to be re-established after SARS CoV-2 will have left and societies may forget that soon they have to deal with SARS CoV-3 etc. Recent neo-Keynesian projects to bring the state and, by implication, regulatory law 'back in', cannot safely be assumed to survive once the costs of the pandemic will have been covered.

Against the secular trend to privatization, this article tried to present some thoughts regarding the legal instruments available for delivering public health services and containing pandemics - ranging from social distancing, wearing masks and quarantine via screening and tracking to lockdown, travel bans and closed borders. In order to contribute to the discussion, we foregrounded the political economy of the pandemic and its relationship to law to set forth two insights we deem important. *First*, health privatization has consequences not only in terms of who is providing and funding health but also, and more importantly, who shapes the legal architecture for times of crisis. In fact, privatization, the business model that it produces along with its corresponding centralization of contracts and corporate governance, privilege an understanding of health care and health protection not as a human right but as profitable endeavour. In consequence, when public health is transferred to corporations, the legal tools available for governments in times of crisis are greatly diminished.

Second and more importantly: Even where health regimes are not totally privatized, as in some Latin American countries, the United States, South Korea and several European countries, many governments have structured their response to the pandemic by arguing that they have to 'privilege the economy' (as if the economy was separable from human lives and society). Protecting the economy 'on its own' distorts any balancing of proportionality in what may be called rule of law systems, and opens the door for authoritarian leaders to either deny or diminish the devastation brought on by a pandemic or as an excuse to further increase their power.

A WHO commission of experts - to look for/into the origin of Corona/COVID-19 - returned these days from Wuhan with a sobering message: While the laboratory can be most likely excluded as the birthplace, more research is needed to locate the source of SARS-CoV-2 and more research will be required to understand the animal-human spill-over, that

122 Ironically, one of the anti-lockdown protesters contracted COPVID-19 - https://www.dw.com/en/germany-anti-lockdown-protest-leader-contracts-covid/a-55915671/> (accessed 19 February 2021).

is the viral circulation, zoonotic transfer and the spread in human populations.[123] It is striking though that the story of the Avian flu, SARS and MERS and other 'deadly companions'[124] often begins in megacities, like Hong Kong, much earlier Marseille and London, not to forget Wuhan.[125] Invariably, these urban agglomerates are markers of the economy's onslaught on the ecological balance by destroying the natural lifeworld, polluting the environment, seeking unwanted proximity and producing underclasses that are thronged in dilapidated living quarters.[126] Until the WHO has decided otherwise, the virus and the bacillus in their infinite variety can be assumed to carry nature's response to an ecological crisis. Historically, animals have often delivered the lethal message that civilization, more recently: capitalism, has once again recklessly crossed a border and rescinded the barrier or rather the buffer zone between the species by scorching the earth, deforestation, land grab for industrial production, strip mining, urban sprawl, displacement of local populations and extinction of species. Fleas, flies, rats, lice, civet cats, and other animals as for instance the dromedary in Saudi-Arabia and minks in Denmark have served as hosts for parasites – amoebas, bacteria and viruses. And now bats and wild animals are suspected, though not quite convicted as culprits for the animal/human cross-infection by SARS-CoV-2.[127] Social distancing and hygiene, masks and quarantine seem to be mild penalties for seeking unwanted proximity.

123 COVID-19 Virtual Press conference transcript - 9 February 2021 - https://www.who.int/publications/m/item/covid-19-virtual-press-conference-transcript---9-february-2021/> (access 19 February 2021).

124 *D. Crawford*, Deadly Companions. How Microbes Shaped our History, Oxford 2007.

125 *E.L. Glaeser*, Cities and Pandemics Have a Long History, City Journal (NYC), 22 April, 2020.

126 To explain at least tentatively the varying patterns of epidemic/pandemic disease circulation that have affected human affairs in ancient as well as in modern times, we take some cues from the fascinating studies of *W.H. McNeill*, Plagues and Peoples, Garden City 1976, p. 4 f; *Crawford*, fn. 127; and *P. Descola*, Beyond Nature and Culture, Chicago 2013; *Gibbs JA* et al., From where did the 2009 „swine-origin" influenza A virus (H1N1) emerge?, Virology Journal 6 (2009),20 ff.

127 By encouraging the ravages of the Amazon rainforest and the genocidal dissipation of the indigenous groups, the Government of Brazil, at least President Bolsonaro, seems to be bent on creating the next site for an animal/human cross-infection.- Fires in Brazil's Amazon Rainforest Jump 28 Percent in July, in: *Newsfeed*, 1 August 2020 - <https://riotimesonline.com/brazil-news/brazil/life-brazil/fires-in-brazils-amazon-rainforest-jump-28/> (accessed on 08 August 2020).