HEALTHY DEMOCRACY & DEMOCRATIC HEALTH

A LOOK AT THE STATE OF DEMOCRACY IN TIMES OF PANDEMIC

CARLO CALDARINI AND FELICIA MODICA (EDS.)

CONTRIBUTIONS BY: EVE ALVAREZ, LÁSZLÓ ANDOR, MARA CALDARINI, VALERIO CANONICO, CLELIA D'APICE, CELIA SALAZAR, ROBERTO SAJEVA, KAUNG SUU LWIN, JOËL VAN CAUTER AND MATTHEW WILLETT

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FOUNDATION FOR EUROPEAN PROGRESSIVE STUDIES (FEPS)

Avenue des Arts 46 - 1000 Brussels, Belgium
www.feps-europe.eu
@FEPS_Europe

FONDAZIONE SOCIALISMO

FONDAZIONE SOCIALISMO

Via di Santa Caterina da Siena 57 - 00186 Rome, Italy
www.fondazionesocialismo.it

Book edited by: Carlo Caldarini and Felicia Modica
Project Director: Roberto Sajeva
Supervision: Luca Cefisi
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Edited by
Carlo Caldarini

Preface by
László Andor

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Preface

We are facing a global health crisis with ethical, economic as well as political dimensions. Beyond the search for effective medical solutions, COVID-19 has exposed systematic underinvestment in health care systems, the segmentation of welfare states, and the short-sightedness of public policy when it comes to sharing vaccine supplies and coordinating protective measures.

The right to health is a fundamental part of our understanding of a life in dignity and thus needs to be guaranteed according to the Universal Declaration of Human Rights. Furthermore, health is supposed to be an inclusive right that contains freedoms, entitlements, access to health services, goods and facilities of good quality and free of discrimination. However, even in the economically developed regions, most countries fail to deliver this in normal times, let alone during a pandemic.

In the name of public health, in Spring 2020 some governments immediately imposed strict measures, whereas others tried to find a different balance between managing health risks and the restriction of free movement. For instance, many countries imposed strict lockdowns, and sometimes even curfews, limiting basic civil rights and freedoms. The right of assembly has been affected too, and employees in various places and sectors had to adapt to extraordinary restrictions.

Those restrictions of movement and lockdowns definitely play a role in controlling a pandemic. However, it comes down to what consequences the emergency powers of executives may have. The added value of inclusive, consultative and democratic approaches to crisis management, where those have been used, need to be studied and appreciated too.

The COVID-19 pandemic demonstrates that governments must always establish a connection between health policy and social justice. Likewise, the association of health and democracy runs deep, since the accountability of public officials, who ensure that they act in the public

interest, is particularly crucial in times of a crisis that raises questions of life or death.

The lack of strategic focus and transparency in the first phase of the crisis response might indeed be connected to the so-called democratic deficit at the EU level. Vaccine nationalism is another major problem. While the EU was able to strike several deals with vaccine manufacturing companies, some countries around the world have difficulties in accessing the necessary vaccine quantities in the first place. According to the WHO, in 2021 Africa dealt with a 470 million shortfall in COVID-19 vaccines.

So, the question here is: to what extent could democratization improve healthcare outcomes? And in more general terms, do democratic institutions reduce all types of socio-economic and demographic healthcare inequalities? What measures would help people who live in poverty and developing countries?

The COVID-19 related restrictions have changed the way people live and work. Digitalization has been given a boost and it has also affected the political world and the way it interacts with ordinary people. However, right now rapid digitalization is seen as an opportunity and a threat at the same time, and many fear it could take control over our daily life and personal freedoms.

One of the main changes the COVID-19 crisis has brought to the EU is the rise of the concept of a Health Union. The phrase as such had already been coined earlier, but the pandemic made it truly irresistible. Needless to say, a Health Union would not mean that the EU would take over the healthcare services or health insurance within the member states. On the contrary, a shared health response mechanism could make a difference when future shocks would hit and a strengthened joint procurement mechanism would result in significant economies.

Minimum standards in healthcare enshrined in a directive would help to prevent European healthcare from breaking up into first, second and further classes. Furthermore, the responsibility to stress-test national healthcare systems could help spot those weaknesses that require reforms and investments to be delivered according to the citizens' expectations.

Setting minimum standards and stress-testing have to take place by

paying attention to the fact that the Eastern enlargement of the EU, together with some of the asymmetric recessions, triggered large-scale migration of doctors and nurses from the East towards the West and the North. Without some rebalancing effort, these tendencies could cause irreversible damage to the capacities in the countries of origin, and thus contribute to more general EU-sceptic sentiment there too.

By assuming a new role in coordination, the European Commission has made a great effort in order to ensure that all member states would receive vaccines based on a fair distribution principle, and that the roll-out would begin simultaneously everywhere in Europe. However, EU coordination is not enough. Vaccines must be treated as a global public good and they must be distributed according to medical needs.

Pushing back vaccine nationalism is key. Political and business leaders must not allow market forces and patent laws to take priority over making COVID-19 vaccines available to all. What happened in the past two years demonstrates that healthcare, as well as public education, are central parts of our civilization, or the 'European way of life'. Therefore, it is not primarily the overall consumption levels that will have to be restored after the pandemic, but the systems that support our social cohesion and enlightened values, with equality at the core.

The EU institutions are now committed to promoting the European way of life, and they have to play a role in forging consensus around this strategy too. European coordination can help establish similar policies and practices in social behaviour, which would thereby strengthen the legitimacy of crisis response measures. This research should help ensure that the EU becomes more democratic, and not just more technocratic, by implementing the concept of the Health Union.

László Andor
FEPS Secretary General

Project Overview

From its inception, the COVID-19 pandemic has clearly been a great test for democracies.

Countries around the world have enforced lockdowns and other restrictions of individual freedoms.

Furthermore, international and supranational organizations immediately began to deal with the new reality, trying to function at their best or to revise their missions.

The European Union was able to give a quick test of decision-making capacity, reinforcing the expectations of a Political and Social Europe.

However, European societies have always produced a certain dissent towards their own democratic institutions, even towards their values. These criticisms are exposing a rough divorce between society and institutions, as well as a deep disassociation between power and knowledge. Occurring in two main dimensions:

1. Despite much progress, a low uptake of democratic culture. Certain key environments (like family, work, political parties and school) are often holdouts of closed societies, unscientific thinking and political apathy;

2. Many politicians, public officials and academicians, not necessarily extremists, harbour a certain grudge against democratic pluralism and free and pure science.

These two dimensions have benefited for years (hence generations) from a certain political laxness. It was not just a question of wholesome tolerance but a sinful negligence in strengthening democratic culture, which goes hand in hand with science.

We immediately understood that it was necessary to accompany the pandemic, a crisis that has involved democratic societies and consciences starting with the bodies of citizens, with a well-rounded project. FEPS promptly picked up our proposal, integrating and powering it.

The core of this project is to address the relationship between public health and the "health" of democracy. Starting with ordinary and extraordinary health policies, comparative studies and finally arriving at the design of greater international integration, especially European.

It was a pilot project, but it produced many new strategic links between progressive scholars and politicians, provided planning and tools to numerous young activists and students.

Workshops, training seminars, conferences, have strengthened an online community that, starting from our inputs, continues to work autonomously on these issues.

This green paper is our tentative to trigger a public debate about the main strategic issue of democracy: inequality.

Roberto Sajeva
Project Director

Carlo Caldarini

Introduction

> Au Moyen Âge, lorsqu'on découvrait un cas de lèpre, il était immédiatement expulsé de l'espace commun, de la cité, exilé dans un lieu obscur où sa maladie se mêlait aux autres. Le mécanisme de l'expulsion était celui de la purification du milieu urbain. Médicaliser un individu signifiait alors le séparer et, de cette manière, purifier les autres. C'était une médecine d'exclusion. Au début du XVIIe siècle, même l'internement des déments, des êtres difformes, etc., obéissait encore à ce concept. Par contre, il a existé un autre grand système politico-médical qui fut établi non pas contre la lèpre mais contre la peste. Dans ce cas, la médecine n'excluait ni n'expulsait le malade dans une région lugubre et pleine de confusion. Le pouvoir politique de la médecine consistait à répartir les individus les uns à côté des autres, à les isoler, à les individualiser, à les surveiller un à un, à contrôler leur état de santé, à vérifier s'ils vivaient encore ou s'ils étaient morts et à maintenir ainsi la société en un espace compartimenté, constamment surveillé et contrôlé par un registre, le plus complet possible, de tous les événements survenus.
>
> Michel Foucault, 1974

> The city is a human settlement in which strangers are likely to meet
>
> Richard Sennett, 1977

According to the sociologist Richard Sennett, the city is a human environment in which strangers meet. He argues that urban geography shapes our social relationships, and cities are essentially a place of encounter with the other: the stranger, the different from us (Sennet, 1977: 39). The COVID-19 pandemic is sabotaging this idea of encounters and freedom. The explosion of communication technologies favours the de-provincialization of exchanges. However, it does not cancel the need for proximity relationships, while rather nourishing and exalting this human need: the barrier gestures, the distances, the fading of face-to-face interactions undermine the inner strength of the city, that is the great diversity and spatial organization of people's different individual and group activities. These occasional, unplanned encounters can lead to contact, dialogue, friction, conflict, creativity and innovation.

This cosmopolitanism is under attack today.

Another strong theme of Sennet's thought is his critique of the culture of social separation, which is typical of our civilisation: the separation of manual and immaterial work, head and hand, planning and execution tasks. Sennet argues that head and hand are separated socially, not intellectually – the social and health crisis we are experiencing today highlights this separation. By infiltrating the weakest characters of our society, a virus called COVID-19 is only reinforcing the existing contradictions. In addition to directly affecting the health of millions of people and undermining the systems of care and social protection, this pandemic affects social inequalities, spatial relationships, individual freedoms and the relationships between knowledge and power: in brief, the very concept of democracy and society.

While governments around the world are being asked to take extraordinary measures based on ever-changing and approximate knowledge, we are all struggling to find an acceptable compromise between health, affection, income and freedom. As it usually happens when facing sudden, unwanted and unexpected changes, one of the immediate reactions is to "look for data": the most naïve randomly search the internet and social media; far-sighted ones try to measure what is happening and to understand where we were and where we are going.

Researchers around the world struggle to get an adequate risk estimate. Unravelling imprecise and incomplete data, they try to distinguish deaths directly caused by the virus from those caused by factors such as co-morbidities or spending cuts. These latter have affected health care systems in many countries over the past twenty years – and it will probably take us another twenty years to get some answers. In this scenario, the consumption and circulation of news grow dramatically with media playing an increasingly important role. Being able to understand conflicting information has become increasingly complicated, together with conspiracy theories and scepticism towards science and politics.

Let's say it loud and clear. Regaining individual freedom comes through a single action: taking the vaccine. Beyond its medical nature, the vaccine is an act of collective responsibility and solidarity - in a word: *democracy*. The only certainty we have is that vaccines save millions of people every day and that the health situation improves proportionally. As a matter of fact, achieving global vaccination coverage will protect everybody's health and freedoms, including people who will not be vaccinated for various

reasons. Nonetheless, it seems that the more rational arguments appeal, the more unscientific and anti-scientific discourses are amplified and consolidated. These discourses manifest themselves through a range of bizarre solutions, such as the addition of chili peppers in food or the introduction of bleach in the human body[1], up to real group violence fomented by neo-fascist arguments and behaviour, as what happened in Rome on 10th October 2021 against the headquarters of CGIL, the main Italian trade union.

To make the scenario more complex, we should note that the crisis has amplified (from its very beginning) the pre-existing problems related to freedom of expression. For example, the Chinese government initially withheld basic information about the Coronavirus from the public, underestimating cases of infection while minimizing its severity. Then, it rejected the likelihood of human-to-human transmission to the point of imprisoning those who spread the news of the virus' epidemic on social media (Human Right Watch, 2020). In early January 2019, Li Wenliang, a doctor from Wuhan hospital, was summoned by the police for warning about the new virus in an online chatroom. He died from the virus a month later2.

In Myanmar – a country that was making significant progress towards the Sustainable Development Goals – the health and democracy situation suddenly got worse after the military coup of 1st February 2021; doctors and health workers are now leading the resistance and civil disobedience. In response, the military regime is cracking down on civilians, threatening health workers, hijacking hospitals and violating human rights.

In Europe, the leaders of the 27 member states have taken more or less drastic measures in response to the pandemic. Italy, the first country to be massively affected by COVID-19, confined its population on the evening of 9th March 2020. Most of the other 26 member states have gradually followed suit with physical distance obligations between people and closing non-essential activities and borders. Spain has implemented one

1 In this regard, it is interesting to look at the warnings against false information on the World Health Organization portal: *Coronavirus disease (COVID-19) advice for the public: Mythbusters*, available at: www.who.int [accessed: October 19, 2021].
2 New York Times (2020), *Chinese Doctor, Silenced After Warning of Outbreak, Dies From Coronavirus*, February 6 2020, available at: www.nytimes.com [accessed: September 15, 2021].

of the most radical measures, banning children from going out for a few days. The virus spread later in Central and Eastern European countries, and blocking measures were implemented in the very early stages of the propagation of the virus. For example, Romania established a national blockade on 24th March – at a time when there were only 726 confirmed cases across the country – and similar decision patterns can be found in most EU countries (Bourdin et al., 2020). On the contrary, Sweden has adopted the least restrictive policy in Europe with the government supporting the herd immunity strategy, allowing the virus circulation and faster population immunization to make the disease harmless. Even in the United Kingdom, Boris Johnson's government has initially rejected any forms of closure in favour of herd immunity, only to contradict itself and backtrack several times (Bourdin et al., 2020).

This is when the Health Democracy project has come to life: an invitation to a collective reflection on the crucial relationship between democracy and health within the current health crisis. Reflection and discussion on the effects of the pandemic and related policy measures, democracy, social inequalities and fundamental rights. Since every crisis is a time for possible bifurcation, the Health Democracy project is also an invitation to seize this opportunity to transform the relationship between democracy and health and, as a consequence, between freedom and responsibility, between care and surveillance, between technocracy and politics, between science and power.

While vaccines are allowing a gradual return to a *new normal*, this book reflects the European and cosmopolitan perspective that animates the whole project. Each chapter is an invitation to think from a local perspective, thus becoming a cardinal point and symbolic testimony of the crisis transnationality. The authors are young researchers and activists: the youngest is 26 years old, the older one is 34. Due to closeness, experience, knowledge or research interest, all of them take the floor around one of the following themes with scientific data and arguments:

1. Social inequalities and health (Eve Alvarez Del Llano and Celia Salazar, from Brussels)
2. Individual security and freedom (Mara Caldarini and Matthew Willett, from London)
3. Politics and technocracy: who is at the service of whom? (Valerio

Canonico, from Rome)

4. Health and democracy (Clelia D'Apice e Kaung Suu Lwin, from Myanmar)

Social inequalities and Health

Let's start from Brussels, one of the most cosmopolitan cities in the world. Regional, federal and international capital, city of congresses and cultural crossroads, host city and city of services. With its one million inhabitants, more than 100 languages and 185 nationalities – when there are almost 200 officially recognized languages worldwide by the UN – Brussels makes cultural exchanges both its specialty and vulnerability. A vulnerability due to the extreme dependence of Brussels on the manufacturing industry, which today is mainly found outside the city limits and even outside Europe, and the fact that most of its inhabitants depend on the manual labour of a few people.

Eve Alvarez Del Llano (29) and Celia Salazar (34) are «social workers». One is a sociologist, the other one is an anthropologist. They are working together on a local project on social and health inequalities in some of the poorest and most densely populated neighbourhoods of Brussels.

Their chapter highlights how, in this city, the health crisis resonates with the other pre-existing and co-existing ones before the pandemic (social, employment, environmental and housing crises). By comparing two neighbouring areas, a wealthy and a poor one, Eve and Celia show how the populations living in the poorest and most densely populated neighbourhoods are also the most exposed to infection, mortality and discrimination in terms of prevention and health care, and that the pandemic has only increased these social inequalities in health. As a matter of fact, people in precarious situations bear a double burden facing the pandemic: most of them live in densely populated neighbourhoods and work in sectors that overexposed to the coronavirus. To use their words: if precariousness rhymes with overexposure, a good financial situation rhymes with fewer health risks.

If examined locally, with the gaze and experience of cities and territories, these disparity dynamics take on greater visibility and concreteness, while helping to understand global changes. In this sense, large cities

are laboratories that allow the observation of vast, hyper-complex and planetary phenomena.

As stressed several times by international political actors (WHO, 201; OCDE 2019), socio-economic disparities, which are mainly due to income, employment, education as well as demographic differences (age, origin or gender), are associated with unequal exposure to health and environmental risk factors. They contribute to health inequalities and almost always expose disadvantaged groups to significantly higher risk.

In the European Union alone, around 80 million people live in relative poverty. Many of them live in damp homes with inadequate heating nor sanitation and with no internet access. Globally, UNDP's 2020 estimates for global human development - as a combined measure of the level of education, health and standard of living - are declining for the first time since the concept was developed in 1990. The decline is expected in most countries, rich and poor, on every continent (UNDP, 2020).

The International Labor Organization predicts that the *jobs gap* induced by the global crisis, including both deadweight and relative job losses due to working hours, amounts to the equivalent of 100 million full-time jobs in 2021 and 26 million in 2022 (ILO, 2021). This shortage of employment and working hours adds to persistently high levels of unemployment, underutilization of labour and poor working conditions, which already existed before the crisis.

According to the International Food Policy Research Institute, the pandemic and its economic fallout are driving extreme poverty (measured at the poverty line of $ 1.90 a day) and food shortages for over 140 million people, with a 20% increase from pre-pandemic levels - unless steps are taken to provide unprecedented emergency economic aid (Laborde Debucquet et al., 2020).

In addition, depending on the severity of the economic downturn, the World Bank estimates that by 2021 the pandemic will push 88-115 million people into extreme, thus increasing the number of people living on less than $ 1.90 a day to 150 million, with sub-Saharan Africa and South Asia being the hardest ones to be affected (The World Bank, 2020). Even more alarming, the projections of the United Nations World Food Program argue that, without immediate action, at least 265 million people will have

to face levels of hunger (World Food Program, 2020).

Individual security and Freedom

International human rights law aims to ensure the highest attainable universal standard of health, forcing governments to take measures in order to prevent threats to public health and to provide urgent medical assistance to those who need it most. The right to health is an inclusive right that goes beyond simple access to health care.

As a matter of fact, it is a global right, including several other ones such as the right to drinking water and adequate sanitation, adequate nutrition and accommodation, healthy environmental and working conditions, education and health information, the right to a health protection system based on gender equality and equal opportunities, the right to disease prevention, treatment and control, and access to essential medicines (OHCHR, 2008). Moreover, the right to health entails freedoms such as, for example, freedom from torture and from any cruel, inhuman or degrading treatment or punishment, and freedom from non-consensual medical treatment. These rights and freedoms constitute the «*underlying determinants of health*».

Then one day, on 13th March 2020, the World Health Organization declares Europe the epicentre of the COVID-19 pandemic. Shortly thereafter, many European governments enact limitations on basic civil rights and freedoms such as restrictions on travel, work and all types of public and private activities considered non-essential, including freedom of assembly and association, and the right to private life and family. Expressions of discontent and revolt appear in various European capitals. In Spain, supporters of the far-right Vox party paralyze traffic by driving their cars at walking pace and «keeping a social distance» while waving Spanish flags to demand the resignation of Socialist Prime Minister Pedro Sánchez. In Italy, while neo-fascists and hooligans show their anger against the management of the health crisis by facing the police at the Circus Maximus in Rome, in Mondragone, near Naples, the anger and frustration of the population towards the curfew health care is unleashed between and against immigrants and Roma. In the Netherlands, following the approval of a night curfew by the Dutch parliament, violent demonstrations (described as the worst violence in the country in more than 40 years)

shook first Amsterdam, Eindhoven, and then Rotterdam, The Hague, Den Bosch, Gouda, Amersfoort and Haarlem.

On the international stage, the British government appears as one of the main critics of the «lockdown policy». According to the Prime Minister Boris Johnson, such restrictions run counter to «*the freedom-loving instincts of the British people*». Here then, from London, the essay by Mara Caldarini (27) and Matthew Willet (26): Mara works at the University of Warwick and is an activist. Her studies focus on the relationships between art, culture and social criticism in the post-industrial capitalist society. Matthew is a front-line social worker, musician and graduate in philosophy from the University of Birmingham. Together, they analyse the British government's response to the pandemic; according to their point of view, an answer supported above all by an instrumental idea of freedom, the daughter of neoliberal ideology.

Mara and Matthew go beyond criticism by showing how the unequal effects of COVID-19 on the population are the result of ancient and deep-rooted social injustices. Therefore, they try to «re-imagine the debate» suggesting a different notion of freedom in the name of a «broader and more inclusive right to public health». A notion of freedom that includes demands for social and health justice, without freedom and public health being put into conflict with each other.

As evidence of this contrast, Mara and Matthew recall that, on the one hand, demonstrators take to the streets with the slogan «*Unite for Freedom*», since they see the public health measures simply as an attack on their individual freedoms; on the other hand, the authors underline that London, Manchester and Bristol are simultaneously the site of other protests demanding justice for others: for the lives of blacks, for the rights of women, against police violence and against all structural inequalities of long standing.

Hence, the *right to health* calls into question other rights and freedoms, among all the freedom of expression whose deterioration over recent years has weakened in European States abilities to adopt shared responses to the crisis. A study carried out by the Council of Europe on the pandemic's impact on freedom of expression highlights how a free and pluralistic public debate is crucial for the functioning of societies and democracies: both for the population fully contextual understanding, and for its ability

to make informed decisions, while limiting the circulation of rumours and unfounded news, to recognize disinformation, foster solidarity and trust in the measures undertaken to address the crisis (Noorlander, 2020).

Politics and Technocracy

According to Foucault, society's control over individuals operates through the body. The French philosopher argues that the body is a bio-political reality, with medicine being a bio-political strategy.

By the end of Middle Ages, what we now call the «emergency plan» existed in France as in almost all European countries: it was implemented when plague or severe epidemic diseases appeared in a city (Foucault, 1974). All people had to stay in their quarters and houses were disinfected using perfumes and incense; each family had to stay in their home and, if possible, each person in their room - nobody had to move. The city was thus divided into neighbourhoods under the responsibility of a specially designated person, a district chief, who was in charge of guardians watching over the streets to see that no one left their home. These street guardians had to submit a detailed report on everything they observed every day to the mayor of the city. According to Foucault, based on a general surveillance system dividing and controlling the city with a centralized information system, the quarantine plan represents the political-medical ideal of a good health organization of the cities of the fifteenth century.

Today, according to Marc Maesschalck, a similar structure of representation and surveillance takes over the management of the health crisis, restricting the space for political action (Maesschalck, 2020).

In the face of an emergency, this structure uses technocracy to legitimize its decision-making power. Political space is occupied by *task forces* whose power goes beyond mere consultation when it pronounces on matters over which no one has control. Therefore, according to Maesschalck, confinement not only limits individual freedoms, but it also leads to the suspension of what political philosophers call «public space», while reducing it to a virtualized form. Faced with the professional political sphere, supporting experts' crisis management, civil society is paralyzed and remains «without mediation».

According to Bernadette Bensaude-Vincent, the fact that the population's generalized confinement has led to the reactivation of an archaic model of action - as in the plague epidemics - reveals the limits of science-based politics. And the fact that the public has been called to obey the injunctions of the experts for its own sake recalls the abyss that separated the learned and the ignorant in past centuries (Bensaude-Vincent, 2020).

In short, one of the central elements for understanding this crisis of democracy concerns the question of scientific competence and knowledge, and the relationship between science and power. This is the theme of the essay by Valerio Canonico, 29, from Rome. With a background in political philosophy, Valerio writes for the Italian journal *Mondoperaio* and he is one of the leaders of the Italian Federation of Young Socialists (FGS). From Valerio's point of view, the technocratic principle and the democratic principle are the two pivots around which Western political history is articulated. The system of power called "techno-capitalism" was born in Western societies with the advent of the industrial revolution and the alliance between technical-scientific knowledge and capitalism. A system in which the political sphere takes possession of the technical sphere becoming intertwined and culturally dominant.

Valerio argues that the relationship between technology and politics has been reversed and got worse during the pandemic crisis, when technical-scientific committees, economic-scientific *task forces*, predictive models and algorithms have suddenly taken over. It should also be kept in mind, that his essay focuses on the Italian context: he observes and writes from a city like Rome, the «*Theatrum Orbis*» of Italian politics, where the dynamics of power are often self-referential despite the direct, and often contradictory, line with the places of European politics.

This might be considered both the strength and weakness of Valerio Canonico's essay. Writing from a city like Rome leads him to look at the Roman political dynamics with a certain acuity, without however proposing facts and ideas really linked to the life of the city, as the two essays before him do instead. It should also be emphasized that such a mobilization of scientific expertise in the political arena is far from ineffective. First of all, it allows to plan and execute measures, such as restrictions and vaccines, in order to avoid catastrophic scenarios. It is equally important that this scientific competence into the political arena constitutes a secular barrier against a certain superstitious, populist and a-scientific demagogy.

However, the problematic consequences of such a transfer of competences, from politics to experts, are manifold. Above all, it obscures the plural nature of knowledge. In order to build a competence to be immediately mobilized by political action, there is a reduction and simplification leaving the social dimensions of the crisis largely in the shade, while mainly focusing on the medical-economic dimension. Another problem of this technocratic management is the insurmountable tension between the urgency of action and the temporality of the work of science – once again, as the vaccine example is clearly illustrating.

Health and Democracy

As originally intended, the heart of this book was supposed to be hold for the three chapters that we have just presented, written from as many European capitals. Then, on 1st February 2021, another dramatically extraordinary event occurs far from the European borders: the *Tatmadaw* (the Myanmar army) illegally takes power from the newly elected *National League for Democracy* (NLD). And the next day, the doctors lead the resistance through a vast movement of civil disobedience organized around the hospitals.

The Myanmar coup takes place at a time of extreme crisis within the global pandemic, when the country's fragile health system is already on its knees. On top of that, the military junta in Myanmar has closed hospitals, destroyed medical supplies and equipment, imprisoned and tortured medical professionals leading to the collapse of an already weak health system. Hence the idea – or rather the need – to broaden our reflection outside of Europe, with our feet firmly planted in the foundations of European democracy. Moreover, the motion approved on 7th October 2021 in Strasbourg makes the European Parliament[3] the first world legislative assembly to recognize the government of Myanmar in exile, as formed by the democratically elected legislators of the NLD and its allies.

Starting from the case of Myanmar, the chapter by Clelia D'Apice and Kaung Suu Lwin focuses on the essential link between health and democracy within three main topics. Firstly, democratic institutions and processes

3 European Parliament, Human rights situation in Myanmar, including the situation of religious and ethnic group, Text adopted on 7 October 2021, in Strasbourg.

as a catalyst for the health improvement of the population. Secondly, the driving role of democracy in relation to the social determinants of health and thus the achievement of health equity. Finally, health as an indispensable human right to exercise all other human rights. In short, democratic societies are a precondition for the affirmation of the right to health and all other human rights.

Clelia, 30 years old, has worked and studied in Myanmar, India, Senegal and Thailand, and she is now pursuing a PhD in Public Health, with focus on Myanmar, at the University of Parma. Kaung, 32, is a Burmese doctor currently residing at the University of Tokyo where she is pursuing her doctoral program at the Department of Global Health Policy. Both experts and activists, their essay offers an interesting synthesis of the themes addressed by the other authors: social and health inequalities, social responsibility and individual freedoms, the relationship in-between science and democracy.

According to Clelia and Kaung, the root causes of health inequities are driven by policies that structure access to the social determinants of health. Therefore, five conditions are necessary to reduce health inequity: good quality and accessible health services, income security and an adequate and equitable level of social protection, decent living conditions, good social and human capital, decent working conditions.

Of course, health outcomes improve when people can have access to the care they think they need, when they work in a secure environment with a living wage, when they have someone to turn to for help, and they feel they have a say in decision making. How could any doctor guarantee and defend the right to health if society is oppressed by a military junta that violates human rights? How could any health worker, wishing to do his/her best for the society, respect the duty to guarantee patients' health? How could he/she close his/her eyes and work within inhuman conditions dictated by an army that destroys both the health system and democracy?

Conclusion

In a nutshell, what is this global health crisis revealing from an ethical, philosophical and political point of view? In Habermas' words, today's pandemic requires, at the same time and on everyone, to think and act in a way that until recently was the prerogative of experts, that is to say "in the explicit awareness of our non-knowledge" [4]. Today we are all learning how our governments must make decisions by clearly accepting the experts' knowledge limits, the same experts who advise them. The German philosopher concludes that the scene of uncertain political action has rarely been illuminated so harshly. Therefore, this unusual experience will leave a tangible mark in the public consciousness.

4 «Jürgen Habermas : Dans cette crise, il nous faut agir dans le savoir explicite de notre non-savoir», propos recueillis par Nicolas Truong, *Le Monde,* 10 avril 2020.

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1 | BRUSSELS

Eve Alvarez and Celia Salazar

Eve Alvarez and Celia Salazar

1 | Brussels: Health inequalities in, the case of the “poor crescent”

Abstract

Despite its average size (just over one million inhabitants), Brussels is a major metropolis, the de facto capital of the European Union and the second most cosmopolitan city in the world, after Dubai. It is a city-region, characterised by a dense urban centre with a dominant tertiary sector and a ring of municipalities and districts, some very rich and some very poor.

With the arrival of COVID-19 and the health crisis, these characteristics caused social repercussions that are similar to those of other large European cities. However, the exposure to risks and the consequences of COVID-related health measures affected some specific geographical micro-areas of the city (neighbourhoods) more than others.

The WHO definition of health considers ‘social determinants’ having a real impact on the well-being and health of individuals.

In Brussels, even before the health crisis outbreak, there was already a significant gap in health conditions between the inhabitants of the so-called “poor croissant” and the rest of the city, due to factors such as socio-economic status, level of education and population density.

Faced with the sudden impact of COVID-19, the contamination and health measures affected the entire population of Brussels equally, but the “poor croissant” rapidly turn to suffer the consequences in a more pronounced and lasting way.

Introduction

The pandemic has not affected everyone in the same way. Although not immediately clear, after a few months the figures showed the results of a significant gap between families in the city-region of Brussels-Capital. Marked by place of residence, these differences are not new to Brussels, where people with greater socioeconomic weaknesses are also affected by social inequalities in health among other things. Moreover, these differences are visible in both statistical and geographic analysis. These socio-spatial inequalities are concentrated in the neighbourhoods that skirt the west of the city center forming a crescent shape: the so-called «poor crescent».[5]

As a matter of fact, the impact of COVID-19 has further weakened groups of people already socially strained by exposure risks, higher mortality rates, poor sustainability of restrictive government measures and less respect for social and health rights.

Seeing inequalities become spatially concentrated is not unique to Brussels. Studies from various countries indicate a differentiated impact between individuals located in the same city or region during the health crisis. But although the findings are similar, approaches and analysis may differ.

What should be politically and socially implemented in order to fight against social health inequalities going far beyond the COVID-19 crisis? Could an approach of proximity and a proportionate universalism be two possible solutions against the gap between the inhabitants of the so-called «poor crescent» and the rest of the city of Brussels?

5 Brussels Health and Social Observatory (2019) «Are all equal when it comes to health in Brussels? Recent data and mapping on social inequalities in health», Common Community Commission, Brussels.

1.1 Theoretical framework

1.1.1 Social inequalities in health and the social gradient

Les inégalités socioéconomiques en santé existent dès la naissance.
Observatoire de la Santé et du Social de Bruxelles-Capitale, 2019

In 1946, the World Health Organization (WHO) stated in its constitution the importance of working to bring all people to the highest possible standard of health. The observation was, and still remains today, that in the world we are not all born equal when it comes to health. In 1986, the Ottawa Charter summarized a new framework for public health intervention. Taking up the various studies carried out by public health actors, this framework indicates the categories of *social determinants* that have an impact on the health of individuals (Berghmans 2009). Among the main categories, there are individual determinants such as age, sex, hereditary factors and individual behaviours (physical activity, diet, consumption of tobacco and alcohol, etc.); determinants linked to social groups and to the communities to which individuals belong; social and structural dimensions taking into account economic, cultural and environmental conditions (income, employment, education and living environment of individuals).

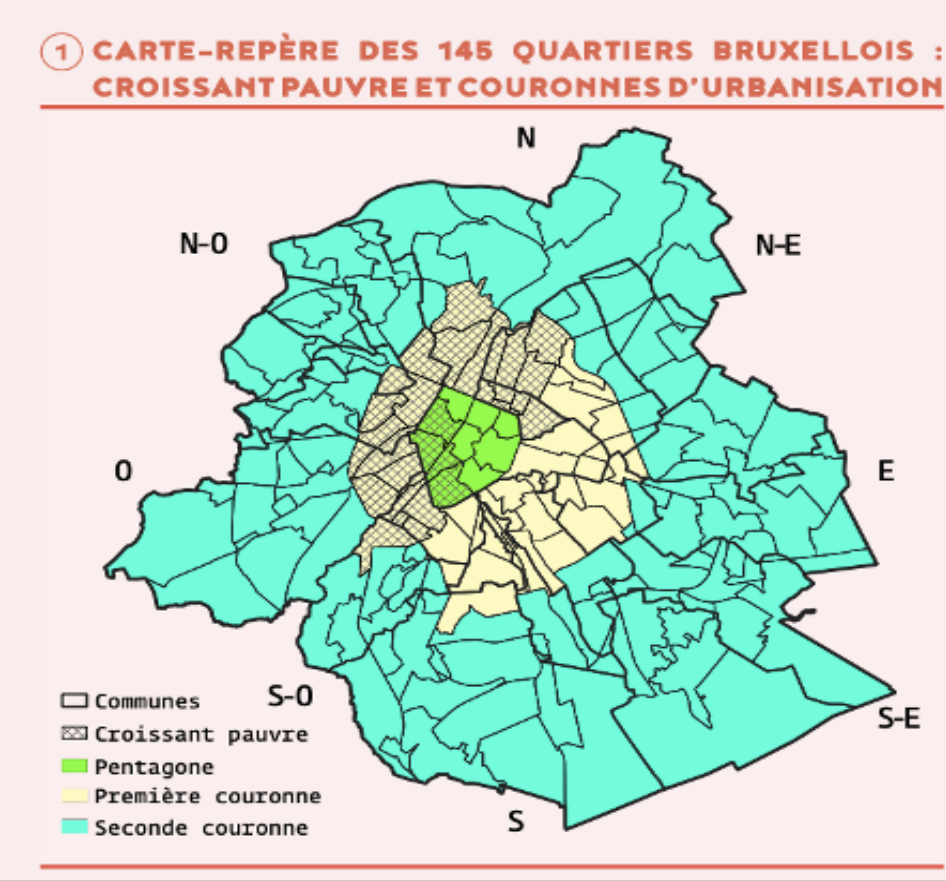
When people experience great socio-economic fragility, the impact on their health is significant, and this is what we mean by «social inequalities in health». These inequalities are not purely dichotomous and do not locate two extremes, but they're actually gradual. Depending on the socio-economic category in which the person is located, it is thus possible to visualize a "social gradient" – health problems are therefore socially stratified (Sandon 2015). This entails that access to services and treatment is different depending on the person's position on the social gradient, same as for the chances of dying during treatment, which are greater for patients with lower incomes (Willems et al. 2007). When we talk about health status, we are referring to both the physical and the mental health of people. As a matter of fact, social inequalities in health are just as visible in mental health and psychiatric care.

The goal of this analysis is to act on social determinants of health in order to reduce health inequalities. This would allow us to avoid deterministic and individualistic reflections in order to carry out sustainable public

health actions for a better state of health of people. COVID-19 and its global crisis have played on these social inequalities in health on different points: some are immediately visible and others will only be visible in the long-haul. Our goal here is to look at determinants of health inequalities that are already visible upstream of this crisis, in the context of Brussels, while confronting them with some known issues of the pandemic because «the impact of COVID-19 replicated existing health inequalities and, in some cases, increased them» (Public Health New England 2020). This kind of approach will lead us to reflect on the approaches and actions to be taken accordingly.

1.1.2 Brussels and its "poor crescent"

Brussels, capital of the Kingdom of Belgium and city region, brings together several key international, European, federal and regional institutions. This capital brings together specific business sectors having strong socio-economic impact on the whole country, while differing from the two other regions of the country, Flanders and Wallonia, because of its official French-Dutch bilingualism and its economic « paradox» in being « a region where a lot of wealth is produced, while the resident population is much poorer » (Avalosse et al. 2019: 11).



Map of the 145 districts of Brussels: poor crescent and urbanization crowns (Source: Monitoring des quartiers – IBSA Brussels)

Significant socio-spatial inequalities can also be observed within Brussels, whose origin is linked to the city history. As a matter of fact, the historically *working-class neighborhoods* were initially occupied by an autochthonous population who progressively moved away from the centre towards the outskirts, and leaving room for immigrant workers who transformed the spaces into «reception districts» for ethnically diverse and less well-off populations. Over the years, these districts have been geographically characterized by a gap from the rest of the city (Mistiaen et al. 1995), both in terms of more affordable rents and migration intensity than the rest of the region (Observatoire de la Santé et du Social de Bruxelles-Capitale 2018). This area, characterized by socio-economic, historical and urban recession, forms a crescent to the west of the centre of Brussels, hence

the term «poor crescent». This definition has now been adopted by the socio-economic and health analysis for many years.

1.1.3 Poor crescent and social inequalities in health

Socio-spatial inequalities are very strong in the Brussels-capital region. Within this analysis, we propose to evaluate the long-observed social health inequalities by comparing two municipalities. On the one hand, there is the municipality of Saint-Josse-Ten-Noode which is located in the so-called «poor croissant» and is characterized by dense population, a fragile socio-economic situation and highly diffused unemployment; on the other hand, there is the municipality of Woluwe-Saint-Pierre which is characterized by more favourable indicators such as less dense population and much higher incomes, and it is located outside the poor crescent, but it is geographically not far from it.

One of the most significant indicators is life expectancy. In 2018, the Brussels Health and Social Observatory found out that a person living in Saint-Josse-Ten-Noode has a lower life expectancy of 5 years than one living in Woluwe-Saint-Pierre. What is the origin of this strong difference? A set of socio-economic indicators creates a gap between individuals and the key factors of well-being such as access to qualitative housing, sufficient incomes, lasting employment, level of education, health care and civil rights claim against discrimination etc.

It is important to note that the situation is even more critical for those many people who fall through the cracks of social security protection, becoming therefore invisible to the existing statistics we've presented here. This is particularly the case of precarious workers, undeclared workers and homeless and undocumented people. (Observatoire de la Santé et du Social de Bruxelles-Capitale, 2020). If the gap was already significant before the crisis, it is not surprising to note the same differentiated impact with the COVID-19 crisis.

1.2 No, we are not all the same in the face of the virus

The inhabitants of Saint-Josse have a 50% higher risk of contracting the disease than the residents of Woluwe-Saint-Pierre.

Luncina e Masini. 2021

Banner in the Marolles district - Brussels (Personal source, June 2020)

1.2.1 Comorbidities and social health inequalities in comparison with COVID-19

At the very start of the pandemic in Belgium, excess mortality was not as strong within disadvantaged geographical areas. However, after several months, the figures began to show that excess mortality in Belgium due to COVID-19 hits lower-income populations more than the biological indicator of age (Willaert et al., 2021).

By looking at the factors of social inequalities in health from before the pandemic, we notice that people in precarious situations are more severely affected by such diseases as diabetes (see Table 1). Several studies conducted on COVID-19 comorbid factors also show that there is a high risk of encountering severe forms of the disease, hospitalization and mortality for people suffering from chronic and respiratory diseases. In Belgium, there is a comorbidity of 21.5% admitted to hospital and 28%

dead from COVID between March and June 2020 (Van Beckhoven et al. 2021). The same has happened in countries like the United States where the diabetic and obese populations have been hit hardest by COVID-19. (Sultan et al., 2021).[6]

Table 1: Incidence of diabetes in 2018 in three Brussels municipalities (number per 1000)

Saint-Josse-Ten-Noode	Woluwe-Saint-Pierre	Brussels Region
69	40	57

Source : Agence Intermutualiste (www/aim-ima.be)

1.2.2 Inequalities within universal measures to counter COVID

> Social inequalities in occupational and financial fields appear to have increased as a consequence of the health crisis.
>
> Bajos et al., 2020

With the introduction of the different lockdowns applied in several parts of Europe between March 2020 and 2021, the Belgian government and regions have adopted different measures to control and reduce the spread of the virus. After a rigorous period of total closure followed by a brief summer reopening, a series of restrictive measures are launched from Brussels starting from September: obligation to wear a mask outside the house, curfew from 10pm to 6am, reduced "social bubble", suspension of courses and activities in schools, closure of numerous places considered non-essential such as hotels, restaurants, cafes, cultural, collective and outdoor events, etc. Although these measures have made life more difficult

6 In the CSS Opinion 9597-9611 of the Belgian Superior Health Council of July 2020 (www.css-hgr.be), patients at risk of phase Ib are defined as follows: «Patients aged between 45 and 65 years with the following comorbidities and at risk of developing severe Covid-19 disease: obesity, diabetes, hypertension, chronic cardiovascular, pulmonary, renal and hepatic diseases and haematological malignancies up to 5 years after diagnosis and all recent solid tumors (or recent anticancer treatments).»

for the entire population of Brussels, their impact has been diversified on the population groups.[7]

Woluwe-Saint-Pierre is almost 8 times larger than Saint-Josse-Ten-Noode (see Table 2), but the population density in the latter is five times higher than the first one. In Saint-Josse, housing, which is more affordable than elsewhere in Brussels, tends to be smaller in size (49.25% of its inhabitants lived in less than 55m2 in 2001 - see Table 3). These overcrowded homes, which have doubled due to the economic difficulties of the population in difficulty (Croix Rouge, 2021), have only increased internal tensions within families, aggravating the mental distress of individuals and the sense of confinement due to the measures imposed.[8]

Table 2: Surface area (km2) of the municipalities of Saint-Josse-Ten-Noode and Woluwe-Saint-Pierre (2019)

Saint-Josse-Ten-Noode	Woluwe-Saint-Pierre	Brussels-Capital Region
1,18	8,85	161,4

Source: Monitoring des quartiers– IBSA Bruxelles

7 Some measures have also been implemented in other regions of the country with differences relating to the use of masks in public places and curfew times

8 According to a 2021 Red Cross poll entitled «Survey: 9 out of 10 Belgians are financially and psychologically affected by the health crisis:» *Nearly 40% of Belgians (39.3%) indicate that their food budget has been affected by the health crisis in the last 12 months and that they had to make sacrifices to eat*.»

Table 3: Annual taxable income (2015), Density of private households (2019), Surface area of dwellings and rental prices (in 2001) of the municipality of Saint-Josse-Ten-Noode and Woluwe-Saint-Pierre and of the Brussels-Capital Region

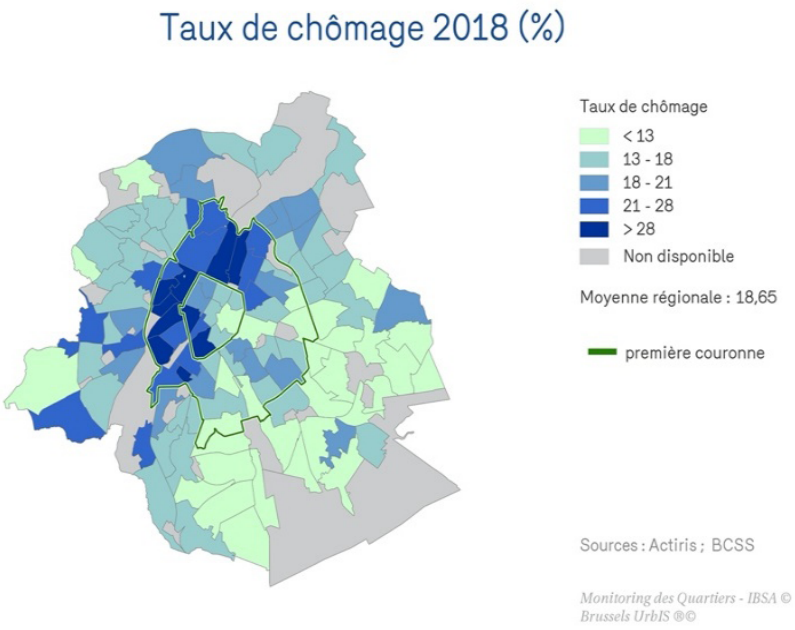
	Saint-Josse-Ten-Noode	Woluwe-Saint-Pierre	Brussels-Capital Region (average)
Average taxable income per capita (€)	8690	19910	13831
Density of households (households / km2)	10 495	2103	3394
Average area per dwelling unit (m2)	63	92	73
Share of dwellings less than 55 m2 (%)	49	20	29
Share of dwellings from 55 to 84 m2 (%)	26	25	26
Share of accommodation over 85 m2 (%)	24	55	45
Average monthly rent per home (€)	638	938	749

Source: Monitoring de quartiers – IBSA Bruxelles

1.2.3 Inequalities in employment and unemployment during the pandemic

Although some economic sectors have adapted to the introduction of smart-working maintaining continuity of service and avoiding the risk of exposure, this has not happened uniformly. The *social reproductive professions*, which respond to the daily needs of human beings, are considered to be of necessity and had to remain accessible during quarantine periods. Therefore, these occupations, in which women and people with lower incomes are the workforce majority (De Simoni, 2020), were more exposed to the risk of contamination since they were moving mostly by public transport.

The construction and hotel sectors, as well as restaurants and cafes, have not been able to remain open to the public or to adapt to remote work, and had to allocate most of the staff in temporary unemployment in the case of permanent contracts. It is important to underline that these are sectors in which precarious and migrant workers work in large numbers without the benefit of the welfare net.



Map of the unemployment rate in Brussels-Capital neighbourhoods (2018, percentage values)

Even before the spread of COVID-19, the area of the poor crescent was the hardest hit by unemployment, with the municipality of Saint-Josse-Ten-Noode in the lead (see map 2). The lockdown measures and health restrictions have only worsened the existing socio-economic precariousness. For example, the so-called "HORECA" sector (hotels, restaurants, cafes) has been closed for almost a year. As a matter of fact, this sector represents 11.90% of the jobs in the municipality of Saint-Josse-Ten-Noode versus 4% in the municipality of Woluwe-Saint-Pierre (Luncina and Masini, 2021).

1.2.4 The failure to claim rights

The failure to claim rights is a key phenomenon to understand health inequalities. It is a situation "in which a person entitled to them does not enjoy one or more rights which he/she could" (Noel, 2021). This is a phenomenon that is strongly present in situations of greater precariousness for which these social rights, including access to health services, nevertheless remain essential.

COVID-19 has disrupted the economic and savings situations of thousands of families: there have been many situations of «no claim» which have amplified over time. Due to factors such as changes in legal status (which influences access to rights), non-accessibility to information (due to the impact of the language barrier of foreign people), the digitization and dematerialization of procedures as well as their complexity, the lack of knowledge of their rights, the scarcity of professional proposals that can verify or assert their usability. Faced with this «obstacle race», most of the «entitled» people are discouraged from applying, postponing treatment. The social gradient is marked: the postponement of health care decreases as the available financial means increase[9]. In May 2021, the Sciensano Institute of Public Health reported that less than 20% of the total population was vaccinated in the municipality of Saint-Josse-ten-Noode, compared with 32% in Woluwe-Saint-Pierre.

While many people have experienced a decline in their standard of living, the most acute problem lies with those who fall through the cracks of the

9 "In the Brussels Region, 38% of households with difficulty making ends meet say they have postponed treatment for financial reasons, compared to 4% among households with more facilities" (Observatoire de la Santé et du Social de Bruxelles 2020).

social security net and have little to no access to their rights.

1.2.5 Mental health in the face of COVID-19, the inability to act immediately

> Thinking about mental health only during an emergency is ineffective, even and especially in a global systemic crisis like today. (...) the effects on the psyche can be immediate, but their impact is often delayed.
>
> M. Yahyâ Hachem Samii, 2020

The impact of the COVID-19 crisis on the population's mental health is particularly significant. In December 2020, severe depression affected 18% of the Brussels population, with sleep disorders up to 75% (compared to 6% and 33% respectively before the crisis). The people in greatest socio-economic difficulty are the most concerned (Observatoire de la Santé et du social de Bruxelles, 2020), given that a more fragile socio-economic situation makes people more vulnerable to depression and anxiety (OMS, 2001).

In 2018, people with higher educational qualifications reported fewer mental health problems, such as severe depression, depressive and anxiety disorders, than those holding a secondary education diploma (Observatoire de la Santé et du Social de Bruxelles, 2020). The pressures induced by the pandemic, the lack of resources, the lockdown within cramped houses and isolation of individuals have only increased the psychological distress of those in a situation of socio-economic fragility and for which mental health care was already limited. In fact, the request for psychologists and the use of antidepressants are reduced or often delayed due to financial problems (Observatoire de la Santé et du Social de Bruxelles, 2018).

The government adopted several emergency measures in order to give the possibility to have a psychological follow-up linked to COVID-19. These aids are currently not meant for long-term ends. However, according to experts in the field, thinking about mental health only as a matter of urgency and immediacy does not seem to be an effective and productive way to help people in need. As a matter of fact, the problems and pathologies experienced by people did not appear only because of the pandemic, but more often than ever not amplified or exacerbated by the living conditions associated with it; for example, due to greater isolation,

loss of connection with the outside world, aggravation of family tensions and domestic violence (Deprez et al. 2020).

In addition to this, the economic dimension and loss of income have exacerbated the feeling of anxiety: several people have been in a situation of socio-economic «freeze» for months. People in an irregular situation and who work outside the labour market legal framework found themselves without financial resources nor potential aid from the State.

Unfortunately, these kinds of difficulties and problems will not end with the end of the pandemic since, like the rest of social inequalities, they were already present upstream and only worsened by COVID. Furthermore, the signs of these troubled times will be deeply rooted in the people who lived through them, and those who «resisted» are only now turning to welfare services. Therefore, ongoing long-term care is necessary in order to enable real support for people to improve their mental health.

1.2.6 British and French perspectives on inequalities

Despite the specificities of the «poor crescent» neighbourhood, the worsening of socio-economic inequalities due to the pandemic goes far beyond the borders of Brussels. As a matter of fact, some geographically located studies show that the inhabitants of the most populated neighborhoods usually tend to have greater social-health discrepancies, and that COVID-19 (with its risks of contamination, mortality and divergent health restrictive measures) has only increased the existing social inequalities.

For example, in the case of the Île-de-France data show huge differences between the Parisian city centre and suburbs such as Seine-Saint-Denis, where the high mortality rate is caused by reasons closely related to those of the «poor crescent»: tightness of housing, employment differences depending on activity sectors and different restrictive measures related to the place of residence (Dubost, Pollak and Reys, 2020).

There are also differences in the city of London where the community aspect is more evident, in addition to residence and income. According to a study by Camargo et al. (2021), ethnic minorities suffer higher death rates and hospitalization from COVID-19 than the rest of the city. The communities concerned are indicated by the British acronym BAME

(Black, Asian & other Minority Ethnic). The particularity of this study lies in the relationship between social and biological inequalities in relation to the BAME communities in London. T

Actually, this comparison goes beyond the picture of the City of London, as several reports from Public Health England in 2020 highlight disproportionate differences in the spread of the virus and its deaths for BAME communities, when compared to the rest of the UK population, as well as a greater risk of comorbidities than «white» people (PHE, 2020).

The relationship between ethnicity and structural inequalities is not new in the UK. Since 1991, the year of the first census that considered the ethnicity factor, this element has been assumed as a factor for the analysis and structural explanation of inequalities. This is what gave rise to the acronym BAME (Lassale, 1998).

Although studies may differ, it is also interesting to note that socio-health inequalities have been found linked to COVID-19 impact on most European cities. In some cases, the inequalities within the same city are geographically stronger, as in the case of Brussels' « poor crescent » or the suburbs of Paris. For others, the ethnic dimensions weigh on the social gradient over the spatial location of individuals, as in the case of the United Kingdom and London where the focus is between BAME communities and the rest of the inhabitants. However, the conclusion is the same: we are not all the same in the face of the virus.

1.3 How to rethink public health policy after the COVID-19 crisis?

It is essential to focus on socio-health inequalities in order to set up public health policies that affect the social determinants of health. In this sense, the effects of socio-health inequalities on the COVID-19 comorbidity rate and the different risks of geographical exposure were highlighted. However, there are still insufficient data on the social impact of the epidemic, as well as studies focusing on the complexity of situations of socio-economic fragility. The Libre Université de Bruxelles (Free University of Brussels, ULB) is currently studying how to strengthen prevention policies aimed at the most vulnerable groups: this is an interdisciplinary reflection that will provide a better understanding of the sociological and

epidemiological profile of COVID-19 patients[10].

In the meantime, we can only observe how much social inequalities in Brussels have been aggravated by the pandemic. What solutions can we propose? How to rethink public health policies to act in a lasting way on the social determinants of health and inequalities in the Belgian capital?

1.3.1 Proximity approach and community health: a local solution to counter social inequalities in health?

> It is more essential than ever to go and look for people house by house, think about neighborhood and citizen-friendly answers, discussing information and prevention systems together with the citizens themselves and on the basis of their realities.
>
> Myaux D. et al. 2020

The most fragile groups suffer from multiple vulnerabilities: mental and physical health problems, inadequate or non-existing housing, financial difficulties and limited access to care and services – only to name a few. In order to counter the phenomenon of non-claiming of social rights, some intersectoral and local responses have been proposed, and proven to be effective strategies, by organizations in the field who have been working with these methodologies for many years (Fédération Bruxelloise de la Promotion de la Santé, 2020).

After a year of fighting the virus, two political bodies have simultaneously built similar solutions to promote accessibility to health and social services in the most vulnerable neighborhoods in Brussels: the deployment of social workers on the front line to go directly meeting populations in fragile socio-economic situations. This is, on the one hand, the «Community Health Workers» program established at federal level by the Ministry of Public Health; on the other hand, there is the «Relais d'Action Quartier» (Passage to neighbourhood action) of the «ALCOV» project organized by the Community Commission (COCOM), the competent institution in the field of personal assistance and health at the Brussels-Capital level. As a matter of fact, multicultural teams can in fact forge bonds of trust with people through a proximity approach that takes into account local realities

10 "ULB, Université Libre de Bruxelles, Inégalités et COVID-19. Profils sociologiques et epidemiologiques des malades du COVID-19" www.ulb.be/fr/fnrs/projets-exceptionnels-de-recherche-per-covid-19

and needs such as language barriers, digital divide, mobility problems, institutional distrust, etc. In general, providing citizens with a direct link to aid, health and care services, in order to engage in the fight against «the failure to claim rights». These programs have been implemented only for emergency purposes and end in 2021. For example, the municipality of Saint-Josse-Ten-Noode set up a local vaccination unit in May 2021 in response to the need for a local approach aimed at building relationships of trust, to be adequately informed and supported in the application of the measures, thus counteracting the mistrust towards the vaccine, against digital barriers and false information circulation.

In addition to the ALCOV project, COCOM is launching some Local Health and Social Agreements in nine neighborhoods of the «poor crescent» in Brussels. By using a community-based approach, these pilot projects intend to rethink the planning of neighbourhood health services while building around situated needs. These actions will seek to improve the quality of life and well-being of residents over a period of 5 years with a holistic view of well-being, cross-sector work and a co-construction process with local and community neighbourhood actors.

In the field of mental health, the proximity approach has made it possible to launch innovative actions in Brussels. There are several «connection places» open to various activities (cultural, artistic, etc.) that are available to people with mental difficulties and disorders, including those already attending mental health centres, but also to the inhabitants of the districts most in difficulty.

The role of «experience expert» or «au pair assistant» is also interesting, meaning a «person who has lived through situations of poverty or social exclusion, and who uses his own experience to report to the institutions the most serious obstacles to access to fruition» (Lemaire, 2021). Although still not widespread, this new profession brings great added value within the involved institutions, and it could possibly play a central role in the co-construction of community health projects.

Community work is a process enhancing participation and involvement within the collective process. It is a long-term action that allows greater participation of inhabitants in prevention policies, as well as an adaptation of health policies to the needs of the population itself. Despite the growing interest in the community health approach, there is still a tendency to

fund one-off projects. In order to establish a true process of change, it is necessary to integrate this effort with the development of structural and sustainable financing (Fédération Bruxelloise de la promotion de la santé 2020).

1.3.2 Proportionate universalism in public health, a second step in the fight against social inequalities in health

Faced with «universal» prevention actions, measures designed for the general population, the so-called *privileged social categories* are often the main beneficiaries (Affeltranger et al., 2018). To give just one example, lockdowns measures and public spaces closure in Brussels have shown profound inequalities in the context of COVID-19. It was not the favored populations to be most affected, but rather those living in the «poor crescent» and who have little to no access to open spaces, finding themselves confined to cramped and overcrowded housing.

Both universal approaches (the same action aimed at the entire population, regardless of their socio-economic status) and targeted approaches (aimed at a specific audience) have disadvantages and limited impact on the social gradient in health. In 2010, Sir Michael Marmot introduced to WHO the concept of «proportionate universalism», which aimed at reducing the gap in the social gradient. It is about «reaching the entire population while being focused on the most vulnerable populations» (Sandon, 2015).

It is a matter of thinking about universal actions within a scale and intensity that are proportionate to the specific needs of different audiences, as well as to their socio-cultural specificities (without stigmatizations). This allows us to offer tailor-made support for those with particular problems. «The principle of proportionate universalism does not only concern the quantitative aspect of the actions, but the qualitative aspect above all through differentiated actions adapted to the local context» (Missine et al., 2017).

Faced with social inequalities in health, public health strategies must be constructed in dialogue with all relevant actors (politicians, professionals and beneficiary groups). It is essential to act on the social determinants of health such as the quality of housing, the type of employment and

access to rights, and particularly through community approaches and proportionate universalism. «The main challenge for public action is to provide a legal, institutional and organizational response regarding the socially and territorially differentiated effect of prevention strategies, and their capacity to reduce health inequalities» (Affeltranger et al., 2018).

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2 | LONDON

Mara Caldarini and Matthew Willett

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2 | London: Narratives of freedom and public health

Abstract

With governments around the world imposing severe restrictions on public and private life, the COVID-19 pandemic has prompted a global conversation about the balance between ensuring public health and protecting individual freedoms. This essay analyses the UK government's response to protests and other pandemic-related events in the context of this global conversation. It will examine the neoliberal ideology that underpins 'freedom' rhetoric in UK politics and media, highlighting how the UK government, like many governments across Europe, has capitalised on narrow conceptions of 'freedom' and 'public health' to pit demonstrations for justice against health safety.

Introduction

On 13th March 2020, The World Health Organisation (WHO) declared Europe the epicentre of the COVID-19 pandemic (2020). Soon after, many European governments enacted limitations on protected human rights such as freedom of movement, freedom of assembly and of association, and the right to private and family life. The UK government initially emerged as a major critic of the lockdown policy with the Prime Minister Boris Johnson declaring that such restrictions exist at odds with "the freedom-loving instincts of the British people". Global conversations surrounding the balance between ensuring public health and protecting individual freedoms have been prominent since the beginning of the pandemic. This chapter seeks to reimagine the debate by suggesting how a different notion of 'freedom' is necessary to realise a broader and more inclusive future for 'public health'.

Firstly, this chapter will analyse the UK government's response to events related to the pandemic as underpinned by neoliberal ideology. Specifically, it will examine government sloganeering and 'freedom' rhetoric in UK politics and media as tools for neoliberal governance. Subsequently, this chapter will suggest that a broader notion of 'public health', rather than the currently offered one by the UK government, is necessary to adequately address health inequality. Research into unequal COVID-19 outcomes has highlighted the extent to which social injustices negatively affect health outcomes in the UK. We will argue that the neoliberal conception of freedom must be challenged to encompass demands for health justice, and that, as a matter of fact, freedom and public health do not need to exist at odds with one another.

2.1 Freedom

Following the WHO declaration on 13th March 2020, governments across Europe have attempted to limit the spread of coronavirus by curtailing civil liberties, including restrictions to travel, work, and all manner of public and private activities deemed 'non-essential'. The implemented measures have included the temporary closure of most businesses from the cultural, hospitality, retail, leisure and service sectors. In some countries curfews have been introduced to prevent people from gathering after work hours, for example in Belgium and Spain. Self-certifications

have been necessary to justify being outside of your own house in nations such as France, Greece and Italy.

The UK has not gone as far as introducing curfews or requiring people to carry self-certifications. The government initially rejected lockdowns in favour of a "herd immunity" response (Wickham, 2021), similar to the one adopted by Sweden (Bourdin and Rossignol, 2020). On 20th March 2020, Boris Johnson decried lockdowns as "going against the freedom-loving instincts of the British people" (GOV.UK, 2020b). Only a few days following the UK's termination of its membership in the European Union, Boris Johnson revealed that he had no intention of letting the spread of the virus inhibit his plans for Britain to become the Superman of global free trade:

> In that context, we are starting to hear some bizarre autarkic rhetoric, when barriers are going up, and when there is a risk that new diseases such as coronavirus will trigger a panic and a desire for market segregation that go beyond what is medically rational to the point of doing real and unnecessary economic damage, then at that moment humanity needs some government somewhere that is willing at least to make the case powerfully for freedom of exchange, some country ready to take off its Clark Kent spectacles and leap into the phone booth and emerge with its cloak flowing as the supercharged champion, of the right of the populations of the earth to buy and sell freely among each other.
>
> Boris Johnson, 2020

However, after a drastic U-turn in the government's response to COVID-19, preventive measures eventually impacted many functions of everyday life. By March 26th, amidst growing infection and death rates, the UK government passed fast-tracked coronavirus legislation[11] to introduce lockdown measures, insisting that people must "Stay home, Protect the NHS, Save lives" (GOV.UK, 2020b). These measures included a public order against non-essential travel and the closure of many public amenities. Wearing a face covering became mandatory in indoor venues in June 2020, although the UK never extended this rule to outdoor settings like many of its European neighbours.

Following Johnson's drastic U-turn, protests against lockdowns, face coverings and vaccines have taken place throughout the country starting in April 2020 and re-emerging with each major government measure. This has been the theme across Europe with significant media coverage of

11 The Coronavirus Act 2020.

demonstrations taking place in Madrid, Amsterdam, Vienna, Brussels and more. Anti-lockdown protesters in the UK have lamented the loss of their individual freedoms under the banner "Unite for Freedom". In this context, individual freedom is seen as impaired by state interference - the restrictions imposed to protect public health are viewed as at odds with the protection of individual freedoms. For example, anti-mask protests have compared face coverings to muzzles, criticising the rule as a restriction on freedom of speech[12]. However, the government's overbearing presence in everyday life is perhaps more immediately felt through "the very simple instruction" that individuals "must stay at home" and only leave the house "when this is absolutely necessary" (GOV.UK, 2020c).

Freedom has been pitted against public health since lockdowns were first introduced across Europe. UK politics and media have been at the forefront of reinforcing this rhetoric in a populist move to gain public support. The London mayoral election, which was supposed to take place in May 2020 but postponed to May 2021 due to lockdown restrictions, saw 'freedom' as central to the rhetoric of many new candidates. Laurence Fox, leader of the newly founded Reclaim Party, joined the race with a manifesto titled "*Free London*" which focused on the promise to "unlock" the city and "free Londoners" (Fox, 2021). He received vast media coverage and devised a large social media campaign which actively criticised the lockdown measures implemented by the UK government. Fox was not the only candidate to prioritise ending COVID-19 rules as part of their manifesto: Piers Corbyn, founder of the Let London Live party, called on the people of London "to refuse to abide by coronavirus restrictions on freedom, life and liberty" (Corbyn, 2021); while Brian Rose's manifesto highlighted "protecting our freedoms" amongst his key policies (London Real Party, 2021). Although these candidates were not ultimately successful in their campaigns, it was made clear that 'freedom' had become a buzzword in the context of the pandemic, whereby evoking a national call for freedom secured extensive media attention. In a similar vein, the various dates scheduled for the easing of lockdown restrictions have repeatedly been labelled by the media as "days of freedom", while the term "COVID-19 Freedom Pass" has dominated news coverage of the potential implementation of 'vaccine passports'. On 19th July 2021, Boris Johnson allowed England to officially enter the 4th step of the country's

12 See: www.dailymail.co.uk/debate/article-8537489/PETER-HITCHENS-Face-masks-turn-voiceless-submissives.html

roadmap out of lockdown, therefore lifting many of the legal restrictions imposed by the government throughout the pandemic. This day became widely referred to as 'Freedom Day' in the media and amongst the public.

The examples above - from Boris Johnson's initial stance on restrictions, the Unite For Freedom protests and the populist choice of rhetoric by politicians and media - all have in common a particular use of the term freedom which serves a broader capitalistic agenda, even if it is loosely employed. Boris Johnson's specific concern for "freedom of exchange" or the right for populations to "buy and sell freely" is central to his initial disregard for state-enforced lockdown measures. This notion of *freedom from* intervention, from obstacles or coercion, is often referred to as 'negative freedom'. Economist and philosopher F. A. Hayek, whose work greatly inspired Margaret Thatcher's neoliberal ideology, conceived freedom as "that condition of men in which coercion of some by others is reduced as much as is possible in society" (1960/2011, p. 57). This condition is essentially an economic ideal, although perhaps felt or understood by Hayek as guided by a deeper moral paragon (De Lissovoy, 2015, p. 46). Hayek argued that state overregulation impinged upon the possibility of markets to maximise competition and capital accumulation. A central condition of the marketplace, when viewed as the playground for freedom, is the ability to make choices - according to Hayek, more choices equals more freedom. According to neoliberalism, a lack of economic regulation and the marketization of social life are most conducive to choice-making and capital accumulation, and thus freedom of this kind (De Lissovoy, 2015, p. 44).

Freedom is central to neoliberal thinking not only on an economic level, but also because of the appeal it has on a moral level. The success of neoliberal hegemony relies in part on the looseness of the term 'freedom'. In this context, what is meant beyond its economic implications is largely uncontested, but it appears as something always worth striving for; it is inherently positive in the social imaginary. Yet, the term is kept purposely vague. Indeed, Boris Johnson's invocation of the British people's "freedom-loving instincts" is an intentional equivocation of economic and moral understandings of freedom. Such equivocation is ceaseless in populist politics and news media, leaving an empty, but highly evocative, conception of freedom which masks its inevitable consequences. As later discussed, neoliberalism as a political philosophy hell-bent on maximalist capitalism has the disempowerment of ordinary people as an inherent

feature. As Monbiot writes: "[t]he freedom that neoliberalism offers, which sounds so beguiling when expressed in general terms, turns out to mean freedom for the pike, not for the minnows" (2016).

Amidst the dominant narrative of individual freedom versus public health policy, the UK also witnessed the demand for a different conception of freedom rising to the surface - one rooted in political emancipation, empowerment and standing against oppression and exploitation: a collective endeavour.

In the spring of 2020, many major cities, such as London, Manchester and Bristol, were home to protests demanding justice for Black Lives, for women's rights, against police violence and other long-standing structural inequalities. In May 2020, London hosted the first of many protests that took place internationally denouncing the murder of George Floyd and in solidarity with the Black Lives Matter movement in the United States. These protests demanded, amongst other things, defunding the police and investing in communities, ending the 'hostile environment'[13] and border controls, funding safe and sustainable futures for Black British people as well as demanding justice in light of the disproportionate impact of COVID-19. (Black Lives Matter UK, 2021).

2.2 Public Health

Only a few weeks following the first Black Lives Matter protest in London, Public Health England published a report detailing the ways in which COVID-19 has been disproportionately affecting Black and other racialized communities in the UK (2020). The review found that the highest rates of COVID-19 were in Black ethnic groups, while the infection rates for White ethnic groups were the lowest[14]. A subsequent review coordinated by

13 "Since 2010 the Conservatives have implemented a range of policies to intentionally and openly create a 'hostile environment' for undocumented migrants in the UK, from blocking access to public funding to making employers, landlords and NHS staff, among others, check people's immigration status. This aggressive policymaking infamously culminated in the Windrush scandal, which saw people who had the right to be in the UK left in terrible circumstances. This has also contributed to the systemic discrimination experienced by migrants and the UK's Black, Asian and minority ethnic population." (Lawrence: 2020, p. 5).

14 486 in females and 649 in males, per 100,000 in Black ethnic groups, compared to 220 in females and 224 in males, per 100,000 in White ethnic groups. (Public Health

Doreen Lawrence detailed how the disproportionate effects of COVID-19 are the consequence of decades of structural injustice, inequality and discrimination (2020, p. 4). Lawrence highlights the early signs of the "avoidable crisis":

> On 10th April 2020, less than three weeks after the national lockdown was declared, the British Medical Association warned that the first 10 NHS doctors to die from the virus were from Black, Asian or ethnic minority backgrounds. A subsequent analysis revealed that 68 per cent of the NHS staff that had died were from ethnic minority backgrounds. Evidence of significant disparities in health outcomes continued to emerge over the following weeks, including the shocking revelation that over one third of patients in intensive care were from ethnic minority backgrounds.
>
> Lawrence, 2020, p. 9

The review summarised its findings in a number of key drivers of the disproportionate impact of COVID-19, including environmental, occupational, financial and health inequalities. Over-exposure to the virus translates into the inability to take adequate actions to protect oneself from exposure. The English Housing Survey of September 2020 estimated that 23 million homes in England were overcrowded, of which only 2% were White British families. The TUC and other unions also emphasized the over-representation of Black, Asian and minority ethnic workers in lower-paid and precarious work (Lawrence, 2020, p. 15), denouncing the government's failure to fully recognise and address the structural and institutional racism[15] in the work world. And precarious workers are not only more likely to contract the virus, but they are also more likely to suffer from the negative economic consequences. Yet again, Black, Asian and minority ethnic workers are overrepresented in those sectors that have been most affected by the economic impact of the pandemic. BAME Labour highlighted in its submission to the review that:

England: 2020, p.4)

15 'Racism' is used, as Reni Eddo Lodge writes, to refer not only to explicit instances of discriminatory violence but also the more covert ways in which racial discrimination is manifested. Racism is not merely the result of morally corrupt actors; it is a systemic force which exists to maintain power structures in societies. See: www.theguardian.com/world/2017/may/30/why-im-no-longer-talking-to-white-people-about-race

'Institutional racism' is used to describe the practices and policies of institutions which, whether intentionally or not, routinely disadvantage people of colour and privilege the interests of white people. 'Structural racism' is identified by a collective history and culture that continues to disadvantage people of colour and privilege the interests of white people. Structural racism informs the practices and behaviours of institutions and societies and as such is used to describe racism in its broadest form.

> Bangladeshi men are four times as likely as white British men to have jobs in shutdown industries, due in large part to their concentration in the restaurant sector, and Pakistani men are nearly three times as likely, partly due to their concentration in taxi driving. Black African and Black Caribbean men are both 50 per cent more likely than white British men to be in shutdown.
>
> Lawrence, 2020, p. 19

Moreover, an IFS (Institute for Fiscal Studies) study emphasised that these same workers are less likely to have a partner in paid employment, and they are less likely to have savings to rely on during a period of financial hardship (2020, p. 21).

On top of this, existing inequalities in healthcare mean that those who are most exposed to the virus are also most likely to suffer from worse outcomes. The Lawrence review outlines that while it is true that some ethnic groups are more likely to have underlying health conditions, this cannot be explained away by genetics alone "given huge genetic diversity within and between these groups" (Kapoor, Patel and Treloar, 2020). Instead, this reductive explanation can be a distraction from the structural and institutional racism at play, which is fuelled by the Government's chronic underfunding of the NHS and failure to implement culturally appropriate public health strategies.

The impact of coronavirus has highlighted how racism has a significant impact on health outcomes: these are decisive factors in determining who gets to live and who is left to die. As a matter of fact, the government's critical underfunding of the NHS, its initial preference for 'herd immunity' and its dire management of the pandemic response are unsurprising symptoms of neoliberal governance. After all, the conception of freedom, on which contemporary neoliberalism is founded, relies on austere structures of oppression, exploitation and disempowerment. In fact, as Hayek himself writes, "to be free may mean freedom to starve, to make costly mistakes, or to run mortal risks" (In De Lissovoy. 2015, p. 46).

Here, freedom is presented as so integral to human life that it supersedes all other basic human rights and needs. Then, defending such a *restrictive* conception of what it might mean to live freely seems hypocritical. In theory and in contemporary society, neoliberalism is so tied to its logical integrity that it completely fails to acknowledge its disastrous consequences. As Lissovoy writes: "it is precisely this idealist austerity that allows neoliberalism to be oblivious to its actual effects, and to the

suffering that it everywhere creates" (2015, p. 46). The inevitable reality of this *capitalistic* freedom is that it is formulated to only benefit capitalists[16].

It appears that there are two different conceptions of freedom at stake here: on one hand, the demand for collective justice; on the other hand, freedom as populist propaganda for the benefit of private economic interest. Perhaps unsurprisingly, the government's ceaseless use of freedom rhetoric did not stretch to include the demands for collective freedom brought forward by the Black Lives Matter protests. Instead, government action following these protests led to the heavily criticised Commission on Race and Ethnic Disparities, a report that investigates the nature of racism in the UK, which has been condemned for delegitimising the lived experiences of those most impacted[17].

2.3 Freedom or Public Health?

On 12th June, the Mayor of London, Sadiq Khan, tweeted advising people not to attend the protests highlighting the risk of spreading the virus. His tweet read: "So please, for yourselves, your family members who may be vulnerable to COVID-19, and for the wider cause, please stay at home over the next few days and find a safe way to make your voice heard" (2020). Of course, Khan's concern for the safety of the protesters and wider community is justified, and he acknowledges the concerns raised by the Doreen Lawrence Review. Yet, his instruction begs the question: what are the alternatives? How can we balance the need for safety and the need for a richer and more inclusive freedom which protects all from government and societal oppression? Can protesting for racial and health equality be justified during a public health crisis, especially when the communities involved in the protests are largely those who are disproportionately affected by COVID-19?

It is true that certain limitations on our freedoms are required to contain the virus. But we have as much a responsibility to criticise and amend the conditions which have created and exacerbated the pandemic - be

16 The term capitalist is used here in accordance with the Oxford Dictionary of English 2010 definition: "a person who uses their wealth to invest in trade and industry for profit in accordance with the principles of capitalism".

17 See, for example: www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=27004&LangID=E

that in protesting for democratic freedoms or supporting more egalitarian economic systems. As we have the responsibility to do all in our power to limit the immediate effects of the pandemic. As it stands in the UK, public health sloganeering suggests a piecemeal social responsibility campaign. Accordingly, the most honourable and democratic slogan one can adhere to is to "Stay Home, Protect the NHS, Save Lives". The UK government suggests that collective agency must temporarily only be manifested as containing oneself. It must not be manifested to demand fairer, more efficient and publicly-owned institutions. As a matter of fact, the government is now trying to make it harder for protest groups to make such demands.

In March 2021 the UK government proposed a new Crime, Policing and Sentencing bill which seeks to give the police greater authority to place restrictions on protests, amongst other objectives. This was introduced amidst the outrage generated by the disastrous police mishandling of the Sarah Everard vigil in London[18], and as a direct response to the wave of climate and racial justice protest referred to as "highly disruptive", "sometimes incredibly dangerous" and "a drain on public funds" in the government's policy paper (Home Office, 2021). Activist groups highly criticised this and they condemned the government's encroachment on the right to speak against the powerful. Ironically, this resulted in further protests united under the banner "Kill the Bill" across the country.

Yet again, we find ourselves asking the question: how else can we enact a more inclusive conception of freedom? The government is underfunding and privatising the NHS, negating structural racism[19] and increasing police powers, despite evidence of institutional racism and excessive violence in the police[20]. Then, how are we going to fight against *these* public health crises? And can we afford not to do so, even with the risks posed by COVID-19? People have tried "safe ways to make [their] voices heard": numerous reports have already documented how deep-rooted and far-reaching experiences of racial discrimination are in the UK, providing

18 See: www.theguardian.com/uk-news/2021/mar/13/as-the-sun-set-they-came-in-solidarity-and-to-pay-tribute-to-sarah-everard

19 "The Review found no evidence of systemic or institutional racism" (Commission on Race and Ethnic Disparities, 2021, p. 77)

20 See, for example, the Netpol *Britain is Not Innocent* report: https://secureservercdn.net/50.62.198.70/561.6fe.myftpupload.com/wp-content/uploads/2020/11/Britain-is-not-innocent-web-version.pdf

countless recommendations for the government to consider[21]. And still, the UK government responded to the Black Lives Matter protests with yet another race report, the Commission on Race and Ethnic Disparities, and one which minimises lived experiences of discrimination in the UK, as previously discussed.

Conclusion

It may seem contradictory to advocate for protesters gathering for public health in the midst of a viral pandemic. COVID-19 rules have prevented large gatherings of people as part of a public health policy. At first glance, dismissing these rules to demonstrate for health justice seems counterintuitive. Yet, the goal of health policy should not be merely to contain the virus. The UK government's concern for 'public health' in the context of COVID-19 has omitted and dismissed the broader and deeper issues behind the disproportionate health outcomes of the pandemic. The narrative that to "Stay At Home" is to fulfil one's social responsibility dismisses the reality of the pandemic as a symptom of a much larger public health crisis. It places the inequalities which existed prior to (and despite) the pandemic as secondary to COVID-19, rather than as a crucial part of its damaging impact.

In much the same way, the government's supposed concern for 'freedom' has decidedly contradicted any movement for social equality and democratic freedom. Like many governments across Europe (European Union Agency for Fundamental Rights, 2021, p. 13), the UK government has capitalised on narrow conceptions of 'freedom' and 'public health' to pit demonstrations for justice against health safety. And yet, also racism is a public health issue. Racial discrimination in the UK has a direct impact on the health outcomes of those who are subjected to it. Outcomes are even worse when racism intersects with other types of discrimination such as, for example, those related to disability, gender identity, sexual orientation, religion or belief (European Union Agency for Fundamental Rights, 2013).

21 The 2017 Lammy Review - 35 recommendations; the 2017 McGregor-Smith Review - 26 recommendations; the 2017 Angiolini Review - 110 recommendations; the 2018 Windrush Lesson Learned Review - 30 recommendations; the 2019 Timpson Review - 30 recommendations; and the 2020 Doreen Lawrence Review - 20 recommendations.

Governments have a duty to facilitate collective freedom which encompasses public health in the broader sense: the right to life for all people. A government that facilitates a *collective* freedom would encompass a notion which does not merely begin with the right to 'choose' and end with the right to perish; it would defend a freedom not hollowed of its egalitarian essence, not void of concern for the other. Then, the contradiction is dispelled in Jewel Mullen's words, Associate Dean for Health Equity at the University of Texas: "I describe it as people's willingness to risk their lives to try to save their lives" (Haelle, 2020). The conversation about public health and freedom is an important one, but it should not be used to pit one against the other. Reimagining what we mean by freedom and its role within public health is an opportunity. Perhaps when a broader and more inclusive social and democratic conception of freedom is afforded, so too is the space and need for cooperation, responsibility and a common good.

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3 | ROME

Valerio Canonico

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3 | Rome: Politics and technocracy in times of pandemic

Abstract

The pandemic has highlighted the shadows of the Western power system. This essay will focus on the consequences of this in Italy and Europe. The crisis of politics and the inability of representative institutions to effectively manage conflicts has led Western institutions to rely increasingly on experts to provide technocratic responses to the pandemic emergency.

We will explore the nature of this new power system, the techno-democracy, whose development is intertwined with three other dominant powers: techno-state, techno-capitalism and techno-science. By techno-democracy we mean that process of rationalisation of power, based on a growing aristocratic principle of competence, aimed at undermining the principle of representation.

This reflects in the growing dominance of the figure of the technician, in public debate and political governance in Italy and Europe, thus eroding the space of political legitimacy in terms of representation and equality while directing the democratic system towards a delegation of political decisions.

Introduction

Technocracy and Politics are the two pivots on which the Occidental History unfolds, both instruments of progress, emancipation and inner contradictions. The latter has always maintained a predominant role in the public and private dimensions of society up until the surge of industrial revolution, when technique started forging an increasingly intimate relationship with a new ally: capitalism. Techno-capitalism was thus born as a power-system in which technology and technique became intertwined and dominant within socio-economic structures in Western society.

This essay overviews the ways in which the relationship between technocracy and politics has been reversed, while creating an imbalance that has been quickly worsening within the pandemic crisis, and notwithstanding the common European welfare policies put up in later stages. By focusing on the Italian context in particular, a city like Rome emerges as the most interesting point of analysis, whereas the dynamics of power have a direct and privileged thread towards the European institutions. As a matter of fact, Rome unfolds as a place of power where a real "Theatrum Orbis" of Italian politics takes place and as a reflection of a part of European politics - inasmuch a European capital-city.

3.1 The consequences of the technocratic approach on Italian Public Health

The *technocratic principle* has often a more impactful weight than political power in the organization of technologically advanced societies; it is based on the specialized knowledge of a few individuals and it coexists with the democratic principle, whose space it has eroded in recent years.

The technocratic principle has been first identified by Daniel Bell, who argued that «if the dominant figures of the last hundred years had been the entrepreneur and the company manager, the new men were the scientists, mathematicians, economists and engineers of the new intellectual technology» (Bell, 1973: 344).

Technical training is today an essential requirement to socio-economically rise to the top of the capitalist world, whereas getting a high-level

education is decisive. This implies, on the one hand, a greater involvement of technicians in decision-making processes and, on the other hand, the essential support of scientific methodologies to decision-making. In this sense, Luhmann (1975) argues that the true function of technocratic power is the reduction of complexity and, therefore, the selection of alternatives legitimately pursuable by social actors and systems. In this meta-functional dimension, there is a reduction of complexity in relation to power and the decision between who stands as an expert social actor and who does not.

The technocratic tendency is thus defined in terms of competence, in other words, a system of legitimation for the management of power, and the pandemic of COVID-19 has deeply rooted democracies' response to the technocratic legitimacy. Mosca (1923) identified two cyclical tendencies in the history of élites: the aristocratic tendency and the democratic one. While the latter manifests itself when a certain social group is on the rise and the demand for democracy opens up spaces of power and representation, the aristocratic tendency characterizes élites who have long been socio-economically consolidated and they justify their long stay in power on the basis of some "superior" attribute.

During the pandemic, the technical-scientific committees, economic-scientific task forces, statisticians, predictive models and algorithms have suddenly taken over all over Europe. For example, in Italy the division of geographical areas of risk into colours (yellow, orange and red) and their indicators (Rt, or rate of reproduction index) of virus transmission have dominated the political choices while completely paralyzing the public debate on socio-economic issues, physical and mental health. According to the Istituto Superiore di Sanità (Italian National Health Institute, 2020), 44% of the over 65 claims had given up at least one medical visit (or diagnostic test), that they would have needed, in the previous 12 months. The 28% of them had to give up because of suspension of service, the other 16% did so voluntarily for fear of COVID-19 infections.

There are also studies on the negative impact of this approach to pandemic management on individual and collective mental health (Brescianini et al., 2020). The Center of Reference for Behavioral Sciences and Mental Health of the Italian National Health Institute demonstrated that, on a sample of 20.720 participants, the levels of anxiety, depression and symptoms related to stress have largely increased during the lockdown, especially in

women. Furthermore, the Center showed that the prolonged experience of lockdown was a significant predictor of the risk of anxiety-depressive symptoms (Giallonardo et al., 2020).

In order to limit the spreading of COVID-19, Italian politicians have delegated choices to technicians more than once. As a matter of fact, over the first months of the pandemic they have, on the one hand, created a specific Technical-Scientific committee to whom they delegated the hardest choices, and, on the other hand, they enacted specific laws (ministerial decrees, or in Italian "DPCM"). These kinds of decrees are laws of abstract content with the characteristic of being rapid and suitable for emergency situations without involving acts of Parliament: a process that ends up eroding the political space of debate in democratic decision-making.

3.2 The response of techno-state and politics to the pandemic emergency

For some time now, in Italy, techno-democracy has been deployed in different areas of political and economic power management in both public and private spheres; its origins are to be found in the state/parastatal apparatus, or more precisely in the *techno-state*. This dimension of power is not devoted to "efficiency", insofar power is nourished and characterized by a management that is typically bureaucratic in structures, rules and procedures while leading to delays in political, administrative, economic and social action.

The element causing the biggest concern is the meeting between the power of bureaucracy and the power of technocracy; as a matter of fact, this mixture has fed the influence technicians and bureaucrats have in political decisions regarding economy and health-care (to support this point, see the report of Corte dei Conti, 2012 and Charron et al., 2019). Assessments on the presence and quality of bureaucracy in international comparison are effectively shown by the Quality of Government Index of the University of Gothenburg, an indicator consisting of three pillars: level of corruption, characteristics of legislation and compliance with the law, quality of bureaucracy. This index shows the effects of individual bureaucratic procedures on the behaviour and performance of both legislators and citizens.

On the other hand, in Europe a similar technocratic framework is rooted on different historical origins: supranational institutions have been characterized by a high degree of technocracy since their very foundation after World War II. The European institutions, whose integration process is based on the delegation of national governments to functional agencies, were born out of neo-functionalist theory and practice, while being based on the objectivity of expert knowledge (see Haas, 2003). According to the functionalists, European integration should thus be achieved through the gradual transfer of tasks and functions to institutions that are independent from Member States and who are capable of autonomously managing common resources.

The European technocratic system has shown significant institutional weaknesses - the financial crisis of 2010-2011 being the main example. During that critical period, the European Central Bank (ECB) enforced structural reforms drawn up by the same institutions and thought to be equally implemented by all EU member states. The tight requirement of programs such as the Stability and Growth Pact, the 1997 international agreement concerning the control of the Eurozone public budget policies, have been heavily criticized by many. For example, Prodi (Osborn, 2002) and Krugman (Krugman, 2013) criticized the fact that the 3% limit applies to total expenditure, without distinguishing between current public spending and public investment expenditure. In order to respect the 3% limit, several countries have in fact reduced public investments and kept current expenditure unchanged. Another problematic point is the limit to the public debt at 60% of the GDP, which deeply hinders countercyclical economic interventions. In this context, the ECB has become the political and economic pivot of the Eurozone; while it buffered the 2010 debt crisis, it did not stop the increasing divergences between EU member states. As a consequence, the integration process has stalled, and the European institutions have not solved their democratic legitimacy issues.

We are experiencing a similar problem in the management of the pandemic crisis today, where the economic and health dimensions are the two essential levels for the making of policies. There have been different political tools put in place to deal with both such as the European Stability Mechanism reform, the Recovery Plan and the Recovery Fund (NextGenerationEU), whereas the Stability and Growth Pact has been suspended in anticipation of radical reforms implemented in all Member States (Pesole, 2020; Riela, 2021). This has been a great

victory of European politics over technocracy: the realization of a large European financing plan for the strengthening of the welfare state is an unprecedented manoeuvre that allowed measures, like the Italian PNRR (National Recovery and Resilience Plan), serving to direct the huge European resources on a national scale.

The Next Generation EU and the PNRR mark a real change for the Italian welfare because "the number of resources deployed to revive growth, investments and reforms amounts to 750 billion euros, of which more than half, 390 billion, is made up of grants. The resources allocated to the Recovery and Resilience Device, the most important component of the program, are found through the issuance of EU bonds, leveraging on raising the ceiling on Own Resources." (Piano Strategico, 2021)

The functional, technocratic nature of the European Union has particularly taken over in regards to vaccination strategies. The creation of a common vaccine plan is still showing delays due to both the lack of European political coordination as well as the slowdowns of national states, while managing to ensure a considerable share of doses in the purchases established in the contracts. Furthermore, the production of vaccines in the European market has been overestimated when compared to the original contracts, and countries like Italy have often been tempted to use vaccines from outside the EU and not validated by the European Medical Agency like the Sputnik (Ansa, March 2021; Il Giorno, April 2021). The EU financed part of the initial costs incurred by vaccine manufacturers using the emergency support facility with budget of about € 2.7 billion (European Commission, 2021).

3.3 Techno-capitalism and public health

In order to understand how technocracy has become intertwined with Western capitalism, the centrality of business is a given to be assumed. The roots of technocracy are to be found in the corporate world because the allegiance in-between academia and economic productivity, scientists and technicians, intellectuals and managers comes from the Taylorist-post-Fordist productive model of power functions. Today, the link between technology and capitalism, expression of the "corporate" capitalist society, is founded on both the search for economic efficiency and the quantification of social relations. This evolution of capitalism is

explained by Braudel (1988), who describes the passage from the market as a cultural and functional device – typical of pre-modern societies – to a self-sustaining, self-regulating and self-referential technical device. The market as an ideal of self-regulation thus penetrates businesses and redefines all hierarchies in a hyper-competitive sense, as described by the theory of transition cost economics developed by Williamson and Ouchi (1981). A following consequence of this new conformation has been the elimination between the institutional and corporate space, between the political and economic dimensions and in-between public and private spheres.

The corporatization of politics provokes a depoliticization of the public field, paving the way for the domination of the elites of techno-capitalism: the neoliberal technocrats in the form of economists, consultants, managers and bankers. This happens both nationally, with the so-called «technical» governments (Mastroianni, 2021), and internationally, with organizations such as the International Monetary Fund and the World Bank that are, as Nobel prize J. Stiglitz puts it, public bodies without democratic management. (Stiglitz 2006; 2010).

This dimension of neoliberal technocracy has repercussions on the management of public health and poverty during the pandemic (WHO, 2020; World Bank, 2021), both in terms of lack of universally accessible health care and medical facilities. As the privatization of health facilities and welfare system could be considered part of this political choice, the Italian trade union UilPA (Unione Italiana del Lavoro Pubblica Amministrazione) affirms that:

> […] it takes a turning point like a global pandemic to recognize the need for well-funded public services and the recognition of the workers who deliver them. The pandemic has made clear the disadvantages of privatization and budget cuts: the priority is [now] to strengthen public health and assistance systems, through fairer and more inclusive fiscal policies, so that those who have the most, contribute more to the financing of national welfare.
>
> UilPA, 2021

The Italian national health system has shown enormous difficulties in managing the pandemic emergency, because of the poor public investments in public health and their fragmentation on a regional scale, as confirmed by the OECD report of 2020 Health at a Glance (2020). This situation had a major impact on COVID-19 death toll with 4,216,003 confirmed cases and 126,046 deaths (up to 10th June 2021, source:

Governo italiano, 2021 b). The inefficient coordination between regions and the central Italian State aggravated the situation during the first part of pandemic emergency; Barone and Bartolini (2020) argued that there was "a great confusion, made evident once more by the overlapping of the emergency measures adopted place by place, from the moment of the outbreak of the crisis, due to the uneven articulation of decision levels in our country". The Italian Constitutional Court expressed itself on the matter in relation to cases like the Aosta Valley regional law imposing different health restriction measures against COVID-19 from the official Italian Republic ones (Bordignon and Turati, 2021).

Nevertheless, the European funding put in place through the PNRR in Italy is an important share of resources that is foreseen to rebuild the country and strengthen its welfare (MEF, 2021). The PNRR has an investment plan with a duration of six years (2021-2026) and a total budget of 672.5 billion euros (312 in direct contributions and 360 billion in subsidized loans). On the other hand, in Europe the conflict between political and capitalistic issues demonstrated a clear issue regarding the relationship with other pharmaceutical multinationals with hegemonic roles in the production and distribution of vaccines around the world. (La Repubblica, 2021). In fact, the system of monopolies imposed by the pharmaceutical companies holding the anti-COVID patents of the approved vaccines is likely to have an unsustainable cost for the economy and health worldwide, as affirmed in the joint document released by Emergency and Oxfam:

> It is necessary to strongly support the suspension of the rules that protect the intellectual property on patents of anti-COVID vaccines and the sharing of the technology necessary for production in other countries, thus making it possible to define a truly effective vaccination plan and that it reaches everyone, both in the poorest countries, in Italy and in Europe.
>
> Oxfam-Emergency, 2021

EU intervened effectively in managing the irregularities regarding the AstraZeneca vaccine by not renewing the contract with the multinational and taking legal action for the delays (Sole 24ore, 2021 b), while it is also trying to find a solution with the intellectual property on patent of vaccines (Ansa, 2021 b).

Conclusion

COVID-19 amplified the way in which technocracy permeates society through habits of thought and action: the virus highlighted the ways in which Italy and Europe have responded to this emergency by deploying different kinds of technocratic power tools. Nevertheless, the legitimacy on which these tools are based is in no way neutral nor purely scientific, since it results as filtered by an ideological perspective and contingent to historical dynamics. Despite this attitude and thanks to the various European political interventions and policies, it has been possible to finally implement a vast plan of investments in public health for the Member States. This is a positive signal that reflects how politics can possibly win over the socio-economic inequalities of technocratic capitalism.

In conclusion, creating innovative models in the management of public health - able to go beyond the hierarchical and elitist models of technocracy - becomes the greatest challenge that Politics has to face. In order to rebuild a new rationality and a more internationalist progressive governance of society, European democracies should thus aim for more equal and fair societies where public health is the first and foremost priority.

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4 | MYANMAR

Clelia D'Apice and Kaung Suu Lwin

Clelia D'Apice and Kaung Suu Lwin

4 | Myanmar: Where health means democracy

This is Burma, and it is quite unlike any land you know about

Rudyard Kipling

Abstract

On February 1, 2021, the Myanmar military illegally seized the power from the newly re-elected National League for Democracy. Since February 2, Myanmar medical doctors are leading the resistance through a Civil Disobedience Movement, minimizing work in hospitals under military control. In response to the protests, the military are brutally cracking down, opening fire on civilians, threatening health personnel, seizing hospitals, and breaching human rights. In a Lancet correspondence, Myanmar medical doctors raised some pivotal and crucial question. Recognizing that their duty as doctors is to prioritize care for their patients, how can they do it under an unlawful, undemocratic, and oppressive military system?

The paper is developed on three main arguments. Firstly, democratic institutions and processes are an important catalyst for improving population health, especially for what concerns health gains for cardiovascular and other noncommunicable diseases. In particular, free, and fair elections are important in improving adult health as they increase government accountability and responsiveness. Secondly, democracy plays a major role in achieving health equity and tackling inequities. Indeed, the root causes of health inequities are mainly driven by policies not considering social determinants of health. Thirdly, health is a human right indispensable for the exercise of other human rights. This right must be defended like all other human rights. Democratic societies are a precondition for the development and recognition of the right to health and

all other human rights, whilst dictatorial regimes remain major sources of human rights violations.

Introduction

Myanmar, also known as Burma, is the largest country in mainland Southeast Asia. It shares borders with Thailand, Laos, China, India and Bangladesh, and it has a coastline on the Andaman Sea and the Bay of Bengal. Clearly, its geopolitical position is strategic but complex.

Myanmar possesses a great diversity of ethnic groups with eight major groups comprising Kachin, Kayah, Kayin, Chin, Mon, Bamar, Rakhine and Shan. It has suffered decades of repressive military rule and poverty due to years of isolationist economic policies, and the civil war with ethnic minority groups. The transfer to civilian leadership in 2011 spurred hopes of democratic reforms. However, on 1st February 2021 the *Tatmadaw*, the Myanmar military, illegally seized power from the newly re-elected National League for Democracy (NLD).

Myanmar's health system has significantly improved under the ruling of the democratic government from 2015 to 2020, both in terms of addressing inequality of access and outcome, as well as to build a modern health education (Bowyer *et al*., 2021). Major efforts were also done in containing the COVID-19 pandemic. On the contrary, military rule in the previous 50 years failed to develop the health system and instead triggered poverty and inequities. The latest reversion to military rule is likely to result in critical deterioration of both public health measures and clinical services.

Starting from Myanmar's case, the paper will offer insights about the essential link between health and democracy, making them reciprocal pivotal conditions, by discussing five main arguments with a focus on Myanmar: Myanmar's military coup and its impact on health, Health is a human right, Democratic institutions and health, Social determinants of health, and Democracy and health equity.

Map of Myanmar. Credit: National Online Project

4.1 Myanmar's military coup and its impact on health

Myanmar gained independence from Britain in 1948. Even after independence, it has experienced various political turmoil and periods of difficulty. The country was ruled by the military from 1962 until 2011 when a new government began ushering in a return to civilian rule. Since then, Myanmar has been undergoing the process of transition to democracy and federalism with the influx and support of international investment and developmental aids.

However, on 1st February 2021, on the eve of the establishment of the newly democratically elected Parliament, the Tatmadaw, staged a military coup announcing that the country had been placed under a nationwide state of emergency. President U Win Myint, State Counsellor Aung San Suu Kyi and several other democratic leaders, parliamentarians and representatives of the civil society were placed under military detention. Calls for anti-coup resistance have quickly gone viral all over the country, also through social media, with people peacefully showing their rejection of the military coup and their devotion towards democratic values, by rallying in the streets and on the web.

Violence and repression from the Tatmadaw seriously increased over the weeks. As of 23rd October 2021, 7,016 people have been arrested, charged or sentenced at one point in relation to the coup, and more than 1,196 people have been killed (Assistance Association for Political Prisoners, 2021). Social media posts show civilian demonstrators attacked and killed with tear gas, grenades, rubber bullets and live rounds (World Health Organization, 2021). Fighting is resuming and growing in several areas, particularly in Chin, Karen and Kachin regions. Large scale displacement of people is taking place both internally and to neighbouring countries. Humanitarian needs - including health care, food, water and shelters - are escalating.

Myanmar medical doctors are leading the resistance through a Civil Disobedience Movement (CDM), minimizing work in hospitals under military control, closing medicine and nursing universities. Nonetheless, not to endanger patients, CDM health personnel are using private and charity clinics to provide medical assistance at reduced fees, collaborate with general practitioners, ensure HIV and TB services, staffed ambulances and clinics in the street, and remain on alert to hurry to the hospitals to

provide emergency care.

Photograph taken in Yangon, Myanmar, during a demonstration in support of the Civil Disobedience Movement. Photo credit @Patrick 2021

As the military are increasingly targeting health workers, arresting, harassing, and forcing them into hiding, many healthcare workers are risking their own lives to deliver life-saving treatment to those injured during the protests (Mahase, 2021; Darzi, 2021). The Tatmadaw is reportedly occupying public hospitals across Myanmar, attacking medical teams and vandalizing medical supplies, equipment and vehicles.

Direct essential health service provision and capacity-building of the public health sector are seriously impaired, hence resulting in limited availability of life-saving health interventions, leading to an increase of preventable morbidities and mortalities. National reporting and surveillance systems are disrupted or not functioning, thus limiting the system capacity for early detection and prevention of communicable diseases. Access to antenatal care, delivery care, postnatal care, family planning and child health care are severely impacted because of non-functionality of the public health sector. Immunization programs, particularly for children, are disrupted and likely resulting in higher dropout and higher risks for vaccine-preventable disease outbreaks (World Health Organization, 2021).

All this is happening at the time of the global COVID-19 pandemic, which has already disrupted Myanmar's existing fragile health systems and affected

the country's health services (Han *et al*., 2021). As of October 2021, there were 491,584 COVID-19 confirmed cases and 18,465 deaths in Myanmar, one of the highest death rates in the region (World Health Organization, 2021). COVID-19 is resurging and quickly spreading in Myanmar due to inconsistent application of contact tracing and quarantine practices, poor surveillance, shortage of supplies, lack of skilled staff and difficulties in accessing testing facilities. Daily testing output decreased from 19,667 as of 26th January 2021, to 1,230 samples as of 28th May 2021 (World Health Organization, 2021). Myanmar's COVID-19 response and vaccine rollout have all but collapsed due to the military's attacks on health workers and facilities across the country. The human rights emergency of the coup is morphing into a public health disaster. Without adequate testing, public compliance and goodwill for isolation, access to acute clinical care and continued immunizations, the implications for COVID-19 spread, morbidity and mortality are threatening not only to the people of Myanmar, but also to the entire Southeast Asian Region. Myanmar risks profound health system collapse amid COVID-19 pandemic (Soe *et al*., 2021).

During the previous over 50 years of military rule, government spending on health has been among the lowest in the world. Decades of neglect, isolation and armed conflict have resulted in severe health outcomes and in a tragic rate of individual out-of-pocket expenditures. Along with the changes in the political system and administrative structures following the 2010 national elections, the government was undertaking reforms to strengthen the health sector and reach universal health coverage. In particular, under the NLD administration, efforts have been made to address inequality of access and outcome, establish emergency care services and build a modern health education system. All these improvements and efforts are now under threat. Reversion to military rule and consequent financial neglect, international economic sanctions and isolation are likely to trigger a deterioration of both public health measures and clinical services in the country, affecting especially the most vulnerable.

4.2 Health is a human right

> As human beings, our health and the health of those we care about is a matter of daily concern. Regardless of our age, gender, socio-economic or ethnic background, we consider our health to be our most basic essential asset" (OHCHR, 2008). Following the World Health Organization (WHO), health is a state of complete physical, mental and social well-being and not merely the absence of infirmity or disease (World Health Organization, 1948). Health must be attainable for everyone

in real life, in all circumstances, at any age, regardless of cultural or socioeconomic status, race or religion, to avoid becoming a utopia

The Lancet, 2009

The importance of the right to health echoes in its enabling role with regard to the right to life. Indeed, to protect and realize the individuals' right to health is, most of the time, to guarantee his or her survival and yet to fulfil his or her right to life: "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition" (World Health Organization, 1948).

Given its primary importance and multidimensionality, the right to health has been enshrined in several international instruments. Inter alia, the Universal Declaration of Human Rights (UDHR) recognized the right to health among the rights of paramount importance for human beings, depicting it as part of the rights to an adequate standard of living (United Nations General Assembly, 1948). Following the International Covenant on Economic, Social and Cultural Rights (OHCHR, 1976), health is a fundamental human right indispensable for the exercise of all other human rights.

Health is a human right, it must be defended like all other human rights, and doctors should be at the forefront to guarantee and defend them (Farmer, 2003). Recently, some Myanmar medical doctors leading the CDM raised a crucial question. Recognizing that their duty as doctors is to prioritize care for their patients, how can they do this under an unlawful, undemocratic and oppressive military system? If doctors join the CDM, do not carry out their work in public structures and only deal with the most serious cases, are they failing in their duty? (Soe *et al*., 2021)

Repression by the Tatmadaw against health workers doing CDM has been brutal, with many doctors arrested or forced into hiding (Mahase, 2021). Sources reported that between 11th February and 30th September 2021, 178 incidents took place across the country in which: at least 290 reported attacks and threats to healthcare, 210 health workers were arrested, 40 were injured and 29 were killed (Physicians for Human Rights, 2021). Additionally, the Tatmadaw is reportedly seizing hospitals in the country and opening fire therewith, hence breaching the Geneva Conventions and customary international humanitarian law. The military reportedly fired

and assaulted ambulances and charity organizations trying to provide first aid to those wounded and to pick up bodies of those killed (World Health Organization, 2021). How can health personnel work under fire? How is it possible for healthcare personnel to guarantee the health of the patients under the spirals of severe human rights violations by the military junta?

Following the WHO's Constitution, "governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures". The country's military has the responsibility to serve the people, defend the country and protect people's security. However, the Myanmar Military are not complying with their responsibilities and are instead breaching and violating human rights, in particular the right to health of the Myanmar people.

4.3 Democratic institutions and health

It is obvious that the way people live and how healthy they are is shaped by political, social, demographic, economic and cultural forces (Mammoth and Allen, 2014). Theoretically, it is straightforward that democracy should improve population health (Ncayiyana, 2004). When enforced through regular, free and fair elections, democracies should have a greater incentive than autocracies to provide health-promoting resources and services to a larger proportion of the population (Martyn, 2004). Moreover, democracies are more open to feedback from a broader range of interest groups, more protective of media freedom, and they might be more willing to use that feedback to improve their public health programs. Autocracies reduce political competition and access to information, which might deter constituent feedback and responsive governance (Ruger, 2005).

People living in countries with strong democratic institutions enjoy better health than those who are enduring under repressive regimes (Ruger, 2005). Countries with more democratic experience were more apt than autocracies to make health gains for those causes that require quality health care and government policy-based prevention and are not heavily targeted by development assistance for health (Martyn, 2004). The effects of democracy are expected to be measurable in terms of factors such as increased government health spending (Franco, Alvarez-Dardet and Ruiz, 2004).

The military regime in Myanmar from 1964 to 2010 resulted in underinvestment in public service including health and education (Brennan and Abimbola, 2020). Despite being rich in natural resources, Myanmar has high poverty and health indicators. Under-five child mortality rate stands at 62.4/1000 live births, and an estimated maternal mortality rate stands at 200/100 000 live births; in both cases, high mortality is due to preventable illnesses (Ministry of Health and Sports, Myanmar, 2016). Although trends show that these rates have decreased in the last decade, they remain the highest in the region, reflecting the great health needs in the population (Ministry of Health and Sports, Myanmar, 2016).

After many decades of military rule, the first democratically elected government took office in April 2016. Among the many priorities of the new government, social sectors including health and education have been repeatedly emphasized as being critical. In line with this vision, the democratically elected government has seen health as a conduit for peace and harmony because improved access to health without financial hardship is directly felt by citizens (Ministry of Health and Sports, Myanmar, 2016).

The previous military government spent a larger share of GDP on defence and a smaller share on health, education, social protection and economic services. This reflects a combination of a relatively small general government and the crowding out of non-defence priorities in the Union budget (Risso-Gill *et al*., 2014). A rebalancing toward non-defence priorities began in 2012/13. The health sector, in particular, benefitted from this rebalancing (Risso-Gill *et al*., 2014). The Ministry of Health and Sports (MoHS) budget increased from 3 to 11 per cent of the total Union government budget in just one fiscal year (Ministry of Health and Sports, Myanmar, 2016). Reprioritization of the government budget has been an important source of fiscal space for health. Because of this reprioritization of the government budget, the health budget increased nine-fold (from 94 million US$ in 2010-11 to 850 million US$ in 2016-17) which was mainly used to finance the delivery of healthcare and expansion of service coverage with a focus on free medical care in hospital settings (Ministry of Health and Sports, Myanmar, 2016).

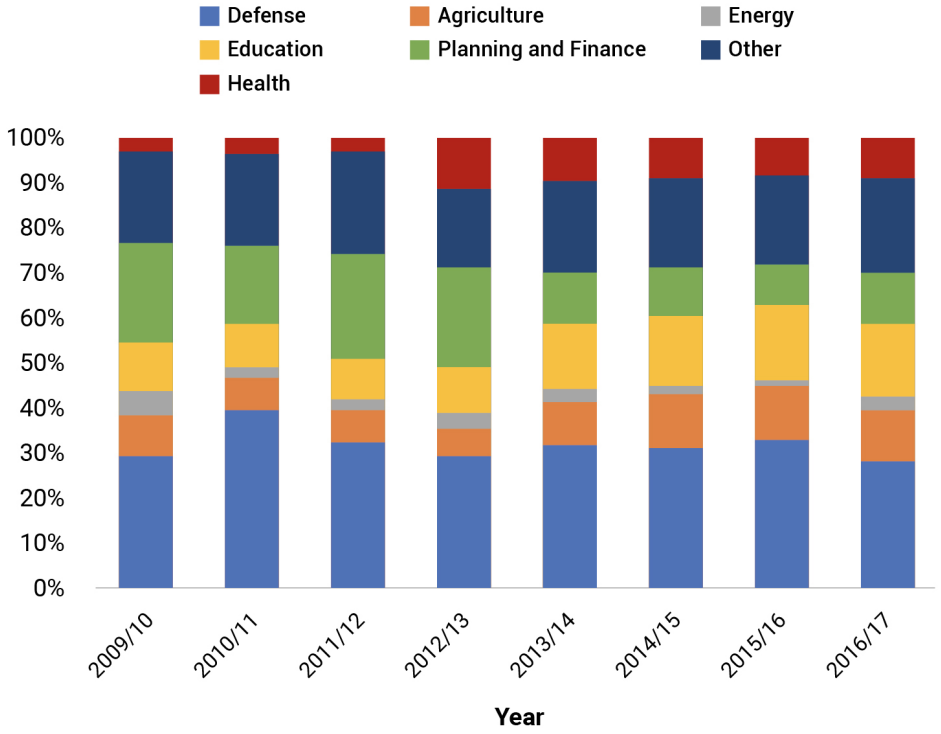

Fig.3. Share of government spending in Myanmar from 2009 to 2017. Credit: World Bank, 2017

Health outcomes in Myanmar have improved substantially and steadily over the last few decades. Life expectancy at birth has risen steadily from just 43 years in 1960 to 66 years in 2015 (Ministry of Health and Sports, Myanmar and ICF 2017). Since 1990, the under-five mortality rate (U5MR) has fallen from 106 to 50 per 1,000 live births, and the infant mortality rate (IMR) has declined from 76 to 40 per 1,000 live births. In this same period, the maternal mortality ratio (MMR) fell from 520 per 100,000 live births to 227 in 2015 (Ministry of Health and Sports, Myanmar and ICF 2017). However, Myanmar's health outcomes remain poor relative to global and regional standards. Myanmar's life expectancy of 66 years is lower than that in its neighbouring countries such as Thailand, Cambodia and Vietnam (Ministry of Health and Sports, Myanmar and ICF 2017). Mortality rates are also substantially poorer compared to regional peers. Myanmar did not achieve its 2015 Millennium Development Goal (MDG) targets of 36 per 1,000 live births for under-five mortality and 130 per 100,000 live births for maternal mortality (Ministry of Health and Sports,

Myanmar and ICF 2017).

Decades of underinvestment in social sectors in Myanmar under the military regime have led to poor health outcomes and high levels of out-of-pocket spending on health. In 2015, 1.7 million people fell below the national poverty line due to health spending (Risso-Gill et al., 2014). Of all Myanmar households that went to a health facility in 2015, 28% took loans and 13% sold their assets to cover health spending (Risso-Gill et al., 2014). The democratically elected government has launched the National Health Plan (NHP) 2017–2021 as a strategy to reform the sector and put Myanmar on a path towards Universal Health Coverage (Ministry of Health and Sports, Myanmar, 2016). The NHP outlines the first phase of Myanmar's journey towards UHC (universal health coverage). Given the country's starting point, as reflected by current weaknesses in the health system and poor health indicators, achieving the ambitious UHC goals will require substantial efforts and investments (Ministry of Health and Sports, Myanmar, 2016).

With the previous democratically elected government's political will to reform the health system, a conducive macro-economic environment, the relatively limited vested interests blocking the pathway to reform and a population thirsty for meaningful change in the provision of affordable quality health services, Myanmar had a window of opportunity to act and achieve significant progress towards UHC (Risso-Gill *et al*., 2014). This continued high-level political support and strong leadership were keeping the reforms on track and strengthening the institutions that are key to their successful implementation (Risso-Gill *et al*., 2014).

However, the military coup of 1st February 2021 is setting back Myanmar's transition to democracy and a path towards UHC (Bowyer *et al*., 2021). The military junta has been committing a series of severe human rights' violations including the systematically targeted attacks on healthcare personnel (Physicians for Human Rights, 2021) which is leading to the collapse of the health system amid COVID-19 posing a national threat to health and human security (Physicians for Human Rights, 2021).

Meanwhile, the National Unity Government (NUG) of the Republic of the Union of Myanmar is established by the Committee Representing Pyidaungsu Hluttaw (CRPH), a group of elected lawmakers ousted in the 2021 Myanmar coup d'état (Ministry of Health, Myanmar 2021). The

Ministry of Health (MOH) under the NUG has been developing the Federal Health System to resuscitate the whole health system after the current health system had collapsed due to the military coup. The Federal Health System guarantees to provide quality, affordable and effective primary healthcare, particularly for the country's poorest and most vulnerable population (Ministry of Health, Myanmar 2021).

4.4 Social determinants of health

The social determinants of health (SDH) are the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems (Marmot and Allen, 2014). The SDH have an important influence on health inequities - the unfair and avoidable differences in health status seen within and between countries (Hanefeld *et al*., 2019). In countries at all levels of income, health and illness follow a social gradient: the lower the socioeconomic position, the worse the health (Marmot and Allen, 2014).

Although Myanmar is replete with resources, it still ranks consistently as a low-income country and one of the least developed countries in the Asia-Pacific region due to the decades of military rule and various political turmoil. Meanwhile, the disparities between urban and rural development levels are increasing, particularly in the realms of employment opportunities, access to health care services and education. The Human Development Index in Myanmar was 0.583 in 2020, ranking 147 out of 187 countries globally with the 67.1 years of average life expectancy at birth whereas that in Bangladesh, the neighbouring country, was 0.632 in 2020, ranking 133 out of 187 countries with the 72.6 years of average life expectancy (United Nations Development Programme, 2020).

4.5 Democracy and health equity

The root causes of health inequities are driven by policies that structure access to the social determinants of health (Hanefeld et al., 2019). Five conditions are necessary to reduce health inequity: good-quality and accessible health services; income security and an appropriate, fair level of social protection; decent living conditions; good social and human capital; decent work and employment conditions (Marmot and Allen, 2014). Health outcomes improve when people can access the care they think they need; when people work in secure employment with a living wage; when people have someone to turn to for help and feel they have a voice in decision-making processes (Marmot and Allen, 2014).

Democratic institutions might relate to health through alleviation of social disparities and income inequalities that result from greater political voice and participation (Franco, Alvarez-Dardet and Ruiz, 2004). Improving the health of the lowest socio-economic status can in turn improve a country's aggregate performance in health. Political institutions might also affect health through their general impact on universal health policy issues such as universal access to quality healthcare services.

Since Myanmar has been undergoing a complex political and economic transformation, from a long civil war and military regime to a peace process and democratization, persistent inequalities exist in health outcomes in Myanmar's seven states and seven regions. Residents of mountainous peripheral states suffer from remoteness, civil conflicts and low socio-economic development (Zaw *et al*., 2015). Because of that, there are wide geographic, ethnic and socio-economic inequalities. For example, the maternal mortality ratio (MMR) in Chin State is 357 compared to 213 in Yangon, and the under-5 mortality rate (U5MR) ranges from 108 in Magway Region to 48 in Mon State (Ministry of Health and Sports, Myanmar and ICF 2017). Children from poorer households are more than twice as likely to be undernourished than those from better-off households (Zaw *et al*., 2015).

Based on the lesson learnt from the past, the MOH under the NUG government is crafting policies to mitigate rather than exacerbate health inequalities by considering decentralization, inclusiveness and equity as its core value of the Federal Health System.

Photograph taken in Yangon, Myanmar, during a 'Save Myanmar' demonstration. Photo credit @Patrick 2021

Conclusion

Health is a fundamental human right, whose realization is pivotal for the enjoyment of a life in dignity for all human beings, and it is a responsibility of governments to fulfil and grant this right to their people. Democratic institutions and practices can affect human development in several ways, including health and well-being. The absence of democracy can have a detrimental effect on the population's health and health systems capacity.

Myanmar had been on the right track towards democratic transition with a hope to develop more after containment of COVID-19 pandemic. However, the military coup has been destroying this hope and turning backward to the dark age resulting in critical deterioration of the whole health system, and unbearable living conditions for the people in Myanmar.

The United Nations Development Programme (UNDP) is warning that the combined effects of COVID-19 and of the military coup could result in 25 million people - nearly half of Myanmar's population - living below the national poverty line by early 2022, a level of impoverishment not seen in the country since 2005 (UNDP, 2021).

Amid the COVID-19 pandemic, Myanmar people are risking their lives

fighting for freedom from military rule and oppression. This military coup is an internal affair, but its impact goes beyond the borders of Myanmar by threatening the health and human security of the wider region, due to the danger of a possible COVID-19 new variants pandemic wave. Thus, urgent action is required from the international community in response to the health and human rights crisis in Myanmar.

The global health community should provide humanitarian and logistic aid, including COVID-19 testing and vaccination. The international community should implement UN Security Council Resolution 2286 which strongly condemns attacks on healthcare personnel in conflict situations (UN Security Council 2016) and fully adopt necessary measures to enhance protection of and access to healthcare in Myanmar.

The international community has the duty to strive for the restoration of health and democracy in Myanmar, as "the health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest cooperation of individuals and states" (World Health Organization, 1948).

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NEXUS. DEBATING FOR FIGHTING

Joël Van Cauter

Joël Van Cauter

Nexus. Debating for fighting

Democracy is in danger. In India, the largest democracy in the world, Muslim citizens are losing their citizenship because of religion. In the United States, the most powerful democracy in the world, a president has encouraged an attack on his Parliament. In Europe, some executives are sabotaging the independence of the press or the judiciary. As if irrefutable proof were needed, the Russian pseudo-democracy has gone to war with Ukrainian democracy.

The two years of Covid crisis we just passed through have increased this danger, because they pointed and highlighted one fact: the inequality of citizens in the face of disease and death. Yet, equality is one of the foundations of democracy, especially because covid has tested governments, highlighted their weaknesses, their short-sightedness and the strangling knots.

The only way to cure democracy is democracy itself, and this is why this collection of articles is so valuable. In order to fight for democracy we have to start arguing, and the chapters of this book, whose specificities complement each other to form a stimulating whole, feed the debate in three ways.

Describing

First, they do so because of their objectivity. The authors put together a series of observations that help us seeing reality, its different and partly converging situations. This is done through rigorous figures, sharp factual descriptions as of the best journalism, references to historical contexts and relevant legal frameworks – all is documented, accurate and irreproachable.

The social determinants of health came into play and condemned the

most fragile part of the population to cumulative penalties: illness *and* daily tensions in cramped housing, job losses *and* psychological disengagement *and* ...

When Wilkinson[22], who also meticulously collected the data, came out with a book on the positive correlation between equality and collective well-being, he observed that: the actors on the field reacted by saying "what you write is obvious"; the others said instead "it is impossible". Reading the facts given here, everyone can experience both impressions simultaneously: it is impossible for such an injustice, such an increased burden on the weakest to take place in a democracy – yet it is evidently happening. First of all, we need to know what we are talking about.

Criticizing

The debate is fuelled by criticism, or rather by critics: of policies, of notions, of macro trends. This part is maybe no more irreproachable. Thus, the notion of collective freedom deserves to be more solidly defined and explored, compared to other alternatives to the justly denounced individualist freedom. Hanna Arendt's work on freedom as a political fact and the experience of a relationship, for example, remains enlightening[23]. Because it is not only a question of denouncing the reduction of freedom to *Homo Economicus*, but also necessary to think of this freedom as living matter in a consciousness. The text on Myanmar makes it clear, without needing the slightest emphasis, that it is individuals, people, subjects, specific existences, committed, embodied, the one fighting.

Also, reading the Covid moment as a symptom of a society dominated by techno-capitalism might be even more compelling. Because, often during the crisis, we have seen that States struggling in a DIY that made them look more like amateur football clubs than technocracies. And because it is difficult to understand – unless one is inhabited by a torrid ideological faith – how States whose budgets represent almost half of their GNP and a social expenditure between a quarter and a third, could become puppets

22 Pikket, P. e Wilkinson, R. (2010). *The Spirit Level: Why Equality is Better for Everyone*. London: Penguin

23 Arendt, H. (2006). *On Revolution*. London: Penguin

of capitalism[24]. To use the distinction of Braudel, there are the forces of the market economy to consider. We can add the alternative forces of civil society and culture dear to Gramsci, a little man in fragile health who can inspire us more than ever.

Let us rejoice in possible disagreements, whose very existence is condition for a reflection: questioning a policy by its underlying conception of freedom makes it possible to go at the heart of the matter, as questioning a form of power through the interest at stake.

Proposing

Finally, the debate is fuelled by proposals. Some are concrete, such as strategies for reaching people who do not ask for medical care, to be vaccinated or to seek access to their rights; another strategy stands in proximity tools such as community health workers, local social and health contracts, etc. Others are on a more general level: the emphasis is put on the bond of trust in care; the expertise that the directly interested person has about their situation and the co-construction of solutions; proportionate universalism, which affirms the need to carry out actions concerning all citizens, but with a scope and intensity proportionate to the need. All this opens up a new, or at least renewed, approach to public action.

All this reflection invites also, more generally, to work with citizens, researchers and intellectuals, actors of the associative, economic and public sector terrain. Have we seen that policies leave the most vulnerable on the sideliners? Then we test some other action. We need to test, test and re-test ... and evaluate to keep what works. Have we seen that the legitimacy of the institutions is criticized by doubts about their relevance, or by suspicions about their independence? Then we need to discuss what the counterpowers can or should be in the age of the internet and social networks. Do we see that there are many promising projects? Then we need working to make them sustainable and allow to function on a

24 See Eurostat data on expenditure:
- public https://ec.europa.eu/eurostat/databrowser/view/gov_10a_main/default/table?lang=en e
- social https://ec.europa.eu/eurostat/databrowser/view/tps00098/default/table?lang=fr

larger scale, in particular by fertilizing the appropriate public bodies with facilitators, investors, regulators etc.

Thinking

The work to be undertaken is necessarily collective, because the crisis of democracy, as these articles show, did not appear out of nowhere. It is rooted in the disruption between us, in-between the sense of state, the urgency.

Perhaps it is even rooted in a certain impasse of social democracy[25]. Is Social Democracy, whose fate interests not only the socialists – punished for failing to pass from an action structured by economic conflict to one based on social alliance? Is Social Democracy punished for its inability to move from the balance of power to the dynamic of common needs?

We all need environments that offer living conditions conducive to health, connection, autonomy and meaning. These conditions are not solely determined by wealth, even if a minimum level certainly remains decisive for well-being[26]. Thus, many middle- and upper-class individuals today face problems that are also those of the poor. Naturally, the frequency and intensity of the problems are diverse. But a poor family whose apartment is too small and have been waiting for years for a popular larger home, or a young working couple with an average salary who cannot afford to buy an apartment due to soaring property prices, both face a housing problem. Both are deprived of a place to live well, a place that is both real and symbolic. A homeless man, who lost his relationships and points of reference due to life on the street, or a wealthy old woman, abandoned by her family in a retirement home, are both destroyed by isolation[27]. And it is clear that the evil of resentment is devouring all social strata – from the chic conformist diners to the more penniless alternative associations.

25 See in particular Gethin, A., Martínez-Toledano, C and Pieketty, T. (2021). Clivages politiques et inégalités sociales. Paris: EHESS / Gallimard / Seuil, as well as data available at https://wpid.world

26 See for example the Belgian inter-university work based on the extensive MEqIn (Measuring Equivalent Incomes) survey: Capéau B., Maniquet F. et alii (2020). *Well-being in Belgium: Beyond Happiness and Income*. Cham: Springler.

27 The decisive character of isolation in well-being is highlighted in the Danish work of the Happiness Research Institute

This does not mean that everything is the same, that poverty is not severe or discriminatory. Again, the figures of this book show discrimination and its scandal. But, recognizing this fact, let us ask ourselves: how can we use the lever of suffering, widely shared in society, in order to understand and fight the pain of the poorest? What are the points of support? How do we all connect through problems and requests, answers and solutions? And how, to put it in John Dewey's words, can we prefer investigation versus case evidence rather than using pre-packaged principles? [28]

Yes, we need to think, to rethink poverty, precariousness, solidarity and politics.

The Covid crisis, with its death and his pain, stands paradoxically as an opportunity. It reminded us about the need for reconnection and the urgency and, despite everything, it has demonstrated the protective power of the state, for the many if not for all.

Yesterday the collective life was partly suffocated by knots of ignorance, of interest, of structure. For tomorrow, thanks to works like this, we will be able to invent new human nexus: bonds that, like the one that connects neighbouring biological cells, will put human brothers and sisters in a fruitful relationship.

It is another way to fight and give a possibility to democracy, as put as the first words of the American and Indian constitution: *we the people…?*

28 Dewey, J. (1920). Reconstruction in Philosophy. New York, Holt and Co.

About the authors

CARLO CALDARINI

Carlo Caldarini (62) is a Belgian-Italian socioeconomist and educationalist, expert in social policies. Between 1990 and 2016, he has been working as a researcher and teacher for an Italian government institute (INEA), the *Université Libre de Bruxelles* (ULB), the *Università Roma Tre* and other training and research bodies, as well as in the international and local trade union world. He is currently Head of Studies and Research for one of the largest public social welfare centres in Belgium. (c.caldarini@proximus.be)

ROBERTO SAJEVA

Roberto Sajeva (36), Director of Health Democracy project, works as editorial consultant for institutions and private companies. He was editorial director of Mondoperaio, the oldest Italian magazine of political culture, and previously national secretary the Italian Federation of Young Socialists (FGS), as well as bureau member of Young European Socialists. He has been working for years in social, sporting and cultural promotion focusing on minors at risk and folklore. Engaged with Marta, physiotherapist, he lives between Palermo, Catania and Rome. (robertosajeva@gmail.com)

FELICIA MODICA

Felicia Modica (29) holds a degree in Political Science from the University of Copenhagen (Denmark) and specialised in Gender Studies at the University of York (England), she worked at the University of Canterbury (New Zealand) and volunteered on international project management in the north of France. Being currently a project manager (national and Erasmus + calls) for the several NGOs in Palermo, her focus are structural educational inequalities. (feliciamodica92@gmail.com)

EVE ALVAREZ

Eve Alvarez (29) works as a sociologist for a municipal Public Social Welfare Centre in the Brussels region. With her colleague Celia Salazar, she is leading an action-research project addressing the lack of access to social and health rights in two of the poorest and most complex neighbourhoods in Brussels. Previously, Eve was a social worker in the same Public Social Welfare Centre in the Brussels region, for which she now works. She holds a master's degree in sociology at the *Université Libre de Bruxelles*. (evalvare07@gmail.com)

CELIA SALAZAR

Celia Salazar (34) works for a municipal Public Social Welfare Centre in the Brussels region. With her colleague Eve Alvarez, she is leading an action-research project addressing the lack of access to social and health rights in Brussels. She has also carried out several human rights-based projects for the Aliado Foundation in the Ecuadorian Amazon, for the United Nations High Commissioner for Human Rights in Ecuador and for the Red Cross in Belgium. She holds a degree in anthropology and sociology from the *Université Libre de Bruxelles* and a master's degree in anthropology, interculturalism and development from the *Université Catholique de Louvain-la-Neuve*. (celia.salazar.w@gmail.com)

MARA CALDARINI

Mara Caldarini (27) studied an MA in Philosophy and the Arts at the University of Warwick before moving to London, where she now lives and works. Mara works on student-based projects in higher education, specialising in interdisciplinary research and academic publishing. Her current research interests sit at the intersection between cultural and political theory, with a particular focus on the relationship between radical politics and aesthetic practices. (mara.caldarini@gmail.com)

MATTHEW WILLETT

Matthew Willett (26) is a social worker and musician, and University of Birmingham philosophy graduate currently based in London. Matthew's current work and research interests revolve around addiction, music, and technology. (matt.willett@hotmail.co.uk)

VALERIO CANONICO

Valerio Canonico (29) holds a degree in Philosophy and a Master in Philosophical Sciences at the University of Roma Tre, specializing in the philosophical perspectives of American Neopragmatism. He then obtained a Master's degree in Human Resources Management at the GEMA Business School and took courses in the field of Human Resources, a field in which he is now working. He wrote for the Italian magazine Mondoperaio and is a leader of the Italian Federation of Young Socialists (FGS), responsible for the Labour and Economic Democracy area. (canonico93@gmail.com)

CLELIA D'APICE

Clelia D'Apice (30) graduated in International Relations at the University of Parma and specialized in International and European Studies at the University of Trento. She has extensive experience in international cooperation and global health, and has worked for different international organizations around the world. She is doing a PhD in Public Health at the University of Parma, with a focus on Myanmar, and working as a Human Rights and Development Advocacy Officer Consultant at the Suu Foundation. She is a founding member of saluteglobale.it and member of the board of the Association for Friendship Italy Burma Giuseppe Malpeli. (clelia.dapice@unipr.it)

KAUNG SUU LWIN

Kaung Suu Lwin (32) is a medical doctor from Myanmar and currently a postdoctoral researcher at the Department of Global Health Policy, the University of Tokyo. She obtained her master and PhD degree in Global Health Policy from the University of Tokyo. She has strong research skill and working experience with different stakeholders from various international organizations such as UNFPA and WHO. Her master research, which estimated the association between socioeconomic status and health-seeking behaviours for diarrhoea and acute respiratory infections among under-5 children in Myanmar, was published in BMJ Open. (kaungsuulwin@gmail.com)

JOËL VAN CAUTER

Joël Van Cauter (56) is a philosopher (Ph.D UCLouvain, master ULB) and economist (master UCLouvain). He works as researcher and consultant. On the one hand, as a Fellow of the Itinera think tank on the issues of poverty and citizenship. On the other hand, he works on issues of collective interest for public institutions and private companies. Previously he managed various social economy associations and structures. Married with three children, he has lived in Africa and Asia for nearly ten years and now lives in Belgium. (joel.vancauter@gmail.com)

Healthy democracy & democratic health

A look at the state of democracy in times of pandemic

As vaccines allow a gradual return to a “new normal”, this book offers an invitation to collectively reflect on the crucial relationship between democracy and health in the context of the COVID-19 health crisis. It is an invitation to discuss the effects of the pandemic and its related policy measures, to reflect on democracy, social inequalities and fundamental rights.

This book reflects a European and cosmopolitan perspective. Each chapter speaks from a local perspective, acting as a cardinal point and a symbolic testimony to the transnationality of the crisis.

With a vibrant background in fieldwork, experience, knowledge and research interests, each author discusses one of the following topics with scientific data and arguments: Social inequalities and health; Individual security and freedom; Politics and technocracy; Health and democracy.

Since every crisis offers a moment of possible bifurcation, this collection of essays is also an invitation to seize the opportunity to transform the relationship between democracy and health and, consequently, between freedom and responsibility, care and surveillance, technocracy and politics, science and power.

Concluding this collection of essays, Joël Van Cauter reminds us that the only way to “cure” democracy is through democracy itself. We must relearn to debate first to fight for democracy. The Covid crisis, with its deaths and pain, reminds us of the urgent need to invent new human “nexus”. Above all, it demonstrates the State’s protective power for the many, not yet for all, however.

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