

Pandemics and Politics

Adam Roberts

A.J.P. Taylor often observed that great events can have very small causes. The 2020 COVID-19 pandemic is fresh evidence for this proposition. The cause is in all likelihood tiny and accidental: a genetic mutation in a virus, which then spreads into the human population. Like earlier epidemics throughout history, it could have happened with no human intentionality. Its consequences are already momentous and will be even more so before it is over.

The novel coronavirus can easily be seen as a profoundly anti-democratic force. In its first eight months, from early January to mid-August, it produced over 20 million cases of the COVID-19 disease. That disease has killed over 800,000 people and counting; put millions out of work; drastically curtailed travel; precipitated states of emergency; and caused citizens to be placed under detailed and intrusive administrative control, demonstrations to be banned, and elections to be rescheduled or postponed. Bitter disagreements have arisen about when and how to ease restrictions on movement. COVID-19 has generated a revival of conspiracy theories and unjustified recriminations, and prompted absurd denials of medical reality by certain political leaders. Among states, the pandemic has actually heightened some long-existing disputes, most notably those on trade and other matters between China and the United States. The capacity of the United Nations

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system to address epidemics has been called into question, not least in harsh American criticisms of the World Health Organization (WHO).

It is too simple to cast the pandemic crisis merely as a narrative of rampant authoritarianism versus embattled democracy. The long history of pandemics, earthquakes and other disasters reminds us of the enduring complexity of disaster management, and of the many controversies surrounding it, including the causes of and responses to plagues. States respond in different ways, raising questions regarding the relative effectiveness of democratic versus authoritarian states. International health organisations, especially the WHO, have important roles in dealing with epidemics, whether regional or global. Yet their formal powers are limited and their effectiveness depends on state cooperation. Epidemics, and action to control them, do sometimes play a part in increased authoritarianism, but they can also give rise to more positive initiatives of various kinds.

Pandemic history

The well-documented history of pandemics suggests that we do not live in uniquely dangerous times. We tend to underestimate past threats and disasters because we know that humankind survived them. Yet many past crises appeared at the time to be every bit as menacing and disruptive as the present crisis. The human cost and major consequences of past epidemics of different diseases have long been known. The historian William McNeill, tracing the numerous effects of epidemics on the rise and fall of empires, concluded his masterly and prescient study of *Plagues and Peoples* thus: ‘Infectious disease which antedated the emergence of humankind will last as long as humanity itself, and will surely remain, as it has been hitherto, one of the fundamental parameters and determinants of human history.’¹

In many parts of the world, bubonic plague (recognisable by the swelling of lymphatic glands) has been the type of epidemic most deeply etched into public consciousness. The Hebrew Bible contains reference to such plagues. Most notable was one afflicting the Philistines, as described in the Book of Samuel, which probably happened in about 1350 BCE. While the plague was implicitly understood as the result of the wrath of God, mice were also indicated as a possible causative factor.² The first of three outbreaks of bubonic

plague that are widely viewed as having amounted to pandemics occurred in 541–49 CE. Known as Justinian's Plague, it affected the Mediterranean countries, Europe and the Near East. It recurred in 588, spreading to what is now France. In 1347–49 came the Black Death pandemic. This killed 30% of Europe's population. For centuries it struck about every ten years, one of the last major outbreaks being the Great Plague of London in 1665–66. Even after that, plagues repeatedly struck cities of North Africa, and also the Ottoman Empire, which endured them up to the first few decades of the nineteenth century. The third plague pandemic occurred in 1855–1900. Believed to have started in Yunnan province in China, it spread to Canton, India and Hong Kong, whence it was reportedly carried by a 'plague ship' (one whose crew and passengers are infected) to Hawaii and San Francisco, causing outbreaks there in 1900.

Epidemics have been linked to a range of phenomena, including grain-storage systems in which rats and fleas can thrive, collapsed or defective health systems, population displacement, revolutions, wars and environmental degradation. Globalisation has been widely seen as another significant factor: epidemic outbreaks have been associated with international trade routes since at least the fourteenth century and still are today.

China, in particular, has been tagged as a possible source of all three plague pandemics, as well as the current coronavirus one. A team of 24 palaeobiologists reported in 2010 that all three historical pandemics had been caused by the same bacterium, *Yersinia pestis*. Regarding its means of transmission, they stated: '*Y. pestis* evolved in or near China, and has been transmitted via multiple epidemics that followed various routes, probably including transmissions to West Asia via the Silk Road and to Africa by Chinese marine voyages.'³

In 2013, Ole Benedictow, a Norwegian historian of plagues, agreed that *Y. pestis* was the causative agent, but disagreed about its transmission and with the implication that China was the epicentre of all plagues. In particular, he criticised as 'untenable' the 'highly disparate attempts at explaining the historical spread of *Y. pestis* either by caravans across the Eurasian continent or by sea from China to East Africa whence it could have spread to western Arabia, North Africa and the Middle East'. He proposed a more historically

based explanation of how, during the Black Death, *Y. pestis* could have moved from ‘the area of the plague focus that stretches from the northern and north-western shores of the Caspian Sea into southern Russia’. He suggests that several plague foci developed over centuries, and that wild rodents played a large part in its transmission.⁴ References to plague-like diseases in various classical works and in the Bible reinforce these conclusions.

The historical record is also valuable for what it says about the responses of rulers to pandemics. Even today, most of our methods of combatting COVID-19 are positively ancient. As François Heisbourg has put it: ‘The best we currently have are medieval measures such as quarantining, travel

*Disasters can
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governments*

bans, wearing masks, confinement and social distancing more broadly.’⁵ Different societies do have strikingly divergent approaches to the problem of managing epidemics, based in part on the differing threats they have experienced, distinct cultural traditions on such matters as face masks and handshaking, and disparate forms of governmental and social organisation.

Disasters of all kinds can of course result in societal breakdown and extreme religious reactions, but they can also give rise to significant transformations of government. The capacity to adapt to disaster appears to have been strong in many European city states. For example, in 1348, during the Black Death, health commissions were set up in Florence and Venice, later developing into ‘permanent magistracies monitoring and regulating civic health’.⁶ In Milan and Mantua, temporary prohibitions of persons from disease-stricken areas were introduced in 1374.

On the eastern side of the Adriatic Sea, in Dubrovnik (also known as Ragusa), a sophisticated anti-epidemic, and more specifically anti-plague, system was built up from the fourteenth century onwards. Nearby were territories under Ottoman control. It was widely assumed that the plague would continue there, hitting rural communities that formed Dubrovnik’s hinterland. The city of Dubrovnik’s first regulation on quarantine was passed in 1377, and its first permanent health office was established in 1390. Over centuries, the city developed tough rules on contact tracing, disinfection and quarantining of goods, and prohibitions against physical contact

with Ottoman subjects. Though premised on controlling the threat rather than eliminating it entirely, these policies appear to have been more successful than those in various neighbouring Dalmatian cities, purportedly due in part to high standards of public hygiene and good hospital organisation. A Croatian historian, while recognising some failures during the so-called 'plague of the maidservants' in 1691, reaches a favourable verdict on plague control 'thanks to good organisation, broad-based public engagement on this task, as well as substantial government support'.⁷

Over the four centuries following the Black Death, a large body of medical work on epidemics emerged in Europe. Works of this genre came to be known as 'plague tracts' – or, in German scholars' delicious term, *Pestschriften*. These studies are sometimes considered conservative, and excessively preoccupied with ancient astrological, religious or merely speculative theories of plague causation. But they increasingly offered detailed and astute observations, drawing attention to methods of treatment that had been observed to work and addressing the role of government. They noted that the poor were particularly vulnerable, and needed to be fed and sheltered to protect them and others from contagion.⁸

The plague crisis of 1575–78, which posed a threat to the entire Italian Peninsula, led to two important medical developments: the tracking of diseases through detailed health-board statistics, and the instruction of princes on public health and its politics. A good example of both is the work of Sebastiano Tranzi, public doctor of the central Italian town of Lanciano. He was asked by the town's archbishop to publish a plague tract in Italian, 'accessible and beneficial' to the town's citizens. In the resulting book, published in 1587, Tranzi expressed confidence in the present and future preservation of Lanciano from plague based on its 'good rule and governance ... that resembled an ancient republic', its magistrates and its laws. He also emphasised the wide range of measures that had kept the city free from the plague's invasion in 1575–78: formation of a public-health board, deployment of eight honoured citizens from the town's best families to guard the gates, and rigorous measures to prevent goods and persons from entering from suspected places.⁹ This was an instance of seemingly successful preventive work to save a town from plague.

Samuel Cohn draws two conclusions from his study of plague tracts: firstly, that ‘epidemics do not necessarily lead to transcendental religiosity and weakening of states’, and, secondly, that effective management of the threat or actuality of plague tended to result in the glorification of leaders and the value of obedience to them, ‘thereby boosting absolutist authority at the end of the sixteenth century and into the next’.¹⁰ This invites obvious questions. Were the authorities that had been successful against the plague all ‘absolutist’? And were all absolutists successful? Many of the Italian and Dalmatian city states had traditions of relative freedom, regularly changing their consuls to ensure that these officials’ lust for power was controlled. These civic traditions had weakened from the thirteenth century onwards, but they were not completely dead.¹¹

Pandemics and the utility of history

Historical studies illuminate seven aspects of epidemics. Firstly, they help trace their origin and spread, and the survival and transmission of pathogens between outbreaks. This knowledge helps in forecasting and addressing future outbreaks. They also expose the weakness of conspiracy theories as explanations of epidemics by showing how complex and varied the routes of transmission can be, and how rare it is that complete elimination of a pathogen can be achieved.

Secondly, history is a guide to preventive measures. Historical studies confirm that epidemics are extremely serious, are best tackled as a public-health problem and require, in addition to treatment of the sick, a huge range of preventive measures that have evolved over centuries. As knowledge of pathogens slowly grew from the late nineteenth century onwards, some of these measures were subtly refined but none was considered irrelevant. Past and recent cases confirm the importance of preparedness, including sound organisation of the social response to an epidemic. They also show how a well-oiled and properly financed system of disaster response can itself be a vital ingredient of a city’s or state’s identity.

Thirdly, historical studies have a place in answering some key clinical questions, including the value of old remedies against new threats – though that place may be distinctly limited. There was not a lot of history involved in the discovery by an Oxford University team in June 2020 that dexamethasone, a cheap steroid first made in 1957 and widely used, reduced deaths among COVID-19 patients on ventilators by a third.¹² However, historical research accompanied by modern epidemiological approaches could clarify what has and has not worked against previous epidemics, and assist in investigating claims for traditional medicine.¹³

Fourthly, a reminder of precedents is salutary. One obvious example concerns the fear of disorder arising in the wake of disaster. After the earthquake in Dubrovnik of

6 April 1667, which killed several thousand citizens, looters and criminals of every description appeared. This led to vulnerability to outside intervention – in that case, from Venice.¹⁴

Fifthly, past cases can focus attention on key policy issues. A particularly critical issue is whether the aim of public measures is the complete eradication of a pathogen or merely the prevention of its further spread. Over centuries, this was a vexing concern for many territories and municipalities that were located just outside the Ottoman Empire. They knew that they had to live side by side with highly infected societies, and did what they could through quarantine arrangements and limits on movement of travellers.

Sixthly, history reveals protection from epidemics as an evolved attribute of statehood. For centuries, they were viewed as a terrible scourge but not necessarily one that governments could effectively address. Thucydides in around 430 BCE and Thomas Hobbes in the seventeenth century lived in plague-ridden periods – Thucydides caught it himself – but it was especially Italian officials in the sixteenth century who began to see plague management as a key part of statecraft. This view became stronger in the nineteenth century as medical knowledge advanced.

Finally, historical cases raise the question of whether certain national or regional variations in the handling of an epidemic (for instance, on wearing face masks) are constructive or not. Such variations may conform to and draw strength from the cultural traditions of particular societies; and they may also provide a wealth of experience, akin to a series of scientific experiments, on what works and what does not work against epidemics.

Types of states and political systems

Many Asian countries reacted promptly to the first reports of what came to be known as COVID-19. Examples include Singapore, South Korea, Thailand and Vietnam. Even China, after initial denials of the seriousness of the situation, took quick and decisive action in ordering a lockdown in Wuhan and other cities in Hubei province on 23 January 2020. These fast responses in East Asia may have a very simple explanation, which has little to do with the type of political system, and everything to do with lived experience. These countries had been affected by the severe acute respiratory syndrome (SARS) outbreak of 2002–04. They were aware that it was different from influenza – in fact, it is caused by a form of coronavirus – and had a higher fatality rate. Elsewhere, at least up to March 2020, many governments still had a flu model of a likely pandemic, and therefore felt less urgency.

The Wuhan lockdown provided the world with an impressive demonstration of one known way to tamp down an epidemic. But the congratulation and self-congratulation accompanying lockdown's end on 8 April, after almost three months, ignored the fact that in the first weeks of the epidemic there had been a partial cover-up at some state, party and administrative levels.¹⁵

Assessing the relative performance of democracies and authoritarian states is, in any event, difficult. In this century, the seductive proposition that countries can be divided neatly into two basic categories – constitutional democracies and authoritarian regimes – has run into trouble. As Martin Loughlin of the London School of Economics has observed:

At the end of the Second World War, there were only 12 established constitutional democracies in the world. By 1987 this number had grown to 66 ... and by 2003 the 1987 figure had almost doubled to 121. By the new millennium, almost every state seeking to legitimate its rule in the eyes of its citizens and the world felt obliged to adopt a written constitution incorporating a separation of powers, a commitment to the rule of law, the protection of individual rights, and the holding of free and fair elections. At the end of the 20th century, it appeared that there was only one game in town, and that game was constitutional democracy.¹⁶

Loughlin goes on to suggest that constitutional democracy had reached its global high point in the period 2006–11 and then went into decline. Democratic states were not overthrown by *coup d'état* or other types of fundamental collapse. Rather, some of them became 'defective democracies' – regimes that retained the formal institutional trappings of constitutional democracies while flouting the norms and values on which they are based.

Consider Brazil. In the 2020 edition of its annual report 'Freedom in the World', Freedom House classifies Brazil as 'free', and describes it as a democracy, but at the same time registers many criticisms: violent attacks on independent journalists and civil-society activists, high rates of violent crime, top-level corruption and disproportionate violence against minorities. Freedom House makes even more criticisms of Peru, but also lists it as 'free'.¹⁷ Both might be candidates for the category of 'defective

democracies', but Freedom House does not employ such a category. An additional problem with its methodology is that it is largely silent on issues of health and medical treatment.¹⁸

One might expect defective democracies, especially those in which press freedom is curtailed, to perform particularly badly in facing major disasters, including pandemics. This would chime with the received view that countries with a free press, independent institutions and the rule of law – in other words, real democracies – are less liable to allow disasters to happen than are authoritarian states. As Amartya Sen and others have pointed out, droughts and other natural disasters may become far more severe if they occur in the absence of political freedoms and independent media. Such institutions tend to act as whistle-blowers, compelling governments and other bodies to mobilise to mitigate material and social damage.¹⁹ In an April 2020 newspaper article on the COVID-19 crisis, Sen mounted a defence of democracy that turned on that kind of contingency:

Tackling a social calamity is not like fighting a war which works best when a leader can use top-down power to order everyone to do what the leader wants – with no need for consultation. In contrast, what is needed for dealing with a social calamity is participatory governance and alert public discussion.

[...]

This applies also to the calamity caused by a pandemic, in which some – the more affluent – may be concerned only about not getting the disease, while others have to worry also about earning an income (which may be threatened by the disease or by an anti-disease policy, such as a lockdown), and – for those away from home as migrant workers – about finding the means of getting back home. The different types of hazards from which different groups suffer have to be addressed, and this is much aided by a participatory democracy.²⁰

Is it feasible to measure the comparative performance of different types of state in the early months of the COVID-19 crisis? The answer depends on the existence of some objective metric. One flawed but still useful measure of

comparative performance is the number of deaths of COVID-19 patients in different countries. Table 1 illustrates, in a rough-and-ready way, the huge variations in these numbers, both absolutely (column 2) and per million of population at different dates (columns 3 and 4).²¹ These statistics need to be viewed with considerable caution. Their obvious limitations include the need to allow for the different threats and circumstances faced by each country; the fact that, in some countries in this list, cases of COVID-19 started much later than in others, so the time frame covered may be shorter; the fact that the death of any individual may have a multiplicity of causes, especially as it is well established that COVID-19's lethality increases in the presence of pre-existing medical conditions; the role of class, ethnicity and other factors; the different practices of states in the attribution of the cause of death; different policies on whether or not those patients who do not go to hospital are tested for COVID-19; and, in many countries, especially those under authoritarian rule, the possibility of widespread and even deliberate undercounting of victims. The 28 countries or territories shown here are merely a sample.

In Table 1, no attempt has been made to formally classify individual countries as democratic or authoritarian, or somewhere in between. This is not only because such classifications would be highly contestable, but also because there is no simple connection between the type of state and its performance. Democracies are all over the place. Take the ten states with the fewest deaths per million of population as of 25 August. Eight of them – Australia, Greece, Iceland, India, Japan, New Zealand, South Korea and Taiwan – are widely accepted as constitutional democracies. Among more authoritarian states, only China and Vietnam are included in the top ten. However, the worst-performing ten states in terms of fatalities per million are all democracies of one kind or another: Belgium, Brazil, France, Italy, Mexico, Peru, Spain, Sweden, the United Kingdom and the United States. Only Mexico fails the Freedom House test, being designated as 'partly free'.

The UK and the US, which have historically seen themselves as the world's leading democratic powers, appear to have set a bad example in the first eight months of the COVID-19 crisis. Particularly in its early weeks, they were slow and indecisive, and American failures have

Table 1: **Reported deaths from COVID-19 in selected countries: totals and per million of population**

Country or territory	Total COVID-19 deaths to 25 August 2020	Deaths to 1 June 2020 per million of population	Deaths to 25 August 2020 per million of population
Australia	517	4.00	20.27
Belgium	9,878	819.35	852.32
Brazil	115,309	137.91	542.48
Canada	9,083	193.28	240.66
China	4,711	3.22	3.27
Denmark	623	99.10	107.56
Finland	335	57.75	60.46
France	30,528	441.25	467.69
Germany	9,277	101.58	110.72
Greece	242	16.79	23.22
Hungary	613	54.45	63.45
Iceland	10	29.30	29.30
India	58,390	3.91	42.31
Italy	35,441	552.66	586.17
Japan	1,196	7.05	9.46
Mexico	60,800	77.02	471.56
New Zealand	22	4.56	4.56
Peru	27,813	136.66	843.54
Poland	1,960	28.11	51.79
Russia	16,448	32.16	112.71
South Africa	13,159	11.52	221.87
South Korea	310	5.29	6.05
Spain	28,924	580.20	618.63
Sweden	5,813	435.18	575.59
Taiwan	7	0.29	0.29
United Kingdom	41,433	551.59	610.33
United States	177,279	315.35	535.58
Vietnam	27	0.00	0.28

Source: Data on cumulative confirmed COVID-19 fatalities and rates per million people is from Our World in Data, 'Coronavirus Pandemic (COVID-19)', <https://ourworldindata.org/coronavirus>, accessed 25 and 26 August 2020.

remained dramatic as such questions as wearing masks and how to relax lockdowns have been bitterly politicised. The weakness of the UK and US performances is particularly embarrassing in light of the notable disconnect between how these two countries performed in practice in 2020, and how they had been graded only months earlier in the 2019 Global Health Security Index (GHSI). Overall, and also in the specific category of 'Rapid

Response to and Mitigation of the Spread of an Epidemic', the UK and US had been ranked as first and second out of 195 countries. Other states with high death rates in 2020 were also highly rated in the GHSI. France, Spain and Sweden were in the top 15, and Belgium was in 53rd place.²² In light of their performance in 2020, London and Washington need to acknowledge that they made some poor decisions – in particular, wasting time at the beginning of the pandemic – and that numerous other countries have been more successful in limiting COVID-19 fatalities.

Table 1, of course, is merely illustrative. It is compatible with the possibility that an effective state response during a pandemic crisis depends less on the type of political system than on other factors that might include relevant experience in handling epidemics; clear-minded leadership; and an efficient bureaucracy, drawing on a wide range of social organisations.²³ This is not to suggest that there is no moral or practical distinction to be made between authoritarian and democratic states, whether in general or in their performance over COVID-19. On the contrary, some of the most difficult issues in the crisis have arisen because of the instinct of certain authoritarian states and leaders to clamp down on publicity and debate about an epidemic within their realm.

Nevertheless, it would be counterproductive to approach the current COVID-19 crisis as a platform for championing democracy over authoritarianism. Even if democratic states were all performing strongly, global cooperation is needed among all kinds of states on numerous aspects of this crisis, including the manufacture of medicines and equipment, scientific research, immunisation programmes, transport and quarantining.

International organisations

Any attempt to control a pandemic requires both action within states and international cooperation. Ideally, the two would be complementary. International bodies of many types, from Médecins sans Frontières to the UN Security Council, have been involved in the COVID-19 crisis.²⁴ By far the most important, and controversial, has been the WHO. It has 194 member states, necessarily includes governments of all sorts and has a notably broad range of responsibilities. One of its key guiding documents

is the International Health Regulations (IHR), covering 196 countries and revised substantially in 2005, the purpose and scope of which are ‘to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade’.²⁵ Under these regulations, the WHO is responsible for deciding when a particular situation should be declared a public-health emergency of international concern (PHEIC). They do not mention the word ‘pandemic’.²⁶

In this century, before the advent of COVID-19, the WHO played a significant but sometimes controversial role in addressing several major outbreaks of viral diseases. In 2002–04, SARS caused an epidemic of great regional concern in Asia. The WHO did not deem it a PHEIC (the concept was still in development) or identify it as a pandemic. The perception that China had initially covered up this outbreak, and that the WHO’s performance had been weak, led to the WHO’s adoption of the IHR in 2005.

In contrast, the WHO proclaimed the H1N1 influenza (or ‘swine flu’) outbreak a PHEIC on 26 April 2009 and a pandemic on 11 June 2009. The mortality rate was low. But the WHO was accused both of exaggerating the danger and of being slow to determine that this was a pandemic.

In 2012, the WHO issued a global alert about Middle East respiratory syndrome (MERS), a coronavirus disease that had broken out mainly in Saudi Arabia and some neighbouring countries, and which later revived in South Korea. The WHO did not designate MERS as a PHEIC.

In 2013–14, the WHO’s slowness in declaring the Ebola-virus outbreak in West Africa a PHEIC increased the scale and severity of this health crisis. The WHO eventually designated it as a PHEIC on 8 August 2014.²⁷ (Subsequently, on 17 July 2019, it designated an Ebola outbreak in the Democratic Republic of the Congo as a PHEIC.)

As its erratic performance suggests, the WHO is a problematic organisation. Its IHR, which prioritise multilateral cooperation, have proved difficult to implement in many countries. Some of the WHO’s wounds have been self-inflicted: in October 2017, it appointed Robert Mugabe, then president of Zimbabwe, as a goodwill ambassador, a decision quickly withdrawn

after an uproar over Mugabe's atrocious record on governance, corruption and human rights. But all international organisations, even those concerned with matters of health, have been riven by differences among member states at some point. A harbinger of the United States' current hostility arose in the 1920s and 1930s, when it refused to join the Geneva-based Health Organisation of the League of Nations.²⁸ The US did remain a member of the Office International d'Hygiène Publique, based in Paris, but its rejection of the League of Nations doomed efforts to merge the Geneva- and Paris-based bodies. Thus, Europe hosted two rival global-health organisations until the WHO was established in 1948. The WHO too has had its inter-state difficulties. In 1949, the Soviet Union left the organisation for a variety of stated reasons, including Moscow's purportedly superior understanding of the causes and cures of diseases, and its denial of the worth of collective WHO action against disease.²⁹ China also had its suspicions of the WHO, which, along with other UN bodies, had until 1971 recognised Taiwan as the official Chinese government.

Now, ironically, the US and others have impugned the WHO for China's supposed sway within the organisation. The WHO recognised the coronavirus outbreak as a PHEIC on 30 January 2020, named the disease COVID-19 on 11 February and characterised its spread as a pandemic on 11 March.³⁰ But accusations surfaced that the WHO had been unduly tolerant of the dilatoriness and sparseness of China's required reporting on the epidemic, especially on human-to-human transmission. There appears to be some truth to these claims.

From 12 December 2019 onwards, some patients in Wuhan, the most populous city in Central China, were identified as suffering from an unusual infection of the lungs. Teams of Chinese medical professionals concluded that this illness involved a new virus strain closely related to the SARS virus experienced in China from 2002 onwards. They noted the potential for human-to-human transmission, and on 3 February their findings were promptly published on the website of the international journal *Nature*. One article was based on a single patient.³¹ A second article was based on five patients.³²

Alongside such evidence of openness there were also signs of a partial cover-up. On 30 December 2019, several medical professionals in Wuhan

had circulated messages expressing concern about a cluster of cases of a flu-like disease, possibly SARS, that had been treated at hospitals in the city. One hospital's supervision department rebuked one of these doctors, Dr Ai Fen, director of the Emergency Department of Wuhan Central Hospital, for 'spreading rumours'. Dr Li Wenliang, an ophthalmologist at the hospital, was detained for several days by the Wuhan police for circulating some messages about the cases, accused of 'making false comments on the Internet about unconfirmed SARS outbreak' and ordered to 'stop spreading rumours'. Dr Li soon died from COVID-19.³³

On 31 December 2019, the authorities in Wuhan reported to the WHO China Country Office an outbreak of cases of 'pneumonia of unknown etiology' in the city. In information provided on that day or a few days later, the Chinese authorities said 44 cases were involved, that some patients worked in the Huanan Seafood Market and that there was 'no evidence of significant human-to-human transmission'.³⁴ Also on 31 December, Taiwan reportedly sent an email to the WHO, warning of cases of atypical pneumonia in Wuhan.³⁵ On 11 January 2020, Dr Yong-Zhen Zhang of the Shanghai Public Health Clinical Center and School of Public Health shared on open websites the full sequence of the coronavirus genome, as detected in samples taken from the first patients. This was an important step towards developing diagnostic tests for the virus.³⁶ The move was widely praised internationally, but the next day the Chinese government closed the clinic 'for rectification'.³⁷ Also on 11 January, Chinese media reported the first death from the novel coronavirus – that of a 61-year-old man who had frequently visited the live-animal market in Wuhan.

Early official Chinese statements about the coronavirus outbreak in Wuhan minimised the significance of these events, conveyed the impression that there was no human-to-human transmission and indicated that the outbreak was exclusively connected with the animal market in Wuhan. Then, after the extreme threat posed by the virus had become apparent, criticisms of China for its handling of the issue mounted. Many reports indicated that the number of those who had contracted the new illness from November

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2019 onwards was significantly higher than had been admitted in official statements.³⁸ The WHO's reaction throughout January was to seek more information from China about the outbreak. It experienced difficulties, of which some details emerged in early June, especially following a detailed investigation by the Associated Press (AP) that uncovered transcripts of tape recordings of meetings in January between Chinese health officials and representatives of the WHO. The AP article describes

significant delays by China and considerable frustration among WHO officials over not getting the information they needed to fight the spread of the deadly virus ... Despite the plaudits, China in fact sat on releasing the genetic map, or genome, of the virus for more than a week after three different government labs had fully decoded the information. Tight controls on information and competition within the Chinese public health system were to blame, according to dozens of interviews and internal documents.

The recordings suggest that rather than colluding with China, as Trump declared, WHO was itself kept in the dark as China gave it the minimal information required by law. However, the agency did try to portray China in the best light, likely as a means to secure more information. And WHO experts genuinely thought Chinese scientists had done 'a very good job' in detecting and decoding the virus, despite the lack of transparency from Chinese officials.³⁹

US President Donald Trump initially lavished extraordinary praise on the Chinese government for its handling of the coronavirus crisis. On 24 January he said in a tweet: 'China has been working very hard to contain the Coronavirus. The United States greatly appreciates their efforts and transparency. It will all work out well. In particular, on behalf of the American People, I want to thank President Xi!'⁴⁰ Consistent in inconsistency, Trump rapidly became more critical of both China and the WHO. He showed no awareness of the contribution of Chinese medical professionals to the world's knowledge of COVID-19. On 14 April he announced that he planned to halt

US funding of the WHO, which he described as ‘severely mismanaging and covering up the spread of the coronavirus’. He also repeatedly expressed his fury at the WHO’s opposition to US-supported travel bans stopping flights from China.⁴¹ On 30 April he reiterated his claim (with no substantiation) that the Wuhan Institute of Virology was the origin of this virus.⁴² When the CIA was asked to support this theory, it reported promptly that it could find no evidence for it.⁴³ Later in the summer a detailed response by Shi Zhengli of the Wuhan institute also rejected the claim.⁴⁴

In a four-page letter dated 18 May 2020, Trump said that if the WHO failed to commit to major improvements in the next 30 days, he would make the temporary freeze on US funding for the organisation permanent.⁴⁵ On 29 May, not waiting for the expiry of the deadline he himself had set, he announced the United States’ severance of all relations with the WHO, stating that the US would redirect its funds to other global public-health needs.⁴⁶ However, instant gratification was not available in this case. Subject to congressional requirements, the US withdrawal from the WHO would be effective on 6 July 2021, long after the US presidential election.⁴⁷ The American Medical Association and other professional medical institutions strongly opposed the move.⁴⁸

Many of the US criticisms of the WHO were illogical or poorly supported. The complaint about uncritical statements on China made by Tedros Adhanom Ghebreyesus, director-general of the WHO, may have been reasonable in a vacuum, but was undermined by Trump’s comparable effusiveness about China. The widespread suspicion was that Trump was blaming China in order to deflect attention from his own failure to effectively address the COVID-19 crisis in the US.⁴⁹ Sadly, the whole episode confirms how easily, even over an issue on which there are powerful reasons for international cooperation, national-level suspicion and rancour can gain traction.⁵⁰

Political consequences of pandemics

Major disasters, especially if they can be blamed on particular governments, may spur significant political developments. But the connections can be hard to trace. For example, as Richard Evans has suggested, although many outbreaks of cholera in Central Europe in the nineteenth

century roughly coincided with revolutions, 'epidemics were less causes than consequences of revolutionary upheavals and the government reactions associated with them'.⁵¹

The 'Spanish flu' pandemic of 1918–19, however, could possibly have given momentum to the incipient Indian independence movement. That pandemic has been well described by Laura Spinney in her book *Pale Rider*.⁵² In an interview, Spinney reflected on the connection:

People were dying in droves and in the absence of any British doctors.

[...]

The people who stepped into that [medical] breach tended to be the militants, the grassroots militant activists for independence who had already worked out how to cross caste barriers and work together for a different goal, i.e. independence.

Once the pandemic passed, emotion against the British was even higher than it had been before ... Those people were far more united than they had been. And now they came together behind Gandhi. He found that suddenly, he had the grass roots support that he had been lacking until then.⁵³

It is a heady thought that a pandemic may have ultimately yielded the independence of India in 1947, and thus triggered decolonisation. However, the proposition that there was a close connection between the pandemic and the rise of activism in India has been challenged. David Arnold, emeritus professor of Asian and global history at Warwick University, and a pioneer in the field of colonial medicine, confirmed the terrible scale of the pandemic's carnage in India.⁵⁴ But Arnold assessed that the pandemic coincided with a diminution of resistance:

If some of India's leading dissidents, such as Bal Gangadhar Tilak and Annie Besant, were less vocal than they had been in 1917, a new whirlwind force was emerging in Mohandas Gandhi, who in a matter of months switched from recruiting soldiers for the Raj to riding the wave

of anti-colonial discontent. Recovering from a protracted illness of his own, he called for non-violent resistance against the repressive Rowlatt Act and so sparked a fresh round of protest and defiance. It might be excessive to argue that agitational politics drove endemic hunger from the newspapers' front pages, or that, imperial violence supplanting epidemic violence, the Amritsar massacre of April 1919, with its nearly 400 deaths, put the twelve million influenza deaths in the shade; but something of that order helps explain why influenza did not command more intense and lasting attention. The Indian middle classes, so vocal over plague, were far more muted over influenza.⁵⁵

Sometimes it is measures taken to tackle epidemics that can lead to public objections – whether on religious, health, prudential or other grounds. This is not a new phenomenon. In 1691, during Dubrovnik's last major urban plague, people who were suspected of infection and had been forcibly relocated to the island of Lokrum rebelled, apparently due to overcrowded conditions.⁵⁶ In the UK this year, one reason for the delay in the governmental decision on lockdown (eventually imposed on 23 March) was nervousness about the potential risk of popular discontent.⁵⁷ Meanwhile, in the US, some of the resistance to lockdowns was anti-science, anti-federal government and violent.

In the first months of 2020, there was a tendency in many countries to accept implicitly a simple set of assumptions about the political consequences of pandemics: that COVID-19 is such a deadly threat to societies that only governments can deal with it, thus fulfilling their most basic responsibility, namely the protection of the people. The corollary was that the time for strikes and opposition movements was over. This was war and required unity.

The war analogy is of course imperfect. I am reminded of a British officer whom I met years ago, who at the end of the Second World War had been military governor of Perugia. A visiting general asked him why he had failed to wage war against the mosquitoes in the area. He replied: 'But we did.' And what happened, asked the general. 'The mosquitoes won.' The struggles against mosquitoes, and against viruses, are by nature very different from

war. A better analogue of the struggle against the virus may be civil resistance to tyranny. Both courses of action are based on an understanding that the adversary – be it an autocrat needing obedient citizens, or a virus needing a warm host to enable it to replicate and spread – is dependent on people for daily cooperation. Both methods aim to undermine the adversary’s sources of power, not so much by fighting as by depriving it of essential resources. And both tend to take a long time to achieve results, leading to frustration among those who have made sacrifices for the cause.

Of course, there are sharp differences. Lockdown tends to be a state activity, while civil resistance is more often initiated by civil-society groups. Even so, lockdown is not in every case a product of government intervention, but can also result from citizen initiative.

Viruses depend on people

Lawrence Freedman has observed that in the UK in March 2020, even before a government-imposed lockdown became mandatory, the public ‘was already taking their own action. By 18 March there was a 40% reduction in transport use in London. Some 45% of Londoners had stopped visiting leisure venues.’⁵⁸ The fact that scientists were heavily and publicly involved in official processes that led to government-mandated lockdown conveyed the message that this was not a government-imposed grab for power, but rather a socially and scientifically necessary step.

Any similarities between lockdowns and civil-resistance movements do not make them natural allies. On the contrary, many governments that have presided over COVID-19 lockdowns have taken a tough line on demonstrations, not least through lockdown rules illegalising all meetings beyond family units. Yet in periods of lockdown, many movements, whether on grounds of health or political prudence, have eased up on demonstrations. Other movements have tried to adapt their policies and *modi operandi*. On 28 May 2020, Extinction Rebellion announced a series of demonstrations in the UK in which people were to be physically distanced at three metres apart and were asked to wear protective face masks. It was not in opposition to the lockdown as such, but it did reflect a criticism of government failure to ‘listen to the science’ on environmental matters as much as on COVID-19.⁵⁹

Of the many social movements active during the COVID-19 crisis, the most visible and influential has been 'Black Lives Matter'. George Floyd, an African-American man, was killed in Minneapolis on 25 May 2020 when a policeman knelt on his neck for over eight minutes; he repeatedly said 'I can't breathe'. This established a symbolic link with COVID-19, many survivors of which had given graphic descriptions of their difficulties in breathing. Especially in the US, a further connection arose from the discrepancy between the rough and arbitrary police treatment of African Americans, and the much gentler treatment of right-wing, anti-lockdown demonstrators. Added to this was growing evidence that COVID-19 was much more likely to kill poor people, and those from Black, Asian and minority ethnic (BAME) groups, as recognised in a report published in the UK on 2 June – just eight days after Floyd's death.⁶⁰ This confluence of facts fed a sense of injustice. Suddenly, in many parts of the world, Black Lives Matter demonstrations burgeoned – many of them playing havoc with lockdown and social-distancing rules. The police could do little about it.

Yet the COVID-19 crisis continued to have illiberal consequences. In over 60 countries and territories, it was the basis for postponing national and local elections.⁶¹ In some places, it has also been a basis for introducing emergency legislation suspending a range of constitutional procedures and citizen rights. Two examples are Hungary and Hong Kong.

In Hungary, the long-standing goal of Prime Minister Viktor Orbán is to create what he has called 'illiberal democracy'. On 30 March 2020, the Hungarian parliament passed a law styled the 'Act on Protection Against the Coronavirus' enabling the government to rule by decree to the extent necessary to address the pandemic's consequences. This special legal order was widely criticised.⁶² On 17 April, the European Parliament condemned it as 'totally incompatible with European values'.⁶³ In an interview on Hungarian radio on 22 May, Orbán presented this rationale for his use of exceptional powers under the law of 30 March. In his view, the end justified the means:

The special legal order was one of our best decisions, primarily because we were able to make every subsequent decision in good time. So, if you look at countries which are usually considered to be better than us – say

Austria, the Italians or the French – you’ll see that in every case here we enacted the first protection measures a week or two earlier than the other countries ... the defence operation in Hungary was so effective that in the end there was no mass infection, the epidemic did not cross over into mass infection ... The special rule of law was a great help to me, because if something happened in a care home, in the economy or at a border crossing, I didn’t have to go to Parliament with a decree to quarrel and engage in a tug-of-war with this left-wing opposition; instead I could react as the situation required – within an hour, if necessary.⁶⁴

Four days later, on 26 May, Orbán submitted a 250-page bill to parliament to end the country’s state of emergency by mid-June. This bill’s complex provisions would allow the government to rule again by decree for an indefinite period of time. A separate bill gave the government the power to declare a state of medical crisis, to last for at least six months. The Hungarian parliament passed these bills on 16 June, by a vote of 190 to nil, and the state of emergency formally ended on 20 June. Unsurprisingly, this transparent ploy was criticised as offering only an illusion of the end of the state of emergency.

In Hong Kong, the problems that provoked a major crisis in 2020 were of long standing. The 1984 Sino-British Joint Declaration, the key international treaty guaranteeing Hong Kong’s autonomy except in foreign affairs and defence, was supposed to chart the status of the Hong Kong Special Administrative Region for 50 years from the restoration of the territory to China on 1 July 1997.⁶⁵ Among the inhabitants, fears of erosion of the existing degree of autonomy were strong. From 2005 onwards there were many large and mainly non-violent demonstrations, generally demanding more democracy. The 2014 student-led ‘Umbrella Movement’, demanding reforms of Hong Kong’s election laws, was strikingly well organised. Then, from June 2019, huge demonstrations, mainly student-led, were triggered by fears about a proposed new Hong Kong law that would have provided for extradition to mainland China of fugitive offenders. Carrie Lam, chief executive of Hong Kong, withdrew the bill on 4 September, but would not concede the demonstrators’ other demands, which included, for example,

her own resignation, retraction of the designation of certain demonstrations as ‘riots’ and an independent investigation of police brutality. Protests continued, being countered, as before, by extensive police use of tear gas and protesters’ use of face masks. There was also increasing violence from a small but significant minority of the demonstrators. Parties supporting the demonstrators’ aims won a landslide victory in the Hong Kong District Council elections on 24 November 2019.

In early 2020, the pandemic brought a change of focus. It appeared to increase the determination of the authorities in Hong Kong and Beijing to end the embarrassing displays of public hostility. In late March, with encouragement from Beijing, the Hong Kong authorities passed a regulation prohibiting gatherings of more than four people on the pretext of disease control.⁶⁶ It failed to stop the demonstrations. Bypassing the Hong Kong authorities completely, the Standing Committee of the National People’s Congress in Beijing passed a sweeping new ‘National Security Law’ for Hong Kong on 30 June, effective immediately.⁶⁷ The UK government declared that the new law was a ‘clear and serious’ violation of the 1984 Joint Declaration on Hong Kong.⁶⁸

The new law pays lip service to ‘ensuring the resolute, full and faithful implementation of the policy of One Country, Two Systems under which the people of Hong Kong administer Hong Kong with a high degree of autonomy’. It includes an article on human rights, stipulating that the provisions of both the International Covenant on Civil and Political Rights, and the one on Economic, Social and Cultural Rights, are to be protected. But its main thrust is its enunciation of new rights and powers for the Chinese authorities in Hong Kong, and its listing of a range of loosely defined offences. In a long list of ‘terrorist activities’, Article 24 includes ‘dangerous activities which seriously jeopardise public health, safety or security’. Article 20, on secession, prohibits many acts ‘whether or not by force or threat of force’, effectively criminalising even non-violent forms of political action.⁶⁹

Following the law’s passage, the Hong Kong government became harsher. On 30 July, 12 pro-democracy politicians were disqualified from standing in elections to the Legislative Council scheduled for 6 September

2020. A day later, these elections were postponed for a year under the Emergency Regulations Ordinance – according to Lam, ‘purely on the basis of protecting the health and safety of the Hong Kong people’.⁷⁰ In addition to seeing COVID-19 per se as an excuse for tighter civil control, China may have regarded the weakened international positions of the US and the UK in light of their poor performance in the pandemic crisis as increasing its freedom of action to impose authoritarian measures without provoking a strong international response.

In several countries with a history of internal conflict, such as Sri Lanka, the armed forces were given increased law-enforcement responsibility.⁷¹ At the same time, Steven Simon has looked at other countries, including Hungary, the Philippines and the US, in which the virus threat might be used in order to ‘inure the public to the erosion of civil liberties and the expansion of executive power’. He has judiciously observed that such moves have other causes as well, and that ‘the current crisis does not really seem to rise to the status of game changer in the long-standing tussle between liberal and illiberal democracies – or competitive democracies – and authoritarian regimes’.⁷² Francis Fukuyama has offered a range of scenarios that COVID-19 could encourage, some pessimistic (rising fascism) and some optimistic (resilient democracy). He entertains the hope that the crisis will have a beneficial selection effect in leading to the exposure of recklessly authoritarian figures such as President Jair Bolsonaro of Brazil. Professionalism and competence may again come to be valued. More broadly, Fukuyama has noted that:

Major crises have major consequences, usually unforeseen. The Great Depression spurred isolationism, nationalism, fascism, and World War II – but also led to the New Deal, the rise of the United States as a global superpower, and eventually decolonization. The 9/11 attacks produced two failed American interventions, the rise of Iran, and new forms of Islamic radicalism. The 2008 financial crisis generated a surge in anti-establishment populism that replaced leaders across the globe. Future historians will trace comparably large effects to the current coronavirus pandemic; the challenge is figuring them out ahead of time.⁷³

Past epidemics suggest a wide range of effects. One obvious one stands out. The United States' reputation as a serious international actor has undergone a major decline. The trend began long ago with the Vietnam War, and gained momentum with fraught conflicts in Afghanistan and Iraq. But Trump's wilful alienation of allies and international institutions has accelerated and intensified the problem. In his serially gormless involvements in the COVID-19 crisis, he has failed to look after his own country. His repeated verbal attacks on China, and on the WHO, have shown an inability to temper disagreement with basic civility and attention to facts. In a long line of major missteps, Trump's crowning failure has arguably been his complete abdication of responsibility for mobilising international cooperation in the pandemic.

* * *

The long-term effects of epidemics have been huge. Dealing with them has always been difficult and remains so today. The history of epidemics suggests that the present crisis is likely to have a long tail, and that other epidemics are to be expected. The scope of the threat is undoubtedly international – COVID-19 spread fast around the globe largely because of modern means of travel – and vigorous international collaboration among medical professionals has been one redeeming feature of this crisis.⁷⁴ The specialised roles of international bodies such as the WHO remain essential. Yet the very scale and expense of the tasks faced, the continuing suspicion among states and the tendency of great-power disagreements to be dragged into such organisations make them unable to assume overall responsibility for managing pandemics.

Tackling epidemics is first and foremost a task for national governments. This responsibility dates back to the fourteenth century, when city states in the Italian Peninsula and the Adriatic began to develop systems for taking administrative measures against plagues. While viruses do not respect borders, their spread and their chances of survival have long depended greatly on the laws, policies and acts of states. However, not all states are up to the job. Their effectiveness in addressing pandemics

does not appear to turn on what position they occupy on the democratic–authoritarian divide. The key factors are rather the competence of leaders, their capacity to make quick decisions, their willingness to listen to scientists, the effectiveness of their bureaucratic machinery and the degree of trust they engender in citizens.

In this crisis there has been much discussion of the performance of women heads of government. Most of the 12-plus governments under female leadership made prompt decisions about lockdowns and other measures, and were effective at communicating with the public. In most cases, their countries suffered relatively low death rates. In the literature analysing this, there are various preliminary explanations as to why women performed relatively well in this crisis, and the phenomenon calls for further investigation.⁷⁵

Struggles against epidemics necessarily involve the hazard-strewn task of goal-setting. In the case of COVID-19, the capacity of the virus to stage a second rise in cases after it had been beaten in a particular area is one of many reasons for caution in promising and claiming successes. Complete worldwide elimination of the virus should of course be an ultimate goal, but is almost certainly unrealistic in the short or medium term. In the meantime, the main aims must be to use a wide range of measures to reduce the circulation of the virus among the population and minimise the susceptibility of the population to it. These include old-fashioned quarantines as well as the sophisticated development of vaccines.

Trust in leadership is essential because struggles against infectious diseases necessitate a degree of individual sacrifice for the social good. If people are required to stay indoors for months, to socially distance, to deploy their skills on the front line or to accept a vaccine despite a barrage of hostile internet propaganda, they need a sense that the advice they are getting comes from an honest source, is given for good reasons and contemplates a plausible goal. While the war analogy is tempting, it does not sit well with struggles against epidemics because the process of coping with virus-laden threats is necessarily slow, decentralised and unspectacularly administrative and social.

The process of ending pandemic lockdowns and other measures may yet prove more socially divisive than their initial implementation had

been. It requires some very difficult and controversial judgements about whether and how to relax certain measures and the risks involved. Within communities, care-home staff or schoolteachers may feel it is unsafe to resume their normal pattern of work without access to certain evidence, protective equipment, test procedures and other support. Within states, there may be fundamental disagreements about how policies and institutions need to change in light of varying experiences with this pandemic. In the international context, disagreements may arise when one country's action, or refusal to act, poses risks for other states and their citizens. Notwithstanding the obstinacy of some leaders, there is no denying the pressing need to coordinate and harmonise policies between all levels of government and across borders.

Notes

- 1 William H. McNeill, *Plagues and Peoples* (New York: Doubleday, 1998), p. 295. This book is about epidemic infections generally, and is not therefore confined to those specifically known as plagues. Compared to the first edition, published in 1976, McNeill did not alter his conclusions at all, but he did add a preface, largely about the AIDS epidemic, in which he reiterated the book's central theme of 'our extraordinary capability for altering natural balances, and the limitations of those capabilities'. McNeill, *Plagues and Peoples*, p. 16.
- 2 See the First Book of Samuel, chapters 5 and 6, in the Old Testament; and Frank R. Freeman, 'Bubonic Plague in the Book of Samuel', *Journal of the Royal Society of Medicine*, vol. 98, no. 9, September 2005, p. 436.
- 3 Giovanna Morelli et al., 'Phylogenetic Diversity and Historical Patterns of Pandemic Spread of *Yersinia pestis*', *Nature Genetics*, vol. 42, no. 12, December 2010, pp. 1,140–3.
- 4 Ole Benedictow, 'Yersinia Pestis, the Bacterium of Plague, Arose in East Asia. Did It Spread Westwards via the Silk Roads, the Chinese Maritime Expeditions of Zheng He or over the Vast Eurasian Populations of Sylvatic (Wild) Rodents?', *Journal of Asian History*, vol. 47, no. 1, 2013, pp. 12, 19, 29–30.
- 5 François Heisbourg, 'From Wuhan to the World: How the Pandemic Will Reshape Geopolitics', *Survival*, vol. 62, no. 3, June–July 2020, p. 7.
- 6 Paul Slack, 'Introduction', in Terence Ranger and Paul Slack (eds), *Epidemics and Ideas: Essays on the Historical Perception of Pestilence* (Cambridge: Cambridge University Press, 1992), pp. 15, 16.
- 7 Rina Kralj-Brassard, 'A City Facing the Plague: Dubrovnik, 1691', *Dubrovnik Annals*, vol. 20, September 2016, p. 110.

- ⁸ See Samuel K. Cohn, *Cultures of Plague: Medical Thinking at the End of the Renaissance* (Oxford: Oxford University Press, 2009), pp. 8, 211–16, 299.
- ⁹ Sebastiano Tranzi, *Trattato di Peste* (Rome: Heredi di Giovanni Gigliotto, 1587), dedication to the Archbishop of Lanciano, on six unnumbered pages, final page.
- ¹⁰ Cohn, *Cultures of Plague*, pp. 294, 297–9.
- ¹¹ See Quentin Skinner, *The Foundations of Modern Political Thought*, Volume 1: *The Renaissance* (Cambridge: Cambridge University Press, 1978), pp. 3–7, 15–17, 23–8, 41–6, 53.
- ¹² ‘Dexamethasone Reduces Death in Hospitalised Patients with Severe Respiratory Complications of COVID-19’, University of Oxford, 16 June 2020, <http://www.ox.ac.uk/news/2020-06-16-dexamethasone-reduces-death-hospitalised-patients-severe-respiratory-complications>.
- ¹³ Reports in the UK media of use of indigenous medicines in areas of Brazil affected by COVID-19 have included Peter Stuble, ‘Brazil’s Remote Tribes in Amazon Turn to Tree Bark and Honey to Treat Coronavirus’, *Independent*, 20 May 2020, <https://www.independent.co.uk/news/world/americas/brazil-coronavirus-amazon-tribe-tree-bark-plants-honey-cure-bolsonaro-a9524551.html>; and Lindsey Hilsum, ‘How an Amazon Rainforest Village Survived Covid-19 with Modern and Traditional Medicine’, Channel 4 News, 8 June 2020, <https://www.channel4.com/news/how-an-amazon-rainforest-village-survived-covid-19-with-modern-and-traditional-medicine>.
- ¹⁴ See Robin Harris, *Dubrovnik: A History* (London: Saqi, 2003), pp. 333, 347.
- ¹⁵ See Lily Kuo, ‘Birth of a Pandemic: Inside the First Weeks of the Coronavirus Outbreak in Wuhan’, *Guardian*, 10 April 2020, <https://www.theguardian.com/world/2020/apr/10/birth-of-a-pandemic-inside-the-first-weeks-of-the-coronavirus-outbreak-in-wuhan>.
- ¹⁶ Martin Loughlin, ‘The Contemporary Crisis of Constitutional Democracy’, *Oxford Journal of Legal Studies*, vol. 39, no. 2, Summer 2019, pp. 436–7.
- ¹⁷ For the detailed Freedom House assessment of all countries in 2019–20, see <https://freedomhouse.org/countries/freedom-world/scores>.
- ¹⁸ See Freedom House, ‘Freedom in the World 2020 Methodology’, <https://freedomhouse.org/reports/freedom-world/freedom-world-research-methodology>; and Freedom House, ‘Principles for Protecting Civil and Political Rights in the Fight Against Covid-19’, 24 March 2020, <https://freedomhouse.org/article/principles-protecting-civil-and-political-rights-fight-against-covid-19>.
- ¹⁹ See, for example, the detailed studies pointing to this conclusion in Jean Drèze, Amartya Sen and Athar Hussein (eds), *The Political Economy of Hunger* (Oxford: Clarendon Press, 1990), vol. I, *Entitlement and Well-Being*, pp. 6–7, 23–4, 146–89; and vol. II, *Famine Prevention*, pp. 145, 153, 159–60, 190–1.
- ²⁰ Amartya Sen, ‘Overcoming a Pandemic May Look Like Fighting a War, But the Real Need Is Far From That’, *Indian Express*, 8 April 2020, <https://indianexpress.com>.

com/article/opinion/columns/coronavirus-india-lockdown-amartya-sen-economy-migrants-6352132/.

- ²¹ Table 1 is based on data from the European Centre for Disease Prevention and Control. These figures take account of changes in certain countries' methods of calculating the number of deaths due to COVID-19. For example, Public Health England announced on 12 August 2020 that it was ceasing to count as COVID-19 deaths all those who had tested positive for the disease more than 28 days before they died, unless COVID-19 was also mentioned on the death certificate. This change was intended to reduce the risk of over-counting – for example, of those who had recovered from COVID-19 but subsequently died of unrelated causes.
- ²² Global Health Security Index, October 2019, pp. 20–2, <https://www.ghsindex.org/wp-content/uploads/2019/10/2019-Global-Health-Security-Index.pdf>. The GHSI is the result of cooperation between the Nuclear Threat Initiative, the Johns Hopkins Center for Health Security and the Economist Intelligence Unit. The GHSI did note that 'national health security is fundamentally weak around the world. No country is fully prepared for epidemics or pandemics, and every country has important gaps to address.'
- ²³ See Francis Fukuyama, 'The Pandemic and Political Order', *Foreign Affairs*, vol. 99, no. 4, July/August 2020, pp. 26–8.
- ²⁴ UN Security Council Resolution 2532, passed unanimously on 1 July 2020 after protracted negotiations, expressed 'grave concern about the devastating impact of the COVID-19 pandemic across the world, especially in countries ravaged by armed conflicts' and demanded 'a general and immediate cessation of hostilities in all situations on its agenda', but added, unusually, that this call 'does not apply to military operations against the Islamic State' and other named terrorist groups. Owing to US objections, this resolution (unlike earlier Security Council resolutions on HIV/AIDS and Ebola) contains no mention of the WHO. For background, see Julian Borger, 'US Blocks Vote on UN's Bid for Global Ceasefire over Reference to WHO', *Guardian*, 8 May 2020, <https://www.theguardian.com/world/2020/may/08/un-ceasefire-resolution-us-blocks-who>.
- ²⁵ Foreword, *International Health Regulations*, 3rd edition (Geneva: WHO, 2016), p. 1. The full text of the IHR is on pp. 6–39.
- ²⁶ WHO sources have defined 'pandemic' as referring to the worldwide spread of a new disease. However, the emphasis on the newness of a disease has not been consistent, and on the day the WHO declared a pandemic regarding the H1N1 virus, the director of the Centers for Disease Control, a US federal agency, indicated that the use of the term 'pandemic' does not suggest that there has been any change in the behaviour of a virus, but only 'that it is spreading in more parts of the world'. Centers for Disease Control and Prevention, 'CDC Press Conference on Investigation of Human Cases of Novel Influenza A H1N1', 11 June 2009, <https://www.cdc.gov/media/transcripts/2009/t090611.htm>.
- ²⁷ For a succinct summary of its poor

- performance in many crises including the 2014 Ebola epidemic, see Francesco Checchi et al., 'World Health Organization and Emergency Health: If Not Now, When?', *British Medical Journal*, 2016, <https://www.bmj.com/content/352/bmj.i469.long>.
- ²⁸ See 'Message of 25 April 1921 from the President of the Permanent Committee of the Office International d'Hygiène Publique to the Secretary-General of the League of Nations', in Norman Howard-Jones, *The Scientific Background of the International Sanitary Conferences 1851–1938* (Geneva: WHO, 1975), pp. 93–4.
- ²⁹ See Charles E. Allen, 'World Health and World Politics', *International Organization*, vol. 4, no. 1, February 1950, pp. 40–2.
- ³⁰ See 'Statement on the Second Meeting of the International Health Regulations (2005) Emergency Committee Regarding the Outbreak of Novel Coronavirus (2019-nCoV)', WHO, 30 January 2020, [https://www.who.int/news-room/detail/30-01-2020-statement-on-the-second-meeting-of-the-international-health-regulations-\(2005\)-emergency-committee-regarding-the-outbreak-of-novel-coronavirus-\(2019-ncov\)](https://www.who.int/news-room/detail/30-01-2020-statement-on-the-second-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-outbreak-of-novel-coronavirus-(2019-ncov)).
- ³¹ Fan Wu et al., 'A New Corona Virus Associated with Human Respiratory Disease in China', *Nature*, vol. 579, 12 March 2020, pp. 265–9. It was also published online on 3 February 2020 at <https://www.natureindex.com/article/10.1038/s41586-020-2008-3>. This article was the work of 19 researchers, six in Wuhan, and almost all affiliated with Chinese public-health institutions. The study was conceived and designed by Yong-Zhen Zhang of Fudan University, Shanghai.
- ³² Peng Zhou et al., 'A Pneumonia Outbreak Associated with a New Coronavirus of Probable Bat Origin', *Nature*, vol. 579, 12 March 2020, pp. 270–3. It was also published online on 3 February 2020 at <https://www.nature.com/articles/s41586-020-2012-7>. This article was the work of 29 researchers, all affiliated with public-health institutions in Wuhan.
- ³³ He passed away on 7 February 2020, having caught the disease from an eye patient who was not known to have been infected. In March, the Chinese Communist Party issued an apology to him and revoked the admonishment. Helen Davidson, 'Chinese Inquiry Exonerates Coronavirus Whistleblower Doctor', *Guardian*, 21 March 2020, <https://www.theguardian.com/world/2020/mar/20/chinese-inquiry-exonerates-coronavirus-whistleblower-doctor-li-wenliang>.
- ³⁴ On 31 December 2019, the WHO China Country Office was informed (evidently by the Wuhan Municipal Health Commission) of the outbreak in Wuhan. Details, including those about the WHO response in early January 2020, are summarised in WHO, 'Pneumonia of Unknown Cause – China', 5 January 2020, <https://www.who.int/csr/don/05-january-2020-pneumonia-of-unkown-cause-china/en/>.
- ³⁵ On the action by Taiwan on 31 December 2019, see 'The Facts Regarding Taiwan's Email to Alert WHO to Possible Danger of COVID-19', Taiwan Centers for Disease Control, 11 April 2020, <https://www.>

- cdc.gov.tw/En/Bulletin/Detail/PAD-lbWDHeN_bLa-viBOuw?typeid=158. The 31 December warning from Taiwan is also mentioned in Lawrence Freedman, 'Strategy for a Pandemic: The UK and COVID-19', *Survival*, vol. 62, no. 3, June–July 2020, p. 30. It is not indicated in the timeline on COVID-19 published on the WHO website. Whether the Taiwan statement, or some advance notice of it, preceded (and therefore potentially triggered) the official statement by Wuhan authorities is unclear.
- ³⁶ Two open websites on which the genome was shared were virological.org and the US government-run National Library of Medicine, <https://www.ncbi.nlm.nih.gov/sars-cov-2/>. See also Jon Cohen, 'Chinese Researchers Reveal Draft Genome of Virus Implicated in Wuhan Pneumonia Outbreak', *Science*, 11 January 2020, <https://www.sciencemag.org/news/2020/01/chinese-researchers-reveal-draft-genome-virus-implicated-wuhan-pneumonia-outbreak>.
- ³⁷ Zhuang Pinghui, 'Chinese Laboratory that First Shared Coronavirus Genome with World Ordered to Close for "Rectification", Hindering Its Covid-19 Research', *South China Morning Post*, 28 February 2020, <https://www.scmp.com/news/china/society/article/3052966/chinese-laboratory-first-shared-coronavirus-genome-world-ordered>.
- ³⁸ For a newspaper summary of evidence about early Chinese cases of COVID-19, see Josephine Ma, 'Coronavirus: China's First Confirmed Covid-19 Case Traced back to November 17', *South China Morning Post*, 13 March 2020, <https://www.scmp.com/news/china/society/article/3074991/coronavirus-chinas-first-confirmed-covid-19-case-traced-back>.
- ³⁹ 'China Delayed Releasing Coronavirus Info, Frustrating WHO', Associated Press, 3 June 2020, <https://apnews.com/3c061794970661042b18d5aeaed9fae>.
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