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Mapping COVID-19 Legal Responses: A Functionalist Analysis

Joelle Grogan and Alicia Ely Yamin

I INTRODUCTION

The global COVID-19 pandemic caused by the novel coronavirus SARS-CoV-2 has focused the world's attention on the central importance of population health to the economic and social well-being of societies and to the multilateral order that depends upon a globalized, interconnected world. It has also highlighted the challenges to the democratic rule of law posed by the widely varying actions adopted by governments in response. The notion that health and democratic rights are intimately connected is not new. For example, Robin West asserts that the sovereign is given a monopoly on coercion in exchange for security against a life that is "nasty, brutish and short" and that the baseline condition of the sovereign's legitimacy lies in the protection of human health and well-being.[1] Therefore, according to West, health protection is foundational, not peripheral, to the liberal philosophical tradition.[2] Similarly, public health and health promotion is a precondition to substantive democracy – as those hobbled by infirmity will be unable to meaningfully engage in democratic self-governance. Historically, movements for universal health care, including the adoption of the National Health Service in the United Kingdom,[3] were democratic struggles to enlarge democratic inclusion.[4] Further, as laid bare during the pandemic, health systems have a role to play in sustaining and reproducing core democratic commitments to formal and substantive equality.

Drawing both on our respective scholarship in these fields as well as on insights from two global symposia on governmental responses held during the early phase of the pandemic, this chapter links analyses of democratic institutions and their capacity to maintain fundamental rights protections with the functioning of health systems

[1] Robin West, Reconsidering Legalism, 88 *Minn. L. Rev.* 119, 130–35 (2003).

[2] Id.

[3] Donald W. Light, Universal Health Care: Lessons from the British Experience, 93 *Am. J. Pub. Health* 25, 26 (2003).

[4] Vicente Navarro, Production and the Welfare State: The Political Context of Reforms, 21 *Int'l J. Health Servs.* 585, 614 (1991).

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and protections for the health rights of diverse people in practice. From April 6 to May 26, 2020, the "COVID-19 and States of Emergency" symposium, co-hosted by the *Verfassungsblog* and Democracy Reporting International, published eighty-two reports and commentaries on states of emergency and the use of power in response to the pandemic.[5] From May 12 to June 12, 2020, the "Global Responses to COVID-19: Rights, Democracy and the Law" symposium, hosted by the Petrie-Flom Center, produced thirty Bill of Health entries, each of which responded to three questions regarding: (1) the legal vehicles used in response to the pandemic; (2) the effects of these on marginalized populations; and (3) the roles of legislative and judicial oversight.[6] The analytical reports on the early months of the pandemic were authored by over 120 contributors worldwide, including academics drawn from the fields of international and constitutional law and health and social policy, as well as judges and lawyers specializing in public, administrative, and international law. These comparative approaches contrasted with efforts in those early days to produce repositories of laws and policies enacted with no contextualization.[7] As both symposia sought a diversity of perspectives about the preexisting legal architectures, as well as complex social and political impacts of governmental responses, they are not susceptible to a simplistic tabulation. Thus, the conclusions presented in this chapter should be read as reflecting the authors' joint interpretations of reported findings across the separate symposia.

This chapter proceeds as follows. First, it considers whether the use of emergency powers (e.g., the declaration of a constitutional state of exception or the use of legislative emergency frameworks which allow for the exceptional use of executive power outside normal constraints) is preferable to using ordinary legislation in managing the impacts on civil liberties of a health and social crisis. This chapter argues that whether countries are successful in limiting the potential for abuse of power in emergencies is dependent on the social and political environment in which the legal rules operate, as much as whether formal limitations and checks on the use of power are present. Second, the pandemic raises questions regarding the role of health policymaking and health systems as democratic institutions, which have been inexorably affected by decades of privatization and reduced social spending on health. This chapter suggests that the background rules that structure health systems (public health and care) and decision-making regarding priorities are as critical to understanding governmental responses as the legal recognition of health-related rights.

[5] For all country reports, see Joelle Grogan, Introduction and List of Country Reports, VerfBlog (Apr. 6, 2020), https://verfassungsblog.de/introduction-list-of-country-reports/.

[6] For all country reports, see Bill of Health, Global Responses to COVID-19: Rights, Democracy, and the Law, https://blog.petrieflom.law.harvard.edu/category/blog-symposia/global-responses-covid19/.

[7] See, for example, COVID-19 Government Response Tracker, Oxford, www.bsg.ox.ac.uk/research/research-projects/covid-19-government-response-tracker; COVID-19 Law Lab, https://covidlawlab.org. Subsequently, other researchers, including the Lex-Atlas project and the CompCoRe projects, developed a more extensive and detailed compendium of comparative legal analyses. See Lex-Atlas: COVID-19, UCL, https://lexatlas-c19.org/; CompCoRe, https://compcore.cornell.edu/.

II STATES OF EXCEPTION AND EMERGENCY

States of exception or emergency enable the exceptional use of powers, typically by the executive outside ordinary legislative processes or scrutiny, justified on the basis of the necessity of an urgent response to an emergency. By their nature and the strength of justifying urgency which calls for their use, emergency powers are at heightened risk of misuse or abuse where significant action can be taken with limited capacity for oversight, and where subsequent judicial review of executive discretion can be "so light a touch as to be non-existent."[8] The extended duration of the COVID-19 pandemic, in addition to concerns that the virus will become endemic, have extended the duration of executive dominance of decision-making,[9] leading to concerns that this will further global trends towards the autocratization and "decay" of democracies which were in motion prior to the pandemic.[10] Even as some countries have lifted many of the most restrictive measures on liberties at the time of writing, most provisions enacted have remained in place on statute books or in practice, leading to concerns that the modes of governance employed during the pandemic have normalized the exceptional in relation to public health emergencies.

Emergencies should not function as opportunities to permanently shift the balance of power toward the executive, resulting in decision-making that is all but unaccountable. Both symposia also underlined the importance of ensuring not only the limited nature of states of exception but, critically, the necessary limitations on the use of power during the emergency. For this, international human rights instruments, including the International Covenant on Civil and Political Rights, the American Convention on Human Rights, and the European Convention on Human Rights, have provided guidelines for safeguards on the use of exceptional power, which are typically premised on: (1) identifying certain non-derogable rights (e.g., the prohibition on torture and the right to a fair trial); and (2) requiring the use of emergency powers to be proportionate, necessary, non-discriminatory, and temporary in nature.[11] Health emergencies, including the current pandemic,[12] have been interpreted to come within these provisions.[13]

[8] David Dyzenhaus, The Constitution of Law: Legality in a Time of Emergency 41–43 (2006).

[9] Tom Ginsburg & Mila Versteeg, Binding the Unbound Executive: Checks and Balances in Times of Pandemic, Int'l J. of Const. L. (June 24, 2021), www.law.virginia.edu/scholarship/publication/mila-versteeg/1334721.

[10] Tom Daly, Democratic Decay: Conceptualising an Emerging Research Field, 11 *Hague J. Rule L.* 9, 9–11 (2019).

[11] See Cassandra Emmons, International Human Rights Law and COVID-19 States of Emergency, VerfBlog (Apr. 25, 2020), https://verfassungsblog.de/international-human-rights-law-and-covid-19-states-of-emergency.

[12] See, for example, Eur. Convention on Hum. Rts., Fact Sheet, Derogation in Time of Emergency (updated Sept. 2020), www.echr.coe.int/Documents/FS_Derogation_ENG.pdf.

[13] See, for example, UN HRC, General Comment No. 29, Article 4 (States of Emergency): International Covenant on Civil and Political Rights (2001); ECHR, Guide, Article 15 (Derogation in Time of Emergency): European Convention on Human Rights (updated Apr. 30, 2021), www.echr.coe.int/documents/Guide_Art_15_ENG.pdf.

A majority of countries in the symposia declared a "state of emergency" (or the domestic equivalent: e.g., a "state of exception" or "state of catastrophe") or relied upon some form of emergency powers in response to the pandemic. The symposia demonstrated a broad range and form of domestic design of both states of emergency regimes and on constitutional and legal safeguards on their use. Examples of constitutional states of exception ranged from highly prescriptive, tiered, and differential states of exception requiring legislative approval depending on the perceived severity of the emergency (e.g., Estonia and Peru) to open-ended and discretionary provisions providing for an exclusively executive decision on what constituted a "threat" (e.g., Cameroon, Malaysia, and Thailand). A number of states alternatively introduced new legislative (rather than constitutional) states of emergency (e.g., France and Bulgaria) or introduced new powers which were designated as "emergency." The latter legislative forms of emergency powers would have been expected to be subject to ordinary democratic checks and balances, including parliamentary scrutiny and judicial review, though often were not, either by legislative design or the degree of deference displayed by parliaments and courts.[14]

In the use of emergency power, a central question is the safeguarding of civil liberties through the permissible degree to which rights can be limited or states may derogate from rights protections. The "limitation" of rights, often as part of a domestic balancing exercise between competing rights or overriding public interest (e.g., the requirement to wear masks in public), is distinguishable from derogation, which is envisioned as a temporary suspension of certain (not all) rights during an emergency subject to a range of justificatory conditions (e.g., proportionality and temporariness) and the oversight of external human rights bodies, in the case of international instruments, or domestic courts, in the case of protections on constitutional rights. What is notable is that while nearly all states acted to place highly restrictive limitations on the exercise of rights, including movement, assembly, and worship, only a minority of these states in the initial phase of the pandemic made official notifications of derogations from international human rights instruments.[15]

There is no common reason why some states did, or did not, declare a state of emergency and it should not be assumed that it was to avoid ostensibly higher levels of scrutiny which may be expected under ordinary legislative processes. For example, a number of populous states, including Brazil, Bangladesh, Indonesia, and India, eschewed a declaration, likely for political reasons to either avoid negative historical associations of abuse of emergency powers or in the underestimation or downplaying of the severity of the pandemic threat. States which did not rely on emergency provisions instead relied on ordinary health legislation. Restricting power within ordinary democratic and legal constraints is in line

[14] Joelle Grogan, States of Emergency, VerfBlog (May 26, 2020), https://verfassungsblog.de/states-of-emergency.

[15] See Niall Coghlan, Dissecting COVID-19 Derogations, VerfBlog (May 5, 2020), https://verfassungsblog.de/dissecting-covid-19-derogations/; Emmons, supra note 11.

with what Martin Scheinin advocates as the principle of normalcy: addressing the health emergency through "normally applicable powers and procedures and insist[ing] on full compliance with human rights, even if introducing new necessary and proportionate restrictions upon human rights on the basis of a pressing social need created by the pandemic."[16] However, in some more concerning cases, any form of parliamentary legislative procedure was abandoned in favor of executive decrees and presidential or ministerial circulars (e.g., Cameroon, India, Turkey, and Vietnam). These measures were emergency powers in effect, though were not considered so in form. The effect in practice of reliance on ersatz "ordinary" powers was the avoidance of safeguards which otherwise were designed to control power under emergency. The commonality exposed is that without a requisite degree of democratic oversight and input, the negative consequences which can arise both under a state of emergency and upon reliance on ordinary legislation are indistinguishable.

Evident from analysis of both symposia is that whether a state has declared a state of emergency is not a reliable indicator of potentially abusive executive practices. Such practices include the targeting of populations in vulnerable circumstances: for example, the Romani in Slovakia (state of emergency), prisoners in Peru (state of emergency), and religious minorities in India (no state of emergency) and Bangladesh (no state of emergency). The wider sociopolitical context is a stronger factor in gauging the likelihood of abusive practices. The autocratizing states of Hungary (declared a state of emergency) and Poland (no declared state of emergency) have both taken advantage of the pandemic to further consolidate executive power, to the detriment of the separation of powers and democratic checks and balances, with the former taking the opportunity to adopt emergency legislation empowering the executive to amend any law of any value in a way which is all but immune from any legislative scrutiny,[17] and the latter adopting questionable restrictions on human rights via executive decrees rather than through parliamentary statute, as required by the constitution for such a limitation of fundamental rights.[18] Paired with the temporary closure of courts, or the restriction of access to only a limited type of cases, and compounded by a pre-pandemic trend toward the demolition of judicial independence in both states, any effective judicial remedy is all but moot.[19]

[16] See Martin Scheinin, 'To Derogate or Not to Derogate,' OpinioJuris (Apr. 6, 2020), http://opiniojuris.org/2020/04/06/covid-19-symposium-to-derogate-or-not-to-derogate/.

[17] Kriszta Kovács, Hungary's Orbánistan: A Complete Arsenal of Emergency Powers, VerfBlog (Apr. 6, 2020), https://verfassungsblog.de/hungarys-orbanistan-a-complete-arsenal-of-emergency-powers/.

[18] Jakub Jaraczewski, An Emergency By Any Other Name? Measures Against the COVID-19 Pandemic in Poland, VerfBlog (Apr. 24, 2020), https://verfassungsblog.de/an-emergency-by-any-other-name-measures-against-the-covid-19-pandemic-in-poland/.

[19] See Laurent Pech, Patryk Wachowiec & Dariusz Mazur, Poland's Rule of Law Breakdown: A Five-Year Assessment of EU's (In)Action, 13 *Hague J. Rule L.* 1, 1–43 (2021); Laurent Pech & Kim Lane Scheppele, Illiberalism Within: Rule of Law Backsliding in the EU, 19 Camb. Yearb. Eur. Leg. *Stud.* 3, 19–26 (2017).

The essential focus, therefore, should be the use and not the form of power, and whether safeguards in the form of legislative oversight and/or judicial review have been effectively utilized – not whether they exist at all. However, this appears all the more challenging in times of crisis if both legislatures and the courts tend to be deferential to the actions of the executive and unwilling to exercise robust forms of oversight or review.[20] Such experience also lends support to the argument of Mexican Supreme Court Justice Alfredo Gutiérrez Ortiz Mena that while courts should be more deferential in cases where formally declared exceptions have been declared, they should exercise heightened review ("strict scrutiny") of the arrogation of ordinary powers by the executive even in times of crisis.[21]

However, there is also emerging evidence of good practices which are not dependent on an emergency/ordinary powers dichotomy, and instead reveals good governance practices inculcated within the wider sociopolitical ecosystem. Those states which aligned law and policy with principles of legality and legal certainty, as well as clarity in public communication, scrutiny, transparency in decision-making, and publication of underlying rationale for (in)action, and engagement with external expertise, civil society, and criticism to reform law and policy have, more often, correlated with higher levels of both public trust and compliance.[22] These practices are essential to effective strategies to combat the virus and the preservation of democratic legitimacy. By correlating infection and mortality rates with levels of restriction adopted, and the impact on ordinary life and governance, we can highlight countries from among the symposia which have epitomized this approach. For example, New Zealand's strategy of early response and engaging a combination of ordinary powers aided by some emergency provisions, and framed by recommendations and social nudges, along with robust parliamentary oversight and government accountability, have correlated not only with lower infection rates but also high levels of public trust. Such practices are evident among the responses of the "best responders" to COVID-19:[23] Finland, Iceland, Singapore, South Korea, and Taiwan. However, such "political

[20] Joelle Grogan & Alice Donald, Lessons for a "Post-Pandemic" Future, in Joelle Grogan & Alice Donald, *Routledge Handbook of Law and the COVID-19 Pandemic* (2022).

[21] Comments of Justice Alfredo Gutiérrez Ortiz Mena, Constitutional Democracy and the Role of High Courts in Times of Crisis: The Case of Mexico (Oct. 23, 2020), https://petrieflom.law.harvard.edu/events/details/constitutional-democracy-and-the-role-of-high-courts-in-times-of-crisis.

[22] See Sheila Jasanoff & Stephen Hilgartner, A Stress Test for Politics: A Comparative Perspective on Policy Responses to COVID-19, in Joelle Grogan & Alice Donald, *Routledge Handbook of Law and the COVID-19 Pandemic*, 294–98 (2022); Grogan & Donald, supra note 20, at 483–84.

[23] See, for example, Ian Bremmer Best Responses to COVID-19, Time (June 12, 2020), https://time.com/5851633/best-global-responses-covid-19/; Tom Frieden, Which Countries Have Responded Best to COVID-19?, Wall St. J. (Jan. 1, 2021), www.wsj.com/articles/which-countries-have-responded-best-to-covid-19-11609516800.

trust needs to be continually earned, and traditions of transparency are deeply ingrained; they do not begin during pandemics."[24]

In sum, the symposia have revealed that the use of power within the wider sociopolitical context, not the form of legal authority, should be the starting point for reimagining democratic controls to contain abuses of civil liberties. First, conditionality within either constitutional provisions or domestic legal frameworks, or even under obligations to international standards on the use of emergency powers, cannot alone limit abuse. Second, neither the declaration of a state of exception nor the exclusive reliance on ordinary legislative powers is a reliable indicator of the likelihood of abuse of power during the pandemic. A stronger indicator, albeit one often more difficult to identify than legal text, is the sociopolitical ecosystem in which legal measures are operating: autocratizing states have capitalized on the emergency to further consolidate power, despite formal legal or constitutional safeguards, while states inculcating democratic values of trust and accountability prior to the pandemic, by contrast, have embodied these values in response. Thus, efforts to reform in order to mitigate the dangers of excessive restriction, arbitrary discrimination, and hypertrophied executive action through formal legal rules alone are largely ineffective, and must instead focus on building a robust democratic system of an independent judiciary and on encouraging active government engagement with parliamentary processes, including debate, review, and scrutiny.

III HEALTH, HEALTH SYSTEMS, AND DEMOCRATIC DECISION-MAKING

The pandemic has brought far greater attention to connections between population health and health systems, on the one hand, and democratic legitimacy of government actions, on the other. The pandemic revealed clearly that inequalities in access to care, as well as in outcomes, reflect larger patterns of discrimination and marginalization within societies, and that normative commitments to the equal dignity of diverse members of the society is encoded in health systems, just as it is in justice systems, for example.[25] Reflections on these symposia suggest that it is insufficient to examine whether health-related rights (including the right to life with dignity when interpreted to include aspects of health care, e.g., India) are enshrined directly in constitutional norms or incorporated from international human rights law through constitutional blocs. It is just as critical to understand the structural conditions that enable health-related rights to be exercised in practice, including the formal and informal practices of subjecting health policies to democratic justification.

[24] See Alicia Ely Yamin, Global Responses to COVID-19: An Inflection Point for Democracy, Rights, and Law, Bill of Health (June 12, 2020), https://blog.petrieflom.law.harvard.edu/2020/06/12/global-responses-covid19-reflections/.

[25] Alicia Ely Yamin & Tara Boghosian, Democracy and Health: Situating Health Rights within a Republic of Reasons, 19 *Yale J. Health Pol'y, L. Ethics* 87, 87–123 (2020).

COVID-19 struck a world already reeling from multiple waves of austerity. Even in countries where universal health care is guaranteed under law (e.g., the Netherlands and the United Kingdom), the symposia underscored that governments' role in financing and provision of public health and care has shrunk dramatically over the last few decades. Indeed, just as socioeconomic rights, such as health, were being formulated and incorporated into constitutions across much of the world, including in most states represented in the symposia, neoliberal economic governance has driven reductions in budgets for public health and increased privatization of health care sectors. International financial institutions have played no small part in driving these trends in the Global South. From the late 1980s to today, loan conditions attached to structural adjustment, fiscal consolidation, and the like have prompted steep cuts in public health spending, the flexibilization of labor in health sectors, increasingly stringent intellectual property restrictions on access to medicines imposed through trade agreements, and the privatization of services and supply chains, together with sweeping disruptions in social determinants of health.[26] At the same time, the political capacity to resolve social demands for health has been constrained by loan agreements that convert these fiscal issues or trade-related aspects of intellectual property into questions for technocratic expert panels to resolve.[27]

Therefore, it is unsurprising that despite health rights being enshrined in constitutional law in each case, contributions to the symposia suggest that countries with well-functioning health care systems, particularly those considered "sacrosanct" in the political culture (e.g., Canada), are inevitably better placed to tackle a major health crisis than those with weak or dysfunctional health systems (e.g., South Africa, Argentina, and Colombia) or those whose systems were already in a state of total collapse prior to the crisis (e.g., Ecuador). Nor is it surprising that chronic shortages are often further compounded by widescale corruption when a sudden influx of emergency funds incentivizes opportunism (e.g., Nepal). However, this insight points to the need for international and comparative legal analysis to pay closer attention not just to the grafting or importing of human rights into domestic law,[28] but also to the structural changes needed, to ensure the infrastructure for fair provision, locally and globally, that legal frameworks based on neoliberal imperatives have made impossible.

The symposia further highlight the importance of decision-making processes in relation to health to the meaningfulness of health rights in practice, as well as the preservation of democratic legitimacy. At one level, at least since Rudolf Virchow's work on the social origins of disease and the need to address epidemics through

[26] Alicia Ely Yamin, When Misfortune Becomes Injustice: Evolving Human Rights Struggles for Health and Social Equality 94–98, 128–30 (2020).

[27] Id. at 94–99.

[28] Roberto Gargarella, The Engine Room of the Constitution: Latin American Constitutionalism, 1810–2010, at viii (2013).

political, not merely medical, means, there has there been an awareness of public health policies and health systems as sites of democratic contestation.[29] As already noted, movements for universal health coverage were often struggles for democratic inclusion. The more recent technocratic conceptualization of health is a contingent historical response to increasingly neoliberal socioeconomic transformations, coupled with technological innovations based on accelerating medicalization after World War II, and biomedicalization in the twenty-first century.[30]

Nonetheless, by the time COVID-19 emerged, decision-making processes regarding health, within health systems and beyond, had largely been exiled from democratic deliberation to insulated islands of professional expertise. As a result, during the pandemic, we have witnessed the widespread adoption of an overly simplistic dichotomy of "objective scientific truth versus political power," coupled with considerable partisan politicization across a number of the countries included in one or both of the symposia (e.g., Brazil under President Bolsonaro and the United States under President Trump). In both symposia, this dichotomy has become encapsulated in the tension of who is (and should be) the decisionmaker, marking often a radical reformulation of roles – for example, "doctor as politician" in Croatia,[31] and "public opinion as epidemiologists" in the Netherlands.[32] Devi Sridhar, a leading public health academic, deploys an analogy to express the need for deference to infectious disease experts in setting policy: "It's like being on a plane and the engine does not work. Everyone gives their opinion on what should happen instead of trusting the people who have engineering experience and have done that for years."[33]

However, there is a difference between politicized dismissal or cherry-picking of empirical scientific evidence and accepting that the forms of knowledge needed to respond to COVID-19 in a democracy have inherently political dimensions that go beyond the expertise of infectious disease specialists and epidemiologists. As Sheila Jasanoff wrote before the pandemic, in relation to science more broadly than health, "risk":

> is not a matter of simple probabilities, to be rationally calculated by experts and avoided in accordance with the cold arithmetic of cost-benefit analysis …. Critically important questions of risk management cannot be addressed by technical experts

[29] Rudolf Virchow, Disease, Life, and Man (1958).

[30] See, generally, Adele E. Clarke et al., Biomedicalization: Technoscience, Health, and Illness in the US (2010); Viviane Quirke & Jean-Paul Gaudillière, The Era of Biomedicine: Science, Medicine, and Public Health in Britain and France after the Second World War, 52 *Med. Hist.* 441 (2008).

[31] Nika Bačić Selanec, Croatia's Response to COVID-19: On Legal Form and Constitutional Safeguards in Times of Pandemic, VerfBlog (May 9, 2020), https://verfassungsblog.de/croatias-response-to-covid-19-on-legal-form-and-constitutional-safeguards-in-times-of-pandemic/.

[32] Antoine Buyse & Roel de Lange, The Netherlands: Of Rollercoasters and Elephants, VerfBlog (May 8, 2020), https://verfassungsblog.de/the-netherlands-of-rollercoasters-and-elephants/; Brigit Toebes, COVID-19, the Netherlands, and Human Rights: A Balancing Act, Bill of Health (May 26, 2020), https://blog.petrieflom.law.harvard.edu/2020/05/26/netherlands-global-responses-covid19/.

[33] Devi Sridhar, Good Morning Britain (Nov. 5, 2020), https://twitter.com/gmb/status/1324272948820267008.

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> with conventional tools of prediction. Such questions determine not only whether we will get sick or die, and under what conditions, but also who will be affected and how we should live with uncertainty and ignorance.[34]

In the reflections from both symposia, and throughout this pandemic, measures implemented to prevent or slow the spread of the virus have had a disproportionately negative impact on vulnerable populations, including the elderly, prisoners, persons with physical or mental disabilities, migrants, racial and ethnic minorities, and refugees and migrant workers. Analyses across countries of different income levels (e.g., Spain, Ireland, Chile, Colombia, Kenya) noted that the sudden onset of mass unemployment among part-time and informal workers, the shutdown of childcare and schools, and stay-at-home orders that led to spikes in domestic violence, had devastating impacts on women. For the millions living with poverty, malnutrition, or with high rates of potential comorbidities, including tuberculosis and HIV, in cramped conditions and with limited access to water (e.g., Argentina, Guatemala, Nepal, Nigeria, and South Africa), the most prevalent political and medical messaging of "stay home and wash your hands" ignored endemic socioeconomic disparity and the underlying structural inequalities which have enabled and embedded it.

There is no reason to believe that public health expertise offers a privileged domain of knowledge in weighing containment of transmission against losing access to other socioeconomic rights and basic needs, such as food, housing, and education. Indeed, Dr. Jonathan Mann, a founder of the "health and human rights movement," argued based on his experience with HIV/AIDS that all "health policies and programs should be considered discriminatory and burdensome on human rights until proven otherwise."[35] In the different dynamics of the COVID-19 pandemic, policies dictated by utilitarian calculations of public health experts have shown themselves to be particularly apt to be rife with blind spots. Cloaked in an aura of objective, apolitical "scientificity," and justified under the idea of safeguarding an unchallengeable good, which is made to appear of heightened necessity when coupled with a generalized fear, these prescriptions are insulated from normal democratic deliberation.

Further, the fallaciously denominated "health versus wealth" tradeoff – public health restrictions versus opening the economy – has in many countries involved dueling fields of expertise and cost-benefit calculations between economists and public health experts, as opposed to enlarging our imagination of how decisions regarding health can be brought into the realm of public reason. As Jasanoff and Hilgartner assert, as both national and international authorities consider the lessons of COVID-19:

> they should revisit their established institutional processes for integrating scientific and political consensus-building. If free citizens are unable to see how expertise

[34] Sheila Jasanoff, Science and Public Reason 168 (2012).

[35] See Jonathan Mann et al., Health and Human Rights, 1 *Health Hum. Rts.* 7, 16 (1994).

> is serving the collective good, at all levels of governance, they will sooner rebel against expert authority than give up their independence. Just as a sound mind is said to require a sound body, so COVID-19 has shown that the credibility and legitimacy of public health expertise depends on the health of the entire body politic.[36]

As reflected in the symposia, the pandemic has only heightened the urgency of grappling with the lack of public accountability and democracy in current health governance across most of the world, and imagining new institutions, processes, and methods for restoring normative questions to addressing health policy in pandemic and "normal" times. The critical role of reasoned justification for how health systems function has often been evidenced by its absence during COVID-19. For example, decisions regarding what services are deemed "essential" have often disproportionately affected sexual and reproductive health and rights.

Insights provided by both symposia indicate that decisions on whom to prioritize and where to allocate testing and treatment have also been questioned (e.g., Croatia, Slovakia, Nepal, and the Netherlands). Across societies, evidence suggests that the social legitimacy of health decisions, just as in others, is based on both sociohistorical context and in the case of local health systems the slow building of trust, which does not happen overnight when a pandemic breaks out. The reflections in these symposia confirm lessons from previous epidemics (e.g., HIV/AIDS and Ebola) in that the best way to implement public health policies, as well as preserve the legitimacy of the health system and government more broadly, is to engage a wider number of constituencies in a meaningful and equitable manner on an ongoing basis, as opposed to undertaking ad hoc consultations during times of crisis.

Whether allocating vaccines or scarce equipment, supplies, and treatments, which follow different logics, there is growing agreement among health ethicists that decision-making processes regarding health require the same principles suggested earlier for the promulgation of COVID-19 measures more broadly – as well as for expectations of democratic decision-making in general. These include: (1) explicit justification and transparency of rationales; (2) transparency about empirical and normative uncertainty; (3) openness to address and include diverse perspectives on competing criteria for decisions, ranking of criteria, and why they matter; (4) inclusion of the perspectives of marginalized and disadvantaged populations as to the formulation of choice criteria, as well as disparate impacts; (5) willingness to revise policy decisions in light of populations' negative experiences with implemented decisions and critical feedback on the rationales for the decisions; and (6) regulation and enforcement of (1) to (5).[37] In addition to including distinct constituencies in

[36] Jasanoff & Hilgartner, supra note 22, at 297–98.

[37] Example, P.M. Maarten et al., Stakeholder Participation for Legitimate Priority Setting: A Checklist, 7 *Int'l J. of Health Pol'y & Mgmt.* 973, 976 (2018); WHO Consultative Group on Equity and Universal Health Coverage, Making Fair Choices on the Path to Universal Health Coverage (2014); see also Alicia Ely Yamin & Tara Boghosian, Democracy and Health: Situating Health Rights within a Republic of Reasons, 19 *Yale J. of Health Pol'y, L. Ethics* 87, 110–21 (2020).

specific allocation decisions or the tradeoffs between containment and other health concerns, such as mental health, reflections on the first phase of pandemic response in the symposia, together with other studies,[38] suggest that democratizing health policy requires making visible how the issues are framed in legal and policy analysis, including structural forms of subordination and exclusion that invariably affect distributions of health and ill-health.

In sum, the effectiveness, as well as legitimacy, of governmental responses to COVID-19 call for thinking more deeply about the role of health systems as democratic social institutions and the ways in which they formally and informally enshrine normative values from macro to micro levels in both pandemics and normal times. As Scott Burris argues, health law is not a matter of "just the formal rules, but how these rules are enacted every day" by the health care program implementers and providers, as well as users of the system.[39] The meaning of health rights, and health laws more broadly, invariably depends upon how multiple actors understand how they relate to other sets of rules and norms beyond the health system. Neither constitutionalization nor legislation enshrining health rights in formal law is an adequate indicator of the normative and social legitimacy of specific health policymaking and priority-setting in practice. Structural conditions underpinning meaningful access, together with the nature of processes for making health-related decisions and setting priorities, are equally critical.

Bringing health policy under the purview of public reason, as is taken for granted with respect to other rights, will likely call for a paradigm shift that enables diverse persons to see public health and access to care in normal times, as well as pandemics, not as the domain of technocratic experts alone, but as assets of (social) citizenship.

IV CONCLUSION

The global but differentiated impacts of the sweeping COVID-19 pandemic present an opportunity, and an imperative, for reflection on the legal, social, and institutional changes required for advancing public health, as well as for strengthening the rule of law moving forward. Joint reflections on the contributions to the symposia, together with other scholarship, suggest at least three insights for building stronger democratic institutional structures to withstand the pressures both of pandemic and autocratizing forces. First, the use of power within the wider sociopolitical context, not the form of legal authority, should be the starting point for reimagining democratic controls to contain abuses of civil liberties. Second, the institutional arrangements and structural conditions necessary to ensure access to public health, as well

[38] See CompCoRe, https://compcore.cornell.edu/.

[39] Scott Burris, From Health Care to the Social Determinants of Health: A Public Health Law Research Perspective, 159 *U. Pa. L. Rev.* 1649, 1655 (2011).

as to medical care, are as important as formal legislative regimes enshrining health-related rights. Third, democratic decision-making processes that include participation by a wide array of experts, as well as by constituencies affected, afford space to critique government (in)action, and are linked to responsive reforms are more effective both in producing equitable health outcomes and in preserving confidence in the rule of law. In short, the COVID-19 pandemic has illustrated starkly that health, perhaps more dramatically than any other area of law and policy, involves what Britton-Purdy et al. refer to as "the need for political judgments about the gravest questions: who should exercise power, of what sort, and over whom? What should count as a human need, and what claims should politically recognized needs give us against the state and thus against one another? Whose dreams come true, and who is enlisted in the realization of others' schemes?"[40]

[40] Jedediah Britton-Purdy et al., Building a Law-and-Political-Economy Framework: Beyond the Twentieth-Century Synthesis, 129 *Yale L. J.* 1784, 1827 (2020).