Time will judge harshly those ignorant but know-it-all commentators who joined the pandemic deniers, anti-science and anti-vax crowds, swinging from 'no worse than a common cold' to 'a plot to poison us all'. Why would people trust them on any other real social issues, in future?
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# How the Pandemic Defrocked Hegemonic Neoliberalism

**The global pretensions of the USA and the UK have been stripped naked by the virus and responses to it. These profit-driven systems failed to protect lives. Only the fabricated anti-China hysteria and the pseudo-science of the pandemic sceptics hides this. In a diverse post neoliberal world, strong public health systems will be crucial.**



The COVID19 pandemic has laid bare the human disaster that is hegemonic liberalism, a project of the Anglo-American powers. In terms of the basic protection of human life the virus has made it plain that there are few countries whose performance is as bad as that of the USA and the UK.

Quite recently those two presented themselves as number one and number two in the ‘Global Health Security’ rankings of those most prepared for an epidemic (IPT 2020). In fact, at the peak of the pandemic over March-May 2020, the USA and the UK showed the largest absolute numbers of deaths and amongst the highest death rates on earth (Worldometer 2020). In future, few serious analysts will take seriously the slogans and ‘model’ of the Anglo-American duo.

What was Anglo-American hegemonic liberalism? It was a political project for propertied and imperial elites, later corporate privilege, which made selective use of nice sounding liberal or ‘open

market' ideas. Historically those ideas helped a massive expansion of private slavery, entrenched colonialism, privileged the US dollar and made use of financial leverage for global domination. In recent times that model preached small and weak states (except for the 'necessary hegemon'), destruction of social controls on global capital and the erosion of public services and social guarantees in favour of privatisation and private 'partnerships'.

In practice this meant that public health guarantees were blocked in the USA while a once decent National Health Service (NHS) in the UK was run down and its public subsidies diverted to private health companies.

The consequences of hegemonic liberalism were dire, both for the populations of 'peripheral' states and for the mass 'metropolitan' populations of Britain and North America. Weak to non-existent health guarantees led to catastrophic epidemic death rates amongst disadvantaged classes (Schifferes 2020), much higher than the high national averages. Poor preventive health preparation (inherent to heavily privatised systems) caught these wealthy countries off guard. The inconsistent and often incoherent responses of leaders Donald Trump and Boris Johnson were not simply idiosyncratic but reflected a long term commitment to corporate profiteering before human life. The primacy of corporate privilege blinded these states to well established principles of public health. And when the seriousness of the pandemic imposed itself, the Anglo-America duo swung from one extreme to the other – from libertarian slogans to repressive measures.

In countries where there was some culture of public health, relative trust in health authorities allowed a fairly rapid collective response. Yet where corporate privilege had become central to the system, populations reacted with fear, anger and cynicism. Accusations of a 'planned' epidemic or a plan for forcible mass vaccinations, covered up the real crime, that these neoliberal systems were designed to abandon human life in favour of corporate profit.

The first section of this essay sets out in some detail the behaviour of the US and UK leadership, to show their essential consistency with the neoliberal project. There was denial, prevarication and avoidance of the serious public health threat. When the level of illness and death imposed itself on those regimes, there were wild swings in their responses from inaction to repressive action. The public health outcomes were very poor and should spark serious debate about those systems. Yet Washington's anti-China campaign and an anti-science brigade of Pandemic Sceptics tend to obscure this failure.

In the second section I outline some of the misinformation from these sceptics who, rather than critically examining the US-UK failures, have launched a range of wild and basically anti-science theories. In the name of opposing greedy corporations they lash out at all medical science and at a 'lockdown' they wrongly imagine was planned by the big powers. Their libertarian critiques mostly echo the approach of right wing populists like Trump and Johnson; while the left populist sceptics (which rightly expose greedy private health corporations) are mostly shallow, attacking symptoms rather than causes.

The third section argues the central importance of public health systems to pandemic responses, and shows how proper understandings can inform practical politics, to help mitigate the present and contain future crises. This logic bypasses the overly general and clichéd arguments about capitalism versus socialism. Decent preventive and public health systems can and should be demanded in every society.

1. **Responses of the USA and UK**

Both Donald Trump and Boris Johnson showed, in their reactions to the pandemic and their focus on economic 'normalisation', that public health was no natural priority. The particular idiosyncrasies of these men should not prevent us from recognising that they faithfully represented a long standing system of corporate privilege through 'open economy' ideology.

Washington moved indecisively, with a series of complacent and repeated assurances throughout February from President Trump, that "we have it very well under control" (Brewster 2020; Guerra 2020). Over an extended period of time, when there were many warnings, Trump tried to play down the virus and play up the economy. On 24 February he said the virus "is very much under control" and the stock market was "starting to look very good to me". On the 26th of February Trump claimed the US was "really prepared" and on the 29th of February claimed that the US was "leading in testing" for the virus (AJ 2020).

In fact, while most countries had not yet published data on testing, at that time, of those which had the USA showed the third lowest testing rate (above that of Nepal and Serbia). Table 1 shows that there were higher testing rates in 15 countries (Ourworldindata 2020). The point here is not that President Trump is an unreliable source of information, though that is obvious; it is that he was consistently downplaying the severity of the epidemic and exaggerating the preparedness and capacity of Washington.

**Table 1: COVID19 testing rates in 18 countries, 29 Feb 2020**

| *Country* | *Testing /1,000* |
|---|---|
| Austria | 0.183 |
| Czech Republic | 0.019 |
| Estonia | 0.033 |
| Finland | 0.069 |
| France | 0.029 |
| Hong Kong | 4.081 |
| Iceland | 0.199 |
| Israel | 0.145 |
| Italy | 0.309 |
| Japan | 0.018 |
| Latvia | 0.061 |

| | |
|---|---|
| Mexico | 0.015 |
| Nepal | 0.008 |
| Serbia | 0.005 |
| South Korea | 1.671 |
| Switzerland | 0.209 |
| United Kingdom | 0.154 |
| USA | 0.013 |

Source: Ourworldindata 2020

Trump announced travel bans on those coming from China, on 31 January, and from Europe on 11 March, the day the W.H.O. declared a global pandemic. On that same day he persisted with this complacency, telling his supporters at a rally in New Hampshire he believed the virus would go away with the warm weather in April: “a lot of people think that goes away in April, with the heat, as the heat comes in, typically that will go away in April … We’re in great shape, though. We have 12 cases, 11 cases, and many of them are in good shape now” (Levin 2020). In fact on 11 March the USA recorded 1,301 cases of COVID19 infections and 38 deaths (Worldometer 2020). On 13 March the President declared a ‘national emergency’, but that was to provide the legislative trigger for a $50 billion package of subsidies to be passed to the states and territories. At the same time he warned against testing those without symptoms. This was “totally unnecessary” he said, as “this [virus] will pass” (AJ 2020).

It was not until 17 March that Trump asked all workers to ‘stay at home’, claiming he had “always known this is real, this is a pandemic. I’ve felt it was a pandemic long before it was called a pandemic” (Koning Beals 2020). A week later, on 24 March, Trump went back to his theme of re-opening the economy by April. On Twitter he argued that “we cannot let the cure be worse than the problem itself”, as US economic output was crashing. He said he would make a decision within 15 days (Trump 2020b; Haberman and Sanger 2020). After that period, on 3 April, the USA recorded 283,477 cases and 8,839 deaths, and the death count was rising. There were 1,263 US COVID19 deaths that day. Those deaths would surpass 2,000 every day for most of the period between 7 April and 7 May, after which numbers began to subside (Worldometer 2020).

Donald J. Trump
✔ @realDonaldTrump

WE CANNOT LET THE CURE BE WORSE THAN THE PROBLEM ITSELF. AT THE END OF THE 15 DAY PERIOD, WE WILL MAKE A DECISION AS TO WHICH WAY WE WANT TO GO!

321K
5:50 AM - Mar 23, 2020
Twitter Ads info and privacy

133K people are talking about this

Trump signed a $2.2 trillion emergency spending bill on 27 March, which included both corporate and social welfare, including a huge $180 billion allocation to private health corporations. The President blamed China and the previous Obama administration, then began to advocate dubious and unproven 'cures' such as use of the malaria drug hydroxychloroquine (see Wong 2020), and the use of bleach (AJ 2020). Much of this should be seen as bluster, simply designed to hide his inconsistent and incompetent reactions.

Similarly, British leader Boris Johnson was accused of complacency, being "slow to act" and even – on 12 March, the day after the W.H.O. announced a global pandemic – suggesting that some natural "herd immunity" might be necessary. This was reported as sounding like the UK government "was deliberately aiming for 60 percent of the populace to fall ill" (Stewart, Weaver and Proctor 2020; Yong 2020). Without proper treatment or vaccines such 'herd immunity' would mean many tens of thousands could die. The UK government clearly tried to keep business open as long as possible, on 11 March directing 30 billion pounds to "protect the economy against coronavirus" and another 330 billion in loans and 20 billion in "tax cuts and grants for companies threatened with collapse" (Manning 2020; Emberson-Dennis 2020). Johnson consulted Trump about the pandemic on 14 March (Manning 2020). They clearly used this moment share ideas on priorities. Then on 16 March, 12 days after COVID19 cases in Britain began to surge, Johnson urged citizens to work from home and to avoid pubs and restaurants, but without mandating measures. It was not until 20 March that the UK government ordered "all pubs, restaurants, gyms and other social venues" to close; on the same day schools were ordered to close (Embury-Dennis 2020; Manning 2020). By that time there were 3,983 recorded COVID19 cases and 194 deaths in the UK. Between 27 March and 12 April Johnson himself contracted the virus and was hospitalized. By the end of April the UK recorded 171,253 cases and 26,771 deaths (Worldometer 2020).

On 13 April, at the height of the crisis, Trump claimed 'total authority' over the states and governors, for the agenda of "reopening" the economy (White 2020). This once again showed his anxiety to resume 'normal' economic activity. It incited public clashes with some Governors. It turns out the 'total authority' claim was overstated; nevertheless, on 16 April the President issued guidelines for the states on reopening businesses and local economies (AJ 2020). A week after he himself had recovered from the virus, Boris Johnson again spoke with Trump and on 22 April they jointly announced "close cooperation through the G7 and G20 to reopen global economies and ensure medical care and supplies reach all those in need" (Reuters 2020).

That is all background to the dismal performance of the US and the UK in face of the virus.

These two countries, which had been ranked first and second in 'global healthy security', and specifically in preparedness for an epidemic, had amongst the highest death rates in the world. Table 2 below shows a selection of countries alongside the Anglo-American duo. It includes those with at least two months of infections, some 'pairs' in apparently similar circumstances (France and Germany; Sweden and Norway) and some independent countries (Iran and Cuba). The final column shows how many days each country had more one death per 10 million people. Less than this

effectively signals no health crisis. All countries, by mid-May, had quite high levels of testing. China's testing rates does not appear in the same datasets, but other sources tell us that it was also very high. China had been carrying out mass testing from early days, including on symptom-free people (Wee 2020; Bloomberg 2020a).

**Table 2: Better and worse performance in COVID19 management**

| | 'Global Health Security' rank | Cases / million | Deaths / million | Tests / million | Popn in millions | Days of more than 1 death per 10m popn |
|---|---|---|---|---|---|---|
| USA | 1 | 4,619 | 275 | 35,903 | 330 | 60+ |
| UK | 2 | 3,592 | 511 | 38,040 | 67 | 64+ |
| Netherlands | 3 | 2,568 | 332 | 16,809 | 19 | 64+ |
| Sweden | 7 | 2,987 | 365 | 17,589 | 10 | 62+ |
| South Korea | 9 | 216 | 5 | 14,693 | 51 | 43 ended |
| France | 11 | 2,752 | 431 | 21,218 | 65 | 67+ |
| Germany | 14 | 2,109 | 96 | 37,584 | 84 | 60+ |
| Norway | 16 | 1,523 | 43 | 39,946 | 5 | 25 ended |
| Greece | 37 | 272 | 16 | 12,324 | 10 | 0 ended |
| China | 51 | 58 | 3 | Na * | 1,439 | 5 ended |
| Iran | 97 | 1,433 | 83 | 8,191 | 84 | 79+ |
| Cuba | 110 | 165 | 7 | 7,232 | 11 | 25 ended |

Sources: Data @ 18 May 2020. IPT 2020; Worldometer 2020; JHCRC 2020; for China's testing see: Bloomberg 2020a, Wee 2020

Observe the very high death rates in the USA and UK, as also in France, the Netherlands and Sweden. These are all countries that were said to rank highly in their preparedness for just such an epidemic. Observe also the relatively low death rates in South Korea, Cuba and China, and the much worse outcomes in France compared to Germany and similarly the much worse outcomes in Sweden as compared to Norway. South Korea, Norway, Greece China and Cuba all 'flattened the curve' to the point that their crisis was over in less than two months. The others (USA, UK, Netherlands, Sweden, France, Germany and Iran) had not done so, after more than two months. Comparing such data sets has its problems but this is the best available evidence. We have no better option but to use it while recognising its limitations.

For example, while some have suggested COVID19 deaths might be over-estimated by conflation with other illnesses, especially amongst older people (Schwalbe 2020), there is also good reason to consider that such deaths may be under-estimated, because of deaths amongst those who did not present and were not diagnosed as infected (Walsh 2020). Serious analysis has to look widely and not just rely on sources which seem to confirm pre-formed ideas.

In any case, the practice and outcomes in the USA and the UK were very poor. The pandemic showed the 'Global Health Security' rankings (IPT 2019) as meaningless. The Anglo-American duo were poorly prepared. They showed great reluctance to identify and act to contain the threat. Maintaining systems of production and accumulation – of corporate profits – remained their top priority. That helps explain their failure to protect human life.

Evidence of these failures keeps emerging. Whistleblower Rick Bright – former director of the Biomedical Advanced Research and Development Authority (BARDA) – told a Congress panel that as early as January he was removed from meetings with the Health Secretary Alex Azar because he was "causing a commotion" over the virus (Naylor 2020). The views of such people were dismissed. Studies show that the introduction of 'stay at home' regimes even a few days earlier could have made a significant difference in infections and lives: "simulation on early-implementation and removal of SAHO reveals considerable impact on COVID-19 daily new cases and deaths" (Xu et al 2020). Stocks of protective equipment were extremely low in the USA and by early April Washington had resorted to buying up stocks destined for other hard hit countries, like Germany and France (Willsher, Borgia and Holmes 2020). One study said tens of thousands of lives could have been saved "if authorities had acted more swiftly in recommending self-isolation and the wearing of face masks" (Chen 2020).


***(Dr. Rick Bright testifies before House Commerce. Credit: CSPAN/ Twitter)**

However these failures have been masked in two ways. First there is the 'blame China' campaign, pushed by Trump. The US President claimed that the virus had its origin in China and that the Chinese government had withheld information from the international community (Trump 2020a). Both suggestions were quite false. Early on China warned that the virus was dangerous and

published the genome, a fact reported on 11 January (Cohen 2020a). Further, while the first recorded mass outbreak of infections came from the Huanan Seafood Market in Wuhan city, multiple studies suggest its origin was not China. Such findings parallels the so called Spanish Flu of 1918-19, which was later found to have its origins in Kansas, USA (Burnet and Clark 1942; Barry 2004).

An early Chinese genetic study suspected that COVID-19 came to Wuhan from elsewhere, suggesting that the virus "was potentially imported from elsewhere; the crowded market then boosted SARS-CoV-2 circulation" (Yu, Tang and Corlett 2020). Another Chinese study of the first hospitalised patients observed that 66% "had been exposed to Huanan seafood market" but 33% had not (Huang et al 2020). "That's a big number, 13 , with no link" said infectious disease specialist Daniel Lucey of Georgetown University (Cohen 2020b). Professor Robert Garry, from the University of Tulane in New Orleans, also pointed out "our analyses, and others too, point to an earlier origin than [Wuhan]. There were definitely cases there, but that wasn't the origin of the virus" (Holland 2020). Then a British study, looking at 160 varieties and combining them in three groups, with A as the ancestral strain, found that most of the COVID19 varieties from Wuhan and from east Asia were Type B and non-ancestral (Forster, Forster, Renfrew and Forster 2020).

The second smokescreen is a proliferation of anti-science Pandemic Sceptic theories, which distract from the root problems. These claims deserve separate treatment.

2. **The Pandemic Sceptics**

Obscuring neoliberal failures in health are a series of claims by 'Pandemic Sceptics', a wide group of western populists and libertarians who share many features with climate change sceptics. Most have adopted 'anti-vax' positions and most are critics of government responses to the pandemic. But they typically misread both the pandemic and the government responses.

Virtually all these theories are deeply anti-science. Hardly any of the proponents have expertise in public health or epidemiology and, what is worse, they see no need to listen to those who do have such expertise. They reject entirely all official data on illness and death and refer only to select dissident figures, just like the climate change sceptics. The libertarian critiques mostly echo the approach of right wing populists while the left populist attacks are most often shallow, attacking symptoms rather than causes. Most deny the seriousness of the pandemic and avoid the public health implications.

At the extreme ends of these theories are those which claim the pandemic was either (a) harmless, just like the common cold, or (b) a planned assault, to kill off millions and reduce the human population (see Joyce 2020). Many raise alarms that the crisis is a plot to impose mandatory and dangerous vaccines. Others link, without evidence, the new 5G microwave networks to the COVID19 virus (Shanapinda 2020). The 'toxic vaccine' theory was a key theme of the documentary 'Plandemic', which relies on fringe scientist Dr Judy Mikowits. That documentary was controversially banned on YouTube, but her ideas are available in many other videos and sites, notably on the site of Robert F. Kennedy Jr (2020), politician and prominent anti-vaccine campaigner (Mole 2019). Dr Mikowitz's arguments are basically these: she helped discover the HIV/AIDS virus; but her work has been suppressed by prominent people, in particular US health official Anthony Fauci; she linked a virus to Chronic Fatigue Syndrome (CFS) and this virus "entered the human virome through a contaminated blood supply and vaccines"; many vaccines including the common MMR (measles, mumps and rubella) and polio are contaminated and are

creating diseases such as autism (Kennedy 2020). Many scientists have debunked virtually all Dr Markowitz's claims, including those about MMR, CFS and the viral contamination of vaccines (Enserink and Cohen 2020; Neuman 2020; Kasten 2020). There is no need to spend more time on that matter here.


***(Screenshot of the Plandemic documentary.)**

Broader anti-vaccine claims have become popular but are not backed by most scientific studies. For example, multiple studies have found no evidence to support claims linking the MMR vaccine and the preservative thimerosol with autism (Gerber and Offit 2009; Woodley 2019). That some vaccines contain mercury is partly true but misleading. The preservative thiomersal contains ethylmercury (cleared from the body more rapidly than the methylmercury found in certain fish) but the tiny amounts used in the MMR vaccine have not been shown to endanger human health or, in particular, any of "the neurodevelopmental disorders of autism, ADHD, and speech or language delay" (Stratton, Gable, McCormick 2001). Nevertheless, because of public alarm, thimerosol in children's vaccines was replaced in the USA by substitute preservatives back in the year 2001. Many scientists, including childhood specialists, have expressed concern at the constant attacks on life-saving vaccines, on the 'mercury' basis, when there is more mercury in a small can of tuna than in a tiny thimerosol preservative (WHO 2011; CDC 2013; Kiefer 2020).

Nevertheless, because of the decades long compromises of neoliberal states, private interests have been embedded in public policy. Pandemic Sceptics use this corporate influence as a pretext to reject all state public health advice and all official statistics. Yet in their place the sceptics use far more dubious, anecdotal or entirely baseless 'facts'.

For example, journalist Vanessa Beeley (2020a; 2020b), while avoiding some of the extreme theories, simply rejects all official statistics. Yet she then uses poor logic and weak evidence to advance her central argument that 'lockdown' is the enemy. Like many, she mistakes the symptoms of the crisis for the causes. She wrongly suggests that, because big health corporations dominate health policy in the UK and the US, (a) the private cartel therefore aimed at a 'lockdown' and that (b) this 'lockdown' is responsible for more death and illness than the virus. Having told us "it is

impossible to rely on official statistics" she presents a graph of those same statistics to suggest that more have died under 'lockdown' regimes than in 'non-lockdown' regimes. She says this "demonstrates the lack of correlation between lockdown and 'saving lives'". Not so.

First, the polemic between 'lockdown and 'non-lockdown' is a straw man. Countries have imposed a range of protective or quarantine like measures, according to their circumstances, their public health capacity and the approach of their governments. The bipolar division is arbitrary. In China the extreme measures taken in Wuhan and parts of Hubei province were called a "lockdown", while other parts of China were subject to "slow down" or "shut down" (Fuller 2020). Almost all states (whether their health policy is captured by private cartels or not) have practised some form of quarantine, including 'stay at home' advice. How that was done varied. But it should have been difficult to ignore the fact that leaders of the more independent countries - like Vietnam, Cuba, Syria and Iran - set examples by appearing in public wearing face masks. They did not deny or avoid the pandemic.

Second, to suggest that 'lockdown' is associated with high death rates (or 'not associated' with low death rates) is to put the cart before the horse. One reason for stronger protective measures must be the magnitude of the threat. Wuhan, for example, had a lockdown because local health authorities suddenly discovered many infections and they acted (quite successfully it seems) to prevent the disease spreading throughout China. In countries with lower infection rates less severe measures were justified.

However, there was another important reason behind the most harshly imposed quarantine measures. After China, the worst 'lockdown' measures came in those regimes which rejected or dismantled public health systems and reacted slowly to their epidemics. They wanted to protect their own profitable corporate regimes. It was the combined pressure of illness, death, public health advice and fear that forced them to change course. Britain and the USA swung from libertarian positions to more repressive policing, because they had little public health capacity and were forced to shift their positions. So to attack the 'lockdown' as a oligarchical plan is to confuse the symptoms with the cause. Throughout the crisis pressures for 'reopening' were confronted with genuine public health warnings, over a possible 'second wave' of infections.

It is similarly illogical to suggest that 'lockdowns' were imposed, through captured states, by the 'Big Pharma' cartel. Vanessa Beeley observes that vaccine industry revenue was "projected to reach almost $60 billion by 2020; [and that] this number may well increase with the arrival of COVID-19" (Beeley 2020a). But how could Big Pharma incite the British state, or any other state, to 'lock down' much of the world? Global economic losses by mid-April were estimated at $7.8 trillion (Fraser 2020), affecting many sectors other than the vaccine industry. In mid-May the US Congress passed a $3 trillion subsidy and stimulus package (Business Standard 2020). How could any corporate elite justify a general 'lockdown' simply to add pressure for a few billion more for the vaccine industry? And all that assumes that a better and cheaper Chinese vaccine does not come out first, undercutting and destroying any anticipated 'vaccine bonanza'. That argument, put up by many, is just absurd.

To support a claim that the lockdown kills more than the virus, Vanessa Beeley reproduces a Twitter post by journalist John Pilger, which speaks of an "'expert' estimate of 150,000 deaths as a result of the lockdown". No source is given. However it seems to refer to a British Daily Mail post, which cited an anonymous source on a "tentative estimate circulating in Whitehall" (Chalmers 2020). Well

no doubt there are serious psychological costs of social isolation, even though mental health workers in many countries maintain their services. But why, on such an important claim, should anyone rely on an anonymous claim in the tabloid media, while ignoring all official statistics about death and illness?

> https://twitter.com/johnpilger

There is a second claim that the British lockdown "is ensuring conditions that will suppress immune systems to dangerous levels and create the perfect environment for COVID-19 to flourish" (Beeley 2020b). Once again, although there are other similar popular media assertions, no scientific evidence at all is given to back up the claims.

There has been a public health consensus on testing, tracing and protective quarantine (including 'stay at home' regimes), in face of a new and unknown epidemic, until infections subside and proper treatments and/or vaccines are in place. Vanessa ignores this and argues (rather like the climate change sceptics) that science is divided: "Scientists, epidemiologists and analysts are not speaking as one voice on COVID-19'. This seems a device to qualify her selective use of public health dissidents, such as Knut Wittkowski, who opposes 'lockdown and social distancing'. She does not cite any of the NHS workers who support protective quarantine measures. Misunderstanding British health policy and practice is easy if one ignores the history and public health ideas of Britain's National Health Service (National Archives 2020), and the views of NHS workers. By pretending that public health policy and practice simply do not exist – rather than being in a compromised relationship with the private cartel – responses to the pandemic can be portrayed as all just a commercial game.

Similarly, the threat of 'mandatory vaccines' and mandatory biometric tracing may indeed be on the agenda of some ambitious corporations. However these issues are hardly foregone conclusions that can be collapsed into a singular 'vaccine agenda'. Well before greedy corporations began to capture patents on medicines there were public health reasons in favour of vaccines. Neither vaccines nor biometric tracing have been generally mandatory, and if either were tried there would be strong opposition.

Australia's Deputy Chief Medical Officer Paul Kelly, for example, said he was opposed to any mandatory vaccine. But he expected, in this case, people would be "queuing up" for it (McIlroy 2020). Today, of the more than one hundred COVID19 vaccines under study, very few of them are financed by the Pandemic Sceptics' favourite villain, Bill Gates. And contrary to many assertions, there is no such thing as a 'global patent', nor a pre-emptive patent. No billionaire can capture future patents. At the time of writing China had five COVID19 vaccines in the second stage of human trials (Bloomberg 2020b) and the Chinese Premier Xi has offered the first of them free or at low cost, as a "global public good" (Wheaton 2020). So much for the Bill Gates vaccine monopoly theory.

There is, however, a global oligarchy which will use its weight in attempts to squeeze out Chinese companies from particular national markets. Whether they succeed depends on national struggles, to ensure equitable access to safe and effective treatments. In some cases there will be socialised generic treatments, in other cases (as in my country, Australia) there are state schemes to pay Big

Pharma massive amounts for bulk purchases, then provide them at nominal cost to the public; in the USA there is a much harsher commercial user-pays logic. It is quite likely that multiple vaccines and various anti-viral treatments for COVID19 will soon appear and compete, in a huge propaganda war.

Many sceptics doubt the fact that governments have reported over 300,000 deaths from the virus. The British alt-media group OffGuardian reports: “as we have been pointing out since day one … the virus is ‘mild’ or even asymptomatic in the majority of cases, and chiefly a danger only to the already ailing or severely immuno-compromised” (Black 2020). Such arguments not only misunderstand the epidemic but encourage the same complacency shown by the neoliberal regimes.

Simplistic Pandemic Sceptic theories with little real evidence do not help a critical understanding of the virus and responses to it. Engagement with public health principles alongside commercial agendas would allow us to see corporations as raiders rather than simple purveyors of false ‘snake oil’ remedies. Because Big Pharma made billions out of HIV/AIDS drugs, do we condemn those drugs? Of course not.

The libertarian arguments (‘my liberties above all else’) are basically anti-social individualism, similar to that run by Donald Trump, Alex Jones and the ‘Minnesota Freedom’ groups. Collective action to combat an epidemic can go to hell, they say. Yet when the quarantine ends they will return to an individualistic ‘everyone for themselves’ health system, based on private insurance and Big Pharma. No room for paternalistic public health here.

There is also what has been presented as a “left argument against lockdowns”. Alexis Fitzgerald argues that lockdowns are causing an economic depression and this will disproportionately hurt the working class and marginalised people. He continues “it is not just our liberty we are losing but our livelihoods and our young peoples’ futures” (FitzGerald 2020). This is a clear line of logic, but it also begins on the wrong foot. ‘Lockdowns’ did not start this crisis. He ignores both the public health arguments and the real politics. The first rebuttal should be obvious: “saving lives will save livelihoods” (Cherukupalli and Frieden 2020). If there is a ‘second spike’ of infections and deaths, as occurred in cities like San Francisco and St Louis, which opened up too soon during the 1918-1919 influenza epidemic (Strochlic and Champine 2020), many more lives will be lost. The burden of death, illness and unemployed in this case will fall disproportionately on working class and marginalised populations. That is already happening in the current crisis, with African-Americans in the USA (Aratani and Rushe 2020). For those who follow public health science this is obvious.

If lockdowns are one’s main concern, why not address the proportionality of particular local issues such as the role of police, limits on movement, curfews and/or school closures? Quarantine regimes vary enormously across countries. Some are terribly repressive, others have already been removed. In mid-May in Britain, with hundreds of COVID19 deaths each day, only 5% of school teachers felt safe to return to school (Hockaday 2020); whereas in Australia, with less than one death per day, schools had already resumed. There is international ‘proportionality’ law on liberties and freedom of movement (HRC 1999: 14), but I am yet to see it seriously cited by the Pandemic Sceptics. They tend to keep their arguments global.

To sum up, Pandemic Sceptics present a range of fanciful ideas which, by raising baseless conspiracy claims, obscure the Anglo-American failure to protect lives. Their common failures are to deny or avoid public health principles and replace social evidence with anecdotal scare stories. Blind opposition to protective public health measures, or to treatment and vaccines, runs a very big

risk of throwing out the public health ‘baby’ with the Big Pharma ‘bathwater’. That is both misleading and disempowering.

## 3. The importance of public health systems

Meaningful critiques of the current crisis should focus on mitigating the crisis and helping contain future crises. Both the pandemic and responses to it deserve assessment, and a focus on public health systems is important. Protective responses have varied across countries according to (1) the severity and trajectory of infections, (2) decisions of the political leadership, and (3) the strength of the public health system. The latter is a project built over time in particular circumstances, as a result of popular pressures.

Apart from the vagaries of where infection hot-spots first arose, the pandemic has already shown that those countries which have done better are well organised societies with strong social guarantees and investment in preventive and public health. This cannot be a simple matter of capitalism versus socialism, since all societies have public institutions, services and guarantees, which can be built or weakened. Every country can build or improve its health system, and strong, well-resourced public health systems offer the best protection against exclusion, unaffordable and/or inappropriate treatments and corporate control.

It is important to recognise that most of the Pandemic related failures of Anglo-American Hegemonic Neoliberalism flow directly from their particular rejection of public health and social support. The following links can be made:

- Weak or undermined public health guarantees, which led to a failure to protect citizens and so mass illness and death;
- Weak or undermined preventive health systems, which caused slow and limited capacity responses to the pandemic;
- Privatised, use-pays approach to health care, which led to complacent and delayed responses, after which pressure of mass illness and death cause reactions from one extreme to the other, with protective response led by policing rather than the public health system;
- ‘Managed Care’ (USA) which allows corporations to determine treatment, which caused fear and distrust of any treatment or even information, whether from government or companies;
- Primacy of commercial processes and corporate privilege, which led to a failure to recognise key principles of public health;
- Economic siege warfare (and other forms of warfare) on dozens of countries, in pursuit of hegemonic control, which undermined international cooperation and sabotaged the availability of health resources (e.g. protective personal equipment) in other countries.

Table 3 below characterises types of systems, pointing to the competing influence of the privatised and public systems. Strong public health systems can ensure the foundational health of all citizens and limit the compromises of private commercial interests. They necessarily include preventive health and health education, efficiencies ignored by commercialised systems. Good public health systems have been created in many countries and they help explain their relatively better performance in face of threats.

**Table 3: How health systems determine public health responses**

| | Highly privatised systems | Universal cover hybrid systems | Public health systems |
|---|---|---|---|
| **e.g.** | e.g. USA (<50% public) with 'managed care' | e.g. west Europeans, Australia, Canada (65-80% public) | e.g. Cuba (>95% public) |
| **Character & orientation** | Private finance given control of services; curative and commercial | Public guarantee subsidises private and providers; some public health; curative with some preventive | State guarantor of services; preventive and social medicine |
| **Role of private finance?** | PF directs treatment, blocks universal guarantee | Public system subsidises PF, which in turn influences services | Little; but PF controls international markets |
| **Emergency response?** | Private insurance and the 'National Guard' | Some public health capacity to extend social guarantees | Social guarantees, health authority manages |

The themes of Table 3 help us understand the links between highly privatised systems and repressive responses. There is neither the capacity nor the trust that is available in strong public systems, to respond rapidly and effectively. Several countries with very low levels of infection closed their schools as a pre-emptive measures to stop the possible spread of infection. The neoliberal regimes dithered. Children were not at great risk of death but they did pose a high risk of taking and spreading infections back into the home. In countries where the quarantine measures were led by the ministry of health, there was often much greater trust than in the US and the UK, where the switch from complacency to ‘lockdown’ was handed to police and the national guard. President Trump saying he would “rapidly” mobilize the U.S. military to distribute a coronavirus vaccine once it was ready can only add to fear, more distrust and conspiracy theories (Watson 2020).

Better understandings of epidemics and health systems help inform political engagement. Dramatic misinformation disempowers and distracts. Neoliberal ideology has repeatedly blocked the construction of social institutions, under the pretext of governments not interfering in markets. Yet the Pandemic has provided a unique opportunity to challenge that dogma. Bregman (2020) observes that even bastions of neoliberal ideology, like Britain’s Financial Times, recognise that neoliberal doctrine is at risk. In early April that paper wrote:

“To demand collective sacrifice you must offer a social contract that benefits everyone. Today’s crisis is laying bare how far many rich societies fall short of this ideal … Radical reforms - reversing the prevailing policy direction of the last four decades - will need to be put on the table. Governments will have to accept a more active role in the economy. They must see public services as investments rather than liabilities, and look for ways to make labour markets less insecure … Policies until recently considered eccentric, such as basic income and wealth taxes, will have to be in the mix” (Financial Times 2020).

No doubt the financialised world will press its own new agendas, trying co-opt popular themes such as health, incomes and the environment. However those concerned at building public health

systems, social support and more accountable states should not miss this chance. Universal health protection is very popular, except with private health finance.

For example, in the UK the crisis should empower demands for reconstruction of the NHS, an institution built on decent universal service principles (National Archives 2020). Critics of the corporate infiltration and undermining of the NHS should use this moment to elevate the voices of NHS health workers and those health professionals and analysts who have tried to defend it for many years. They know the problems and where reconstruction is needed.

In the USA the decades long movement to actually create a public health guarantee, betrayed by both major parties, could be put back 'on the rails'. Yet in an election year the Democrats have joined the Republicans in a new round of subsides for the private health insurance companies (Johnson 2020), maintaining the dreadful user-pays status quo that was so powerfully exposed by Michael Moore's film Sicko (Moore 2007).

The demand for and development of social support schemes such as guaranteed minimum income (GMI), or universal basic income (UBI), so valuable during long periods of unemployment, has already gained impetus with this crisis. Some wealthier countries which already have social security, like Australia, extended that during the crisis into 'job keeper' schemes (Cassells and Duncan 2020), to maintain positions and business during the 2 to 3 month quarantine period. In poorer countries we see renewed reliance on the subsidies of basic food items, a practice neoliberalism through IMF loans tried to suppress, because such subsidies distorted 'open markets'. These are precedents, the logic of which can be developed.

The important field of vaccines has been attacked for years by an anti-vaccine movement, a bandwagon which most Pandemic Sceptics have joined. As indicated above, most of the generic criticisms of vaccines are unfounded. Vaccines have saved millions of lives, particularly in infectious diseases such as measles and tuberculosis (Anderson 2006). Yet failures in public support for the MMR vaccine recently led to dozens of children's deaths in Samoa (UNICEF 2020).

Critics have decried the capture of vaccine markets by big companies; and those companies have great influence in neoliberal governments. But the world has changed since US companies pretended to run the world. The centres of industry and leading technology are shifting eastwards. While the Pandemic Sceptics scream 'Bill Gates' and his cartel, China offers the best chance of an affordable vaccine. At the time of writing China had 5 COVID19 vaccines in the second stage of human trials (Bloomberg 2020b). Then in mid-May the Chinese president said that China's first vaccines would be made available to the world "as a public good", presumably at a very low cost. China's leader told the World Health Assembly in a virtual gathering, "this will be China's contribution to ensuring vaccine accessibility and affordability in developing countries" (Wheaton 2020). That is the best answer to the Bill Gates scare stories.

Vaccines present no single answer to an epidemic. The threat will diminish with protective measures, effective treatment and with a subsidence in rates of infection. But a safe and effective vaccine could save millions of vulnerable lives. The anti-vaccination campaigns have had their greatest impact in parts of Europe, but worldwide "79% of people agree that vaccines are safe and 84% agree that they are effective" (Wellcome 2019). In the USA polls show there has been a fall in confidence, but 84% still believe "say vaccinating children is important" (Reinhardt 2020). New treatments from China may even preclude the need for a vaccine. Laboratory manufactured 'neutralising antibodies' are said to "shorten the recovery time … and even offer short term

immunity". Unlike plasma from recovered patients, which is also effective, this treatment can be mass produced (Ye and Knight 2020). Wider options are always a good thing.

China's 'public good' vaccine proposal will be met by the anti-China 'international investigation' plan, into what Trump has already branded a 'Chinese virus' (Trump 2020a). Meantime the Trump administration is reported as having taken steps to hijack and divert protective equipment destined for several other countries, to control exports of experimental treatments and to claim exclusive access to new vaccines (Jeffery 2020; Oltermann 2020). This mercantile behaviour led the Chair of the Coalition for Epidemic Preparedness Innovation (CEPI), Jane Halton to warn against "vaccine nationalism" as it amounted to a threat to public health (McIlroy 2020).

China's commitment is a real blow to hegemonic neoliberalism, which typically aims to capture new technology and resell it at a maximum price. That is exactly the neoliberal theory of international 'technology transfer' (Reddy and Zhao 1990): that the transmission of new knowledge between countries occurs through the 'normal' commercial activities of multinational private companies. Cooperation can change that. Yuanqiong Hu, senior legal and policy adviser for MSF Access Campaign, pointed out that international debate at the WHA may "be key to devising [new] rules for how countries collaborate" (Wheaton 2020).

International cooperation, or lack of it, remains a key issue. The Chinese initiative of 'public good' vaccines may widen or be limited, depending on levels of cooperation. Its main current obstacle seems to be the 'blame China' campaign. Yet there are enormous potential benefits in enhanced international cooperation. First of all sharing lessons between countries is of critical importance. China took a first step by publishing the genome of COVID19 and the emerging giant has helped many other countries with test kits and PPE supplies, including the USA (Stevenson, Kulish and Gelles 2020). But obstacles to the importation of treatments are often created within national health systems, largely through the influence of Big Pharma and local regimes. For example, Cuba has unique treatments for diabetic ulcers and lung cancer, and these are available in a number of countries but blocked in others, such as the USA (Reed 2016; Almendrala 2016). Partnerships with US companies have been made difficult, so Cuba has developed agreements with Russia and China.

Similarly, China has for some time produced the best anti-malarial medicine, from the *Artemesia* plant, but various obstacles (e.g. US influence through the W.H.O.) delayed international recognition for decades (White, Hien, and Nosten 2015). In the current crisis a group of US Congress members introduced a "COVID-19 Vaccine Protection Act, to prevent the Chinese Communist Party from stealing or sabotaging American COVID-19 vaccine research" (PTI 2020). That foreshadows the competitive battle to come over treatments and vaccines. Greater cooperation could remove such obstacles.

What lessons can we learn from the more independent countries, like Vietnam, Syria and Cuba? (All COVID19 data in this paragraph is at 20 May 2020 and from Worldometer). Despite sharing a border with China and with a population of 97 million, at 20 May Vietnam had recorded only 324 cases and no deaths. Vietnam's response, led by the Health Ministry, closed all borders and schools and set in place state-hosted and funded quarantine for all those thought to be at risk. Testing, tracing, public education and face masks were used (Tran, Gregorio and Nixon 2020). Despite being occupied by three foreign armies and large terrorist gangs, war-torn Syria had only recorded 58 infections and 3 deaths. It quarantined almost 7,000 and some particular areas, imposed a curfew and closed all schools before the country had even registered a single case. Testing is free of charge,

but priority is given “to the elderly, those with chronic diseases, pregnant women and people with disabilities” (Shaza 2020).

Cuba was exposed to infections from a very large tourist industry, and the first cases were registered amongst tourists; but after more than two months the country had only registered 1,887 cases and 79 deaths. While sending specialist brigades of doctors to more than 20 other countries, Cuba maintains a health system which has a presence in every residential block. Even when there were no recorded cases, Cuban health authorities began to impose quarantine measures, including ‘stay at home’ advice. Overseas tourism was shut down. Public transport was shut down except for essential workers (Anderson 2020b; Sánchez 2020). In each case the response was led by health authorities and followed the W.H.O. agreed principles of protective measures, testing and tracing, according to each country’s circumstances. These examples are valuable, as they help distinguish practice based on widely accepted public health principles, from those that are far more heavily influenced by corporate lobbies.

Public exposure of the failures of Anglo-American hegemonic neoliberalism opens a number of doors. Many raise the reasonable question: what could have been done in health and preventive health systems in the USA, if it were not for the six trillion dollars spent on multiple wars across the Middle East (Baraka 2019; Cole 2020)? in the largely futile attempts at extending its influence in that region. Others are pointing out that the proverbial ‘emperor’ has no clothes: “the world stands aghast at the naked truth that America is not only incapable of leading the world, but [is] also failing to protect its own people” (Zogby 2020). Lessons can certainly be learned, across cultures, but ‘models’ cannot be simply copied or transplanted from one country to another. They must be built on the historical circumstances of each particular country (Anderson 2010). There are a range of possible outcomes in a post neoliberal era, but none of them should neglect a decent public health system.

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