The Necropolitics of COVID-19: Will the COVID-19 pandemic reshape national healthcare systems?

The COVID-19 pandemic has made necropolitics – the politics of life and death – unavoidable . Drawing on the work of Achille Mbembe, **Hamish Robertson** *and* **Joanne Travaglia** *argue that, as in previous crises, COVID-19 reveals many of the hidden assumptions underpinning national healthcare systems. As the current crisis continues to bring these assumptions into the mainstream and disrupts business as usual, they suggest that COVID-19 points towards opportunities to reshape the relationship of society to its most vulnerable members.*

We are currently in a time of crisis, brought on by a historically familiar theme of viral infection, the scale of which is unprecedented in living memory. Thus, we are experiencing a global reaction to what has come to be seen (in the richer, healthier and increasingly older countries) as a 'black swan' event. Perhaps not surprisingly this event is occurring at a time when the rising threat of antimicrobial resistance (AMR) has become a major issue for health care systems and providers globally. While AMR and COVID-19 present very different challenges, the distinction between actual and potential health events can be seen as a related part of the problem we are now experiencing – a lack of preparedness. This includes planning for, resourcing and anticipating future events that have both a recent (e.g. SARS) and longer historical record (e.g. The 1918 Influenza Epidemic). We have been here before, and yet at the social policy level there tends to be a denial, rather than acceptance, of history.

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This lack of preparedness in many countries is a reminder that decisions made and not made, such as what level of capacity our health systems should possess, are marked by political and ideological positions, rather than scientific knowledge. As Dye drily defined "*Public policy is whatever governments choose to do or not to do*". In the USA much of the contemporary commentary suggests universal healthcare access is a major benefit for societies in a pandemic scenario. In principle the idea is that universal systems pre-empt many of the problems associated with for-profit systems, such as inability to pay for care when needed, prioritising some treatments (or payments) over others, and or waiting until illnesses are severe before seeking treatment. The basic logic is that universal healthcare enhances population-level health and creates a level of health reserve that may stall or moderate otherwise rapidly developing health crises.

However, universal access can itself be critically unpacked and it is not the same thing as universal treatment, or equal care within all parts of a healthcare system. Some groups continue to experience inequalities and inequities even in purportedly universal healthcare systems both before and during a crisis event. Because societies generally affirm various kinds of inequality on a daily basis, the consequences of a pandemic scenario for people whose lives are precarious, may be especially serious. We need only consider the risks experienced by those in institutional forms of 'care' including prisons, undocumented migrants, refugee or migrant holding facilities, and people with mental illnesses, through to residential aged care facilities and, of course, people who are homeless. The disability community in the United Kingdom is already talking about a potential genocide.

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The hidden assumptions of healthcare systems

One of the more common philosophical positions of the health professions generally, and in a time of crisis, is a crude form of utilitarianism. This is implicit in the idea that medical decisions about access to and provision of treatments will be assessed on the basis of individual need, a 'need' that is frequently interpreted through a lens of both perceived social utility and a capacity for 'clinical benefit'. In other words, people who are already ill, have co-morbidities or disabilities may be less likely to receive care during crisis events such as a pandemic. In the United States there is, as usual, already a racial dimension to the Covid-19 morbidity and mortality statistics.

It is for these reasons that what we have often been seeing in the early stages of this crisis, is a repetition of entrenched ideas about, and attitudes towards, a variety of individuals and groups in the community. This is when and where we see remarks about who needs to survive and who does not, where we see public discourse deploy terms such as 'herd immunity' without direct acknowledgement that such ideas, and their implementation, carry enormous mortal risks for specific groups of people and, by inference, their families and supports. This, following the work of Mbembe, can be interpreted and inquired on as a form of *necropolitics*.

Necropolitics and COVID-19

Mbembe's 2003 conceptualisation of necropolitics, exercised via techniques of necropower, focused on the state's right to decide who *may* live and who *must* die (our emphasis) as the "ultimate expression of sovereignty". This clearly has resonance under the current circumstances in which governments and political functionaries are making comments that suggest some lives may be (are) more important than others. However, in a crisis it is not always the state that chooses to make the decisions about life and death. As in previous crises, such as Hurricane Katrina, individuals in acute situations may make decisions not only to allow weak and vulnerable people to die, but to proactively end their lives. Already we have seen cases in Spain of the abandonment of older people to their fates in residential care facilities.

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Our concern here is that these patterns of behaviour are not even remotely unique to crisis situations (would that they were), instead they are a consequence of how people living in highly dependent and vulnerable living situations are frequently characterised and summarily dismissed. As feminist bioethicists have argued, capitalist systems in general, and neoliberal ones in particular, have a deep antipathy towards dependent people and even to the very concept on relational dependency, hence the poor pay and conditions associated with commodified care work. The concept of commodification is deeply entrenched in our healthcare systems, since so few of them are resourced to the level of actual population health need. Instead we see both implicit and explicit narratives about the need to ration resources, which in the final account means the rationing of treatment and care.

The necropolitical moment

COVID-19 has highlighted in an extraordinary way many of contemporary society's necropolitical assumptions. These issues are pushed to the side when things are progressing 'normally' and institutional forms of power hold sway, leaving limited room for negotiation. Now is the time to engage more actively with our societies' necropolitical assumptions, because as existing orthodoxies are destabilised, it creates openings to understand and reimagine our own necropolitics

Clearly the global situation is volatile, and it is still unclear how long it will endure. Our proposal here is to consider the discourses, both 'business as usual' and those of exception, from a necropolitical perspective. Clearly some people are more at risk than others, clearly people who were vulnerable before are even more so now. Some of that vulnerability is a consequence not of their individual or social health categorisation (*the* elderly, *the* disabled, *the* chronically ill), but due to our prevailing necropolitics and unexamined positions in respect of those necropolitical arrangements. COVID-19 compels us all to inquire very closely on these arrangements, the political challenge of the post COVID-19 world will be to seize this necropolitical moment, before the situation returns to those established relationships and assumptions – until the next crisis event.

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