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What Went Wrong
Corona and the World after the Full Stop

"It is as though mankind had divided itself
between those who believe in human omnipotence
(who think that everything is possible if one knows
how to organize masses for it) and those for whom
powerlessness has become the major experience
of their lives."

Hannah Arendt

The measures that governments across the world have taken to contain the spread of corona virus disease are massive and unprecedented. As a result of these measures, life has come to an almost complete standstill, with many countries under lockdown. Never in the history of humanity have such drastic interventions into the lives of populations occurred in the name of health on such a scale and in such a short period of time.

As a result of the world's largest and perhaps most stringent lockdown, millions of daily wage laborers lost their source of income in India. Healthcare workers have been evicted from their homes because they are seen as potential spreaders of infection.[1] Neighborhoods are scared into panic when an ambulance appears on the street. Due to the sudden ban on any form of transportation, migrant workers are stranded between the cities where they used to work and the villages where their families are living.[2] Cancer patients are unable to receive essential medical care because they cannot reach the hospital. It is the poor, the marginalized and the vulnerable that are most affected by today's drastic measures which exacerbate already existing inequalities.

In Kenya, the police enforced a coronavirus curfew using teargas and excessive force against presumable violators of lockdown law.[3] In Bangladesh, the government created a special unit to monitor social media and arrest people for spreading "misinformation" about the virus.[4] In Hungary, parliament passed a law allowing Prime Minister Orban to limit freedom of speech, defer elections and suspend rules and regulations by decree.[5] In the United States, over 6.6 million people lost their job and filed for unemployment benefits in one single week.[6]

Unfortunately, many things are completely unknown in this pandemic despite intensive investigation. For example, we don't know what has helped contain the outbreak in China. Have the dramatic interventions contained the spread of the virus? Or has everyone who was susceptible been infected and the virus has burned out and moved on to other susceptible populations? The fact is: We simply

don't know. But we proceed as if we do and impose extreme measures to manage the outbreak.

Today, many wonder how we ended up where we are. How was it possible for a virus to trigger such a massive response that threatens society and the entire economy, with so little discussion about the costs and consequences of extreme measures? Why is there widespread agreement that aggressive interventions to "flatten the curve" are necessary and justified? It seems that this unprecedented public health experiment occurred without any serious consideration of the social, political and economic consequences.

The failure to take into account the impact of extreme measures that have become the norm in this pandemic is stunning. It will haunt us for decades.

How it all began

The corona virus disease (Covid-19) outbreak seems to have started in the Chinese city of Wuhan in December 2019. In January, the Chinese government imposed a regional lockdown and introduced "social distancing" and "self-isolation" measures to contain the spread of the virus. Officials implemented a risk-based approach with specific measures for specific regions. As a WHO report noted, "specific containment measures were adjusted to the provincial, county and even community context, the capacity of the setting and the nature of novel coronavirus transmission there."[7] At the time, major media outlets in the United States called the measures "harsh," "extreme," "severe," and "controversial," emphasizing that they offered "no guarantee of success."[8] In the UK, newspaper articles suggested that the Chinese government would not be able to keep large parts of the country "closed for business indefinitely."[9]

In February, the virus continued to circulate and soon appeared in other countries. In March, the World Health Organization (WHO) declared the Covid-19 outbreak a global pandemic. Over the following weeks, a much less dynamic, differentiated and targeted version of the Chinese intervention became the norm promoted by experts, officials and the media across the world.

A few countries like South Korea veered from this norm and chose a classic infectious disease intervention: test-trace-isolate, with a highly centralized approach to public health intelligence gathering. Emphasizing mass-testing and meticulous contact tracing to interrupt the chain of transmission, South Korean health officials closed schools and managed the crisis successfully without any lockdowns, roadblocks and few restrictions of movement. Significantly, South Korea learned from earlier outbreaks of infectious disease (SARS in particular), imposed central control, used digital technologies, enforced quarantines and witnessed one of the lowest Covid-19 mortality rates. By the end of April 2020, around 10,000 cases of infection had been detected, but only 240 people had died.

Germany developed its own testing protocol, which was published on 17 January 2020 by the WHO.[10] When the first case was detected on 28 January, Germany launched mass-testing, systematic contact tracing and early hospitalization, keeping the mortality rate low and hospitals functional even when cases of infection increased.[11] Health officials relied on an extensive network of laboratories and were able to conduct over 500,000 SARS-CoV-2 tests per week.[12]

Despite WHO's emphasis on testing and South Korea's early success in containing the spread of the virus, most countries put testing at scale second and relied on an extreme version of the Chinese approach of lockdown, "social distancing" and "self-isolation." In contrast to the tailored approach and regional focus that prevailed in China and that sought to minimize the socio-economic impact of the response, governments in Europe imposed nationwide lockdowns that went beyond China's authoritarian intervention. In practice, these lockdowns amounted to curfews (often legalized after the fact by emergency laws).[13]

Italy was the world's first country with a nationwide lockdown/curfew. Many countries followed suit, partly driven by shocking images of overwhelmed hospitals in Italy's north. A crude version of the Chinese approach became the international norm. Shutting down society and the economy appeared as an appropriate response and the only possible way of dealing with the crisis, no matter what the costs and consequences. In all of this, Italy figured as an ambivalent role model. To avoid Italy's disaster, governments appropriated the Italian response as a one-size-fit-all intervention.

Dramatic references to the magnitude of the threat served as justification, making considerations of costs and consequences seemingly irrelevant. This extreme approach and its rigid implementation was driven by a growing sense of panic, constant media sensationalism, deep authoritarian longings, increasing political pressure to contain the spread of the virus, disturbing accounts of overwhelmed hospitals unable to cope with the surge of patients, misleading mortality calculations and, most importantly, a trust in the power of disease modeling.

There was an abiding sense among observers and the public that it is clear what is happening; that everyone knows what is going on because everyone can see it. However, what an endless stream of media reports from around the world obscured is the fact that it is impossible to know what is happening in a population when there is no systematic testing. The lack of testing created a lack of data that was subsequently filled by the flexible evidence of disease modeling. In the absence of ground data, disease modeling emerged as the presumably best and only science to inform policy.

Media hyperbole focused on absolute numbers and made Covid-19 deaths politically visible. Disease modelling (often based on data derived from viruses such as influenza) took the place of accurate epidemiological surveillance. Numbers played an important role in estimations of the magnitude of the threat, fueling fear and panic in the absence of reliable data. There was a widespread sense, among experts and the media, that the SARS-CoV-2 virus was much more lethal than seasonal influenza. That this pandemic was different from influenza and thus required a different approach was typically claimed on the basis of the case-fatality rate, the number of deaths as a subset of those infected with SARS-CoV-2. The case-fatality rate played a crucial role in the justification of the public health experiment now unfolding before our eyes.

Obscuring the lack of evidence with numbers

Estimates of the case-fatality rate initially varied hugely from 0.17% to 17%. In an article published in The Lancet, a prominent peer-reviewed journal, scientists claimed it could even be as high as 20%.[14] In early March 2020, the WHO Director-General stated that the case-fatality rate for SARS-CoV-2 was 3.4%. He added: "By comparison, seasonal flu generally kills far fewer than 1% among those infected."[15]

Whatever the estimates, the truth is that it is impossible to calculate the case-fatality rate in the absence of systematic testing. Given the lack of evidence, the only scientifically valid statement at the time would have been to say that *we simply don't know how lethal the virus is*.

Early on in this pandemic it became clear that up to 50% of infected people experience no symptoms at all. This means that a testing regime where only sick people with symptoms are tested, excludes a large number of infections. Additionally, patients with symptoms are much more likely to die than asymptomatic people. The result is an exaggerated case-fatality rate.

Testing strategies differed across countries and changed within countries over time. For example, on 25 February 2020, the Italian Ministry of Health published a revised policy for testing, prioritizing patients with severe clinical symptoms (and thus higher chances of dying). This change in policy resulted in an apparent increase in the case-fatality rate of 3.1% on 24 February to 7.2% on 17 March.[16] Suddenly the virus seemed to have become much more lethal.

Changes in testing policy seem to have gone even further in China, where test-positive asymptomatic patients were apparently excluded from being counted as a case of infection. This would mean that the number of officially confirmed cases didn't reflect all cases of infection.

Last but not least there was no agreement on what counts as a death caused by the virus in the first place. In Italy, Covid-19-related deaths were defined as those occurring in test positive patients, "independently from preexisting diseases that may have caused death."[17] This is particularly concerning in terms of data quality because the vast majority of deaths occur in patients who are older than 65 with one or more comorbidity. Test positive patients who die because of heart disease or terminal cancer are not necessarily dying because of SARS-CoV-2 infection. Yet they appear in the statistics of some countries. This confusion between patients who die with the virus and those who die from it had an impact on the data and its quality, making comparison between countries challenging, to say the least.

Almost all tests are currently done with RNA tests, which can detect an infection as long as the virus is present in the body. These tests, however, cannot tell whether a person had the virus in the past. Only serological tests for antibodies against the virus can provide an accurate picture of how many people have been infected in a given population. And yet, such systematic serological studies are missing.

Given the lack of testing and taking into account the role of selection bias, the large number of asymptomatic cases, the confusions in case definitions and the changes in testing policies, the denominator cannot be reliably determined. And when there is no denominator it is mathematically impossible to calculate the case-fatality rate. Despite the lack of data, experts, officials and the media continued to present high case-fatality rates.

Over the past few weeks, more and more testing has been done. Not surprisingly, estimates of the case-fatality rate have come down significantly, mainly because the denominator has gone up due to the increase of testing. In Iceland, 6% of the population has been tested using PCR-based tests independent of symptoms, suggesting an infection-fatality rate of 0.06%.[18] This figure is over 50 times lower than WHO's official estimate. A study using both PCR-based and serological tests

conducted in one of Germany's most affected regions indicated a case-fatality rate of 0.37% and an infection-fatality rate of 0.06%.[19]

We know from epidemics and pandemics of the past that the case-fatality rate is often massively overestimated at the beginning of an outbreak because case detection is limited, largely based on hospital patients and typically biased towards the severest cases of disease. When the H1N1 swine flu pandemic occurred in 2009, the estimated case-fatality rate varied between 0.1% to 5.1% in the first 10 weeks of the outbreak. In 2019, a decade after the pandemic, the WHO reported that the swine flu pandemic turned out to have a case-fatality rate of 0.02%. This means that the actual case-fatality rate was five times lower than the lowest estimate.

Social science scholarship has shown how numbers can deceive. Numbers have the ability to reveal as well as conceal. Therein lies their magic. They can make things seem more certain than they actually are, displacing attention away from the conditions under which they were produced. Abstracting from these conditions and focusing on meaningless absolute numbers is dangerous because it makes things comparable that are not comparable, because it suggests scientific knowledge where there is lack of evidence, and because it creates the sense of a major threat obscuring the differential nature of risk.

Structural fragilities

Among the more interesting figures of the pandemic is the number of deaths per million inhabitants per country. This number is probably more reliable than the case-fatality rate because deaths are less likely to be missed (ignoring for now the difficulty of defining deaths caused by SARS-CoV-2) and because the denominator, a country's population, is known.[20] Here are the current numbers for five countries as of 22 April 2020:

Spain: 455
Italy: 408
France: 319
Germany: 61
South Korea: 5

The staggering differences between countries cannot solely be explained by the rates of infection (some countries seem to have more infected people per million inhabitants than others and so might be overwhelmed, though this is also a question of time – how many cases per week per region). What the differences might reveal – if they turn out to reflect reality – is that some healthcare systems are able to deal with the crisis in a better way than others. The structural fragilities of an underfunded, understaffed, overstretched and increasingly privatized healthcare system contribute to higher mortality rates.[21] In a sense, each society has the mortality it deserves.[22]

Where medical care is easily accessible, staff sufficient and well-trained, and capacities are flexible, patients are more likely to receive better care and survive. In this sense it matters that Spain turns out to have 3 beds per 1,000 inhabitants, Italy 3.2, France 6, Germany 8 and South Korea 12.3.[23] Although beds per inhabitants is a crude indicator, it is noteworthy that Germany can rely on over 30,000 staffed intensive care beds, out of which only 11,500 were occupied in early April 2020.[24] And this at a time when there were more cases in Germany than in

France and the UK and slightly less than in Spain and Italy. This is clearly not a healthcare system overwhelmed by a sudden surge of patients. Ironically, organizations such as the OECD frequently scolded Germany's healthcare system in the past for "oversupply" of hospital beds and its inability to "rationalize hospital capacity."[25]

The case-fatality rate is not just dependent on the biological nature of the virus and the demographic and health structure of the population (people most at risk of death are 65+ with one or more comorbidity). It also depends on systematic testing, meticulous contact tracing, well-trained healthcare workers, nursing homes with adequate resources and the ability of the healthcare system to cope with the crisis (excess as well as surge capacity) and provide high quality medical care, particularly keeping medical workers save and healthy. In this sense, the pandemic will brutally expose policy failures and structural healthcare system deficits.

The situation in many hospitals in Italy, Spain and France is troubling, especially in densely populated areas. But it is important to understand why these hospitals are overwhelmed with patients. Many hospitals are in a crisis on a daily basis.[26] Intensive care units have neither excess nor surge capacity. When a new virus appears, things start to fall apart. Then everyone gets scared, extreme measures are implemented in a more or less improvised manner, and trillions of dollars, euros and pounds are pumped into the economy to make up for the loss. Once the worst is over, the "normal" crisis continues.

Rebuilding the world after the full stop

This pandemic will haunt us for decades in ways we can barely imagine at this point. The nature and sheer scale of the intervention are staggering, and the consequences – social, political and economic – are unforeseeable. There are no models predicting the total costs of interventions, nor do we have any idea about the number of indirect deaths due to the lockdowns/curfews, the "social distancing" and the "self-isolation." Nor is there a plan that would outline how we might learn to live with a virus that is unlikely to disappear any time soon.[27]

We might, however, reframe the corona conversation to cut through the confusion and dimness that is pervading this pandemic in the following ways:

<u>I Orientations</u>

1. The emergence of new viruses in human populations is normal. It has happened before; it will happen again.
2. Coronaviruses are common and circulate widely in humans. They have infected people and killed thousands year after year, especially in winter.
3. Worldwide, between 300,000 to 500,000 people die from seasonal influenza viruses every year. The SARS-CoV-2 virus has killed 180,000 people so far. There is no doubt, SARS-CoV-2 is causing a serious infectious disease, but so far it is still in the range of what we observe in terms of mortality during a severe seasonal influenza outbreak. The main difference is the speed of infection, the clinical picture of the disease and the impact on demographically older populations causing massive compression of morbidity and mortality that is overwhelming weak healthcare systems with no excess and low surge capacity.
4. The 1957 influenza pandemic killed between 1 and 2 million people worldwide and the 1968 influenza pandemic killed between 2 and 4 million

people. Covid-19 has killed 180,000 people so far. In Italy, it caused 24,000 deaths. This is equivalent to the number of people who die every year due to influenza in Italy. Clearly, the world has seen worse, including 1.3 million deaths due to TB each year, 770,000 deaths due to HIV infections each year and 435,000 deaths due to malaria, all preventable and treatable conditions.

5 This observation does not mean that influenza and Covid-19 are clinically similar or that nothing should be done to contain the spread of SARS-CoV-2 and mitigate the consequences. However, it raises the question of why fear and panic are spreading like a wildfire today and why experts and government officials are willing to mount an unprecedented effort for SARS-CoV-2 but have never ever even considered similar lockdowns for the 300,000 to 500,00 people who die every year due to influenza. Influenza is a relatively well-known virus. To say that SARS-CoV-2 is an unknown virus doesn't automatically justify the most extreme measures that the world has ever seen.

II Diagnosis

1 It is difficult to overestimate what we are witnessing today.

2 What makes this pandemic unprecedented is not the virus but the response to it.

3 Extreme measures to contain the spread of the virus have resulted in extreme fallouts.

4 The response to the pandemic is driven by a fantasy of control. This fantasy is causing enormous harm. It is unrealistic, misleading and bound to fail. A pandemic like this cannot be controlled; it can only be managed.

5 If we keep using words such as "control" we are only setting ourselves up for disappointment. This pandemic is far from having found a language that is adequate to the problems it is posing. We urgently need new concepts but seem to have little imagination.

6 Loose science, lack of data, speculative evidence, strong opinions, misinformation, exaggerated mortality rates, the 24/7 news media attention and the rapid spread of dramatic stories on social media have led to poor political choices and major public anxiety.

7 We are afraid of corona virus disease. We are not afraid of seasonal influenza. We see one thing as a public health emergency and another as a fact of life. Today, we are learning an old insight the hard way: Not every life and not every death is equal. Some deaths are more important than others, drawing more attention, triggering a bigger response and mobilizing more resources. Today's attempt to "flatten the curve" is limited to politically visible deaths. It leaves all other causes of death and disease untouched.

8 In this pandemic the belief seems to have taken root that health is an absolute value and that every life needs to be saved by all means. Meanwhile millions of people are dying of influenza, TB, HIV, malaria and diarrhea. There appears to be little urgency for these preventable deaths.

9 Some healthcare systems were overwhelmed in this pandemic. Others were not.

10 For decades governments have underfunded and understaffed healthcare systems across the world.

11 The response to SARS-CoV-2 took a particular shape, converging in extreme measures that have become the norm in many countries. Was it the only possible way of managing the crisis? Why has a crude version of China's approach become the role model? At the heart of this pandemic is the

widespread assumption that there were no alternatives to extreme measures implemented with little consideration of cost and consequences.

12 It seems that some officials saw Covid-19 as a disease that could be contained. As the WHO Director-General suggested in early March 2020, "we don't even talk about containment for seasonal flu – it's just not possible. But it is possible for Covid-19." This perception may have contributed to the radically different approach.

13 The idea of "flattening the curve" is suggestive, but there is no guarantee that the effort will impact the total number of deaths. It may ultimately simply spread the same number of deaths over a longer period of time and thus perhaps reduce the pressure on hospitals but not overall mortality.

14 Lockdowns are not a solution. They prevent infections as long as they are in place, but they also keep people susceptible. This is particularly concerning in a pandemic where the virus has become endemic. Once lockdowns are lifted, the number of infected people is likely to rise again.

15 In Germany, 86% of the people who died due to Covid-19 are 70 years or older.[28] A majority of the patients who died have one or more underlying health condition such as hypertension, diabetes, cardiovascular disease, chronic respiratory disease or cancer. This means that the pandemic is killing predominantly people with an already reduced life expectancy. The key question then becomes excess deaths – the difference between the statistically expected number of deaths and actually occurring deaths over a period of time. There is no doubt that there will be excess deaths due to Covid-19, but it is unclear how large that number will be. This underlines how misleading a focus solely on absolute numbers is.

16 The pandemic response will create a substantial toll of untreated illness. Prohibition of public transport has made it difficult for patients and staff to reach hospitals. Many hospitals are closed for regular services and patients with other conditions than Covid-19 avoid doctors because they are afraid of contagion. Essential public health programs have stopped; many resources have been reallocated. This means that patients are neglected, receiving no or less medical care, leading to untreated illness and a rise in mortality.

17 A virus causes disease, not hunger. It is not the pandemic, but the response to it that threatens the livelihood of millions of people. Patients without Covid-19 and the poor who struggle for survival bear the brunt of the pandemic response.

18 This pandemic is not just about health, it is about fear, and the objects that are singled out and then made the ground and motivation of systematic thought and action. To be afraid has become an obligation, a responsibility, a duty. People are afraid because they are told to be afraid.

19 Public discourse is highly moralized. On social media, "lockdown warriors" accuse citizens of lack of patriotism and failure to "do their duty" in the face of danger. In this highly moralized public discourse, life has become an absolute value justifying almost every form of intervention in the name of health.

III Towards Another Politics of Life

1 Public health needs to be front and center in any infectious disease intervention.

2 Disease modeling cannot replace systematic epidemiological surveillance on the ground. The most effective way of managing an infectious disease outbreak is to test, trace and isolate.

3 Interventions need to be phased over time; they need to be dynamic, regionally targeted and risk based. All interventions must take into account the social and economic impact, as well as the indirect impact on other health conditions.
4 Absolute numbers cannot be used for policy, they only fuel panic and drive hysteria.
5 Lockdowns are not a solution. They protect people, but they also leave them exposed. Once restrictions are lifted, cases of infection are likely to increase again. There is no exit from the pandemic; there is only an exit from the response to it.
6 We are still at an early stage of understanding how best to clinically manage Covid-19 both as a disease and as a risk factor to potentially vulnerable populations. It is vital to find better ways of sharing quality data and effective practice to ensure health systems learn and adapt quickly.
7 What this pandemic shows is a lack of "preparedness." This will come as a surprise, given the billions of dollars, euros and pounds that were spent over the past 15 years on pandemic preparedness, including experience with past epidemics and pandemics such as Ebola and swine flu. How can it be that hospitals ran out of N95 masks in week one? Where did all the billions spend on preparedness go? Insufficient stockpiles have put healthcare workers at risk and have weakened healthcare systems further.
8 Key preparedness concepts need to be at the heart of the response. 15 years of pandemic preparedness seem to have evaporated into thin air in this pandemic. Instead of activating existing plans and drawing on concepts such as the Pandemic Severity Assessment Framework, countries imposed a massive, untested and unproven generic lockdown with unforeseeable social, political and economic consequences.
9 SARS-CoV-2 is less lethal than all scenario exercises that have been conducted for preparedness planning. It will be important to understand why key preparedness concepts were sidelined in this pandemic, despite the attention that "preparedness" received and the substantial resources it consumed for over a decade.
10 The fear of death is powerful in societies eager to repress the inescapable reality of death. In such a context it is important to flatten the curve of extreme speaking, feeling and acting. What is urgently needed is moderation and perspective.
11 Attempts to obscure political failures are growing rapidly. Those who contribute to extreme predictions and apocalyptic readings of the current situation are only contributing to the obfuscation of the policy failures and underlying structural issues that are responsible for many of today's problems. Already there are attempts to rewrite failure as success. Not surprisingly, governments are calling on citizens to participate in public spectacles and demonstrate national unity in the face of danger and celebrate collective strength and resolve. Yet healthcare workers who are risking their lives deserve more than patriotic feelings and symbolic clapping. They deserve better healthcare policies. To challenge and critique now is essential.
12 The political slogan of saving each and every life is not innocent.
13 There is a whole story to be told how the Chinese approach became a model for lockdowns in the Global North, which were then exported to countries in the Global South, with dramatic consequences for millions of people struggling to survive without any source of income. Ironically, these lockdowns were demanded by people eager to criticize the authoritarianism of the Chinese state. Across the world the pandemic unleashed authoritarian

longings in democratic societies allowing governments to grasp the chance, create states of exception and push radical agendas. To love power and to call for its meticulous application is what this pandemic is teaching people.

14 As a result of the unforeseeable social, political and economic consequences of today's extreme measures, governments across the world have launched record "stimulus" bills costing trillions of dollars, pounds, pesos, rands and rupees. Earmarked predominantly for individuals and businesses, these historic emergency relief bills are pumping staggering amounts of money into the economy, but they are not intended to strengthen the public health infrastructure or improve medical care. The trillions that governments are spending now as "stimulus" packages surpass even those of the 2008 financial crisis and will need to be paid for somehow. Today there is a massive global recession in the making. If austerity policies of the past are at the root of the current crisis with overwhelmed healthcare systems, the rapidly rising public debt is creating the perfect conditions for more austerity in the future. The pandemic response will have major implications for education, welfare, social security, environment and health.

15 If you think something good will come out of this crisis, you should think again. Today we are just driving faster and with a much bigger car, but it is the same road with the same destination.

To continue to engage in today's competition for evermore extreme predictions is dangerous. It will only support those who ignored the virus initially and who are more than willing to blame it now for the mess. Equally dangerous is a public health populism of clapping hands that leaves out any consideration of the social, political and economic costs and consequences of extreme measures. The tragedy of today's political moment is that right-wing politicians pushed many into embracing measures that one thought were only possible in authoritarian regimes.

Emblematic for today's tragic situation is the fact that critique has become difficult because it is seen as playing into the hands of Trump, Johnson and Bolsonaro, political figures who never cared about public health and the staggering inequalities that afflict our world and whose public statements have reached an unmatched level of ignorance and incompetence. However, beyond this complaint, it is important to understand that the strategic combination of confusion, contradiction and the play of extreme opposites is foundational for authoritarian rule. Everything that intensifies the crisis magnifies the desire for decisive action.

As scholars and citizens, we have the obligation to think beyond the crisis, create openings in the world and consider, critically and democratically, how we want to govern ourselves. The pandemic and the response to it will require us to reimagine lives and rebuild conditions of existence. Like every engagement in a serious pedagogical project, it will entail a reconsideration of the objects we desire.

Today's fear is fueled by four main forces:

1. Epidemiological modelling – a flexible and highly adaptable tool for prediction, often based on assumptions that are difficult to scrutinize from the outside.
2. Neoliberal policies – systematic disinvestments in public health and medical care that have created fragile systems unable to cope with the crisis.
3. Nervous media reporting – an endless stream of information, obsessed with meaningless numbers, exploiting the lack of trust in the healthcare infrastructure and magnifying the fear of collapsing systems.

4. Authoritarian longings – a deep desire for sovereign rule, which derives pleasure from destruction and tries to push the world to the edge of collapse so that it can be rebuilt from the scratch.

This set of forces inspires thought, action and passion in powerful ways. It connects elites in science, politics and the media and releases evermore shocks of excitement pushing hard against our confined, anxious, restless bodies. Epidemiological modeling, neoliberal policies, nervous media and authoritarian longings fuel a fatal spiral centered around the fear of collapse.

This fear is now literally in the air; it moves in and out of us with every breath; it operates as animating medium of our intense isolation and immobility. Significantly, this fear is also a form of excitement – excitement derived from the secret pleasure of spoiling a precious thing, wasting enormous resources and engaging in an all-consuming project with total dedication. What we might call the provocation of the crisis, its intensification, expansion and totalization beyond any notion of utility, seems so excessive and extreme that it borders on sheer madness. What could be more dangerous, more daring, more exciting than a walk on the wild side, an excursion to the other side of reason?

Coda

Melodramatic phrases such as "beating the virus," "winning the war" and "defeating the darkness" are rhetorically powerful and contagious. Equally popular notions like "corona heroes" and "lockdown warriors" are symptoms of overidentification in a hegemonic discourse of power. All these terms reveal how this pandemic is "fabulously textual, through and through," and yet, at the same time, is lacking a source of imagination strong, creative and disturbing enough to move our engagement with the world beyond the most conventional of tropes.[29] The language that we are asked to adopt today, in the midst of this pandemic, is contaminated with words that are stiff, stale and corrupt like putrid air.

Given that so much of today's response is based on and driven by disease modeling and given that millions of lives and livelihoods are destroyed before our eyes, it is not an option anymore to exclude the "externalities" of a pandemic response that lacks imagination and that has resorted to the crudest interventions of all: the full stop. For those with permanent jobs and a comfortable house, this unforeseen interruption may feel like a gift, a welcome relief from the non-stop world of global capitalism. Yet for millions of people living in less privileged parts of the planet, the pause button spells unemployment and hunger, not breaktime and downtime. Without income, food and access to basic healthcare people are not making the most of the confinement outside in the garden; they are desperate and dying.

We urgently need to look beyond the virus if we want to understand the real seriousness of what is happening today. How did we end up in this strange space of thinking, acting and feeling that has normalized extremes and that is based on the assumption that biological life is an absolute value separate from politics? Never has it been more important to insist that another politics of life is possible.

The latest Imperial College disease model report summarizes the staggering blindness that has prevailed in this pandemic: "We do not consider the wider social and economic costs of suppression, which will be high."[30] The time to cast the costs and consequences of interventions as an externality to model-based policy is over.

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Bio

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