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Lessons for the future from an effective and rights-based response to the COVID-19 pandemic

Report¹

Committee on Social Affairs, Health and Sustainable Development

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Summary

An outbreak of the disease COVID-19, provoked by the novel coronavirus SARS-CoV-2, was first reported to the WHO Country Office in China on 31 December 2019, and declared a Public Health Emergency of International Concern on 30 January 2020 by WHO, and a pandemic on 11 March 2020. The virus spread to six continents, infecting millions and killing hundreds of thousands within months.

The disease hit the world largely unprepared. The price of the initial inaction, subsequent slow response, overhasty measures and premature re-openings may well be paid in lives lost, as well as in possibly lasting damage to political, democratic, social, financial and economic systems, and in the non-respect of several of the rights guaranteed by European and international conventions.

The lessons from the suffering of the past few months must be that, to avoid a disastrous outcome in terms of lives lost and burden of sickness, and equally disastrous knock-on effects on the economy and on human rights, we need to act fast to contain outbreaks, using tried and tested, effective measures, implemented in a rights-compliant way, nationally, regionally and internationally co-ordinated, communicated clearly and applied fairly, as recommended in this report.

The Council of Europe and the European Union must build a regional system capable of supporting the responsible international institutions in their endeavours to ensure effective pandemic preparedness. WHO needs to be reformed in order to allow it to better fulfil its function of achieving the highest attainable standard of health for everyone. An enduring system of inspection at the United Nations for current and future high consequence biological events should be established, possibly including a permanent, designated facilitator in the Office of the UN Secretary-General. The UN should also ensure international oversight and accountability for pandemic preparedness through an independent external entity.

1. Reference to Committee: Reference 4511 of 7 May 2020.



Contents	Page
A. Draft resolution	3
B. Draft recommendation	6
C. Explanatory memorandum by Mr Andrej Hunko, Rapporteur	7
1. Introduction	7
2. What we know about the novel coronavirus	8
3. A preliminary attempt at contemporary history: responses and their effectiveness	11
4. Real-world consequences and risks to human rights	15
4.1. Right to life and equal access to health care	15
4.2. Protecting vulnerable groups: the situation of older persons, in particular in care homes	16
4.3. Proportionality of the public health response	18
4.4. European and international co-ordination and public health governance	18
4.5. Saving the economic and financial system	19
4.6. Guaranteeing social rights and social cohesion	21
5. A brave new world?	22
5.1. Overcoming the pandemic	22
5.2. Minimising harm to the economic and financial system: put the people and the planet first	23
5.3. Upholding social rights now and in the future	24
5.4. Looking to the future of a post-pandemic world	24

A. Draft resolution²

1. The World Health Organization (WHO) developed a special tool for determining which diseases and pathogens to prioritise for research and development in public health emergency contexts in 2015. In 2018, “Disease X” was added to this list, representing the knowledge that a serious international epidemic could be caused by a pathogen at that time unknown to cause human disease.
2. Following the Ebola epidemic of 2015-2016, the Parliamentary Assembly adopted [Resolution 2114 \(2016\)](#) on the handling of international public-health emergencies. In this resolution, the Assembly made a number of recommendations – which remain valid – to prepare the world better for the inevitable next international pandemic, urging new ways of working to face international health crises before they happen. The Assembly’s call unfortunately went largely unheeded.
3. “Disease X” hit the world largely unprepared, in the form of COVID-19, provoked by a novel coronavirus: 2019-nCoV (also called SARS-CoV-2). First reported to the WHO Country Office in China on 31 December 2019, the outbreak was declared a Public Health Emergency of International Concern on 30 January 2020, and a pandemic on 11 March 2020. The virus spread to six continents, infecting millions and killing hundreds of thousands within months.
4. Unfortunately, in the face of a rapidly spreading virus and stark mortality predictions, some States opted for nationalist isolation and repressive and authoritarian responses, instead of cool-headed and warm-hearted, evidence-based, internationally co-ordinated, human rights-compliant, effective action. Many States also seem to have realised the danger they were in too late (or had not wanted to realise the danger). Even at the European and international level, including at WHO, the impression of a tardy reaction is hard to ward off.
5. The price of the initial inaction, subsequent slow response, overhasty measures and premature re-openings may well be paid in lives lost, as well as in possibly lasting damage to our political, democratic, social, financial and economic systems, and in the non-respect of several of the rights guaranteed by the European Convention on Human Rights and other Council of Europe legally binding instruments, as well as United Nations conventions, such as the Convention on the Rights of Persons with Disabilities. Public-health control measures for disease mitigation with human rights implications (such as quarantining, physical distancing, contact tracing, border controls and travel restrictions) must be based on relevant standards and on public trust to be effective: they need to be designed and implemented in a transparent, evidence- and rights-based manner, be de-politicised, nationally, regionally and internationally co-ordinated, communicated clearly and applied fairly, as outlined in Assembly [Resolution 2114 \(2016\)](#).
6. Although the first peak of the pandemic seems to have passed in most European countries, the health crisis is not over – and may not be for some time yet. The lessons from the suffering of the past few months must be that, to avoid a disastrous outcome in terms of lives lost and burden of sickness, and equally disastrous knock-on effects on the economy and on human rights, we need to act fast to contain outbreaks, using tried and tested, effective measures, implemented in a rights-compliant way.
7. The Assembly thus recommends that member States, during outbreaks of the coronavirus SARS-CoV-2 on their territory:
 - 7.1. take rapid and sustained action to reduce human contact through physical distancing, as far as possible on a voluntary basis, and – if necessary – rights-compliant shutdowns/lockdowns for the time it takes until active community spread of SARS-COV-2 is reduced to a level controllable through rigorous testing, data protection-compliant contact tracing, quarantine and self-isolation, respecting the principle of proportionality and taking into consideration the impact such measures have on fundamental rights including social and economic rights, as well as physical and mental health, and implementing measures to offset those negative impacts;
 - 7.2. procure protective gear for health and other essential personnel, boost and optimise health system capacity by mobilising inactive health professionals, and by boosting supplies of required equipment to diagnose and treat patients safely and effectively – in particular diagnostic tests, oxygen and ventilators / respirators, as well as boosting the numbers of available acute-care beds in hospitals;
 - 7.3. ensure that all public health measures respect human rights, are gender-sensitive, involve women in decision-making in a meaningful way, and protect vulnerable groups of the population (in particular, persons with disabilities, children and the elderly);

2. Draft resolution adopted by the Committee on 2 June 2020.

- 7.4. put in place conditions to isolate and care for symptomatic cases not requiring immediate hospitalisation, on a voluntary basis, with a view to preventing household/family infection clusters and having the necessary medical supervision in place to allow rapid hospitalisation when a patient's condition deteriorates;
- 7.5. open borders and lift unnecessary travel restrictions to allow for an unhindered emergency response across borders, within the European Union at least allowing public health measures to be designed centrally and implemented along regional rather than jurisdictional (member States) lines, as needed depending on where outbreaks are situated.
8. The Assembly recommends that member States, at all times:
 - 8.1. make available reliable information on the comparative dynamic changes in the number of deaths due to different pathologies in the last three years, and the number of those infected with COVID-19 among them;
 - 8.2. communicate information in a full, clear to all, and timely manner, accessible to persons with disabilities, and make decision-making, which should be based on evidence-based scientific opinion, transparent (including by publishing expert advice);
 - 8.3. organise active and broad community testing of all persons present on their territory regardless of status, not just limited to those admitted to hospital or health or other essential personnel, and roll out wide antibody testing of representative samples of the population as soon as feasible;
 - 8.4. actively promote responsible research, development and production of medicines, diagnostic kits, vaccines, and personal protective equipment, and set prices in a spirit of solidarity, ensuring that any medicines, tests or vaccines thus developed are accessible and affordable to all, in particular to vulnerable groups;
 - 8.5. prioritise and systemise European and international solidarity, co-ordination and co-operation; protective gear should not be hoarded by nation States "just in case", but rather distributed across Europe and the world to where the need is greatest;
 - 8.6. establish and keep up to date an open access transborder directory of available intensive care unit (ICU) beds, as well as ventilated and staffed beds in ICUs, and make them available to member States in need;
 - 8.7. avoid executive overreach, disproportionate and unnecessarily repressive measures infringing human rights or human dignity, as well as all discrimination in the implementation of public health measures; with special attention to discrimination against persons with disabilities and the elderly, notably avoiding discriminatory triage systems;
 - 8.8. reaffirm the fundamental role of parliaments in their mandate of overseeing government actions and ensure that they are able to fully exercise this mandate, by providing them with both the technical means and the required level of information;
 - 8.9. ensure that their economic recovery and safeguarding plans do not create the conditions for a future degradation of ecosystems likely to generate other epidemics of a zoonotic nature, and thus condition the aid put in place on the fulfilment of ambitious environmental and social criteria in line with the UN Sustainable Development Goals.
9. Furthermore, in the face of the current pandemic, the Assembly calls on member States to intensify efforts to:
 - 9.1. evaluate the state of their health systems, pandemic preparedness and infection surveillance systems, with a view to ameliorating them as necessary, in order to guarantee free access to public high-quality health care guided by the needs of patients rather than interests in profit, regardless of their gender, nationality, religion, or socio-economic status;
 - 9.2. evaluate the effectiveness, as well as the collateral damage (in particular to the full exercise of human rights, including socio-economic rights), of the measures taken to confront the current pandemic, in order to apply the lessons learned to future public health emergencies.
10. Beyond the current pandemic, public health preparedness and global health security must embrace a One Health approach, embracing the interactions between animals, humans and the environment which contribute to and protect against disease. Efforts must be stepped up nationally and internationally to find the next zoonotic disease before it jumps into humans, to continue to strengthen the co-ordination of animal and human systems for disease detection and response, and to protect the ecosystems that underpin human,

animal and environmental health. This includes identifying and fighting climate change as a driver of emerging health threats and improving policies regulating animal agriculture and addressing human destruction of pristine habitat.

11. International and European health security and pandemic preparedness interventions must also be data-driven, evidence-based, and incorporate human rights provisions. Diverse sources of publicly available data need to be brought together to create an internationally unified data infrastructure, which can facilitate modelling for decision making. These models need to be translated into triggers for action. In case of transferring sensitive data, appropriate privacy and security safeguards must be guaranteed.

12. The Assembly thus recommends that the European Union build a regional system capable of supporting the responsible international institutions in their endeavours to ensure effective pandemic preparedness and reaction.

13. Furthermore, the Assembly recommends a reform of WHO in order to allow it to better fulfil its function of achieving the highest attainable standard of health for everyone, which:

13.1. makes WHO independent of voluntary contributions to fulfil its essential functions;

13.2. gives WHO the necessary power to visit member States unannounced in a public health crisis which could become a Public Health Emergency of International Concern;

13.3. re-examines and strengthens the International Health Regulations to reframe global governance of disease, make the treaty more fit for purpose (including the governance of information such as sample and genetic sequence sharing), and explore mechanisms for compliance;

13.4. puts in place an effective and independent, ideally parliamentary oversight of the organisation: at international level, through the Inter-Parliamentary Union, and at regional level, through regional parliamentary assemblies, such as the Parliamentary Assembly of the Council of Europe for the WHO Europe region;

13.5. binds WHO to develop regionally adaptable containment strategies to fight future health hazards, taking into account the everyday realities of countries, regions and populations.

14. The Assembly proposes to member States to step up their efforts to make progress regarding the European Social Charter (ETS No. 35 and ETS No. 163) and the Council of Europe Convention on Human Rights and Biomedicine (Oviedo Convention, ETS No. 164) which facilitate the safeguarding of social, economic and other human rights which are the most vulnerable during responses to a pandemic.

15. Finally, the Assembly proposes to establish an enduring system of inspection at the United Nations for current and future high consequence biological events, possibly including a permanent, designated facilitator in the Office of the UN Secretary-General. The United Nations should also ensure international oversight and accountability for pandemic preparedness through an independent external entity.

B. Draft recommendation³

1. The Parliamentary Assembly refers to its Resolution ... on Lessons for the future from an effective and rights-based response to the COVID-19 pandemic.
2. The Assembly believes that the Council of Europe's human rights mandate requires the re-establishment of comprehensive intergovernmental co-operation and co-ordination in the field of public health, including with a view to building a regional system capable of supporting the responsible international and European Union institutions in their endeavours to ensure effective pandemic preparedness and reaction.
3. The Assembly thus recommends that the Committee of Ministers urgently re-establish an intergovernmental steering committee on public health as a first step towards this goal, and consider how the European Directorate for the Quality of Medicines and HealthCare (EDQM) of the Council of Europe could be associated with efforts to prevent and deal with international public-health threats and to design appropriate public-health strategies.

3. Draft recommendation adopted by the Committee on 2 June 2020.

C. Explanatory memorandum by Mr Andrej Hunko, Rapporteur

1. Introduction

1. The World Health Organization (WHO) developed a special tool for determining which diseases and pathogens to prioritise for research and development in public health emergency contexts in 2015. In 2018, “Disease X” was added to this list – representing the knowledge that a serious international epidemic could be caused by a pathogen at that time unknown to cause human disease.⁴ Most bets were on a zoonotic disease,⁵ and on a highly contagious illness which the globalised world would find difficult to contain. However, few – if any – countries prepared properly for a pandemic sparked by such a novel disease.

2. “Disease X” thus hit the world largely unprepared, in the form of COVID-19, provoked by a novel coronavirus: 2019-nCoV (also called SARS-CoV-2). The disease “ticks all the boxes”: zoonotic disease, respiratory illness (which can cause severe to fatal viral pneumonia), and very contagious – including before the onset of symptoms. First reported to the WHO Country Office in China on 31 December 2019, the outbreak was declared a Public Health Emergency of International Concern by WHO on 30 January 2020, and a pandemic on 11 March 2020. At the time of writing, the virus had spread to six continents, infecting more than 6.4 million people and causing more than 380 000 deaths worldwide⁶. The epicentre of the disease moved from China to Europe (in particular, Italy, Spain, Germany, France, United Kingdom, and the Russian Federation), the Middle East (in particular, Iran), the USA, and Brazil, with cases in India and Africa growing at a worrying rate. Worst-case scenarios predicted 40 million deaths worldwide⁷, and a collapse of health-care systems due to an overwhelming demand of intensive-care beds and the absence of a safe and effective vaccine. However, an effective and human rights-compliant response to COVID-19 has the capacity to save many lives, as well as to protect the rights which underpin our democracies. Never has European – and indeed global – co-operation and solidarity been more necessary to overcome a disease which knows no borders.

3. Following the Ebola epidemic of 2015-2016, the Parliamentary Assembly adopted [Resolution 2114 \(2016\)](#) “The handling of international public-health emergencies”.⁸ In this resolution, the Assembly made a number of recommendations to prepare the world better for the inevitable next international pandemic, urging new ways of working to face international health crises before they happen. While the Assembly’s call unfortunately went largely unheeded, the Resolution also spelled out how to design and implement public-health control measures for disease mitigation with human rights implications (such as quarantining, physical distancing, border controls and travel restrictions) for them to be effective and rights-compliant at the same time.

4. Unfortunately, in the face of a rapidly spreading virus and stark mortality predictions, some States opted for nationalist isolation, and repressive and authoritarian responses, instead of cool-headed and warm-hearted, evidence-based, internationally co-ordinated, human rights-compliant, effective action. It has not helped that many States seem to have realised the danger they were in too late (or had not wanted to realise the danger), thus forcing them to take ever more stringent and far-reaching measures as the epidemics in their countries spiralled out of control and their health-care systems were overwhelmed. Even at the European and international level, including at WHO, the impression of “too little, too late” is hard to ward off. With many countries faced with devastating unemployment figures and a big knock to the economy, temptation has also been rife to “open up” economies too early after lockdowns and shutdowns.

5. In fact, the global financial system and many health systems are already buckling under the pressure, with worse to come. Other real-world consequences include risks to European democracies through creeping authoritarianism and/or public distrust, as well as through the undermining of human rights, discrimination against migrants, refugees, “foreign-looking” people, minorities (including the Roma) the poor and the marginalised, people in institutions (such as prisons, detention centres, psychiatric hospitals, etc.), further deepening of inequalities (including amongst children), and a particularly harsh impact on women, the elderly, the homeless and persons in fragile health.

4. www.who.int/activities/prioritizing-diseases-for-research-and-development-in-emergency-contexts.

5. A zoonosis is any disease or infection that is naturally transmissible from vertebrate animals to humans. Zoonoses may be bacterial, viral, or parasitic, or may involve unconventional agents. www.who.int/topics/zoonoses/en/.

6. According to the COVID-19 Dashboard by the Center for Systems Science and Engineering (CSSE) at Johns Hopkins University (JHU), <https://coronavirus.jhu.edu/map.html>.

7. www.imperial.ac.uk/news/196496/coronavirus-pandemic-could-have-caused-40/.

8. <https://assembly.coe.int/nw/xml/XRef/Xref-XML2HTML-EN.asp?fileid=22755&lang=en>.

6. The focus must thus now turn to coming together to learn the lessons of the first wave of the pandemic, and ensure an effective and human rights-compliant response to COVID-19, as well as to future international public health emergencies, in order to save lives and guarantee access to health care to all those who need it, as well as to manage the social, economic, financial and political consequences of the pandemic in an equitable way through European and international co-operation. The work of national, regional and international health authorities, including WHO, as well as all national and European decision-making, must be transparent and de-politicised, and put human lives and rights first.

7. This report is the outcome of a motion on “COVID-19 – an effective and human rights-compliant response” which was tabled by my colleague, Ms Jennifer De Temmermann (France, ALDE), myself and more than 60 other colleagues on 27 March 2020.⁹ I was appointed Rapporteur on 19 May 2020. The same day, the Committee held a hearing on the subject with the participation of the following eminent experts:

- Ms Stella Kyriakides, Commissioner for Health and Food Safety, European Commission,
- Ms Dunja Mijatović, Council of Europe, Commissioner for Human Rights,
- Mr David Nabarro, Special Envoy on COVID-19 to the World Health Organization Director-General,
- Ms Rebecca Katz, Director of the Center for Global Health Science and Security, Georgetown University, USA.

2. What we know about the novel coronavirus

8. Despite the many conspiracy myths swirling around the internet, and misinformation spread by some actors, it appears that the 2019-nCoV coronavirus emerged end of November / early December 2019 in Wuhan city¹⁰, the populous capital of China's province of Hubei. The original host of the virus was probably a bat, with the intermediate host not yet clearly identified (possibly a pangolin). In any case, human-to-human transmission began rapidly in Wuhan, although it was not reported as such by the Chinese authorities at first. By the end of December, the number of severely ill people with a pneumonia looking suspiciously like the disease caused by the SARS coronavirus and not responding to standard treatment in Wuhan's hospitals led to a small group of doctors blowing the whistle – and immediately being reprimanded by the local authorities, for “making false comments” and “spreading rumours”.¹¹

9. China (including Hong Kong) had already been exposed to a novel coronavirus before: in 2003, with the SARS epidemic.¹² Other countries – in particular Saudi Arabia, the United Arab Emirates, and South Korea – saw disease outbreaks caused by another coronavirus, MERS, from 2012.¹³ However, our knowledge of these novel coronaviruses is limited. In contrast, there are a number of representative studies about other coronaviruses which have been infecting human for a long time, going back to the 1960's. They found that these coronaviruses usually cause mild disease (such as the common cold), often even without symptoms and only detectable by serum antibody testing^{14,15}. Because the true number of people infected by novel coronaviruses in the population is still unknown, the reported case-fatality figures from MERS – approximately 35% of reported patients with MERS-CoV died – and SARS – with a case-fatality rate (CFR) of 11% – may not show the full picture. The pandemics of the 20th century most engrained in our memory were caused by influenza viruses, the “Spanish flu” in 1918-1919,¹⁶ the “Asian flu” of 1957 and the “Hong Kong flu” in 1968.¹⁷

9. Doc. 15094.

10. WHO, [Novel Coronavirus \(2019-nCoV\) situation report 1](#), 21 January 2020. Whether the virus originated from the Huanan Seafood Wholesale Market, as originally suspected by the Chinese authorities and reported to and by WHO, or whether the Market was rather the first cluster of cases, will probably never be established with 100% certainty. It appears unlikely, however, that the virus was released or escaped from the Wuhan high security biolab, the Wuhan Institute of Virology (WIV), as some conspiracy myths contend.

11. One of the whistle-blowing doctors, Li Wenliang, an ophthalmologist, himself died of the virus he had contracted while working at Wuhan Central Hospital in early February 2020. www.bbc.com/news/world-asia-china-51403795.

12. The SARS coronavirus (SARS-CoV) was identified in 2003. It is thought to be an animal virus from an as-yet-uncertain animal reservoir, perhaps bats, that spread to other animals (civet cats) and first infected humans in the Guangdong province of southern China in 2002. An epidemic of SARS affected 26 countries and resulted in more than 8000 cases and 774 deaths in 2003. www.who.int/ith/diseases/sars/en/.

13. www.who.int/emergencies/mers-cov/en/.

14. Arnold S. Monto and Sook K. Lim. The Tecumseh Study of Respiratory Illness. VI. Frequency of and Relationship between Outbreaks of Coronavirus Infection. *The Journal of Infectious Diseases*. Vol 129, No.3, March 1974.

15. H.S. Kaye, H.B. Marsh, and R.W. Dowdle. Seroepidemiologic Survey of Corona Virus (Strain OC 43) related infections in a children's population. *Am J Epidemiology* 94: 43-49, 1971.

10. The problematic handling of the H1N1 pandemic in 2009 by WHO and many States (considered to have “over-reacted”, with decisions taken tainted by real or perceived conflicts of interest),¹⁸ has eroded public trust in scientific and expert opinion, as well as in international health governance. Despite the deadly SARS and MERS epidemics, few seemed to believe a coronavirus could be so dangerous – and some believed WHO was “crying wolf” too soon or unnecessarily, mainly because of a perceived lack of evidence of the comparatively high observed CFR of the new coronavirus compared to that of the seasonal flu (due to insufficient testing of representative samples of the population in most countries, and wildly differing reported case-fatality and all-cause mortality rates).¹⁹

11. What we know about the novel coronavirus so far is the following: The virus is more contagious than the seasonal flu, but not as contagious as measles. It mainly spreads through droplet infection, although recent studies suggest it may stay airborne for up to 3 hours in certain circumstances,²⁰ it can be carried in the humidity of an expelled breath²¹ (let alone a cough or a sneeze) and survive on contaminated surfaces for many hours.

12. The virus is estimated to have a reproductive rate of R_0 in the range of 2 to 2.5,²² meaning that, if no measures are taken to contain the virus, every person infected with the virus will statistically infect another 2 to 3 persons. This type of contagion is exponential: It means that a caseload of 500 can become one million within a relatively short period – it just needs to double 11 times. WHO puts the average growth rate – the time it takes for cases to double – at six days (which means the million would be reached after 66 days), but some countries temporarily reported growth rates as short as three days (which means the million would be reached in half that time).²³

13. It is this capacity for exponential growth which risks possibly overwhelming health systems, even when only a relatively small percentage of those infected require hospital treatment, and an even smaller percentage intensive care. Early models based on preliminary data estimated that, although the majority of cases remain mild, up to 40% result in hospitalisation and 5% require intensive care.²⁴ The burden of severe disease is much greater in older people, particularly men and those with underlying health conditions. Infection occurs across all ages but apparently proportionally less in children under the age of 15. Among those who had lost their lives by the beginning of April, two-thirds were male and 95% were over the age of 60, with most of them having one or a combination of underlying conditions, such as cardiovascular disease, diabetes, lung or renal disease (with obesity apparently also a factor).²⁵ Most of those severely affected needed two weeks or more of artificial ventilation in an intensive-care unit (ICU) before recovering (if they recovered).²⁶

16. It is estimated that about 500 million people (or one-third of the world's population) became infected with this H1N1 virus, leading to at least 50 million deaths worldwide. Case-fatality was high in people younger than 5 years old, 20-40 years old, and 65 years and older. www.cdc.gov/flu/pandemic-resources/1918-pandemic-h1n1.html.

17. The “Asian flu” of 1957 and the “Hong Kong flu” of 1968 were both met with more modern tools of disease surveillance and had death tolls in the range of 500 000 to 2 million. www.vox.com/2020/3/9/21164957/covid-19-spanish-flu-mortality-rate-death-rate.

18. See Assembly's Resolution 1749 (2010) “Handling of the H1N1 pandemic: more transparency needed”. It is estimated that nearly a quarter of the population caught H1N1, but the mortality rate, at 0.02% was relatively low, with 284 000 deaths recorded. www.healthline.com/health-news/how-deadly-is-the-coronavirus-compared-to-past-outbreaks.

19. See, for example, the views of Wolfgang Wodarg, former doctor and former member of the Assembly: www.wodarg.com, or an article published in the journal *Stat* on 17 March 2020 by Stanford Professor of medicine and epidemiology John P.A. Ioannidis: www.statnews.com/2020/03/17/a-fiasco-in-the-making-as-the-coronavirus-pandemic-takes-hold-we-are-making-decisions-without-reliable-data/.

20. For example, the results of a study done by the National Institute of Allergy and Infectious Diseases' Laboratory of Virology in the Division of Intramural Research in Hamilton, Montana (USA) were published in the *New England Journal of Medicine* on 17 March 2020.

21. www.news.com.au/lifestyle/health/health-problems/coronavirus-exponential-growth-explains-terrifying-spread-of-virus/news-story/6f17b9f488c71f5fe3b858daf10b3ee2.

22. www.nature.com/articles/d41586-020-00758-2. Other estimates go up to a reproductive rate of 4; see www.focus.de/gesundheit/news/epidemiologe-simuliert-verlauf-herdenimmunitaet-oder-weiter-kontaktverbote-die-corona-szenarien-nach-2-wochen_id_11811050.html.

23. www.news.com.au/lifestyle/health/health-problems/coronavirus-exponential-growth-explains-terrifying-spread-of-virus/news-story/6f17b9f488c71f5fe3b858daf10b3ee2.

24. WHO press conference on 8 April 2020, www.who.int/emergencies/diseases/novel-coronavirus-2019. This figure is a moving target, in particular due to a lack of widespread testing of asymptomatic cases, currently believed to hover at around 30% of all infections.

25. Ibid. See also: www.news-medical.net/news/20200324/Overweight-and-obese-people-at-higher-risk-of-COVID-19.aspx.

26. Official Chinese data cited by CNN, <https://edition.cnn.com/2020/03/20/health/covid-19-recovery-rates-intl/index.html>.

14. The incubation period seems to last up to 14 days. However, most infected persons develop symptoms (fever or feeling feverish, dry cough, headache, sore throat, muscle ache / joint pain, breathing difficulties / tightness in the chest, diarrhoea, nasal congestion, loss of smell and/or taste) after around 5 days. There are also asymptomatic carriers of the disease (currently believed to make up around 30% of infections)²⁷, who do not show symptoms themselves, but are capable of infecting others. To know the number of asymptomatic infections is crucial for an unbiased estimate of the Infection Fatality Rate (IFR). Infected persons seem to be contagious up to 48 hours before the onset of symptoms, and up to 7 days after symptoms subside. Many people may thus infect others before they show symptoms (if they show any at all), and in mild cases, also during and after the symptomatic phase, since symptoms can be mistaken for those of the common cold or the flu.

15. According to the initial official data from China, the CFR was estimated at 4% of confirmed cases on 19 March 2020, an order of several magnitude of that of the seasonal flu (0,1%). The official data from China should not be taken at face value, for several reasons.²⁸ Data becoming available in Europe, such as in the hard-hit regions of Italy, France or Belgium, indicate that the CFR can be far higher (up to 16,3%²⁹) even in regions with high-quality health-care systems, when those health-care systems become dangerously overwhelmed, in particular when it comes to a shortage of ventilated and staffed beds in ICUs for an ageing population with many underlying health conditions.³⁰ In fact, CFR of COVID-19, understood as the number of reported deaths per number of reported cases, vary significantly between countries and over time. They have been calculated from over 15% to less than 1%.³¹ IFR include all infected people and, in that sense, also mild and asymptomatic cases. A recent systematic review of studies suggested a point-estimate of IFR of 0.64% (0.50-0.78%) “with high heterogeneity”.³² Worryingly, data coming from Italy, Spain and the USA also suggest that the number of younger people requiring hospitalisation because of breathing difficulties is far higher than originally thought, putting further strain on scarce ICU resources.

16. It is assumed that there is no natural immunity against 2019-nCoV, since it is thought to be a novel coronavirus which has only just crossed the species-barrier. Due to some similarities to the SARS-1 coronavirus, however, the length of vaccine development may be shortened. It is hoped that a vaccine may become available to the general public in 12 to 18 months’ time. There are also voices of experts considering that the development of a vaccine will prove impossible.³³ Clinical trials of medicines which could possibly be used as treatment have already been started or are currently being authorised, for example in a WHO-run “Solidarity” trial, or the European study “Discovery”.³⁴ Unfortunately, few of the trials so far have shown promising results.

17. As with all infectious diseases for which a vaccine is currently not available, well known public health and hygiene measures are effective and should be applied: regularly washing hands with soap and water (or hand sanitiser if no water is available), since both soap and alcohol destroy the coronavirus’ membrane; sneezing and coughing into the elbow, a tissue (to be binned), or wearing a mask when infected, to avoid droplet infection; keeping a physical distance of 1-2 metres minimum and avoiding shaking hands, hugging or kissing; avoiding touching one’s face, to avoid smear infection from hands having touched contaminated surfaces. Since a strong immune system is needed to ward off and/or overcome the infection, improvement of social conditions and a healthy lifestyle are also important – lifting people out of poverty, unemployment and hunger, encouraging healthy eating habits, regular physical activity, stress-reduction, and no smoking or vaping, amongst others.

27. Knowledge of the number of asymptomatic carriers is crucial for an unbiased estimate of the true number of the infected (denominator), as a prerequisite for the calculation of unbiased case-fatality rates.

28. It is likely that the official Chinese data published understates both infection and case-fatality rates – both because some of the data will simply not have been recorded in the first place, and because the Chinese leadership may have found it inopportune to publish the recorded data for political reasons.

29. Johns Hopkins Coronavirus resource center, mortality in the most affected countries, observed case-fatality ratio: <https://coronavirus.jhu.edu/data/mortality>.

30. www.telegraph.co.uk/global-health/science-and-disease/have-many-coronavirus-patients-died-italy/.

31. Global Covid-19 Case Fatality Rates, Regularly updated overview by the Centre for Evidence-Based Medicine (CEBM) at Oxford University. Case Fatality Rates in member States span from over 10% (Belgium: 16.25%, France: 15.54%, Italy: 14.28%, United Kingdom: 14.18%, Hungary: 13.23%, Netherlands: 12.85%, Sweden: 11.98%) to less than 2% (Slovak Republic: 1.85%, Armenia: 1.23%, Azerbaijan: 1.19%, Russian Federation: 1.05%, Iceland: 0.55%).

32. Gideon Meyerowitz-Katz, Lea Merone, *A systematic review and meta-analysis of published research data on COVID-19 infection-fatality rates*, 27 May 2020.

33. *Why we might not get a coronavirus vaccine*, *The Guardian*, 22 May 2020.

34. For example, of remdesivir (a drug originally developed to treat Ebola), of different antivirals used in HIV-treatment, of chloroquine/hydroxychloroquine (an old anti-malaria drug, sometimes associated with the antibiotic azithromycin), and various antibody treatments.

18. What we also do not yet know about the novel coronavirus SARS-CoV-2 is how long the immunity acquired through surviving infection lasts. It is reasonable to assume that immunity will last at least one to two years, as with most other coronaviruses.³⁵ The hope is also that even if immunity should only be relatively short, a second infection would lead to less severe illness in survivors³⁶, and that mild and asymptomatic infection nevertheless confers sufficient antibodies to trigger immunity. It was hypothesized that, in order for the population in this pandemic to acquire “herd” immunity (in the absence of a vaccine), 60-70% of the population would have to be infected³⁷. In the absence of containment measures, this could be expected to happen within a year. The current status of immunity in the population of each country should therefore be determined by multiple representative cross-sectional studies starting immediately and repeated regularly. Since not all countries applied the same containment measures, such comparisons could provide valuable insights with respect to herd immunity. In the 850 million population of the Council of Europe, a risk of millions of deaths was projected for the strategy of pursuing herd immunity without a vaccine, with most deaths projected to occur in the cohort of the elderly, and those with underlying medical conditions. It is also not yet clear whether some survivors are left with lasting lung or other damage from the infection. It should thus come as no surprise that few countries have chosen to try and achieve herd immunity through infection rather than a vaccine.³⁸

3. A preliminary attempt at contemporary history: responses and their effectiveness

19. While first attempts to systematically record government responses to the COVID-19 pandemic have begun,³⁹ reliable data on the effectiveness of non-pharmaceutical interventions (NPI) to contain the spread of the novel coronavirus SARS-CoV-2 are still too scarce to reach final conclusions. Given that and the very short time period available to prepare this report, the following can only be a preliminary attempt at evaluating the responses in the current pandemic.

20. Following an initial phase of denial and an attempt at suppression, China took drastic measures in Hubei province, locking down the epicentre of the outbreak, Wuhan (and other cities in the province), on 23 January 2020 – when the country was reporting 500 cases and 17 deaths. However, the horse had already bolted:⁴⁰ about 7 million people left Wuhan before lockdown was enforced, and carried the virus to Beijing, Shanghai and other major cities. International travel restrictions came too late to be effective – the epidemic had already been seeded (as about 85% of infected travellers went undetected), including in New York City and Seattle (USA), Sydney (Australia), Bangkok (Thailand), Tokyo (Japan), Singapore and Seoul (South Korea). In the meantime, there are indications that the virus was also spreading in Europe end 2019.^{41,42}

21. A WHO delegation was only admitted to China on 16 February 2020. The Head of this delegation, Doctor Bruce Aylward, in a press conference on 25 February 2020, praised the drastic measures taken by the Chinese authorities.⁴³ He claimed that China had bought the rest of the world valuable time to prepare for their own outbreaks. However, a study by scientists from Southampton University, came to the conclusion that an earlier response with combined non-pharmaceutical interventions would have had a significant impact on the spread of the virus.⁴⁴

35. The SARS-1 coronavirus actually conferred longer immunity, lasting 8 to 10 years. www.nytimes.com/2020/03/25/health/coronavirus-immunity-antibodies.html.

36. This is not yet certain this early into the pandemic, since for certain illnesses – such as dengue fever – a second infection is actually more dangerous than the first.

37. www.nytimes.com/2020/04/26/health/can-antibody-tests-help-end-the-coronavirus-pandemic.html.

38. The United Kingdom and the Netherlands briefly flirted with the idea; the only country which has been actually applying it (though not as the official goal) is Sweden. Results are mixed: while a lockdown has been avoided, the per-capita death toll is relatively high, in particular amongst the elderly and those with underlying diseases. www.businessinsider.fr/us/sweden-coronavirus-plan-is-a-cruel-mistake-skeptical-experts-say-2020-5. A recent study also showed that only 7.3% of people living in Stockholm had developed antibodies to the disease. www.theguardian.com/world/2020/may/21/just-7-per-cent-of-stockholm-had-covid-19-antibodies-by-end-of-april-study-sweden-coronavirus.

39. See for example Thomas Hale et al., Variation in government responses to COVID-19, BSG Working Paper Series, University of Oxford, April 2020, www.bsg.ox.ac.uk/sites/default/files/2020-05/BSG-WP-2020-032-v5.0_0.pdf.

40. See “How the virus got out”, *New York Times*, 22 March 2020.

41. Lucy van Dorp et al. Emergence of genomic diversity and recurrent mutations in SARS-CoV-2. *Infection, genetics, and Evolution* 2019.

42. A Deslandes, et al. SARS-CoV-2 was already spreading in France in late December 2019.

43. The report of WHO-China Joint Mission on Coronavirus Disease 2019 (COVID-19) can be downloaded on www.who.int/emergencies/diseases/novel-coronavirus-2019/events-as-they-happen.

44. “If interventions in China could have been conducted one week, two weeks, or three weeks earlier, cases could have been dramatically reduced by 66% (IQR 50% – 82%), 86% (81% – 90%), or 95% (93% – 97%), respectively.” Shengjie Lai et al., *Effect of non-pharmaceutical interventions to contain COVID-19 in China*, *Nature*, 4 May 2020.

22. It is a matter of debate whether valuable time was squandered by the rest of the world. Despite the praise by WHO of China's methods, many of these were considered not to be possible or acceptable outside of authoritarian systems.⁴⁵ Some of them were deemed effective in turning the tide of the epidemic, others less so. But many of those that were considered to have worked⁴⁶, probably could have been adapted to the rest of the world more quickly. Countries besides China which were classified by Johns Hopkins University to have been successful so far in containing the epidemic are Taiwan, South Korea, Singapore, New Zealand and Iceland (other countries managed to keep the mortality rate down: for example, Germany has an observed CFR of 4,5%, and Israel of 1,7%⁴⁷).

23. Measures that have been described to work well in the media are:⁴⁸

23.1. Rapid action: In the face of a pandemic, timing is crucial. Precisely targeted, timely responses open the possibility to avoid harsher, more drastic containment measures that can become necessary once the spread of a virus spirals out of control. According to media reports, drastic containment measures can allow other, less or unaffected parts of a country, to help fight the epidemic when the outbreak is still relatively small (less than 500 infections) and concentrated in certain hotspots (such as Wuhan in China, or Alsace in France). Famously, two hospitals were built in Wuhan within weeks, but the possibly less well-known sending of 40.000 medical workers into Wuhan from other Chinese provinces was probably as crucial to success in containing the spread of the virus in Wuhan. In order to keep other parts of a country relatively unaffected, it appears necessary to enact strict containment measures quickly in these areas, as well. In contrast, the reports argue that the Italian experience has shown that staggering the response (for example locking down first only the worst-affected towns, and then regions, and only then the whole country) does not work.⁴⁹ It is argued that tens of thousands of lives could have been saved in the United Kingdom and in the USA if the lockdowns/shutdowns had been put in place just one or two weeks earlier (indeed, restrictions might have been lifted much earlier and in a safer way in that case, too).⁵⁰ Examples from countries like Iceland show that early and targeted measures combined with large scale testing can be a way of containing the virus without falling back on complete lockdowns/shutdowns.

23.2. Communication of information, and transparent decision making: It is common knowledge that people will modify their behaviour if they understand it is in their own best interest – or when they are forced to do so. However, a recent report in *The Guardian* on the experience in the Indian State of Kerala suggests that adherence will be higher in the first case⁵¹. When decision-makers downplay or exaggerate risks, withhold information, are not seen to take scientific and expert advice, or make decisions behind closed doors, public trust – and thus adherence to containment measures – dwindles. This, in turn, can possibly necessitate harsher control measures, which can sap police resources, inspire conspiracy myths, and can create further opposition to authority. Anecdotal evidence in the current pandemic already shows that countries which continue to operate in an open and democratic way have higher adherence to voluntary containment measures, less panic-buying, etc.

23.3. Testing and contact tracing, combined with quarantine or self-isolation: As the Director-General of WHO, Doctor Tedros Adhanom Ghebreyesus, pointed out on 16 March 2020: “You cannot fight a fire blindfolded”. His message to States was thus: “Test, test, test”.⁵² This strategy, although prone to selection bias towards the symptomatic cases, was successfully used in South Korea, where lockdowns could be avoided for some time through mass testing and aggressive contact tracing (using

45. For example, it would be difficult (or even impossible) to enforce the type of lockdown Wuhan was subjected to, with residents literally locked up in their apartment blocks, not allowed to leave them even to procure basic necessities (these were procured by so-called “neighbourhood committees”). www.theguardian.com/world/2020/mar/06/fake-fake-senior-chinese-leader-heckled-by-residents-on-visit-to-coronavirus-epicentre.

46. For example, China was able to mobilise thousands of health-care workers from other parts of the country to join the “front line” in Hubei province, not by forcing them to, but by fostering a sense of national identity and a “fighting spirit” in public messaging.

47. Johns Hopkins Coronavirus resource center, cases and mortality by country: <https://coronavirus.jhu.edu/data/mortality>.

48. This evaluation is the author's own, informed by WHO, as well as expert opinion published in accessible sources such as *The Guardian*, the *New York Times*, etc. Special mention should also go to: www.nytimes.com/2020/03/22/health/coronavirus-restrictions-us.html.

49. Fateful mistakes were also made in Iran and France, where elections were allowed to go ahead when the epidemic had already taken hold in the countries.

50. www.nytimes.com/2020/05/20/us/coronavirus-distancing-deaths.html.

51. www.theguardian.com/world/2020/may/14/the-coronavirus-slayer-how-keralas-rock-star-health-minister-helped-save-it-from-covid-19.

52. www.who.int/emergencies/diseases/novel-coronavirus-2019/events-as-they-happen.

phone and credit card data). Infected persons are quarantined in government shelters, while those potentially exposed are quarantined at home (with high fines for quarantine-breakers). South Korea was assessed by the media to have found the right balance for its population as regards quarantine – not so restrictive that people will try to avoid or flee quarantine, but stronger (and easier to police) than self-isolation, and thus safer for the general population. The only remaining problem in this situation (which was similar in China) is that quarantining the possibly infected at home could lead to the infection of other members of the household, thus creating small clusters of infection. However, known clusters of infection (which accounted for up to 80% of total infections in China) are easier to contain than other types of infection vectors. There is also an urgent need for population-based testing for antibodies, to find out who is immune to the infection regardless of the outcome of RT-PCR testing.

23.4. Reducing human contact through physical distancing and shutdowns/lockdowns: In a pandemic caused by a virus which is contagious before symptoms appear, and where there are asymptomatic carriers and symptomatic carriers who do not know they are infected (mistaking their symptoms for other infections), as well as sick people who feel they cannot afford to stay home or afford to see a doctor or otherwise get medical help, early shutdowns of places where people mingle is crucial: sports and cultural events, restaurants, bars and cafés, gyms, shopping malls, etc. All work which can be done from home should be done from home. Strong shutdowns/lockdowns more or less confining everyone to their homes – as were in place by beginning of April for half of the world’s population – are deemed to be effective at breaking transmission chains within two to three weeks of their imposition.⁵³ They are applied in the expectation that they buy time for countries to better prepare their emergency response, and – depending on how early they are put into place – can “flatten the curve” of the epidemic, thus helping to avoid the overwhelming of health-care systems which drives up mortality (indeed, New Zealand achieved not just a flattening of the curve, but practically eradication). However, without population-based infection data, it is unclear whether these extreme measures with severe repercussions on countries’ economic and financial systems, and society as a whole, are justified at all or for how long they should be left in place. If they are lifted too soon, or if their lifting is not accompanied by other public health measures such as effective testing, contact-tracing, and isolation, there is a risk of “epidemic yoyo”, where the exponential growth interrupted by lockdowns restarts once a lockdown is lifted, possibly necessitating a renewed lockdown if local outbreaks go undetected and/or cannot be brought under control.⁵⁴ Media outlets report that 8 to 12 weeks of lockdown may suffice in those countries where the epidemic is not too far advanced,⁵⁵ but scientific evidence to corroborate these claims is currently not available.

23.5. Pandemic preparedness: Observed outcomes in Europe so far have varied widely. While, according to media reports, an early response is often correlated with a much lower increase (if any) during the pandemic of the all-cause mortality rate, other factors may also have been at play, such as the level of pandemic preparedness (including the availability of personal protective equipment and testing for health-care personnel), the financial health of the health-care systems, the availability of hospital and intensive care beds, as well as laboratory testing and contact tracing capacity.

24. Measures that do not seem to work well are:

24.1. International travel restrictions: WHO advised against the application of travel and trade restrictions to countries experiencing COVID-19 outbreaks from the beginning. As its recommendations updated on 29 February 2020 state: “In general, evidence shows that restricting the movement of people and goods during public health emergencies is ineffective in most situations and may divert resources from other interventions. Furthermore, restrictions may interrupt needed aid and technical support, may disrupt businesses, and may have negative social and economic effects on the affected countries. [...] Travel measures that significantly interfere with international traffic may only be justified at the beginning of an outbreak, as they may allow countries to gain time, even if only a few days, to rapidly implement effective preparedness measures. Such restrictions must be based on a careful risk assessment, be proportionate to the public health risk, be short in duration, and be reconsidered regularly as the situation evolves.”⁵⁶ If the virus is already circulating in the community in a country,

53. www.weforum.org/agenda/2020/03/why-lockdowns-work-epidemics-coronavirus-covid19/.

54. www.theguardian.com/commentisfree/2020/mar/21/the-case-for-shutting-down-almost-everything-and-restarting-when-coronavirus-is-gone Historically, a comparison of the death rates and infection curves of the similarly-sized cities of Philadelphia, Pennsylvania (mortality: 12 000) and of Saint Louis, Missouri in the USA (mortality: 700) during the 1918 pandemic of the “Spanish flu” are often used as a model for the success rates of early and lengthy lockdowns, as practiced in Saint Louis.

55. For example, this option may have been open to Australia in mid-March 2020. www.theguardian.com/commentisfree/2020/mar/21/the-case-for-shutting-down-almost-everything-and-restarting-when-coronavirus-is-gone.

closing the borders makes no sense, as the enemy is already “within”.⁵⁷ Experience has shown that, in Europe, the closing of borders was ineffective in preventing the importation of cases of COVID-19 or in slowing the growth of the epidemic, and instead impeded the flow of goods and weakened the solidarity of European States.⁵⁸ The effect of travel restrictions in Europe was rather to promote nationalist isolation, xenophobia and scapegoating.

25. Measures on which the jury is still out:

25.1. School/day-care closures: Almost all countries affected by the current pandemic opted for partial or full school closures as a means to contain the virus spread.⁵⁹ Closing down schools and day-care institutions for children appear to be efficient public health measures in epidemics, as children are usually very effective vectors of disease, as well as in the high-risk group for severe disease and death. In the case of COVID-19, however, children – in particular those younger than ten – have rarely seemed to fall ill, developing only mild symptoms or none at all even when infected⁶⁰ (worrying reports of a new Kawasaki-like inflammatory disease still lack evidence of a connection to SARS-CoV-2, which needs to be investigated further). It is also still unclear whether children are effective vectors of COVID-19. There are disadvantages in closing schools: requiring many essential workers to choose between staying home to look after children, or risk having grandparents (who are in the high-risk group) look after them, if no alternative arrangements can be made, for example, by the State; putting children at risk of violence in the home⁶¹, as well as at risk of hunger⁶², and increasing existing inequalities between children in access to learning opportunities and education. There is simply not enough data at the moment to know whether the advantages of closing schools outweigh the disadvantages. Partial or complete school re-openings in some countries are too recent to evaluate their effect on the propagation of the virus and should be further investigated.

25.2. Mask-wearing: The only type of mask which can protect someone relatively effectively from infection are masks with air filters, such as FFP1 / FFP2 / N95 masks. However, there is some evidence that surgical or cloth masks can provide some protection against infecting someone else with droplets (for example from a sneeze or a cough). This comes with so many caveats, though, with a disease which spreads through aerosol as well as droplet infection, and a general public outside of many Asian countries unused to handling masks correctly, that face mask rules risk becoming politicised⁶³.

25.3. Isolating high-risk groups: Great Britain has asked individuals at high risk of severe illness and death from COVID-19 to self-isolate for at least three months; most countries have put in place visiting restrictions in old people’s and nursing homes. It is not yet clear how effective such measures are, nor for how long they can realistically be applied. They also come with strong downsides as such measures can lead to discrimination, job loss, poverty, loneliness, and other negative effects. Observed high CFR in nursing homes suggest that infrastructural improvements such as smaller units, increased staffing and better equipment supply might be more effective than complete isolation.

25.4. Broadcasting who is infected or places infected persons have visited: It is only human to want to know whether one’s neighbour, work colleague, or supermarket cashier is infected, or whether one’s path in a restaurant or on public transport has been crossed by an infectious person. Whether this is an effective way of avoiding infection oneself, or finding out whether one is infected, is quite another matter. Stigmatising or even attacking the persons whose privacy has been thus violated is certainly not effective,⁶⁴ which is why the electronic system used in South Korea only broadcasts the places which infected persons have visited (though the anonymisation of the data did not always work well, making

56. www.who.int/news-room/articles-detail/updated-who-recommendations-for-international-traffic-in-relation-to-covid-19-outbreak.

57. At the most, borders could be closed to tourists; returning citizens and residents can be subjected to 14 days of self-isolation or quarantine.

58. For example, strict controls at the German-Polish border led to 55 km-long traffic jams of lorries.

59. Thomas Hale et al., *Variation in government responses to COVID-19*, BSG Working Paper Series, University of Oxford, April 2020.

60. Ilaria Liguoro, *SARS-COV-2 infection in children and newborns: a systematic review*, 18 May 2020.

61. Including sexual violence, see Doc. 15109 “Addressing sexual violence against children: stepping up action and co-operation in Europe” (Rapporteur: Baroness Doreen Massey, United Kingdom, SOC).

62. For example, almost a fifth of United Kingdom homes with children go hungry in lockdown: www.theguardian.com/society/2020/may/03/exclusive-fifth-of-uk-homes-children-hungry-lockdown.

63. www.theguardian.com/uk-news/2020/may/21/face-mask-rules-more-political-than-scientific-says-expert.

some people recognisable – including the fact that they may have been to places they were not meant to be). It is not yet clear whether such systems are effective as a public health measure. Any “tracking apps” also pose severe risks of violations of data-protection rights, amongst others.⁶⁵

25.5. “Immunity passports”: There have been plans in some countries, including my own country, Germany, to put in place so-called “immunity passports” in order to allow citizens to regain fundamental rights that have been restricted due to containment measures fighting the virus spread, based on the immune status of a person. Such measures can be a valid approach for essential workers such as health-care personnel on the front lines who are immune from infection and thus pose no danger to others, to look after high-risk patients. For the general public, the idea is highly problematic on several levels, though: First, there is as yet no data on whether the fact of having antibodies in the blood protects from renewed infection, and if so, at what level and for how long. Second, regaining rights through immunity may give perverse incentives to try and catch the disease in order to become immune.

4. Real-world consequences and risks to human rights

26. From the experiences of countries so far, it appears obvious that in the fight against the spread of SARS-CoV-2, the only way to avoid far-reaching measures with rights implications such as lockdowns / shutdowns is to act timely, precisely, and effectively. The later the response to an outbreak, the more drastic the measures have to be. But how can this be done in the most human rights-compliant way possible, while bearing in mind that without respect for the right to life, no other human rights are enjoyable by definition? While there is thus a clear hierarchy of human rights in pandemic situations which threaten the right to life, as in this case, no fundamental right can be considered absolute.

4.1. Right to life and equal access to health care

27. The right to life must be protected at two levels in pandemic situations: at the level of public health and at the level of clinical medicine. We have already looked at the public health measures put into place to protect people, in particular vulnerable population groups, from infection in the first place, in order to protect the right to life. However, once a person is sick, and in particular if that person is severely ill, the right to life must be protected at the level of the individual, through access to quality health care.

28. All our member States have ratified the European Convention on Human Rights (ECHR), most have ratified the European Social Charter (ETS No. 35 and ETS No. 163) and the Council of Europe Convention on Human Rights and Biomedicine (Oviedo Convention, ETS No. 164). They are thus bound to uphold everyone's right to life. No derogation is possible from this right, not even in times of war or other public emergencies threatening the life of the nation.⁶⁶ The State should thus not discriminate in granting access to life-saving health care to everyone in their jurisdiction in emergency situations such as the one we find ourselves in now, regardless of their gender, nationality, religion, other status, etc. – or their ability to pay.

29. However, such discrimination may and will still happen, of course, in practice. What are the ethical guidelines for making clinical decisions of granting or refusing access to life-saving care (for example, a ventilator in an ICU) when demand outstrips supply? While it is practically universally acknowledged that care can be refused if it is considered medically futile (for example the patient will die anyway), what methods should be used to determine who receives access amongst those with a fair chance of survival? Again, while it is practically universally acknowledged that medical personnel must make the final assessment and decision on the spot, who decides on the ethical guidelines or guidance documents underpinning those decisions – professional ethics committees, ministers, parliamentarians?

30. The answers are not that obvious. A “first come, first served”-principle, or a lottery, may seem the fairest, but may also lead to higher mortality rates than if patients with higher chances of survival are given priority. Those with higher chances of survival will usually be the younger and healthier patients. Giving these

64. The reason the wearing of face masks is required and/or is the social norm in many Asian countries is that a face mask is effective in minimising the risk of infecting others when one is infected oneself. If only the infected wear face masks, they are easily recognisable and could be subjected to social stigma or worse. Also, a person may not know that they are infected. Thus, if everyone wears a face mask, people's privacy is protected, and a positive effect on public health.

65. I will not go into the details of the risks to human rights of tracking applications, since they will be investigated in the report under preparation in the Committee on Legal Affairs and Human Rights.

66. Article 15.2 of the ECHR protects the right to life from derogation (except in respect of deaths resulting from lawful acts of war).

patients priority will keep mortality rates lower, but enables ageism and ableism, as well as possible discrimination on the basis of poverty and prior access to health care (since the poor and marginalised, as well as migrants and refugees, members of national minorities, etc., will usually be less healthy to start with because of the social determinants of health, such as problems in accessing health care). Most people are comfortable with giving priority access to doctors, nurses and other essential medical personnel infected in the line of duty (estimated at 12-15% of such personnel at the moment), as well as allowing patients to voluntarily forego life-saving medical treatment.

31. In practice, most countries already have some kind of guidance in place. Quite often, the underlying principles are utilitarian: preference to those who can save others (essential medical personnel), and to those with the greatest chance of survival and the longest remaining life spans.⁶⁷ This is the case, for example, in both Italy and Great Britain. In Lombardy (Italy), some hospitals decided no longer to admit severely ill patients over the age of 65 (in France, over 80); in England, there was reportedly planning at one point to hand out “palliative care packs” to such patients, who would be left to live or die at home if the National Health Service were overwhelmed.⁶⁸ It can thus be assumed that clinical decisions would profoundly alter our society if public health measures fail to protect the vulnerable groups of the population: the old, the frail, the poor, the marginalised, and those with underlying health conditions, would be the most likely to die, with difficult-to-quantify knock-on effects to social cohesion. In fact, this is exactly what is currently playing out in the United Kingdom and in the USA, where members of minority groups have a far higher risk of contracting the virus and becoming severely ill with it or dying of it.⁶⁹

4.2. Protecting vulnerable groups: the situation of older persons, in particular in care homes

32. We are not all equal when it comes to epidemics. Some population groups are more vulnerable than others, for various reasons, including their age or state of health (for example pre-existing medical conditions). COVID-19 is no exception to that rule. The figures show that 80% of deaths linked to COVID-19 involve older persons aged over 70, which makes them a particularly vulnerable group.

33. In accordance with Article 2 of the ECHR, all States are required to take the steps necessary to protect their population, including the most vulnerable groups, against pandemics. However, in spite of repeated warnings about the impact of the epidemic on older persons,⁷⁰ several European countries were slow to respond.⁷¹ Living conditions in residential care facilities for older persons (namely many people living close together) have favoured the spread of the novel coronavirus, further aggravating the situation for this group, who already suffer higher mortality. In fact, one study suggests that care homes account for half of the total number of deaths attributed to Sars-CoV-2 in some European countries.⁷²

67. www.nytimes.com/2020/03/24/upshot/coronavirus-rationing-decisions-ethicists.html

68. www.theguardian.com/commentisfree/2020/mar/17/coronavirus-force-nhs-terrible-choices-covid19

69. “As the cases of coronavirus disease 2019 (COVID-19) continue to increase across the world, evidence is continuing to emerge that the pandemic could be disproportionately affecting people from black, Asian, and minority ethnic (BAME) communities”, [www.thelancet.com/journals/lanres/article/PIIS2213-2600\(20\)30228-9/fulltext](https://www.thelancet.com/journals/lanres/article/PIIS2213-2600(20)30228-9/fulltext). Reasons include higher rates of pre-existing conditions known to lead to worse outcomes, but also, for example in the United Kingdom, “people from ethnic minorities being more likely to live in areas badly affected by COVID-19 infection”, or, in the USA, “people from ethnic minorities being more likely to live in more densely populated areas and housing, to use public transport more, and to work in lower paid service jobs without sick pay, meaning they would be more likely to go to work under all circumstances, increasing the risk of exposure”.

70. www.age-platform.eu/sites/default/files/AGE_letter_to_EU_Commission%26European_Council_Presidents_on_COVID19_17Apr2020.pdf.

71. It would seem that even the seriousness of the epidemic was greatly underestimated at the outset, on the ground that it was only fatal among older persons, thereby highlighting the ageism (age-based discrimination) prevalent in our societies. The late inclusion of deaths from COVID-19 among residents in care homes in the official statistics in Spain, Italy and Belgium is indicative of a widespread indifference about the fate of older persons. In the popular imagination, older persons are ready to die and are of no use to society. Yet “the dignity of an individual does not depend on their usefulness”.** In a speech on 2 April 2020, Helena Dalli, EU Commissioner for Equality, said that “There’s no place for ageism in the EU”.***

* “Human rights don’t have a best-before date: COVID-19 lays bare rampant against ageism”, *The Globe And Mail*, 13 April 2020.

** Paper by the French National Advisory Committee on Ethics (CCNE): [Contribution du Comité consultatif national d’éthique: Enjeux face à une pandémie](https://www.ccnec.fr/IMG/pdf/Contribution_du_Comite_consultatif_national_dethique_Enjeux_face_a_une_pandemie_13_Mars_2020.pdf), 13 March 2020.

*** Helena Dalli (EU Commissioner for Equality), 2 April 2020 www.age-platform.eu/sites/default/files/Covid-19_%26_olderPeople-Dalli_statement-Apr20.pdf.

In [Resolution 2168 \(2017\)](#), the Assembly made recommendations on combating ageism, improving care for older persons and preventing their isolation and social exclusion.

34. The most devastating consequences of the pandemic have therefore occurred behind closed doors, against a background of much ignorance and indifference. Care homes have become scenes of mass fatalities. The lack of material and human resources which had been widely recognised yet left untackled for many years has not been resolved during the health crisis.⁷³ While the staff of some facilities chose to self-isolate in the homes with the residents (in Romania, the government made this compulsory),⁷⁴ thereby saving lives and preserving the residents' dignity, some carers abandoned their posts for lack of adequate protection.⁷⁵

35. In addition, the unprecedented overwhelming of hospital intensive care units made patient triaging necessary in some localities. Doctors were forced to make choices which should not be expected of them, in other words, deciding who would receive treatment that would save their lives and who would have to die. Such triaging is unacceptable and is reminiscent of war-time care. Doctors in Strasbourg admitted restricting access to ventilators to those aged under 80.⁷⁶ In Italy and Spain, doctors also recognised age as a key factor in medical decisions. Lastly, some patients chose to sacrifice themselves by offering their ventilators to other patients. A 72-year-old priest in Italy gave up his ventilator to a younger patient.⁷⁷ The French National Advisory Committee on Ethics (CCNE) is very concerned about this aspect and considers that "the need to triage patients raises a very major ethical issue in terms of distributive justice".⁷⁸

36. It should also be stressed that the lockdown of the population, which was vital to limit the spread of the virus, resulted in isolation for many older persons who were left alone in their own homes⁷⁹ or in their rooms in care homes, without any contact with the outside world for several weeks (and, among other things, with no possibility of receiving psychiatric or end-of-life care for those who needed it). The press ran headlines like "elderly people at risk of dying of boredom and loneliness".⁸⁰ As the CCNE says, respect for human dignity includes the right of dependent persons to maintain social ties.⁸¹

37. As the Council of Europe Commissioner for Human Rights pointed out in her latest statement on "Lessons to be drawn from the ravages of the COVID-19 pandemic in long-term care facilities"⁸², in accordance with their obligations under Article 2 of the ECHR regarding the right to life, member states must shed light on all the deaths occurring in these institutions, without exception (...) Member States must also ensure that residents in long-term care facilities continue to have human interactions with their loved ones, especially if they are sick. The absolute priority right now must be to make sure that this experience is never again repeated over the course of the COVID-19 pandemic.

72. Robert Booth, "Half of coronavirus deaths happen in care homes, data from EU suggests", *The Guardian*, 13 April 2020.

73. A decision by France's highest administrative court, the *Conseil d'État*, dismissed trade union demands and declined to rule that the government's handling of the situation in care homes had been inadequate: www.conseil-etat.fr/ressources/decisions-contentieuses/dernieres-decisions-importantes/conseil-d-etat-15-avril-2020-depistage-systematique-et-regulier-des-personnes-residant-en-ehpad.

74. Centre for Legal Resources, 16 April 2020, www.crj.ro/en/romania-covid-19-protecting-residents-with-disabilities-and-the-elderly-by-isolating-employees-in-nursing-and-social-care-homes/.

75. In one extreme case, the Spanish army discovered 25 dead bodies, abandoned in rooms in a care home. "Coronavirus Pandemic in the EU: Fundamental Rights Implications", *European Union Agency for Fundamental Rights*, p. 27.

76. *Idem*, p. 26.

77. *Idem*.

78. Paper by the French National Advisory Committee on Ethics (CCNE): *Contribution du Comité consultatif national d'éthique: Enjeux face à une pandémie*, 13 March 2020.

An opinion published by the CCNE in 2009 already warned about a possible departure from fundamental ethical principles during a public health state of emergency. The requirements for support and care must not be abandoned under any circumstances. "Everyone, without exception, has the right to life-saving interventions (...). The scarcity of resources (...) should never be a justification to discriminate against certain groups of patients".* In practice, however, older persons are discriminated against in access to care, and receive less protection in spite of their vulnerability.

*www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25746.

79. Many voluntary schemes were quickly set up across Europe to help older persons with their daily lives. However, it is governments that are responsible for ensuring the distribution of the food and medicines people need, in particular in the case of the most vulnerable groups, who have to avoid leaving their homes.

80. www.lepoint.fr/sante/coronavirus-les-personnes-agees-risquent-de-mourir-d-ennui-et-de-solitude-13-03-2020-2367054_40.php#.

81. www.ccne-ethique.fr/sites/default/files/publications/ccne-_reponse_a_la_saisine_du_26.03.20_reforcement_des_mesures_de_protection_en_ehpad_et_usld_0.pdf.

82. www.coe.int/en/web/commissioner/-/lessons-to-be-drawn-from-the-ravages-of-the-covid-19-pandemic-in-long-term-care-facilities.

38. Given the fact that older persons are especially vulnerable to COVID-19, living and working conditions in care homes are of the utmost importance. Europe's care home sector is concentrated in the hands of a few large private groups, often run by pension and investment funds.⁸³ This can have a significant negative impact on conditions in care homes, if profit interests predominate over the needs of residents and health requirements of the infrastructure. The same is true of austerity measures that leave care homes underfunded. Understaffing, overcrowding, and huge care homes with too little distance between residents are some of the negative effects of that development, resulting in even higher vulnerabilities during virus outbreaks. Member States should urgently tackle these problems in order to protect the most vulnerable.

4.3. Proportionality of the public health response

39. The COVID-19 pandemic has prompted many member States to take drastic measures to protect public health. Article 15 of the ECHR is a derogation clause that allows member States, in exceptional circumstances and in a limited and supervised manner, to derogate from their obligation to secure certain⁸⁴ rights and freedoms under the Convention. The Convention is still adaptable to any and all circumstances and continues to regulate the actions of member States even in the event of national crises. Most member States have taken measures that restrict a number of individual rights and liberties enshrined in constitutions and the Convention, and a fair number of them have notified the Secretary General of the Council of Europe about their derogations to the ECHR. States must keep the Secretary General of the Council of Europe fully informed, and this duty will be more extensive the more extensive the derogation. The Assembly's [Resolution 2209 \(2018\)](#) on "State of emergency: proportionality issues concerning derogations under Article 15 of the European Convention on Human Rights" should be fully respected in such circumstances. The response to the threats in the pandemic must be strictly proportionate to the threat which they are supposed to counter, and member States should strive to limit any derogation to the Convention. The Committee on Legal Affairs and Human Rights will be looking into this issue in more depth in its upcoming report.

4.4. European and international co-ordination and public health governance

40. One can be forgiven for thinking that European and international co-ordination was "missing in action" in the first months of the pandemic. With the responsibility for public health usually at country level, or in federal States, devolved to regional level (or even sub-regional level), even the European Union has found it difficult to co-ordinate a response to this public health emergency, as member States balk at sharing their sovereign emergency powers, or their public health mandate.

41. The resulting cacophony of public health measures has seriously undermined their effectiveness and has sometimes been plain counterproductive.⁸⁵ Borders have reappeared in the Schengen passport-free travel zone (against WHO advice), complicating the lives of millions of cross-border commuters, as well as blocking goods. Some countries have even closed their borders to foreigners altogether; countries are spending millions to repatriate their citizens stranded elsewhere. Six member States put in place export bans on medical equipment.⁸⁶ The positive stories are unfortunately few and far between: Hospitals in countries such as Germany, Switzerland and (in the beginning) France took in critically ill COVID-19 patients from Alsace (France) and Lombardy (Italy). European Union leaders are setting up a new permanent European crisis management centre and have organised €50 million to buy needed medical equipment to distribute to hospitals where it is most needed. By mid-May 2020, despite its limited mandate in the field of public health, the European Union had adopted over 200 initiatives to fight the COVID-19 crisis⁸⁷, and had provided swift support to the health systems, societies and economies of its member States.⁸⁸ China, Cuba, the Russian Federation, Romania, Turkey and Albania have sent doctors, nurses, and medical supplies to hard-hit countries.

83. [The deadly impact of COVID-19 on Europe's care homes](#), Euronews, 8 May 2020.

84. ECHR Article 15.2: No derogation from Article 2, except in respect of deaths resulting from lawful acts of war, or from Articles 3, 4.1 and 7 shall be made under this provision.

85. For example, some countries allowed potentially infected returnees from risk-areas to go to school or work, while others asked them to self-isolate or quarantined them for 14 days; some countries also classed hairdressers or tobacco shops as essential businesses in shutdowns or lockdowns.

86. Italy, Bulgaria, Romania, Poland, the Czech Republic and the Slovak Republic. France has nationalised its supplies. Germany initially banned the export of supplies like masks, protective gear and medical equipment, www.nytimes.com/2020/03/26/world/europe/coronavirus-eu.html.

87. Through Joint Procurement Agreements, and close collaboration with industry, the European Union is trying to help Member States access essential medical and protective equipment, and ramp up European production of safe, high-performing medical devices.

88. Statement by EU Commissioner Stella Kyriakides at the Committee's hearing on 19 May 2020.

42. On the positive side, it seems that the European Union has learned its lesson, even if it was learned the hard way. As EU Commissioner for Health and Food Safety, (former President of the Assembly) Stella Kyriakides, said at the Committee's hearing on 19 May 2020: "The overriding conclusion here, is that we can only deal with such threats together. Fragmentation of effort makes us all vulnerable. Looking inwards will only decrease our chances of tackling the invisible threat. It is only through solidarity and co-operation across borders that we can defeat the virus." I could not agree more. Beginning of May, the European Commission co-convened a Coronavirus Global Response pledging event, bringing together partners from around the world to mobilise funds to support work on diagnostics, treatments and vaccines for the novel coronavirus. By mid-May 2020, €7.4 billion had been raised – €1.4 billion of which was pledged by the Commission. The Commission is now working towards a new, dedicated EU Health Programme, with an unprecedentedly significant budget going forward to reinforce the block's resilience.⁸⁹

43. Of course, solidarity and co-operation across borders must not be limited to Europe. WHO was, unfortunately, also slow to react in the beginning, its public health governance system weakened by years of cost-cutting and down-sizing. Only 20% of its budget is covered by assessed contributions from member States, with the balance mobilised through voluntary contributions.⁹⁰ The WHO relying on just 20 contributors for 80% of its voluntary contributions poses serious questions about its capacity to act independently.

44. Only on 25 March 2020 did the United Nations launch an appeal for a new USD 2 billion global humanitarian response plan, with WHO setting up a six-point action plan to prepare and respond to the pandemic in the poorest communities: those affected by crisis, including those "uprooted due to conflict, displacement, the climate crisis or other disease outbreaks".⁹¹ Unfortunately, this may come far too late to avert a humanitarian catastrophe, as the virus has started to circulate in packed refugee camps and slums worldwide.

45. WHO's actions (or perceived lack of action) have been criticised particularly sharply by the President of the USA, Donald Trump, who has also threatened to withhold the country's membership dues from the organisation, or to withdraw from it altogether. Our own President of the Assembly and our Chairperson are on record criticising Donald Trump's stance and calling for support for WHO⁹². At the meeting of the 73rd World Health Assembly on 19 May 2020 – its first-ever to be held virtually – delegates adopted a landmark resolution to bring the world together to fight the COVID-19 pandemic, finding the necessary consensus to support the organisation. Once this pandemic is over, WHO and its public health governance structure urgently needs strengthening (and de-politicising) in order to put it in a position to deliver on its mandate. As the Chairperson of our Sub-Committee on Public Health and Sustainable Development, Ms Jennifer De Temmerman (France, ALDE) has said: "With more power should also come more responsibility and accountability. Parliamentary oversight is sorely lacking at WHO. Any WHO reform should also introduce an element of such oversight, which is essential for building trust and solidarity."⁹³

4.5. Saving the economic and financial system

46. When COVID-19 started spreading across China in January 2020, few except the specialists could anticipate the global contagion – not only in medical terms, but also in terms of economic and financial fallout. Yet, with China being a vital link in the global value chains, the recipe for disaster was in the making.

47. The fight against COVID-19, including its containment measures to keep the population at home as far as possible, has put a serious break on overall economic activity (notably travel, leisure and other services; production capacity due to factory closures; cross-border and country-wide circulation of goods, ingredients, commodities, workers and users). The OECD expects a sharp slowdown in worldwide growth in 2020 with the world's GDP growth declining by 2% for every month of strict lockdown).

48. The International Monetary Fund (IMF) warned that COVID-19 could cause a "deeper downturn than the last financial crisis" even if the rebound could be relatively strong in 2021. But in the near future we should be worried about sustaining the national economies in real time. It is therefore reassuring that major international institutions and individual countries are mobilising extraordinary economic and monetary response measures to both fend off the epidemic and also keep economic systems afloat.

89. Ibid.

90. www.who.int/about/funding/financing_the_pb/en/.

91. www.who.int/dg/speeches/detail/who-director-general-s-remarks-launch-of-appeal-global-humanitarian-response-plan---25-march-2020.

92. Statement "Let's help the WHO help all of us", 20 April 2020.

93. Ibid.

49. The IMF has committed to providing emergency financing (about USD 1 trillion) to over 90 countries that have already requested its help (the emerging market economies appear to be worst hit by the COVID-19 crisis).⁹⁴ In Europe, the finance ministers of EU-27 have agreed to suspend government borrowing limits, triggering the so-called general escape clause⁹⁵ of the EU fiscal framework in the face of “a severe economic downturn in the euro area or the Union as a whole”.⁹⁶ This unprecedented decision gives member States flexibility “to take all necessary measures for supporting our health and civil protection systems and to protect our economies, including through further discretionary stimulus and co-ordinated action, designed, as appropriate, to be timely, temporary and targeted”. The European Central Bank (ECB) also pledged to take “appropriate and targeted measures” so that banks could cope with lending to business and households more easily and launched a €750 billion package of quantitative easing (money creation tool) for the eurozone market. This followed the ambitious steps taken by the US Federal Reserve and the Bank of England.⁹⁷

50. That said, some Council of Europe member States will be in great difficulty. Italy was in a delicate budgetary situation even before the COVID-19 crisis, with the weakest growth figures in the eurozone and very high sovereign debt (134.8% of GDP in 2019 compared to 84.1% of GDP in euro area⁹⁸); it is now the European country worst hit by the novel coronavirus. The ECB’s targeted measures will have to support Italy as a matter of priority. However, other eurozone countries such as Greece, Spain and France, may need a similar prod from the ECB. So far, the main spending priority for many governments has been action to save lives and to reassure both the businesses and the population, including through temporary tax relief, partial compensation of revenue loss for those subject to “technical unemployment”, support to small and medium enterprises to prevent bankruptcies and preserve jobs. However, as the analysis of the Centre for Economic Policy Research (CEPR) argues, “care must be taken to ensure that temporary solutions don’t create long-lasting problems”.⁹⁹

51. It is reassuring that, by the end of March 2020, 27 European countries (belonging to the European Union) had rolled out national emergency programmes to sustain their economies. Ranging in size from €300 million in Luxembourg to €1.1 trillion in Germany and unlimited commitments in Hungary and the Slovak Republic, they provide a mix of sovereign support (targeted grants, direct payments and compensations; tax relief and incentives; cashflow facilitation; loans and State credit guarantees, public investment in local corporate bonds; deferrals in payment of rents or certain utility bills; derogations regarding working time) to public healthcare and social services, workers and households, vulnerable population groups, local authorities, enterprises (notably small businesses).¹⁰⁰ As the time goes by and the needs become clearer, those packages will probably have to be enhanced and adjusted.

52. Moreover, by early April 2020 all the remaining Council of Europe member States had announced economic support measures for vulnerable population (notably income support and minimum income guarantees, tax relief, rent deferrals, bonuses for healthcare and social workers, bans on termination of contracts) and enterprises with disrupted activity (credit lines and guarantees, break on bankruptcy proceedings, moratorium on debt repayments, subsidies to tourism and transport sectors), as well as more general macroeconomic measures (such as lowering of reference interest rates and liquidity facilities by central banks, public investment programmes). Some countries, such as the Republic of Moldova, have obtained the IMF’s co-funding for their emergency programmes.¹⁰¹ The Council of Europe Development Bank (CEB) issued COVID-19 Response Social Inclusion Bonds in April, thus mobilising €1 billion; it has already approved €300 million loans each to Italy and to the Czech Republic and a €200 million loan to Madrid

94. Statement by IMF Managing Director Kristalina Georgieva on 23 March 2020 and further news, www.imf.org/en/Topics/imf-and-covid19.

95. The general escape clause was put in place in 2011 as a result of the European Union seeking to draw lessons from the financial and economic crisis. The Stability and Growth Pact requires national budget deficits to be no more than 3% of GDP and national debt not to exceed 60% of GDP.

96. Statement of EU ministers of finance on the Stability and Growth Pact in light of the COVID-19 crisis, Council of the EU Press release, 23 March 2020.

97. “ECB U-turn shows it fears coronavirus could destroy eurozone project”, article by Larry Elliot, Economics Editor, *The Guardian*, 19 March 2020.

98. Eurostat data of April 2020. The highest ratios of government debt to GDP at the end of 2019 were recorded in Greece (176.6%), Italy (134.8%), Portugal (117.7%), with Belgium and France being close to 100%; the lowest levels are in Estonia (8.4%), Bulgaria (20.4%) and Luxembourg (22.1%).

99. “Mitigating the COVID Economic Crisis: Act Fast and Do Whatever It Takes”, edited by Richard Baldwin and Beatrice Weder di Mauro, a CEPR Press VoxEU.org eBook, March 2020.

100. EU Member States economic decisions, published by Robert Schumann Foundation on 26 March (information updated on 25 March 2020).

101. “COVID-19: Overview of OSCE participating States’ Responses as of 02 April 2020” by the OSCE Parliamentary Assembly.

municipality (Spain) to combat the COVID-19 pandemic¹⁰². In May, the CEB approved by fast-track procedure eight new loans totalling close to €1.3 billion to its member countries (Croatia, Estonia, Greece, Kosovo*¹⁰³, Latvia, the Republic of Moldova, Serbia and Turkey) to fight the COVID-19 pandemic¹⁰⁴. The loans are provided under the Public Sector Financing Facility of the CEB, which offers a flexible and timely use of CEB funds.

53. In addition, the European Investment Bank has mobilised some €40 billion in potential financing for European companies affected by the crisis, mainly through bridging loans or the suspension of loan repayments. At the same time, the EU leaders struggled to agree on the use of collective action mechanism – a credit line worth some 2% of their economic output from the European Stability Mechanism (ESM) fund for the eurozone (19 member countries), or, alternatively, something that could take the form of European COVID-bonds. This has shown the persisting divide between “the ailing south and the fiscally conservative north”.¹⁰⁵ Jacques Delors, a former President of the European Commission (1985 to 1995), called those divisions a “mortal danger” for the European Union,¹⁰⁶ while the French Minister for European Affairs, Amélie de Montchalin, warned that the European Union was facing an existential crisis as “credibility and usefulness” of the union rested on its collective response to the coronavirus crisis.¹⁰⁷ Although the agreement to tap the ESM was finally reached on 9 April, the conditionalities attached to its use remain problematic from the perspective of potential user-countries.

54. Thereafter, the European Commission published a proposal to use the EU budget “to protect lives and livelihoods”. It launched an initiative called SURE (Support mitigating Unemployment Risks in Emergency), worth €100 billion, aiming to support workers and businesses. All available structural funds will be redirected to the response to the novel coronavirus, while farmers and fishermen will receive targeted support.¹⁰⁸ In a similar drive for action, the US Congress approved a USD 2 trillion emergency package for the national economy. This is the largest economic stimulus programme in the history of the USA. The rescue fund will support households to compensate for the loss of income due to temporary unemployment (USD 300 billion), hospitals (USD 100 billion), vaccine and medication development (USD 11 billion), loans to struggling industries including airlines (USD 500 billion), schools (USD 30 billion), food stamps and child nutrition (USD 25 billion), as well as farmers (USD 24 billion).¹⁰⁹

55. In their turn, the G20 leaders, pledged “to do whatever it takes to overcome the pandemic”, “both individually and collectively”, and “to do whatever it takes and to use all available policy tools to minimize the economic and social damage from the pandemic, restore global growth, maintain market stability, and strengthen resilience”. They said they were “injecting over \$5 trillion into the global economy”. G20 finance ministers and central bank governors were mandated to develop an action plan together with international organisations so as to “swiftly deliver the appropriate international financial assistance”, while trade ministers were tasked to address international trade disruptions and work towards “a free, fair, non-discriminatory, transparent, predictable and stable trade and investment environment”.¹¹⁰

4.6. Guaranteeing social rights and social cohesion

56. Social rights – guaranteed by the European Social Charter, to which practically all member States are bound – are human rights, as well. Many of them are being impacted by public health measures taken during the epidemic, or their consequences: The right to work, especially for those judged “non-essential” who cannot work from home (for example in the hospitality or entertainment industries), or workers laid off in shutdown or lockdown situations; the right to just, safe and healthy working conditions, especially for “front-line” medical personnel or other essential workers (including in supermarkets, funeral parlours, or cleaning jobs) working long hours, often without adequate protection from infection; the right of children and young persons to social, legal and economic protection, impacted through closures of schools, universities, day-care

102. <https://coebank.org/en/news-and-publications/news/>.

103. * All references to Kosovo, whether to the territory, institutions or population, in this text shall be understood in full compliance with Resolution 1244 and without prejudice to the status of Kosovo.

104. <https://coebank.org/en/news-and-publications/news/ceb-approves-eight-new-covid-19-response-projects/>.

105. “EU leaders agree on more time to decide coronavirus economic rescue”, Reuters, 26 March 2020.

106. «Le manque de solidarité est un «danger mortel» pour l'Europe, selon Jacques Delors», article in *Le Figaro*, 28 March 2020.

107. “Unity must be more than a slogan for EU in crisis, says French minister”, *The Guardian*, 29 March 2020.

108. “Coronavirus: the Commission mobilises all of its resources to protect lives and livelihoods”, Press release by the European Commission, 2 April 2020.

109. “Senate approves \$2 trillion COVID-19 stimulus bill”, WBRZ news, 25 March 2020; “Here's what's in the \$2T stimulus package – and what's next”, *Politico*, 25 March 2020.

110. G20 Leaders' Summit – statement on COVID-19: 26 March 2020.

centres, with possible knock-on effects regarding their protection from violence in the home in lockdown situations; the right of elderly persons to social protection when asked to self-isolate for months at a time or when deprived of in-person visits for the protection of their health; the right of workers with family responsibilities to equal opportunities and equal treatment when schools and day-care centres close; the right to protection against poverty and social exclusion, in particular as regards housing in lockdown situations.¹¹¹

57. Member States which have had to enact public health measures in the pandemic that impact on these rights have sought to limit their application in time, and to mitigate their effects by, for example, making financial support available to businesses, workers, and vulnerable groups,¹¹² or organising on-line teaching. However, it is quickly becoming clear that the pandemic is exacerbating existing inequalities: the self-employed and workers in the platform economy often cannot access financial support as easily as workers with permanent contracts; the poor and less well-educated find it harder to “home-school” their children (and may not have access to the necessary technical resources); lockdowns are harder to bear in sub-standard or cramped housing or in the presence of a violent partner or parent. Women, who usually bear the largest burden of care in both families and the medical world, are particularly at risk of being impacted by discrimination, violence – and sheer exhaustion. The poor and the marginalised (including the homeless, refugees, migrants, asylum-seekers, minorities such as the Roma) are bound to suffer the most.

58. In this respect, it is particularly important that the personnel on the front lines be properly protected from harm – and be given their just reward (in terms of higher wages, more secure job contracts, etc). The pandemic has made the lack of States’ preparedness for public health emergencies painfully obvious – health-care personnel the world over battled with a lack of personal protective equipment (PPE), putting themselves, but also their patients, at risk of infection, illness and death. Other essential workers – supermarket cashiers, delivery drivers, mortuary and funeral parlour employees – were also called upon to work long hours in dangerous conditions. It quickly turned out that essential workers were essentially women, many of them underpaid and overworked even before the pandemic struck. It is high time that the inequality in pay for “caring” professions and for jobs traditionally performed by women is addressed, as I am certain the upcoming report by the Committee on Equality and Non-Discrimination will do.

59. We are already living in times in which social cohesion is sorely tested – the pandemic will constitute a supplementary burden if we decide to isolate ourselves in our homes and look out only for ourselves. But it doesn’t have to be that way: The pandemic is showing us how much we depend on others, and has sparked new social activism – members of local football clubs or churches are spontaneously organising food deliveries for self-isolating, high-risk persons; thousands of people are volunteering to help out in multiple roles, such as manning phone lines; neighbours are looking out for one another; and across entire countries people are applauding the efforts of health care personnel every evening.

5. A brave new world?

60. The situation we are in is unprecedented – we have not been confronted with a pandemic on the scale of the “Spanish flu” for a century. Our societies have evolved significantly since then, not only in terms of medical and technological progress. But we are basically making it up as we go along, which hinders our ability to react rapidly and learn from others. Political and geopolitical fault lines are undermining our willingness, and thus our capacity for European and international solidarity and co-operation. However, it is not too late to turn the tide: we can overcome this epidemic together, and seed a new, better, world, based on the core values of the Council of Europe. This would enable us to meet the UN Sustainable Development Goals by 2030 and overcome the next big challenge looming after the pandemic – the climate change emergency.

5.1. Overcoming the pandemic

61. First, however, we need to overcome the current challenges posed by the pandemic. To avoid a disastrous outcome in terms of lives lost and burden of sickness, we need to act fast to contain the outbreaks, using the tried and tested, effective measures outlined in chapter 3, implemented in a human rights-compliant way while respecting the principle of proportionality.¹¹³

111. As with the ECHR, it is possible for States Parties to take measures derogating from their obligations under the ESC in time of war or other public emergency threatening the life of the nation, but no derogations have been communicated to the Secretary General of the Council of Europe so far.

112. See the non-exhaustive list in paragraph 51.

113. The [ELS policy brief published by the OECD on 20 March 2020](#) provides a more detailed guide.

62. For many of our member States, this means: Rapid and sustained action to reduce human contact through physical distancing, as far as possible on a voluntary basis, and – if necessary – rights-compliant shutdowns/lockdowns for the time it takes until active community spread of SARS-COV-2 is reduced to a level controllable through rigorous testing, data protection-compliant contact tracing, quarantine and self-isolation, respecting the principle of proportionality and taking into consideration the impact such measures have on fundamental including social and economic rights, as well as physical and mental health, and implementing measures to offset those negative impacts; procuring protective gear for health and other essential personnel; boosting and optimising health system capacity by mobilising inactive health professionals, and by boosting supplies of required equipment to diagnose and treat patients safely and effectively – in particular diagnostic tests, oxygen and ventilators/respirators, as well as boosting the numbers of available acute-care beds in hospitals; ensuring that all public health measures respect human rights, are gender-sensitive, involving women in decision-making in a meaningful way, and protecting vulnerable groups of the population (in particular, persons with disabilities, children and the elderly); putting in place of conditions to isolate and care for symptomatic cases not requiring immediate hospitalisation on a voluntary basis with a view to preventing household / family infection clusters and having the necessary medical supervision in place to allow rapid hospitalisation when a patient's condition deteriorates. It means opening borders and lifting travel restrictions to allow for an unhindered emergency response across borders, within the European Union at least allowing public health measures to be designed centrally and implemented along regional rather than jurisdictional (member States) lines, as needed depending on where outbreaks are situated.

63. For all of our member States it means: Make available reliable information on the comparative dynamic changes in the number of deaths due to different pathologies in the last three years, and the number of those infected with COVID-19 among them; full, clear and timely communication of information, and transparent decision-making on the basis of evidence-based scientific opinion (including publishing expert advice). Active and broad community testing (not just limited to those admitted to hospital or health or other essential personnel); as soon as feasible, antibody testing should also be widely rolled out, including antibody testing of representative samples of the population, in order to identify those already immune to the disease). Active promotion of responsible research, development and production of medicines, diagnostic kits, vaccines, and personal protective equipment in a spirit of solidarity, ensuring that any medicines, tests or vaccines thus developed are accessible and affordable to all, in particular to vulnerable groups. European and international solidarity, co-ordination and co-operation should be prioritised and systemised. Protective gear should not be hoarded by nation States “just in case”, but rather distributed across Europe to where the need is greatest. Establish and keep up to date an open access transborder directory of available intensive care unit (ICU) beds, as well as ventilated and staffed beds in ICUs, and make them available to member States in need. Health care personnel which has become immune to the disease should help out in other countries once the need in their own country subsides. Executive overreach, disproportionate and unnecessarily repressive measures infringing human rights, as well as all discrimination in the implementation of public health measures should be avoided. Parliaments should continue to be in a position to exercise their mandate of controlling the government's actions.

64. Furthermore, in the face of the current pandemic, member States should intensify efforts to evaluate the state of their health systems, pandemic preparedness and infection surveillance systems, with a view to ameliorating them as necessary; as well as evaluate the effectiveness and the collateral damage (in particular to the full exercise of human rights, including socio-economic rights), of the measures taken to confront the current pandemic, in order to apply the lessons learned to future public health emergencies. They should ensure that their economic recovery and safeguarding plans do not create the conditions for a future degradation of ecosystems likely to generate other epidemics of a zoonotic nature, and thus condition the aid put in place on the fulfilment of ambitious environmental and social criteria in line with the UN Sustainable Development Goals.

5.2. Minimising harm to the economic and financial system: put the people and the planet first

65. Our countries are interconnected and interdependent – for better and for worse. The pandemic has set in motion shock waves that have not only exposed and amplified vulnerabilities in health-care systems, but also overwhelmed our economies. As the OECD's Secretary General notes, “the behaviour of financial markets reflects the extraordinary uncertainty of the situation”, yet “it is too early to tell how far-reaching an impact COVID-19 will have” on our countries.¹¹⁴ We need to keep the economy going – not least to beat the pandemic, and to have a critical look at how to make it work better for the lasting well-being of all. We need a more sustainable economic and financial system that would underpin the real economy, not financial

114. “COVID-19: Joint actions to win the war”, the op-ed by Angel Gurría, OECD Secretary-General.

speculation for the benefit of the few. With the unprecedented rescue packages, governments hold the reins of regulation stronger than ever and should use the strings attached to demand businesses to invest more in people and “greener” development.

66. The COVID-19 pandemic is a test of our collective capacity and solidarity – at local, national, regional and international levels. Drawing lessons from the pandemic, I believe that our governments should seriously rethink the strategic pillars of national economy and well-being with long-term sustainability and security in mind. Certain essential necessities (such as medicines, food and energy) should be fully produced ‘close to home’, benefitting local economies and building on European solidarity as appropriate. In the short-term, we must shield the most vulnerable people and businesses, putting fundamental rights first.

5.3. Upholding social rights now and in the future

67. It is our duty to try and uphold social rights as far as possible during the pandemic – and to make a renewed and stronger effort to fight poverty (in particular, child poverty and extreme poverty) once the pandemic has ended. Right now, we must make certain that everyone’s right to equal access to health care is respected, especially in emergency situations: it must not be your wealth or your “connections” which determine whether you get access to the care you need. But ultimately, we also need to address the social determinants of health, such as poor housing and lack of access to services – and the inequalities which undermine the social rights and the social cohesion on which we depend for our survival. States should step up their efforts to make progress regarding the European Social Charter and the Oviedo Convention which facilitate the safeguarding of social, economic and other human rights which are the most vulnerable during responses to a pandemic.

5.4. Looking to the future of a post-pandemic world

68. It is clear that our world will change, possibly beyond recognition, in the next few years. It is up to us whether the world changes for the better or the worse. The pandemic has already shown us that we cannot go back to where we were before: unprepared for worldwide catastrophe, particularly because the next worldwide catastrophe is already in the making – the man-made climate change emergency. We have already missed several tipping points to avert the disaster of this pandemic: we cannot afford to miss the tipping points of the climate change emergency.

69. It is important that we learn the lessons from this pandemic at all levels. The first lesson to be learned, as pointed out by Professor Katz at our hearing on 19 May 2020, is: “Public health preparedness and global health security must embrace a One Health approach, embracing the interactions between animals, humans and the environment which contribute to and protect us against disease. We must strive to find the next zoonotic disease before it jumps into humans, to continue to strengthen the co-ordination of animal and human systems for disease detection and response, and to protect the ecosystems that underpin human, animal and environmental health. This includes identifying and fighting climate change as a driver of emerging health threats”, and, I would add, and improving policies regulating animal agriculture and addressing human destruction of pristine habitat. Global health security and pandemic preparedness interventions must also be data driven, evidence-based and incorporate human rights provisions. We must get better at using diverse sources of data, creating unified data infrastructure, as well as modelling for decision making; and translating these models and data into triggers for action.

70. We must put in place a stronger, more powerful WHO, which is properly funded and not dependent on voluntary contributions to fulfil its essential functions. A WHO which has been reformed in order to allow it to better fulfil its function of achieving the highest attainable standard of health for everyone. This is not just a question of money: WHO should also be given the necessary power to visit member States unannounced, as can, for example, the Council of Europe’s European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT). As proposed by Professor Katz at our hearing on 19 May 2020, we should re-examine and strengthen the International Health Regulations to reframe global governance of disease, make the treaty more fit for purpose, and explore mechanisms for compliance.¹¹⁵ We must also revisit how we govern information, including sample and genetic sequence sharing. And there must also be proper, independent, ideally parliamentary oversight of WHO with a view to building the trust and solidarity needed for the world to be able to beat pandemics together.

115. This requires either a full re-negotiation of the treaty text, or, to borrow from other treaties, a review conference for members States of the World Health Assembly to reach understandings about implementation of the articles in a changing world, according to Professor Katz.

71. As proposed by Professor Katz at our hearing on 19 May 2020, it would also be a good idea to establish enduring leadership at the United Nations for current and future high consequence biological events, including a permanent, designated facilitator in the Office of the UN Secretary-General. The United Nations should also ensure global oversight and accountability for pandemic preparedness through an independent external entity.

72. And it is for us, at European level – and not just at the level of the European Union – to build a regional system capable of supporting WHO in its endeavours. This could take the form of a regional agreement between our Assembly and WHO Europe, modelled on our co-operation agreement with the OECD; but it should not stop there: public health intergovernmental co-operation and co-ordination needs to be re-established at the Council of Europe, as well.