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Democracy, Death and Dying: The Potential and Limits of Legal Rationalisation

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I. Introduction

‘When I hear that everything else has to step back from the protection of life, then I have to say: That is not right in this absoluteness ... If there is any absolute value in our Basic Law, then it is human dignity. It is inviolable, ... but it doesn’t rule out the fact that we have to die.’¹ In April 2020 the President of the German Bundestag stated that it would be wrong to give the protection of life the highest priority in the fight against the coronavirus pandemic, although the state has to guarantee the best healthcare possible for all.

Pandemics that arise and spread necessarily lead to more people dying than without the diseases involved. Societies have dealt with this situation as a condition of nature since the beginning of mankind, at least since people began to settle. While in medieval times, pandemics had to be dealt with on a local level, especially in towns and cities, in a post-Westphalian world the role of states as the relevant actor in dealing with pandemics has become increasingly relevant.² Health issues force governments and administrations to implement preventative, provisional and prohibitive measures.

By the end of December 2020, 84 million cases of COVID-19 had been documented around the world and 1.82 m people had died.³ An estimated 5.3 m people

* The author is thankful to Lukas Wieser for research assistance; I would like to express my gratitude to the discussion group of the SFU Faculty of Law for a valuable and inspiring debate.

¹ Wolfgang Schäuble is President of the German Bundestag (first chamber of German Parliament) see www.zeit.de/politik/deutschland/2020-04/corona-krise-wolfgang-schaeuble-schutzmassnahmen.

² Private companies and organisations as well as civil society must also be taken into consideration.

³ See ourworldindata.org/covid-deaths.

died in the EU in the year 2019; in the year 2020, up to the end of November, 444,300 people died in the EU and UK due to COVID-19, which represents about 8 per cent of the overall deceased persons.⁴ One hundred years ago, the Spanish flu led – within three years – to an estimated total of 2.64 m deaths throughout the whole of Europe.

An epidemic (from the Greek ‘upon the people’)⁵ is a disease which affects a large proportion of a population within a short timeframe (more than 15 cases per 100,000 people in two consecutive weeks), and it becomes a pandemic (Greek: ‘all the people’)⁶ when it affects larger regions, continents or the whole world. Since epidemics and pandemics have a dramatic effect on the people, it is also up to the people to decide how to approach their consequences. This perspective already involves the role of death and dying in democracies.

The first part and starting point of the chapter (section II) refers to the shift of the paradigm of death from an unpredictable though inevitable condition of life to the economised timing of death. This rationalised approach has given governments the possibility to influence death and dying. In terms of Foucault’s bio-politics, governments not only control the bodies of the people, but also decide upon their life and death. During the COVID-19 pandemic, (European) states have come under pressure to protect the lives of the people and to keep death rates low.

This role of the state in managing death and dying is also expressed in law, which I will focus on in the second part of the chapter (section III). Democratic processes have created the legal framework of life and death (legal thanatology). Budgetary law can serve as an example for the democratic decision-making about life expectancy. As courts strengthen and enhance the effectiveness of rights, they also have an effect on the life and death of human beings. While the discussion on a traditional liberal rights perspective can be understood as an empowerment of the people to decide for themselves about life and death (individual autonomy), state obligations to guarantee liberal rights (eg, the right to life) or social rights (eg, right to health) affect the government’s decisions about life and death. The possibilities and limits of the rationalising function of the rights-based case law will be discussed.

In the third part of the chapter (section IV) the effects of legal thanatology in the COVID-19 pandemic will be analysed. Different approaches of European democracies illustrate that decision-making on life and death will lead to different consequences. Moreover, an international perspective demonstrates European privileges as well as European responsibilities in a post-colonial world. In the concluding section V, the necessity to negotiate about death and dying in democratic societies will be addressed.

⁴ This percentage does not express the number of excess deaths, which means that the percentage of increased mortality is lower.

⁵ ἐπί (epi), δῆμος (demos).

⁶ παν (pan), δῆμος (demos).

II. Pre-Requisites of Legal Thanatology

A. The Economised Timing of Death

The Encyclopaedia Britannica defines death as ‘the total cessation of life processes that eventually occurs in all living organisms’.⁷ The end arrives when total cessation occurs. Life and death are irreconcilably opposed to one another. Death terminates the (human) life and life ends with the occurrence of death. While death cannot be negotiated, it sometimes seems possible to cheat it. Away from such exceptional circumstances, however, human existence is defined and terminated by death.

The randomness of death as an unpredictable though inevitable condition of life is set against the attempts of humanity to prolong life. Human beings have long dreamt of eternal life and victory over death.⁸ As an important step towards the prolongation of life, the enlightenment not only rationalised human existence but also led to an analysis of fatal risks, from child mortality and all kinds of diseases to age-related illnesses. The numbers are impressive: in the year 1800, almost 1 billion people were alive on earth, while the figure was 1.65 billion in 1900, 6.14 billion in 2000 and 7.79 billion in 2020.⁹ The global child mortality rate has fallen over the last 200 years,¹⁰ while life expectancy has increased significantly (more than doubling from 32 in 1900 to 72.2 in 2015).¹¹

The enlightened and rationalised approach has led to manifold scientific and technological advances. The increase in possibilities to prolong life is remarkable: modern hospital management, genetic analysis and data management, diagnostic devices (including the use of artificial intelligence in diagnosis), organ transplants, artificial organs, traditional or alternative therapies and specialised pharmaceuticals or vaccines. If all of these possibilities are available in cases of emergency or severe illnesses, or just as preventive tools, the enormous developments in life-prolonging processes become evident. With these tools, the range of options to keep human beings alive is not only incredibly broad, but also fundamentally linked to the economic dimension of modern medical care.

An enormous amount of resources is already necessary to facilitate a general medical supply on a technologically feasible level. While investment in targeted medical treatment of individuals enables an even higher success rate in keeping humans alive, it is closely linked to exponentially higher investment of resources. This economic dimension of the health system has great relevance regarding the

⁷ See www.britannica.com/science/death.

⁸ See eg S Knell, *Die Eroberung der Zeit* (Suhrkamp, 2015).

⁹ See eg www.worldometers.info/world-population/world-population-by-year/.

¹⁰ See eg ourworldindata.org/child-mortality.

¹¹ See eg ourworldindata.org/life-expectancy. The leading causes of death globally include ischaemic heart disease, responsible for 16% of the world's total deaths, strokes and chronic obstructive pulmonary diseases, responsible for approximately 11% and 6% of total deaths respectively, as well as lower respiratory infections.

possibilities to postpone death. In the following section, this development will be addressed as the economised timing of death.

The economised timing of death results in many philosophical questions, political possibilities and legal challenges. The state has the possibility to influence and control this economised dimension of death. From a democratic perspective, one would expect an open public debate, but this is lacking or occurs only indirectly. Although death is nowadays much more than a random, uncontrollable incidence, it still often seems to be a taboo subject. From a legal perspective, we can observe detailed judgements on rights-based discussions about individual fates on the one hand, and judgements about state obligations and social rights on the other hand; the democratic discourse on the economised timing of death is missing. Before turning to the legal dimension, it is necessary to analyse the correlation between death and governance in democracies.

B. From Biopolitics to Necropolitics

We have Foucault to thank for drawing attention to the state's power over the human body and the regulation of the population. Starting from the Roman tradition of the *patria potestas*, which included the possibility to rule over the lives of children and slaves, the state gradually took control of human beings' life and death.¹² The death sentence and war represented two varieties of the right of the sword.¹³ The state purposes changed and a new era of biopolitics was developed by the state, which included the capability and aim to control birth and death rates as well as the health level of the population; from a neo-liberal perspective, the relevance of human capital became decisive.¹⁴ The state can organise, influence and control the population in general and discipline individuals. Institutions like schools, barracks, and factories were developed and served the aims of capitalism.¹⁵ While epidemics and hunger were reduced in the eighteenth and nineteenth centuries, bio-politics took over control of the human body.¹⁶

While Foucault's analysis is focused on the development of the government, Giorgio Agamben radicalises the concept and carries it to the extreme.¹⁷ By combining Carl Schmitt's state of emergency with Foucault's biopolitics, the absolute control over the human body became the characteristic of the absolute

¹² M Foucault, *The History of Sexuality: 1: The Will to Knowledge*, transl Robert Hurley (first published 1976, Penguin, 1998) 135.

¹³ *ibid*, 136–37.

¹⁴ *ibid*, 139–41.

¹⁵ *ibid*, 139.

¹⁶ *ibid*, 141–42.

¹⁷ G Agamben, *Homo Sacer. Sovereign Power and Bare Life*, transl Daniel Heller-Roazen (Stanford University Press, 1998).

sovereign or sovereignty itself.¹⁸ The sovereign rules over the bare (sacred) life of the individual (the *homo sacer*). Agamben chooses the Nazi regime symbolised by the concentration camp ('Lager') as the unique horror and cruelty of the twentieth century to illustrate the total control over the human body, in which the state does not leave anything to the human being, not even the essence of being human.¹⁹ Agamben demonstrates that states of emergency proliferated in democracies and become a regular part of states shifting between democracies and dictatorships.

Agamben shifts the focus towards the negative potential of biopolitics and the end of humanity and human existence having liberty and autonomy taken away by the state. The state is not characterised by state power but by state terror. Agamben's approach reveals the abysses of bio-power. His perspectives make it possible to look through the realisation of the negative potentials of states back to (contemporary) challenges, which makes it clear that brutal state control over the human body is a permanent paradigm of human existence in the institutional setting of a state.

Achille Mbembe²⁰ based his research on racism and colonialism on Foucault's bio-politics and applies Agamben's perspective of negative state powers to racism and colonialism. Mbembe identified necropolitics as subjugating life to the power of death. He illustrates how Western democracies are deeply involved in necropolitics both in their own territories (racism) and globally (colonialism). He analyses 'the brutality of democracy', which creates various 'forms of violence and irregular forces'.²¹ Following Agamben's discussion on Schmitt and Foucault, he states that the 'ultimate expression of sovereignty largely resides in the power and capacity to dictate who is able to live and who must die. To kill or to let live thus constitutes sovereignty's limits, its principal attributes. To be sovereign is to exert one's control over mortality and to define life as the deployment and manifestation of power. This sums up what Michel Foucault meant by biopower: that domain of life over which power has asserted its control'.²²

Mbembe exemplifies necropolitics in the context of colonial repression and racism including the exploitation of humans and resources. He shows that 'the sovereign right to kill is not subject to any rule in the colonies. In the colonies, the sovereign might kill at any time or in any manner. Colonial warfare is not subject to legal and institutional rules'.²³ Moreover, 'racism is the driver of the necropolitical principle insofar as it stands for organized destruction, for a sacrificial economy, the functioning of which requires, on the one hand, a generalized cheapening of

¹⁸ *ibid.*

¹⁹ *ibid.*, 166–80.

²⁰ A Mbembe has been linked to controversy regarding statements and activities concerning the Palestinian conflict, see eg www.dw.com/en/why-achille-mbembe-was-accused-of-anti-semitism/a-53293797.

²¹ A Mbembe, *Necropolitics*, Steven Corcoran tr (Duke University Press, 2019) 16.

²² *ibid.*, 66. Biopower, in Foucault's work, appears to function by dividing people into those who must live and those who must die. Mbembe (n 21) 71.

²³ *ibid.*, 78.

the price of life and, on the other, a habituation to loss.²⁴ Necropower also includes a spatial dimension by 'the dynamics of territorial fragmentation'.²⁵

Mbembe brings a specific international perspective to the negative side of biopolitics, which goes beyond the specific (especially Northern) nation states and the role of particular vulnerable groups within societies. The racist concept of necropolitics is not limited to nation states, but has further international effects.

The debate around bio- and necropolitics has created an important perspective to understand the economised timing of death in times of the COVID-19 pandemic. The following thoughts, however, will not build upon a Schmittian understanding of the state of emergency, but will bring the constitutional and legal framework back into consideration. Dealing with health crises in liberal democracies cannot be found in concepts beyond constitutional and legal rationalisation, but lies within the legal concept of addressing human rights and debating death and dying in a democratic society.

C. State of Emergency in the COVID-19 Pandemic?

The COVID-19 pandemic has not created a state of emergency as neither states nor state organs have come under threat. Some states, however, have faced a partial breakdown of their healthcare systems. They have faced a loss of control of the governmental bio-power, which includes an uncontrolled dying of human beings. This creates a dangerous situation for governments as societies might change their attitudes towards governments, which can then lead to social upheaval. While society can react to unreasonable governance by using reason and adopting the necessary measures themselves (eg, staying at home), it can also react with anger (eg, violent demonstrations).²⁶ A constitutional threat which dissolves state orders has so far not emerged.²⁷ The challenges have turned out to be much more a question of the effectiveness of the administrative state.

Some states declared states of emergency to accumulate power at the governmental level and to limit human rights. The limitation of human rights, however, is always a question of proportionality. Severe situations will require severe measures, which can be justified if dramatic events make them necessary. However, a

²⁴ *ibid.*, 38.

²⁵ *ibid.*, 80. Borders are understood as 'dead spaces of nonconnection which deny the very idea of a shared humanity'. Mbembe (n 21) 99.

²⁶ See KL Scheppele and D Pozen, 'Executive Overreach and Underreach in the Pandemic' in M Poiars Maduro and PW Kahn (eds), *Democracy in Times of Pandemic. Different Futures Imagined* (CUP, 2020) 38–53; M Ignatieff, 'The Reckoning: Evaluating Democratic Leadership' in M Poiars Maduro and PW Kahn (eds), *Democracy in Times of Pandemic. Different Futures Imagined* (CUP, 2020) 89–103; R Gargarella, 'Democracy and Emergency in Latin America' in M Poiars Maduro and PW Kahn (eds), *Democracy in Times of Pandemic. Different Futures Imagined* (CUP, 2020) 66–76.

²⁷ This, however, shall not relativise the dramatic situations in Italy, New York, Brazil and India, where hospitals were overloaded, and proper funerals for the dead were no longer possible. The organisational health crisis requires quick and decisive action.

suspension of parliamentary and judicial scrutiny can never be justified. A romantic Schmittian call for an emergency situation could not even have been justified in the serious health crisis, which would call for rational measures and not politics unbound. Thus, sovereignty cannot be defined by declaring a state of emergency, but a sovereign in a democratic sense is one who, while not declaring a state of emergency, takes the necessary actions under full parliamentary and judicial scrutiny.

From the perspective of biopolitics, the governments accumulated bio-power during the pandemic to regain their power to decide over life and death, which they had (partly) lost. Death could not be controlled by governments anymore, at least not to the extent they were used to (at least from a European perspective). The biopolitical regime followed the logic of the security state (conceptualised in the post 9/11 responses to counter terrorism²⁸). In some countries, the state of emergency was even promoted as a state of war,²⁹ with the ongoing war a struggle for the control of death.

The security state of the pandemic can be understood as a sanitary state or hygienic state. The population was disciplined from a health perspective. While democracies were typically unprepared and disorganised in their first responses, societies themselves were qualified as undisciplined and confronted with a new regime of obedience. The statistical data of infections and deaths became the guiding concept in imposing discipline on these societies. The spatial dimension of the new regime referred to the closing down of society, roadblocks, travel limitations and restrictions in freedom of movement; borders became a revived paradigm in the pandemic.

The core paradigms of the pandemic, however, have been hospital wards, especially the intensive care units (ICUs). The potential overloading of hospitals and the threat of applying triage to decide on life (hospital care) and death became the guiding impulse behind governmental approaches towards the pandemic.

While the sanitary state focussed on the fight against the pandemic, the existence of many other diseases and health issues was ignored. Like a rabbit sitting mesmerised before the snake, governments chose to prioritise the pandemic and forgot about the short and long-term psychological and physical effects of the measures taken. While death counts related to COVID-19 have dominated, other also deadly factors and effects have been repressed, not only in the implementation of governmental measures, but also within public perception. Other needs and necessities, eg regarding education, culture or work, had to take a back seat and were downgraded in terms of societal importance by the state. The chosen

²⁸ See eg K Roach (ed), *The 9/11 Effect: Comparative Counter-Terrorism* (CUP, 2011).

²⁹ See A Jr Golia and others, 'Constitutions and Contagion – European Constitutional Systems and the COVID-19 Pandemic' (2021) 81 *ZaöRV/ HJIL* 147, 156; S Brunet, 'The Hyper-Executive State of Emergency in France', in this book; M-L Basilien-Gainche, French Response to COVID-19 Crisis: Rolling into the Deep, (*Verfassungsblog*, 18 March 2020) verfassungsblog.de/french-response-to-covid-19-crisis-rolling-into-the-deep/.

rationalisation empowered the states to swiftly regain a certain control, which has since been shaken by the occurrence of new waves of infections and variants.

The transformation towards a sanitary state occurred very rapidly. The dominant principle of liberty was exchanged for a principle of protection against the pandemic.³⁰ The sanitary state proved to be governmentally driven, restricting freedoms and focusing on disciplinary measures to minimise infections and reduce fatalities³¹ based on scientific expertise and modelling. The development of governmental reactions started with lockdowns (including penalties for lockdown breaches), added concepts of testing (thereby controlling) societies and was followed up by vaccinations. All three elements are deeply linked to economical and technical preconditions of (European) societies in the twenty-first century.³²

This chapter is not arguing in favour of an irrational approach towards denying the occurrence of a pandemic. On the contrary, liberal democracies are obliged to address health crises and to find solutions based on proportionate measures. The proportionality of the measure will be reviewed on the basis of the existing constitutional framework (especially from a rights perspective), and within the existing leeway of governance, the democratic process contributes significantly to the decision-making. Thus, the developments towards a sanitary state were confronted with the role of death and dying in the respective legal culture, which created a particular framework of conceptualising life and death.

III. Legal Thanatology: Rationalisations of Life and Death

A. Thanato Law: Governing Life and Death

As analysed in the previous chapter, death and dying are not merely a matter of fatalities anymore. Biopolitics is understood through the state's influence and access to the life and death of the population. In a democratic setting, biopolitics is transformed into state action by parliamentary decision-making. The legislator sets the agenda in bio-law and politics in manifold ways. The most significant and influential decision-making refers to the structural and budgetary dimension

³⁰ See a critical approach towards positive obligations of the state: L Lavrysen and N Mavronicola, 'Postscript Coercive Human Rights in Times of Coronavirus' in L Lavrysen and N Mavronicola (eds), *Coercive Human Rights: Positive duties to mobilise the criminal law under the ECHR* (Hart Publishing, 2020) 453–56.

³¹ Regarding the different approach in Sweden, see J Reichel and J Dahlqvist, 'Swedish Constitutional Response to the Corona Crisis – The Odd One Out' in this book; see also H Wenander, 'Sweden: Non-binding Rules against the Pandemic – Formalism, Pragmatism and Some Legal Realism' (2021) 12 *European Journal of Risk Regulation* 127, 134–42.

³² The Global South, however, struggled with these measures as the resources have not been available to the same extent; see section IV(B) of this chapter.

of the health system of the respective country. The extent of investment in the healthcare system in general and the geriatric nursing in particular reveals the role of a government's life-prolonging strategies. These measures are general and structural, and do not directly affect the lives of individuals. Their long-term effect on death and dying cannot be overestimated, since the individual possibilities deeply depend on these general decisions. Moreover, the parliamentary decision-making creates the institutional, procedural and social framework which in the end will have an impact on the life and death of individuals.

This economic dimension of the influence of death and dying in a society raises different issues, which are – most of the time – negotiated indirectly but not discussed explicitly, neither in parliament nor in public. Most importantly, life cannot be prolonged at any cost, but only to an economically reasonable extent. But where are the limits of reasonableness when it comes to the prolongation of life or the acceptance of death? The dilemma becomes even more evident when one takes a closer look. Most of the (European) states are struggling with the rising costs of their healthcare systems.³³ The reason for these increased expenses in the national healthcare systems lies in newly developed and exclusive pharmaceuticals or expensive medical equipment, which enables new forms of medical treatments.³⁴

If governments would still provide the same level of healthcare as 20 years ago, the costs of the healthcare systems would decrease, since the now outdated technology has become cheaper. The claim of (European) governments is, however, to improve the drugs or treatments provided. The dilemma of too many possibilities, which cannot be provided for the whole society, also involves a significant social problem and challenges of distributive justice (within different groups of patients). The financing of healthcare systems, both by the state and by social security systems, will finally decide on the resources available, which again will directly affect life expectancy and survival probability. Moreover, the role of private financing of the healthcare system is also crucial in many countries.³⁵

Although there is a general claim regarding individuals that every life shall be equally protected and prolonged, the opposite happens through general decision-making about the investment of resources in the healthcare system. Due to the enormous capabilities of medical care, the theoretical possibilities to prolong the lives of individuals are significant; the economic limitations, however, lead to a

³³ See T Popic, 'European health systems and COVID-19: Some early lessons' (LSE EUROPP, 20 March 2020) blogs.lse.ac.uk/euoppblog/2020/03/20/european-health-systems-and-covid-19-some-early-lessons/; see eg also European Commission, 'The 2018 Ageing Report. Economic & Budgetary Projections for the 28 EU Member States (2016–2070)', ec.europa.eu/info/sites/default/files/economy-finance/ip079_en.pdf.

³⁴ This is a greatly simplified presentation of the complex reasons for the rising costs in healthcare systems. It cannot, however, be analysed in detail here.

³⁵ Even in countries like Sweden, the role of private healthcare is on the increase; see eg C Mason, 'Public-private health care delivery becoming the norm in Sweden' (2008) 179(2) *Canadian Medical Association Journal* 129–31.

(complex) process, which prioritises and selects different forms of medical care and their financing. In the end, certain people can live longer based on these decisions, while others will die early. Thus, legislative, governmental and administrative general decision-making in a democracy has a significant impact on the life and death of people through structural, institutional and economic choices at all times.

This decision-making process cannot only be seen as an internal balancing of resources within the healthcare system.³⁶ Budgetary decision-making includes the entire dimension of budgetary negotiation of the whole government. Distribution issues concern not only the distribution of money within the healthcare system, but also that between different public duties and services. The state's investment in environmental protection, roads or schools competes with funding for new hospitals or intensive care units. The argument could even be accentuated by contrasting a budgetary investment in the healthcare system at the expense of a reduced cultural budget. The opposite is also possible: the increase of the cultural budget to the detriment of the health budget. It becomes clear that not all money can be invested in the healthcare system and that any reduction of the budget will most likely affect the lifetime of human beings in an efficient healthcare system.

Obviously, there are also other factors at play than just the financial dimension (if the money is used inefficiently, an increase in the money available might not have any direct effect on the lives of the people), which become relevant in influencing the effectivity and efficiency of the healthcare system, but the conflict of objectives remains clear. As health is a crucial, but not exclusive objective of states and societies, the political limits of the optimisation of life duration and healthcare have to be accepted. In conclusion, the state has to balance the possibilities of prolonging life with other seemingly minor public objectives. The role of existing resources in each individual case depends on the previously taken general decisions. The optimisation of the healthcare system is limited by the necessity to balance the prolongation of lives with other public interests, even if they cannot be compared from an extension of life perspective. The state is therefore guiding (in a general, not individual, dimension) the lifespans of human beings and their access to healthcare.

Parliament thus decides on life and death, which cannot be avoided; the question arises to what extent the parliamentary majority must invest in the healthcare system. Again, the possibilities of the state are more complex since different investments in the healthcare system will have different effects. The economised dimension of death creates the necessity for the state to decide on the life and death of the people in general. As will be discussed below, a

³⁶Regarding the complex budgetary consideration, see eg D Elson, R Balakrishnan and J Heintz, 'Public Finance, Maximum Available Resources and Human Rights' in A Nolan, R O'Connell and C Harvey (eds), *Human Rights and Public Finance: Budgets and the Promotion of Economic and Social Rights* (Hart Publishing, 2013) 24–55.

(social) rights perspective can contribute to the rationalisation of this decision-making to a certain extent, but remains limited when it comes to a final political conclusion.

B. Thanato Judgements I: Dignity and Autonomy of Death and Dying

Over the last decades, European, constitutional and supreme courts have become more and more involved in deciding about buying death and dying. In a micro-perspective, courts have developed case law with regard to abortion,³⁷ assisted suicide³⁸ or weighing lives in terrorist attacks.³⁹ The courts have decided on the constitutional basis of human and fundamental rights. This rights-based approach (human dignity, right to life, right to a private and family life, general right of privacy, right to equal treatment) has led to a perspective of self-determination and autonomy of individuals to decide for themselves on death and dying;⁴⁰ moreover, the balancing of different lives is partly decided (abortion) and partly understood as undecidable (downing of aircrafts). The courts have had to decide in individual cases and in many cases⁴¹ had to consider the specific circumstances of the individuals.

In a rights-optimising way, the lives of the individuals concerned have gained increased protection and the autonomy of the individual to decide about death and dying has been strengthened. Based on this concept of human dignity and autonomy, living and dying should be laid in the hands of the humans concerned.

In a prominent ruling in 2020, the German Constitutional Court decided on the right to a self-determined death, which the Court established on the basis of the general right of personality as an expression of personal autonomy.⁴² The judges argued that ‘the right to a self-determined death includes the freedom to take one’s own life. Where an individual decides to end their own life, having reached this decision based on how they personally define quality of life and a meaningful

³⁷ See, regarding recent developments, H Guimarães de Oliveira, ‘My Body, the Majority’s Choice? A Comparative Overview of Abortion Laws in Ireland and Argentina’ (*Verfassungsblog*, 3 September 2018) verfassungsblog.de/my-body-the-majoritys-choice-a-comparative-overview-of-abortion-laws-in-ireland-and-argentina/; C Lops, ‘What to expect when you’re not expecting – Abortion backlash in the US and constitutional standards’ (*Verfassungsblog*, 18 May 2019) verfassungsblog.de/what-to-expect-when-youre-not-expecting-abortion-backlash-in-the-us-and-constitutional-standards/; E Łętowska, ‘A Tragic Constitutional Court Judgment on Abortion’ (*Verfassungsblog*, 12 November 2020) verfassungsblog.de/a-tragic-constitutional-court-judgment-on-abortion/.

³⁸ See below.

³⁹ See below.

⁴⁰ See eg German Constitutional Court (BVerfG), 26.02.2020, 2 BvR 2347/15; 2 BvR 651/16; 2 BvR 1261/16; Austrian Constitutional Court (VfGH), 11.12.2020, G 139/2019.

⁴¹ In other cases (eg downing of aircrafts case of the German Constitutional Court) courts dealt with generally applicable statutory law and reviewed this act of parliament without a concrete individual complainant.

⁴² German Constitutional Court (BVerfG), 26.02.2020, 2 BvR 2347/15; 2 BvR 651/16; 2 BvR 1261/16.

existence, their decision must, in principle, be respected by state and society as an act of personal autonomy and self-determination.⁴³ The Court thereby clarified that the individual decision about life and death shall be in the hands of the individual herself.

This perspective on human dignity and autonomy can be supplemented by the example regarding the downing of aircrafts, in which the Court had to decide on the governmental killing of innocent people.⁴⁴ The German constitutional court decided that a statutory provision, which enables the downing of civil aircrafts in cases of terrorism, is unconstitutional.⁴⁵ 'Even if in the area of police power, insecurities concerning forecasts often cannot be completely avoided, it is absolutely inconceivable under the applicability of Article 1.1 of the Basic Law to intentionally kill persons such as the crew and the passengers of a hijacked plane, who are in a situation that is hopeless for them, on the basis of a statutory authorisation which even accepts such imponderability if necessary. It need not be decided here how a shooting down that is performed all the same, and an order relating to it, would have to be assessed under criminal law [...]. What is solely decisive for the constitutional appraisal is that the legislature may not, by establishing a statutory authorisation for intervention, give authority to perform operations of the nature regulated in § 14.3 of the Aviation Security Act vis-à-vis people who are not participants in the crime and may not in this manner qualify such operations as legal and thus permit them. As missions of the armed forces of a non-warlike nature, they are incompatible with the right to life and the obligation of the state to respect and protect human dignity.'⁴⁶

The German constitutional court refused to accept the weighing of lives in counterterrorism measures under uncertain circumstances and stressed the role of human dignity to protect innocent individuals, even if the risk of greater harm to an even bigger group of people could be avoided.⁴⁷ In a constitutional perspective, the statutory authorisation of the active killing of innocent individuals was rejected.

The examples presented illustrate a strong commitment to human dignity and autonomy of individuals, which shall prohibit statutory law and administrative action to risk the life of individuals. The courts claim the necessity of the state to intervene to protect life, and to abstain from an intervention which actively leads to the death of individuals, as long as dying is not part of the individual's autonomy, freedom and self-determination. This foundation of liberal societies can, however, not provide a solution regarding the use and distribution of resources for healthcare.

⁴³ *ibid.*

⁴⁴ See German Constitutional Court (BVerfG), 15.02.2006, 1 BvR 357/05; O Lepsius, 'Human Dignity and the Downing of Aircraft: The German Federal Constitutional Court Strikes Down a Prominent Anti-terrorism Provision in the New Air-transport Security Act' (2006) 7 *German Law Journal* 761–76.

⁴⁵ See German Constitutional Court (BVerfG), 15.02.2006, 1 BvR 357/05.

⁴⁶ *ibid.*

⁴⁷ *ibid.*

C. Thanato Judgements II: Enabling Life, Avoiding Death

i. *State's Obligations and Equality Rights*

While liberal rights empower the individual to make autonomous decisions, they do not enable the balancing of lives when human dignity prohibits further argumentation. While European states have been hesitant to implement social rights in their constitutions, the Sozialstaat principle⁴⁸ has been introduced in many constitutions and the courts have been ready to activate it.⁴⁹ Moreover, positive obligations of the state have been used to introduce social rights guarantees. These guarantees include certain minimum requirements to protect life (eg, providing criminal prosecution),⁵⁰ prohibit inhumane treatment and enable private life (eg, right to health).⁵¹

An example can be used to illustrate how rights-based judgements increased the state's responsibility to guarantee a dignified life and limit the possibilities of death and dying. In the case *Paposhvili v Belgium*, the Grand Chamber of the ECtHR unanimously decided that the applicant, an asylum seeker suffering from leukaemia, pulmonary tuberculosis and hepatitis C, could not be legally deported to Georgia in accordance with Article 3 ECHR.⁵² The Court stated that in very exceptional cases Article 3 ECHR also protects aliens suffering from an illness against removal on humanitarian grounds: '[...] the applicant had been in greater need of protection owing to his particular vulnerability linked to his state of health, the stakes in terms of his life and physical well-being, his emotional and financial dependency and the existence of his family ties in Belgium. The Belgian State's responsibility under Article 3 of the Convention stemmed from the fact that it was proceeding with the applicant's removal without taking these factors into account, thereby demonstrating a lack of respect for his dignity and placing him at serious risk, in the event of his return to Georgia, of a severe and rapid deterioration in his state of health leading to his swift and certain death.'⁵³ Although the Georgian government intervened and argued that an extensive programme of universal medical cover had been implemented, the ECtHR introduced a prohibition of deportation due to the health situation of aliens.⁵⁴

⁴⁸ See eg W Heun, *The Constitution of Germany: A Contextual Analysis* (Hart Publishing, 2010) 44–45; JA King, 'Social Rights, Constitutionalism and the German Social State Principle' (2014) E-Pública: Revista Electronica de Direito, available at discovery.ucl.ac.uk/id/eprint/1472218/1/J%20King,%20Social%20Rights.pdf.

⁴⁹ C O'Cinneide, 'Austerity and the faded dream of a "social Europe"' in A Nolan (ed), *Economic and Social Rights after the Global Financial Crisis* (CUP, 2014) 169, 174–77.

⁵⁰ L Lavrysen, 'Positive Obligations and the Criminal Law: A Bird's-Eye View on the Case Law of the European Court of Human Rights', in Lavrysen and Mavronicola (n 30) 62–98.

⁵¹ M-A Kolliniati, *Human Rights and Positive Obligations to Healthcare: Reading the European Convention on Human Rights through Joseph Raz's Theory of Rights* (Nomos, 2019) 167–227.

⁵² ECtHR 13 December 2016, *Paposhvili v Belgium*, Application no. 41738/10; see also V Stoyanova, 'How Exceptional Must "Very Exceptional" Be? Non-Refoulement, Socio-Economic Deprivation, and Paposhvili v Belgium' (2017) 29 *International Journal of Refugee Law* 580–616.

⁵³ *ibid.*, para 148.

⁵⁴ *ibid.*

Going a step further, the right to equal treatment can be understood as a foundation to rationalise distribution issues. The obligation to justify decisions, to create the non-discriminatory availability of and access to medical support or to develop fair distribution of medicine can be derived from the right to equality.⁵⁵ It can therefore serve as a legal basis to improve healthcare in countries. It helps to create fairness within a healthcare system, but cannot, however, resolve questions of balancing different budgetary preferences of the parliament (government).

ii. Right to Health in India

State obligations stemming from liberal rights have led to the establishment of social rights case law, which has contributed to the balancing of different state objectives. In other countries, constitutional law already explicitly provides social rights. The case law of India, South Africa and Colombia can be consulted regarding the right to health.

Article 47 of the Indian Constitution contains an obligation of the state to improve public health.⁵⁶ Starting with the *Mullin* Case in the 1980s, the Indian Supreme Court derived the right to health from the right to life.⁵⁷ The Supreme Court stated the obligation to access pharmaceuticals and treatment which linked Article 47 and the right to life.⁵⁸ In the 1990s, the Supreme Court conceded that 'the obligation of the state to provide medical aid to preserve human life could not be disregarded because of financial constraints of the state'.⁵⁹ The Indian courts enabled the reduction of costs for HIV medicine (at least to a certain number of people). The judgment has only had a limited effect on the individuals concerned as quantity and access have been severely restricted. The courts enabled reimbursement of medical expenses to employees.⁶⁰ It is important to know that '[c]ommunicable diseases, maternal, perinatal, and nutritional disorders are responsible for 38 percent of deaths in India'.⁶¹

In *Ram Lubhaya Bagga*, the Supreme Court looked to balance financial constraints of the state with its obligation to improve public health by facilitating access to quality health care facilities, goods, and services in a private hospital.⁶² The Court, however, recognised that the right to health was subject to the state's

⁵⁵ A Grover, M Misra and L Rangarajan, 'Right to Health: Addressing Inequities through Litigation' in CM Flood and A Gross (eds), *The Right to Health at the Public /Private Divide* (CUP, 2014) 445.

⁵⁶ *ibid*, 431.

⁵⁷ *ibid*, 432; *Francis Coralie Mullin v The Administrator, Union Territory of Delhi*, A.I.R. 1981 S.C. 746 (India).

⁵⁸ A Grover, M Misra and L Rangarajan, 'Right to Health: Addressing Inequities through Litigation' in Flood and Gross (n 55) 435.

⁵⁹ *ibid*, 437; see *Paschim Banga Khet Mazdoor Samiti v State of West Bengal* (1996) 4 S.C.C. 37 (India).

⁶⁰ PB Mehta and S Shankar, 'Courts and Socioeconomic Rights in India' in V Gauri and DM Brinks (eds), *Courting Social Justice: Judicial Enforcement of Social and Economic Rights in the Developing World* (CUP, 2008) 146, 157.

⁶¹ A Grover, M Misra and L Rangarajan in Flood and Gross (n 55) 424.

⁶² *ibid*, 440; *State of Punjab v Ram Lubhaya Bagga* (1998) 1 S.C.R 1120 (India).

'economic capacity and development. Distinguishing this case from Mohinder Singh Chawla, the Court held that as the policy had been reformulated, the respondent employee could not claim benefits under the old policy'.⁶³ The Court thereby limited 'the right to access of quality treatment based on the state's alleged financial constraint'.⁶⁴ The budgetary limitations of the rationalising effects of social rights became evident. A similar situation could be observed in South African case law.

iii. Social Rights in South Africa

In South Africa in 1998, 40 per cent of the population were under the poverty threshold and 40 per cent were unemployed. Poverty and unemployment levels have become worse since then.⁶⁵ 80 per cent of the population were still dependent on the public healthcare sector in 2008.⁶⁶ The share of the total government budget spent on the healthcare sector decreased from 11.5 per cent to 8.75 per cent from 2000 to 2010. Life expectancy fell to 43 years and infant mortality increased,⁶⁷ with HIV proving to be the main cause for these devastating developments.⁶⁸

Section 27 of the South African Constitution explicitly provides for a right to health, which includes that '[e]veryone has the right to have access to health care services' and the obligation that the 'state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights'. In the famous *Grootboom* case, the South African Constitutional Court recognised with regard to the right to access adequate housing (section 26) 'that the state could not be required to do more than available resources permit, and that while resources would determine the content and pace of realization, the government nonetheless should give adequate budgetary support to social rights, and plan and monitor efforts to meet all needs. The Court found that national housing policy fell short of the government's constitutional duties, and declared that section 26 required a comprehensive program to realize the right to access to adequate housing'.⁶⁹ In the TAC (Treatment Action Campaign) Case, the Court found that 'state policy to be unreasonable and held that excluding the drug in question in public health care facilities pending study results unreasonably denied a potentially life-saving drug to children born to mostly indigent mothers

⁶³ A Grover, M Misra and L Rangarajan, 'Right to Health: Addressing Inequities through Litigation' in Flood and Gross (n 55) 441; *State of Punjab v Mohinder Singh Chawla* (1997) 2 S.C.C 83 (1996) (India).

⁶⁴ A Grover, M Misra and L Rangarajan, 'Right to Health: Addressing Inequities through Litigation' in Flood and Gross (n 55) 441.

⁶⁵ L Forman and JA Singh, 'The Role of Rights and Litigation in Assuring More Equitable Access to Health Care in South Africa' in Flood and Gross (n 55) 291.

⁶⁶ *ibid* 293.

⁶⁷ *ibid*, 300.

⁶⁸ *ibid*, 301.

⁶⁹ *ibid*, 308.

dependent on the state for their health care. The Court focused on the grave suffering and limited survival prospects of these children, and stressed that the case was concerned with newborn babies whose lives might be saved by the administration of simple and cheap intervention, the safety and efficacy of which had been established, and which the government itself was providing in pilot sites in every province.⁷⁰ While the Court in the beginning was willing to extend social rights, the Court's approach in the *Mazibuko* case in 2009, however, raised concerns about whether it was willing to enforce them.⁷¹ The financial dimension of state expenses seemed to become relevant; moreover, the Court limited the extent of state obligations, which seemed to cease at a certain level without the possibility for the individual to gain the relevant resources.

In contrast to these developments in South Africa, the Colombian Constitutional Court went one step further and started to enforce the right to health in a way which significantly affected the state's budget and governmental leeway in deciding about resources.

iv. Colombian Conflicts on the Right to Health

In Colombia, where the right to health was established by the Constitutional Court interpreting the right to life,⁷² the Court extended and enforced the right to health to a significant extent. In the Case SU-480/97,⁷³ the Court 'ruled that a private insurance company had to provide "excluded" antiretroviral medication to a plaintiff living with HIV/AIDS, because his life was at stake.'⁷⁴ In its case T-760/2008, the Colombian Constitutional Court outlined the necessary strategy of the legislation and government to resolve structural problems regarding the right to health in Colombia. These reforms refer to the 'baskets of health services, the unification of the subsidized and contributory regimes, and the improvement of the health system's financial arrangements and universal coverage of the social security system.'⁷⁵ Consequences have been a unified basket of health services as well as a price-regulation of pharmaceuticals.

This case law led to an escalation of a conflict regarding the budgetary consequences of the right to health between the President and the Constitutional Court. The President declared an 'economic state of emergency' and enacted decrees opposing the Court's case law. The Constitutional Court, however, declared these decrees to be unconstitutional.⁷⁶ In many cases, the Constitutional Court has

⁷⁰ *ibid*, 309.

⁷¹ *ibid*, 316.

⁷² C Prachniak-Rincón and J Villar de Onís, 'HIV and the Right to Health in Colombia' (2016) *Health and Human Rights Journal*, www.hhrjournal.org/2016/10/hiv-and-the-right-to-health-in-colombia/.

⁷³ Colombian Constitutional Court, 25 September 1997, SU-480/97.

⁷⁴ E Lamprea, 'Colombia's Right-to-Health Litigation in a Context of Health Care Reform' in Flood and Gross (n 55) 131, 143.

⁷⁵ *ibid*, 146.

⁷⁶ *ibid*, 148.

awarded costly pharmaceuticals and procedures despite the fact that there is not enough medical or scientific evidence to conclude that they are the most effective medical treatments for the plaintiffs.⁷⁷ Expenditure on pharmaceuticals increased to 3.15 per cent of GDP in 2009;⁷⁸ 20 high-end pharmaceuticals produced by international corporations were responsible for 45 per cent of the overall expenditure. The solution was found in the price regulation of pharmaceuticals.

The Colombian example illustrates the possibilities to enforce the right to health, but also the limits of the possibilities for rationalising the decision-making process of state governments by social rights.

v. The Rationalising Effect of Social Rights and its (Budgetary) Limits

While exemplifying the case law on the right to health, it is important to note that many social rights have an effect on life and death, including rights satisfying basic needs like the right to housing, right to food or the right to water. The impact on life expectancy of an effective right to education can also not be overestimated.

Social rights demand that the state deals with certain issues and develops state programs. They support the rationalisation of social support, eg prioritising the poorest of the poor; social rights strengthen the establishment of state welfare institutions and economic obligations to reimburse the costs of pharmaceuticals. They also help to support certain healthcare measures. They are not limited to matters concerning the state's budget, but primarily influence the compliance of the government with legislative obligations and are able to change the role and possibilities of private actors (eg, pharmaceutical companies).

Social rights first of all provide a bottom line, a minimum level which has to be guaranteed by the state. This minimum level contributes to the rationalisation of basic public services and can develop certain substantial guarantees. The function of social rights is still not to decide upon the entire state budget (instead of the parliament or the government); on the contrary, social rights present a claim to dedicate a certain amount of the budget to certain state objectives. This does not resolve the conflict between different state objectives.

The financial crisis of 2008 followed by austerity programmes, eg in Southern Europe, showed the limits of social rights approaches, which were limited by economic restraints at the expense of the healthcare system.⁷⁹ Even without state cuts in the healthcare system, people had to reduce their standard of living, which necessarily affected their health, while the recession also had a negative impact on mental health.⁸⁰ Cost-cutting by the state had even greater effects. Spain's

⁷⁷ *ibid*, 151.

⁷⁸ *ibid*, 149.

⁷⁹ NJ Lusiani, 'Rationalising the right to health: is Spain's austere response to the economic crisis impermissible under international human rights law?' in Nolan (n 49) 202–33.

⁸⁰ *ibid*, 207.

cutbacks due to an austerity programme in 2012 profoundly affected the healthcare system.⁸¹ The Spanish government excluded non-citizens, such as irregular immigrants, from access to the Spanish healthcare system; 0.5 m people lost access to healthcare.⁸² People earning less than €18,000 had to pay 40 per cent of the pharmaceutical costs on their own.⁸³ The cuts in state expenses had an effect on people's life expectancy, since access to healthcare and pharmaceuticals was limited (especially excluding poor and helpless people in a discriminatory way).⁸⁴ People's lives counted for little, when pure economic savings were considered more important. Strong social rights case law could prevent the worst in such situations.⁸⁵

IV. No Bailout – The Role of Death in the COVID-19 Pandemic in Liberal Democracies

A. Different Approaches towards Death in European Democracies

The COVID-19 pandemic has shown that European countries, despite investing billions, cannot resolve this health crisis only financially. Lockdowns combined with enormous state aid, investments in pharmaceutical industries and financial support for businesses are not sufficient to deal with all the challenges posed by pandemics. The COVID-19 pandemic demonstrates that many difficult trade-offs between infections and fatalities on the one side and freedoms and liberties on the other side are necessary. The closure of societies might be a short-term strategy to prevent an explosion in infection rates, but it cannot serve as an overall solution. Parliaments and governments decide on death rates by choosing their responses to the pandemic. Although certain measures did prove to be highly successful (when compared to the possibilities some decades or even centuries ago), the attempts to control a pandemic revealed their limits. Different approaches (eg, Sweden, Germany, Hungary or Italy) illustrate that, during a pandemic, decisions are made that will have effects on life and death of the people.

Avoiding death is not the only objective of a democratic society and it has to be integrated into more comprehensive governmental strategies. Although democracies promise to support the prolongation of citizens' lives, they also have to accept increased fatalities in order to enable other liberties during a pandemic

⁸¹ *ibid.*, 208–09.

⁸² *ibid.*, 214, 217.

⁸³ *ibid.*, 215.

⁸⁴ *ibid.*

⁸⁵ See eg the developments in Portugal: M Canotilho, T Violante and R Lanceiro, 'Austerity measures under judicial scrutiny: the Portuguese constitutional case-law' (2015) 11 *European Constitutional Law Review* 155–83.

(eg, education, business, religion, culture or freedom of movement). Interestingly, different European societies enabled different liberties (eg, culture in Spain,⁸⁶ religion in Austria,⁸⁷ education in Sweden⁸⁸). These prioritisations affected death rates. The question arises to what extent this balancing of objectives has been adequately discussed in public during the COVID-19 pandemic.

Decisions about life and death have to be accepted in democratic societies, but should not be concealed. Negotiating death rates does not create an inhumane society, but simply implies an acceptance of death as a part of life. Concealing these decisions does not mean that they are not made. European societies in the twenty-first century have to learn to accept that the (technological, medial, etc) opportunities which have arisen in the last centuries and decades, also come with the responsibilities to make decisions which will have corresponding consequences.

B. International Perspectives on the COVID-19 Pandemic

While the protection of life and health seem to be the domestic motivation of European governments, the international ambition of European governments to save lives and fight pandemics was already limited before the COVID-19 crisis started. The underfunding of the WHO can be seen just as a symbol.⁸⁹ While statistical data for COVID-19 fatalities is observed and presented on a daily basis (including about 1.82 m deaths in 2020),⁹⁰ statistics concerning other diseases which are not significantly relevant in Europe are not even known (eg, tuberculosis, which caused about 1.4 m deaths globally in 2019,⁹¹ is responsible for around 100–150 deaths in Germany every year).⁹² Although an investment of not even a thousandth of the money spent in COVID-19 times would have helped to prevent millions of deaths from other diseases, this funding was not provided by European governments. While the (post-)colonial bias still exists, the motivation to fight the COVID-19 pandemic is primarily owed to their own people (focussing on domestic democratic considerations, while the focus on human dignity seems of secondary importance and stops at the domestic borders).

But also within the European borders, we turn from thanato- to necro-law during a pandemic by excluding irregular migrants and other people without a

⁸⁶ See www.ft.com/content/9e6795d5-438c-410b-ae6d-259b77d639db.

⁸⁷ See K Lachmayer, 'Muddling through Mutation Times or the Return of Federalism in Austria: From Covid-19 Response to the Vaccination Campaign, (*VerfBlog*, 8. May 2021) verfassungsblog.de/muddling-through-mutation-times-or-the-return-of-federalism-in-austria/.

⁸⁸ See eacea.ec.europa.eu/national-policies/eurydice/content/sweden-keeps-schools-open-during-covid-19-pandemic-results-situation_en.

⁸⁹ See eg www.nature.com/articles/d41586-020-01121-1.

⁹⁰ See ourworldindata.org/covid-deaths.

⁹¹ See www.who.int/news-room/fact-sheets/detail/tuberculosis.

⁹² See www.rki.de/EN/Content/infections/epidemiology/inf_dis_Germany/TB/summary_2018.html; see also L Fiebig and others, 'Tuberculosis in Germany: a declining trend coming to an end?' (2016) 47 *The European Respiratory Journal* 667–70.

valid permit from access to the healthcare system. When intensive care units in hospitals are only open to regular residents and vaccines are only available for such people, the legal system is already choosing between life and death and creates necro-law, in which the irregular migrant is doomed to die if her physical condition is not good enough.⁹³

In the COVID-19 crisis, the limited global solidarity was even intensified by a 'nation-first' concept regarding vaccines. Although EU member states created a common approach towards vaccination (one exception is Hungary),⁹⁴ the global dimension was represented in a very limited way in the approaches of European governments. While biopolitical decision-making in the EU was concealed, the international effects of European necro-politics were ignored still further. The usual double standards have been applied. While resources of the global south are used by the global north, the vaccine deals are still based on IP law.⁹⁵ The economised dimension of the pandemic enabled many⁹⁶ European states to use enormous economic resources to fight against the pandemic with huge investments, while other states were left to their own devices. Death and dying in the north therefore differ from in the south.⁹⁷

V. Conclusion

Discussions about death in democratic societies do not mean unleashing politics in an inhumane way, so that each group tries to create benefits for themselves. Creating medical possibilities (based on an economised use of new technologies) requires the assumption of responsibility. Democratic debates about death and dying start with the acceptance of death as a negotiable objective. Discussions about death presuppose discussions about its complex implications. In the COVID-19 pandemic, it means not only looking at COVID-19 fatalities, but at all the other people affected by deadly dangers (such as suicides, homelessness and other diseases) as well.

⁹³ See M Mallet-Garcia and N Delvino, *Migrants with irregular status during the COVID-19 pandemic: Lessons for local authorities in Europe*, Working Paper 2020, available at www.compas.ox.ac.uk/wp-content/uploads/CMISE-Impact-of-COVID-on-access-to-services-for-irregular-migrants.pdf; Open Society Foundation (2020), 'COVID-19 and Undocumented Workers', available at www.opensocietyfoundations.org/explainers/covid-19-and-undocumented-workers.

⁹⁴ See eg www.reuters.com/article/us-health-coronavirus-hungary-russia-idUSKBN29R0WB, www.nytimes.com/2021/03/11/world/hungary-sinopharm-covid.html.

⁹⁵ But see the discussion by US president Biden on the suspension of patents of COVID-19 vaccines; see eg www.nytimes.com/2021/05/05/us/politics/biden-covid-vaccine-patents.html.

⁹⁶ The different economic and budgetary preconditions of the different European states shall not be ignored.

⁹⁷ The Asian developments in the pandemics demonstrate that other experiences with pandemics as well as cultural approaches can also lead to efficient measures. See VV Ramraj and M Little, 'A Short History and Thematic Overview' in VV Ramraj (ed), *Covid-19 in Asia. Law and policy contexts* (OUP, 2021) 3, 14–16.

A public debate on death has to include science and scientific results in the decision-making process, but finally requires a political decision by democratic, accountable institutions.⁹⁸ Governments should still act on the basis of acts of legislation which do not decide on individual fatalities, but rather according to general (financial and institutional) preconditions. The limits of political decision-making arise from human rights, especially the concept of the right to health and the protection of the right to life. Learning from the global south will be an indispensable pre-condition to advancement in a European discourse on the rationalisation of these processes. Within these limits, biopolitics in democracies will be revealed, but should uphold the accountability of the decision-makers.

The COVID-19 pandemic illustrates the difference between rationalised and irrational approaches. The economic costs, limitations of freedoms and death rates in countries like Brazil have been even higher.⁹⁹ The different approaches of European countries also reveal that there is not only one possible solution to a pandemic. This, however, does not take away the global responsibility of European governments in the post-colonial settings which we still face.

This chapter argues that it is necessary to understand death and dying as a core issue of public debate in democracies, which are not only negotiated by (supreme/constitutional) courts regarding individual rights and liberties, but also as part of a societal *conditio humana*, which is deeply rooted in the particular culture (including the understanding of death, the way of living and resulting legal framework) of death and dying. In that regard, the balancing of liberty and death requires a public debate to reinsure an open society in a liberal democracy.

⁹⁸ Death and dying in a democracy are not only about rights and politics, but also about care and compassion; see PW Kahn, 'Democracy and the Obligations to Care: A Demos Worthy of Sacrifice' in M Poiars Maduro and PW Kahn (eds), *Democracy in Times of Pandemic: Different Futures Imagined* (CUP, 2020) 196–207.

⁹⁹ See with regard to the executive underreach, KL Scheppele and D Pozen, 'Executive Overreach and Underreach in the Pandemic' in Poiars Maduro and Kahn (n 98) 38, 43–47.