03 2020

On Quarantines, Oikonomia and the Clinamen

Angela Mitropoulos

Introduction

Below are two texts. Most of the first, “Against Quarantine,” was written in late January and originally published in *New Inquiry* in mid-February. The second, much shorter text was written in mid-March as a postscript to *Contract and Contagion: From Biopolitics to Oikonomia* (2012).

The first text addresses the growing recourse by governments to quarantine measures. It argues that quarantines are ineffective in slowing the spread of the virus, but nevertheless effective in promoting a racialised understanding of health and disease and, moreover, one that converges with both privatised healthcare and authoritarian governance.

The emphasis placed on border closures and travel bans was a distraction from other, effective measures—such as widespread testing and case isolation, increasing healthcare capacity and coverage, information about handwashing, distancing and the use of masks. That a number of governments did not prioritize these is nothing less than racist-induced complacency, as if Europeans were

immune from something that was perceived and described as a 'Chinese virus.'

What I did not anticipate at the time of writing—though the distinction is made clear in the text—is the extent to which some would insist on confusing case isolation with quarantine. Case isolation depends on widespread testing and infrastructures of care. Quarantines treat geography as a proxy for identifying infections. The terrible circumstances of cruise ships (such as the Diamond Princess) or that of people in prisons and detention camps should serve as a stark warning against confusing the isolation and care of confirmed cases with measures to stop the spread of infections.

As for the detail in this text: As more has become known, the number of those with underlying health issues in Wuhan's Jinyintan Hospital rose to around 90% (from the over 50% mentioned below). Additionally, there is ongoing debate over the how long prior to showing symptoms someone infected with the virus is contagious.

It is important to be accurate, not least because the key antagonism is at present between those who want to save lives and those who want to defend a Way of Life, or sacrifice the lives of others for the sake of 'the economy.'

The only thing that has been changed in the first text from the original version is the adoption of more recent nomenclature: SARS-Cov2 (the virus) has replaced COVID-19 (the name given to the diseases with which the virus is associated).

The second text—the postscript—may seem opaque to those who have not read the book, but it nevertheless underlines the extent to which many governments are increasingly seeking to displace the risks of disease and the burdens of healthcare onto private

households—that is, accelerating the endogenous turn from neoliberalism to fascism described in *Contract and Contagion*. Flattening the epidemiological curve (the rate of infections) is crucial, but doing so without growing infrastructures of care will simply displace the burden onto the uneven foundations of inherited familial wealth, not to mention the gendered-raced divisions of labour that underpin what is often described as the work of social reproduction.

The text briefly alludes to the increasing confidence of Malthusian and ecofascist responses—calls for a 'culling' of the weak, for sacrifices in the name of 'the economy,' or for depopulation and disposability. These must be rejected, but they cannot rigorously be countered by falling back on oikonomic (nationalist, racial or gendered) understandings that share their assumptions about what 'the economy' means. That will require another kind of swerve, and a reminder that no strike requires a mass demonstration in order to be effective.

Against Quarantine: How responses to the new corona virus territorialize disease and capitalize on a virus

The genetic identification of a novel strain of coronavirus (2019-nCoV) in Wuhan, China, in early December 2019 appears to have entrenched a recourse to quarantine measures around the world. Wuhan, a city of over 11 million people, has been placed in a lockdown, borders have been closed, and a number of governments have instituted selective travel restrictions and prohibitions based on citizenship and legal status—including suspending visas to anyone with a Chinese passport.

NCoV—since renamed SARS-CoV2—is a serious health issue, particularly for those already suffering from chronic and respiratory diseases. The effectiveness of quarantines, however, is doubtful, raising the question of what value there is to quarantines if it's not public health.

There is political value in the quarantine for those who implicitly believe biological-racial purity is a condition of health, but there is also financial value in substituting a social approach to health and illness with a selective, nationalist model conducive to the development of patented treatments and private health insurance.

For some, the quarantine rationalizes xenophobia and calls for ethnonationalist separation. The United States government has imposed a travel ban—or, more accurately, significantly expanded its obsession with restricting the movements of nonwhite people. Drawing on a long history of anti-Chinese sentiment, the Australian government has prohibited the entry of noncitizens from China and proposed to transport Australian citizens—many of whom will have traveled to China to celebrate the New Year with relatives—directly into a period of confinement at the immigration detention center on Christmas Island. While major hospitals on the mainland are equipped to handle serious diseases and pandemics, the island detention center is not—and so, if anyone quarantined develops the disease, they will have to be flown to a major city hospital for treatment in any event. The effect of these policies on some 200,000 students (a proportion of whom are returning from China for the new academic year in Australia) is unclear but will be enormous. Some universities around the world have mandated a period of dormitory confinement; others—such as UC Berkeley—issued advisories implying that xenophobia was an understandable response (since retracted under pressure).

As with the extralegal approach pursued by the Australian government, the Philippines government has proposed the use of military facilities on Caballo Island and Fort Magsaysay as quarantine zones. The Russian government has moreover threatened "the deportation of foreign citizens if they have such a disease." This use of citizenship status as a proxy for detecting COVID19 is likely to ensure noncitizens avoid seeking treatment for associated symptoms—and it is, in any event, unclear how deportation might minimize the spread of the virus.

These practices highlight what Howard Markel describes as "quarantine's aggressive potential for harm." The harm is—as Markel suggested in his history of the treatment of East European Jewish immigrants in New York at the end of the 19th century—exacerbated for those who happen to find themselves on the "other" side of a quarantine border; its spread cannot be restricted along those lines because a virus is neither synonymous with a group of persons nor can it be identified by a passport.

While the World Health Organization declared SARS-Cov2 a serious health emergency, it advised against closed borders as an effective means of handling the virus. It warned that "closing borders was probably ineffective in halting the transmission of the deadly novel coronavirus from China and could even accelerate its spread," in part because punitive approaches make it that much more difficult for health workers to treat cases and track the spread of diseases.

Immigration detention emerged from the intertwined histories and techniques of quarantine confinement and prisons. For most of the 20th century, the use of the cordon sanitaire (or "sanitary cordon") as a public-health measure had largely disappeared—relegated to agricultural protocols at airports and ports but otherwise lingering

as the metaphorical accessory of racializing policy—as I discuss throughout my book *Contract and Contagion* (122, 131-332).

The reappearance of the cordon sanitaire since the late 20th century has occurred at the intersection of a number of changes. It has reemerged after decades of a decline of social understandings and treatments of health and disease—or, the privatization of health and the socialization of disease. Further to this, the development of genome sequencing and bioinformatics has made it possible to identify new strains of virus; yet while genetic identification may be important in the development of treatments for some diseases, the ability to identify and map new strains does not imply some postmodern quickening in rates of microbial mutation. And, not least, the resurgence of far-right politics around ethnonationalism and anti-immigrant sentiment have given credence to the fantastical idea that biological purity is a condition of health and life.

In what follows, I want to underline four interconnected points:

First, claims that quarantines are effective in containing the spread of viruses such as SARS-Cov2 or improving rates of survivability are debatable. The general view is that they are counterproductive.

As for the aesthetics that bolster the apparent urgency of quarantine measures: Mathematical models of contagions might furnish dramatic, speculative visualizations of fractal spreads that are able to be restrained by the presumably solid lines of national borders—but they are not real-world, field-tested exercises. Similarly, the terms and numbers used to describe emerging transmissible diseases have become intense conduits of misinformation, as with the reception of the basic reproduction number, or R0. Treated by researchers as a useful but provisional

numerical estimate for developing hypotheses about rates of infection, the initial circulation of one such R0 on social media was greeted as if it were evidence of an unfolding apocalypse. Moreover, the use of non-symptomatic proxies (such as nationality) as a means of detecting SARS-CoV2 was briefly promoted by the publication of a report which suggested that asymptomatic transmission was possible, but that study has "proven to contain major flaws and errors," and wrong in its conclusions.

Measures other than quarantine have been found much more effective in preventing widespread contagion. In a lengthy review of the research on the comparative effectiveness of a number of measures (short of vaccines and antiviral drugs) to prevent the transmission of respiratory viruses—screening at entry ports, medical isolation, quarantine, social distancing, barriers, personal protection, and hand hygiene—the use of surgical masks and regular handwashing emerged as the most consistently effective set of physical interventions. The review also found that the medical isolation of symptomatic patients was important but that "global measures, such as screening at entry ports, led to a non-significant marginal delay."

As one scholar from the Johns Hopkins Center for Health Security has put it, "no one should think that there won't be more cases" simply because there is a travel ban.

Yet even if one were to grant the dubious assumption that the transmission of diseases might be halted (or meaningfully slowed) through territorial restrictions on people's mobility, the genomic identification of a new strain of virus—while accelerated by the introduction of automated genome sequencing—would invariably occur subsequent to its appearance. In any event, expenditure and focus on quarantine restrictions tend to represent a redirection of

resources away from measures likely to be more effective in both the immediate and longer term.

That is, quarantines often exacerbate viral dangers, because they foster the illusion that the isolation of a virus is synonymous with (or achievable through) the territorial confinement of groups of people, whose confinement is determined not by whether they are symptomatic or diagnosed with a disease but by a purportedly preemptive measure that uses nationality and geography as a proxy for exposure.

Second, the resort to quarantines draws on the biological-racial understanding of nations as discrete organic entities and prevents or displaces a social understanding of health and disease. Quarantines promote the imagination of a conflict between the preservation of presumably well-defined biological categories (the human, the family, the nation, the race) and the viral proliferation of boundary-blurring contagions.

It is however doubtful that humans could have evolved without the species-jumping, recombinant action of bacterial genetics transmitted through viral infections. More to the point, all vaccines involve the modified administration of an infection, and immunization is only effective at the largest (rather than national) population scales.

While some media attention has focused on Wuhan's "wet markets" as the scene of species jumping, the privatization of health care and the socialization of ill-health remains largely ignored as a contributing factor in both infection and mortality rates. As a recent study shows, just over half of those infected with SARS-CoV2 in Wuhan's Jinyintan Hospital had prior underlying

chronic illnesses—such as cardiovascular or cerebrovascular diseases, respiratory-system diseases, or malignant tumors.

Further, China's public health-care system was dismantled in the 1980s. This occurred during a period of rapid, fossil-fueled economic changes—and precipitated an enormous rise in (untreated) chronic illnesses, in particular respiratory, cardiovascular, and cardiopulmonary diseases, in a city with some of the worst air pollution in the world. Its air quality has an annual average PM2.5 concentration of over 120µg/m3. By way of comparison, the WHO stipulates an annual average below 10µg/m3, above which total, cardiopulmonary, and lung-cancer mortality have been shown with more than 95 percent confidence to increase.

Around 97 percent of the deaths presently attributed to SARS-CoV2 around the world have been recorded in Wuhan. China's decentralized, commercially oriented health system and the lack of health-care coverage have, in all likelihood, worsened the impact of any single disease—as some have argued they already did during the SARS outbreak.

It may be that the recent construction of dedicated hospitals represents an effort by parts of the Chinese government to expand health-care and insurance coverage—albeit under the administrative control of the military. Which is to say, it is also part of the evolution of a system in which increasingly precarious populations can only access what should be routine health care through their involvement in experimental emergency procedures—which may or may not increase their chances of recovery, but in which they bear most of the risks of (eventually) patented vaccine or other drug or biotechnical developments.

Meanwhile, the shares of a U.S. biotechnology company, Gilead Sciences, spiked after reports that it would be launching a trial of its antiviral drug (remdesivir) on some 270 patients in China who developed mild to moderate pneumonia after having been infected with SARS-CoV2. The WHO recently advised that there is as yet no evidence for the effectiveness of antiviral treatments. Some treatments may yet prove to be effective. But at present they are experiments, speculative endeavors that leverage desperation and are oriented toward the growth of private markets in patented drugs. Moreover, while the open sourcing of data is crucial to health care, there are few if any impediments to its mining for commercial products at a consequently lowered cost.

As a consequence of these and other mutually reinforcing systems, there is a broad financial value in substituting a social model of health and disease—which involves a complex understanding of disease transmission and the factors that contribute to illness and mortality rates—with a reductive model amenable to private insurance, the subsidized development of patented drugs or treatments, and the continuing externalization of the downward risks of harmful industries and practices that contribute to ill-health and mortality.

Third, therefore the combination of the declared emergency, quarantine confinement, and lower regulatory standards significantly diminishes the cost of human drug trials and inflates the value of and market for patented drugs. There is commercial value for biotechnology and pharmaceutical companies in (speculations on) the development of patented vaccines, antivirals, or broad-spectrum antibiotics through the spatial delineation and immobilization of a cohort of research subjects.

Indeed, the collapse of public health care in China was accompanied by the introduction of a system in which hospital administrators were permitted "to profit-earn from new pharmaceuticals and medical technologies (after strong lobbying by the relevant multinational corporations), with salary bonuses for the staff involved." There are a range of industries and practices that can leverage quarantines for gain—the military, detention or security contractors, and those organizations that combine these things with quasi-medical emergency response teams.

As it happens, the Australian government has required anyone interned at Christmas Island to sign a waiver—presumably one that indemnifies the government and the private contractors who manage the facility in the event that internment results in infection or other health issues. In other words, the quarantine on Christmas Island will be little more than a means of observing people who are confined for the average time that it takes SARS-CoV2 to incubate—if, that is, the virus is present among those detained. It is difficult to see how this exercise might be distinguished from the techniques that would develop a virus among a group of test subjects, whose progression could be mined for data—given that anyone who falls ill, in any way, will have to be moved to a large hospital on the mainland for treatment.

Fourth, and finally, there is political value—for some—in forging a seeming consensus around the purported necessity and urgency of authoritarian population-control measures and restrictions on mobility, one that both is grounded in and fosters the stigmatization of groups of people through a territorial-national, and therefore racialized, association with a disease.

By way of a summary, this recent history of quarantine measures does not exactly replicate the cordon sanitaire of earlier centuries.

The practical importance of virology in the development of the biomedical and pharmaceutical industries means that quarantine zones are not outside circuits of value, even while the quarantine acts as a means of segregation. The contemporary quarantine represents a merger between the authoritarian governance of populations and the facilitation and growth of private, selective health-care infrastructure. Given the importance of nonselectivity and scale to public health, nationalist approaches to health are more accurately described as a way of privatizing public health by other means.

Postscript to Contract and Contagion

When every home becomes a quarantine zone, and every epidemiological map is mistaken for an accurate representation of molecular spread, the convergence of neoliberalism and fascism around an oikonomic understanding of health and disease is all but complete.

Verging on completeness does not, however, mean that an apparatus is either triumphant or, for that matter, effective in what it purports to do. It persists as an apparatus, in an array of policies, approaches and assumptions premised on categorical understandings of life, biological processes and living things that shapes the world by being operationalized, irrespective of how faulty its account of life might be. Which is to say, systematic 'errors' are functional to a given system and, of course, a great deal depends on definitions of 'effectiveness.' The grotesqueries who openly applaud the prospect of "culling" have a very distinctive view of the value of their lives and others—mysteriously, they never offer themselves up as tribute to their Malthusian God.

Still, it has been particularly ineffective in dealing with the spread of a virus like SARS-CoV2—arguably the 21st century's first overwhelming biomolecular swerve, or *clinamen*, whose outcome is undetermined but whose collection of stakes could not be, at once, more intensified and global. As for contracts, wildcats are a kind of swerve too.