Discrimination, Othering, and the Political Instrumentalizing of Pandemic Disease
Two Case Studies

by
Martina Baradel, Emanuele Costa

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Discrimination, Othering, and the Political Instrumentalizing of Pandemic Disease
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Martina Baradel, Emanuele Costa *

The complex history of pandemics has created a diversified array of anti-epidemic responses, which have allowed structures of authority to express their power in multiple ways. In this paper, by considering theories applicable to cases ranging from Europe to Asia, from the 11ᵗʰ to the 18ᵗʰ century, we conduct a comparative analysis capable of identifying common traits and radical differences, aiming to show how such deployment of power was not always commensurate with the medical theories of the age, and with the gravity of the epidemiological situation. Specifically, we analyse how Western European States, in their process of formation, employed the concept of 'public health' to create the grounds for an unprecedented exercise of power over the private sphere. Furthermore, we compare this attitude with the discrimination of the minority known as burakumin *in Japan, which was destined to undertake any 'dirty' or 'impure' occupation, to preserve the immunity of the community. In other words, we examine how structures of power have exploited states of exception to implement control measures beyond the needs of the situation through an increasingly hypertrophic apparatus of security; and ways in which political authorities have not aligned with medical or philosophical authorities of their times, for opportunistic reasons that benefited their own social, religious, or racial group.*

*Birkbeck College, University of London (*martina.baradel @ gmail.com*); Visiting Scholar, Vanderbilt University (*emanuelecosta108 @ gmail.com*).

1. Introduction

Scholarship surrounding pandemic diseases has often reflected upon the legacy of socio-political changes, triggered by outbreaks of contagious illnesses. However, many of these scholars examined pandemics that had spread through past societies. Thus, they were able to assess the effects of the disease in retrospective. In 2020, we face a most unique opportunity, as for the first time in contemporary history a pandemic has halted the movements of people and goods on a global scale. Pandemics and endemic disease have affected different areas of the world at different times, having severe repercussions on local communities and economies. The scale of Covid-19 is such that, as scholars, we are forced to consider the repercussions of pandemics while experiencing one. At this junction, it is thus even more appropriate to analyse the socio-political impact of pandemics.

In this paper, we analyse the evolution of the political measures which societies around the globe implemented to respond to pandemic diseases. This analysis will utilize a critical theoretical lens, which we describe in Section 2, to construct a conceptual framework. Such a framework is necessary to examine profoundly diverse (in historical and geopolitical terms) case studies. In fact, the two cases we shall discuss range from Western Europe to Japan (respectively, in Sections 4 and 3). We shall begin our analysis from the Middle Ages and witness the development of "public health" paradigms throughout the Renaissance and the Early Modern period.

The theoretical lens established in Section 2 shall allow us to develop a social and critical analysis based on the insurgence of paradigms of segregation, segmentation, and exclusion, aiming at the creation of an immune society. However, as we shall demonstrate, 'immunity' is a politically charged term, as it often requires the othering and exclusion of minorities and/or discriminated social groups. In the current crisis, generated by the outbreak of the Covid-19 pandemic, the concern for potentially exclusive and discriminatory practices is warranted by a worrying pattern of behaviours. Such behaviours include attacks against Asian minorities, higher risk of infection and medical complication for disadvantaged communities, and an intensification of biopolitical surveillance towards foreign individuals and 'strangers'.

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In our paper, we shall demonstrate how these patterns are dangerously well-established in the history of political authority, and how the response to epidemic disease has often been hijacked for political purposes. Generated either through the conscious actions of the established structures of power, or through socially dangerous behaviours, these actions carry the risk of defending an imagined "immunity" at the expense of discriminated minorities.

2. Theoretical Framework

In this section, we explore the theoretical implications of the historical measures deployed to tackle the insurgence of pandemics in a variety of geopolitical circumstances. We shall consider theories applicable to cases ranging from Western Europe to East Asia, from the 11th to the 18th century, with the aim of a comparative analysis capable of identifying common traits and radical differences. The range of these measures, often utilizing discrimination as a key component of their structural response, includes segregation, segmentation, and immunity. The theoretical outline developed in this section will be applied to the analysis of our case studies, in Sections 3 and 4.

As contemporary understanding of epidemics and disease outbreaks teaches us, containing the spreading of the infection is at the forefront of response strategies for most institutionalized structures of power. However, the social construction of the experience of disease plays a fundamental role in dictating which measures are available for implementing containing strategies. Contemporary epidemiology and medicine have revealed how microorganisms such as bacteria and viruses are responsible for human diseases, including epidemic diseases. Yet, the range of explanations provided by ancient, medieval, and Early Modern medicine and natural philosophy to explain the outbreak of diseases ranged much further and wider. It encompassed various theories regarding the nature of illnesses, their means of propagation, and the efficacy of countermeasures to contain contagions and to reduce death tolls.

The complex history of disease ætiology (i.e. the inquiry into the causes of an illness and its spreading) created a diversified array of anti-epidemic responses, which allowed structures of authority to deploy their power in multiple ways. In this paper, we aim to show how such deployment of power was not always

commensurate with the medical theories of the age, and with the gravity of the epidemiological situation. In other words, we shall examine how structures of power have exploited a frenzied and scared population to implement control measures beyond the needs of the situation; and ways in which political authorities have not aligned with medical or philosophical authorities of their times, for opportunistic reasons that benefited their own social, religious, or racial group.

During the development of epidemiology and disease aetiology, the concepts of 'pure' and 'impure' recurred at an obsessive rate, motivating the segregation and discrimination of the 'unhealthy'. In this paper, we explicitly focus on how social and political factors influenced the construction of these categories. The process of 'othering'—as we shall show in both our case studies, regarding Early Modern Europe and Japan—was at the center of most epidemiological responses. The rationale of such process was the identification of disease 'carriers' or ideological causes, resulting in isolation, discrimination, and punitive action. Thus, authorities directed their energy against the groups who were perceived as responsible either for the creation or the transmission of a disease. As Snowden points out, during the waves of plague that disfigured Europe throughout the late medieval and Early Modern ages, "authorities took action although there was no medical understanding of the mechanisms governing the disease they were facing".[1] Structures of power often seconded popular beliefs, enabling discriminatory behaviours rooted in non-medical notions of sin, punishment, and purity. As Mary Watson establishes, "where the social system explicitly recognises positions of authority, those holding such positions are endowed with explicit spiritual power, controlled, conscious, external and approved—powers to bless or curse".[2]

Historically, then, 'purity' became an ideal to be preserved at all costs, in order to protect 'respectable' citizens from the consequences of 'impure' behaviours. Epidemics provided the practical grounds for a theoretical answer, expressed in what we may call a permanent state of exception.[3] In turn, this

[1]Frank M. Snowden, *Epidemics and Society: From the Black Death to the Present* (New Haven, CT: Yale UP, 2019), 69.

[2]Mary Watson, *Purity and Danger: An Analysis of the Concepts of Pollution and Taboo* (London: Routledge, 1984), 100.

[3]Giorgio Agamben, *Homo Sacer: Sovereign Power and Bare Life*, trans. D. Heller-Roazen (Stan-

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state of exception is embodied through practices of biopolitical surveillance and suspension of civic rights (which we will address below), isolation, seclusion, othering, and finally, outbursts of physical violence. It is not a coincidence that during the exceptional circumstances created by epidemics, people who were subject to regulation by structures of power often (if not always) happened to belong to social groups already at the outskirts of full political life. In Early Modern Europe, as demonstrated in Section 4, this applied to beggars, 'poors' (as described by various iterations of Venetian laws), prostitutes, Jews, and other 'undesirables'. In medieval Japan,[1] as we shall see in Section 3, the same strategy specifically applied to the population known as *burakumin*, an occupational minority that included those who worked with impurity (death and dirt), destined to bear the social and physical risk of infection.

In this sense, it is worth noting that—at least in Europe—the development of biopolitical containment measures for epidemic diseases coincided with the establishment of stronger political authorities. In particular, the strictness and level of organization of these measures augmented proportionally with the birth of national States.[2] During the late medieval times and the Renaissance, even radical political theorists such as Machiavelli would not have formulated as strong a response to epidemics as the ones developed, almost casually, by stronger structures of power at the peak of the Modern era. In fact, Italian medieval and Renaissance intellectuals such as Boccaccio and Machiavelli often lamented the loss of decency and social structure brought about by the plague and the panic that ensued.[3] However, few (if any) intellectuals and political theorists of their times outright demanded a higher control by the authorities. The lack of expectations towards the body politic and the established power structures can be seen as a consequence of the underestimation of public health in Europe, until the establishment of the Venetian Boards of Health (as we shall

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ford, CA: Stanford UP, 1998), 90.

  [1]Medieval Japan can be defined to start in 1185 with the Kamakura period. The advent of the Tokugawa period in 1603 marked the beginning of Early Modern Japan.

  [2]Cf. Snowden, *Epidemics and Society*, 69.

  [3]Cf. Giovanni Boccaccio, *The Decameron*, trans. J. Payne (New York: Modern Library, 1955), 11-12; William J. Landon, *Lorenzo di Filippo Strozzi and Niccolò Machiavelli: Patron, Client, and the Pistola fatta per la peste / An Epistle Written Concerning the Plague* (Toronto: University of Toronto Press, 2013), 187.

see in Section 4). Further evidence for this reasoning might be provided by the observation of the Japanese case, in which the transition from regional authorities to a strong centralized state similarly resulted in an organized biopolitical response to the risk of infection (see Section 3).

Therefore, we may infer that the very conceptual possibility of biopolitical control is dependent upon the existence—or the creation—of a unified structure of power capable of implementing it. By contrast, once the national State is established, the threat to public health is perceived as a security problem, to be addressed in terms of confinement, separation, and exclusion.[1] Infected individuals become the 'others'. Thus, the established authorities see it as their duty—and their right—to exercise a high level of biopolitical control over the infected in order to preserve the 'healthy'. Of course, the drawing of such boundaries, which is political in nature, runs along familiar lines of oppression and social discrimination, since they overlap with the ideological borders that regulate the circulation of individuals within a biopolitical context.[2]

The institution of pesthouses (confinement buildings or hospitals destined to host patients suffering from the plague) in Early Modern Europe, for example, served both as a sanitary device and as an embodiment of political control enforced by fear. Being sentenced to isolation in a pesthouse separated an individual from the body politic, suspending their political rights, and—due to the exorbitant costs charged to the few survivors—effectively destroying their economic stability. Moreover, such internments "carried a dishonouring stigma because [pesthouses] were used as places of punishment where the authorities relegated those whom they regarded as noncompliant with their regulations".[3] The psychosocial effects of biopolitical control thus matched preventive 'scare tactics' with the theoretical possibility of discerning between healthy and unhealthy, pure and impure.

While biopolitical control was enforced by civil authorities, a consistent share of the ideological framework that allowed such control was provided by religious authorities. The very idea of 'purity' is highly influenced by ideological

[1]Michel Foucault, *Security, Territory, Population: Lectures at the Collège de France 1977-78*, ed. M. Senellart, trans. G. Burchell (London: Palgrave Macmillan, 2007), 1-2.

[2]Cf. Michael Dillon and Luis Lobo-Guerrero, "Biopolitics of Security in the 21st Century: An Introduction", *Review of International Studies* 34 (2008): 268.

[3]Snowden, *Epidemics and Society*, 74.

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and religious factors. As we shall show in both of our case studies—such factors shaped the way in which contagion, and the response to contagion, was to be intended. Just to provide a noteworthy example, we may consider the fact that in the early Muslim world, far from identifying the unhealthy with sinners, becoming a victim of the plague was equated with martyrdom. Scholars explain the striking difference between this Islamic conception and the Western European interpretation of the plague as God's punishment by appealing to historical circumstances. In fact, troops who were undertaking *jihād* to spread Islamic rule experienced the first pandemic in Syria in the 7th century. Thus, religious authorities attributed a sanctifying effect to dying on behalf of the community—and its expansion according to the will of the Prophet—at the hands of the plague.[1] The conceptualization of plague as a divine punishment for sin, then, is patently a result of social religious construction, which applied unevenly depending on the political circumstances that engendered and accompanied such construction. However, this is not an exclusively Christian or European occurrence. As we shall emphasize in Section 3 of this paper, Shintoism and its insistence on the concept of 'purity' played a fundamental role in the social construction of the barrier between healthy and unhealthy. In turn, this sanctioned the ostracization of *burakumin*, as they represented the embodiment of uncleanness.[2]

In *Birth of the Clinic*, Foucault discusses the evolution of the concept of disease and diseased body. He argues that "the exact superposition of the 'body' of disease and the body of the sick man is no more than a historical, temporary datum".[3] Thus, the clinic is an institutional space that has been differently utilized throughout history according to shifting medical paradigms. In this sense, until the 18th century the disease was understood to be spread uniformly within the bodily boundaries of the patient. However, with the introduction of new tests and techniques of examination, the disease began to be located only in certain specific parts of the sick body. In particular, Foucault argues that the latter conceptualization of the disease emerged after the alliance of medicine and

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[1] Justin Stearns, "New Directions in the Study of Religious Responses to the Black Death", *History Compass* 7 (2009): 1366.

[2] June A. Gordon, "Caste in Japan: The Burakumin", in *Biography* 40 (2017): 269.

[3] Michel Foucault, *The Birth of the Clinic. An Archaeology of Medical Perception*, trans. Alan Sheridan (New York: Pantheon Books, 1973; Taylor& Francis e-Library, 2003), 3.

the State. Thus, truth/knowledge and power are mutually constitutive.[1] In this sense, illnesses cannot only be understood as an epidemiologic phenomenon that prompts a limited response from a local or national government, which acts in order to suppress the infection.

Diseases succeed one another as secular fears, stimulating reactions tending to separation, exclusion, and purification.[2] For instance, the rituals that emerged in Early Modern Europe around leprosy—i.e., the creation of lazarettos or isolation hospitals destined to host incurable patients—were not directly aimed at suppressing it, but rather to keep it at a consecrated distance. Nevertheless, even when leprosy disappeared from the continent, the set of values and images that became intertwined with lepers, the meaning of their exclusion from the community, remained.[3] In the same way, the rituals of exclusion that determined the segregated life of the *buraku* community from Japanese society persists to the present day, as they acquired a further significance that went beyond the exclusion of the *buraku* from the community for sanitary reasons. In the same way, the consequences of the regulation and 'othering' of undesirable subjects (beggars, "poors", prostitutes, Jews) lasted for much longer than the epidemics during which these regulations were deployed.

However, during the history of the management of disease, the strategies used to deploy power shifted from segregation to segmentation.[4] While leprosy bequeathed to the community rituals of exclusion and segregation between two sets of people (emphasizing once more the dichotomy between pure and impure), the plague brought about multiple separations enforced by a system of surveillance, control, and, in general, intensification of power. Thus, while the political ideal pursued with leprosy was that of a "pure community", the project pursued during the plague is that of a disciplined society,[5] obtained through political *segmentation*, rather than segregation.

The centrality of the body as the object of biopolitics continued to be a central tenet of the studies on the body and its role in relation to power, but the intro-

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[1]Ian Anderson, "Bodies, Disease, and the Problem of Foucault", *The International Journal of Anthropology* 37 (1995): 69.

[2]Michel Foucault, *History of Madness*, ed. J. Khalfa (New York: Routledge, 2006), 8.

[3]Foucault, *History of Madness*, 6.

[4]Michel Foucault, *Discipline and Punish. The Birth of the Prison* (New York: Vintage, 1995), 200.

[5]Foucault, *Discipline and Punish*, 198.

duction of new technologies shifted the understanding of the body towards its fragmentation. As in the 18th century the discovery of new medical notions and examination techniques led to a new form of biopower, one that determined a new spatialization of the disease (from being homologous to being located only in restricted areas of the patient's body), the discovery of the immune system, can be argued, led to a new step in the deployment of power that could finally manifest itself through hypertrophic apparatuses of security. Indeed, if the realms of medicine—and in particular disease—and society—and in particular its control—merge in the field of biopolitics, the immune system is that apparatus that aims at safeguarding the body/society from the disease. In Donna Haraway's words, "the immune system is a plan for meaningful action to construct and maintain the boundaries for what may count as self and other in the crucial realms of the normal and the pathological".[1] In this sense, the immune system confers a further significance to biopolitics as it was hitherto understood. Politics and life, power and body, are not connected by an immediate relationship anymore: the apparatuses that protect the body (i.e. the immune system, or those devices that are used for the protection of the body) mediate the relationship.

The *immunitas* (immunity) that is the aim of the government's action in face of an epidemic is a central concept in exploring the socio-political measures deployed by governments to keep the community safe. In Roberto Esposito's view, immunity is a comparative and dialectical concept.[2] It represents the state of diversity compared to the condition of others (as carriers), rather than the exemption from the condition. However, this state of diversity, insofar as it establishes identity through a process of differentiation from another which is only contingently 'other', carries the germ of its own dissolution.[3]

In particular, between the 18th and 19th century, with the birth of medical bacteriology, the idea that a small amount of infection can protect from the disease itself came forward, suggesting a new 'preventive' logic. Under this paradigm,

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[1]Donna Haraway, "The Biopolitics of Postmodern Bodies: Determinations of Self in Immune Discourse System", in *Feminist Theory and the Body*, ed. J. Price and M. Shildrick (New York: Routledge, 1999), 204

[2]Roberto Esposito, *Immunitas. The Protection and Negation of Life* (Cambridge: Polity Press, 2011), 8.

[3]We are grateful to an anonymous referee from this *Journal* for this point.

the disease is to be contrasted by including it within the boundaries of the organism, rather than excluding it completely. The idea translated in the social sphere through the concept that a minority contradicting the rule of the community with its presence within the city reproduces in a controlled way the evil from which the community needs to protect itself from.

According to Esposito, all communities have some sort of immune system, embodied through biopolitical surveillance, and this is a further proof of the inseparability of community and immunity.[1] Similarly, Peter Sloterdijk posits that "immune *dispositifs* are what enables systems to become systems, forms to become forms, and cultures to become cultures in the first place".[2] The similitude between the social organism and the biological form is such that through the establishment of an immunitary boundary communities "ascend to the level of self-organizing unities, preserving and reproducing themselves with constant reference to a potentially and actually invasive and irritating environment".[3] The dialectic of segregation between internal and external, pure and impure, healthy and unhealthy, lies therefore at the very heart of the social establishment.

These dynamics could be observed in the recent outbreak of Covid-19, in which unprecedented strategies of security and surveillance were deployed to control the population, based on the attention for the boundaries and the fear of contagion by strangers, and the consequent installation of defensive barriers. These strategies are part of the discourses on the immune system, which since the beginning assumed militaristic connotations of 'defence'. Indeed, the fear of contagion by the 'stranger' or the 'foreigner' (in this case usually embodied by someone with Asian traits) was a predominant theme during the Covid-19 pandemic and escalated into racist attacks against Asian communities in many Western countries.[4] At the same time, these events can also be framed as the identification of disease carriers that are isolated and discriminated against.

Moreover, the attention to both geographic and bodily boundaries has been particularly heightened during the Covid-19 pandemic. First, we witnessed the

[1]Esposito, *Immunitas*, 18.
[2]Peter Sloterdijk, *You Must Change Your Life*, trans. W. Hoban (Cambridge: Polity, 2013), 7.
[3]Sloterdijk, 7.
[4]Suyin Haynes, "As Coronavirus Spreads, So Does Xenophobia and Anti-Asian Racism", *Time*, March 6, 2020.

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closing of borders that had not been closed in decades, causing the disruption of cross-border social and economic bonds of many border communities. Secondly, there has been a strong emphasis on protecting the access routes to the body, as demonstrated by the infinite loop of messages on television and in public spaces that reminded the public to cover mouth and nose, and to sanitize vehicles of germs that could bring the disease into the body. These strategies also mirror the state of exception that underpins an extraordinary deployment of power to protect the community.

In sum, this section examined how biopower has manifested itself throughout history in the anti-epidemic response, arguing that these responses were not entirely based on the nature or gravity of the epidemic. Rather, they were following a certain agenda that benefitted one group of people at the expense of a marginalized community. This remains true across the diverse paradigms of epidemiological response highlighted above, such as segregation, segmentation, and immunity.

At the same time, the apparatus of security that has been developed in response to diseases has become increasingly powerful, reaching the point observed during the Covid-19 pandemic, in which both dimensions of 'immunity' (i.e. fear of contagion by foreigners and attention on geographical and physical boundaries) and the system of security/surveillance have materialized. We shall now move to analyse how these theoretical tendencies have been embodied in practical instances, focusing on two specific case studies.

3. Burakumin and the Othering of Impurity in Japan

In this section, we shall delineate how diseases and pandemics in Japan contributed to the historical discrimination of the *burakumin*, a caste of 'untouchables' relegated to performing 'impure tasks'. Before proceeding, it is important

to note that while scholarship became interested in the *burakumin* issue in the 1970s, on the wave of social upheavals, studies on this minority gradually faded out, and at the moment of writing the scholarship on this subject is rather limited. The extensive research produced throughout the 1970s though, does offer thorough information on the historical dimension of the *burakumin*, which is the focus of this article.

Epidemic trends in Japan were historically different from the pandemic impacts faced by Mediterranean and European areas. Japan was isolated from major commercial routes until the 1850s, and therefore epidemics that had been particularly deadly in Europe, such as the bubonic plague and typhus, did not cause high rates of mortality in Japan until the arrival of Western ships. Smallpox, measles, influenza, and diarrheal infections were the cause of severe epidemics but did not impact significantly on the mortality rate in Early Modern Japan[1]. However rare, epidemics did occur in pre-modern Japan. This section analyses how the origins of the longest-standing minority in Japan, the *burakumin*, are intertwined with the history of disease, and the related history of pollution. In particular, we shall examine how power was deployed as a response to epidemics, and reinforced structures of power to the detriment of an oppressed community. As noted in the theoretical framework above, Japan's politicized response has strong connections with an ideological framework provided by religion: in this case, Shintoism and Buddhism.

The history of *burakumin* is long and complex, but many sources trace their existence back to the 11th century. At this juncture, plagues were widespread in the capital of Kyoto, and sudden death was a common occurrence, as floods, earthquakes, and fires were usual events[2]. Until the Heian period (794-1185), lowly status was not determined by contact with pollution. However, starting from the 11th century, pollution, and specifically contact with death, came to be a reason of social discrimination. Leprosy, in particular, was known as the 'karmic retribution disease' and it was believed to be a punishment for evil

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[1] The period from 1603 to 1867, coinciding with the Edo or Tokugawa period. On this topic, see Ann Jannetta *Epidemics and Mortality in Early Modern Japan* (Princeton: Princeton UP, 1987), 15.

[2] Sarah Horton, "Mukaekō: Practice for the Deathbed", in *Death and the Afterlife in Japanese Buddhism*, ed. Jacqueline I. Stone and Mariko Namba Walter (Honolulu: University of Hawai'i Press, 2009), 38.

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acts committed in the previous or present life.[1] Lepers were therefore soon categorized as *hinin* (non-people), in other periods also known as *eta* (meaning 'defilement abundant'). However, as bearers of the physical manifestation of sin, they were also considered capable of providing a possibility of salvation to those who offered to help them (ibid.). As it is reported in a *saiseki* (diary of a nobleman), as early as 1017 we can observe facilities called *hiden-in* that were used to maintain lepers and other terminally ill patients. At this point in Japanese history, leprosy was considered a divine punishment that was inflicted upon people who had committed evil acts in the present or past life. Leprosy was the most dreaded of all the diseases that were common in medieval Japan. Similarly to what happened in Europe, lepers were abandoned by their families and banished from the community. They took refuge in the *hiden-in*, which were usually established near a river so that the water would cleanse the pollution they were carrying around.[2] In the Early Modern period, leprosy continued to be understood as a disease linked to bad behavior, and lepers became the objects of exclusionary practices: terrified of contagion, families forced lepers out. Thus, they became itinerant beggars, and organised their own community at the margin of society.[3] When in 1907, the Diet passed a law that instituted five leprosaria to host lepers who had been forced out by their families, they did so by following a segregation logic according to which these institutions were separated from the rest of the community by walls and gates. In two cases the leprosaria were even built on small archipelagos.[4] While at first confinement was voluntary, since the 1930s it became mandatory.[5] Thus, it is possible to see how 'power' manifested itself through these measures, as the organisation and sanitization of the community was based on the biopolitics of the exclusion of the sick, that became a part of the more extended community of outcasts that would have become known as *burakumin*.

[1]Susan L. Burns, "Making Illness into Identity: Writing 'Leprosy Literature' in Modern Japan", *Japan Review* 16 (2004): 194.

[2]Keiji Nagahara, "The Medieval Origins of the Eta-Hinin", *The Journal of Japanese Studies* 5 (1979): 387.

[3]Burns, "Making Illness into Identity": 195.

[4]For the application of a similar strategy in Europe, see the analysis of the Venice lazarettos in Section 4.

[5]Burns, "Making Illness into Identity": 196.

The marginalized status of the *burakumin* became increasingly institution-alized with the establishment of social order typical of Tokugawa (1603-1867) Japan, which was crystalized in a hereditary four-classes organisation that included the samurai (warrior/rulers) at the top, and in descending order peasants, artisans and merchants. Other groups of people lived outside this caste-systems, such as the *eta* or *kawata* (hereditary pariahs) and those who were excluded from the social organisation as a punishment (*hinin*).[1] In the Sengoku period (the period of warring States between 1467 to 1615) feudal lords recruited groups of pariahs to perform humble but necessary jobs in their castle cities, but with the advent of the *pax* Tokugawa, these groups of outcasts were relocated to margins of town and formed their own communities. However, periods of crop failure and public hardship strained the relationship between commoners and *burakumin*. In order to protect the interests and self-esteem of villagers, local and national governments introduced new regulations that imposed symbols of status distinction, which enforced separation of residence and function.[2]

In the Middle Ages, the formation of outcast groups was connected to the othering of those who were excluded from the social order (beggars, prisoners, performers, lepers, *eta*...), and they were kept outside of the class system. In this caste structure, the outcasts were considered as 'subhuman', in contrast to the Imperial family, who were considered 'superhuman'. Outcasts did not take part in the basic relations of production. Furthermore, they were prevented from being involved in property relations[3]. In particular, during the medieval period jobs that were considered lowly and dirty (e.g. tanning, leatherwork, itinerant singing, peddling, marine transportation, ditch and well digging, public execution, cattle breeding) were assigned to the lower classes, known as *Senmin*, who lived in the river banks or on barren land within the precincts of manors, known as *Sanjo* (a name that *burakumin* neighbourhood retained until recently). Beggars and other social outcasts gathered in these communities and contributed to the historical development of the group known as *burakumin*.[4]

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[1]Conrad Totman, *A History of Japan* (Oxford: Blackwell, 2005), 281.

[2]Totman, *A History of Japan*, 283.

[3]Cf. Toshio Kuroda, *Nihon Chusei no Kokka to Shukyo* [State and Religion in Japan's Middle Ages] (Tokyo: Iwanami Shoten, 1975), 380.

[4]Nobuo Shimahara, *Burakumin: A Japanese Minority and Education* (The Hague: Nijhoff, 1971), 16-17.

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The development of these neighbourhoods can also be understood through the 'immunity' paradigm examined above, as the preventive confinement of impure people would have prevented the infection of the community at large. The outcast status of the *burakumin* was finally enshrined in law in the Tokugawa period of 1603-1867. Although this was changed with the Emancipation Edict of 1871, which compared them to other common citizens, the material life of the burakumin community continued as before.[1]

Burakumin communities were most prevalent in the Kinai area (which corresponds roughly to today's region of Kansai), which included Kyoto, Osaka, Nara, and Hyogo. This area was the centre of power of the Emperor, who established his court in Nara and then in Kyoto during the medieval period. Because of the proximity to the centre of power, the social order and the status ranking were more developed than in the peripheral areas of the State.[2] The proximity to the physical and imagined centre of power corresponded therefore to an increased marginalization. In this sense, as we argued in Section 2, power manifested itself in the very territory which it controlled. This manifestation took place through the othering of the groups that were deemed to be the bearer of infection, which were displaced outside the village and therefore occupied a physical space removed from the organised reality of the community. Moreover, in the case of the *burakumin*, power manifested most intensely at the centre. Thus, the segmentation of the community and marginalization of undesirables happened in a geographical space that increasingly faded as it moved away from the centre.

As mentioned above, religion played a central role in this process of 'othering'. Religious authorities often provided the ideological framework within which the biopolitical power manifested itself. The case of the *burakumin* verifies this argument, as Buddhism and Shintoism directly contributed to the widespread belief that outcasts in Japan were, to some extent, polluted. Around the 8th century, the practices of Shintoism began emphasizing the necessity to avoid contamination with the unclean: interacting with those performing occupations that dealt with illnesses, wounds, and death was therefore a sin of uncleanliness. At the same juncture, Buddhism stressed that compassion had

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[1]Shimahara, *Burakumin*, 14.
[2]Nagahara, "The Medieval Origins of the Eta-Hinin", 386.

to be extended to all living beings and prohibited the slaughter and killing of all animals. These two arguments "contributed to the development of the concept of 'untouchability' and encouraged the relegation to outcast status of those engaged in tasks dealing with blood, death, and dirt".[1] Therefore, one of the rationales for the social exclusion of certain social groups was rooted in the Shinto notions of pollution as a product of association with death, birth, or blood, or with crime or disease. In particular, diseases with a high coefficient of contagion, such as leprosy, were understood to be the most dangerous.[2]

However, there is a part of scholarship that sees the discrimination of groups such as the *burakumin* as being solely a product of social context. As Hatanaka argues, "*buraku* discrimination is status discrimination which was formed within the social structure of the modem emperor system and systematically supported and re-created within it".[3] Therefore, according to him, a group of people known as *burakumin* have continued to exist in Japan (with different levels of social exclusion) until the present day, but their belonging to the outcast class is but a product of social context. There is no objective and observable criterion that transcends social structure that characterize *burakumin*, and thus the continuity across the centuries of a *buraku* lineage is questionable. Given that according to Hatanaka, discrimination is the effect of social context, and this has shifted and changed many times, over time people could eventually move across the boundaries of the groups that were identified as *burakumin* (or any other discriminated group). In this sense, the politics of pandemics can be interpreted as an instrument that supported the policy of othering to the detriment of certain groups.

Moreover, the fact that this discrimination happened in a social system that organized society in classes by birth supported the perpetuation of discrimination against *burakumin*. The people who constituted this minority were not ejected from the community on an ethnic basis. Rather, their discrimination was the result of a political intervention finalized at separating those who were

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[1]Shimahara, *Burakumin*, 18.

[2]Cf. Tetsuichi Niunoya, "Kebiishi: Chusei no kegare to kenryoku" [The Capital Police: Ritual Pollution and Political Power in Medieval Japan] (Tokyo: Heibonsha, 1986), 57-78.

[3]Toshiyuki Hatanaka, *Burakushin no Owari* [The End of Buraku History], 190 (Kyoto: Kamogawa Shuppan, 1998), quoted in Ian Neary, "*Burakumin* at the End of History", *Social Research* 70, no. 1 (2003): 282.

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in some way in contact with impurity, in order to preserve the purity of the community. According to Nagahara, the *burakumin* came to be discriminated against because of "conscious political decisions reflecting social and religious beliefs of the past".[1] Since it is virtually impossible to distinguish a *burakumin* (ethnically Japanese) from a commoner, their othering had to be sanctioned in such a way that they would be immediately recognizable. Feudal rulers enforced regulations which sanctioned that the *burakumin* must wear humble clothing and attach a rectangular piece of cloth on it to further mark their status. Furthermore, *burakumin* could not perform daily activities such as sitting and eating in front of commoners.[2] Thus, the confinement of the *burakumin* group, which had no other basis than an arbitrary line based on pre-existent categories of discrimination, had to rely on visual signals to the population.

While it has notably declined, to some extent the discrimination of the *buraku* minority continues to the present day, beyond the sanitary and religious reasons linked to uncleanness that were the root of their social exclusion. As argued above, the rituals of exclusion that determined the segregated life of outcast communities are found also in the reiterated experience of social rejection of the *buraku*. To conclude, the issue of *burakumin* discrimination showcases but one facet of the consolidation of statal power in Japan, but the persistence of the issue and the way in which it power has continued to intervene throughout modern Japanese history makes it particularly suitable to analyse these structures of power in Japan and political and societal responses to pandemics.

4. Pandemics in Europe at the Dawn of the Modern Era

In the previous section, we analysed how epidemics and disease played a part in shaping the assertion of political authority in the case of medieval and Early Modern Japan. In the present section, we shall instead focus on how Europe (and the Mediterranean basin) dealt with similar issues. We acknowledge that the study of the two cases will present necessary distinctions, due to the relative isolation of Japan from major trade routes. However, the similarities

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[1]Nagahara, "The Medieval Origins of the Eta-Hinin", 386.
[2]Shimahara, *Burakumin*, 18.

among these different cases are significant. They shall provide further evidence of the political and social influence that structures of power have on determining societal responses to disease.

The onset of the plague epidemic in Europe is widely considered to be one of the most significant events, shaping the context for the beginning of what we consider the Early Modern age. A significant distinction can be made between the short-term and the long-term effects of the pandemic. In the short term, the plague ripped "tears in the fabric of society which undermined social discipline and cohesiveness", segmenting European civilization along the familiar lines that divided "those in the cultural mainstream and those at its margins".[1] In the long term, the plague had amplified and indirect effects which threatened the continuity of the traditional way of living constituting the very foundation of Western civilization. In this section, we shall focus primarily on the short-term effects, as they are more clearly analysable through the theoretical lens developed above, in Section 2. However, this should not be taken as an indication that the long-term fallout of the plague was less politicized, or socially constructed. For obvious historical reasons, nonetheless, it is more convenient to primarily focus our analysis on a more homogenous setting. Such a setting is represented by the intensely politicized response to the plague pandemic during the years ranging from the middle of the 14th century to the beginning of the 17th.

The outbreak of Black Death on European soil in the 1350s is considered one of the closing moments of the medieval era, since it represented an unprecedented upsetting of the cultural and traditional establishment. The elites leading society were perceived by the population to have failed, given the disastrous results of their administration.[2] Trust and obedience towards the authorities plummeted, pointing at the lack of a centralized authority capable of justifying, through the defence of common welfare, a stratification of society that certainly distributed its privileges unequally.[3]

The Black Death of the 14th century was interpreted not only as a divine chas-

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[1] David Herlihy, *The Black Death and the Transformation of the West*, ed. Samuel Cohn Jr. (Cambridge, MA: Harvard UP, 1997), 59.

[2] Brian Pullan, "Plague and Perceptions of the Poor in Early-Modern Italy", in *Epidemics and Ideas: Essays on the Historical Perception of Pestilence*, ed. T. Ranger and P. Slack, 116 (Cambridge: Cambridge UP, 1992).

[3] Herlihy, *The Black Death and the Transformation of the West*, 64.

tise, but also as a social leveller. While the first wave of contagions impacted more heavily on the lower social strata, the plague quickly overcame social and biological barriers, beginning to hit people across "every condition, age, and sex".[1] However, there are significant differences in rates of mortality across social groups. This circumstance can be explained by the availability, for richer and nobler people, of the only possible remedy against the plague: flight. As testified by texts as early as Boccaccio's *Decameron*, composed between 1349 and 1353, anyone with the means to escape the cities—epicentres of the outbreaks—had an increased chance at survival.[2] Thus, despite the potentially cohesive experience of a shared risk at the hands of the pandemic, the social filter provided by class and economic privilege nullified these unifying effects. The result is the distrust towards socio-political authorities described above, in Section 2, and the consequent attempt—by said authorities—to reinforce their position of power through any means necessary.

While the traditional response against contagious diseases such as leprosy was an established practice of social segregation, plague brought about a veritable segmentation.[3] The impact of the Black Death was the fragmentation of society in a myriad of pieces, following blind attempts by the political authorities to respond to a new phenomenon, which the medical protocols of the age did not anticipate, nor understand thoroughly.

The Hippocratic-Galenic medical standards of the medieval age did not provide helpful treatment against the plague, and where the self-government of outdated medical guilds failed, the political authorities overstepped their traditional boundaries to create 'public health boards'.[4] The most avant-garde of such institutions, the Venetian board of public health, established the first two lazarettos (*lazzaretti*), i.e. specialized hospitals (respectively in 1423 and 1471),

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[1] Samuel Cohn Jr., *The Black Death Transformed: Disease and Culture in Early Renaissance Europe* (London: Bloomsbury, 2003), 126.

[2] Samuel Cohn Jr., *Cultures of Plague: Medical Thinking at the End of the Renaissance* (Oxford: Oxford UP, 2010), 210.

[3] Foucault, *History of Madness*, 52; cf. also Michael A. Peters and Tina A.C. Beasley, "Social Exclusion/Inclusion: Foucault's Analytics of Exclusion, the Political Ecology of Social Inclusion and the Legitimation of Inclusive Education", *Open Review of Educational Research* 1 (2014): 99-100.

[4] Carlo Cipolla, *Public Health and the Medical Profession in the Renaissance* (Cambridge: Cambridge UP, 1976), 7.

dedicated to plague patients and funded by the Republic. The board itself was definitively established in 1489 and it would "only grow in power over the next century, ultimately exerting control over parochial poor relief, suppression of begging, and control of prostitution".[1] Thus, the overstretched notion of 'public health', which found justification in a state of exception such as the outbreak of the plague, became an institutionalized and perennial intervention of the State authority in medical and urban life.

Yet, we should not take the institution of public health as an orderly restoration of civic authority. As Agamben argues, the response to emergency circumstances through an extension of power (a 'state of exception') institutionalizes the crisis itself as a form of government, which can be defined *anomia* (i.e. absence of laws) despite the hypertrophic legalism it *prima facie* offers.[2] Thus, institutions created in response to an emergency through the invocation of a state of exception often incorporate and embody the 'spirit' of such emergency.

This is the case of the *pogroms* and the wave of antisemitism that followed the Black Death in the middle of the 14th century. In 1348, a rumour was spread that "the Jews of northern Spain and southern France were poisoning the Christian wells, and thus disseminating the plague".[3] In the general distrust that surrounded established authorities such as emperors and kings, the frenzied population did not even listen to the pontifex, Pope Clement VI, who officially declared the accusation "unthinkable" in the papal bull *Sicut Judæis*.[4] Instead, inhabitants of several cities convinced the municipal authorities to interrogate, torture, and—after their extracted "confession"—execute Jewish citizens in several massacres dated between 1348 and 1349. The chronicles especially mention Chinon, Chambéry, and Strasbourg as sites of the persecution; but sources confirm that the *pogroms* spread throughout Europe, including Germany and Poland.

While past scholars had argued that these massacres resulted from unspecified 'economic tensions' due to shortages connected to the plague, research has

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[1] David D'Andrea, *Civic Christianity in Renaissance Italy: The Hospital of Treviso 1400-1530* (Rochester, NY: University of Rochester Press, 2007), 101.

[2] Giorgio Agamben, *State of Exception*, trans. K. Attell (Chicago: University of Chicago Press, 2005), 65-73.

[3] Herlihy, *Black Death*, 65.

[4] Cf. Herlihy, *Black Death*, 65; see also Snowden, *Epidemics and Society*, 65.

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lately shown how they more likely were "the result of social elites in shock due to the extent of the natural disaster that had befallen them".[1] In this example, we can observe once more the segmentation resulting from the establishment of a state of exception, justified by the pandemic-generated *anomia*. The sudden lack of trust towards established authorities (pope, king, emperor) caused a segmentation of society, which turned to local institutions and invested them with exceptional powers in order to react to the situation.[2] Such local authorities, selected through social elitism, played their role, identifying in the most proximate minority the scapegoat to justify their power, ultimately reproducing the *anomia* that had brought them to exercise their *potestas*.

If the *pogroms* of the mid-14th century represented the sudden overturning of the established medieval downwards structure of power—from top to bottom, from God to pope, from emperor to vassal—the Italian committees of the 15th and 16th century, instead, "constituted the first form of institutionalized public health".[3] The main difference between the former and the latter examples is the exceptionality of the situation. While in the 14th century plague struck as an unprecedented disaster which caught authorities unprepared, the 15th and 16th century outbreaks were met with a conscious, if still anomic, utilization of the powers granted by the epidemiological permanent state of exception. When "a city besieged by a major plague epidemic became a perfect dystopia" and "bonds of community and family ties were severed", authorities tapped at their new array of draconian measures, martial law, and miscellaneous prohibitions and obligations.[4]

[1]Justin Stearns, "New Directions", 1367; cf. also Samuel Cohn Jr., "The Black Death and the Burning of the Jews", *Past and Present* 196 (2007): 11.

[2]Agamben, *State of Exception*, 79.

[3]Snowden, *Epidemics and Society*, 69.

[4]Snowden, 78.

The medical profession, too, reproduced the prejudicial instinct towards the segmentation of society. In the late 16th century, the Roman plague doctor Francesco Tommasi identified the pestilence as peculiar of "the filthy plebs and those who were dirty, such as Jews, butchers, cooks, tailors, and then the greedy and unclean and disorderly types, gluttons and libidinous men, whose activities gave rise to putrefied blood".[1] Clearly, the separation between pure and impure, healthy and unhealthy, is drawn along lines of discrimination remarking pre-existent racial, occupational, socio-religious, and economical prejudices.

The differentiation among the aforementioned categories of 'impure' people became less and less meaningful as plague settled in Early Modern Europe as a recurring pandemic; "poor" became the general term to describe the most vulnerable groups. The association between vulnerability to the plague and 'poorness' was definitely established in the 15th century "on the basis of the nature of the bodies of the poor, their actions and environments".[2] The essentialist nature of this association meant that rich and poor (aliases for pure and impure, healthy and unhealthy) were treated differently in the face of a disease that, as we noted earlier, was initially perceived as a leveller, impacting population across traditional boundaries.[3] As the plague became more endemic, the prejudicial lines separating healthy and unhealthy also remarked the all-too-familiar discrimination of gender. Women were perceived as biologically more inclined to become infected, and to die at the hands of the plague; such biased distinction is "unlikely to have been caused by biological differences but instead by the greater number of women living in difficult and poor conditions".[4] This prejudiced conception became so entrenched that plague ended up being described, in the iconography of the 17th century, as an old and poor woman.[5]

So far, in this section we have highlighted how practices of public health brought about configurations of segregation and segmentation in Early Modern

[1]Francesco Tommasi, *Tractatus de Peste* (Roma: Torneri and Donangeli, 1587), 14. For a similar description in the 17th century, cf. Girolamo Gastaldi, *Tractatus de avertenda et profliganda peste politico-legalis* (Bologna: Manolessi, 1684), 344.

[2]Jane Stevens Crawshaw, *Plague Hospitals: Public Health for the City in Early Modern Venice* (Farnham: Ashgate, 2012), 99.

[3]Cf. D'Andrea, *Civic Christianity in Renaissance Italy*, 105.

[4]Stevens Crawshaw, *Plague Hospitals*, 104.

[5]Cesare Ripa, *Iconologia* (Padova: Pietro Paolo Tozzi, 1611), 421-422.

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European society. The creation of *lazzaretti*, however, can also be interpreted as a practice aimed at building immunity for the city and the community. In fact, the 'preventive' logic of immunity, was deployed through the proactive seclusion of community members considered at risk.[1] The aim was a comparative security for those who had not been infected—according to the subjective judgment of the *pizzigamorti* (body clearers and coroners), known for being subject to corruption and abuse of power.[2] The expendability of 'poor' lives in order to maintain the immunity of the community as a whole became more established in the 17th century, when the appearance of plague as a social leveller had entirely faded.[3] Thus, the inoculation in the body of the city of the *lazzaretti* as a controlled site of infection was considered an acceptable measure to manage public health, building immunity for the community as a whole, while treating "poor" workers employed to maintain the hospitals as expendable.

In sum, in this section we have demonstrated how Early Modern responses to the plague—whether they adapted a paradigm of segregation, segmentation, or immunity—were highly politicized. As we have seen, these reactions cannot be taken as a mere fact of history, since it would be wrong to affirm that they were 'just' medical responses to a sanitary crisis. With Foucault, it may be argued that they created the very idea of 'public health' as a biopolitical vehicle to establish control over the population. While the exaggeration of this claim is certainly wrong, the historical fact remains that emergencies throughout the dawn of the Early Modern era were appropriated by structures of power to generate a certain kind of centralized power, which acted in dialectical ways to separate the healthy from the unhealthy, the pure from the impure. This dialectic effectively created a permanent 'state of alert' which paralleled "the anticipatory preparedness of the living system for an encounter with potentially lethal powers of irritation and invasion"—the other, the infected, shortly became an enemy.[4]

The justification of discriminatory practices through the acknowledgement of a sanitary emergency such as the plague corrupted the concept of public

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[1]Esposito, *Immunitas*, 8.

[2]Cf. Jane Stevens Crawshaw, "The Beasts of Burial: *pizzigamorti* and Public Health for the Plague in Early Modern Venice", *Social History of Medicine* 24 (2011): 570-587.

[3]Stevens Crawshaw, *Plague Hospitals*, 134.

[4]Sloterdijk, *You Must Change Your Life*, 8.

health, subjecting it to the logics of anomia, born from a state of emergency. Thus, the overarching political responses to plague were *in principle* polluted by the circumstances and mindset that originated them. As a result, we have shown that those historical reconstructions, which aim at justifying the Early Modern conception of public health as an appropriate—if ill-informed—response to extraordinary epidemiological events, fail to take into account the transitive property of exceptionality. In other words, by establishing a political paradigm through appeals to a state of exception, Early Modern public health inherited the exceptionality and anomic nature of the crisis itself, reproducing its inequalities and discriminatory practices.

5. Conclusions

In the theoretic section of this paper, we formulated the hypothesis that political and societal responses to major disease outbreaks (epidemics or pandemics) are often biased and dictated by pre-existing structures of power. Through this lens, 'public health' has been shown as a heavily charged term, often employed to re-establish biopolitical structures. The latter, threatened by the social uprising and consciousness of inequality caused by fast-spreading diseases, have sought to reaffirm their stability through practices of control, isolation, social segregation, and segmentation.

From the analyses developed in the subsequent sections, it emerged that in Japan as in Europe, the turn from the medieval age to the Early Modern State signified a more unified political authority, which assumed the role of 'protector' through the establishment of permanent public health institutions and political devices. The ultimate goal of these latter institutions was the creation of an imagined 'immunity' for the community subject to these biopolitical authorities. However, the criteria for selecting who had to be protected and made

'immune' were highly politicized, and were formulated according to caste, sex, ethnicity, or social class prejudices.

In conclusion, we have shown how the development of public health as a concept, stemming from a 'state of exception' creates the ground for biopolitical oppression, which could perhaps be termed a 'State of exception'. For this reason, even in 21st century responses to pandemic diseases such as Covid-19, there appears to be cause of alarm. There is, however, a significant difference in the structures of power that oversee the anti-pandemic measures today: as it was argued above, in the Early Modern period, State authorities had a shaky basis, and used anti-disease measures as one of the means to assert their power and reinforce discriminatory structures that favoured the elites. In the 21st century, instead, States are firmly grounded in social, political, and economic conventions and do not have a need to corroborate their power. Authority is already established and increasingly pervasive, and the advent of neoliberal structures of power determined a significant shift in the structures of power, which are increasingly intertwined to the economic fate of the state. This has been particularly evident in the unwillingness and tardiness of conservative populist governments—such as those led by Donald Trump and Boris Johnson—to implement lockdowns for the fear of economic repercussions.

However, due to the social effects of the Covid-19 pandemic, 'othering' tendencies manifested against communities that had already been heavily affected by the economic crisis that hit most of Western countries in 2008 and by a welfare system impoverished by neoliberal policies. Amongst the many examples that can be given to this regard, the mortality rate amongst black communities in the United States is one of the most prominent. The rate at which Black Americans are infected by, and die because of Covid-19 infections are higher than other racial groups in the US. Pre-existing health conditions have surely played a part in the higher mortality rates. However, they are also the product of a systemic discrimination that has everyday detrimental impact on black population.[1] One of the secondary effects of the pandemic is the economic downturn that has already started to affect all major global economies. Those who were already suffering from disadvantaged positions and discriminations on the job market are more severely impacted by the consequences of the pan-

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[1] Keeanga-Yamahtta Taylor, "The Black Plague", *The New Yorker* April 24, 2020.

demic. For instance, studies show how the Covid-19 pandemic is having harsh consequences on gender equality: women's income and employment opportunity are likely to be more heavily affected than men's.[1] Similarly, individuals born or resident in disadvantaged countries are affected by discrimination and prejudice. The regular immigration fluxes have been halted. Undocumented migration has become even riskier for the desperate individuals who are forced to face the perils of being impounded in immigration detention centres. Insofar as they are hosted in structures that do not comply with safety and hygiene standards, migrants are exposed to high risks of contagion, as testified by the *Human Rights Watch* advocacy group.[2] Higher contagions in detention centres, in turn, help xenophobic groups to further the 'stranger danger' rhetoric and discriminate against refugees, propagating the fallible 'immunity' paradigm analysed above.[3]

While health services have notably expanded and improved since medieval Japan and Early Modern Europe, the social inequalities that are becoming increasingly intrinsic within neoliberal democracies exacerbate discrimination against certain communities. It is certainly true that the evolution of the neoliberal State determined that structures of power are now more concerned with the flux of capitals and goods rather than the direct control and restriction of citizens. However, this might be interpreted as a mutation in the manner of power reproduction rather than a radical reshaping of political ideas. In conclusion, the possibility of furthering structures of oppression behind the appearance of public health concerns, as we have shown in this paper, is a historical constant and an ongoing preoccupying trend.
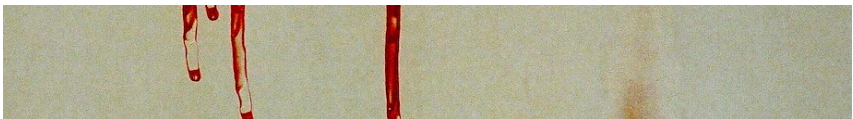
[1] Tali Kristal and Meir Yaish, "Does the Coronavirus Pandemic Level the Gender Inequality Curve? (It Doesn't)", *Research on Social Stratification and Mobility* 68 (2020): 1-5.

[2] Human Rights Watch, "Europe: Curb Immigration Detention Amid Pandemic" April 27, 2020.

[3] Imran Khan, "Are EU countries using COVID-19 to clamp down on refugees?", *Al Jazeera News* August 24, 2020.

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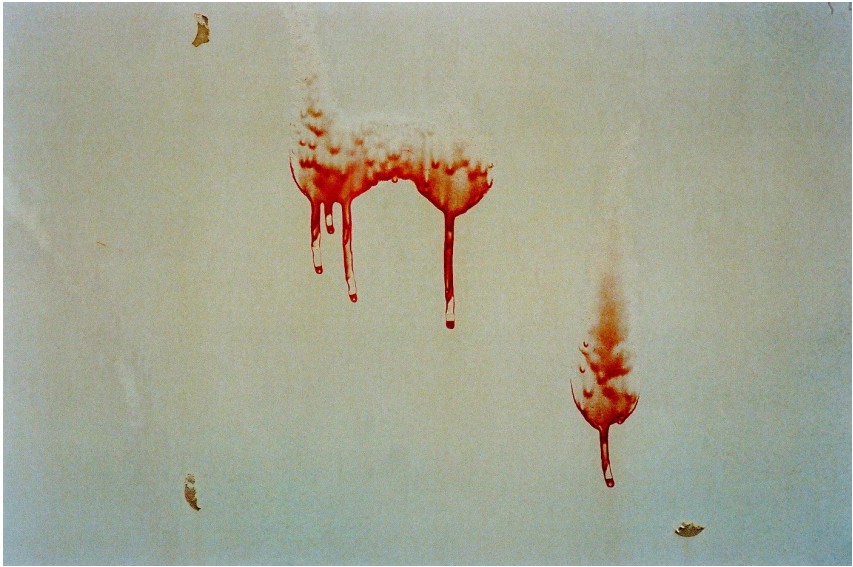
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