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Interactive Index

Macao, How the Little Giant is Successfully Controlling the Pandemic

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In December 2019 the first alarming news of a new flu plaguing the province of Hubei, about 1000km away, reached Macao. An unknown disease was spreading rapidly and causing death. In addition to the geographical proximity, the biggest concern for Macao was the massive invasion of tourists (35 million in 2018, dropped to 27 million in 2019), the overwhelming majority coming from mainland China. The hypothesis of the new virus was therefore very real. The question was not "if", but "when".

The unknown coronavirus tested the crisis management capacity of the new executive, recently inducted when it was forced to deal with this unprecedent health crisis.

The legal basis of the measures taken can be found in Law No. 2/2004, the Law for the prevention, control and treatment of communicable diseases. As indicated by its date, the law was created in the aftermath of the health crisis generated by SARS pandemic in 2001-2003, which seriously affected Macao. The region took the hard lessons of SARS and created a legal framework that allows the prompt and accurate taking of the necessary measures.

One of the first actions put in place (even before the diagnosis of the first infection in the territory), and still maintained, is the widespread implementation of body temperature measurements when entering various places (public services, schools, restaurants, stores, and even public parks and parking lots). Anyone with fever is prevented from going in.

In January, the authorities began imposing control measures at the borders, in an increasing degree of severity, in accordance with the growing gravity of the events: body temperature measures, presentation of health declarations, medical examinations. Gradual entry bans were imposed, until eventually only the residents of the so-called Greater China (Macao, Hong Kong, Taiwan and Mainland China) were allowed to come in. However, the newcomers were subject to mandatory quarantine in hotels available for this purpose, at the Government's expenses in case of Macao residents. This ban is still in place (but, due to the existing travel restrictions, no one is arriving to Macao).

In early February, Macao asked its inhabitants to remain in voluntary quarantine. It was never necessary to impose it as a mandatory measure because it was strictly complied with by everyone. Currently, the population is in social restraint, but most activities were

resumed (education is the most relevant exception).

The use of facemasks remains controversial. The World Health Organization does not recommend it as a regular protection measure, but many studies encourage its use, and it is a common behavior (even as a politeness rule) all around Asia. In Macao the use of facial masks became mandatory to enter public services and various stores, to ride a bus or a taxi, and even to enter residential buildings. The Macao Executive ensured the distribution of face masks to the population at a symbolic price to prevent difficulties in purchasing them due to trade speculation.

Another measure of great importance was the implementation of the so-called Personal Health Declaration. For the purpose of accessing various public and private places, each day citizens are required to fill in an on-line declaration. It contains information such as the person's complete identification and contact details, the places where he/she has been in the last 14 days and the existence of any symptom that may indicate an infection. If the person is identified as being infected, it will be possible to track his/her steps, namely to know the places where he/she has been and with whom, and alert potentially infected individuals. On the 3rd May the system devolved to a QR code by colors (not that different from the previous model, but symbolically closer to the mechanism used in China). Each resident has a color assigned - green, yellow or red – which dictates the level of freedom of circulation each one has. Only green codes are allowed in all public and private venues.

Macao successfully controlled the first 10 cases of infection (all recovered) and managed to remain without new cases for about 40 days. In the mid-March a new wave of cases started (35 identified cases), brought by residents coming for abroad, but they were all perfectly controlled. Button line: no life was lost.

One may wonder why Macao did not use the so-called draconian measures, as some of its neighbor jurisdictions?

I believe there are two main reasons for it.

First, in Macao money is not a problem. When people were asked to stay at home they simply stayed because unemployment and concerns about meeting basic needs are not on the table for residents (note that the same is not valid for nonresident workers). In February, the Government imposed the closure of all casinos for 15 days, in the peak of the health crisis, something that never happened before. Macao's annual revenue comes mostly from the gambling industry and its associated services, ascending to six times that of Las Vegas. It was US $37.6 billion in 2018, decreased to $22.9 billion in 2019 (due to circumstances such as the trade war between the United States and China and the political tension in Hong Kong), and due to the pandemic it will suffer a dramatic drop in 2020. Macao Government will be deprived of a substantial part of its revenue, since 80% come from taxes paid by casinos, but this measure shows the Executive's commitment in fighting the pandemic. The fact of being one of wealthiest places on the planet certainly helps to take the blow, not only for the Government, but also for families. For instance, for the next three months water and electricity costs are paid by the Government and until August each resident will receive around 900 euros in consumption vouchers.

Secondly, people naturally comply with governmental decisions. The community has trust in the Government and there is a general feeling that authority must be obeyed. Several reasons explain this particularity of Macao: political (still related with the overwhelming and constant influence of a one-party state), economic (casinos allow the Government to take care of its people) and philosophic (Confucianism and the idea of the common good, which prevails over individual interests).

The modus operandi of Macao could hardly be emulated in other jurisdictions. For it to work you need money, public trust and some luck. In Macao, the house always wins.

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Portugal, The Surprise of Southern Europe

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When the first cases of infection by Covid-19 in China began to be discussed worldwide, Portuguese official entities devalued the virus, saying that it would not "arrive" in to Portugal and that the chances of contamination among human beings were scarce. The reality has shown us something else quite different with the numbers in China –predominantly in the Wuhan region -, increasing. When the first European cases arose, we were under the belief that Portugal, located at the southwestern most point in Europe and bordering only with Spain, stood at an advantageous point when compared with other European countries. It's remaining territory was of no concern as it bordered the Atlantic Ocean. It is perhaps for this very reason that the first infected individuals appeared later than in many other European countries like Italy, Spain, France, etc ... As the numbers of infected people increased and frightening news arrived from Italy, with regard to Europe, civil society in Portugal immediately reacted by demanding its governmental and health leaderships take immediate action. Perhaps for this reason - strong pressure from civil society - Portugal adopted protective measures early when compared to the rest of European countries. Many of the measures were implemented before there was news of deaths by Covid 19 in Portugal and when the number of known infected people was still quite low. We knew that we could not escape this pandemic, so the objective was to extend the number of infected people in time so that we could avoid very high peaks that would lead to the rupture of our health system, as happened, for example, in Italy and Spain. As of the date I write these lines (29 April), I think the goal has been achieved. In fact, the famous curve has remained on a plateau, allowing health services, despite being overloaded, not to break. This, however, leads us to question the monitoring of the remaining pathologies. The truth is that during the month of March, if we compare it with the same period in Portugal in 2019 we had an increase of approximately 900 deaths - they occurred due to a deficient monitoring of other pathologies since the resources were mainly allocated to fight the pandemic, either because there were deaths from complications due to Covid 19 that were not diagnosed, or for any other reason that we are not aware of.

But, after all, what were the measures that Portugal applied? Portugal did not impose mandatory confinement. First, the Government began by ordering the closure of all educational establishments. Then the citizens themselves began to close their establishments, by choice. People began to practice social isolation and social distancing. Finally, through Decree of the President of the Republic no. 14-A / 2020, published on March 18, the state of emergency was declared throughout the national territory, based on the verification of a situation of public calamity (cf. Articles 1 and 2). The state of emergency, with a duration of 15 days (in Portugal it cannot be decreed for more than 15 days), started on March 19, 2020 and ended on 2 April 2020, without prejudice to possible renewals, under the terms of the law (see article 3). What happened through the Decree of the President of the Republic no. 17-A / 2020, published most recently on April 2, was based on the verification of the continued situation of public calamity, covering the entire national territory (cf. articles 1 and 2nd). This renewal of the state of emergency also lasted for 15 days, starting on April 3, 2020 and ending on April 17, 2020, without prejudice to any new renewals, under the terms of the law (see article 3). On April 16, a further state of emergency was decreed for another 15 days, which will end on May 1, 2020 (this legislation has already provided for the possibility of partially opening certain sectors of society). The Portuguese state of emergency, despite not imposing a mandatory quarantine, determines the situations in which residents in Portugal can be absent from their residence (for the purchase of essential goods, travel for health reasons, physical exercise in the vicinity of their residence, travel to work - in sectors that are still in operation and whenever the activity cannot be practiced in teleworking regime), etc. The Portuguese, as a rule, have respected these limitations to their freedom in favor of the greater good. Today we are considering reopening certain sectors of commerce, education, etc. The reopening will be in stages and subject to conditions. For example, the school year in Portugal starts in September and ends in July. We already know that children and teenagers will not have to take face-to-face classes again this school year. Only students who are in the years of preparation for access to higher education will return to face-to-face

classes, but only in the core subjects and under strong restrictions.

Although I think that the figures released are far from the actual numbers of infected people in Portugal, it is my belief that it is specifically Portugal's early-stage reaction which allowed it - for now -, to prevent the collapse of our national health system (with rates of daily increase in new infections at an average of 4%, 3% or 1% or with mortality rates of approximately 3% - a figure close to Germany that goes up, however, if we limit it to people over 70 years old where the lethality rate is more than 10%). There was an adequate response from government bodies, but also from civil society. We will see how the crisis, in terms of health, advances. In the expectation that a short-term response will emerge in prophylactic terms, the economic crisis is certain to last for a long time.

29 April 2020

The Italian Lockdown: The Complex Management of the CoViD-19 Pandemic


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The first confirmed cases of the new Coronavirus (CoViD-19) in Italy were recorded between the end of January and the beginning of February, 2020. Within less than one month, the number of cases quickly increased, in particular in Northern Italy. To control the spreading of the virus, a first act was adopted by the President of the Lombardy Region and by the National Health Minister, by which a handful of small towns was swiftly put on lockdown. On 8 March, 2020, the Italian Prime Minister announced the expansion of the quarantine zone to cover much of Northern Italy, an area populated by over sixteen million people. On 9 March, the quarantine measures were expanded to the entire country. According to the initial scheme, all public gatherings were banned, and any travel was only allowed for "urgent, verifiable work situations and emergencies or health reasons". The lockdown, initially supposed to last until April 3, was then extended first to April 13 and then to May 3. Moreover, more tight restrictions were progressively introduced such as the closing down of all commercial and retail businesses, except those providing essential services, and of all non-necessary industries.

Among the most thorny legal issues related to the management strategy of this pandemic, two have been particularly debated and have been dividing the legal scientific community. The first one relates to the sources of law that were used to restrict certain fundamental rights, including, first and foremost, freedom of movement.

From an institutional viewpoint, the measures adopted by the Government at the outspread of the emergency and in the following days raised some concerns on/over their legitimacy and the fear that the executive was going to exercise full powers without any control from the Parliament. To be clear, after some emergency ordinances were adopted within the framework of civil protection rules (i.e. those aimed to protect the safety of the population from danger or serious risk), the executive adopted a series of law-decrees (provided by the Constitution as a general instrument to legislate in extraordinary circumstances of necessity and urgency - art. 77). As said, Covid law-decrees introduced some relevant restrictions on fundamental rights and were further completed by secondary sources of law.

According to some authors, the instrument chosen by the Government put Parliament in a sort of subsidiary position. At the same time, though, the ordinary work of the Chambers was slowed down by distancing measures and the country was desperately in need of quick interventions. Some other authors, while confirming the formal legitimacy of governmental acts, criticized their contents, deemed disproportionate.

A second set of legal issues concerns the tense sharing of competences on healthcare issues between the central state and the regions. At present, the central level establishes the health benefits that shall be equally granted to people, while the concrete organization and management of healthcare services is in the hands of the regions. In the last twenty years, a huge territorial differentiation on healthcare services has developed and, during the emergency, the relationships between central and local administrations haven't always been plain.

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Organizational choices undoubtedly played a central role in the whole evolution and management of the crisis. The severity of the measures adopted by the Government, in fact, can partially be explained by the unpreparedness of the National Public Health Service and by the limited resources available, in particular in the context of intensive care units (ICUs). During the emergency, improper management of CoViD-19 cases at a territorial level and the quick hospitalization of confirmed patients caused huge pressure on hospitals and on the National Healthcare Service as a whole. The main fear was that the number of patients requiring hospitalization could become much greater than the system can cope with.

In reaction to the concrete fear of intensivists that had to deal with hard choices on patients' resuscitation, the Italian Society of Anesthesia, Analgesia, Resuscitation, and Intensive Care published a document on Clinical ethics recommendations for the allocation of intensive care treatments, in exceptional, resource-limited circumstances. The document swiftly raised a huge public debate, as the recommendation to give preference to clinical criteria including biological age (as distinguished from actual - biographical - age) was read as a suggestion to choose younger patients for ICU treatments. Whereas the medical society made it clear that when choosing between scarce resources, clinical appropriateness of treatments shall be given prevalence, the National Committee for Bioethics published its opinion on Clinical decision-making in conditions of resource shortage and the "pandemic emergency triage" criterion, which aimed to add distinguished opinion to the bioethical debate on the matter.

In the meantime, thanks to the social distancing measures, the contagion rate started to decrease, and proportionally also the number of patients in ICUs.

With a total of more than 29.000 deaths (as of May 8, 2020), thousands of infected people among healthcare professionals, and alarming outbreaks in retirement homes for elderly people, starting from May 4, 2020, phase 2 is going to begin. The priority, in this phase, is to reconcile the protection of the right to health with the promotion of other rights and liberties, such as work and freedom of movement, also relying on the wider use of diagnostic and serological tests and other individual tracking systems (such as the app Immuni, that the Government is expected to release by the end of May). Time will tell whether the moment and means for rebalancing fundamental rights were ripe and appropriate. We do hope so.

8th May 2020

Insights from Spain: COVID-19 in the country with the highest percentage of deaths by population in the world

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Talking about COVID-19 in Spain is as much as talking about a tragedy. At the time of writing, May 2020, Spain is the country with the highest number of deaths per million inhabitants from this disease in the world. There are several reasons that explain this circumstance. Some are related to its population pyramid (clearly aged). Others have to do with the high percentage of coexistence between young and old people and the lack of adoption of adequate measures to protect the elderly who live in retirement homes. The fundamental issue, however, may be the lack of sufficient foresight, which failed to prevent (and even caused) the incidence of the pathology to be much higher than in other countries. I will now focus on this last aspect.

In the light of the data we currently have, there were already chains of native contagion in Spain during the last week of February. However, at that time the director of the Centre for the Coordination of Health Alerts and Emergencies, Fernando Simón, was still stating the opposite. This disparity between the probable reality and the scenario outlined by the official Spanish authorities led to a general state of ignorance of the seriousness of the situation. As a result, although on 25 February the main Spanish newspaper, EL PAÍS, published on its front page an article entitled "The WHO asks the world to prepare for a "potential pandemic due to the coronavirus", the majority of Spaniards remained unaware of the danger that was approaching.

The crucial moment of the expansion of the pandemic, however, must be placed in the second week of March, more specifically in a day that will soon be of fatal memory for the Spanish: Sunday, March 8. On that

date, an enormous number of massive events were held in Spain, from feminist marches that brought hundreds of thousands of people to the streets, to political party rallies plus the corresponding sports competitions. To this day, it is still difficult to understand why the government allowed these events to take place. They probably helped to spread the pandemic exponentially. Officially, it is said that there were no data to support the belief in mass contagion, but this information is highly controversial. Especially, if we bear in mind that only a few hours after all the mass events of that Sunday were over, the official discourse began to change, admitting that the situation was out of control.

Only three days later, on March 11, WHO changed the qualification of the events from a public health emergency to an international pandemic. Two days later, the president of the Spanish government, Pedro Sánchez, made an institutional declaration announcing that he would approve the State of Alarm (one of the exceptional states provided for in the Spanish legal framework) the following day, March 14. From that moment on, the circulation or presence of people or vehicles in certain hours and places was drastically limited, while the vast majority of the population was forced to remain confined to their homes.

All these measures, however, did not prevent the Spanish health system from having to face an exponential increase in the numbers of patients admitted to its hospitals. Many of them showed complicated clinical conditions, which eventually made it necessary for them to be placed in the available ICUs. In a few days, the situation became extremely complex in the automous communities (regions) of Madrid, Álava and La Rioja, where the need to establish a triage to decide who could have access to resources that were already scarce became apparent. In the following days, other autonomous communities, such as Navarre, Catalonia, Castile and Leon were in very similar situations. In all of them, moreover, there was a dramatic lack of protective equipment for healthcare professionals who had to deal more directly with the sick, which led to a very high percentage of infected healthcare personnel. It is estimated to be more than 10%, although it is difficult to determine, because of the exasperating lack of available diagnostic tests.

The proclamation of a State of Alarm and particularly aggravated confinement in the first half of April made it possible to reduce the incidence of the pathology, but many of the deficiencies in its management remain. To date, we still do not have sufficient medical material and diagnostic tests. In fact, there are enormous problems in finding reliable data on the incidence of the pandemic, while even the number of deaths has been called into question on the basis of well-founded reasons. This does not say much for the degree of transparency with which information is being transmitted, even though this is a legal requirement in Spain. Nor is there any evidence that the government has an elaborate plan to end the confinement. On the contrary, what we have been told is that nobody knows very well how to get out of a situation like the one we are experiencing right now. What seems certain, in any case, is that the political disputes between different parties and between the central government and the different autonomous communities into which the Spanish administration is divided continue and will probably increase. Meanwhile, thousands of Spaniards are still wondering what will happen when the economic crisis takes the place of the public health crisis.

COVID-19: Australia's Legal Responses

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Screening commenced for COVID-19 in Australia on 23 January 2020. The first confirmed case was identified two days later when a Chinese citizen who had arrived from Guangzhou on 19 January tested positive. However, Australia's response to the emerging pandemic was not as quick as would have been ideal. It took until 20 March for borders to be closed to non-residents and on the next day social distancing rules were imposed. In the latter part of March the number of cases was running at about 350 per day, but the social distancing rules proved successful and by early May the numbers had reduced dramatically and only in the order of 25 new cases per day were being identified. Assertive contact tracing was being pursued in relation to all cases. Australia had dropped

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from being amongst the worst 10 in the world for the incidence of COVID-19 to 50th.

Australia is a federation of 6 states and 2 territories. Matters such as immigration, foreign affairs and national security are commonwealth matters. Other matters, many of them in relation to health, are the responsibility of the state and territory governments. On 1 February 2020 the commonwealth government banned the entry of foreign nationals from mainland China and ordered its own citizens to self-quarantine for 14 days when they returned from overseas. Shortly afterwards, it made similar orders in respect of visitors Iran, South Korea and Italy.

A social distancing rule of 4 square metres per person in any enclosed space was agreed to by the National Cabinet constituted by the Prime Minister and the Premiers and Chief Ministers of the States and Territories (akin to an emergency War Cabinet), to be implemented through State and Territory laws. On 22 March 2020, the State governments of New South Wales and Victoria imposed a mandatory closure of non-essential services, while the Governments of Western Australia and South Australia imposed border closures. Other states and territories followed suit in the succeeding days.

On 22 March places of social gathering were closed throughout Australia, including registered and licensed clubs, licensed premises in hotels and bars, entertainment venues, including cinemas, casinos, nightclubs and places of worship. Cafes and restaurants were permitted to remain open, but limited to providing takeaway meals only. Similarly, enclosed spaces for funerals were obliged to adhere to a strict four square metre rule.

A general travel ban was made pursuant to the Biosecurity Act 2015 (Cth) on 25 March 2020. On 25 April 2020, the Biosecurity (Human Biosecurity Emergency) (Human Coronavirus with Pandemic Potential) (Emergency Requirements—Public Health Contact Information) Determination 2020, made under subsection 477(1) of the biosecurity legislation, was signed into law by the Health Minister. Its purpose was stated to be "to make contact tracing faster and more effective by encouraging public acceptance and uptake of COVIDSafe", a mobile app created to record contact between any two people who both have the app on their phones when they come within 1.5 metres of each other. The encrypted data would remain on the phone for 21 days of not encountering a person logged with confirmed COVID-19. By 8 May 2020 over 5 million people had signed up to download it, but it had emerged that it failed to work with Apple iPhones. However, considerable controversy has attended the human rights and privacy ramifications of the app, especially in light of the involvement of Amazon in data storage.

In Queensland a public health emergency was declared on 29 January and the state's powers were strengthened on 6 February. In Victoria a state of emergency was declared in 16 March and schools were closed from 22 March. While they remained open elsewhere in Australia, few students attended. It is likely that schools will not reopen until the third term of the school year which commences in July. The declaration of a state of emergency entitles a State's Chief Medical Officer to give directions in relation to a wide variety of matters in the interests of public health and safety.

In a significant decision Ginnane J of the Victorian Supreme Court was asked in *Rowson v Department of Justice and Community Safety [2020] VSC 236* to release a prisoner into home detention because of the risk of his contracting COVID-10 in the context of his having a variety of particular health vulnerabilities. The prisoner was not released but the expert evidence adduced highlighted the particular health risks for some categories of prisoners in a congregate penitential setting. Ginnane J concluded that the evidence established a sufficient basis, when taken with the absence of risk assessments conducted by the prison:

> to establish a prima facie case that the defendants have breached its duty of care to him, which exposes him to risk of significant injury.

While no infection has been detected amongst prisoners or employees, the Commonwealth Government and the Victorian Government, in particular, have continued the current lockdown. That is a significant step because it prevents the normal operation of a free society and largely confines citizens to their homes under sanction of substantial fines. Those governments obviously think it is appropriate that the lockdown continue. There is no end in sight.

> … there is a risk that the virus may gain entry to the Prison and if it does it will spread more rapidly than in the usual community because of the 'congregational' nature of a prison. That risk is not insignificant. ([98]-[100])

The outcome was orders that the prison conduct risk assessments in respect of the health vulnerabilities of prisoners.

Formal inquiries were instituted by government in Tasmania into a serious outbreak in two rural hospitals to learn quickly whether errors were made and better procedures needed to be instituted and in New South Wales where large numbers of persons became infected after virus-positive patients were permitted to disembark from a cruise ship, the Ruby Princess. This has constituted an additional form of high-profile accountability. In Victoria too, a parliamentary inquiry has been established to monitor the government's response to the pandemic – with two separate reporting dates.

There have been instances of individuals and corporations marketing products as treatments for COVID-19, although they have no therapeutic legitimacy. The Therapeutic Goods Administration (similar to the Food and Drugs Administration in the United States) intervened with the first, involving a high profile chef who promoted a BioCharger NG, as a treatment for COCVID-19, imposing heavy fine, and is investigating the second, a church, that has promoted bleach as a COVID treatment and is likely at the time of writing to take imminent assertive action; in the meantime it issued an urgent advisory, warning consumers to be alert to misleading claims about a particular bleach for the treatment, cure, prevention or alleviation of COVID-19.

The extended period of closure of work, other than essential services, and of hospitality, tourism and other industries, required a variety of legislative responses throughout Australia, including substantial provision of income support. An example of legislative responses was the COVID-19 Omnibus (Emergency Measures) Act 2020 (Vic) which was passed by bipartisan support in a day. It was radical legislation permitting regulations to be made (without statutory enactment in the form of legislation) modifying procedures applying to applications for bail, judge-alone criminal trials, and making procedures more flexible for witnessing documents. Measures were also included to modify circumstances in which residential and retail leases could be terminated by landlords. Powers were also provided to deploy reasonable force to require quarantining, including for prisoners in jails.

As of 8 May 2020, the first measures had been agreed to by the National Cabinet to commence a scaling back of the social distancing rules and permitting larger number of persons to congregate on a trial basis, to be implemented in three-weekly gradations, so as to maximise the prospects of successful avoidance of a second wave of infections. It is anticipated that an Australasian hub will be established imminently to allow relatively free travel within Australia, and between Australia and New Zealand but limitations on international travel are expected to remain in force indefinitely.

Public Health Actions for COVID-19 Infection: Hong Kong Journey

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The epidemiological triangle of agent, environment and host in the pathogenesis of disease underlies the principles in preventing the occurrence of communicable diseases. Rigorous precautionary measures such as restriction of population movement, strict hygiene measures in public such as deterrent to those with no face mask and strict hand hygiene upon entering and leaving public places are needed to control the three factors.

Since the first 44 cases in Wuhan, Hubei Province reported to World Health Organisation (WHO) Office in China in early January 2020, there were over 10 folds increase in China in less than 3 weeks with one third outside Hubei and a lot more countries with infection and most cases with travel history to Wuhan. The WHO Director-General declared that the outbreak of 2019-nCoV constituted a Public Health Emergency of International Concern (PHEIC) and issued this advice as Temporary Recommendations under the International Health Regulation (IHR) on January 30. The Committee emphasised the declaration to be seen in the spirit of support and appreciation for China and did not recommend any travel or trade restriction. Countries should be cautioned against actions that promote stigma or discrimination in line with the

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principles of Article 3 of the International Human Rights.

Did this declaration bring out a strong public health message to step up infection control or consolation? This had implications on Hong Kong (HK) government policy on imposing strict precautionary measures. From January 23 to 29 January, the first ten cases in HK were all imported cases from mainland China. The Chinese New Year started on 25 January 2020 with anticipated massive population movement. Although 'shut down' action was implemented on Jan 23 in Wuhan city, the city population is over 10 million (including mobile population). It would be unreasonable to expect any government to achieve 100%. Even though 0.1% of population would come out, this would be over 1,000. One had observed doubling of cases within 2 days from 23 Jan in China and outside China, and also the number of countries affected. HK Government refused closing all the borders with mainland China. Mandatory health declarations at all borders and ports demanded by medical experts were initially rejected. On 30 January, high-speed rail link with mainland China and all cross-border ferry services were suspended, and the number of flights from mainland China and cross-border bus services were reduced. However, other major check points were still open. On Jan 31, the HK Chief Executive during her interview with Radio Television Hong Kong said that a complete closure of the border would not be in line with advice given by WHO, which had not recommended any restrictions on travel and trade with China. She added that a ban specifically on mainland visitors would also be going against WHO advice, "….in the World Health Organisation statement, it makes it very clear that countries and governments are cautioned against actions that promote stigma or discrimination."

Public sector health workers of a newly formed union, Hong Kong Hospital Authority Employees Alliance (HKHAEA) denounced the government measures "too little and too late". Since the outbreak, the supplies of face masks, disinfectant products and even non-medical products such as bottled water, rice, toilet papers were under pressure. HKHA reported stock of surgical masks had fallen below three month supply in late January and personal protective equipment was also tight. By first week of February, the cases in Hong Kong had increased more than double and continued to accelerate. On 3 February, the Government closed more borders, but refused closing all borders with mainland China leaving four cross borders open (Bridge linking to Macau and mainland, Shenzhen Bay Port, international airport and Cruise Terminal). The HKHAEA initiated industrial action between 3-7 February after HK Chief Executive refused to attend the negotiations for their urge for border closures as well as ensuring a stable supply of medical masks, requesting sufficient isolation wards and support for healthcare staff looking after patients in isolation, as well as a halt to all non-emergency services. On 8 February, HK confirmed a state of public health emergency and enacted a regulation to require all entrants from the mainland China (except those exempted) to undergo home quarantine. The Education Bureau closed all schools with resumption expected by stages in late May and early June. Public facilities such as museum, sport centres, public libraries were closed. The rise of cases slowed down in Hong Kong from mid-February due to tighter precautionary measures.

Hong Kong faced the second wave in mid-March with global pandemic. On 25 March, HK closed all borders to all incoming non-residents arriving from overseas. All returning residents were subject to the Compulsory Quarantine Order and those from UK, US and Europe continent were required to undergo enhanced screening. On 29 March, indoor and outdoor public gatherings of more than four people were banned and restaurants were required to operate at half their capacity and set tables at least 1.5 meters apart. In early April, HK Government announced temporary closure of karaoke lounges, nightclubs, mah-jong parlours, pubs and bars. In early May, Government announced easing of some of those measures. The community had been very vigilant in adopting preventive measures. From 12 April, the number of daily new cases was single digit and no new local transmitted cases have been reported for over 2 weeks at time of writing (7 May).

Macao and Taiwan are also close to mainland China with heavy cross border travel, the pandemic has a lessor impact than her neighbours such as Hong Kong, Korea, Japan. Macau and Taiwan had adopted series of strict measures since early January. Prompt public measures taken after once observing a suspicious outbreak with an exponential increase within a short period , a spreading to other territories and further stepping up with cluster outbreaks, have been found to be effective to reduce the magnitude of the infection. It is time for stronger community action to prepare for future health crisis (http://www.chep.cuhk.edu.hk/covid19). Global health leadership needs a new era.

This article reflects the academic view of the author, not the institutions associated with him.

COVID-19 in Indonesia: Challenges and Changes

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(Honorary Associate)

Indonesia faces an unprecedented challenge due to the Coronavirus Desease 2019 (“**COVID-19**”) pandemic. Due to the pandemic, Indonesian government has declared the public health emergency through the Presidential Decree No. 11 of 2020 regarding the Stipulation of COVID-19as Public Health Emergency (“**Presidential Decree 11/2020**”). Presidential Decree 11/2020 stipulated COVID-19 as a type of disease that causes a public health emergency. Presidential Decree 11/2020 further provides that the mitigation measures in Indonesia shall be implemented in accordance with the prevailing regulations. At the global level, on 31st of January 2020, the World Health Organization (“**WHO**”) has also declared COVID-19 as a public health emergency of international concern (PHEIC).

In handling the pandemic outbreak issues, Indonesia has been criticized for several issues e.g. lack of transparency on the actual COVID-19 data including mortality data, a few laboratories which have been the weakest link in Indonesia’s health services, and a low testing rate which masks the scale of the COVID-19 pandemic.

We focus the discussion to several challenges arising due to the pandemic outbreak and changes that have been made by the Indonesian government to overcome such challenges. In particular, on the government’s effort in maintaining the implementation of the Universal Health Coverage (UHC) system as conceived by the WHO.

As is widely known, the main purposes of UHC are as follows: (i) access to essential medicines and technologies; (ii) health workers who are motivated; and (iii) sufficient in number and skills/protection of health workers.

Indonesia’s ability to achieve the UHC

Indonesia’s health system and its ability to achieve UHC were already under huge scrutiny prior to the pandemic outbreak. As it happens, the increased pressure is owing to three inter-related factors: first, the unequal distribution of healthcare workers in Indonesia; secondly, difficulties with testing tools used in Indonesia; and thirdly, the shortage of PPE.

Maldistribution of healthcare workers

The current ratio between physicians and the population in Indonesia is still well below the ideal ratio recommended by the WHO. In 2017, the WHO data showed that Indonesia had 4 doctors per 10,000 people.

Testing tools used in Indonesia are plagued with problems

In a recently published investigative report conducted by the Organised Crime and Corruption Reporting Project (“**OCCRP**”) along with other media including Tempo, several testing tools were found to be plagued with problems. One of them is VivaDiag which was produced by VivaCheck Biotech Hangzhou Co Ltd. The testing tool received a recommendation for importation by the Indonesian National Board for Disaster Management (Badan Nasional Penanggulangan Bencana) on 31st of March 2020.

Imported by an Indonesian company, namely PT Kirana Jaya Lestari, VivaDiag was used in Bali on 30th April 2020. Inaccuracies were then found from the VivaDiag test results. As a consequence, the VivaDiag test was pulled from all health care facilities in Indonesia by the Director of PT Kirana Jaya Lestari.

Lack of PPE for healthcare workers in Indonesia

Another issue is the lack of PPE for healthcare workers. Indonesian medical workers threatened to cease their work at the end of March 2020 due to the inadequeate protective gear. This warning was specified in a joint statement issued by Indonesian Medical Association (IDI), the Indonesian Dentist Association (PDGI) and the Indonesian Nurses Association (PPNI) on 27th of March 2020.

The Indonesian government in its effort to ensure the availability of PPE and testing kits, issued incentives in the form of exemption on import duties for several goods for combating the outbreak including the test kit (in pursuant to the Minister of Finance Regulation No. PMK 34/PMK/04/2020) as well as a curb on exports of PPE (pursuant to the Minister of Trade Regulation No. 23 of 2020). Such regulatory actions pursued by the Indonesian government are similar to the actions taken by both the US and the European Union, which were deemed as a global approach that is especially valuable.

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We will further discuss the regulatory actions that have been pursued by the Indonesian government to overcome this issue, i.e. the accelerated legal changes taking a turn in the fiscal front.

Import licensing of PPE and related devices to combat COVID-19

Provisions on the import licensing of medical devices and related devices to combat COVID-19 have experienced significant changes since February 2020. There has been an acceleration of the importation of medical devices and PPE. This acceleration can be observed from the issuance of the Minister of Trade Regulation No. 28 of 2020 regarding the Eighth Amendment to the Regulation of the Minister of Trade No. 87/M-DAG/ PER/10/2015 regarding Provisions on the Importation of Certain Products ("**Minister of Trade Regulation 28/2020**").

Under the initial regulation, several goods are restricted to be imported subject to the following requirements:

a. It may only be imported provided that the required Surveyor Report (Laporan Surveyor) has been issued in the country of origin or port of loading; and

b. It may only be discharged/delivered to a certain port of destination in Indonesia.

Article 19A of the Minister of Trade Regulation 28/2020 exempts several products categorized under 17 (seventeen) Harmonized System Code ("**HS Codes**") which include inter alia PPE and antiseptic products ("**Exempted Products**").

Further, previously a Bill of Lading (B/L) and Invoice are required to prove the shipment of the Exempted Products. The Minister of Trade Regulation 28/2020 only requires the B/L to prove the shipment of the Exempted Products. This import relaxation is valid until 30th of June 2020.

Conclusion

The aforesaid regulations in relation to the fiscal and procedures to conduct certain import and export activities constitute a pragmatic legal approach. It could be considered as an 'on point' strategy taken by the Indonesian government.

Through ensuring the availability of the testing tools and PEE, Indonesia has endeavored to meet its obligations in relation to the UHC.

Nonetheless, the Indonesian government is still expected to also ascertain the quality of the testing kit, to issue a policy and/or to take the necessary action to manage the distribution of the healthcare workers in Indonesia. Especially in these challenging times, the accuracy of the test results and proper distribution of healthcare workers are essential for saving more lives. In that scenario, Indonesia could be assisted to fully achieve the UHC wherein "*all people obtain the health services they need without suffering financial hardship when paying them*".

Acknowledgement

We are thankful to Stefanny Oktaria Simorangkir & Reynard Kristian – Budidjaja International Lawyers, and Stephanie Doris Short – the University of Sydney, Australia for their feedback. Farah is a senior counsel at Lawyerindo & an affiliate at Sydney Asia Pacific Migration Centre, the University of Sydney.

WAML President's Report

Thomas T. Noguchi,
President of WAML

Since the last issue of the Newsletter, the world has changed distinctly: the coronavirus pandemic came in our lives. All of us in the WAML leadership offer our sympathy and concern for all of our members affected by this life changing disaster.

The matter evolved rather quickly, now in the US a national emergency has been declared and the State of California has gone on lock-down, advising us to stay home. Cooperating with national and global instructions for preventing or slowing down the spread is essential.

Universities are now relying on online instruction for registered students. Some courses are not scheduled to reopen until summer. The Olympic games may be affected by the rules of social distancing.

The online EC Meeting took place on April 4, 2020, where we discussed more details on the upcoming Congress and future meetings.

This year is the first time during WAML's long history that we have had to cancel a Congress. It is not our choice, it is a global emergency. Currently the majority of us are under lockdown order by the authorities or under severe traveling restriction. By not having the Congress this year, it means we will not have the Board of Governors or general assembly (membership) meetings this year. So all current officers, members of the Board of Governors, of committee and their chairs, and other statutory appointees must continue to serve until we meet again in Istanbul, Turkey in August 2021.

We will continue to do whatever we need to do to maintain the progress of the WAML.

We hope you are all safe and well. WISHING YOU ALL CONTINUE TO BE WELL.

The program chair for the coming Istanbul Congress is Prof. Berna Arda from Turkey and she already has a brochure ready for distribution.

We are looking forward to meeting again in the coming Istanbul Congress.

Thomas T. Noguchi
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WAML Secretary General's Report

Ken J. Berger
MD, JD
WAML Secretary General

I am pleased to report that the Executive Team of the WAML has been able to fully resolve matters with the Congress site in Toronto.

This did take some imagination and efforts and I really thank Denise for her great experience and strong stewardship, as always.

We were very fortunate that the hotel was flexible and our team acted decisively, as the hotel gave us limited time for amendments to the contract that protects WAML.

I am so very pleased as a result to report that the Toronto meeting has been rescheduled officially to August 8-11, 2024. I have spoken to many of the anticipated speakers, Committee members and partners and they are very thankful for this rescheduling, as the Covid-19 ruined our well intended plans and they gave their commitment to me in 4 years, truly amazing. We would not have been allowed with Covid-19 to put forward the same Congress with the same number of delegates from different Countries that we had planned and by deferring this 4 years, it is now possible again. Everyone has reset their schedules and the stakeholders have kindly committed to this change.

Upon hearing this update, I am so very grateful for some of our more Senior members, who serve on Committees, were very happy with this development, however, I pray and lets all pray that they will still be healthy and strong in 4 year to make the journey to Canada as well as joining us on the road through Istanbul, Gold Coast, and then to Vilnius and Toronto.

We did have other options of moving the meeting later in 2020 or rescheduling it earlier but based on the nature of the contract and the contractual commitments we had with other Congress sites, this was by far the best solution and received unanimous support from the EC.

With this Covid-19, I think it will be important for us to develop even more collaborative and fiscally responsible strategies moving forwards, as I think we may, like other organizations, face future financial challenges.

Luckily under our consistent leadership team we have been very successful growing the financial stability of the WAML, so we are better prepared to face the ongoing hardship of Covid-19 and come out even stronger.

However, we cannot let our guard down and will need to continue to maintain the strength of our membership, recruit new members and continue to create value for our membership.

Furthermore, I wish to congratulate Thierry and Nicola for the launch of the WAML book series on Informed Consent. I am sorry we could not have the launch party in Toronto, but I have transferred this plan and responsibly to Berna where I am sure she will have something special planned for us. I also wish to thank Jonathan for agreeing to move the Davies

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award to Istanbul from Toronto and his ongoing kind generous donation to Young Researchers.

Finally and most importantly, we thank the Governors for their wisdom and loyalty, as we have recommended as an EC, for us all to reinvigorate ourselves for Istanbul and they have been with us every step of the way, and we will come out of this Covid-19 with even more brilliant Health Law initiatives.

I look forward to sharing those mutual goals with all of you! I wish everyone safety, good health and prosperous times with your families and loved ones during these truly unprecedented times.

Very truly yours,

Ken J. Berger MD, JD

Secretary-General and Board of Governors,
World Association for Medical Law

Program Chair, 2024, 26th WAML meeting,
Toronto, Canada

WAML Executive Vice-President's Report

Prof. Dr. Vugar Mammadov,
WAML Executive Vice-President
Chairman of WAML Education Committee

COVID-19 has changed the world.

4 billion people suffered from complete or partial lock-down for months.

Most of international and national flights, cruises, travels, events and gatherings, sport and cultural programs are cancelled.

Olympic Games, World Expo, World Cups, world congresses are postponed. WAML was forced to cancel 26th World Medical Law Congress in Toronto, Canada, scheduled for August 2020. This was a hard decision for Executive Committee to discuss this proposal of the President Noguchi, but it seems it was the only way to protect the safety of members and secure success of the Association.

WAML Education Committee has cancelled planned activities in Rwanda, Qatar, Jordan and Costa Rica.

Cancellation of WAML Congress due to force majeure has never happened before in 53 years WAML history. Many things have never happened before. So we are living in extraordinary times. World economics and social life collapsed. This became real force majeure. International organizations, national and international leaders could not shade their own weakness and mis-orientation. A lot of wrong decisions and non-justified actions and declarations… I think image of WHO has downgraded in eyes of international and professional community very significantly also. They could not manage situation well and have shown themselves not as leaders, but rather conductors of certain interested groups and pharmaceutical companies having transnational power.

Such times may be challenging also…I wish to believe that WAML will take more leadership on such calls in future to provide proper response to public and international needs. I wish all WAML members strong health and security. I am missing a lot not to meet you in August 2020 and look forward to seeing you all in Istanbul in 2021!

WAML Treasurer Report

Prof. Berna Arda
(MD, MedSpec, PhD)
Ankara University School of Medicine
Ankara - TURKEY

On "the New Normal"

The concept of 'the new normal' that we have started to hear more and more often during the Covid-19 pandemic can be regarded as a concept that has a wide application. However, specifically the economic aspect

of this particular concept comes into prominence. Deceleration of economic growth, reduced job opportunities and the economies being at risk would create many new problems. It is thought that for the young and educated part of the population to experience unemployment, the loss of hope regarding the future, , an increase with regards to inequality and some social problems to be experienced in the future will become a serious problem.

It was expressed for the first time that, especially with regards to developed countries, the future generations will be in a much worse financial, social and political situation. It is also indicated that, instead of acting to find a solution and comprehend all aspects of the problem, this situation is presented to the public and the individuals as 'the new normal.' In this regard, the public and the individuals are expected to cooperate. Therefore, the emerging mistrust and the problems, such as not being able to anticipate the future events, are thought to have an impact on the ethical attitude and actions of the public and the individuals.

The concept of 'the new normal' with regards to social phenomenona and the ethical impacts of defining this concept may be expected to be more distinct. The concept of 'normal' is a tremendously powerful cultural element in our era. A similar situation to appear using the concept of 'the new normal' in the cultural sense would not be surprising. Regarding the economically centered definition of 'the new normal' and the presentation of this concept, the leading role of the financial executives should not be forgotten. In this regard, the concept of 'the new normal' has a variable context that is subject to changes in time, location and expected benefits. The message that is being delivered to the public and to the individuals includes the demands of accepting the current situation and getting adapted to the new events. In other words, a context that is intended to pacify the people.

The relationship between the use of the term "the new normal" and social reality creates many examples, especially as a result of the common use of social media . Certain figures are constantly visible in this structure, information that is produced continously by them exists in this network as just media information, but it is considered as if it were an official discourse, approved and presented as a "new normal". In this context, situations such as injustices and inequality are being transformed into a morally legitimate situation for the society. Therefore, the discourse created by this power can be regarded as an element that is causing inequality and suppressing an atmosphere for criticism. Normalization of inequality, the spread of uncertainty, the individual and the society to be influenced easily by the expressions of the media and important figures, the detachment of individuals from rational thinking and the work to become meaningless will be the results that we will encounter in "the new normal" world.

The concept of "the new normal" gives a strong pragmatic message especially for the working individuals. However, this message is not only limited to the business world. It finds significant responses especially in the political field. If this argument is continued; "Taking every path for the sake of success" without any moral responsibility will find a correspondance in every field.

Today's social structure where the global market has an important role, is a structure full of polarization and separation, adorned with risks. Pandemics such as COVID -19, global terrorist threat, crisis of confidence, uncertainty, negative foresight for the future and environmental problems are on the agenda of the world. The world has gained an irregular structure. Along with the chaotic structure and functioning, feelings such as uncertainty, fear and helplessness, parallel to the faintness of the borders are evidently observable. Today, it is expected that a very different number of individuals will be exposed to global and individual risks. Losing social solidarity also increases these risks at the individual level. There are no comprehensive solutions for these risks brought about by globalization. Policy development in education, economy and social areas becomes difficult. Social forces are being replaced by market forces. The mechanism that makes the society and the individuals feel safe against future risks is disappearing.

Therefore, "individualism, irregularity and irrationality" are launched as the three main elements of "the new normal". It will be easier for the social solidarity to weaken, for the individual to remain unfounded in the search for trust and to accept bowing to the new power focuses.

Maintaining a "nature friendly" and "more modest" life and increasing social awareness can alleviate these problems. To develop ethical approaches that will protect human dignity within the "new normal" seem as to be an important requirement.

Wishing you all healthy days

Berna Arda
Treasurer

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WAML Meeting Planning and Administration

Denise McNally,
WAML Administrative Officer and Meeting Planner

The COVID-19 pandemic has caused many events around the world to be cancelled or postponed and unfortunately the 2020 World Congress on Medical Law in Toronto, Canada, August 13 - 16, 2020 has been postponed until 2024.

JOIN US AT THE 26TH WORLD CONGRESS ON MEDICAL LAW (WCML) AUGUST 4 – 6, 2021 ISTANBUL, TURKEY

Hilton Istanbul Bosphorus will be the Lodging and Congress Venue

Hilton Istanbul Bosphorus is offering a reduced group rate of $150 EURO for single occupancy / $170 EURO for double occupancy per night. Rates include buffet breakfast and internet.

We encourage you to join the leading experts in medical law, legal medicine and bioethics by submitting your abstract in English only online. A call for abstracts will be announced to the membership in the future.

Categories:

1. Vulnerability: Respect and Protection
2. Gender Issues
3. Patient Safety
4. Human Rights in Medicine and Law

WAML Book Series

Following the 50th golden anniversary meeting of the World Association on Medical Law in Baku, Azerbaijan, two governors of the WAML: Professor Thierry Vansweevelt (Belgium) and Professor Nicola Glover-Thomas (United Kingdom), suggested a WAML-book series on medical law. This idea was warmly received by the Executive committee- Ken Berger, Vugar Mammadov, Oren Asman, and Thomas Noguchi. The book series Global Perspectives on Medical Law will be published by the prestigious Edward Elgar Publishing house.

Professor Thierry Vansweevelt Professor Nicola Glover-Thomas

The first book concentrates on the fundamental issue of informed consent - Informed Consent and Health: A Global Analysis. It contains chapters from countries all over the world giving a much-needed global insight into how individual autonomy and consent is understood and articulated. The book concludes with a comparative analysis.

This first WAML-book will be published in early summer 2020 with a formal book launch at the WAML-conference in Istanbul, Turkey in August 2021.

http://wafml.memberlodge.org/resources/Documents/Promotional%20leaflet-IC%20and%20Health.pdf

Membership Dues

The purpose of the World Association for Medical Law (WAML) is to encourage the study and discussion of health law, legal medicine, ethics and forensic medicine, for the benefit of society and the advancement of human rights.

Membership in WAML is Annual and reminder notices for your 2020 membership were emailed out in November. If payment has not been made a reminder will be sent. Membership dues are $150. WAML members enjoy many benefits which include access to quarterly E-Newsletters, discount registration fees to the WAML Congress, notice of upcoming events, active website information, the "Medicine and Law" electronic Journal and discounted access to activities of affiliated organizations.

Do you have an idea, comment, or suggestion?

Please contact
Denise McNally
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FUTURE MEETINGS

Of Affiliated National Associations and Collaborating Organizations

NAME 2020 Annual Meeting
October 9 - 13, 2020
Denver, Colorado (USA)
Website: https://www.thename.org/annual-meetings

26th Annual WAML World Congress
August 4 – 6, 2021
Istanbul - TURKEY
Website: www.thewaml.com

NAME 2021 Annual Meeting
October 15 - 19, 2021
West Palm Beach, Florida
Website: https://www.thename.org/annual-meetings

28th Annual WAML World Congress
August 1 – 3, 2022
Gold Coast, Australia
Website: www.thewaml.com

29th Annual WAML World Congress
August 2023
Vilnius, Lithuania
Website: www.thewaml.com

29th Annual WAML World Congress
August 8 – 11, 2024
Toronto, Canada
Website: www.wcml2020.com
www.thewaml.com

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World Association
for Medical Law

SAVE THE DATE

AUGUST 4-6

2021

The 26th Annual WAML World Congress

Instanbul - Turkey
www.thewaml.com

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