Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

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Intervention

Interventions in critical health geopolitics: Borders, rights, and conspiracies in the COVID-19 pandemic

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1. Introduction

Tristan Sturm & Julien Mercille

Within health and medical geography, the politics of health and medicine has often been under-appreciated, undertheorized and underexplored. Given the emerging geopolitical questions brought by the COVID-19 pandemic, we ask how a 'critical health geopolitics' might be conceptualized, theorized and scaled from the global to the local. In doing so, we consider how existing research can be remobilized and applied to the (post)pandemic world, whether directly in relation to COVID, or indirectly in relation to shifting relationships between states, publics and international bodies (as manifested, for instance, in global health governance, security-driven emergency measures, health-care privatization ventures and health activism).

Efforts to contain the pandemic and to create a long-term solution through vaccines have intersected with a range of political issues relating to healthcare systems, political representation, human rights, sovereignty, mobility, and borders. More than just the topic of the moment, then, the pandemic is an opportunity for political geography to take seriously the geopolitical underpinnings of health, healthcare systems, and medicine. Foucault (1980) offers a point of departure. In 'The Politics of Health', Foucault outlined a new form of politics that emerged from medical practices, one in which politics relies on the medical and in which medical agents are political subjects who exercise power over the medicalized—that is, those objectified by the systems of power that govern medical care and produce scientific truth. The normative separation of the medical and the political, his analysis suggested, is itself political, separating health into an ostensibly disinterested, technocratic sphere.

Following on from this focus on power, critical health geopolitics examines how geopolitical power—real, imagined and represented—manifests itself in relation to issues of health, disease and healthcare. Situated between health geographies and critical geopolitics, critical health geopolitics represents a constellation of social, spatial, and discursive practices, operating through medical regimes and health care systems, that border and define places and identities. Critical health geopolitics asks how health/medical practices are incorporated into governance and governmentality, and how these practices might be resisted as imaginings of political spaces and identities.

Health and medical geography has been largely concerned with ecological relationships between place and health status, outcomes, experiences, and processes (Crooks, Andrews & Pearce, 2018). But there have been important attempts to refract health and medical geography through the lens of the political. Donovan and Duncan (2010, 173–174) for instance, employ Brown and Staeheli's (2003) analytical distinctions between 'distributive' processes (relating to the unequal 'apportion of rights and resources' associated to health care access), 'antagonistic' processes (relating to 'competition among political stakeholders' over health policy or resources), and 'constitutive' processes (relating to the 'justice, equity, and rights'). Within political geography and cognate fields, interest in the politics of health have prompted attention to a number of themes: the global competition for new biotechnologies and regenerative medicine (Salter, 2009), the biopolitics of disability (Puar, 2009), the body as a site of politicised health (Mountz, 2018), political ecologies of health (King, 2010), indigenous health rights within the settler colonial state (Nelson & Wilson, 2021), geopolitical and biopolitical health care rationalities (Kivelä & Moisio, 2017),

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more-than-human understandings of virus flows (Braun, 2008), and, of course, the foundational work of Alan Ingram (2005) on the geopolitics, biopolitics, and governmentality of disease. Ingram's (2005) framework, and his call for investigation into the 'geopolitics of disease', is especially salient in the geopolitical landscape of the COVID pandemic. The genealogy of the pandemic has been squarely linked to the global economy and the accelerating flow of people and human encroachment into forests and animal spaces. These flows have the potential to destabilize state sovereignty, but also to contribute to the 'instrumentalization of health' vis-à-vis state security.

Furthering the work of Ingram and others, the essays in this Intervention explore critical health geopolitics through the COVID pandemic, and in doing so, show a way toward more sustained and foundational inquiry into relationships between health, disease, power, and space. The four papers examine four key themes: the exercise of geopolitical power during the COVID crisis; the power exercised by interest groups over borders and mobility during COVID; the role of geoeconomic policies in state responses to COVID; and the articulation of geopolitical imaginaries through COVID conspiracy theories.

First, Cole and Dodds caution against the normalization of bordering practices instituted during the pandemic that erode hard-fought rights to free movement in the EU. COVID-19 has created new opportunities and justifications for building physical, political, and economic borders. The result has been a geopolitics that is widening and reinforcing health inequalities and hierarchical relationships within and between the Global South and Global North.

Second, Mercille analyses the fragmented discourses, interests, and policy preferences of various 'elite' and 'non-elite' groups with respect to border closures and mobility restrictions during the pandemic. Using Ireland within the European Union as a case study, he asks who benefits and who loses from tight or porous borders and from strict or loose mobility restrictions. Mercille pays attention to the spatiality of restrictions, and, in particular, to interactions between localized measures and international mobility controls.

Third, Longhurst explores the marketization of care, medical rights, and care quality, and the geopolitics and geoeconomics of life and death. Specifically, this account explains the impact of COVID-19 in the Long-Term Care (LTC) sector in Canada in terms of policy learning and failure. More broadly, this analysis considers how government responses vis-à-vis this vulnerable sector have been constrained by lobbying, decentralization, and provincialization, and how political economies of health produce disease and shape healthcare decision-making. In the context of neoliberalism, the highly uneven right to quality health care divides patients geographically (provincial, national, and international) and socially (young versus old, sick versus healthy, poor versus wealthy).

Finally, Albrecht and Sturm examine how global conspiracy theories around medicine and health have challenged normative modes of inquiry. Embedded within conspiracy theories are geopolitical imaginations that frame the 'plandemic' as part of an ongoing global plot to impose a New World Order of surveillance and control, part of a growing set of discourses they term 'conspiratorial geopolitics'. Exploring German 'mutations' of COVID-19 conspiracism, they argue that conspiracy theories are versatile counter-elite geopolitical discourses that mediate and adapt to local cultural spaces as they spread virally across the globe.

Overall, this intervention illustrates the many theoretical possibilities—critical geopolitics, critical race theory, and feminism among them—available to a critical health geopolitics. This collection also contributes foundationally to this emerging field by developing some of the diverse empirical themes that might be included under the rubric of critical health geopolitics. These themes range from the socio-spatial dynamics of state and international cooperation to the impacts on mobility and borders; from the geoeconomics of health-care policy to the unequal categorization of bodies; and from the technical discourse of policy elites to the geopolitical representations offered by conspiracy theories. Our hope is that this collection spurs further engagement among political geographers with issues of health, medicine, and disease beyond COVID-19.

2. Critical health geopolitics and the COVID-19 pandemic: an emerging agenda

Jennifer Cole & Klaus Dodds

Political geographers have considerable opportunities to connect with and to learn from established scholarship by health and medical geographers on diseases such as AIDS and SARS, and from work on the social geographies of (anti-) vaccination movements (Durbach, 2004; Ingram, 2005). During the COVID-19 pandemic, the role of four factors has taken on considerable salience: stigmatization, risk/vulnerability, international health co-operation and border infrastructure. We consider each in turn and make the case for a critical health geopolitics.

One key topic of interest to any critical health geopolitics should be systems of power that stigmatize individuals, countries, and communities as threatening, risky, or unworthy. As scholars of the AIDS epidemic noted in the 1990s, disease can and does act as a 'provisional and problematic signifier', complicating, distorting, and masking a medley of geographical, social, economic, and political circumstances (Epstein, 1998; Treichler, 1999). Mindful of the dangers of geographical framings of diseases, the World Health Organization (WHO) had suggested in May 2015 that the naming of any new human infectious disease would need to recognize potential harm to cultural, national, regional, and ethnic groups. Nonetheless, in President Trump's tweeting repertoire, the Sars-CoV-2 virus transmogrified into the 'Wuhan virus', 'Kung Flu' or 'China' virus, amplifying Sinophobia and encouraging anti-Asian violence. Shaming, blaming, and stigmatizing is, as AIDS and critical race scholars remind us, endemic to the manufacturing of hierarchies of humanness, especially when it comes to non-white and LGBT+ communities (Epstein, 1998; Lim, 2020). The demands to 'return to normal' in many European and North American countries have carried with it a suite of ramifications for the most vulnerable communities, who never have had the luxury of protecting themselves from the virus by 'screening' and 'gating' measures.

For the Cameroonian intellectual Achille Mbembe, the unequal geographies of exposure, risk and vulnerability have laid bare who has the right to breathe and who does not (Mbembe, 2020). This point has been brought into even sharper focus in the wake of a suite of deaths of African Americans by US police officers using firearms and brutal restraint methods. Globally, COVID sufferers have discovered that access to oxygen and associated medical care can and will be rationed and/or denied due to a lack of supplies. The racial and geographical implications of the pandemic continue to unfold as the privileged hoard resources, limit the capacities and rights of others, and pursue strategies designed either to amplify the dangers or, paradoxically, to dismiss the impact of the pandemic on many lives, especially racialized minorities, who are over-represented amongst 'essential workers'. Former U.S. President Donald Trump, tweeting in October 2020, shortly after leaving the Walter Reed Memorial Hospital (where he had been treated for COVID), was adamant that people should not let the pandemic 'dominate your life'. Even by his provocative standards, the tweet was incongruous at a time when the global death toll from COVID-19 was approaching 2.5 million people (out of around 120 million confirmed cases globally) and the United States was the global 'leader' of COVID-19 mortality per 1,000,000 population.

Engaging with indigenous, feminist, critical race and Global South scholarship, and with literatures on the biopolitical and racialized implications of disease and ill-health, provides critical health geopolitics with further insights into the racialized and gendered logics of viral reproduction and transmission and the suffocating embrace of inequality and marginalisation. Established public health scholarship is relevant to the task at hand. For instance, 'blue marble health', which highlights pockets of extreme poverty in affluent societies, where

diseases like tuberculosis and hookworm infections thrive but are ignored, has been used to draw attention to the disease burden of the poorest communities in the Global North (Hotez, 2016). While non-communicable diseases (NCDs) such as diabetes and coronary artery disease are often cited as 'underlying conditions', this fails to acknowledge how laws, public policies and corporate practices lead to the disproportionate distribution of ill-health and to premature death. As other scholars have warned, connecting disease and health to individual and collective characteristics fails to recognize the toxic and toxifying legacies of racism and classism, alongside the damaging effects of public healthcare austerity, environmental inequalities, housing discrimination, inaccessibility to nutritious food, and general neglect (Davies, 2019).

COVID-19 is yet another disease that hits those made vulnerable not by their genetic background but by deep-seated structural inequalities. This includes the elderly and those with NCDs, who are more likely to be from poorer communities in which Black and brown people are over-represented. As Laurie Garrett (1994) warned in her popular book, *The Coming Plague*, disease is enabled by structures of exploitation and domination that deepen disparities through concentrated community exposure, biodiversity loss, (im)mobility and (in)accessibility to public health. Compounding disparities is a sense of 'acceptance' rather than 'emergency' because much of the harm has been visited upon poor and marginalised communities. Wealthier groups have been better able to protect themselves from exposure to infectious diseases like Ebola and Zika. Notably, the COVID pandemic has sparked governments and leaders to advocate urgent policy measures such as lockdowns and border closures often without addressing the impact of these measures on communities already weakened by austerity, exposure air pollution and environmental toxins, and the lack of affordable and accessible health provision and/or employee benefits like sick pay.

Farhana Sultana (2021) recently noted that the overlapping socio-ecological crises of climate change and the COVID-19 pandemic intensify the interactions between crisis and injustice. Living with disease is, for many communities around the world, an everyday risk-filled reality. As with the rapid emergence of a literature on the 'war on terror', which made violence and insecurity seem new, there is a danger that a new public health threat will be treated as a novelty. Reflecting on Ghana's experience of the COVID-19 pandemic, Ama de-Graft Aikins remarks (2020, 411), 'while COVID is a new public health threat, living in complex and unpredictable health environments is not new for Ghanaians. A double burden of infectious and chronic diseases has been the epidemiological and social norm for decades'. Aikins notes that while COVID might appear to be a 'civilizational crisis' for the Global North, it is something infinitely more familiar for a country where individual and collective memories of Ebola are ever-present (Aikins, 2020).

Reckoning with the unequal burden of disease is further complicated by a failure to acknowledge the effects of previous pandemics, such as Spanish Flu in 1918–19 and AIDS since the 1980s, and the enduring legacies of colonial medical science and past vaccination practices (Lowes, 2021). Public health crises, as Aikins notes (2020, 411) 'are shot through with complex historical legacies while everyday political cultures fail to recognize the framings of disease as indicative of relations of global domination and inequality'. There is a long history of international health collaboration that has been underpinned by the civilizational intentions of Western power, eager to protect itself from the diseases of others. The International Sanitary Conferences that emerged as a response to the 1829 Cholera Pandemic, enabled its (Western European) members to investigate the cause of diseases that were more likely to emerge in the less 'civilized' East, with Turkey taking a gatekeeper role on the borders between the civilized/sanitary and uncivilised/unsanitary world. Underwritten by racialized theories of disease and progress, the International Sanitary Conferences were informed by civilizational visions of world order where controls on movement would be imposed on non-European others (Bell, 2020).

The World Health Organization (WHO) was established in 1948 with a stated goal of 'the attainment by all peoples of the highest possible level of health', as noted in Article I of its Constitution. The establishment of the WHO led to the closure of regional health bodies such as the Pan American Sanitary Organization as it sought to improve the co-ordination of global health. Structural inequalities, funding gaps and rival alliances and actor constellations complicated the generation of shared objectives such as the eradication of disease and universal access to vaccination. During the Cold War, countries such as Nigeria and Pakistan often found themselves on the frontline of public health interventions designed to shore-up wider geopolitical agendas. Vaccination campaigns, while integral to childhood well-being, were used cynically to enable third-party, in-country intervention under the guise of public health. This had, and continues to have, implications in terms of suspicion of foreign-funded vaccination and public health programmes.

The COVID-19 pandemic provides a fresh opportunity for political geographers to consider the socio-spatial dynamics of global co-operation and to ask whether the practices and goals of public health agencies are shared or not. Some of that work might explicitly address competing conceptions of regional and global governance. For example, the pandemic has revealed the very real limits of the WHO. Its funding is determined by UN members via the World Health Assembly, but the second biggest donor, after the United States, is the Bill and Melinda Gates Foundation. Much of the work the WHO does is to provide specialist advice: it has no legal authority to force countries to accept/implement its guidance. The radically different ways in which WHO member states have chosen to respond to the pandemic reveal stark tensions between maintaining economic interests, travel and mobility, on the one hand, and supporting public health measures such as social distancing, lockdown and vaccination programmes, on the other. Where one might wish for greater evidence of global co-ordination in a time of pandemic, we see schisms over the desirability and necessity of even basic public health measures.

Border infrastructures have been enrolled in public health security planning. Critical scholarship on borders has focussed on the migrant crisis in and around the Mediterranean and on the US-Mexican borderlands (Delmas & Goeury, 2020), noting how EU countries and the US have used border patrols, surveillance technologies, data collection, physical barriers and legal mechanisms to deter and displace potential migrants. In the aftermath of the pandemic, these border strategies have become a great deal blunter and more varied as EU countries, in particular, have sought not only to seal their external borders but also to dismantle internal movement within the EU itself. In other words, EU citizens and not just non-EU migrants have found themselves targeted by widespread border closures and shutdowns. The very technologies and practices used to deter and detect unregulated migration have been transformed into a public health intervention. Recognising that the scale and extent of that transference does vary from country to country and region to region, critical health geopolitics provides opportunities to consider further how border technologies and practices are used as crude health security mechanisms that threaten to undermine the international legal rights of asylum seekers and refugees.

In sum, disease is a geopolitical issue because it is shot through with social-spatial strategies and practices designed to separate out some bodies and communities from others (Cole & Dodds, 2021). Disease becomes part of the realm of the geopolitical as it reveals starkly the desirability, feasibility, and durability of national, regional and global governance architectures. With COVID-19, some Western governments have accused Russia and China of using their medical supplies and vaccines to generate strategic advantages in other parts of the world, including within the European Union. If there is a 'new geopolitics' it is underscored by an old geopolitical order, which builds on entrenched hierarchies of authority, knowledge, and resources (including, in this case, vaccines). The UN programme, COVAX, will as ever be dependent on the support given by the UN member states with the most medical-pharmaceutical privilege. The implications for the

geo-politicization of disease in the name of public health are multi-scalar and multi-sited. As such, they also touch upon other areas of interest to political geographers, including legitimacy – that is, who has the right to exercise authority, and who has the right to resist public authorities (Kenworthy et al., 2021). We must continue to pose questions about how anti-vaccination and conspiracy-based movements can act as site-s/actors of resistance to public health while the 'slow violence' inherent in health inequalities continues to flourish (Davies, 2019). These complexities must be integral to any critical health geopolitics, as not allowing the pandemic to 'dominate your life' is a luxury that many will find hard to avoid.

3. Restricting mobility and closing borders during the COVID-19 pandemic: elite and non-elite discourses and interests

Julien Mercille

As of this writing (May 2021), the global COVID-19 pandemic death toll stands at 3.2 million and the cumulative number of cases at 154.4 million (Johns Hopkins University, 2021). Political geographers are well positioned to interpret the complex spatial politics created by the pandemic (Dodds et al., 2020). Public health strategies like quarantine, social distancing and travel restrictions are inherently geographical because they seek to restrict people's mobility and travel. Spatial and territorial controls may create inequalities (Liu & Bennett, 2020), but they are effective instruments to contain the pandemic (Lu et al., 2021). Who, then, decides which measures are acceptable to achieve public health aims and which are not?

This brief piece identifies and discusses the fragmented discourses and policy preferences of key interest groups in relation to border closures and mobility restrictions during the pandemic. I focus on contrasting 'elite' and 'non-elite' groups and highlighting the diversity within them. Moreover, I discuss the power relationships involved in promoting and opposing certain plans to restrict mobility and travel. I use Ireland, and its situation within Europe, as one case illustrating these varied configurations of interests. The empirical material mentioned is drawn both from secondary sources and from my active involvement in Ireland's Independent Scientific Advocacy Group (ISAG, 2020), a collective of experts in public health, epidemiology, and pandemic management, through which I have held extensive conversations with interest groups (in particular, political parties and business lobbies) in Ireland and Europe in relation to COVID-19.

This intervention engages with existing work on mobility and borders during COVID-19, with scholars convincingly describing borders as complex political and spatial configurations (Casaglia, 2020). In academic work, borders often have been recognized as instruments of power imposed by the powerful under neoliberalism to exclude unwanted bodies from specific places (Loong, 2019). More specifically, borders under neoliberalism enable certain mobilities (e.g., capital, trade flows, cheap labour) while excluding others (e.g., unwanted migrants) (Nevins, 2007). These accounts highlight the filtering capacity of borders (Fauser et al., 2019) and the arbitrary and often violent character of the state's bordering practices (Jones, 2016). Those theorisations highlight the injustice that borders cause in reducing certain individuals' freedoms (Casaglia, 2020). But to make sense of borders during COVID-19, I argue that we must address David Newman's (2003, 22) key question of 'borders for whom?' That is, who benefits and who loses from enclosing, or being enclosed by, others? This, in turn, raises questions of power relations: Which groups in society desire borders? And what are the decision-making and enforcement processes that enable certain, often elite, groups to make these decisions?

The COVID-19 pandemic constitutes a novel context within which a range of political and economic elite and non-elite groups have sought to impose or oppose border and domestic mobility restrictions. Globally during the pandemic, border and mobility restrictions have been implemented at a range of spatial and temporal scales (Ferhani & Rushton, 2020; Radil et al., 2020). Some measures have targeted localized mobilities (e.g., curfews, distance limits on movement outside people's homes and work from home orders) while others have been concerned with international mobilities (e.g., travel bans, border closures and mandatory quarantine). Moreover, the temporal deployment, both in duration and timing, of those restrictions has varied enormously from one country to another. Most obviously, Asia-Pacific countries, which have been significantly more successful in suppressing COVID-19 than European and North American countries, have utilized those movement restrictions systematically and comprehensively (Lu et al., 2021). However, in Europe, a mosaic of policies to restrict mobility and travel have largely failed to eliminate COVID-19. International travel from designated countries has been restricted, but European Union member states have been reluctant to introduce border controls for fear of jeopardizing the principle of free movement across national borders. While temporary border controls have been activated, there has been significant opposition to these measures, as when the European Union put six member states (Belgium, Denmark, Finland, Germany, Hungary and Sweden) on notice to lift their COVID-19 border controls because they undermined the free movement of people and goods (Boffey, 2021).

In Ireland, some business groups have opposed the tight regulation of travel as well as (aspects of) lockdowns because they impede their ability to conduct normal business activities. Most notable among these business groups are the airline industry and the hospitality and tourism sectors, all of which are dependent on international travel to various degrees. Ryanair, one of Europe's leading budget airlines, criticized 'isolationist' travel policies (O'Halloran, 2020) while the hospitality industry has voiced significant opposition to tight mobility restrictions (Black, 2020).

The business community, however, is not homogeneous, and it has not been affected uniformly by the pandemic and mobility restrictions. A 'K-shaped' impact has been identified whereby some sectors that depend on social interactions and movement have suffered significantly (hospitality, tourism, entertainment, retail) while the export sector (computer services, pharmaceuticals) has fared better (O'Toole, 2020). Thus, some sectors like the restaurant industry and pubs have been vocal in opposing restrictions, while others like 'Big Tech' have adjusted better.

Public opinion, on the other hand, has on average been strongly in favour of strict public health measures, including travel and mobility restrictions. Weekly opinion polls taken since March 2020 have asked the question 'Do you think the reaction of the government to the current coronavirus outbreak is appropriate, too extreme or not sufficient?' (Amárach, 2021). They reveal that at the beginning of the pandemic, only about 10 percent of respondents regarded the measures to be 'too extreme', while approximately 90 percent described them as 'appropriate' or even 'insufficient'. Only since March 2021 has the number of respondents believing that the measures are 'too extreme' increased, to a peak of 23 percent in April 2021. Moreover, other recent nationwide polls have found that 86 percent of respondents agree with mandatory hotel quarantine for incoming travellers (Michael, 2021), while 71 percent support closing the border with Northern Ireland (Keena, 2021). The latter is particularly remarkable because there is strong consensus in Ireland to keep the border open in normal times, and especially as Brexit unfolds, because cross-border communities are tightly integrated and there are fears that border policing could bring back the violent tensions of the not-so-distant past.

The Irish political class has been as divided as the business community. The three parties in the governing coalition, Fine Gael and Fianna Fáil (centre-right) and Greens (centre-left), implemented several relatively long lockdowns throughout the pandemic that restricted localized mobilities. However, they have been reluctant to restrict international mobilities—hotel quarantine was established only in March 2021, and in a very limited form. Moreover, closing the border with Northern Ireland has been strongly rejected by the government due to historical symbolic and real tensions, although some minimal measures (checkpoints) have been implemented.

As a result, the government has repeatedly failed to contain the pandemic either because it refused to control borders tightly or because it lifted lockdowns too early, before daily case numbers were low enough. For example, in summer 2020, in the aftermath of the first lockdown, Ireland had effectively eliminated the virus from its territory. However, the government failed to preserve this favourable situation by implementing a quarantine system for international arrivals and tighter measures at the border with Northern Ireland. Instead, pressurized by the hospitality and airline industries to re-open the country to domestic and international tourism, it relaxed restrictions, which eventually led to a second wave and second national lockdown in autumn 2020. Similarly, in December 2020, the second lockdown was lifted too early, resulting in a dramatic increase in case numbers over the Christmas period, placing Ireland among the world's worst affected countries in terms of cases per capita in January 2021. The pressures on government to re-open the economy over Christmas came from the restaurants and retail industries, which sought to make up on their financial losses during the lockdown. Their claims were circulated widely in the mass media, often in an uncritical way (Paul, 2020).

The three main opposition parties (Labour, Social Democrats, Sinn Féin), all centre-left, have been more supportive of restrictive public health measures. However, they have also preferred localized mobility restrictions over international ones: restrictions at the Northern Ireland border have remained very sensitive, and the opposition parties only rallied behind mandatory hotel quarantine in late 2020-early 2021 as Ireland suffered a massive spike in cases at the time, and as the realization dawned that vaccines would need to be supplemented with strong public health measures in order to drive cases down substantially. In contrast, the smaller, radical left party People Before Profit, has supported a 'Zero Covid' approach to eliminate the virus from early on in the pandemic.

Returning to the theoretical issues presented by this forum, critical health geopolitics examines how geopolitical power manifests itself in relation to issues of health, disease and healthcare. In particular, critical health geopolitics explores governance and governmentality relating to health and medical practices and considers, as well, how certain political actors might resist these practices. By focusing on decision-making processes surrounding mobilities and borders, this commentary asks, who has the power to decide which restrictive measures should or should not be implemented to achieve public health aims? Who decides on the spatiality and temporality of those measures? Who benefits and who loses from specific mobility controls?

The case of Ireland suggests that the politics of borders and mobility during the pandemic have been shaped at multiple scales simultaneously. Understanding health geopolitics therefore requires that we ground our analysis partly in 'domestic' politics. In Ireland, business lobbies have shaped, at key moments, public health measures and thus the course of the pandemic. Because of their pressure on the state, national lockdowns have often been lifted too early, resulting in immediate commercial benefits despite giving rise to new waves of infections. As well, international mobility restrictions have been weak, both for international arrivals and along the border with Northern Ireland. Large corporations and the trading sector have been keen to facilitate normal capital and labour flows so as not to slow down production, by bringing into the country high-skilled (e.g. engineering) or low-skilled (e.g. construction) labour and supply materials. Therefore, the corporate sector has been largely comfortable with lifting restrictions and/or not implementing drastic measures such as hotel quarantine for international arrivals, which would have disrupted their production and trade activities. This points to the geopolitical and geoeconomic power of certain segments of the business community and the partial sovereignty this community exercises over borders.

Yet, the business community clearly does not operate unimpeded. Regardless of their push to re-open the economy, the economy could not function normally so long as the virus circulated in the population and people stayed home and people withheld spending. For this reason, the business community gave some support early on to public health measures. Nevertheless, it appears that on balance, the business sector has opposed a strong, systematic, and comprehensive scheme of public health restrictions until the virus could be eliminated completely from the country.

As for governing elites, they have been responsive to business interests, but they have also had to take into consideration popular opinion, which has been strongly in favour of some restrictions for public health reasons. Public pressure has required the state to act against corporate interests by implementing some decisive public health measures and restrictions, including border controls. This pressure is felt by the political class but less so by the business community because politicians must seek re-election and are thus sensitive to political opinion (Mercille, 2008). Moreover, politicians, both in government and opposition, have had to tread carefully on the very sensitive issue of the border with Northern Ireland, as mentioned above. This longstanding geopolitical dynamic, both real and imagined, and intensified by Brexit, has clearly influenced the nature of the Irish response to the pandemic.

In sum, a mosaic of interests and varying capacities to shape public health measures can be described in relation to Ireland's experience with COVID-19. Geopolitical and geoeconomic dynamics, imaginings and power operate not only through the state, but also through multiple publics, including business interests. Even as we identify broad patterns of mobility restrictions during and beyond the pandemic, we must also be attuned to the fragmented, localized political dynamics that produce uneven outcomes.

4. Political geographies of policy learning and failure: COVID-19 and long-term care

Andrew Longhurst

The COVID-19 pandemic has disproportionately affected residents of Long-Term Care (LTC) homes (or nursing homes) and the frontline workers who provide intimate daily care (Webster, 2021). Among 22 high- and middle-income countries, LTC residents comprised, on average, 41 percent of total COVID-19 related deaths (Comas-Herrera et al., 2020, 21) and 69 percent in Canada (CIHI, 2021, 6). Using the case of COVID-19 and Canada's LTC sector, I argue that COVID-19's devastating impact requires critical geopolitical attention to analyse the ways in which policy learning and failure of neoliberal care marketization has shaped and constrained state responses in this vulnerable sector. I situate the Canadian case within the geoeconomic marketization of care systems across the Global North.

Critical geographical approaches to policy studies conceptualize governance and decision-making as relationally produced through territorially situated actors, institutions, and politics as well as globally circulating knowledges (McCann, 2011; Temenos & McCann, 2013). More specifically, the concept of policy learning can be defined as both a technical exercise and as a deeply political construct that is territorially instituted and connected to global flows and networks. For McFarlane (2011, 115), the process of policy learning includes the 'forms of power that promote, frame or structure particular kinds of learning', the object of learning, the form or organizational nature of learning, and the imaginaries at work in learning or identifying what learning seeks to accomplish.

Unpacking the critical geopolitics of LTC policy learning also requires attention to how market-oriented policies and practices fail. Moving beyond the literalism of policy failure dominant in orthodox policy studies, Wells (2014, 475) develops the concept of *policyfailing*, which refers not to 'policies that have unintended consequences or policies that have not met with great success [but to] moments in which policies are defeated, stopped, or stalled, plain and simple'. In a slightly different vein, Baker and McCann (2018, 2), conceptualize failure 'in terms of its complex social, political, spatial, and, particularly, temporal contexts', and they explain how the 'derailing of particular proposals

may generate subsequent outcomes [in which] failure cannot be taken at face value or understood as a discrete condition'. In this way, a critical public health geopolitics can benefit from theorizing the failures of LTC marketization – and its biopolitical effects (Kivelä & Moisio, 2017) – as part of the global circulation of neoliberal reforms remaking territorial welfare politics and care systems (Harrington et al., 2017; Peck & Theodore, 2001). The movement of market mechanisms and New Public Management principles into previously sheltered spaces of care provision has implications for state and global biopolitics.

Canada's first COVID-19 outbreak was declared on March 6, 2020 at a private for-profit care home in British Columbia – the western and third-most populous province. The virus rapidly moved through the facility, infecting 102 residents and staff and resulting in 20 deaths (McKeen, 2020). With 55,410 cases and 14,739 deaths in the first two waves, the impact of COVID-19 on LTC homes has been called Canada's 'national shame' (Ambrose, 2020). Canada had the highest proportion of deaths occurring in LTC among OECD countries in the first wave (CIHI, 2020), and yet, Canada's second wave was more deadly than the first (CIHI, 2021, 7). Despite widespread condemnation, few structural policy changes were implemented following the clear lessons from the first and second waves. Like many high-income countries, political attention has recently shifted away from the LTC sector with the vaccination of LTC residents and diminishing deaths.

The deleterious effects of COVID-19 in Canada's LTC sector can be conceptualized as a case of policy failure when looking at policy (in) action between the first and third waves. At the time of writing (April 2021), federal and provincial governments have not pursued changes that would signal phasing out for-profit care provision, which has been conclusively shown to result in inferior care quality and higher risk of COVID-19 outbreaks and deaths compared to public and non-profit provision (McGregor & Harrington, 2020). In Canadian provinces, as in jurisdictions globally, LTC is delivered by a mix of public health authorities, non-profit organizations, and for-profit companies, which have become increasingly dominant.

No fewer than 12 major investigations recommended improving staffing and working conditions and much greater attention to ownership and organizational context (CIHI, 2021, 23). In April 2020, upon the request of the provincial government, the federal government dispatched the military to seven of Ontario's hardest hit LTC homes – the majority of which were for-profit, including chain-owned operations (Government of Ontario, 2020). The Canadian Forces reported facilities to be severely under-staffed, 'such that it is impossible to provide care at a pace that is appropriate to each resident'; the report also noted 'a general culture of fear [among staff] to use supplies because they cost money' (TVO, 2020). COVID-19 has exacerbated a pre-existing workforce crisis, with chronic staffing shortages, which is fuelled by the devaluing of low-paid, racialized and immigrant women by for-profit care chains (Strauss & Xu, 2018). While not unique among OECD countries, the Canadian state has encouraged the flow of immigrant labour from the Global South while failing to address deteriorating working conditions resulting from marketization.

The Canadian experience adds to the large body of international research evidence accumulated over decades on the problems of LTC marketization (Armstrong & Armstrong, 2019; Mercille, 2018). As two leading biomedical researchers put it, 'evidence shows that ownership matters when it comes to staffing, and staffing matters when it comes to managing outbreaks of COVID-19 in LTC facilities' (McGregor & Harrington, 2020, E961). Ontario's COVID-19 Science Advisory Table, in its advice to government, concluded that for-profit chain ownership was one of the key risk factors determining severity of outbreak (Stall et al., 2021). The Royal Society of Canada, the country's most prestigious scholarly organization, identified the lack of paid sick leave and the deterioration of LTC working conditions, requiring employees to hold multiple jobs, as central concerns requiring urgent action (Estabrooks et al., 2020). Despite this evidence and public concerns about the role of investor-owned LTC, federal and provincial governments have not initiated policy changes to reduce provinces' structural dependence on financialized care chains.

The failure to learn from the first and second waves must be understood in relation to three geopolitical realities. First, health care policymaking and health system governance in Canada are highly decentralized (Braen, 2004). In its evaluation of the experience in the LTC sector, Canada's health information agency concluded that 'countries with centralized regulation and organization of LTC (e.g., Australia, Austria, Hungary, Slovenia) generally had lower numbers of COVID-19 cases and deaths' (CIHI, 2020, p. 4). In the absence of federal standards, some provinces attempted to ameliorate the worst effects of financialized business models that extract profits through the degradation of feminized caring labour (Longhurst & Strauss, 2020; Strauss, 2021).

Second, provincial electoral geographies are shaped by the political influence of corporate LTC chains which contribute financially to political parties and seek to influence government decisions through industry lobby associations and media pressure. The industry lobby is also granted access to provincial bureaucracies when other stakeholders are not (Press Progress, 2021). In Ontario, for example, lobbyists donated to the governing Progressive Conservative party. Even then, the spaces of governing and lobbying often collide. Mike Harris, former premier and architect of Ontario's neoliberal 'common sense revolution' which delivered greater LTC deregulation in the 1990s, is the chair of one of Canada's largest chains (Milstead, 2021). In British Columbia, the former minister of health became the industry lobby association's CEO three years after serving in government (BCCPA, 2020).

The industry's political influence in Canada is of geoeconomic significance, as it is part of a global pattern of increasing corporate power in the Global North (Armstrong & Armstrong, 2019). Three of the five largest for-profit chains in Canada have been active in the US or UK, including the involvement of joint ventures with US real estate investment trusts (Harrington et al., 2017). These connections are exemplified by the acquisition of the real estate assets of British Columbia's largest care chain by Anbang Insurance, the troubled Beijing-based investment firm. The estimated $1 billion transaction reinforced the desirability of British Columbia's valuable urban real estate markets and Canada's role within wider circuits of capital across the Pacific Rim (Ponder et al., 2020).

Third, provincial governments prioritize funding hospital and physician services as required by federal legislation. Consequently, provinces are reluctant to finance LTC capital infrastructure and services since it is not required by federal legislation. The exclusion of LTC under federal and provinces' ideological commitment to fiscal austerity has encouraged LTC infrastructure and service marketization (Longhurst et al., 2019; Ponder et al., 2020).

Although LTC marketization itself did not cause outbreaks and deaths, these structural factors made LTC more vulnerable to the virus. For elderly residents, their families, and workers, policy learning and failure is a matter of life and death. Even before COVID-19, empirical research demonstrated ownership to be a determinant of care quality and resident outcomes, and yet policymakers did not act on this evidence. It took COVID-19 to lay bare the profound effects of political decisions made over decades to encourage LTC marketization. The reluctance to implement federal care standards and initiate changes to shift away from for-profit care demonstrate the political nature of policy learning. Choosing what is to be learned (or not) is political.

The geopolitical dynamics of policy learning and failure in the health care arena remain undertheorized. We must also attend to the timescale of policy trajectories in analysing the generative effects of failed or impeded attempts at policy reform. Despite the apparent failure to learn from the deadly effects of COVID-19 in LTC, there is growing political advocacy for federal standards. Canada's experience is not unique. In the United States and England, too, COVID-19 reveals the intensification of struggles between the global spread and hegemony of markets in welfare provision, on the one hand, and the relative worth of certain lives affected by these policies, on the other hand.

5. Conspiratorial geopolitics and COVID-19 counter-epistemic knowledge mutations in Germany

Tom Albrecht & Tristan Sturm

The COVID-19 pandemic has been accompanied by a global 'infodemic' that has contributed not only to widespread denial of the existence or threat of the Sars-CoV-2 virus and distrust in vaccines but also to a rise in general scepticism towards institutions that support restrictive infection-prevention measures. Conspiracy theory discourses have emerged on the internet that claim that the pandemic was intentionally brought about by global elites to justify restrictions on individual rights and freedoms and to establish surveillance states through mind-control vaccinations. Other conspiracy theorists see the virus as an intentional Chinese attack on the USA and/or the western world or view COVID-19 symptoms as caused by 5G technologies (Stephens, 2020). Such conspiracist discourse draws an alternative reality of global politics that challenge Liberal, Realist, and Marxist geopolitical approaches and that explain global politics in terms of scheming, power-obsessed conspirators. We call these alternative knowledge-claims 'conspiratorial geopolitics'.

While COVID-19 conspiracy theories are versatile concerning their central political and scientific arguments, they commonly assume the existence of global power-structures with the capacity to enact an international conspiracy of the magnitude of the COVID-19 pandemic. COVID-19 conspiracy theories 'generate a simple model of the world' (Dodds, 2007, p. 21) that presumes collusive arrangements between nation-states, intergovernmental organizations or sometimes occult supernatural forces. These theories deny the actual epidemiological complexities of the pandemic while offering simple geopolitical imaginations of sinister powers who conspire against the world's population. Through their lens, the pandemic becomes an intentionally precipitated 'plandemic'.

Geopolitical discourses can be subtly or overtly embedded in COVID-19 conspiracy theories, but such discourses are a necessary condition to make the alleged conspiracy work. As we explain elsewhere (Sturm & Albrecht, 2021), apocalyptic forms of coronavirus conspiracy theorizing maintain that the overall purpose of the pandemic is to create public acceptance of authoritarian global governance, or the New World Order (NWO), which presents itself as the only possible solution of the global COVID-19 crisis. The COVID-19 pandemic thus becomes embedded within established apocalyptic right-wing geopolitical imaginations of an imminent and immanent restructuring of the world's order (Lynch, Sturm & Webster, 2021).

Due to such narratives and the overall global and political dimensions of the pandemic, coronavirus conspiracist geopolitical discourse provides 'particular types of knowledge about the way the world functions' (Jones, 2012, p. 48) that contradict knowledge-claims propagated by political elites, mainstream media outlets and epistemic authorities. Consequently, coronavirus conspiracy theories can be approached as counter-elite or counter-epistemic knowledge-claims (Robertson, 2016), but with important geographical constraints. The perceived legitimacy of conspiracist geopolitical knowledge is not only linked to the political power of actors who advance such alternative knowledge, but also to a community's pre-existing social, cultural, and epistemological dispositions and place-based power-relations (Ophir & Shapin, 1991). 'Space matters' (Livingstone, 2003, p. 5) in the construction, dissemination, and perception of knowledge, but scale matters as well: what is conspiracist 'counter-epistemic knowledge' on the macro level of a nation can still be valid 'elite knowledge' in small-scale social spaces. In this sense, established beliefs of a community affect how the community's members interpret the knowledge-claim (Shapin, 1994). In the era of Trump (which continues despite Trump's loss of the U.S. presidency), these developments also indicate that traditional distinctions between elite and common/popular imaginations no longer hold. Rather, knowledge-claims and the clout of those who make them are distributed across different, often digital, spaces. Geopolitical conspiracy claims are, as Aistrope and Bleiker (2018, 177) explain, 'best understood as narratives that are legitimized or delegitimized within the hierarchies of authority and modes of knowledge production present in particular interpretive communities'. Like other conspiracist narratives, COVID-19 conspiracy theories are a form of political resistance – a geopolitical and social practice designed to criticize and deconstruct what is perceived as the dominant way of knowing, eventually to provide alternative geopolitical realities (Johnson-Schlee, 2019; Jones, 2012).

However, on a general societal scale, conspiracy theorizing has moved closer to the political mainstream. Barkun (2016, 116) explains that 'beginning in the early and mid-1990s, the clear boundary between fringe and mainstream began to erode'. Knowledge-creating institutions and political institutions were increasingly challenged and democratized as a wider spectrum of beliefs and opinions entered the public sphere with the rising popularity of digital technologies (Morris & Morris, 2013). The emerging epistemic diversity requires the conceptualisation of 'abstract spaces', in this case largely virtual spaces, as 'intellectual, social, and cultural arenas' which co-exist simultaneously within and across states and societies (Livingstone, 2003, p. 6).

In the last two decades, those arenas have emerged on the internet in the form of Facebook groups, YouTube channels, religious online forums and large-scale internet sub-channel communities within 4chan, 8chan, or Reddit. It is important to acknowledge that the internet is 'not an amorphous, spaceless and placeless cloud' but a site of discursive practice that alters societal discourse (Graham, 2014, p. 99). Online and offline cultures do not exist separately, but influence each other as complex, mutually affecting, sets of social relations that transcend binary conceptualisations (Ash, Kitchin & Leszczynski, 2018). Here, popular world views are increasingly produced by ordinary people. It is not only movie makers, cartoonists or journalists who shape popular geopolitical imaginations, but also ordinary people who post (geo-)political memes online.

In addition to the rising popularity of the internet, several socio-political factors have increased the social acceptance of conspiracism. These include general distrust for authority, the rise of populism, which disparages 'expert' knowledge, and enhanced government secrecy in the US after the 9/11 terror attacks. Conspiracy theories as an element of mainstream entertainment—from *X-Files* and *The Manchurian Candidate* (1967/2004) to formulaic Netflix and History Channel documentaries—have also normalised the idea of real-life conspiracies (Barkun, 2016). The Trump Administration's propensity for 'alternative facts' further contributed to the diversification of truth-claims in mainstream politics in the US and the Western world more broadly. For instance, Hornsey et al. (2020) argue that the former American president legitimized anti-vaxx conspiracy theories and caused increased scepticism towards vaccinations. Today, due to a variety of technological and socio-political developments, we find conspiracy theories 'at the center of contemporary writing of global space' (Laketa, 2019, p. 160) and as popular knowledges that govern geopolitical imaginations for many.

Dittmer & Dodds (2008, 449) argue that in different spaces, distinct meanings are attached to the same geopolitical knowledge-conveying texts since the 'audience is constrained by its social location to interpret a text using only the cultural meanings available in that location'. However, geopolitical knowledge is not simply interpreted or replicated when it travels digitally around the globe. Rather, it becomes adjusted to national or local histories; in this sense, the diffusion of knowledge through societies, cultures, spaces, and time needs to be understood as a dynamic process (Livingstone, 2003). Germany's history and conspiracy culture, for instance, has become intertwined with American narratives on the NWO and global COVID conspiracism, resulting in German mutations of coronavirus conspiracy theories.

We illustrate this by looking at speeches held by the vegan cookbook author and TV-personality Attila Hildmann on August 29, 2020, the day of the attempted attack on the Reichstag by protestors opposing

infection-mitigation measures. As one of the most popular German conspiracy theorists during the pandemic, Hildmann repeatedly participated in protests in different cities in Germany but also received significant public criticism due to his conspiracist and anti-Semitic utterances. Hildmann claimed in front of large audiences that the pandemic was initially planned in the 1980s by the NWO, the Rothschilds and the Rockefeller Foundation to introduce a 'bolshevist dictatorship' and to reduce the global population via 'genetically modified lethal injections' disguised as COVID-19 vaccines. In doing so, he echoed popular American apocalyptic geopolitical conspiracists like Alex Jones who posited the arrival of a communist one-world-government through the backdoor of the crisis (Sturm & Albrecht, 2021).

However, drawing upon an alternative geopolitical imagination of the German state that rejects any sovereignty and legitimacy of the Federal Republic of Germany (BRD), Hildmann argues that the pandemic and lockdown measures are another attempt by the NWO to deprive Germans of reclaiming sovereignty over the space that constituted the German Reich. Here, Hildmann draws from the conspiracist right-wing Reichsbürger-movement, which holds that the German Reich continues to exist and is still at war with the US and other nations due to a missing peace treaty following World War II. The BRD, consequently, is believed to be an externally controlled, faux nation-state, introduced by victorious powers after end of World War II to exploit and subdue Germans. Organized around these beliefs, anti-lockdown protestors assembled at the US embassy in Berlin, waving flags of the German Reich and chanting 'Friedensvertrag' (peace treaty) to demand the end of heteronomy and to finally re-establish German sovereignty.

In front of the US embassy, Hildmann claimed that 'the NWO will be destroyed here in Germany since Germany knows this enemy better than any other nation' due to decades of suppression by the NWO through an alleged puppet state. The German conspiracist further stated that the 'Rothschild NWO' cannot be defeated elsewhere, but only in Germany. These knowledge-claims were later repeated by Hildmann during his speech before the attempted storming of the Reichstag. Similar to American exceptionalist geopolitical imaginations, Hildmann, as well as the anti-lockdown protestors and Reichsbürger movement who support him, see Germany at the epicentre of global history because of the fight against the NWO. Furthermore, Hildmann illustrates the counter-elite traits of his conspiracist discourse by arguing that the fight against the coronavirus restrictions is a fight between 'the top' and 'the bottom', drawing an imaginary in which suppressed people resist a cabal of elites. In that context, many protestors compared the current German government lockdown restrictions to the Nazi dictatorship. Some German protestors even started wearing the Star of David with the word 'ungeimpft' (unvaccinated) on their clothes, suggesting that unvaccinated people, like Jews during the Third Reich, will be marked by a suppressive German government (Ginzel & Stoll, 2020).

Nevertheless, it must be noted that not all protestors advocate narratives of the German right like the Reichsbürger conspiracy theory or compare themselves to Holocaust victims. German coronavirus conspiracism is versatile and supported by myriad socio-cultural groupings, including the political right, esotericists and conservative Christians, among others. These groups perceive themselves as today's critical thinkers, and they unify in the German 'Querdenker' movement (lateral thinkers) to confront what they perceive to be a wrongheaded societal consensus. On the macro-scale, pandemic conspiracism is a minority position in Germany. Still, there is something popular about conspiracist coronavirus discourse across Germany, and in micro-scale digital spaces within conspiracist channels on the Telegram messaging service, for example. On Telegram, Hildmann is supported by other German celebrities like the pop singer, Michael Wendler. Moreover, the well-known singer and apocalyptic QAnon supporter Xavier Naidoo released a song about the NWO and the pandemic in March 2021 which was shared by Nena (of 99 Red Balloons fame) in an Instagram post in which she 'thanks' Querdenker protestors. This indicates the rising popularity of geopolitical conspiracism among celebrity 'elites' and across mainstream social-media platforms.

The rise of conspiracism is of serious consequence to civic life, public health, and conceptions of global politics. Many COVID conspiracy theories find their legitimacy in alternative geopolitical realities, from communist plots and the NWO to vaccine surveillance and the power of big tech capitalism. As an alternative set of knowledge claims, COVID conspiracism is perhaps the most influential popular geopolitical practice in recent years. Far from a fringe American phenomenon, such COVID conspiratorial geopolitics have global reach and resonance, and, as we argue, it can take on national epistemic diversity, creating specific conspiratorial geopolitical cultures. The pandemic has become intertwined with German culture, politics, and history, resulting in a regionally specific conspiracy discourse that resonates with pre-existing beliefs of the country's right-wing, conspiracist and esoteric milieus. This global digital flow of conspiracies has also inspired geopolitical events like the storming of the US Capitol building and Reichstag. While conspiracies embedded in geopolitical narratives are not new, common themes are now more readily borrowed because of shared digital platforms that allow for conspiracy theorists within and between states to share and improvise themes with ease. Conspiracy theories have taken on improvisational resonance at state scales, adding clout to them as valid knowledge. This phenomenon will continue to challenge the provision of public health across the globe and is therefore a crucial theme for critical health geopolitics.

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No conflict of interest for any authors.

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