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COVID-19 PANDEMIC AND THE RIGHT TO LIFE – DIFFERENT RESPONSES ACCORDING TO THE STATE HEALTH SYSTEM: COMPARISON STUDY IN DIFFERENT REALITIES

Claudia Toledo
Juiz de Fora Federal University
Juiz de Fora – Minas Gerais
http://lattes.cnpq.br/5439982757257919

Ian Botelho de Abreu
Juiz de Fora Federal University
Juiz de Fora – Minas Gerais
http://lattes.cnpq.br/7640935908773224

Abstract: This article presents a comparative study carried out between countries from all continents of the world (with the exception of Oceania and Antarctica) in the context of the COVID-19 pandemic, in order to identify the governmental measures taken to combat the emergency crisis, their effectiveness in protecting the fundamental rights to the life and health of the population, and the differences in the guarantee of these rights according to the health system model (public or private) adopted nationally. To this end, bibliographic and documentary research was carried out (in governmental sources, national and international institutions and non-governmental organizations). The data collected were comparatively analyzed, according to the following parameters: (I) rates of contamination, lethality and vaccination of the population; (II) nationally adopted health system; (III) government measures taken to combat the pandemic. The period evaluated by the research was from March 2020 (month in which the pandemic was officially declared) to July 2021 (end date of the research project). The following countries were investigated: Brazil, USA, Mexico, Italy, UK, Spain, Germany, China and South Africa.
Keywords: COVID-19; Right; Pandemic; Health; Life.

INTRODUCTION

In March 2020, the World Health Organization (WHO) (2020) declared a pandemic of the disease COVID-19, caused by the new coronavirus, which emerged in Wuhan, a city located in China. Since then, the world has been in a state of complete anomaly (sanitary, social, political, economic). Different reactions and governmental measures were noticed worldwide to combat the pandemic, with greater or lesser success in protecting the rights to life and health of the population of each State. An essential factor for guaranteeing such rights is the organization of *the health system* – public or private, universal or not – in each country, whose socioeconomic reality is also a determining element for the success or otherwise of controlling the health crisis.

Based on this context, a comparative research was carried out on the reality of different affected countries, aiming precisely to identify the effectiveness of those protective state measures and the effectiveness of national health systems in guaranteeing the fundamental rights to life and health of their citizens. Central and peripheral countries, with different health systems and located on different continents, were analyzed: in America (Brazil, Mexico, USA), in Europe (Italy, United Kingdom, Spain and Germany), in Africa (South Africa) and in Asia (China). Data related especially to the following issues were investigated: (i) rates of contamination, lethality and population vaccination, (ii) the nationally adopted health system (public or private, universal or not) and (iii) government measures taken to combat pandemic. *Bibliographic* research was carried out on scientific articles progressively published throughout the pandemic, having the work of the German jurist Robert Alexy as a theoretical framework, and *documentary research,* using the *official websites* of *institutional bodies* in each country (such as ministries, departments), *international organizations* (such as WHO, World Bank), *NGOs* and *public institutionsand national private ones* (such as the *Medical Care Organization,* National Council of Justice).

CRITERIA FOR COMPARATIVE ANALYSIS OF THE SELECTED COUNTRIES - CONTAMINATION, LETHALITY AND VACCINATION RATES

Table 1 shows the absolute values and those relating to the contamination and lethality of the pandemic.

Country	Number of contaminated	Number of dead	Contaminated per 100,000 inhabitants	Killed per 100,000 people
Brazil	20,999,779	586,851	9,879.49	276.09
Mexico	3,511,882	267,748	2,723,81	207.66
United States	40,804,998	655,172	12,327.7	197.94
Italy	4,609,205	129,955	7,728,19	217.89
UK	7,256,563	134,261	10,689.34	197.77
Spain	4,915,265	85,393	10,384.52	180.41
Germany	4,089,476	92,686	4,917.2	111.45
South Africa	2,860,835	85,002	4,823.64	143.32
China	123,642	5,688	8.4	0.39

Table 1: Absolute and relative values referring to contamination and lethality[1]

Source: own elaboration, 2021.

Country	fully vaccinated	Vaccinated with at least one dose	Vaccine doses administered	People fully vaccinated per 100 people
Brazil	65,249,629	134,564,769	195,324,776	30.7
Mexico	37,513,581	59,925,105	89,500,945	09.29
United States	177,919,118	215,797,373	379,082,955	53.75
Italy	38,487,931	43,722,953	80,755,924	64.53
England	43,343,855	48,270,113	91,725,196	63.85
Spain	35,070,311	37,126,744	68,205,694	74.09
Germany	51,561,208	55,214,189	103,981,687	62
South Africa	7,187,179	7,482,982	14,670,161	12.12
China	973,499,691	1,099,508,925	2,118,288,886	66.17

Table 2 : Absolute and relative values referring to vaccination[2]

Source: own elaboration, 2021.

Country	Health services available	Percentage of GDP invested in health
Brazil	universal public	10%
Mexico	For public and private insurance; it's not universal	6%
United States	By private insurance; with some assistance programs for some vulnerable groups; it's not universal	17%
Italy	universal public	9%
UK	universal public	10%
Spain	universal public	9%
Germany	By insurance (about 87% of the population is covered by public insurance) and universal	11%
China	For insurance partially subsidized by the government; close to universal	5%
South Africa	For private insurance for a small portion of the population; informal and public for the rest	8%

Table 1: Health services of each country and percentage of GDP invested in health[3]

Source : own elaboration, 2021.

1. Data taken from the W.H.O. (World Health Organization) website as of 14 September 2021 (WHO, 2021).
2. Data taken from the WHO website as of 14 September 2021 (WHO, 2021).
3. Data extracted from the IndexMundi website, for the year 2017 (INDEXMUNDI, 2021).

In turn, in Table 2, numbers corresponding to the absolute and relative values of vaccination against COVID-19 are broken down.

NATIONALLY ADOPTED HEALTH SYSTEM

Table 1 above shows the public and/or private, universal and non-universal health services available in each country and the percentage of GDP invested in health in each national reality. Then, we move on to the analysis of each country specifically.

BRAZIL

The Federal Constitution (1988) guarantees the fundamental rights to life and health (arts. 5, 6), stipulating health as a universal right and a duty of the State (art. 196) and creating the Unified Health System (SUS, art. 198). The SUS is regulated by Law nº 8080/90, which states that "the set of health actions and services, provided by federal, state and municipal public bodies and institutions, the direct and indirect administration and foundations maintained by the Public Power, constitute the Unified Health System (SUS) " (art. 4). The system decentralizes responsibilities in the different federative entities, with its financing coming from fiscal resources and contributions from federal, state and municipal governments. The SUS offers access to comprehensive and free services for everyone, from undocumented immigrants to Brazilian-born citizens (COMMONWEALTH FUND, 2020, p. 17). However, historically, the SUS faces underfunding problems, intensified by the austerity measures that have been established in the country since 2015. The growing underfunding of the SUS generates, therefore, the gradual dismantling, consequently reducing its capacity to respond to emergencies such as the COVID pandemic. -19 (SOUZA, 2020, p. 1-5).

MEXICO

The Mexican health system comprises the public and private sectors. The public health services available to the population are different, depending on whether they are individuals with formal work (social security) and those who do not fit into this situation (social assistance). In turn, the private sector comprises insurance companies and service providers that work in private practices, clinics and hospitals. Depending on the aspects presented, it is concluded that the Mexican health system has a highly fragmented structure, with several different programs reserved for different segments of the population (DANTÉS et al., 2011, p. 224) (KRASNIAK et al., 2019, p. 277-279). In 2003, Mexico initiated health reforms aimed at increasing the population's access to health care (WHO, 2013, p. 81-82). To this end, the Popular Insurance was implemented in the country in 2004, financed by federal and state revenues and with the co-participation of families. However, Krasniak et al. (2019, p. 274, 279-283) point out that, in 2012, about 38% of the Mexican population was covered by Seguro Popular, 40.6% by social security and 21.4% remained without any form of guarantee of access. to medical services. Thus, Mexico has a system directly related to income, with formal workers having greater access to health services, thus promoting a true institutionalization of inequality.

UNITED STATES

Since its inception, health care in the United States has been seen as an individual matter. For the vulnerable, only a few specific actions were promoted by charities and local governments. It was only around 1960 that public health care programs emerged, the federal government health insurance

programs called *Medicare*[4] and *Medicaid*[5] (BUSS; LABRA, 1995, p. 178) (WHO, 2013, p. 22). Thus, the US healthcare system mixes insurance and healthcare providers, public and private, for-profit and not-for-profit. It must be noted, however, that, on the one hand, about 8.5% of the population (27.5 million people) do not have health insurance, having no form of access to health care, and, on the other hand, a large part of the population is in debt, due to the high cost of financial burdens related to health services (COMMONWEALTH FUND, 2020, p. 211) (DUCHIADE, 2020).

ITALY

The Italian healthcare system offers universal access to the public system, with ample free provision of medical services for all legally resident citizens and foreigners. Servizio *Sanitario Nazionale* (SSN) is financed by taxes, collected by the central government and distributed to regional governments responsible for medical care. The approximately 20 national regions are assigned the functions of organizing and distributing health services, and they are authorized to generate their own additional resources. It is also noteworthy that only a small portion of the population, about 10%, uses voluntary private insurance, in a complementary or supplementary way (SANFELICI, 2020, p.194) (WHO, 2014, p. 13) (COMMONWEALTH FUND, 2020, p. 117-118). The SSN was structured based on local health units. Reforms in health services promoted the regionalization of the system, granting full autonomy in the planning and organization of such services. However, there are regional heterogeneities in the application of policies and provision of health services according to the region of the country (MANEGUZZO; FIORANI; KEINERT, 2010, p. 301-302).

UNITED KINGDOM

The *National Health Service* (NHS) provides universal access to medical services. Thus, all citizens and legally established residents of the United Kingdom are entitled to free medical care (GOV.UK, 2022). This system is publicly financed by taxes and, to a lesser extent, national insurance contributions, payments made directly by the user. The government agency *NHS England* is responsible for oversight and resource allocation for most inpatient and outpatient care (COMMONWEALTH FUND, 2020, p. 59-62) (BOYLE, 2008, p. 1-2) (WHO, 2011, p. 22). It is worth mentioning the organization of public hospitals such as *NHS Trusts,* organizations linked to the NHS with administrative autonomy to run the hospital and meet health demands. Private hospitals offer services not available on the NHS or with very long waiting periods. The small private health sector is financed by private medical insurance (in 2015 only 10.5% of the population had them), direct payments and contracts with the NHS (COMMONWEALTH FUND, 2020, p. 59-62) (BOYLE, 2008, p. 1-2) (WHO, 2011, p. 22-23).

SPAIN

The Spanish healthcare system is predominantly public, financed mainly by taxes. The provision of services is considered close to universal, with mostly free provision of medicinesat the time of medical care (W.H.O., 2018, p. 16). As for the organization, the inter-

4. A federal insurance program focused on health care for those over 65, regardless of income, people with disabilities and dialysis patients, in which medical bills are paid via trust funds that those covered by the program have paid. In addition, patients pay part of the costs through deductibles for hospital costs and other expenses (DIGITAL COMMUNICATIONS DIVISION, 2015).
5. A care program administered by state and local governments within federal guidelines aimed at serving low-income people of all ages, in which patients bear part of the medical expenses related to services covered by the program (DIGITAL COMMUNICATIONS DIVISION, 2015).

territorial council of the health system in Spain is responsible for the coordination between the administrations of the central government and the various autonomous communities. As a result of the 2008 economic crisis, in 2011 legislative changes were initiated involving various austerity policies aimed at reducing the breadth and scope of the Spanish health system. The result of these changes were significant changes in the Spanish social welfare system (WHO, 2018, p. 17-18).

GERMANY

The German health system has as a principle compulsory insurance for all citizens. A large part of the population (87%) is covered by the public system (Social Health Insurance). Funding is provided through insurance premiums paid jointly by employees, policyholders and employers, as well as government subsidies. Germans who earn more than US$68,000 annually can opt out of Social Health Insurance and take out private insurance (FUNDAÇÃO OSWALDO CRUZ, 2020, p. 14-16) (COMMONWEALTH FUND, 2020, p. 83-87), (INSTITUTE FOR QUALITY AND EFFICIENCY IN HEALTH CARE 2018). The German government has a regulatory role and is not directly involved in the provision of health services. The Ministry of Health formulates national public policies, establishes regulations and determines the financing of the system, as well as being responsible for the control of sanitary emergencies. Governors are responsible for determining hospital capacity, financing hospital investment and overseeing public health services (COMMONWEALTH FUND, 2020, p. 83-87) (FUNDAÇÃO OSWALDO CRUZ, 2020, p. 14-16).

SOUTH AFRICA

South Africa is marked by the colonial past and the *apartheid racial segregation regime,* which lasted until 1994 and has consequences to the present day. The country has notorious racial and gender discrimination, which are reflected in the functioning of medical care, amplifying the difficulty of accessing basic health services (CONMY, 2018, p. 1-7) (COOVADIA et al., 2009, p. 817-825) (MAYOSI; BENATAR, 2014, p. 1344-1353). In 2009, the South African Department of Health created social health insurance called the National Health Insurance Plan, aiming to reduce the financial burden of illness, improve overall health and make health care more accessible. The system provides for mandatory contributions from employees and employers to fund it, as well as tax increases. However, it is still in the implementation phase and must officially start in 2026 (CONMY, 2018, p. 1-7). At the moment, most health care is financed by the National Income Fund, which presents itself as a bundle of payments to local, provincial and federal governments. The private sector, which operates through voluntary health insurance, serves a small part of the population (15%). The public health system serves the rest of the population, although it still lacks formal protection, which must only be formalized with the implementation of the National Health Insurance (CONMY, 2018, p. 1-7).

CHINA

The country has reached 95% of the population with publicly subsidized health insurance. Being insured in the country is not mandatory and there are two programs: the *Urban Employee Medical Scheme* (UEMS) and the *Urban-Rural Resident Basic Medical Insurance* (URRBMI) (Basic Medical Insurance for Urban-Rural Residents). UEMS is aimed at formally employed workers residing in urban areas and is financed primarily by payroll taxes, both by employers and employees. The URRBMI is voluntary, offered to rural and

urban residents without formal employment, financed by the central government and local governments through individual premium subsidies (COMMONWEALTH FUND, 2020, p. 37-40) (EGGLESTON, 2012, p.7-13). Reforms in recent decades have made China reach close to universal access to healthcare, but still superficial, since the benefits of the basic model of voluntary insurance URRBMI still do not cover a wide range of services, unlike mandatory insurance UEMS for urban workers and civil servants. The central focus of the system is now to expand services covered by voluntary insurance (EGGLESTON, 2012, p. 7-13) (COMMONWEALTH FUND, 2020, p. 37-40).

GOVERNMENT MEASURES TAKEN TO COMBAT THE PANDEMIC

The following are the governmental measures taken in the selected countries, in the order mentioned.

BRAZIL

At first, the federal government's attitude was to deny the existence or strength of the pandemic. Consequently, there was a notable lack of central coordination by the federal government in the application of measures to mitigate the spread of the virus, leaving the protagonism to the governors. The fight against the pandemic was then characterized by fragmentary measures, directly affecting the national response capacity and public policies that could be centralized in the Unified Health System (SODRÉ, 2020, p.1-5) (HUMAN RIGHTS WATCH, 2020, p. 105-107).Within the scope of social assistance policies, the Federal Executive Power, in joint action with the Federal Legislative Power, provided the so-called *Emergency Aid,* classified by the World Bank (2020, p. 113-114) as a "powerful response" to the shock. economy caused by COVID-19. The provision of emergency aid was, however, marked by instability, with fixation, extension, extinction of the aid, new fixation at a lower pecuniary value, new extinction, another fixation with a new reduction in value, until its complete extinction, despite the lack of simultaneous extinction of the pandemic.[6] Despite the initial success of the emergency aid set in April/2020, with the reduction of inequality in the country that year, hunger, food insecurity and inequality in Brazil intensified in the months without aid, and the new aid, with a lower value, did not proved sufficient (BANCO MUNDIAL, 2020, p.113-114) (INSPER, 2020) (MEDICINA UFMG, 2021).Emergency health measures were made possible, such as the use of telemedicine and the hiring of doctors, in addition to reducing taxes and import fees for essential medical supplies (IMF, 2020) (BANCO MUNDIAL, 2020, p. 35). Nevertheless, as Sodré (2020, p. 1-10) explains, the federal government was responsible for creating a false dilemma between the economy and health, positioning itself against measures to contain the contagion, such as quarantine and social isolation, and making intensive pressure to open up businesses. Not enough, it invested and encouraged the use of medicines without scientific proof, such as hydroxychloroquine, even buying thousands of the so-called "Covid Kit" (SHALDERS, 2021).

MEXICO

The Mexican government has promoted campaigns seeking to minimize the risk of transmission of COVID-19 through basic hygiene and social distancing measures.

6. The first aid was fixed in April / 2020, extended until September / 2020, when it was extinguished and new aid with reduced value until December / 2020, with the population left without any financial support between January and March / 2021, when the last benefit, with a reduced value again and valid until July/2021 (Law No. 13,982/2020, Provisional Measure No. 1,000/2020, Period from January to March 2021, Provisional Measure No.

It also launched the "Programa de Apoyo Financiero a Microempresas Familiares", offering credit to small businesses that were up to date with their tax obligations and had maintained their average workforce (OEDC, 2020) (CONEVAL, 2020, p. 46- 50). In addition, unemployment insurance was made available to workers who had a mortgage from the housing institute, and additional resources were allocated for social spending. The government implemented low-interest housing loans for workers, low-rate personal loans, and deferred monthly payments. There was also investment in the infrastructure of basic services and housing renovation for people living in marginalized areas (IMF, 2020) (CONEVAL, 2020, p. 72-76). However, like the president of Brazil, Mexican President López Obrador has repeatedly played down the pandemic. Obrador also suggested the so-called "herd immunity" and urged people not to maintain social isolation, having even referred to the Mexican people as a "strong ethnicity", which can "beat various types of plague", in a speech centered on the economic scope (COLOMBO, 2020).

UNITED STATES

Former President Donald Trump took reckless conduct to combat the pandemic, such as the severing of the country's relations with the WHO and the underfunding of health services (WOOLHANDER, et al., 2021). It adopted a denialist stance in the face of the pandemic crisis, underestimating its effects, disseminating false information about the disease and its treatment (such as the suggestion that the injection of disinfectants could neutralize the virus), in addition to encouraging solutions without scientific proof, such as hydroxychloroquine. (G1, 2020) (ESTADÃO, 2020). However, during 2020 (already under the management of President Joe Biden), important laws were passed in the country to face the pandemic. The *Coronavirus Preparedness Supplemental Appropriations Act* established funding for research and development of medical technologies (IPEA, 2020, p. 21-22). The *Families First Coronavirus Response Act* instituted a program aimed at protecting employment and income, food, coverage of COVID-19 tests, among other social measures (IPEA, 2020, p. 23-27). O*Coronavirus Aid Relief and Economic Security Act* (CARES Act) established 2.3 trillion dollars to combat the effects of the pandemic and determined a set of social measures, such as direct cash transfers and an increase in the supply of medical-hospital services and products. This project was also added twice in a row and the launch of stimulus packages worth USD 900 billion and USD 1.9 trillion (IPEA, 2020, p. 27-38) (LOBOSCO; LUHBY, 2020), (ROUBICEK, 2021).

ITALY

Initially, the Italian government's reaction was against measures such as quarantine and social isolation. As a result, the country became, in mid-March 2020, the world epicenter of the disease, surpassing China, a situation that led the Italian government to change its stance and adopt restrictive measures. In this sense, the *lockdown is highlighted,* imposed in the country and withdrawn a number of times, according to the epidemiological situation (ALESSI, 2020). There was a strengthening of the Italian health system and state support with the consecutive taking of social measures, such as income support for families and workers and the offer of credit to a wide range of civil society groups (SANFELICI, 2020, p. 199-). 201) (IMF, 2020) (OEDC, 2020). Hospitals were built and converted to treat patients with COVID-19, with the hiring of more health professionals and the facilitation of the purchase of medical equipment (SANFELICI, 2020, p.197-198),

(MINISTERO DELL'A ECONOMIA E DELLE FINANZE, 2020).

UNITED KINGDOM

At first, there seems to have been a "relative underestimation of the health dynamics, but above all, the socioeconomic dynamics by the UK authorities with regard to the pandemic" (IPEA, 2020). The *Coronavirus Action Plan* focused on a four-phase strategy: containment, delay, research and mitigation. The first three phases were carried out simultaneously and basically consisted of sanitary measures. The last phase of the plan began to be applied late, being the only one with economic measures (IPEA, 2020, p. 38-40). The government of Prime Minister Boris Johnson has provided additional funding to the NHS, public services and charities. Within the scope of support to companies, there were compensations for sick leaves and the launch of loan schemes to facilitate access to credit (IMF, 2020) (IPEA, 2020, p. 40-43). In a similar vein, the country's social security was strengthened, increasing the *Universal Credit scheme* and other benefits (IMF, 2020). However, most of the measures adopted were classified as reactive, having been taken only with the worsening of the crisis. At first, the country's government focused its policies on strategies such as herd immunity, denial of the severity of the crisis and inaction. However, in a second moment, the country made efforts to adopt more restrictive and coercive measures based on scientific evidence and even on the Chinese experience (CALNAN, 2020 p. 3-5) (HUNTER, 2020) (IPEA, 2020, p. 49).

SPAIN

Initially, among the measures adopted by the Spanish government, budgetary support to the Ministry of Health's contingency fund, financial transfers to regions and regional services are mentioned. Measures related to the business sector and maintenance of employment relationships were taken, such as the exemption of social contributions for affected companies that maintain jobs or reintegrate workers. There was also exemption from social contributions for the self-employed and deferral of tax payments for small and medium-sized companies (IMF, 2020). Regarding assistance measures, the right to unemployment benefit was expanded and an increase in sickness benefit was granted to workers infected with COVID-19 or quarantined (IMF, 2020) (IPEA, 2020, p. 54-66). The Spanish State was one of those that initially underestimated the crisis, taking time to implement more restrictive non-pharmacological measures. After this delay, the central government began to apply measures such as a *lockdown.* In the scope of economic and assistance policies, the country bet on a wide range of measures through the Royal Decrees-Laws, offering, at that moment of instability, several measures that contributed to effective social protection (ROYO, 2020, p. 182-187) (IPEA, 2020, p. 49-52).

GERMANY

Especiallyafter the repercussions of the consequences of the pandemic in Italy, the German central government, in coordination with the federal states, began to adopt more stringent containment measures, such as *lockdowns.* An incentive-based approach was used to promote voluntary compliance with measures. However, local authorities could stipulate fines based on violation of the infection protection law (DOSTAL, 2020, p. 542-544, p. 547-550) (EUROPEAN UNION AGENCY FOR FUNDAMENTAL RIGHTS, 2020, p. 1-5). As an economic measure, the German parliament allowed workers to have easier access to the workload reduction allowance. For companies, there was a deferral of tax payments. Access to social security systems

was facilitated, especially for low-income and self-employed families (EUROPEAN UNION AGENCY FOR FUNDAMENTAL RIGHTS, 2020, p. 5, 11-13) (IMF, 2020) (OEDC, 2020). Also noteworthy is the expansion of funding to hospitals, with the aim of rescheduling them and keeping beds available for patients with COVID-19, as well as the capacity of ICU beds. The German government also launched the *Corona Warning App,* which allowed tracking of possible contacts with infected people and focused efforts on testing for early identification of those infected (FUNDAÇÃO OSWALDO CRUZ, 2020, p. 16-20), (IMF, 2020). The German strategy successfully focused on controlling the spread and strengthening the country's already strong health system (FUNDAÇÃO OSWALDO CRUZ, 2020, p. 20).

SOUTH AFRICA

The South African government adopted a nationwide *lockdown,* which was gradually relaxed. During the period of heightened restrictions, the sale of alcohol and tobacco was prohibited. Outside this period, the sale of alcohol was allowed, but subject to restrictions, and tobacco continued to be prohibited. On certain occasions, according to the epidemiological situation, the country has adopted curfews from 11 pm to 4 am (IMF, 2020) (BROADBENT; COMBRINK; SMART, 2020, p. 1-3). The government offered assistance to companies and workers through the unemployment insurance fund (UIF) and industrial cooperation and development programs. There were tax subsidies for workers with wages below a certain threshold and vulnerable families. Still in the economic sphere, funds were made available to companies that suffered a drop in demand due to COVID-19 and the deferral of certain tax obligations for small and medium-sized companies was allowed (IMF, 2020). However, criticisms are made of the undemocratic nature of the South African government's interventions, which goes back to the country's own history. In this sense, the lack of communication with civil society in the implementation of restrictive measures and the confused communication between the various spheres of government are pointed out. Furthermore, curfews were enthusiastically imposed by the police and army and restrictions on the sale of tobacco and alcohol were not evidence-based (BROADBENT; COMBRINK; SMART, 2020, p. 1-3). Another criticism refers to the obligation imposed on individuals to carry out tests, treatments and remain in isolation and quarantine, as determined by the South African police or military forces. In a similar vein, the obligation imposed on homeless people to remain in temporary camps characterizes the South African approach to the crisis as punitive and restrictive in a notoriously disproportionate way to fundamental rights (STAUNTON, 2020).

CHINA

With the worsening of the pandemic in the country, there was epidemiological investigation in the streets, shops and people's work. The Chinese government used an application based on a color system that served as permission or not to carry out various activities. There was also the use of street cameras to identify people without masks and who had symptoms (ALTAKARLI, 2020, p. 46-47) (IMF, 2020) (XU et al., 2020). *Lockdowns* were determined in several cities, in addition to social distancing measures at the national level. In most locations where families were quarantined, one person in the family could leave the house every two or three days to shop for daily necessities. In other communities, no one could leave the house and they received their daily necessities

from people designated by the government (IMF, 2020) (XU et al., 2020). Economic measures taken by China included production of medical equipment, spending on epidemic prevention and control, acceleration of unemployment insurance and its extension to migrant workers. Likewise, there was a reduction in taxes and exemption from social security contributions (IMF, 2020). Whole hospitals were built in approximately two weeks and *fangcang hospitals* (a kind of field hospital) were built to increase the number of beds. Medical expenses were covered by national health insurance and workers could not be laid off or take pay cuts if they were quarantined. Testing was carried out nationally, combining door-to-door visits by professionals and reports by residents themselves (CHINA WATCH INSTITUTE, 2020, p. 5-23), (IMF, 2020) (XU et al. 2020).

CONCLUSIONS

Based on the various information and empirical data collected in bibliographic and documentary sources, the following conclusions can be reached, in summary, regarding the fight against the pandemic carried out by the analyzed countries, considering the governmental measures taken and the health system adopted nationally.

Regarding the measures taken to combat the pandemic, the countries of the American continent analyzed - Brazil, Mexico and the USA - unfortunately have a relevant point in common: omissive posture and denialist attitudes of their presidents. Although all three countries presented specific measures to combat the pandemic, in the general context, considering the specific peculiarities of each national context, the response proved to be insufficient to combat both the health effects of the pandemic. Lethality rates were high in all three countries (especially Brazil and the US – markedly during the Trump administration). It must be noted the greater US capacity for economic recovery due to the solidity of its domestic economy, compared to the other countries studied. Regarding the adopted health system, only Brazil has a public and universal system (SUS). Despite the comprehensive list of medical services offered by the SUS, the system is marked by underfunding, which had a negative impact on the limitation of its capacity to respond to health emergencies. Thus, even with a public and universal health system, guided by integrality and equity, Brazil presented high rates of lethality, equaling countries with less robust health systems. Mexico, in turn, has little difference in relation to Brazil in terms of national investment in health, presenting the second lowest percentage of GDP destined for this purpose, a situation that causes similar underfunding of its system. The Mexican system has several private and public insurances, which generates the offer of different medical services to people of different social classes, promoting social inequality. The exclusionary structure of this system, added to the ineffective response of government measures to combat the pandemic, resulted in high rates of lethality, demonstrating the inability of the system to guarantee the fundamental rights to health and life. The USA is, among the countries studied, the one that invests the most in health in proportion to its GDP. However, it is not a universal system, offering only some specific benefits to some vulnerable groups, through the aid called *Medicare* and *Medicaid*. This way, many people end up not having any medical support and others are highly indebted due to the way the system works. The high fatality rates in the US can surely indicate not only failures in government measures to combat the pandemic, but also the inadequacy or inability of its system to guarantee the rights to health and life of its population.

On the European continent, with regard to the measures taken in response to the pandemic by the countries analyzed - Italy, the United Kingdom, Spain and Germany -, it must be noted that, despite the fact that, at first, the effects of the disease were underestimated. coronavirus, all countries presented a correct political prognosis based on the expansion of services provided by their health systems and health measures that kept proportionality between the benefit to individual freedoms in times of slowing down of the pandemic and the prevalence of the collective interest in the preservation of fundamental rights to health and life when the health crisis worsens. With regard to the health systems adopted, all the European countries studied had a large list of services provided, with most of the systems being public and universal, except for Germany, which works through compulsory insurance - even so, the majority of the German population (87%) is insured with public subsidies. These strong health systems proved essential in responding to the emergency crisis.

Finally, South Africa and China, despite the differences in their health systems, presented the unfortunate coincidence of taking measures blatantly violating fundamental rights in the course of combating the pandemic - such as the obligation for homeless people to remain isolated in temporary camps. in South Africa, and the chaining to metal posts of people who violated distancing measures in China. The authoritarian nature and restriction of the rights to freedom and physical integrity of the measures adopted by these countries hamper the analysis of the effectiveness of both such measures to combat the pandemic, as well as the medical services provided. Nevertheless, there is a clear distinction in the health systems of these two countries. While in South Africa there is no formal medical coverage, with only a minority portion of the population covered by private insurance, China has two systems that work in parallel, one for employees in urban areas and the other for inhabitants of urban and rural areas. (with less coverage). Through these two non-mandatory insurances, close to universal coverage was achieved in the country.

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