War on All Fronts

A Theory of Health Security Justice

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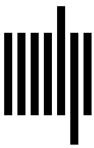

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1 Introduction

This is a book about war. Imagined, metaphorical war, but one with a catastrophic toll all the same. It is a book about what it means to be at war, to do battle, and on what terms we win and lose.

The "war" I have in mind is the war against communicable disease. This war is metaphorical because literal wars are wars between humans. But efforts to respond to infectious diseases have for at least the last thirty years become increasingly *securitized*, conceived of in terms of national and global security. This has led to the formation of the field of "health security," which is the subject of this book.[1]

As a metaphor, drawing a comparison between war and infectious disease is a form of analogy. And in places, this analogy seems to bear significant weight. Public health crises, and especially those caused by disease pandemics, may require mobilization of extensive resources in response. They may require us to make hard decisions about resource constraints even when we are prepared, and equally hard decisions about preparation during times of relative peace. And they may inform the structure of our most basic social institutions in the service of protecting individuals and communities from catastrophe. Armed conflict is a social, political, and ethical issue on a grand scale; so too is the war against communicable disease.

Rather than simply claim a mere analogy, however, in this work I claim that there is a relationship between the principles that govern the ethics of armed conflict, and those that should govern our responses to public health crises. I call this a theory of *just health security*, itself a reference to the tradition of just war theory that has dominated the ethics of war for a millennium. As a work of philosophy, my aim is to show how an understanding of the ethics of armed conflict provides a defensible view of a just, securitized public health ethics. As a work of health security, my aim is to formulate

an account to guide action, particularly as the world deals with the fallout from the coronavirus disease 2019 (COVID-19) pandemic.

The War on COVID-19

This book is not about COVID-19, but it is inspired by the respiratory illness caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). COVID-19 emerged on December 31, 2019, with a report of a cluster of pneumonia cases of unknown etiology in Wuhan, capital of Hubei province in the People's Republic of China (PRC).[2] By January 21, 2020, when the World Health Organization (WHO) began its first situation report on what was then called "novel coronavirus 2019 (nCoV-2019)," 282 cases had been reported, of which all but four had been in China, and all were connected to Wuhan.[3] Already, warnings had been issued about the possibility of exponential growth in cases, with some focusing on the Lunar New Year celebration in China scheduled for January 25 as a source of mass movement through the nation, and thus movement of individuals infected but not yet ill with the virus.[4]

Those warnings were justified. By January 31, 2020, WHO confirmed 9,826 cases globally.[5] The day before, WHO Director General Tedros Adhanom Ghebreyesus declared the virus a public health emergency of international concern (PHEIC);[6] a day later, Massachusetts would report its first case as a college student returned to Boston from Wuhan.[7] By then, 132 cases had been recorded as travel from China pushed the virus into twenty-three countries.[8] The pattern would repeat, doubling once every ten days or so.

Public fears mounted, but with the exception of proactive and prepared nations such as the Republic of Korea, whose experience with Middle Eastern respiratory syndrome had led to reforms in its public health infrastructure,[9] most countries did nothing. It would not be until March that new hotspots would raise alarms: in Italy, of physicians increasingly driven to ration ventilator support for critical cases,[10] and in Iran, where the press would report breathlessly of "burial pits in Iran so vast that they're visible from space."[11] But by that time, it was too late.

Cancel Everything

Most developed nations finally responded to the threat of COVID-19 in March. Responses were varied. Travel restrictions were imposed not just

externally, but within local jurisdictions. Stay-at-home orders were applied and enforced, some nations locked their populations down with police enforcement, in-person schooling was canceled, and nonessential businesses and restaurants were closed. Contact tracing systems were used to try and place individuals in the context of transmission events and locate other cases. Most nations did some of these; a rare few did all of them. Some did none.

The media landscape, and health messaging within it, was a maelstrom. Some authors referred to "flattening the curve"—that is, the epidemic curve of daily cases that dictated when resource limits would be exceeded in hospitals and public health agencies. Still others referred to variations on "the hammer and the dance," referring to sequential implementation of restrictions and reopening to suppress the virus until a vaccine could be produced.[12] Commentators leaned into the "Swiss cheese" model for risk reduction in which layers of risk mitigation policies protect a population through their sum: one group, in what must be a self-defeating attempt to improve public communications, attempted to rename this the "Emmentaler cheese" model.[13] Into this morass—fueled by chaotic messaging from Donald J. Trump, the forty-fifth president of the United States, who among other things likened his political opponents' concerns over COVID-19 to a hoax[14]—stepped a slew of other messages. Some of those messages were well meaning, others were pernicious and exploitative.

Often scarcer than ICU beds, or respirators, was the political will to act, and continue to act, to suppress and eliminate the virus. In his article "Cancel Everything," political scientist Yasha Mounk made the following case for extensive suppression tactics to deal with COVID-19:

1. cases of COVID-19 were increasing in an exponential fashion (i.e., a person infected with the virus would on average infect more than one other person);
2. COVID-19 had a higher fatality rate than seasonal influenza, and thus constituted a grave threat;
3. only "extreme social distancing"—according to Mounk, canceling public gatherings, so-called self-quarantine, and sealing off Wuhan and the province of Hubei—would curtail the spread of the virus.[15]

From this, Mounk concluded that social distancing was not only permissible; "serious forms of social distancing" were necessary.

What best defined the political moment were two corollaries made by Mounk. The first corollary was, given social distancing would be ineffective

if people could not get treatment or afford to stay home from work, that the government needed to enact additional policies. He argued that the government should take on the costs of medical treatment, grant paid sick leave to stricken workers, promise not to deport undocumented workers who seek medical help, and invest in rapid expansion of ICU facilities. But second, Mounk claimed the federal government would not enact the above, and thus it was up to *individuals* to pursue social distancing.

The measures that eventuated were certainly not sufficient. Indeed, it is hard to find a single government worldwide whose track record would be unassailable over the course of the pandemic. But the transference of responsibility to individuals, and Mounk's insistence on measures such as broad travel restrictions *without* social support, which cut against the ethical and scientific standards of public health, would become a disaster in its own right.[16] Mounk was not alone, and governments and popular messaging articulated "flatten the curve" as an individual strategy but never came up with an adequate plan of what to do next.[17] By the end of 2021, two years into the pandemic, even countries that began with excellent records of preventing the transmission of the virus would start to collapse, as variant after variant of SARS-CoV-2—the "delta" and "omicron" variants in particular—would overrun health systems and regions that had lapsed in their vigilance, leading to case counts and deaths higher than the first waves of the pandemic and the return of overflowing ICUs and crisis standards of care.

The Long War (on Everything)

Amidst all of this, war was declared on COVID-19. One of the earliest references to this war came from the PRC during its early reckoning with COVID-19, when Ma Guoqiang, Chinese Communist Party secretary for Wuhan, described the increased response to then-named nCoV-2019:

> Wuhan must strictly implement the public health emergency action level-II requirements set by Hubei province, completely enter a state of war and put resolute efforts to curb the spread of the novel coronavirus.[18]

The same week, the *Wall Street Journal* described the shaky footing of global pandemic preparedness efforts in military terms, noting that efforts by China to exclude Taiwan from the WHO hampered the "war on epidemics."[19] President Trump would follow suit when America finally began its belated response, declaring himself a "wartime president" against an invisible enemy. He used the rhetoric to advance a narrative of self-sacrifice, invoking the

costs of World War II and claiming "We must sacrifice together, because we are all in this together, and we will come through together. It's the invisible enemy. That's always the toughest enemy, the invisible enemy."[20]

The war metaphor would be used to advocate for strategies used against the outbreak; to describe the "front lines" where healthcare workers[21]—but curiously, not "essential workers" such as grocery store clerks—battled the virus. It would be used in more literal senses, such as invoking the US Defense Production Act, a piece of legislation authorizing the government to commandeer industry and other resources in aid of national defense.[22] Still more would use it to describe the virus's "rampage through the body."[23] It would be used supportively to promote ideas about the outbreak, but also critically to distinguish failures in "strategy" and "tactics" in pandemic response. And it would be used to describe the dead as they overflowed hospital morgues into makeshift tents in communities.[24]

This is hardly a new phenomenon, and Americans are perhaps the best known for their zeal at declaring war on everything from nations to abstract concepts, having long perfected the art of war metaphors. President Nixon declared "war on cancer" in 1971 with the signing of the National Cancer Act, mobilizing the National Cancer Institute and creating the National Cancer Advisory Board.[25] This war has continued through the twenty-first century, incorporating parallel metaphors such as the "cancer moonshot"—which, for those familiar with the history of the space race, know is just as militant.[26] We have had wars on HIV/AIDS, on the SARS-CoV-1 virus that spread through the world in 2002–2003, on Ebola virus disease, and even on antimicrobial resistance[27]—each disease with different etiologies and mechanisms of action, prevalence levels, morbidity and mortality, treatment pathways, and public health status. The instinct to use war as a metaphor is hardly unique to the United States, however, and is a rallying cry to mobilize resources and draw attention.[28] But over the last forty years it has become increasingly central to the calculus of public health as the emergence of the term "health security" situating public health—and responding to communicable disease in particular—as a national security concern.

And, like most metaphorical wars, the world lost the war against COVID-19.

The War within the War

It may seem premature to declare the war on COVID-19 lost, but the span of two years bears this out. Five million people had died by the beginning

of 2022.[29] Economies in ruins: at its worst in April 2020, 14 percent of workers in the United States—1 in 7 Americans—were unemployed, and half of those still unemployed a year later;[30] worldwide, almost 9 percent of the world's population was out of work.[31] Other diseases were neglected and left to run rampant, such as a "comeback" for tuberculosis in Peru.[32] A terrifying increase in domestic violence occurred worldwide, leading *Time* magazine to refer to it as a "pandemic within the pandemic."[33] Plus an educational crisis,[34] and more. And more cases daily by the end of 2021, as in the worst of the first wave. By 2022, much of the world had stopped counting the toll with any precision, except insofar as excess mortality from COVID-19 remained high.

These losses, moreover, are not equally distributed—just as in war. Of those unemployed in the United States as a result of the early pandemic, the majority were service workers, who experienced an unemployment rate of 40 percent at the peak of the crisis,[35] affecting predominantly people of color, women, young, and people with disabilities.[36] In the United Kingdom, more than 50 percent of COVID deaths were among people with disabilities.[37] And the long-term sequelae of COVID-19, the "Long COVID" as it is known, will potentially leave millions with lingering illness.[38] As New Zealand, one of the staunchest opponents of the virus, announced relaxing its pandemic lockdown standards, it was predicted that indigenous Māori are more likely to suffer as a result than white Kiwis.[39]

The obvious response—and one made by a reviewer of this book—is that the early arrival of vaccines signaled a profound victory over the virus. It is true vaccines exist, but the where and for whom of vaccination highlight the depths of the failure to wage war on COVID. Fifteen percent of the world's population possesses 60 percent of the world's vaccination supply, and by the end of 2021 only 2 percent of people in low-income countries had received one dose of a COVID-19 vaccine, compared to 65 percent of people in high-income countries.[40] All the while, rich countries continue to hoard vaccines for additional boosters as new variants of SARS-CoV-2 challenge their population.[41] While high-income countries vaccinated at a high rate compared to their poorer neighbors, their initial successes were coupled with a premature easing of so-called social distancing measures, and new spikes in cases. Many experts and policymakers, it seems, became comfortable with the SARS-CoV-2 virus circulating in the developed world in the

medium to long term so long as it didn't result in hospitalization or death for the vaccinated, and so long as the economy remained stable enough. For the rest of the world political will has faded, and needless deaths have accrued.

This is not D-Day or Iwo Jima. This is at best a public health Afghanistan. It is more likely the infectious disease equivalent of the Charge of the Light Brigade, a health security Gallipoli, or even a public health Stalingrad. This is not a war of heroes. It is an unending slog.

Individuals who have securitized healthcare are thus struck with a problem: declaring war on COVID, as with other things that aren't actually war, does not actually lead to successful—much less just—outcomes. If anything, it is associated with failure more than success. This book, at a fundamental level, is about addressing whether there is a just way to wage war on infectious disease.

Health Security

At the heart of the war on COVID-19—or Ebola, or AIDS, or antimicrobial resistance, or some future "Disease X"—is the idea of health security. Health security is less a discipline united by a common set of epistemic norms and methodologies and more a cross- and interdisciplinary collection of activities centered around the idea of health and public health as a component of national security. Lorna Weir has documented the rise of the concept of "(global) health security" as an act of securitization beginning in the 1990s, with Canadian and US efforts to define and then incorporate into global governance the concept of "emerging infectious diseases," and then "render WHO responsible for preventing the international transmission of emerging infectious diseases."[42] Through the early 2000s, this became a task to which WHO, driven by what Weir identifies as the interests of the Global North, responded by outlining a system of disease surveillance and control they termed the "world on alert," a metaphor explicitly tying health to security. It ultimately dovetailed with ongoing efforts to update the international health regulations (IHR) and after the terrorist attacks of September 2001, became explicitly associated with responding to chemical, biological, radiological, and nuclear attacks. These two factors, among others, led to proposed IHR drafts that explicitly favored a "threat-defense" conception of public

health, and one that focused not on responding to endemic diseases but to emerging diseases that crossed international borders. The use of the language of threat, in particular, Weir rightly identifies as the language of security rather than public health conceptions of risk.[43]

In 2022 WHO defines "health security," or rather "global public health security," as activities required, both proactive and reactive, to minimize the danger and impact of acute public health events that endanger people's health across geographical regions and international boundaries.[44] Two central preoccupations emerge from this definition's historical antecedents. The first is an (albeit not exclusive) concern with infectious disease, and in particular disease pandemics caused either by natural events or biological weapons. The second is the framing of these events as a threat to national and global communities, and the continuation of the social fabric and international order.

When it comes to bioterrorism, health security arguably arises from concerns of developed nations about state and nonstate biological weapons activity,[45] and the risk of a deliberate or accidental release of a biological agent into the human population.[46] This focus predates the twenty-first century[47] but received considerably more interest at the turn of the millennium following the anthrax attacks of 2001 and the emergence of "dual-use research" that could be used to advance both the beneficial and malicious uses of the life sciences.[48]

Next, health security deals with conventional public health issues by recognizing naturally arising pathogens as a national security threat in their own right. While there are many ways to discuss this, there is perhaps none more extreme—or indicative—than the claim made in an editorial in *Nature* during the SARS epidemic that "nature is the ultimate bioterrorist." This claim was followed with the purported good news that "the genome sequence of the prime suspect . . . will become available any day now. This should help to reveal where the virus came from, suggest reasons for its lethality, and speed the development of rapid tests for its presence."[49] The conception of nature as a perceived threat predates SARS. Threats imply an intentionality, an obviously nonsensical concept in the case of the virus itself.[50] But they also imply a right to self-defense which, famously, does not require intention to be justified.

The idea of self-defense is critical to American conceptions of public health in general. The landmark case in public health, *Jacobson v. Massachusetts*,

upheld the authority of states to enforce compulsory vaccination laws. In that ruling, the court held that:

> Upon these principles of self-defense, or paramount necessity, a community has the right to protect itself against an epidemic of disease which threatens the safety of its members.

Jacobson will become important in later chapters, in part because it defines a quintessentially American interpretation of public health in the context of disease epidemics. That interpretation holds that infectious *people* present a threat to their community, against which the community has a right to self-defense. Interestingly, it also invokes the principle of necessity, which brings up a longer and older tradition of jurisprudence that covers state responses not only to particular exigent circumstances but also to individual rights and responses in the face of the overriding demands of nature.[51] Under *Jacobson* a community is justified in exercising power, even coercive or violent power, against others in order to protect against the "threat" of infectious disease.

Not all concepts of health security stem from analogy to personal self-defense but may touch on other elements of security. While Australia has a *National Health Security Act*, much of its public health powers mobilized against pandemic disease are through its *Biosecurity Act* of 2015. This, however, is a replacement not for a human security instrument, but an initially *agricultural* instrument, the *Quarantine Act* of 1908. This act was first designed to provide the federal government of Australia with powers over quarantine against infectious diseases that superseded those of the states but was over time amended to encompass a wide range of human and animal pathogens.

The relationship between human and animal security dovetails with the trend toward health security as a war in response to the threat of nature itself. This has manifested in the emergence, for example, of climate change as a health security issue.[52] The 2018 Zika virus outbreak brought with it the fear that as climate changes, and host ranges of mosquitoes expand, the likelihood that Zika and other *Aedes Aegypti*-borne diseases will infect Americans will increase.[53] Since the elimination of yellow fever in the US, few mosquito-borne illnesses have established themselves on the continent. With that potential change has come increased pressure to deploy novel methods such as gene drives, and genetically modified mosquitos to eliminate the creature the Centers for Disease Control (CDC) refers to as the "World's Deadliest Animal."[54]

Public Health Ethics and Health Security

Public health ethics became entwined with health security following the anthrax attacks of fall 2001 in the US. One central issue that concerned both was the possibility that an adversary of the US would be in a position to attack using a biological weapon, requiring the allocation of extreme amounts of human and medical resources to counter. The number of deaths involved depends on the course of action but estimates of a particularly successful attack with a sophisticated anthrax weapon were believed to be in the tens to hundreds of thousands.[55]

What emerged in the wake of this was the development of both legal and ethical frameworks to address exigent circumstances such as bioterrorism, a literature bolstered first by the emergence of SARS in 2003, highly pathogenic avian influenza H5N1 in 2005, and the IHR reforms that followed.[56]

A central concern for authors, and one this book takes up, is what to do in extreme public health crises where human rights conflict with broader utilitarian concerns around saving lives. To this end, a popular framework for public health ethical decision-making was developed, describing a system of tradeoffs that recognize common moral commitments, and a framework for deciding when individual interests could be overridden in the pursuit of public health priorities.[57] It claimed that individual interests were overridable just in case a public health action was effective, necessary, had risks proportionate to its benefits, was the least infringing measure available, and publicly justifiable.

This framework, which I describe in full in chapter 3, is also significant in that its author list includes the architect of the US Model State Health Emergency Powers Act (MSHEPA), which was ultimately used by states within the US to enact legislation that governs emergency responses to bioterrorism or other public health disasters.[58] This model act became one of the earliest instantiations of modern health security, and its ultimate use in state legislation would become the basis for political action against COVID-19, for better or worse.

However, the concern about mass casualty events such as bioterrorism and pandemics, and the theme that emerged within that literature that individual rights could and should be overridden in the name of public health, has not been without its critics. As soon as the framework and its subsequent instantiation in policy appeared, critics remarked that leaning

into a policy that countenanced rights infringement would undo the hard work of activists and scholars, particularly in the context of HIV/AIDS, to center human rights in health. Accompanying this were concerns about the internal consistency of the principles described in the framework, to what extent they could guide action, and how the presumption of certain values underpinning them would translate outside of the American-centric author group and context in which the framework arose.

Having read this framework in graduate school, where I was also writing on military ethics, one of the things that struck me about the principles is how closely they hewed to the tradition of just war theory, which (at least in its orthodox formulation) contains a set of principles governing when it is morally permissible to declare war, and how one should wage war. This book makes the case that this connection is not an accident—historically or philosophically. But its interpretation misses some critical features that the ethics of war can provide us. More importantly, the ethics of war gives us a way to think constructively about the value of rights in public health, and what it means to protect the people who hold them from, and during, emergencies.

Methods, Limits, and Structure of This Book

This book provides a novel theory of *just health security* and its relation to the practice of conventional public health (and public health ethics). Methodologically, I draw on the literature from armed conflict, with which public health ethics—or public health ethics that considers security—shares common principles, but which sometimes lack a set of deeper normative commitments. I argue that like just war theory, as a view that begins at pacifism and then steps back to ask under what limited conditions it is ever permissible to kill, so too should just health security begin with the idea that public health at its heart should hold human rights as critical, only in the most extreme of circumstances allowing those rights to be infringed upon, and doing so with an aim to quickly and justly restore a community after an emergency.

This is a preliminary work in some respects and is inspired by two works, neither of which are in public health. First, I draw strongly from Larry May's *Contingent Pacifism*. Like May in that book, my intention is to provide an argument that people will take seriously. It is not my intention to provide an airtight version of this novel theory, and indeed it will become clear that

much more work may need to be done in order for that to arise. Rather, it is my intention that this argument is one that the reader—even if not persuaded by it in whole or even in part—will take to be a serious contender for a moral basis of health security. Indeed, while normally reserved for the acknowledgements section, I am indebted to Larry for a number of conversations more than thirteen years ago at the Australian National University about the ethics of war, conversations that have stuck with me and inform the larger project here.

My second aim is to provide an account of something with which people are familiar—or at least, a wide segment of people in the health sciences and humanities—but is increasingly subject to a series of argumentative moves that contain misleading or even bad faith arguments that shield particular visions of public health and national security from reasonable critique. In this aim, I am indebted to Hugh LaFollette's *A Defense of Gun Control*. LaFollette, born and raised in Louisiana and a longtime gun owner and hunter, mounts an argument in that book that he acknowledges himself is one he has taken time to arrive at: that gun control in the United States is not only morally required, but able to be implemented in a way that accounts for good faith defenses of the right to possess firearms. The argument LaFollette constructs, however, is one that deeply considers what is required for a defense of guns, or gun control, to be in good faith to begin with. In the same way, rather than either uncritically accepting the tenets of health security or rejecting the move to securitized health out of hand, I wish to provide a reconstruction of health security in terms that are defensible and compelling, before I describe its implications and limits.

These two inspirations come together to provide an account of health security that on the one hand is grounded in a theory of national and global security, acknowledging that even legitimate visions of national and global security entail state coercion; but on the other hand, the moral content of that vision should commit us to surprising, and indeed peaceful conceptions of state and human rights. Even if we believe coercive public health practices are justified in the name of national security, May's work provides a thoroughgoing analysis we can apply to states that consistently fail to meet the standard required of them in the real world, and what we should do with knowledge of their failures. LaFollette provides the means to rebuild an account of public health that is aligned with the best insights

into the metaphor that public health is national security, before applying an analysis that takes seriously the demands of justice.

Throughout this book, I use the phrase "communicable disease." While the main examples I use are infectious diseases, and the US CDC regards communicable diseases as interchangeable with infectious diseases, I want to caution against this restrictive view. Some disease "epidemics" have a communicable nature, but that communicability is arguably totally social in nature. The most common of these I will refer to is the overdose epidemic gripping North America, passed through communities, between generations, and across regions. But there may be others: depression is communicable as a "social contagion," for example, and environmental disasters may have long-standing and even intergenerational effects or have reservoirs that continue to "spread" the disease beyond a single point of exposure. Many of the claims in this book are applicable to this wider set of communicable diseases, and the application of health security to attempt to solve things like overdoses. My account provides a guide to why and how, from a political-philosophical standpoint, treating "diseases of poverty" with the same tools as respiratory diseases is *possible*, but requires radically rethinking both.

Many of the examples I use are located in the US, though not all. One reviewer has suggested to me that I make this book entirely about health security in the US. I don't want to pretend that my position as an Australian living and working in the US is irrelevant to my perspective and analysis. Certainly the trauma of living through the US response to COVID-19—and with an immunocompromised spouse—has been a huge impact on this book. But my claims about the nature of public health threats do not depend on the passport held by the person vulnerable to those threats. And the arguments in chapter 5, in particular, depend on the nation-state, but not its particular American instantiation. The illustrations are US focused, but the analysis should be applicable, perhaps with additional twists, to many if not most other nations.

In the next chapter, I subject the war metaphor to detailed analysis. Starting with COVID-19, I provide examples to sketch what it means for public health, and in particular infectious disease, to pose a threat to the security of individuals and communities that lends itself to the war metaphor: threat, mobilization of resources, high stakes decision-making, and the role of social institutions in security. I then turn to the primary critique

of the war metaphor, grounded in securitization theory. This theory claims that, at best, the war metaphor inadvertently places an existential finger on priority setting in health, and at worst is a mere performance that serves vested interests. I ultimately reject this critique of securitization, or at least its normative instantiation. I argue instead that the critique shows why the war metaphor, and its instantiation in public health norms and policies, needs to be deeply examined in the context of ethical and political-philosophical theories about state power.

What follows in chapter 3 connects the war metaphor to public health. The most obvious way, I argue, is through the orthodox view of public health ethics. I articulate this view in detail and describe how it tracks important elements of the war metaphor. The debate between critics and supporters of this partly securitized version of public health ethics is instructive in understanding the war metaphor in ethical and political-philosophical terms. I argue that the most compelling argument for securitized public health ethics is the strong connection between the orthodox view and just war theory, the millennia-old theory of the justification for going to and killing in war. I show how this connection manifests and determines that a first step in a theory of just health security, or securitized public health, is justifying public health as appropriately the function of a nation-state.

Establishing this justification is the focus of chapter 4. I argue for an *impersonal account of disease* as the appropriate target of public health institutions, in which the appropriate "enemy" is the causative agent of disease itself, but not the victim of that disease. I compare this account to theories of noncombatant immunity in military ethics and show how both accounts provide a view to (a) the appropriate risks innocent people may be exposed to in responding to a threat, (b) the kinds of liability the state and its proxies must assume for the purpose of responding to a public health threat, and (c) our obligations to avoid the material conditions that lead to public health emergencies.

Chapter 5 then focuses on the appropriate institutional home for public health. Beginning with a reflection on the degree to which federalism has largely undermined the response effort to COVID-19 in the US, I argue that a critical step in health security is to establish public health not as a function of government *simpliciter*, but of the highest authoritative form of governance available to us—in this case, the nation-state. I then examine three broad political-philosophical theories: libertarianism, liberal contract theories

(with a focus on the work of John Rawls), and utilitarianism. After discussing their limits and earlier attempts at plural theories of public health ethics, I argue a central problem in justifying a robust public health state is a *deep pluralism* around what kinds of values are important. I then turn to Michael Moehler's recent contractarian account of a minimal moral state and show how even this account of political philosophy from pure instrumental reason can provide a justification for a robust public health state, albeit one that at times must override individual rights or interests in the service of collective welfare. I sketch some limits of this account to return to at the end of the book: in particular, questions about legitimacy, authority, and assurance in contemporary states.

Chapter 6 concerns the declaration of public health emergency. Starting at the declaration of COVID-19 as a PHEIC and working backward, I argue that a central gap in public health ethics is a lack of systematic treatment of public health emergencies as distinct phenomena from "public health peace." I show why this gap explains some of the justified critiques from chapter 3 against the orthodox view and then offer a framework for declaring a public health emergency ethically. This framework explains why we ought not to use forced quarantine or other measures in nonemergent but serious public health events such as bad flu seasons, and thus generate a normative regime that can successfully conceive of rights-respecting public health during "peacetime," while accommodating rare emergency cases in which rights might be justifiably infringed upon for community safety. I then expand on the previous chapter's account of necessity and last resort as a component of this declaration framework as informing duties of states prior to emergencies. I turn finally to an obvious objection—that this framework unduly constrains public health practice—and examine it through the lens of the military ethics debates around the use of force short of war, and of supreme emergency.

Chapter 7 addresses the classic public health ethics issue of the use of "liberty limiting measures" including surveillance, measures that increase social distance, mandatory vaccinations, and quarantine. After recapitulating the important move of the previous chapter—the normative significance of a public health emergency—I argue that while public health ethics has often conceived of these measures in piecewise terms, a robust, securitized public health ethics will conceive of portfolios of options that include the imposition of serious liability on the state in the accomplishment of

its goals. This arises from the stronger form of rights protections outlined in chapter 4, and the noncombatant analogy in chapter 5, which makes demands on states and their proxies in the achievement of their goals. I use as my example the now-ubiquitous "social distancing" measures applied during COVID-19 and show how even if we believe some kind of social distancing measures are justified, the liability required under the necessity condition of securitized public health obligates the state to provide robust supportive provisions.

In chapter 8, I consider the "front lines" of a public health crisis. Beginning with the astonishingly recent development in health security that seriously considers individuals in nonhealth service positions as "essential," and the moral implications of that in the context of the COVID-19 pandemic, I turn to an account of the responsibilities and roles of different institutional actors during a crisis. I argue that professionalized public health and medical services do in fact incur some liability in the service of defending society against public health threats. This liability is far from unlimited, but it is less sensitive to negative popular reactions against public health measures than might be initially presumed. I then turn to what I consider one of the critical elements of public health response: leadership. I argue, using the example of COVID-19, that leadership is not merely a set of personal qualities in an individual, but a normative claim about the role a person has in an institution of public health. Leadership emerges from—and in turn should inform the structure of—public health institutions, and I show how US leadership is incomplete even on the best of days, as judged not from the individuals in power but the lines (or lack of lines) of power and communication that beset the US Public Health Service. I conclude with a brief comment on the limits of that power and the role of conscientious objection and disobedience in public health.

Chapter 9 rounds out the basic argument of the book with a view to "public health peace." I argue that a central implication of securitized public health is not "war," but rather that war should be seen as the unfortunate and, by the demands of justice, rare exception to a state of peace. I then inquire as to what this peace might mean. I do so through the lens of what the public health state should look like outside of the crisis, focusing on funding and the distribution of resources and priorities. I then turn to the transition from war back to peace in public health, with a look at reparation, rebuilding, and accountability of actors during the crisis.

The final chapter is policy focused and asks the question "so what?" This chapter is a series of reflections on the state of health security as one of its practitioners, informed by the findings of this book. I present three narrative visions—stories of what a consequence of this work might be if taken seriously, for interested parties. The first vision is titled "Health Hawks, War Doves" and considers what an ambitious and comprehensive view of changing public health practice might look like. I do not attempt to estimate the actual size of the lift here, but I am clear on the contours of just how demanding this revolution might be. The second vision is titled "Business as Usual, with a Twist" and considers what the most modest view of this book's prescriptions might entail with a focus on chapters 8 and 9—which I consider the book's easiest lifts. The final vision attempts to wrestle with a persistent concern foreshadowed in this book—that the authority of the public health state might be unsalvageable. Titled "The Breakdown," I consider what a reader who is (as I am at times) deeply skeptical about the possibility that the nation-state can deliver on the demands of justice, and truly protect the public's health, might do about health security. I conclude with a comment on the relative compatibility of these visions.

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