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War on All Fronts

A Theory of Health Security Justice

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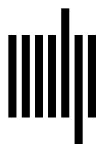

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2 The War Metaphor

The war metaphor is ubiquitous. It frames policy documents, international statements, scholarship, news, and opinion. In COVID-19, the "invisible enemy"[1] that was SARS-CoV-2 threatened the "[physician, nurse, and scientist] heroes on the front lines"[2] of healthcare and required "mobilizing against COVID"[3] including a "Manhattan Project for COVID"[4] to "defeat"[5] the virus over a "long war."[6]

There are other books on the role of military metaphors in a variety of settings. There are books about their relation to specific diseases, what they do to people and institutions, and the consequences of those actions. What I want to start with, however, is the idea that war metaphor is at its heart a series of choices about who counts (physicians and nurses) and who doesn't (non-"heroic" personnel such as low-paid service workers), what people really think about the reality of waging war (an epic struggle, rather than boredom punctuated by death), and what people who think about health security care about (arguably, not rocking the political boat even if it means forgoing meaningful change).

For a tight, interesting version of this phenomenon, we can look to Peter Daszak of the Eco Health Alliance. Speaking to the *New York Times* about the search for future pandemic diseases, Daszak said:

> We don't think twice about the cost of protecting against terrorism. We go out there, we listen to the whispers, we send out the drones—we have a whole array of approaches. We need to start thinking about pandemics the same way.[7]

There's a lot to unpack here. First, we certainly do think twice about the cost of protecting against terrorism: many, many people care deeply about the cost and ultimate effectiveness of US and global counterterrorism, including relative spending compared to other important social goods such

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as public health. And typically, the forgotten costs of counterterrorism include civilians in foreign theaters injured or killed by operations, including when we “send out the drones.” It isn’t clear that Daszak thinks the War on Terror is justified, but the effect is to endorse it as a template on which to build responses to global public health crises: a cruel irony given that the US, and its allies, have almost certainly lost that war.

The purpose of this chapter is to build out and describe the relationship between public and national security with an eye toward a normative argument in future chapters. That is, I show not just that there are parallels between war and disease, but that these parallels can inform how we should act in public health crises.

First, I address the obvious concern that securitizing health—turning health into a security issue—is at best a mistake, and at worst an intentional move to capture health under the rubric of national security, with all the perils that entails. Securitization theory is a broad landscape of theories, and I deal here with those elements that speak against any further comparison between health and armed conflict.

Next, I outline a series of properties that communicable diseases can possess that makes the comparison between health and security so apt. These are (1) the presence of a threat to a large number of individuals in society, and/or the continuity of society itself; (2) the requirement to mobilize against that threat being fulfilled best or only by the state; and (3) that mobilization requiring particularly weighty decisions—surrounding killing or otherwise severely limiting the life plans of individuals—to fulfill its aims. These provide a *pro tanto* reason to accept the idea of health security, though the details have to be filled out.

I conclude by examining one method by Rita Floyd, which is to consider a “just securitization” of health in certain cases.[8] I argue that this fails on a key count, which is that Floyd considers securitization a transient affair in which things come to, and cease to be, security issues. I contend that this is a mistake in the case of public health, because (1) the issue here is not strictly security, but a set of principles which public health may hold in common with security; and (2) even if public health is a national security issue explicitly, it can never be “desecuritized.”

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Securitization

A central criticism of health security is securitization theory and begins with the pragmatics of language. Securitization theory is concerned with speech acts that frame something as a security issue:[9] while there are a number of distinct traditions in this theory,[10] the branch that deals most with the pragmatic critique of the war metaphor is the work of Barry Buzan, Ole Wæver, and Jaap de Wilde. Securitization, they hold, casts a particular issue as a "security issue" that is distinct from normal political or policy concerns by using the language of security, threats, and vulnerabilities "staged as existential threats to a referent object by a securitizing actor who thereby generates endorsement of emergency measures beyond rules that would otherwise bind."[11] Put another way, securitization is the process by which people use the language of national security to convince each other that an issue is a threat, a critical issue for policy and politics, and one that requires expanded power and authority to address.[12]

Securitization theory typically is not an account of what security ought to be but rather a description and critique of the process by which things come to be seen as security issues.[13] The process described has its analogue in the works of J. L. Austin, whose work described three elements to speech:

- Locution: the propositional content of the act, i.e., what the words mean;
- Illocution: what kind of act it is (e.g., warning, questioning);
- Perlocution: what kind of effects the act has.[14]

Securitization is clearly concerned with the perlocution of security language: what happens when you use words to describe something in the language of security. But securitization theorists are also, I suspect, concerned with illocution. The war metaphor, among other things, is a warning to an audience. While the result is particularly important, the form of the message surely matters as well. The perlocution is that we are persuaded to treat health as a security issue; the illocution is that we are warned or urged to do so.[15]

Not all writers on securitization theory consider securitizing health to be negative overall.[16] At its most stark, however, the pragmatic critique of treating health as a security issue is more or less propagandistic. That is, securitization is the process by which security risks are *created* through the language of security. This process is rarely, maybe never, analytic: there is no principled reason why the issues we label health security ought to be thought of as

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security issues. Rather, the effect of the speech act itself is the process of creating agreement, justified or not, that health is a security issue.[17]

Lorna Weir has documented the rise of the language 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."[18] 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 IHR, and after the terrorist attacks of September 2001 became explicitly wrapped up in responding to chemical, biological, radiological, and nuclear attacks. These two factors, among others, led to proposed drafts of IHR that explicitly favored a "threat-defense" conception of public health, and one that focused not on responding to endemic disease but on emerging diseases that crossed international borders. In particular, Weir rightly identifies the use of the language of threat as the language of security, rather than public health conceptions of risk.[19]

Another account of the securitization of health comes from Colin McInnes and Kelley Lee, who note that while diseases have crossed territorial borders since antiquity, their successful move into the realm of foreign policy has been achieved only recently. They identify two causes for the move in predominantly Western circles: the HIV/AIDS epidemic as indicative of novel disease threats to national interests, and fears of bioterrorism. They argue that while this has successfully connected the domains of public health and national security, this connection is in practice largely unidirectional, favoring health issues that threaten the interests of the rich, privileged economies that pioneered the securitization of health—a rhetorical move that applied national security concerns to public health institutions but not the other way around. They note, however, that foreign policy issues such as national stability and transnational criminal activity have not been singled out for their public health impacts, given the burgeoning overdose epidemic in North America at the time of their publication.[20]

Both these accounts reveal reasons to accept part of the securitization critique. First, Weir's account notes the idiosyncrasy of WHO using what we

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can take to be a war metaphor ("world on alert") and the language of security ("threat-defense") as a rhetorical move to generate political cachet in the international governance landscape. McInnes and Lee note that a concern about securitization is that it risks replacing the logic of public health with national security rather than linking (and, we might hope, reconciling) the two. Indeed, Weir notes that the introduction of the threat-defense conception received considerable pushback from states in the Global South, of which the most forceful is the so-called Montevideo Document produced by the governments of Argentina, Bolivia, Brazil, Chile, Colombia, Ecuador, Paraguay, Peru, Uruguay, and Venezuela.[21] That document noted that

> We propose to replace the concept of *threat* with *risk* throughout the document, especially in the definition of a *public health emergency of international concern (PHEIC)*.
>
> We support the definition of *public health risk* presented in the Proposal by the Chair and we justify the use of this broader concept which is more adequately suited to public health purposes.[22]

The Montevideo Document rejects the use of "threat" precisely because of its perceived ill fit with the aims of public health. Interestingly, over the next decade the attitudes of roughly half of these actors would begin to change, as Argentina Chile, Colombia, Paraguay and Peru would ultimately join the Global Health Security Agenda, arguably the first explicitly "health security" multinational agreement.

Amanda Moodie and colleagues, in their recent survey of health security, identify three major assumptions that health security practitioners make in choosing to identify health as a security issue:

1. Securitising health generates resources for responding to severe disease outbreaks.
2. Securitisation fosters multilateral cooperation on public health problems.
3. Synergy between national security and public health communities is necessary for rapid responses.[23]

They note, however, that none of these assumptions hold, and in fact often the practice of labeling a health issue one of security backfires, creating the opposite result to those assumed. Here, I describe how this arises.

First, consider briefly the United States' categorization of Ebola virus disease as a health security threat in the United States. This entailed, among other things, a large amount of basic and applied scientific research into medical countermeasures to treat Ebola virus disease; the stockpiling of

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resources to respond to the disease; and the generation of policy and legal tools to deal with the disease as a security threat, from surveillance efforts to restricting access to samples of *ebolavirus* under the Federal Select Agent Program.[24] Yet the background to this is that the United States saw the beginnings of the collapse of confidence in vaccinations and the resurgence of previously controlled diseases such as measles,[25] the continued tragedy of the HIV/AIDS epidemic left to fester in the 1980s, and the current overdose epidemic catastrophe. While Ebola virus disease *is* a public health concern, it is largely not one in the US.

Second, not only does its status as a national security threat likely not serve Americans, the national priorities of the US and other developed nations in ensuring their own safety against a disease that has caused fewer than a dozen deaths in the developed world since 1974 may also have come at the cost of the public health of nations that are vulnerable to Ebola virus disease as funds were directed toward securitized diseases, while more common diseases with much higher absolute mortality and morbidity remained underfunded. Even when low- and middle-income countries have attempted to engage in their own public health measures, security may frustrate this indigenous capacity: for example, the UK has been accused of using national security legislation to prevent Western African communities from accessing their own blood for viral samples of Ebola virus disease for use in conducting research to prepare for future pandemics.[26]

This last problem dovetails with the second concern Moodie and colleagues raise: multilateral cooperation. By and large, the rise of health security has failed to make the world safer from infectious disease. This is primarily because while some progress has been made in limited areas, overall foundations of global health remain very weak. Funding for WHO, for example, remains incredibly low relative to the needs of global health. The global patent system currently stymies the creation of large amounts of vaccines and medical countermeasures under the assertion by developed nations that it is necessary to promote "innovation"—innovation that developing nations can never afford. And those resources developing nations often do have in abundance—samples of either pathogens or of plants and animals that may be reservoirs of protein and other small molecules that inspire medical innovation—are frustrated as developed countries refrain from supporting international instruments that would allow them to fund their economies and public health systems using the profits from access to natural materials.[27]

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The third and final issue is most stark, and amply demonstrated through the long use of not international but domestic security as an arm of public health. The use of policing as a framework for public health has its own considerable and ugly history. Perhaps best-known outside of medical history, the rise of criminalized approaches to people living with HIV/AIDS led to a number of pernicious effects. First, laws criminalizing the transmission of HIV/AIDS or failure to disclose a person's status backfired, leading to increased suppression of HIV/AIDS awareness and education and an uptick in cases. Moreover, it had distinct gendered effects through the criminalization of women with HIV/AIDS subject to sexual violence in case their attacker contracted the disease.[28] In more recent times, the use of criminal justice institutions to address the ongoing overdose epidemic has failed to stem the rate of overdoses, and the use of prisons to house individuals experiencing substance abuse disorder has exacerbated suffering and death without any proportionate benefits.[29]

The last twenty years of international security have not helped things. Weir notes that the negotiation of securitized language in IHR occurred during the beginnings of the war in Iraq, and member states raised concerns that use of IHR to investigate alleged uses of chemical, biological, radiological, and nuclear agents could manifest in pernicious ways, including espionage.[30] This concern may have been particularly incisive given both the status of the evidence used to justify the war in Iraq and the technical dominance at the time of the US CDC, which situated it as (at least in the eyes of some state parties) the operational arm of WHO.[31] The war metaphor is off to a shaky start in part because of the history and character of wars past. To return to Daszak's comment at the beginning of this chapter: if the War on Terror is the model, it is perhaps the worst model we could choose.

The Strength of the Comparison

Securitization theory presents a significant challenge to health security. The critique is largely descriptive, asking "how have people used securitized health and to what effect?" But there are two other ways we might interrogate the war metaphor. The first is to ask, "what kinds of concepts might the war metaphor describe?" The more important sense in which we might interrogate the war metaphor is analytic or ameliorative. By this, I mean we can ask the question "To what goal should the concept in question aim?"[32]

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Securitization theory will claim, and rightly, that the war metaphor is socially constructed. But if this is so, then we can inquire into what point there is in keeping such a construction around, and if there are points to which we could apply a concept like the war metaphor in order to do productive work.

The first of these alternate methods of inquiry is my method in this chapter. The study of war as a metaphor in health is hardly new. Susan Sontag's work *AIDS and Its Metaphors* is the iconic view of this area, in which Sontag describes efforts to reduce mortality from a given disease are called "a fight . . . a war."[33] There are many relationships between armed conflict and health (including medical and biological) concepts, and I won't deal with them all. I set aside, first, the work of actual intelligence and military agencies in responding to pandemic disease, such as the warnings of the danger of COVID-19 given to the US government by its intelligence community that went unheeded.[34] That is, I am not interested in health security merely as health work *done by security forces*. There may be an argument for using the armed forces in this way, but that is not my project here.

Some biological comparisons, I only deal with in passing, such as the description of patients—especially cancer patients—as "fighting" their disease, which may be interwoven with normative judgements about people's deservingness of their condition.[35] And I will largely ignore the use of military metaphors in describing biological processes, such as Ed Yong's use of T-cells and B-cells that remain after an infection as "veterans of the COVID-19 war of 2020, bunkered within your organs and patrolling your bloodstream."[36]

Rather, my focus on the war metaphor is an entry into interrogating how ideas about national security might inform public health ethics. The war metaphor describes three things:

1. the scale of the *threat* of infectious disease (or a particular outbreak) as similar to the threats that motivate armed conflict, cashed out in terms of
    - the harm they cause;
    - the psychological effects they elicit;
    - as a threat to national sovereignty, community integrity, or social function;
2. the mobilization required to respond to that threat as similar to that required by war, and its locus in *a social institution*;
3. the kinds of decisions that institution may be required to make in virtue of the exigent circumstances presented by the threat.

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It is the ultimate mission of this book to determine a principled foundation for these things the war metaphor describes, and examine their prescriptions and probe their limits. Here I sketch out the features of each arm of the war metaphor to connect the ethical and political-philosophical features of public health, through this analogy, to the same features of military ethics. This will motivate further examination of the justification for the use of political power and force, broadly construed, to achieve public health aims.

Threat

In the previous chapter, I noted that President Trump invoked the war metaphor to advance a narrative of self-sacrifice during COVID-19.[37] It is not clear that this is the first American use of the war metaphor during COVID-19, but it is perhaps one of the strongest and most public instantiations of it in the early phases of the pandemic, at a time when US cases were still measured in the hundreds and there seemed a possibility of "winning" the war.

Other leaders echoed the use of wartime metaphors. In her address to the nation, Queen Elizabeth II recalled the blitz of 1940, saying, "today, once again, many will feel a painful sense of separation from their loved ones," referring to the social distancing measures enforced on the country, "but . . . know, deep down, that it is the right thing to do."[38] This depiction of COVID-19, and the measures required to address it, as analogous to the threat of Nazi invasion, frame the pandemic in terms of wartime threats to individuals and communities. The Queen even invoked Vera Lynn's anthem, *We'll Meet Again*, in her speech, further coupling World War II to COVID-19 as equivalent moments in history.

Greg Koblentz and Michael Hunzeker referred to COVID-19 as an "adversary" capable of removing a US Navy aircraft carrier from service for the first time since World War II.[39] They noted that the threat of the disease could undermine US military readiness through attrition from illness, or through the need to redeploy units to the homeland to assist in maintaining public infrastructure. But they also argued that historically, pandemics have been more deadly than war in terms of the number of lives they claim, and that if unchecked, COVID could kill more Americans than the combined death toll of post-World War conflicts.

Koblentz and Hunzeker unknowingly echoed the context framing the Tuskegee syphilis study. That work was begun due to ongoing concerns that, among other strategic issues, the emergence of syphilis outbreaks in

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the US armed forces could render troops unfit for duty, compromising US force strength. Resolving that concern would ultimately be the responsibility of the US Public Health Service (PHS) and US Surgeon General, who exploited African American men as a model for other populations on the racist belief that treatments for syphilis were not effective on “promiscuous” African Americans, who would thus not be harmed by their absence.[40] It’s extremely doubtful Koblentz and Hunzeker intended this comparison but, as securitization theorists note, their unwitting connection to the dark history of the US PHS is not unexpected: a key effect of securitization is using the language of security to justify otherwise extraordinary or impermissible acts.

These uses reveal three separate senses in which disease poses a threat, and how that motivates comparisons to war. First, disease and war both kill, and appear to kill indiscriminately, arbitrarily, and capaciously. Michael Walzer, in introducing the “crime of war” in his foundational *Just and Unjust Wars*, notes that the basic and easy answer behind why war is wrong is simply that “people get killed, and often in large number. *War is hell*.”[41] So too, then, is disease: in her *Pale Rider*, Laura Spinney describes the effects of the 1918 H1N1 influenza outbreak, mistakenly named “Spanish flu,” and asks:

> How could you explain the randomness with which the disease selected its victims, if not as the work of a vengeful or vindictive force? Yes, the young and firm were in the firing line. But why was one village decimated, while a neighboring one got away relatively unscathed? Why did one branch of a family survive, while a parallel one was snuffed out? In 1918 this apparent lottery was inexplicable, and it left people profoundly disturbed.[42]

Disease, and infectious disease in particular, threatens human life and well-being on a grand scale. While estimates of the total number of dead vary greatly, World War II resulted in somewhere between 35 and 80 million deaths; the 1918 H1N1 influenza outbreak is estimated to have killed between 50 and 100 million people.[43] The worst single disease epidemic in human history then is equivalent, in lives lost, to one of the worst armed conflicts in human history. Smallpox, over the course of the twentieth century before its eradication in 1980, is estimated to have killed half a billion people—more than all wars of the same century.[44]

However, loss of life doesn’t seem motivate the war metaphor by itself. Influenza claims between 12,000 and 60,000 American lives annually,[45] of

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an order similar to US casualties in Vietnam, at roughly 52,000.[46] However, we typically do not think of a "war on flu" in the same way we have spoken about the war on COVID-19. Even though the pandemic is much larger in terms of its death toll, seasonal influenza is a persistent enemy that we consistently fail to repel. Or so the war metaphor might suggest.

One reason we might not consider influenza an annual Vietnam is that influenza is not a discrete event, but a series of repeat outbreaks of different kinds. This claim falls short, however, given other sources of mortality such as cancer. 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, against a "disease" with a diverse series of etiologies and biological differences. The war on cancer has continued through the twenty-first century, and the incorporation of parallel metaphors such as the "cancer moonshot"—which, for those familiar with the history of the space race, know is just as militant—in more recent phases of the war. But while cancer kills hundreds of thousands of Americans per year, and even if we granted its singular nature in that "war," we don't see the war on heart disease or medical error, which cause similar rates of death per year.[47]

One possibility is that like other security threats, there is a set of events, actors, and circumstances that make us unsafe, and another set that makes us *feel* unsafe.[48] Not all of the former belong to the latter, a disjunction with important consequences. Writing in May 2020, Shad Thielman noted that by April, COVID-19 had killed the same number of people as the reported total number of Americans who died in Vietnam. Thielman's article concerns American reactions and mourning to a protracted and unjust event that resulted in the deaths of tens of thousands of Americans. Arguably, the country is as divided about the appropriate response of the US government to COVID-19 as it was to Vietnam, but Thielman points to the psychological impact of COVID as parallel to that of the war, albeit leading us there through mention of the specific number of casualties—the number of which is now in excess of any war but World War II. In contrast, fears of highly pathogenic avian influenza H5N1 led to 2005 appropriations by the US Congress that, by 2012, meant the US allocating $13 million per case of the virus in humans worldwide, an astonishing amount of money compared to the amount it spends on basic healthcare on each American.[49]

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Mobilization

Another important sense in which the war metaphor applies is the mobilization of resources required to counter a threat. At times, this aspect of the metaphor is only skin deep, such as the offhanded reference in *Nature* to scientists "redeploying to fight coronavirus," referencing the reallocation of scientific labor from non-COVID research tasks to both research and development, and testing patient samples for the virus.[50] James Hamblin, writing in *The Atlantic*, described the allocation decisions made by healthcare workers around expertise and equipment as similar to those experienced in natural disaster or war, stating that while "widespread rationing by healthcare providers is unprecedented in the modern history of the United States, it is constantly happening around the world"[51]—ignoring, perversely, that rationing is widespread for many millions of Americans who lack access to adequate healthcare outside of a pandemic, and have to routinely allocate choices between care and other necessities.

On April 5, 2020, then US Surgeon General Jerome Adams entered the fray of military metaphors. During a period in which states were pleading with the federal government for access to medical equipment and testing supplies, Adams claimed that the pandemic represented a "Pearl Harbor moment," utilizing the Rosie the Riveter slogan "We Can Do It!" However, the comments were met with condemnation from state governors around the country, who noted among other things that World War II was a period of federal, rather than individual state mobilization.[52]

But the metaphor became much more literal. On April 6, US Representatives Susan Brooks (R-IN) and Ami Bera (D-CA) forwarded a proposal for a "COVID-19 Response Corps" to help stop the pandemic. The proposal was based on earlier work by the Center for Strategic and International Studies, which suggested the development of a "US Global Health Crises Response Corps" to strengthen and maintain US health security beyond what was considered a boom-and-bust cycle of preparedness measures.[53] The Response Corps, they argued, could be overseen by the Federal Emergency Management Agency in collaboration with the US CDC and PHS. While Senate Democrats enacted a bill to expand national service programs to respond to the pandemic, this bill was stuck in the Senate Finance committee. The name, however, appears to have gained some traction, used by the CDC Foundation,[54] Boston University,[55] and North Carolina state government.[56]

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Mobilization in the war metaphor relies on the connection between the industrial nature of war, and modern war in particular; and the resources required to address a critical public health need, particularly a public health emergency. Public health is not cheap. Even though the adage that an ounce of prevention is worth a pound of cure definitely applies in public health, it is still costly. This cost, unlike the slick adverts of military power around the world, is largely invisible to the population.

It is not the mere cost of public health that ties together the mobilization aspect of the war metaphor. The political economy of public health means firms[57] have very little incentive to act individually to promote public health. In some cases, public health may even be a barrier to profit maximization in nonemergent contexts.[58] That is, precisely because an ounce of prevention is worth a pound of cure, the treatment of disease can be more profitable than its prevention in environments where medicine is still wholly or predominantly a profit-making entity.

Critical accounts of national security may further hold up a profit motive in war as undesirable[59] and/or unethical.[60] In a similar vein we might think that one of the strong connections between war and public health is that the incentives that drive response should be if not wholly, then substantially removed from individual profit motives. This is obviously not the case in practice—this book was written a few miles from Raytheon!—but remains a significant normative concern with which we must wrestle.

Even absent disincentives, coordination remains an issue. Public health events, like armed conflict, are often geographically broad and logistically burdensome. Substate actors may lack the power, resources, or incentives to act on a scale that actually addresses a public health need, particularly in emergent cases. One of the reasons the nation-state might have claim over public health within its borders is that there aren't other actors that have the incentive or the capacity to coordinate activities over the appropriate geographic range and population. In the US this problem is particularly acute, where fifty separate states can act autonomously without any overarching coordinating principle against a given outbreak. Public health is also a global phenomenon over which nations should have aligned interests, so this need for authority might conceivably even need to be global or at least multilateral.

Coordination problems have been a source of inspiration and criticism during the COVID-19 crisis. In March, President Trump used the Defense

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Production Act (DPA) to press General Motors into the production of ventilators for use on critically ill COVID-19 patients. Designed to mobilize industrial and infrastructural resources during armed conflict, DPA has been promoted by former members of the US National Security Council and FEMA as a means to secure the necessary human and resource capital to address the ongoing pandemic.[61] However, Jared Brown notes that DPA's use during the 2009 H1N1 influenza outbreak underscored the need for reform of DPA to adequately handle pandemic disease and other threats to public health.[62] Despite this need, the ability to reform DPA has been hampered by its status as a political football, including conspiracy theories circulated during the Obama administration about the then-president's intentions to "seize control of the economy," made by a range of right-wing figures from Congresswoman Kay Granger,[63] Jim Powell of the Cato Institute,[64] to *InfoWars* host Alex Jones, among others.[65] Mobilization, like threat, is thus connected to broader normative appeals around public health and its relation to state power.

Mobilization ties to security because the kinds of threats that fall under the rubric of national security are typically those with very high costs. Because individual actors may be unable or unwilling to respond, some kind of response by the state may be warranted. This may include the state compelling private entities to reallocate resources to respond to a public health crisis, compelling public citizens to maintain social distance and break the chain of transmission, or repurposing government funds through executive power to fund a response effort. This kind of mobilization parallels what we imagine is required to repel adversaries in armed conflict.[66] There are public health mirrors to defense production, conscription, censorship, and war bonds.

High-Stakes Decisions

The third sense of military metaphor is in the decisions required of individuals and communities in responding to a threat. War is a situation in which authorities and individual soldiers must make extraordinary, even seemingly impossible decisions. Part of the impetus for just war theory is that the "crime of war" is so extreme that it may only be pursued for a just cause. Killing is almost always wrong, and so exigent circumstances are warranted to engage in individual killing in war, much less the industrial or automated carnage of modern war.

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The logic of military decision-making emerged during COVID-19. Tom Frieden, the former director of the US CDC, wrote in March 2020 that America faced “a long war ahead” in fighting COVID-19. Frieden’s use of the metaphor drew parallels between the strategies of waging war and responding to COVID-19. He used it, in particular, to critique the newly imposed shutdown orders around the country, claiming “strategy is important. The leading concept, now remarkably widely understood, is flattening the curve. This is an important tactic to protect patients and health care workers from a surge that can overwhelm our hospitals, increase death rates and put health care workers’ lives at risk. But it is not a strategy.”[67] Frieden’s conclusion was that then-new social distancing measures enacted by the United States were not sufficient to ultimately deal with the pandemic in the long term but needed to adapt.

Frieden’s comments emerged from a melee of war metaphors. Richard Danzig and Marc Lipsitch invoked the “long war” some two days before Frieden, laying out a plan to deal with the “surprise attack” of COVID-19: minimizing errors and uncertainties and maximizing confidence in judgments about recovery and immunity to the disease, meeting healthcare demand for COVID-19 patients over a long period of social distancing, protecting critical infrastructure that might be impacted by the pandemic, holding national elections during the pandemic, and addressing the long-term challenges for school-age children. Their central message was that the US would “[win] the war against COVID-19 as we have won other wars: by treating it as both an emergency and a long-term challenge.”[68] It’s not clear precisely what other wars they were referring to, if any, but the emphasis they placed on the tension between emergent response and long-term challenges will reappear in later chapters.

Micha Zenko used the war metaphor as a device of criticism against the Trump administration.[69] Zenko described COVID-19 as a “strategic surprise,” which for nonnational security readers is a term of art that describes an event or development against which a nation-state is unprepared, and thus results in a sudden defeat or very high cost to repel. It is used typically to describe developments by other human actors, but dovetails with more recent concerns in the national security community about the role the changing natural environment, including emerging infectious diseases or climate change, may play in threats to US national security.[70] Zenko’s

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articulation of COVID-19 as a strategic surprise does not necessarily mean it was *unexpected*, but rather that it is an artifact of the lack of institutional readiness we would expect in national security.

Both war and public health emergencies involve high-stakes decision-making. A classic high-stakes decision in war is how much risk to impose on noncombatants when pursuing operations.[71] If we take the killing of innocents to be impermissible on its face, and that the ends of war require us to leave open the way to return to civilian peacetime, we might think civilians cannot be attacked at any time. But the uncertainty of war, and proximity to civilian centers, means that noncombatants will ultimately be placed in harm's way. Deciding if, when, and how it is permissible to put noncombatants at risk is a difficult decision, raising questions about both the proportionality of the use of force in war, and its necessity.[72]

In the early days of the pandemic, a high-stakes decision that received considerable attention was the two-week quarantine of passengers on the *Diamond Princess*, a cruise ship docked at Yokohama.[73] Quarantine is a prototypical "liberty-limiting measure" in which the rights of individuals exposed to a virus but not yet ill are subverted by an authority in order to contain an infectious disease outbreak. In public health ethics and modern American health law, the justification for quarantine loosely parallels that of killing in war: proportionality, necessity, and the least infringing measure (in lieu of the "last resort" condition of going to war).[74]

Decision-making becomes particularly salient when considering the allocation of scarce resources.[75] While the lay public may have only discovered this problem when media began reporting on ventilator shortages in hospitals, particularly in Italy in the early phases of the pandemic,[76] the issue of allocating ventilators during public health emergencies and mass casualty events is a commonly discussed bioethical problem that received considerable attention since 2001.[77] As a general class of bioethical issues, allocation problems are some of the first encountered by bioethicists with Rescher's 1969 article "The Allocation of Exotic Medical Lifesaving Therapy,"[78] and the Seattle "God Squad" that presided over the allocation of the first hemodialysis units.[79] They are commonplace in the allocation of solid organs, and may arise for otherwise plentiful resources during emergent contexts, such as the ongoing shortage of hemodialysis units in the context of the Syrian civil war.[80]

While it has received little to no attention in the context of COVID-19 despite the use of the war metaphor, military medicine has its own logic

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around allocating scarce resources. Here, the logic typically is different than in civilian contexts. First, a concern in battlefield triage is if a soldier can be treated on site and returned to duty, or whether their injuries are so extensive that even with treatment they will not be able to fight. Second, doctors may experience moral tensions between allocating scarce medical resources to friendly soldiers, and to noncombatants including prisoners of war. While both groups deserve medical care, tensions may arise when there are not sufficient medical resources to adequately care for both groups.[81]

Just Securitization Theory

The above are three critical areas in which health and security overlap significantly. This gives us a reason to take the analogy between health and security seriously. But what ought we do about that?

One way, suggested recently by Rita Floyd in her *The Morality of Security: A Theory of Just Securitization*, would be to treat health security issues as times when we ought to securitize health, for a time, before returning it to its normal state. Floyd outlines a theory of just securitization, which follows along similar lines to the ethics of armed conflict doctrine of just war theory. She outlines a number of criteria for establishing the just cause for securitizing an issue, the kinds of conduct we can expect during a period of securitization, and the process of terminating a securitized state regarding an issue.[82] Might we securitize health in the same way?

I think the answer is no, for two reasons. The first and most obvious, that health security practitioners acknowledge, is that health security does not *end* as such. A public health emergency might, but this is not the same as health ceasing to be a security issue. Floyd's primary example, following her previous work, is climate change. We could imagine that at one time climate change might not be a security issue for many years, even hundreds or thousands. But health security issues arise, sometimes multiple times, within generations. They require institutional maintenance and upkeep, and in fact the lack of these, the "cycle of panic and neglect" is sometimes attributed to why they arise in the first place.

But I think the second reason why just securitization does not quite work is that we have not established that Floyd's stated goal with securitization—*making an issue the province of the national security apparatus of a state*—is what is happening here with health. There are comparisons between health

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and security, to be sure. But whether they actually fall under the same rubric philosophically, much less institutionally, is another matter. Nothing yet about these features of health that lend it to security make health a security issue. This remains an analogy, and like all analogies has its limits. And as I will make clear, the normative foundations on which health security relies come apart strongly from those of national security, even if they are both essential arms of the modern state.

For these reasons, we need something more. What we need is a theory of public health that operates, at times, in ways that are much like national security. But we need a theory of how and why that arises, and what form it should take.

Conclusion

In this chapter, I provided a reason to consider health to be a security issue, or like one. Following from the description of metaphors around health security in the previous chapter, I articulated the primary reason against considering health a security issue, embodied in securitization theory. I then provided three positive reasons to accept the analogy between health and security. Finally, I argued why we shouldn't see health security as mere (and transient) securitization, but something more comprehensive.

Reasons to accept an analogy, however, don't make for a set of principles to govern our conduct. In the next chapter, I examine what I consider to be the dominant framework in public health ethics, as it applies to crises that fall under the rubric of health security. I argue that these principles take us further than a mere analogy and provide us a foundation for thinking about just health security, informed by the ethics of armed conflict.

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