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War on All Fronts

A Theory of Health Security Justice

By: Nicholas G. Evans

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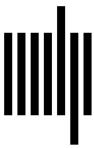

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3 Reconciling Military and Public Health Ethics

In March of 2020, Texas lieutenant governor Dan Patrick made the somewhat astonishing claim that, rather than endure a complete lockdown in the face of COVID-19, many people over seventy would be willing to risk contracting the disease so as not to "sacrifice the country." Given the death rate of COVID-19 increases precipitously among those in Patrick's age group, the only reasonable message was that to protect the country, people over seventy would have to die. (Of course, at the time, as a white man in the pre-vaccine US, Patrick would statistically be half as likely to die as an African American of the same age.)[1] The trade-off presented looked simple: risk death, or stay safe at the cost of freedom, or at least freedom as Patrick saw it.

The choice between freedom and safety resulted in a hodgepodge of responses globally. The United States in particular, it appeared at times, was committed to giving its citizens the worst of all worlds. COVID-19 is, at the time of writing, certainly not gone. Social distancing measures had an initial positive effect, but for a variety of reasons most nations lacked the will and capacity to maintain this long term, leading to peaks in summer and again at the end of 2020 and 2021. In the background, the United States Congress failed to pass meaningful relief for individuals subject to public health measures, or simply caught in the disruption of the pandemic. Unemployment peaked at 14.7 percent in April 2020, though this was unevenly distributed: the leisure and hospitality industry peaking at 39 percent, part-time workers experiencing unemployment at almost twice the rate of full-time workers, teen unemployment peaking above 30 percent, and racial and gendered unemployment rates persisting over the first year of the pandemic.[2] Hospitals canceled and deferred medical procedures, and more individuals stayed away for fear of the virus. Twelve percent of Americans avoided emergency care, while 32 percent avoided routine medical care, with unpaid caregivers

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for adults, persons with underlying medical conditions, Blacks, Hispanics, young adults, and people disabilities disproportionately avoided seeking care for non-COVID-19 medical needs.[3] The disruption in trade and employment created a food crisis globally;[4] in the United States, 54 million people were plunged into "food insecurity" with uncertain impacts on their lives and health long term.[5] Domestic violence spiked as survivors, often women, were suddenly confined at home unable to escape violent intimate partners or family members.[6] Childhood poverty rose 10 percent over two years, according to UNICEF, an increase of 100 million children living in multidimensional poverty.[7] Vaccinations rolled out in 2021 reduced the risk of death from COVID in some countries, but the rise of escape variants of the disease brought cases, hospitalizations, and deaths roaring back—in some cases, in record numbers.[8]

Elsewhere in the world, more coordinated countries met with initial success, though some also faltered over the two-year span. In Australia, successive lockdowns enforced by police presence in some states appeared to stem the tide, and the country enjoyed a near-COVID-free life until the end of 2021 when omicron upended the nation, whose will crumbled amidst the rapid onset of the variant.[9] South Korea's rapid deployment of tests, masks, and contact tracing made it a model nation in the first year of the pandemic,[10] and while it too would experience high levels of omicron, they were lower than in other comparable economies, leading to a much slower pandemic wave and "flattened curve," to use the parlance of the early stages of the pandemic. And Vietnam's response and early success with the virus was attributed to, among other things, a long-standing engagement with public health and infectious disease that was mobilized at the right time, in the right way by government.[11]

A full analysis of every public health measure, globally, against COVID, is well beyond the scope of my inquiry. But what is important to know is that even when successful, these responses can lead to tragedy, loss, or violation. And as in war, the "toll" of COVID-19 will likely only ever be represented by the "direct" casualties, and not in the disruption and chaos that followed. Even now, it is more common to speak only of deaths or hospitalizations as the cost of COVID-19, and not, for example, the disability that arises from long-term sequelae or "long COVID."[12]

In the previous chapter I argued that far from being necessarily mere performance, a comparison between war and health captures important aspects of public health crises as people experience them. I concluded that

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these aspects lend themselves to a theory of just health security. Fully establishing the ethical and political-philosophical connection between armed conflict—the "war" in the war metaphor—and public health is the task of this chapter. I use the public health ethics framework pioneered by James Childress and colleagues to make this connection. This framework is not explicitly militarized, but is a foundational framework in a securitized arm of public health ethics that became important in the context of bioethics' turn to catastrophic health risks, such as the use of biological weapons[13] or the escape of recombinant organisms from high-containment laboratories.[14] It is a framework that is important to health security,[15] shares institutional origins with elements of the field, and thus is a useful starting point for investigating the possibility of just health security.

In what follows, I describe this "orthodox view,"[16] and argue that while prominent criticisms of it fail, they reveal problems that prompt a strong revision of the framework. By looking at the connection between the orthodox view and just war theory, a millennia-old framework for morally justifying acts of war, we can understand the foundations of the orthodox view in a way that gives credence to its critics and establishes the need for a fairly radical reform into a more robust theory of just health security.

The Orthodox View

Health security has an analogue in public health ethics. This view, which I'll refer to as the "orthodox" view, arises from the work of James Childress and colleagues in their "Public Health Ethics: Mapping the Terrain."[17] This is obviously not the only work that informs the current state of the art in public health ethics writ large,[18] but it is significant as one of the most cited and enduring pieces of work in the field. "Mapping the Terrain" lays out a framework for public health ethics beginning with the observation that in public ethical decision-making, disagreement on fundamental moral principles is almost certain, and it is necessary to articulate principles corresponding to general moral considerations agreed to by most.[19] The list they arrive at is one that is posited to take into account first the general preferences of individuals and respect for their autonomy, against the welfare-focused (and, they argue, paternalistic) aims of public health. The list of principles they arrive at (table 3.1) include effectiveness, proportionality, necessity, least infringement, and public justification.[20]

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Table 3.1
The orthodox view of public health ethics

Principle	Description
Effectiveness	It is essential to show that infringing one or more general moral considerations will probably protect public health.
Proportionality	It is essential to show that the probable public health benefits outweigh the infringed general moral considerations—this condition is sometimes called proportionality.
Necessity	Not all effective and proportionate policies are necessary to realize the public health goal that is sought. The fact that a policy will infringe a general moral consideration provides a strong moral reason to seek an alternative strategy that is less morally troubling.
Least infringement	Even when a proposed policy satisfies the first three justificatory conditions—that is, it is effective, proportionate, and essential in realizing the goal of public health—public health agents should seek to minimize the infringement of general moral considerations.
Public justification	When public health agents believe that one of their actions, practices, or policies infringes one or more general moral considerations, they also have a responsibility, in our judgment, to explain and justify that infringement, whenever possible, to the relevant parties, including those affected by the infringement.

The status of the orthodox view *as orthodox* is first, the paper—at least as far as general frameworks for public health ethics go—is one of the most cited in the field, at around 1,000 citations at the time of writing. While it is not on a par with, say, *The Principles of Biomedical Ethics* (of which Childress is also an author), it is clearly one of the most enduring public health ethics frameworks in the field to date.

The orthodoxy of this view, however, is even more strongly established in the way the principles of the framework dovetail with other important legal and political statements about the use of force, particularly in public health. The Model State Health Emergency Preparedness Act (MSHEPA or Model Act), for example, includes principles of proportionality, necessity, and least infringement that closely align with "Mapping the Terrain." Indeed, one of the key architects of the Model Act, Lawrence Gostin, was also an author of the orthodox view, and it forms the basis for his normative justification of it.[21] It might be that the orthodox view is even an

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outgrowth of the Model Act, given it was developed in October 2001 and "Mapping the Terrain" would be published late 2002.

Likewise, the IHR restricts activities states may take to control public health risks, with the general provisions opening by noting that for public health purposes, states may require travelers, on arrival or departure, to submit to "a non-invasive medical examination which is the *least intrusive examination that would achieve the public health objective*."[22] It modifies this, however, by noting that invasive medical examination *inter alia* shall not be required except when "*necessary* to determine whether a public health risk exists"[23] or pursuant to the general provisions. The orthodox view is also cited in WHO's documentation on global health ethics.[24]

At their broadest, the principles of the orthodox view share a language and general architecture with foundational instruments in law. Timothy Allen and Michael J. Selgelid, for example, have argued that the framing of the necessity and least infringement conditions in "Mapping the Terrain" may have been influenced by the Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights, which includes requirements that interventions be both necessary, and use "no more restrictive means than are required."[25] Alan Sykes has suggested that the "least restrictive means" standard pervades jurisprudence, including that of the First Amendment to the US Constitution and the policing powers of the Treaty of Rome, the precursor to the European Union.[26] In their description of the creation of the MSHEPA, its authors—Gostin, above, and James Hodge, Jr.—place the least restrictive means as its lynchpin, as a means to limit the power of government to override civil liberties during emergencies.[27]

The orthodox view of public health has been subject to substantial debate, and in particular it has been critiqued in the context of health security, and its concern with both deliberately caused and naturally occurring catastrophic disease outbreaks. An initial subject of this critique is the basis on which it is consonant with other public health approaches, and in particular those that take as their starting point a firm foundation of human rights. While the human rights and health literature has as its origins the development of instruments on economic, social, and cultural rights after World War II, its "birth" has been credited to the work of Jonathan Mann and others in the context of the WHO Global Program on AIDS in the

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1990s.[28] Two of the prominent goals of these movements were to (1) bring to attention the human rights considerations motivating the provision of care to people and communities living with HIV/AIDS, and (2) to push back against punitive or coercive public health measures mandating screening, disclosure, and even isolation of people living with HIV/AIDS.[29] While much of this work preceded the orthodox view, the HIV/AIDS literature, in conjunction with adjacent literature in immigrant health, global health, and harm reduction, continues to field views that form explicit and implicit critiques of the orthodox position.[30] Hodge and Gostin frame this critique in terms of the position of bioethicists and activists to portray civil liberties and human rights as inviolable over community or utilitarian concerns.[31] Importantly, Mann and his followers sometimes frame human rights as a legal instrument distinct from ethics, but here I take the two to be of a kind, insofar as human rights have, or should have, philosophical grounding.[32]

The second main thrust of the critique against the orthodox view arises in the context of the post-9/11 world in which counterterrorism has been a central pillar of national security.[33] Critics claim that the excesses of the US government in other counterterrorism responses are further repeated in developing public health policy frameworks in which individual rights are subordinated to executive power without due process. George Annas has gone so far as to refer to the Model Act, and its lack of appropriate due process and limits as it was ultimately adopted by states, as a public health version of the infamous PATRIOT Act.[34] A key move here is that even if the Model Act is in principle a well-constructed and ethically justified piece of *model* legislation, its enactment in practice is far more varied and complex. Florida's revisions to its public health ordinances in response to the Model Act, for example, included the capacity for officials to quarantine or isolate individuals for a broad array of reasons up to and including HIV/AIDS or seasonal influenza, a far cry from weaponized anthrax or COVID-19. The Floridian version of the act authorizes officials to use "any means necessary."[35] Reframing necessity from a constraint on the state, to a prerogative,[36] is a significant and frightening normative revision from the original framers of the Model Act.

Rebecca Haffajee and colleagues picked up this thread in 2014 with questions about when public health emergencies, for which the Model Act was designed, end. Noting that the majority of state implementations of the Model Act either had insufficient detail about the end of an emergency, or omitted it entirely (including my home state of Massachusetts), they write:

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> The notion that highly coercive measures such as mandatory blood tests, quarantines, or property seizures could be imposed for common threats without democratic procedures and full due process offends our constitutional values. The lack of clear triggering thresholds for terminating emergency powers is particularly troubling, creating the possibility that critical legal protections might be suspended indefinitely.[37]

Both the earlier and later critiques are united in the following way. The orthodox position provides a series of potential justifications for coercive public health interventions that may infringe on individual rights. However, the principles—especially when applied in practice—seem to be subject to the whims of what Annas calls "worst case thinking," in which the mere possibility of disaster is used to loosen constraints of democratic accountability in order to provide a flexible response.[38] This flexibility is vulnerable to being exploited, and critics claim is actually exploited, without sufficient justification. This tracks the main thrust of securitization theory: that it places health in the realm of national security and opens the door for certain kinds of power beyond traditional democratic oversight. The orthodox view, on this reading, does not successfully articulate a view of the scope, weight, or demand of rights to ethically justify action. In practice, it subordinates rights *ab initio* without appropriate procedural or substantive checks on power, while failing to adequately prioritize other public health needs.

The conflict between the thought of Annas and Gostin is illustrative of this debate. Annas's views are strongly representative of the critical side, while also making use of the securitization critique of the war metaphor to further his claim against the orthodox view. He claims that "human rights and health are not inherently conflicting goals that must be traded off against each other" but rather linked, citing Mann and global HIV/AIDS activism.[39] He further rejects the idea he claims underlies the Model Act that "during a public health emergency, there must be a trade-off between effective public health measures and civil rights."[40] He cites *Jacobson v. Massachusetts*, but unlike proponents of rights-infringing measures in public health he notes that the precedent the US Supreme Court used in *Jacobson* was the military draft, a wartime norm now recognized as not always required and even counterproductive.[41] Annas concludes that coercive or liberty-limiting public health measures should go the way of the draft, and be replaced with measures and tactics appropriate to the twenty-first century.

Gostin regards trade-offs between liberty and public health as fairly common, and likely inevitable. Writing on these trade-offs, Gostin variously

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charges of liberty and public health "more often than not they collide,"[42] and "although public health and civil liberties may be mutually enhancing in many instances, they sometimes come into conflict."[43] While Childress and Bernheim have characterized this in direct opposition to Annas,[44] this is probably overstating things. Gostin, for example, at times characterizes the trade-offs in terms of conflicts *between* rights, and in particular the clash between civil and political rights that he takes to be individualistic, and purportedly community-focused economic and social rights to health, employment, and education.[45] He also, in providing personal reflection, notes his own collaboration with Mann in informing his thoughts.[46]

However, one thing that does remain is that the principled grounding for these trade-offs is somewhat lacking. In their explanation of the Model Act, for example, Hodge and Gostin write, "In our view, individuals are not entitled to be free from every infringement of their freedoms, only those infringements that are without justification."[47] They go on to say that the state is limited in that these infringements must be the least restrictive means necessary, but do not engage in a more systematic inquiry into what the limits of those powers might look like in principle. Rather, in discussing vaccination mandates and other coercive powers of the government, they merely note that they may be required for the common welfare.[48] Elsewhere, Allen and Selgelid have noted that there also remains an ambiguity surrounding the degree to which least infringement (in the orthodox framework) and least restriction (in Hodge and Gostin, and Gostin's other writing) can be considered equivalent, all the more curious given Gostin's hand in both:

> Least infringement is thus a broad requirement that implies least restriction (other things being equal), which is a narrower corollary requirement that focuses on costs to liberty. The two are not logically equivalent: the least infringement requirement implies the least restriction requirement, but not vice versa.[49]

Gostin and colleagues' take on domestic civil rights flows into his work on international human rights. Writing in 2020, Benjamin Mason Meier and Thérèse Murphy write with Gostin that the United Nations Declaration of Human Rights recognizes that public health requires individual rights limitations provided that

> Everyone shall be subject only to such limitations as are determined by law solely for the purpose of securing due recognition and respect for the rights and freedoms of others and of meeting the just requirements of morality, public order and the general welfare in a democratic society.[50]

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But we can note here that these are legal requirements, and the nature of what it means "to secure due recognition and respect for the rights and freedom for others" is still ambiguous, morally, as to the degree to which the recognition must be equal or simply proportionate remains obscure.

The contours of this debate and its responses[51] provide an opportunity and raise three possibilities. The first is the orthodox view is simply unjustified, or so mired by historical injustices that it cannot—and should not—survive. The second is the orthodox view is incomplete: while its principles reveal part of our obligations in public health, they require further elaboration in order to be justified. The third is the orthodox view is in fact correct, and its critics somehow mistaken.

The reason we cannot easily reject the orthodox view follows from the argument in the previous chapter for securitization. It is true that human rights are incredibly important, and in most cases are insensitive to welfare or other trade-offs. That, in no small part, is what it is to possess rights: to possess claims against interference, or for certain things that are insensitive to calculations about the outcomes that result from respecting those rights—at least directly.[52] But much as in armed conflict, there are rare occasions where the costs of respecting those rights are so large, perhaps even catastrophically so, that we may be obligated to infringe upon or violate those rights in aid of some much larger moral project. In this regard, pacifism is a theory of armed conflict, but one that denies this claim. But for most of us, I suspect, the question is how and when we decide to engage in those infringements, and what means we take to do so. The orthodox view recognizes this but is not alone in doing so: the same principles appear in arenas such as non-health civil rights instruments, jurisprudence, and trade law. This argument is compelling beyond its connection to national security concerns. The *relationship* may be novel, but the principles are not.[53]

We cannot, however, merely deny the critics of health security, or of the orthodox view. Instead, the orthodox position is in need of reform in important ways. And these reforms can be drawn from the ethics of armed conflict itself.

Normative Regimes, Imperfectly Realized

In the previous section I posited that the orthodox view of public health ethics was, in part, securitized. This view of public health presents as its

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opening gambit a set of rights, duties, and other moral considerations that inhere to individuals in a community. In particular, these considerations are claims against the state and other actors to respect, protect, or fulfill some important interest.[54] Unless some particularly stringent condition obtains, these considerations protect an individual's interests even if the consequences of doing so are sum-negative; for example, leading to less than maximized global utility. In the case of rights, they may in turn be negative claims against interference or positive claims to be guaranteed something, sometimes called autonomy and welfare rights, respectively.[55]

The orthodox view considers cases when these overriding conditions might obtain. One early example, mandatory public health surveillance, takes the trade-off between individual rights to forgo medical testing (as derivative of both general rights to bodily autonomy and privacy), and community interests in detecting and responding to communicable disease. The authors of "Mapping the Terrain" consider the conditions under which an intervention that trades off against these considerations might be justified, and the burden on the intervening actor (in this case, a public health department) to act in a certain way with respect to those whose interests are being infringed, including the risk the actor might be required to take on in executing this task.[56] Surveillance is a general ethical issue in public health,[57] but is also a feature of public health emergencies involving communicable disease.[58]

As widely accepted as this kind of conclusion might be, its normative foundations are somewhat less clear. In "Mapping the Terrain," the justificatory conditions are put down to a series of "general moral considerations" stipulated to be held by most, at least in America, and at least now.[59] Some of the authors, in separate works, provide some analysis of how we might arrive at these commitments. Nancy Kass, for example, provides a similar framework that asks

1. What are the public health goals of a proposed program?
2. How effective is the program in achieving its stated goals?
3. What are the known or potential burdens of the program?
4. Can burdens be minimized? Are there alternative approaches?
5. How can the benefits and burdens of a program be fairly balanced?

Kass, however, does not present these conditions as a set of criteria for justifying action, but rather as "an analytic tool, designed to help public health professionals consider the ethics implications of proposed interventions,

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policy proposals, research initiatives, and programs."[60] Her work is further derived from a version of bioethical principlism, albeit an older model reminiscent of the "Belmont Report" whose three basic ethical principles that underpin US research ethics.[61] This view holds that there are three commonly recognized general moral considerations: respect for individual autonomy, beneficence (in that report, maximizing benefits and minimizing harms), and justice.[62]

Gostin, for his part, grounds work framing his version of the orthodox view in terms of basic commitments in liberal societies. In 2003 he claimed a basic scheme of rights as constitutive of both liberal and communitarian political theories of the twentieth century. He argued that in general, public health—and in that article, responding to public health emergencies in particular—involved the trade-off between utility and/or social and economic rights on the one hand, against civil and political rights on the other. He characterized one of these social and economic rights as the right to health, against which other freedoms might be traded off to respond to, among other things, a bioterrorism attack.[63]

Gostin, however, makes a critical mistake of conflating liberal and *libertarian* thought in the same broad sphere of political theories, depicting the works of John Rawls's liberal egalitarianism and Robert Nozick's libertarian as broadly in the same family of American liberalism, and then taking the latter as his central target.[64] Along the way he accuses Annas of a kind of "left libertarianism," dovetailed into what he considers to be the core of liberalism—the limits of government interfering with self-governing behavior, claiming liberals oppose public health interventions that seek to govern fatty foods, seatbelt laws, and unsafe sex.[65] He then claims that liberals acknowledge the harm principle, associated with writers such as John Stuart Mill and Joel Feinberg, in which individual behavior that threatens others is permitted to be restricted by the state. He concludes that some economic libertarians will also permit additional restrictions based on solving economic externalities.

This basic conflation is somewhat of a problem for Gostin. While he is right that twentieth-century American liberalism is in part a response to utilitarian political philosophy, the libertarian tradition exemplified by Nozick critically arose as a response to both Rawlsian liberalism and the communitarian tradition of the same period that Gostin sets in opposition to liberalism.[66] Nozick and Rawls, I suspect, would have vastly different

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things to say about public health that cannot be attributed to the harm principle or concerns over externalities. Rawls, it is likely, would view public health interventions as permissible—first, so long as they respect the most expansive, coextensive scheme of basic liberties; and second, to the degree they favor the least well off as part of a scheme of basic institutions. Both are concerned with respect for persons and rights, as is Nozick, but the architecture that follows from this is quite different, in that it involves both limits on rights insofar as they are able to be jointly respected between individuals, and a distributive principle that arises from individuals' desire to maintain a fair social order.

Nozick, on the other hand, *would* almost certainly reject most forms of basic public health that relied on a redistributive welfare state. It is plausible, as Gostin illustrates, that he would condone some public health that threatens national interests to the same degree as armed conflict, or to defend against a "moral catastrophe" on par with a nuclear attack.[67] But I think Gostin overemphasizes what libertarians will condone, in part because he conflates the basic structure of libertarian and liberal thought. It is absolutely false that Nozick and other libertarians (at least Nozick himself)[68] would accept vaccine mandates, as Gostin claims.[69] And while he caveats this in terms of "high risk circumstances,"[70] Gostin is throughout referring to high risk for particular individuals, not for society-level catastrophes where Nozick might bite the bullet. Not only is anyone who has lived through COVID-19 familiar with what libertarians will or will not tolerate in practice but also, in principle, this conflation becomes a hazard for Gostin's position. This is all the more unfortunate given the divergence between Rawls and Nozick, and indeed between liberal and libertarian thought that has its direct analogue in contemporary approaches to public health ethics: Rawls's view being more or less directly translated into healthcare access through the work of Norman Daniels,[71] while a view of mass casualty response in the vein of Nozick is found in the work of Gryphon Trotter.[72]

This is important for a theory of health security because it means one of the architects of the orthodox view—and a dominant player in health security on the global stage—presumes too much first of the overlap between the political commitments of individuals, and second about the relevant options at stake when we think about responding to infectious disease using potentially coercive means. Liberal views on public health are *much* more responsive to moderate rights claims. But they are likely to be more

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responsive in interesting ways, privileging redistributive policies that shore up basic health outcomes, provide access to care, and increase opportunity than they are to responses to only extreme health events. They include redistributive commitments that libertarians typically lack completely. Conflating these arguably places all the political and ethical emphasis on responding to risks, and potentially shoehorning risks into threats and attributing them to individuals—just as Annas fears—rather than engaging in broader political projects to prevent these risks from arising. Liberalism is much more compatible with redistributive policies that encourage, say, sexual education and availability of affordable or even free screening than libertarianism, which is likely to favor criminalization of undeclared disease status leading to transmission of sexual diseases as a putative violation of the nonaggression principle, and avoid anything that might require progressive taxation.

The second, related concern is that even liberal thought properly defined may take divergent positions on public health, and between conventional and emergent public health decisions. Liberal thought, whether it derives from Rawlsian accounts or elsewhere, takes as its starting point that the basic freedoms of individuals are largely inviolable, even if there are some net negative consequences for doing so. A routine public health intervention that minimally satisfies the orthodox view may not be consistent at all with liberal thought. On the other hand, the use of those criteria *in extremis* may be permissible due to the emergent nature and broad threat posed by these events—though, as above, precisely what counts as emergent here will remain up for debate.

Gostin's account is explicitly concerned with emergent events, yet even here, his thinking on emergencies is still somewhat at odds with contemporary scholarship on the nature of rights. In an exchange with scholars who argue that obesity prevalence possesses the features of a public health emergency,[73] Gostin objects to the use of "public health emergency" on political and pragmatic grounds. While he denies that obesity constitutes an epidemic, much less a public health emergency, he nonetheless claims that

> whether a threat rises to the level of an "emergency" and when it ceases to be an "emergency" are both unclear. It may be more useful to think of a health threat as a continuum—as measured by the percentage of the population affected and the gravity of the harm. Thinking of an emergency as a continuum rather than a threshold makes it possible to calibrate the needed surge in resources and exercise of powers so that these are commensurate to the level of the threat.[74]

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It is true that threat exists on a continuum: characterized, for example, as expected loss of life, it could be any expected number of deaths from none to all life on earth, and even all of future human life.[75] In terms of moral reasoning, if we believe some level of emergency justifies actions that infringe on rights—say, 100,000 expected deaths—though it may be wrong in some sense if we decide to act in the same way about a threat that might cause an expected 99,999 deaths, it is wrong only in a very strict and arguably morally fetishistic sense.[76] If our expected justified value for a rights infringement is 100,000 but our confidence interval ranges from 10 to 10 billion, we might be justified *ex ante* in acting even if we are later shown to have overreacted, especially if a risk is potentially catastrophic but quite rare.[77]

Yet this does not mean that from a substantive moral sense that rights violations exist on a continuum in principle, much less in practice. And this is where Gostin's account, and the orthodox view in general, arguably runs into trouble. The existence of continua does not mean that our obligations, much less actions, are also continuous in nature—the existence of shades of grey does not eliminate the difference between black and white. One central feature of nonconsequentialist moral theories, including the rights Gostin invokes in his account, is that violating them is especially bad and requires a compelling justification. Even if the threat is continuous, the consequences of acting are weighty and binary in this important sense. In almost all cases, violating rights (or duties, etc.) is worse than respecting them, and because of this we may have good reason for rights-infringing acts to be strongly protected against.[78] Being uncertain about whether or not rights infringements are justified should give us extra pause: it may generate an obligation to forgo infringement either until we have more information or even all together; and it may generate additional obligations to assume liability for our actions that constitute infringements.

From this perspective, Gostin invites precisely the challenge Annas brings. That is, the empirical claim that public health emergency thinking has largely been driven by catastrophization, fueling a cycle of "panic and neglect" to the detriment of the effectiveness, trust in, and even *presence of* basic public health, gives rise to a powerful reason to resist the idea that health security decisions that involve rights infringements can or should exist on a sliding scale. Treating all public health decisions as matters of degree, in a political sphere, leads to three possible consequences. First, it may confer excess breadth over decisions to enact liberty-limiting actions

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into spaces that on close analysis should not, utilizing the possibility of the worst case. Second, it may allow the decision maker dominion over a particularly vulnerable decisional sphere: in this case, public health authorities with the power to decide when to limit individual rights.[79] Third, it leads to the neglect of the positive duties of public health as an institution, and how government may be obliged to act in ways that prevent rights violations from being necessary. These correspond, broadly, to the critique of health security presented by Moodie and colleagues.

Public Health and Military Ethics

The orthodox view of public health ethics provides a guide to ethical action, but it is incomplete. It fails to consider the broader issue of how public health as a social institution ought to address limits on individual liberties, and its role in protecting rights when pursuing its charge. How then, should we proceed to think about public health? Military ethics offers a path to thinking about

1. the elements to a threat articulated by the war metaphor:
   - threat;
   - mobilization;
   - high-stakes decision-making;
2. the orthodox view in more robust terms, including
   - the justification of trade-offs between rights and threats to community;
   - the role of the state *qua* state in making decisions;
   - the way institutions ought to structure responses to continuous and uncertain levels of threat.

The combination of these situates military ethics as providing an insight into a common foundation with public health ethics.

The commonality between public health ethics and military ethics is on first blush quite straightforward. Military ethics has been principally informed by the development of just war theory over the last thousand years. A central connection to bioethics is Thomas Aquinas's reflection on the duty of Christians not to kill, and squaring that with the obligation to protect the innocent, and the resultant formulation of requiring a just cause; that the evil act not be a means to a good end, not intending the bad outcome even if one foresees it; and proportionality between good and bad outcomes.[80] This

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doctrine of double effect still finds use in contemporary bioethics, most famously in debates about abortion[81] and euthanasia.[82] Aquinas's insights into necessity, just cause, and proportionality were ultimately folded into Hugo Grotius's ideas of war as a relation between states and the distinction between *jus ad bellum* (the law of going to war) and *jus in bello* (the law in war), a distinction still used in ethics and international law.[83]

Conventional just war theory, unlike the orthodox view of public health, is thus divided into conditions that apply at different stages of conflict (table 3.2). *Jus ad bellum* concerns the reasons states may go to war, and

Table 3.2
The (classical) principles of just war theory

Condition	Criteria	Description
Jus ad bellum	Just cause	Armed conflict must be conducted only with just cause (e.g., as a defense against aggression, or defense of another).
	Last resort	Other forms of solution must have been exhausted prior to the declaration of war.
	Legitimate authority	The power to declare war should come from a legitimate authority empowered to make such a declaration (typically, though not always a state).
	Right intention	Armed conflict should be pursued as a means to fulfill a just cause, and not for other ends
	Reasonable success	Armed conflict should be pursued only if the party has a reasonable chance of success.
	Proportionality	The just cause for going to war should be proportionate to the suffering war entails.
Jus in bello	Necessity	Actions in war must be necessary to achieving the proximate and ultimate aims of war (and in particular, war's end).
	Proportionality	The harm of an act of war should be proportionate to its ends.
	Discrimination	Noncombatants should, consistent with other principles, be spared the harms of war (including when doing so incurs liability on soldiers).

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under what circumstances war may be engaged. Those principles envisage, broadly, a state resisting aggression by another (including defending a third party), engaging in war as a last resort once other means have been exhausted, and conducting it for the just aim of ending aggression or the defense of another. War, ethically justified, is something pursued only after peaceful relations have failed.

Jus in bello governs the use of force once war has been joined. In particular, it proscribes acts of war that are used indiscriminately on noncombatant populations, or are disproportionate, or unnecessary to ending the war. (From here on, I will frequently drop the "*jus*" as is the convention in much of military ethics.)

How does the orthodox view of public health ethics relate to just war theory? As a first step, there is a degree of homology between their principles. But interestingly, that homology arises only in terms of *in bello* considerations, leaving open a question about whether the equivalent *ad bellum* principles exist in public health (table 3.3).

Two things can be said at this stage. The first is that these comparisons need not be exact. For example, the discrimination and least infringement conditions have common features, in that they both articulate a principle of limiting the harms that certain kinds of acts cause in pursuit of the larger mission of an institution (whether winning a war or responding to a public health issue), and in particular to avoiding harming individuals

Table 3.3
Comparing just war theory and public health ethics

Temporal/contextual feature	Just war theory	Public health ethics
Before the crisis	Just cause	??
	Last resort	??
	Legitimate authority	??
	Right intention	??
	Reasonable success	??
	Proportionality	??
During the crisis	Necessity	Effectiveness/necessity
	Proportionality	Proportionality
	Discrimination	Least infringement
	??	Public justification

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who are not involved or only circumstantially involved in the crisis at hand. This is why, for example, in their SARS guidance, the US CDC recommends contact tracing ahead of isolation, ahead of close contact quarantine, ahead of community quarantine, and so on.[84] It is not merely a question of proportionality—community quarantine might be proportionate in the context of a very high-risk pathogen or a biological weapon attack—but about avoiding harm to individuals who do not need to be harmed to achieve a public health goal even if this incurs greater effort or cost to the state.[85] This is similar, but not the *same* as decisions about using precision munitions or avoiding the use of air power in urban warfare to prevent civilian casualties, even if this incurs a greater burden, and lethal risk, to a state.[86]

The second thing we can note is that some principles may have no direct corollary. For example, if we consider public justification an independent criterion, it might ultimately have no analogue to armed conflict. *In bello* considerations are made in a fog of war, and moreover may require some kind of secrecy or suppression to be effective, given the importance of operational security in war. However, as I show later in this book, we might think of publicity as part of analogues to proportionality and discrimination, given the kinds of interventions public health authorities seek to achieve.

The Thin Account: Moral Exceptionalism

The comparisons between just war theory and public health ethics are significant, but that's not enough to motivate using military ethics as a basis for thinking about a reformed public health ethics. We need to explain why these principles are similar, and how that generates a reason to move from mere illustration of principles to a probative function of military ethics in establishing, critiquing, reforming, or contesting public health ethics principles. One possibility is that just war theory and the orthodox view are both examples of "moral exceptionalism," which arises when typical ethics must give way to the weight of circumstances. These frameworks could be moves to deal with cases where competing considerations override standard accounts of rights or other non-consequence-based accounts of ethics.[87]

This claim could be fleshed out first as a conceptual move similar to theories that claim rights are resistant to consequences except in very rare cases where the weight of those consequences is so great that they outweigh or override individual rights.[88] Public health ethics theories, like the orthodox view and just war theory, might both simply establish that some

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moral considerations (rights) are sometimes outweighed by competing considerations (some kind of threat). This is on its face broadly in agreement with the orthodox view insofar as it acknowledges a pluralistic form of ethical commitments, and seeks to balance them—but may lean more toward Annas's view if we think that the chance we are going to impermissibly violate individual rights, if allowed to do so, is very high.

As a methodological move, the moral exceptionalism claim would follow from the risk of getting our intuitions wrong about when to engage in some kind of otherwise restrictive action. This claim does not rely on the existence of rights, unlike the conceptual claim, and so is compatible with, for example, strict act consequentialist accounts of ethics. Rather, the uncertainty and potential costs of acting inappropriately through inaccuracy, inattention, or malice are high enough that a heuristic is required to determine when to act, and how. This is broadly in agreement with Kass's "analytic tool" comment, insofar as it is less about the moral commitments the frameworks espouse and more about a procedural check on decision-making.

There are reasons to reject these accounts. The first is that the emergence of just war theory was never really a threshold view, either in the early Christian or later Grotian view of the theory. There *is* a consequence-based view in Walzer's just war theory, but it is another level above the permissions and restrictions on a just war, and part of a "supreme emergency" clause in which an existential threat requires a unique and extreme response in order to preserve a community against extinction.[89] But under just war theory, the threat required to mobilize a response is not then simply a threat of harm, but a particular kind of threat that undermines community sovereignty, rights, or some other important moral consideration.[90] It is a kind of threat that constitutes a just cause for armed conflict. This is why, for example, trade wars are not reasons to go to war even if they harm nations.

Recent work in international law has established this as a component of armed conflict. Larry May has documented how even in war, the presumption that international humanitarian law is unique, or the *lex specialis*, has been steadily viewed with more and more skepticism. Writing on the problem in war, May notes "some kind of restriction on humanitarian law considerations needs to be drawn so that the entirety of the doctrine of human rights, or what is of central importance to it, is still operable for some wartime situations and other emergencies where clearly the individuals who are involved are still humans."[91] That is, even in cases of infringement of human rights,

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those rights *remain*, and govern our actions even if exigent circumstances justify us acting in certain otherwise impermissible ways. This is not merely a threshold view, nor a form of moral exceptionalism. Rather, we need to apply our concepts of rights in ways that remain demanding of us even in times of emergency.

The Thick Account: Common Concerns and Histories

There are better ways, I think, to account for the relationship between public health ethics and just war theory. The first is historical, and this dovetails into the second, around the kind of moral and political framework they articulate for social institutions.

The historical route brings us back through the work of the lead author on "Mapping the Terrain," James Childress. In some ways, the connection between just war theory and the orthodox view is made simple by Childress: his early work, prior to his work in bioethics, was on just war theory. Of particular interest to my project is his "Just-War Theories: The Bases, Interrelations, Priorities, and Functions of Their Criteria." Childress's work, as an opening move, picks up from something resembling the thin approach: what makes just war theory so iconic is that it looks like other cases where our duties conflict and that conflict must be resolved, including non-war cases involving the use of force and disobedience to the state.[92] This marks the approach as of a kind with public health which, while not always, does at times involve the use of force. This force exists in a broad sense: mandating certain kinds of screening and reporting for infectious disease potentially against the interests of individual privacy; or forcing individuals to stay home from their jobs, potentially impacting their and their family's future well-being. But it can also, perhaps too frequently, exist in the strict sense of physical coercion. For example, in a report to the US National Academies of Science, Engineering, and Medicine Board on Population Health and Public Health Practice, Beletsky describes how law enforcement has been mobilized in American cities to deal with the ongoing overdose crisis. While noting that police can in limited cases aid in harm prevention strategies, Beletsky argues that in practice police arrests, or syringe or condom confiscation, are counterproductive and are associated with increased levels of infectious disease.[93] This is far from the only use of state force in public health: on a basic level armed conflict and public health involve a similar in principle conflict between the use of state violence against individuals in aid of collective aims, and the need for our actions to be justified on strong

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moral principles such as necessity, proportionality, and least infringement conditions.

Childress's work moves beyond mere exceptionalism, however, by defining the structure of our thinking about this value conflict. Childress notes that conflicts between duties can arise even at individual levels, such as keeping promises or telling the truth.[94] But what sets war apart is the content of the *prima facie* duties that are violated, and so shape the kind of response that might be warranted. War holds the lives and deaths of whole communities in the balance, but also citizens' capacity to lead good lives, including self-determination about what that good life constitutes. Military intervention comes with a serious cost. That cost may be worth paying, but it requires special justification for the scope of duties that can be violated.

Finally, Childress sets up the central question for just war theory as—in a manner that is reminiscent of Gostin—a question of authority. That is, Childress claims the first criterion of just war is legitimate authority, claiming that "it determines *who* is primarily responsible for judging whether the other criteria are met." This is a question that is, as Childress notes, central to political philosophy, because it asks who has the monopoly on the force that war entails. This question of authority is also central to public health, given the infringements public health responses can involve and the use of state power to achieve certain health goals. Public health is thus bound up in questions of the authority and legitimacy of the state, as it is in war.

I think, however, that we should be cautious in following Childress's view of just theory into public health ethics. For one, this is an idiosyncratic view even of just war theory, which typically has as its starting point the just cause, and typically self-defense against an aggressor. Similarly, I think that public health is unlikely to be justified solely on the *ends of the institution of public health itself*, as scholars like Gostin and Hodge, Jr., do, by simply asserting the historical interest the state has in protecting public health. There is a circularity in which the institutional ends of public health are assumed, rather than justified, as a way to further justify the existence and function of that institution.

Rather, much like just war theory, health security as a particularly stark outgrowth of public health can be justified based on a threat. That is, it is the threat of communicable disease to large numbers of individuals, and even to community integrity and long-term survival, which justifies a certain kind of response. The magnitude of that threat may be great enough at times that an emergency arises in which acts that infringe upon the rights of others are

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justified. The structure of these rights infringements will differ from war in part because the "aggressor" is not a human agent. But even if not against an agent per se, that act of defense may infringe upon the rights of third parties in important ways. We start, as with just war theory, from the presumption that these infringements ought not happen, and then seek to examine what circumstances might trigger an emergency that leads us to act otherwise, and what our obligations are during that emergency.

This brings us to a proposed foundation for health security, and its relationship to conventional public health. Under this model, public health is first rights-respecting and rights-preserving; consistent with, to borrow a term from Rawls, a coextensive set of rights for members of a society. Conflicts do exist, but in general, according to Annas—and I suspect Gostin—promoting rights is broadly consistent with promoting public health. Where conflicts do arise, moreover, they are subject to the standard democratic process to engage in the negotiation of those rights to determine whether the scope of individual rights is indeed preserved, or if those rights need to be restructured to preserve rights for others, including the right to health.

Health security enters this equation as an instance in which rights infringement is justified in response to emergent conditions. This involves at times considerable interference with individual rights, not just of individual civil and political rights but also economic and social rights. As COVID-19 has demonstrated, infectious disease emergencies can usher in a radical change in social character, one that is scarring and even lethal. Deciding to act in this way requires special justification on behalf of the state, as does exiting it. Public health ethics currently lacks such a justificatory apparatus: it lacks its equivalent to *jus ad bellum*, though I will leave it to Latin scholars to determine what such a term would be.

This sets up the theoretic basis that informs the rest of this book: the homology between just war theory and public health ethics, commonalities in how they respond to threats, their joint grounding in the nature of moral claims against the state, and the state's role and authority in protecting its members from threats against their lives. This is partly consistent with Gostin, who derives his concept of public health ethics from broader liberal political theory. But it also attends to the concerns of Annas, and indeed of those same political theorists Gostin invokes, around the special kinds of justification that are required to engage in liberty-limiting or rights-infringing measures of citizens. This results in a framework that takes both views as partly correct,

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but in specific and complementary ways. What is missing is the normative framework to understand why conflicts arise, and how to justify using force, direct or indirect, to maintain public health.

Objections

Three objections are foreseeable in making the connection between military ethics and public health ethics. The first, familiar to much of bioethics, is: So what? The connection is interesting, but it doesn't necessarily give us much more out of public health ethics. But military ethics has two advantages on public health ethics that make it a useful resource. First, but weakest, is that compared to the half century or so of modern bioethics—only loosely connected to ancient medical thinkers—military ethics is an extremely long-lived discipline. Tenacity hardly tracks validity, however; compared to the age and volume of public health ethics and health security scholarship, military ethics has an extensive and deep philosophical foundation from which to work. It has moreover considered issues of rights infringement in incredibly granular detail, including the kinds of liability rights *infringers* retain when they act in certain ways.

A second response is that recent work in just war theory has connected justice issues between the conditions that lead to war, its declaration and conduct, ending, and ultimate resolution. This provides a connective framework over which we can lay the relatively narrow ethics of liberty-limiting measures in public health ethics and conceive of it as continuous with issues including social determinants of health, routine disease surveillance, public health emergencies, and what rebuilding means after a pandemic. This allows us to view questions of liberty-limiting measures in public health not as mere questions of proximate justification, but ones of political philosophy and distributive justice as well.

The next objection concerns the kind and scope of the violations a state inflicts during different crises. Surely, one might argue, the kind and scope of the violation in public health is rarely if ever as serious as seen in war, in which thousands if not millions of people die due to *intentional* killing. There is simply no comparison to public health, which at worst deprives individuals of civil and political liberties but not their lives.

The easy response to this is simply to deny, as I have, that public health never entails the intentional, or at least reasonably expected loss of life. But

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I think we could do better. A central character of civil and political rights or liberties is that they are resistant to consequences because they are essential to the self-governance of individuals in communities of equal respect.[95] So the fact that someone has not died is in some ways dismissive of the kind of infraction that occurs when civil and political liberties are undermined. These conditions are frequently thought of as preconditions for a good life, and while contested it is not the case that they are less serious, in principle, than one's life. The ethics of war considers likewise not just wars of annihilation, but conquest and colonization; punishment and terror. Wars where few or no soldiers die can be incredibly harmful to communities; conversely, poorly or unjustly pursued public health policies don't have to use guns to kill people or maim whole communities.

In another sense, the infractions may be all the more serious if the public are by and large innocent bystanders in many, if not most public health emergencies. Even if they resist public health orders that tend to be effective, the citizens of a state are individuals to which a state has a fiduciary duty more than it does enemy combatants or citizens of other nations. As I will establish in the next chapter, the enemy is the disease condition identified as serious enough to warrant a public health action. Public health actions are analogous to military actions that cause high levels of "collateral damage" against the state's own citizens. In war, even the permissibility of killing other combatants is neither straightforward nor obvious; how much more for acts that might harm one's own citizens? Thus even nonlethal rights violations could be very serious as a result.

The final objection is that the nature of public health is constant, where wars are discrete. Communities are always at risk of disease and other public health threats, where war is (the war on terror notwithstanding) a discrete circumstance. The response to this is the two elements of the common foundation I have established. Wars are sometimes discrete, but they can also be continuous with the politics of states. Public health emergencies, I will argue, can be viewed as a continuation of the largely peaceful but turbulent politics of health. Engaging in the process of securing our health against threats, and treating each other's health with respect, is indeed constant. But so is preventing war. Diplomacy and other means of preventing war are as important to an account of the ethics of armed conflict as the proximate ethical decisions behind killing. The state imposition of liberty-limiting measures, or measures that violate our duties to each other, requires a special kind

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of threat. Public health is indeed constant, but some instances of public health break away from the usual order of things to become emergencies.

This returns us to the tension between Annas and Gostin. They illustrate, to me, points on a continuum similar to that we find in military ethics between pacifists who think war is never justified, and political realists who think war is totally continuous with politics as usual. So too in public health we may have, in principle, strong views on health and human rights that always forbid infringements on rights, compared to other views in which rights violations are simply the practice of justified public health in the name of the common good. I have argued that Gostin is not a realist in this sense about public health, but the conflict between these two demonstrates the deeply contested question about how often public health conflicts really arise, what causes them, and what we do about them. The account I have given follows the view that just war theory is a response to pacifism, seeking to start with the presumption that infringing on rights is impermissible, and showing in what cases that presumption can be overridden.[96]

Conclusion

In this chapter, I introduced the orthodox position as a securitized view of public health and defended an ethical framework for public health as an institution that may at times infringe on individual liberties. I identified the central debate, using Annas and Gostin as examples, about how often these liberty trade-offs need arise, and related this to the just war tradition. I then articulated the connection between military and public health ethics, and why a thick account of this connection provides a way forward to resolve the debate and come up with a more robust ethics of public health.

Having done that, the first order of business is to fill in some of the gaps in table 3.3 about when a state may engage in liberty-limiting measures on its own population in the name of public health. This requires first establishing the nature and range of public health threats, their impact on communities, and how these threats might engender a response. It then requires a criterion for when a public health emergency may be declared, and a view of legitimate authority. This will establish the equivalent of *ad bellum* considerations of public health before we move into deeper analysis of other elements of public health ethics using military ethics as a guide and source.

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