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War on All Fronts

A Theory of Health Security Justice

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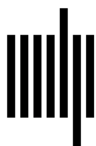

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5 The Moral Foundations of the Public Health State

War is, in the main, an act carried out by communities. In the modern era, one constant in war[1] is the presence of at least one nation-state.[2] Wars may be fought between nation-states, within nation-states, or by outside groups against nation-states. In all of these, however, the state plays a role.

So, too, with public health. At the highest level, authority for public health stems from the state. Medicine is the practice of protecting and healing individuals. Public health is the social control of the conditions that lead to the development and spread of disease; it inheres to communities. Hodge Jr. and Gostin go far enough to say that "protecting public health during an emergency is an essential goal of government."[3]

The role of the state is most obvious when the subject of public health is communicable disease. A critical step in securitizing disease, historically, is the recognition that infectious diseases "don't respect borders." The IHR exist, among other things, as an agreement between states to report disease outbreaks that may be a threat to the global community, and to coordinate and act to prevent the spread of infectious disease.[4] As such, the nation-state becomes, at least right now, a critical actor in preventing the transmission of disease, in virtue of its ability to maintain borders and enforce restrictions on the movements of people and goods across the world.

In chapter 3, I noted that a central historical connection between public health ethics and military ethics was Childress's account of the just war as grounded in legitimate authority. I argued this connection was not necessary to motivate the connection between military and public health ethics, and that it was better to formulate health security as a response to threat. I provided that formulation in the last chapter. But discussions of legitimacy are essential to justifying the role of public health as an *institution* with moral

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ends, and to the use of force by the state to achieve those ends. By institution, I mean a part of general social arrangements, laws, norms, and political entities that provide for an important dimension of social and political life. National security, I have argued, is an institution,[5] and public health is if not its own institution, a major component of the broader institution of health.[6]

In the previous chapter I argued that a key issue for health security has been its tendency to flatten public health concerns and favor technocratic solutions that, for example, deprioritize basic public health while overemphasizing the creation of novel therapeutics.[7] One reason for this, I articulated, is that health security appeals to what is presumed to be the common and nonpartisan appeal of national security to advance its aims. Dazak did this, recall, in appealing to, of all things, the war on terror to motivate stronger public health. National security, I suspect, is presumed by health security to be "apolitical" in that its status quo existence is agreed to by a broad segment of society. What could argue against the need for national self-defense?

This move has largely been a failure, if the nature of global health governance is anything to go by. This is partly because national security is not "apolitical." In particular—as a widespread global phenomenon—national security frequently receives widespread support when it concerns buying of new hardware, but not when it comes to expanding the diplomatic corps, providing humanitarian aid to stabilize regions, and developing strategic relationships that are mutually beneficial to all parties for the purpose of common advancement. National security is "apolitical" only if it is conservative, hawkish, and militaristic, and even then I suspect only because there are social mechanisms to maintain that group dynamic in the national security community. To borrow from the literature on the politics of governance, national security has been depoliticized, placed at a remove from the contested nature of politics and governance, quite intentionally.[8] But doing so has been the product of a series of specific policy and political choices.

A considerable amount of research has documented the turmoil as civil society has tried to offer an alternative to this current state of affairs and I won't rehash that history here.[9] Rather, what is important is that the substantive moral foundations of the national security state are not the subject of a broad consensus, and perhaps not a consensus at all. Assuming so as a foundation for health security, and public health more broadly, is thus a mistake. And while I claimed there is a homology between public health

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ethics and just war theory, a robust account of the *public health state* is needed to establish just why that is.

In what follows, I tie the aims of public health to the state and ground the state as the legitimate authority in public health. But I do so in a way that sets up the problem of what Michael Moehler has called "deep pluralism," and the limits on what a rational but divided people can accept for public health. I begin with justifications for public health as a state institution with which many will be familiar: libertarianism, contract theories in the liberal tradition, and utilitarianism. I show how each gives us an account of public health as a state institution, but one that clashes deeply with other commitments of members of states, and over which conflicts will need to be resolved.

I argue that most theories of public health ethics do not provide a robust means for thinking through what could justify a robust public health state—including health security's place in that state—that can account for deep pluralism. Given the deep tensions in modern states, and the currently unsubstantiated assumption by health security researchers and practitioners about shared values, it is appropriate to motivate a view of public health that can be sensitive to the need to resolve conflicts between individual agents. Moreover, this view gives us an account of political philosophy that justifies a very robust public health institution.

Public Health and Legitimacy

The question of legitimacy is critical to public health which, while often local in its ultimate practice, is still a broad collective enterprise. As a collective enterprise, we require an account of how we establish rules, enforce them, and represent the interests of individuals engaged in the enterprise in a way they can endorse. Importantly, legitimacy is a key component of modern claims against the state interfering with, or neglecting, the health of marginalized communities. This is particularly important in the domain of health. To take an example from outside mainstream health security, in his book on disability rights, James Charlton notes in his introduction to activism by the disability community:

> For the first time in recorded human history politically active people with disabilities are beginning to proclaim that they know what is best for themselves and their community. This is a militant, revelational claim aptly capsulized in "Nothing About Us Without Us."[10]

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This famous saying, "nothing about us without us," is reflected in the struggle for recognition and treatment by the state in HIV/AIDS activist communities. In his *How to Survive a Plague*, David France describes the May 21, 1990, protest at the NIH headquarters to demand that the AIDS community play a guiding role in coordinating the national effort to end the epidemic. After an incident involving violence against a protestor, a press conference was held in which Dr. Anthony Fauci—who would become a hero of the COVID-19 epidemic thirty years later—claimed the protest was "interesting theater. But it was not helpful." Keith Cylar responded:

> I think Fauci understands, and at times appreciates, what we do. Fauci himself understands that he does not have the power himself to do what needs to be done. That's why the system has to open up.[11]

A critical demand of ACT UP was that government excluded individuals with HIV/AIDS from determining how and when their needs would be met, and how an epidemic that involved them would be managed. His comment on Fauci is instructive as a comment on the limits of civil service—the National Institutes of Health in the United States is a part of the executive branch of government—to accomplish just goals through their own means. In both this and the case of disability, the implicit message is this: the state is only legitimate insofar as it is a reflection of, and promotes, an appropriate set of interests of its citizenry. It must be responsive to those interests in order to be legitimate.

The public health ethics theories canvased in chapter 3 assume a certain structure of or legitimacy of public health and/or health security, namely the existence of a broad agreement as to the values, norms, and institutions of the (usually American) state. I want to start to take the opposite tack. Thomas Hobbes, famously, gives us a thought experiment in the form of the state of nature, a world without government, in which all humans war against all others for survival. As a key move in his political philosophy, Hobbes notes that in this world, human options are extremely constrained:

> Whatsoever therefore is consequent to a time of Warre, where every man is Enemy to every man; the same is consequent to the time, wherein men live without other security, than what their own strength, and their own invention shall furnish them withall. In such condition, there is no place for Industry; because the fruit thereof is uncertain; and consequently no Culture of the Earth; no Navigation, nor use of the commodities that may be imported by Sea; no commodious Building; no Instruments of moving, and removing such things as require much

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> force; no Knowledge of the face of the Earth; no account of Time; no Arts; no Letters; no Society; and which is worst of all, continuall feare, and danger of violent death; And the life of man, solitary, poore, nasty, brutish, and short.[12]

This ties the security of the state to human endeavor. Moreover, I think it captures something about pandemic disease, and certainly COVID-19 bears some of this out. Being unable to interact with each other for fear of a threat (even if nonresponsible, as I argued in the previous chapter) undermines more than simply our health in the case of infection. It alters life plans in serious ways, stalling careers (or in the case of young people preventing them from beginning); ends personal relationships or prevents them from flourishing; generates new economic injustices or exacerbates the old; disables trade and commerce; undermines the pursuit of knowledge; and leaves us in a state of constant fear of death.

While the state of nature is a philosophical tool, it is on its face a good analog to the disordered world in which public health does not govern the health of communities, or does not exist—close to the world we live in today. This is a world without any health security: indeed, the state of nature is a world that is absent security.[13] The justification for effective public health is then simply the observation that no rational person wants to live like this, and the state provides a mechanism for community health to be regulated, including the long-term and even intergenerational effects of illness in communities, as a way to escape this state of nature. What the details of this look like, however, is a harder question.

This is the realm of political philosophy, rather than ethics. Bioethics has not spent much time on political philosophy, or on questions of how the states and political communities ought to be structured. But these questions are essential insofar as public health is a political institution. Three basic justifications for public health often mentioned are libertarianism, liberal egalitarianism typically represented by liberal contract theories, and utilitarianism.[14] These are less concretely theories so much as *families* of theories, with considerable variation within each family, so I sketch these primarily for readers who are not familiar with them.

Libertarianism

Libertarianism holds that rights govern all transactions between individuals, and that almost all other nonconsenting transfers are coercive and illegitimate. Robert Nozick, arguably one of the more famous proponents of this theory,

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establishes a hypothetical society in which there exists a "just set of initial acquisitions," some just arrangement of goods in the world. All individuals have a set of rights to life and property and may be deprived of those goods only under conditions of contract, for example, consenting transfers between individuals. All other transfers are illegitimate and coercive, and famously libertarians consider progressive taxation as "coercive" in this sense.[15]

Typically, the sole exception to this is the so-called night-watchman state, which justifies a modicum of national security that may require taxation to stand up. The basic justification here is that all individuals in a particular community have a right to defend themselves, but no one person can accomplish this against either internal (criminal) or external (military) threats. This coordination problem, and the seriousness of these infractions in that one cannot be compensated for one's death (among other things) by contract, sets up a justification for a national security apparatus that the state may fund.

Nozick's views (and, I suspect, other libertarian views) are almost certainly incoherent on their own grounds.[16] On the one hand, no such set of just initial acquisitions exists in practice, and would presumably require considerable redistributive transfers to rectify.[17] On the other, the precise contours of why the night watchman state can be motivated but no other public service, are opaque. But Nozick does provide the most plausible version of libertarianism and has made what I consider a good-faith rational reconstruction of his views.

In terms of public health, we could imagine a similar justification to the night watchman state: a "night nurse state." That is, individuals have rights to life and property, but are sometimes unable to adequately coordinate against internal (locally transmitted) or external (pandemic) threats. Some analogue to the night watchman state, but for public health, might be justified to coordinate against these threats to individual rights.

Note, however, that this is still a very, *very* thin account of public health. It would provide no rationale for most public health surveillance, health programs, antismoking campaigns, disability insurance, health insurance, data or sample sharing, foreign aid, threat reduction programs, capacity building in other nations, childhood vaccination programs, nutrition programs, and so on. Of note, where in a previous chapter I charged Gostin with conflating libertarianism and liberalism (which he contrasts together

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with communitarianism), this is one important separation between liberal and libertarian theories. Libertarian theories offer almost nothing in the way of a state beyond merely enforcing contracts and protecting life in very specific ways.

At best, a night nurse state would likely concentrate only on communicable diseases that

1. are transmitted without the knowledge of the carrier;
2. spread fast enough and are deadly enough that containing them is both in the interest of all community members because it threatens their ability to form any reliable contracts or maintain the minimal state, but is not able to be accomplished via individual coordination.

This is obviously a very small set of public health concerns. But note here that this restrictiveness does not pertain to rights themselves, but to the particular architecture of rights that holds them to be inviolable and justifies only minimal state involvement. Someone like Nozick, I suspect, would hold that it might be *good*, all things considered, if people didn't die from smoking that was causally implicated to predatory advertising campaigns. But he would likewise maintain that there is no justification for the state to intervene in consenting parties doing that to themselves—and likewise, no justification for the use of taxation to fund a health insurance system that would care for those people if they do develop lung cancer caused by smoking. Likewise, so long as it does not disrupt the state and the ability to make contracts, he would oppose most pandemic responses on the grounds that individual rights to choose and contract on their own terms are more important than even thousands, or hundreds of thousands of deaths.

Liberal Contract Theories

It is likely that just as libertarianism gives us a minimal "night watchman" security state, it will also give us no more than a minimal "night nurse" approach to public health providing protection from the worst public health crises, but not much else. This limitation is in part why Gostin's conflation of liberalism and libertarianism is egregious: the view they give us of the justification of public health, and thus the moral limits of the use of power or force by public health institutions (the idiosyncrasies of what libertarians consider "force" aside), are divergent.

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There are a range of alternatives available, the largest group of which I'll simply refer to as contract theories. There are quite a number of flavors of these theories in contemporary political philosophy, and some of them have received attention in public health ethics.[18] However, I will stick with arguably the most influential of these theories on the field, Rawls's theory of justice spanning forty years of the twentieth and twenty-first centuries. His central theory, justice as fairness, was presented in *Theory of Justice*; I will draw from *Theory*, but also from his later *Justice as Fairness: A Restatement*, which serves to clarify Rawls's work at the end of his life.

Rawls's theory of justice as fairness emerges as a response to utilitarian political philosophy (see below), drawn from Kantian claims that—very loosely put—we should respect the interests and agency of individual persons. Rawls argues that to establish principles of justice, we should imagine rationally self-interested agents discussing the creation of an ideal society. These agents are in the *original position* and must all agree on the circumstances of justice. They are, moreover, under a *veil of ignorance* where they do not know the circumstances under which they will live in this society, including class, gender, race, natural abilities, and so on.[19] The original position under the veil of ignorance is justified by Rawls as a precondition for fair and equal negotiations between parties in establishing the basis of fair cooperation. The original position allows citizens to reach, for themselves, an agreement that is fair for all. The veil of ignorance, according to Rawls, is one in which negotiating citizens have a point of view that is not distorted by the particular features and circumstances of the existing basic structure of society.[20]

The result, Rawls claims, is a form of risk aversion that arrives at two principles of justice:

1. Each person has the same indefeasibility claim to a fully adequate scheme of equal basic liberties, which scheme is compatible with the same scheme of liberties for all; and
2. Social and economic inequalities are to satisfy two conditions: first, they are to be attached to offices and position open to all under conditions of fair equality of opportunity; and second, they are to be to the greatest benefit of the least-advantaged members of society (the difference principle).[21]

Rawls has received sustained criticism of his treatment, or lack thereof, of features including race,[22] gender, and the family structure,[23] and health and disability as instantiations of justice or relevant features in formulating a just society.[24] The most important one for our purposes is the last,

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and Norman Daniels extends Rawls by identifying what he considers to be a critical component of Rawls's theory: protecting the opportunities of citizens, both as a condition of realizing the first principle of justice and as an explicit part of the difference principle. It follows, Daniels argues, that if promoting health helps to protect opportunity, then meeting health needs protects opportunity. Since Rawls requires us to protect opportunity, it follows that Rawls also requires us to protect health, especially as part of the difference principle.[25]

Daniels's work does not explicitly deal with the legitimacy of the public health state, but his work provides a guide. On the one hand, the original position behind the veil of ignorance provides us no information about our health states, or future health states over time, in society. Rational agents engaged in justifying the basic structure of society will thus support, through the difference principle, a basic structure that is expected to protect their opportunities whatever they might be. Agents would thus support a state that administers public health insofar as it protects those opportunities and maximizes the welfare of the worst off.

This kind of state is distinct from the libertarian state partly because it authorizes transfers to fund a public health state that satisfies the difference principle. Moreover, basic liberties are justified as claims against state interference only insofar as they are coextensive with everyone else's liberty. Presumably, this means that the state has some quarantine power—it may restrict movement of individuals or goods that pose a risk to the lives of others, contingent on those restrictions being in principle equally applied across the population. It may also legislate against a broad array of market failures if they benefit the worst off. These include things like occupational and environmental harms, fraudulent manufacture of medical goods, cost of pharmaceuticals, infection control, and so on.

This account, however, doesn't necessarily establish public health as a central feature of the state. Much of what we care about in health—and public health in particular— may be derived from the more general right to life, but only insofar as they are connected either to the violation of that right, or to the effect pursuit of an individual's ends.[26] It is unlikely an independent, *positive* right to health exists under a Rawlsian scheme, such as might justify access and benefit-sharing schemes to pharmaceuticals outside traditional markets, or access to universal healthcare beyond the scope of protecting some minimal set of opportunities, or equitable vaccine distribution.

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Rawls noted in later work that he took the basic liberties to be essentially negative in their conception, and that any positive elements were derivable from the background conditions of a property-owning democracy, together with fair equality of opportunity and the difference principle.[27] This is why, coupled with the difference principle, Battin and colleagues' account of Rawls leading to solidarity-based approaches to public health is mistaken. Improving the worst-off representative group in society is not the same as improving the worst situation for every person in that society, nor is solidarity captured under a scheme of basic liberties. Rather, liberalism under Rawls is a modification to the status quo of capitalism in a democracy much like the United States.

Rawls's work assumes that the difference principle does not significantly trade off equality for utility. However, this may not always be so in the case of health. Selgelid gives us an example of an anencephalic child—born with no brain above the brain stem—that can be kept alive for a long time but only through the use of immense amounts of resources. If we assume some level of scarcity, and that being born with anencephaly makes one relatively "the worst off," then the difference principle may mandate allocation of resources to these children at the expense of potentially many, many other needy people who are only slightly better off but can have their situation improved with the application of comparatively fewer resources.[28]

Utilitarianism

A utilitarian public health state would start from a general consequentialist framework of:

1. Some theory of what constitutes a good state of affairs;
2. A way to rank different states of affairs;
3. A way to select between states of affairs as a guide to what one ought to do.

Act utilitarianism's account of these three elements is that a good state of affairs is identified in terms of its pleasure and/or pain, satisfaction of individual preferences, or some objective list of goods (i.e., utility); that one state of affairs is better than another just in case the probability-adjusted sum of all utilities in the former is greater than the latter (aggregation); and that the selection method is just the act of ranking states of affairs. Utilitarianism has experienced a recent resurgence in health security circles

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with interest in the Effect Altruist movement in global catastrophic biological risks.[29]

A starting point in thinking about public health is what utilitarianism can and can't do about healthcare. Allen Buchanan argues that utilitarianism is incapable of providing a universal right to a decent minimum of healthcare.[30] As with any concern for rights for utilitarianism, it cannot in principle guarantee *anything* to people, but is always contingent on promoting the greatest aggregate utility. It may be, as Buchanan notes, that there is some possible world in which access to healthcare as a matter of rights does in fact promote the greatest utility, but Buchanan claims that under a plausible conception of the actual world we live in, a universal right to healthcare would not in fact do so.

However, public health and access to healthcare is not the same, and here utilitarianism is much simpler and easier than the previous two positions I've discussed in establishing the public health state. First, if we take health as a component of,[31] or precondition to achieving well-being,[32] we ought to promote public health just in case it promotes aggregate well-being in a population. And on this count, famous public health policies do so very straightforwardly*:* the Salk vaccine, smallpox eradication, and fluoridation are unequivocal successes that have raised up the health of millions of people around the world, and delivered us—in the case of the second—a world free of a microbial scourge.

Second, a utilitarian public health state relates strongly to contemporary health security. The emergence of "global catastrophic risks," risks that threaten the continuity of meaningful human society,[33] as a field of study and policy activism dovetails with the post-2001 concern about bioterrorism and genetically modified viruses with pandemic potential as a rationale for public health. Measures that could prevent the onset of a catastrophic risk (of biological origin or otherwise) could save billions of actual lives, and moreover benefits potential *trillions* of future lives by maintaining a human community that can eventually become spacefaring and expand into the rest of the universe.[34] Very little of the catastrophic risk literature does anything so prosaic as advocate basic public health. One reason I have been given by a member of this community is that catastrophic risks will largely be of an exigency that preventing them is almost always the only way to survive them—health systems cannot, in any real sense, be prepared for

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them. But in almost all subcatastrophic but still devastating events, public health is worthwhile and desirable.

Three more things should be said about this basic justification. First, utilitarianism is agnostic about the state as the locus of public health. If the nation-state is the entity best poised to maximize utility, utilitarianism recognizes it. But subnational or supranational mechanisms may be better equipped or more likely to maximize expected utility. I set this aside for now; as long as there are still states, utilitarianism can recognize their role as coordinating actors, and I suspect a public health move that seeks to disband the state is likely seen as intractable by most contemporary utilitarians.

Second, utilitarian appeals to public health will likely be *radically* agnostic about public health as an institution. It is unconcerned about what "counts" as public health, and only with promoting expected aggregate utility. So if labor rights promote public health as a means to promoting global utility, then utilitarians should care about labor rights. Utilitarians, I suspect, must care about public health, but will be—to health security and public health practitioners, maddeningly so—unconcerned about the form that takes.

Finally, unlike libertarian and liberal egalitarian accounts, utilitarians have a much less complicated approach to liberty-limiting measures. On criminalization and other punitive public health measures, utilitarians only care about guilt, praise and blame, or responsibility, if those concepts promote expected aggregate utility. It is empirically unlikely they do in most cases. But conversely, utilitarians are also likely to be unconcerned about liberty-limiting public health measures, no matter how coercive, just so long as they promote expected utility. So, utilitarians are not in principle opposed to quarantining or even killing the sick to protect the public. They may have empirical reasons to suggest why this is not the best option to pursue, but nothing in act utilitarianism itself means these are in principle impermissible.

Utilitarianism nonetheless has an important role in liberal thought about public health through John Stuart Mill's "harm principle." In his *On Liberty*, Mill claims "The only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others."[35] While *On Liberty* is subordinate to Mill's utilitarianism,[36] the harm principle[37] is a mainstay of liberal thought and, even when not explicitly identified with utilitarian work, is its most enduring contribution.[38]

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Problems of Deep Pluralism

A central problem we arrive at is that these accounts diverge in their account of legitimacy in a public health state, and in the limits and powers such a state ought to have. Accounting for why we should grant the public health state legitimacy is thus deeply contested. This is a problem for a public health state that seeks to justify *publicly* its legitimacy and the powers it has, and is, I suspect, partly what justifies the good-faith turn to national security as "apolitical."

By "deeply pluralistic" I mean that justifications for the public health state are justifications that exist in a world in which the basic tenets of liberalism are not preserved even within ostensibly liberal nations. It is a world inhabited, and in which we must appeal to liberal agents, nonliberal agents, and nonmoral agents alike.[39] Given that public health ethics is, like the rest of bioethics, a discipline ultimately grounded in philosophical justifications for practical actions, we should take this deep pluralism seriously.

Previous attempts to accommodate this pluralism run into trouble. The work of Childress and colleagues—or, at least, the connection between Childress's earlier work and "Mapping the Terrain"—represents what some call mid-level theorizing.[40] That is, the authors take that a particular set of duties or considerations arise intuitively, are noninclusive and subject to revision and/or trade-offs in particular contexts. They are, however, subject to agreement in liberal, secular societies of the kind they envisage, like the US. This is broadly consistent with the position of bioethical principlism made famous by Childress and Tom Beauchamp.[41] I suspect as well that it broadly aligns with Moreno's position on American pragmatism in bioethics, where "actual moral problems are living problems and problems of living; they are 'contested' or embedded in states of affairs,"[42] Kass's procedural approach described in chapter 3, and Gostin's general claims around liberalism.

An alternate strategy is one advocated by Michael Selgelid, concerning "moderating values." This strategy holds that central values promoted by libertarianism, liberal theories, and utiltiarianism—liberty, equality, and utility, respectively—are all fundamentally valuable. The major shortcoming in each theory, then, is not that it fails to signal some important value but that it takes a single value to be either the only important value, or the most important of a ranked list of values. Selgelid, instead, suggests these values "moderate" one another. In some cases, utility will outweigh liberty and equality; in

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others, liberty will outweigh utility and equality; and in some, equality will outweigh liberty and utility. No one value is more important than another. Selgelid claims finally that there remains, then, some empirical question about when each value is or is not important, and in what way.[43]

Both approaches, however, struggle with deep pluralism. Mid-level theorizing relies heavily on social context; it does not give us a reason to establish public health in either (1) a national context in which there are significant segments of the population who cannot agree on what general moral commitments we ought to have, much less which one is important when; or (2) when we are required to engage in deliberation between those in the local context the mid-level theory derives from, and agents from elsewhere. This, it seems, is a consistent problem for approaches in bioethics and public health ethics broadly that assume a very particular view of the United States (or, more charitably, the Anglophone world) as a starting point when our concerns—as with many public health crises—are so much larger. These theories might conceivably work in practice in clinical scenarios where the number of actors and their views is somewhat limited but fall apart (as any theory would) when its assumptions no longer hold. A sociologist might have more to say on *why* this very particular group of mostly white, mostly elite scholars would have such a view of America, and how they might struggle to explain public health ethics in a country that has a long, history of deep moral divisions, but this is not that kind work.

Moderating values approaches fail, in a similar fashion, just in case we can't agree on which set of values is fundamental, or where there is substantial disagreement about which value is outweighed by another in a broad range of cases. This could be because of framing issues: one way to solve the anencephalic child case, for example, is to claim that the fault lies not with Rawls or with the demands of justice, but with the system that requires a child to die when we could redeploy significant resources from national defense, or policing, or increase marginal taxation rates, and so on. But in other cases, we may simply have incredibly divergent views on what matters. In either case we are stuck with deep pluralism.

Minimal Morality and the Public Health State

Because public health is at least in part a political philosophical problem, novel strategies exist within that literature to accommodate the problem of

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deep pluralism. The one I shall develop arises from Michael Moehler's work in his *Minimal Morality*.[44] Moehler develops an account of political theory that arises from a minimal conception of human commitments beyond pure instrumental reason. Moehler asks what individuals could agree to if they were

1. forward-looking; that is, capable of having interests in the future;
2. instrumentally rational; that is, capable of adopting suitable means to their ends;
3. self-interested; that is, privilege their own interests ahead of those of others except in cases where it is mutually advantageous to do otherwise;
4. conflict resolving, which Moehler specifies as possessing the "overriding goal of securing peaceful long-term cooperation."

In this minimal level of morality, Moehler claims, solutions to political-philosophical problems can be described as ones that can be endorsed by agents that satisfy only the above conditions. Moehler has defended not just a democratic welfare state on these terms, but one that supports a basic universal income.

This kind of theory can accommodate a robust public health state in the following way. Some projected health state is required for our future goals (condition 1). In the immediate term, individuals' future goals require they be healthy today in order to prepare, gather resources, and engage in community (including participating in politics) to be able to achieve their goals. They will need, moreover, to be able to maintain their health through to their goals, and potentially beyond. Achieving our goals, including nonhealth goals, will often require a particular health state (condition 2). Importantly, these are an individual's health goals, and are arguably necessary for them to advance their interests, independent of whether their health advances the goals of others (condition 3). We all have a deep personal connection to our own health states, whatever those are.

Unlike some liberal theories that ask us to envision a world where we don't know our health states going forward, Moehler's theory does not require us to adopt an uncertain (e.g., probability blind or equiprobable) view of health.[45] It does not require, for example, that we imagine the possibility that we could be born into a body that has a congenital disorder. Rather, Moehler's theory assumes only that individuals know who they are in real life, and the social and economic circumstances of their society.

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They are further assumed to be uncertain only about the particular cases of conflict in which they might become involved, the future, and their precise positions in each of these situations.[46]

This kind of public health state can be quite robust. Let's return to the principal focus of health security: communicable disease. There are a broad range of communicable diseases to which individuals are vulnerable, even in relatively developed societies: recall the US experiences up to 50,000 deaths from flu per year,[47] or up to one Vietnam War of influenza deaths every year. These infectious diseases can and do frustrate the goals of individuals in a range of ways, from death to time spent not pursuing other activities while recovering.

However, a coordination problem arises, regardless of the moral commitments of the agents in question, in which routine interactions for business or pleasure form a possible route of transmission of those diseases, and which without an agent's interests would be frustrated. That is, absent the public health state, our conditions can look a lot like the state of nature in some very important respects. Few rational agents want to become sick with an infectious disease, and while in many areas they might be willing to risk it absent other options, there are compelling reasons to accept a state that handles the control of communicable diseases so that individual agents can better achieve their goals, and achieve them with less risk. While communicable diseases are the primary focus of this book, there are other areas where risk sharing is in the interests of a very broad coalition of parties, including environmental and occupational health risks.

This, moreover, provides a very robust emphasis on the nation-state's health infrastructure in aid of public health. COVID-19 gives us a great example of how robust this kind of arrangement might be once fully described. In an op-ed in June 2020, Luciana Borio, vice president at In-Q-Tel—the venture capital arm of the Central Intelligence Agency, and thus securitized health if ever there was—noted that clinical trials to generate knowledge about COVID-19 and develop treatments and novel therapeutics were hampered by fragmented healthcare systems.[48] Borio, while lauding the Randomized Evaluation of COVID-19 Therapy (RECOVERY) trial platform that provided rapid and robust data on therapies for COVID-19, did not explore its mobilization of the UK National Health Service, and that the existence of the NHS in terms of common standards of care provision and a unified health records system made such innovative trials possible.[49] A comprehensive and

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unified healthcare system is itself an asset to the coordination problem of health security. Independent of our other moral commitments, from a self-interested, instrumentally rational perspective, universal healthcare *is* pandemic preparedness. In addition to solving issues around risk pooling that can arise with more fragmented health systems, it solves key coordination issues that may arise when the first notification of a public health crisis comes from a patient reporting symptoms, to responding quickly to novel diseases through high-quality data generation.

A common concern in these kinds of arguments is what we do about free riders. That is, the degree to which these kinds of state measures are vulnerable to exploitation by individuals who do not pay into the system, but instead simply draw from it. But here, a robust public health system can be justified on what Moehler calls "productivist grounds," referring to the broad welfare states of social democratic states such as those in the Nordic League.[50] This is because the preventative effects of a robust public health system are extremely net cost saving. They benefit producers, including employers, in virtue of reducing the burden of disease on the population that causes losses in productivity. Seasonal influenza, for example, exerts an economic burden of approximately $11.2 billion on the USA, of which approximately 70 percent is due to indirect costs such as productivity loss from 20 million or so sick people a year.[51] Even if there are free riders, the sheer volume of lost productivity from even vaccine-preventable infectious diseases can justify substantial investment in public health.

Likewise, public health can protect social fabric writ large, with considerable gains in productive labor that overwhelm free-riding concerns. This enters into condition 4, and the satisfaction of interests in a way that secures long-term peaceful cooperation. Pandemics can debilitate states, depleting economies and undermining the capacity for individuals to fulfill their basic needs. The structure of communities can be undermined through long term public health effects resulting from disease pandemics, including lack of access to education, other medical care, and basic services. In this way, the public health state is justified just in case it provides a *security* against catastrophic events that undermine the possibility of long-term peaceful cooperation.

Finally, robust public health in principle provides a mechanism for accounting for the considerable unpaid labor that goes into supporting fragmented or undervalued public health systems. Taking care of sick children

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or adult relatives, time off work to attend doctor's visits or to recover, individuals bearing costs of measures to prevent the transmission of disease—all of these constitute a form of unpaid labor that prevents individuals from otherwise pursuing their own ends. This, on the one hand, relates to the kinds of social arrangement a broad set of individuals can agree to above—there are broad segments of society who enter into these unpaid labor arrangements, including everyone who raises children. But this also folds into productivist reasons to enhance the public health state to allow individuals to enter into these otherwise unpaid circumstances to prevent the spread of disease: rather than worrying about free riders, the amount of uncompensated labor that goes into responding to the routine spread of infectious disease is immense relative to the costs, I suspect, of supporting individuals to prevent its spread.

Two final points are relevant here. The first pertains to negotiation. Given that Moehler's account doesn't assume an ideal negotiating position, should we expect to a public health state to be agreed to in the kind of world we have? I'll set aside politically enforced barriers to participation until the final chapter, but for now it is worth showing why a coalition of citizens can be constructed to support this strategy. That is, the fabric of our society can help describe precisely why actual rational agents would endorse this vision of the public health state. For 26 percent of Americans, it is a disability. This includes the almost 14 percent of Americans who have a mobility disorder, and all members of the community who engage in unpaid labor to support them.[52] For almost 60 percent of Americans, it is a chronic disease such as heart disease, cancer, lung disease, or diabetes. It is the 43.5 million people in the US who will have children between the ages of 15 and 50, and their partners. Most all of these individuals have an interest not simply in medical care, but in public health measures that prevent illness and provide a mechanism to prevent its spread in a mostly voluntaristic way. I assume that in most other nations, the numbers above may change, and additional groups may be folded into this account, but the general sketch of a coalition remains the same. The number of people with an interest in a robust public health state simply overwhelms the people who have little to no interest in it.

Note I am not suggesting healthism—preoccupation with personal health as a primary, and often *the* primary, focus for the definition and achievement of well-being[53]—is the rational or moral option here. Lots of things are required for a good life, and no good life need be the same on my account.

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But many of the things individuals value about their lives can impose risk on themselves. This might include certain kinds of food, drink, drug use, travel, hobbies, or athletic, sexual, social, and other activities that people engage in that carry some kind of health risk. But here, the need for robust public health infrastructure is at its most stark, and the negotiating aspect features heavily. With rare exception, no one group of individuals that has an interest in being protected by the state from one public health risk, or supported if they incur the negative outcomes resulting from the pursuit of another, has the power to otherwise demand of others that they refrain from a risky practice or pursuit. Individuals who prefer food that carries a higher risk of foodborne illnesses likely lack the power to demand that people who like to hike outdoors, where they might encounter parasites, are not covered by the public health state. But both have an interest in public health mechanisms that permit those activities but invest in detecting and responding to them as needed. Thus, surveillance of foodborne outbreaks and of seasonal parasite densities are both part of the contract, whereas banning oysters and raw sprouts are not. In fact, there is an advantage to both groups to negotiate for the protection of their activities, say, modern capital, whose leaders may prefer not to incur the taxes to pay for more robust public health. Just as with disability, or childrearing, all rational agents who have an interest in securing long-term cooperation have strong interests in forming these kinds of health coalitions.

A final set of individuals who enter into this coalition are individuals who are at risk for losing employment through the spread of disease. First, in April 2020, roughly 14 percent of US workers were unemployed, half of whom never returned to the workforce. Second, individuals experienced long-term harm from disease even if they survived: an international survey of "long COVID" sequelae found that of respondents with COVID-19, 45 percent required reduced work time compared to pre-illness, and another 22 percent left the workforce.[54] Finally, individuals experienced the year-to-year insecurity that arises from a lack of access to paid sick leave, or sick-leave policies that do not provide substantial, feasible access to time off for major illness. These individuals will recognize that living in a society that broadly protects individuals from becoming sick is in their interests. I suspect they will also have personal experience with the idea that access to paid sick leave is itself a form of infectious disease control, and immediately grasp why countries with paid time off are estimated to have up to 40 percent

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lower influenza burdens.[55] But between these groups, individuals suffering from chronic illness, individuals with disabilities, and individuals with care obligations, we can imagine a coalition that promotes an incredibly robust public health state—and has the relative bargaining power to enforce it.

This account of public health assumes nothing about the substantive moral commitments of individuals. It is unlikely to fully satisfy the moral demands of libertarians, contract theorists, or utilitarians. However, it provides a structure that all should be able to agree to as part of an effort to maintain long-term peaceful cooperation, and insofar as they hold beliefs that preclude them dissolving the social contract altogether. It will also satisfy the interests of individuals who, in all likelihood, do not maintain a single coherent normative theory of the state, but also possess those qualities described above.

This view of the public health state has two levels. The first level strongly promotes a rights or interests-promoting account of public health. This is because while individuals have a fundamental interest in maintaining their health (in some state) in advancing their goals, they will not agree to a social contract that does not protect their existence as separate agents and does not allow them to satisfy their basic needs. Those needs, moreover, may be divergent. Because the precise, substantive value of health may differ for individuals, public health must be able to account for individuals for whom health is intrinsically valuable or is its own benefit. But it must also account for (I suspect, but cannot be certain, is much a larger set of) individuals for whom health is a means to an end, and where those ends diverge radically: from elite sportspeople who require an extremely high level of performance beyond the subsistence needs of their bodies, to people with disabilities for whom guarding against certain pathologies and maintaining access to their central projects and autonomy is centrally important. It must also deal with individuals for whom health is minimally important, and important merely to facilitate their lives and non-health goals. The people who "don't care about their health" are, paradoxically, likely to be the healthiest among us (likely from brute luck) in that they don't notice their own good health.

The second level of public health, on the other hand, looks highly securitized on its face. This level of public health seeks to protect against severe health events that may damage society, temporarily or permanently, to the degree that individuals have a preference that those events be prevented or

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mitigated, and against which individuals are uncertain about their place and outcomes in future such events. This level of public health is securitized in the sense that it seeks, like the institution of national security, to maintain the structure of the state against exogenous threats.

This provides a strong reason basis for health security as, effectively, the militant arm of public health. Note, however, that this does not establish a theory of the state that sees health security as part of *the national security state* against human aggressors. Rather, it establishes the state as a legitimate authority from which to provide public health in securing the aims of individuals against external threats. What form that takes is a further issue to resolve.

Objections

Two objections arise here, which are important to map out now but whose resolution I will leave for later in the book. The first is what we do if we loosen some of the conditions of Moehler's account further, and in particular the fourth condition about long-term cooperation. Surely, someone could say while pointing to the mess that is COVID-19, there are plenty of individuals who at this stage would rather break long-term cooperation than maintain it. In these cases, their relative bargaining positions would be less important because they are not interested in bargaining, or because they are powerful enough that they control an outsized share of power. Examples readers might suppose here are anti-mask protests,[56] or violent white nationalist groups threatening to intentionally infect their victims, or the QAnon movement and other conspiracy theorists that prefer to disrupt society despite its impact on public health.

Moehler has a partial answer to this, and he acknowledges the possibility of this in general terms:

> In cases of conflict . . . the parties to a conflict are so severely negatively affected by the points of contention that, if the conflicts remain unresolved, they are prepared to engage in destructive actions and threaten peaceful long-term cooperation, because they consider such actions to be more beneficial to them than remaining in their current situation. To be clear, typically there is a continuum from peaceful cooperation to the mere rejection of cooperation to socially disruptive but nonviolent resolution to explicitly violent conflict resolution.[57]

Moehler's solution, then, is that in most cases rational individuals will prefer peace to conflict because the costs of conflict are very high. In some

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cases, individuals might not be rational, but in others they may prefer conflict because the state of affairs of their negotiations is so poor that conflict becomes *preferred* to peaceful resolution.

I buy this account, though what we ought to do about it is a more complex matter. Part of this, however, returns us to coalition building. Given the broad set of individuals who have an interest in a robust public health state, it seems that a key challenge for that coalition is exerting pressure on individuals who do not have the same interest. While this pressure might involve persuasion, it might—to return us to the struggles of disability and HIV/AIDS activists—also involve confrontation. This is consistent with Moehler's account, though I suspect it will not be a happy conclusion for some.

This dovetails into the major concern about negotiation, and falls into what political philosophers would call "nonideal theory." The issue at stake is that currently, political and social incentives are arranged in such a way that the coalitions mentioned are largely fragmented. How do we get not just to a point of collective action to agree to something like the above, in all its inevitable complexity, but do so in the existing political system?

I have some suggestions to this, which I lay out in the final chapter. I take the nonideal question to be broader than this book, despite being a through line in some of the ethical and political philosophical claims I make throughout. What is clear, however, is that considerable support exists for broad public health promotion, including institutional changes outside of public health proper that would support the public health state. Universal healthcare, free or subsidized education, paid time off, and living wages are all connected to the public's health, and if I understand my colleagues in political science, all receive broad support from citizens despite their nature as political hot buttons. The overarching question is one of how we build coalitions in that environment.

A second objection would be to contest how rights respecting this system would be. This dovetails partly with the securitization angle, in terms of the capacity for communities to buy in to the most egregious government programs as they did during the war on terror. But it also dovetails with the history of public health, and the public's willingness to accept draconian public health measures so long as they target people other than themselves.

A preliminary response to this is that, as ideal theory, I accept that in practice actual negotiations may take a different tack. But I note that the architecture of this theory provides a robust degree of safety that satisfies concerns

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individuals have about public health measures—there are ways to satisfy the aims of more restrictive public health measures, if we have the imagination and will to act. This leaves open room for more liberty-centric public health practices that are seen not only as the best means to solve public health and view securitized practice as a last resort but to promote the self-interest of other parties as well. This does not mean that individuals, presented with evidence, may not decide to impose their will on others regardless. But as mentioned above, the response to this may be to make that imposition untenable as a means to resolve conflict.

Conclusion

In this chapter, I establish a general legitimacy of the public health state: the role of the structure of basic institutions of the state in maintaining the public's health. I outlined a broad contractarian argument for why diverse and deeply pluralistic societies can consent to an arrangement of institutions aimed at this goal, with an appeal first to the role health plays in individual lives, and then through an appeal to the role public health plays in maintaining the possibility of peaceful, long-term cooperation in a society.

The next step required is to justify public health as uniquely deserving of an explicit institutional role in modern states. This argument will turn on the nature of the threat in public health, with a focus on the latter level of the public health state: protection against threats that threaten long-term stability. Through that, I will show how we can account for other public health operations, albeit at different levels of decision making. But in particular, the role of the largest coherent collective actor—currently the nation-state—as the authority comes into its own in cases where stability is threatened.

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