War on All Fronts

A Theory of Health Security Justice

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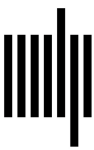

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6 Justly Declaring an Emergency

The COVID-19 epidemic arrived on December 30, 2019, when China notified WHO of a cluster of pneumonia cases. It would take another month for the outbreak, however, to become officially an emergency in the eyes of the international community, when the WHO director general declared COVID-19 a public health emergency of international concern. In the lead up to this decision, as in previous outbreaks, considerable attention was paid to when, and why, the emergency committee at WHO would issue its recommendation of a public health emergency of international concern to the director general, and what the result would be.

The declaration of the public health emergency of international concern was fraught for a couple of reasons. On the one hand, it was clear to observers that COVID-19, which had spread to more than a dozen other countries at that point, had long posed a risk to the international community.[1] On the other, the severe lockdown in Hubei province a week earlier raised fears that countries would react in regressive ways, potentially even those detrimental to a pandemic response.[2] The lack of rationale provided to WHO by China for instituting public health measures beyond WHO recommendations, something required under IHR, raised fears that international norms would fall by the wayside in the panic.[3] On both counts, the why and when of the declaration mattered not just for definitional purposes, but as authorization for what was and was not an acceptable response to a crisis.

This chapter deals with the ethics of declaring a public health emergency. The previous chapters described the impersonal account of disease as entailing a last resort before implementing emergency measures that violate the rights of citizens, and the fundamental tension at the heart of health security arising from the structure of the state as a legitimate authority

in promoting public health. These provide a strong presumption against infringing on rights in the pursuit of public health goals. Powers exercised during public health crises can be severe, tend to disproportionately harm the most vulnerable members of society, and can harm communities for generations. They are, moreover, frequently exercised through the executive powers of government, and can be difficult to hold accountable or resist when used inappropriately.

In this chapter, I consolidate the principles discussed in previous chapters into an account of a just declaration of a public health emergency. I begin first with a note on the definitional ambiguities surrounding what constitutes a public health emergency. I then clarify the work of the previous chapters establishing legitimate authority and last resort criteria as the criteria for declaring a just public health emergency.

I then turn to the remaining criteria. I distinguish between proportionality and necessity as important and distinct concerns in declaring a public health emergency, and their interaction with last resort criteria. I finish with a comment on how the chance of success, and the possibility that a health emergency might make certain threats worse, could provide reasons not to declare a public health emergency. I then consider objections, and importantly the possibility of using liberty-limiting public health measures outside of an emergency.

A Problem of Definitions

Little literature exists on what exactly constitutes a public health emergency. This is a significant omission in public health ethics, and more so because of the proliferation of competing and varied accounts of a public health emergency in law, as described in chapter 3. This significance lies in questions of the ethical implications of declaring an emergency, and in particular what powers it authorizes the use of in aid of resolving an emergency.

WHO is a good place to start. A PHEIC is defined as "an extraordinary event which is determined to constitute a public health risk to other States through the international spread of disease and to potentially require a coordinated international response," formulated when a situation arises that is "serious, sudden, unusual or unexpected," which "carries implications for public health beyond the affected state's national border" and "may require

immediate international action."[4] Within that, important elements emerge: the risk of transnational spread; the requirement for a coordinated international response; and a serious, sudden, or unexpected event.[5]

The PHEIC, however, is neither the arbiter nor model of the public health emergency. In the United States, for example, a number of definitions exist and may differ depending on the scope and level of government actor. The Stafford Act defines a "major disaster" as "natural catastrophe (including any hurricane, tornado, storm, high water, wind-driven water, tidal wave, tsunami, earthquake, volcanic eruption, landslide, mudslide, snowstorm, or drought)."[6] But the act defines an defines emergency as "any occasion or instance for which, in the determination of the President, Federal assistance is needed to supplement State and local efforts and capabilities to save lives and to protect property and public health and safety, or to lessen or avert the threat of a catastrophe in any part of the United States. The Public Health Service Act states that the secretary of the Department of Health and Human Services is authorized to declare a public health emergency on finding that "1) a disease or disorder presents a public emergency, or 2) a public health emergency, including significant outbreaks of infectious diseases or bioterrorist attacks, otherwise exists."[7] However, the same act does not actually define what constitutes that emergency.

The Model Act designed by Gostin and colleagues provides an outline for a health emergency as an occurrence or imminent threat of an illness or health condition that:

1. is believed to be caused by any of the following:
    i. bioterrorism;
    ii. the appearance of a novel or previously controlled or eradicated infectious agent or biological toxin;
    iii. [a natural disaster;]
    iv. [a chemical attack or accidental release; or]
    v. [a nuclear attack or accident]; and
2. poses a high probability of any of the following harms:
    i. a large number of deaths in the affected population;
    ii. a large number of serious or long-term disabilities in the affected population; or
    iii. widespread exposure to an infectious or toxic agent that poses a significant risk of substantial future harm to a large number of people in affected population.[8]

As I explained in chapter 3, however, the definition in the Model Act rarely finds its way into state acts in whole or in part. Some states retain the wording of the Model Act, such as Indiana, which defines it as "occurrence or imminent threat of widespread or severe injury, or loss of life or property resulting from any natural phenomenon or human act, including an epidemic and public health emergency."[9] Others, such as Massachusetts and Florida, have no definition of what counts as an emergency.

Rather than merely assess which jurisdictions do or do not define emergencies, however, we can assess what kind of properties best describe a public health emergency. First, the structure of nation-states is strongly determinant of an emergency declaration. Not only do individual nations differ from the WHO in what counts as an emergency, but individual substate jurisdictions within those nations differ, including between each other, about what constitutes a health emergency. This reaffirms the ameliorative, critical piece of this project: to engage with health security with an eye toward institutional reform.

Second, while commonalities exist between definitions of a public health emergency, such as the seriousness of the event, even those commonalities are vague. What constitutes a serious event, or one requiring mobilization, or significant risk, is far from clear. This is not necessarily avoidable but motivates further analysis. Moreover, different legal histories among jurisdictions may mean that features of these terms may be interpreted in divergent ways. So even if we have the same definition, the effects may be different.

The presence of language around a public health emergency does not just describe what such an emergency constitutes as a descriptive feature of the world. Declaring a public health emergency is an action that, once performed, creates certain kinds of outcomes for the world. The relationship between the definition, the declaration, and its outcomes is an important social-scientific phenomenon, but what that relationship ought to be is also an important philosophical question.

What Is a Public Health Emergency (And What Should It Be)?

Rather than a formal definition, I present a conceptual framework that distinguishes between what properties public health emergencies might have, and the reasons we declare emergencies. I do so quickly, to consolidate previous discussions in earlier chapters.

To the first, a descriptive account of an emergency can be read from my account of disease as a security issue. Public health emergencies are first exigent and immediate. They come on quickly, and before a conventional political response is capable of addressing them. This property is contingent on how good our political responses are, but we can imagine that even the best designed political systems are vulnerable to shocks they cannot absorb.

The second is the harm that arises. Public health emergencies can kill or otherwise harm large numbers of people. These numbers can be so large that, like in war, they can appear to be indiscriminate. Public health will never absolutely be able to prevent disease and death, but the magnitude of the excess harm that constitutes an emergency is a threat to the continuation of the social fabric, in addition to the health of individuals. Countries or communities might survive these events—they need not be existential threats—but are left changed by them, potentially for generations.

Third, and related to the above, is the capacity for response. Even relatively small infectious disease outbreaks can overwhelm a weak or underprepared health system. The Ebola virus disease outbreak in Liberia was so challenging in part because Liberia, recovering from a civil war in 2003, had approximately 298 physicians for its 4.5 million population,[10] and lost 8 percent of its healthcare workforce over the course of the pandemic.[11] While this is not the only measure of vulnerability that is relevant, it is indicative of the kind of damage that a disease can do when it strikes a weak health system. Exigency, harm, and capacity are related properties that capture central features of what makes public health issues into public health emergencies.

This, however, is not what constitutes *declaring* a public health emergency. Rather, the above recapitulates the threat that may prompt the declaration of an emergency. But not all emerging threats justify declaring a public health emergency. Like a war, a declaration of emergency is not a natural phenomenon, but a choice by an institution or state. It is moreover a choice that implicates states (singular or plural), a disease event, and the people caught in the middle.

What a declaration of an emergency typically does is change the power structure of a state. This happens in three ways. First, it relaxes executive powers to perform public health measures during an emergency, and the enforcement powers of states to ensure compliance with those orders. This may include removing or withholding licensing to perform certain activities, the use of criminal justice powers and law enforcement, and even the

deployment of military units to perform operations in aid of an emergency. This is a wide variety of enforcement options, but part of this breadth is arguably intentional because it provides an executive with discretion to use the means they deem necessary to accomplish their goals.

These powers typically enable the infringement of civil, political, social, and economic rights or liberties otherwise protected by law, in order to respond to a threat. This typically lasts for the duration of the emergency, is authorized for a particular set of representatives of the executive or legislative bodies of a state and is overseen by judiciaries for appeals and contests of certain powers. The paradigm of the kind of powers in use is quarantine, in which a person's freedom of movement is curtailed because they are suspected of being exposed to an infectious disease.[12] While quarantine of humans might be used in nonemergent scenarios as well, it is typically found in emergencies as a loosening of traditional powers of healthcare institutions and government. Where quarantine differs from isolation in healthcare facilities is that isolation is the confinement of someone who is already sick and thus clearly poses a danger to themselves and others; where it differs from prison is that people under quarantine are not charged or guilty of a crime.[13] Emergency powers provide a mechanism for this otherwise impermissible or at least highly restricted use of state power in a public health emergency, though hopefully not one that is unlimited.

Second, a declaration of emergency allows the mobilization of resources to respond to a threat. Resource requests may be freed from budget constraints brought about by typical governance processes. Existing resources may be reallocated from other projects by the executive or its representative, such as a public health commissioner or chief medical officer. And an emergency may authorize the deployment or requisition of specific emergency supplies that are set aside for such an event.

Finally, public health emergencies may trigger changes in the regulatory powers used by the state to govern the practice of medicine or other essential fields, to allow them to operate in ways they might not otherwise in aid of an emergency response. A public health emergency may justify, for example, loosening existing regulatory requirements that are otherwise in place to ensure public safety, such as allowing emergency authorizations of therapeutics or vaccines. We might also see looser privacy regulations to increase the speed and breadth of health information sharing in order to mobilize contact tracing and other interventions.

Just Cause

What an emergency is, and does, connects us to the moral basis of a public health emergency. An appropriately designed public health state is robust, and has strong, rights-preserving obligations to prevent public health emergencies from arising. What an emergency declaration allows is for the state to disrupt that order temporarily to protect the community. That kind of disruption, however, has to be for the right reason. In war, this reason is the just cause.

Previously, I provided a list that tracked the correspondence between the orthodox view of public health ethics and just war theory. Below, table 6.1 has been updated to reflect the work of the previous three chapters in establishing a last resort and legitimate authority as important features of a securitized public health ethics. I established the impersonal account of threat and connected it to the principle of last resort. The communicable disease threat posed by individual humans does not motivate strong defensive permissions, and thus should play little role in the acts of the public health state in responding to communicable diseases. We can thus, I argued, consider the public as similar to noncombatants under the war analogy. Their rights against interference are not waived in virtue of the risk they pose to others, and this provides a strong claim against others to refrain from using coercive or other harmful means to prosecute a response to a public health crisis. Critically, because of the magnitude of the harms and deprivations

Table 6.1
Correspondence between just war theory and public health ethics (update 1)

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

public health emergencies can inflict on the public, the state has an obligation to ensure that the conditions that led to public health emergencies are addressed, such that a public health emergency response arose as a last resort.

I then identified the basis of the state as the ultimate provider for the public's health, based on a thin account of moral consensus in which self-interested actors could plausibly bargain with a state that supported a robust public health apparatus not just for protection against health emergencies, but the protection of a robust range of public health functions. This state, I claimed, supported the social institution of public health as part of its moral function, and thus possessed the authority to enact public health policy as part of traditional democratic means, and to declare and react to public health crises.

These two principles in military ethics join additional criteria, including just cause and right intention. I think, however, that the latter of these is unnecessary for an account of just health security. Right intention, historically, has been focused on the dispositions of the people going to war: Christians in particular, in early versions of the theory, were expected to refrain from sentiments like lust for revenge and to treat the vanquished with mercy.[14] While it is absolutely possible, as in the case of vilifying minority populations, to act in public health with bad intentions, it seems unlikely that our dispositions matter if we accept the impersonal account of disease. It might reflect something poor about our dispositions for us to hate viruses or fungi, but it does not seem to track the declaration of a public health emergency in the same way as if our enemy were persons. And if we have identified persons as our threat, we have likely erred not simply in right intention, but in the last resort, legitimate authority and just cause.

This, then, brings us to the just cause for a public health emergency. A just cause arises in which

> *Just cause*: the just cause for a public health emergency is to respond to a threat to the public's health that threatens mass harm or community stability, is exigent, and is overwhelming.

Not all health crises are necessarily public health emergencies, and some might be prosecuted for the wrong reasons. Take the Ebola virus disease outbreak of 2014. In Connecticut, Governor Malloy issued a "cautionary" public health emergency declaration on October 16, 2014, which remained in place until April 1, 2016.[15] During that time, individuals were quarantined independent of their exposure to EVD, including individuals returning from

the African continent who had never been near an affected region.[16] While right intention would be difficult to determine for a governor's office, on its face the declaration was made in a state that had never experienced a case of Ebola, had a healthcare system more than capable of responding to a single or even a handful of cases, and a functioning public health department for a disease that was only transmissible when a patient was showing symptoms. Given the CDC's orders at the time—which recommended only screening and ongoing temperature checks for individuals returning from areas with known cases of Ebola virus disease—there was no reason to declare a public health emergency. There was simply no threat, relevantly defined, to the area in question. Ebola virus disease may have been, in an immediate sense, a public health emergency satisfying just cause in Western Africa—but not in Connecticut, or Australia, or the United Kingdom, where the threat did not exist.

Note, however, that a different kind of declaration might have been permissible. Sometimes scholars of war refer to "defense of another" as just cause. Here, the declaration of war by a state is not to protect itself, but to protect an ally. It may be permissible, as long as other criteria of just health security are satisfied, to declare a public health emergency in aid of assisting another in responding to an exigent, harmful, overwhelming threat. But note that if this was the kind of declaration the state of Connecticut, or another nation, had made, activities like the one above would need to be justified on defending another nation from the threat—and here the actions taken would have to reflect that cause.

Consider, alternately, the ongoing overdose epidemic in the United States. The states of Massachusetts, Florida, Alaska, Arizona, Virginia, and Maryland, by 2017, had declared public health emergencies in response to this epidemic.[17] In the first case, the declaration of a public health emergency in Massachusetts by Governor Baker served to restrict access to opioid analgesics and redirect funding from other projects to the overdose crisis. Massachusetts attempted to overrule the FDA's approval of a hydrocodone-only pill, which was later struck down for exceeding the state's authority. It also provided some funding for the emergency purchase of naloxone by the state, and for civil commitment of individuals with opioid use disorder.[18]

The overdose epidemic, however, is difficult to justify as a public health emergency on the basis of just cause. It is certainly harmful and might arguably be considered overwhelming. But it is not exigent in the sense that a

justified threat entails, because it is *not one threat*. Housing crises, job crises, mental health crises—all of these are ongoing and have been for decades, not only in the state of Massachusetts but around the United States. The crisis that is the referent of these public health emergency declarations, moreover, is the deaths from overdose associated with opioids. But these "deaths of despair" are not necessarily solvable within the strictures of the—by design—temporary provisions of a public health emergency. A public health emergency that never ends because it is a symptom of a larger political system is not a public health emergency, relevantly defined. The source of the emergency is endogenous and political, not exogenous and emergent. It is almost a public health civil conflict, declared by government against its own failures.

This is not to say we should do nothing about the overdose crisis: just that it is not the right kind of public health issue against which to deploy emergency powers. The use of emergency powers here reflects a lack of political will and due care for fellow citizens. Writing this in Lowell, Massachusetts, less than ten miles from the epicenter of the overdose epidemic in the state, the problems of the Merrimack Valley and surrounds are almost a century old, from the collapse of meaningful work to the lack of attention paid to the northern part of the state for redevelopment and investment, to the fragmented governance of the state. But this is not the kind of crisis for which emergency powers, and the disruption they can cause, are justified.

In some cases, however, there may be structural or local factors that are the appropriate triggers for just cause. This is the health security equivalent of a preemptive war. We could imagine a large, emergent cluster of avian flu infecting a poultry flock that, while normally well cared for in correspondence with appropriate surveillance and animal care, leads to the transmission of the disease through the family that runs the farm. Rapid contact tracing by public health officials identifies the existence of two cases in contacts of the family, but who do not report dealing with poultry in close contact. A trigger here is a novel, highly pathogenic flu strain showing signs of secondary human transmission where it normally only affects individuals in direct contact with animal reservoirs. We might think that preempting this possible pandemic (given what we know about the potential for pandemic strains of flu to spread) is a sufficient, reasonable aim to motivate an emergency, but it is a borderline case and would need to be balanced against other criteria.

Prevention, on the other hand, arises in war when one attacks a potential enemy in order to undermine their ability to one day attack you in

the future. It is widely understood to violate the just cause criterion in war, but that case is more difficult to understand in the context of public health ethics. After all, preventing the causative agent of a communicable disease from causing a disease outbreak appears to be precisely the kind of goal public health should have. But framed in the context of declaring a public health emergency, wariness about prevention makes more sense. This is because prevention in routine public health is considerably different in terms of the kinds of institutional power wielded by the state under a health emergency declaration. It is less about whether prevention is a good or bad thing, and more about whether prevention can ever be a reason to authorize the powers of a public health emergency.

Here, I think there is a robust case to be made against most kinds of prevention using the tools of a public health emergency. This lies at the intersection of just cause and the principle of last resort. If a public health emergency declaration is used on a potential public health issue that has not yet risen to or is imminently approaching the level of threat that would otherwise provide a just cause, then the principle of last resort is very unlikely to have been fulfilled as well. Moreover, even in some rare situation where there may really be no other options available to a state in dealing with a public health issue, it might still not satisfy just cause because the institutional arrangements of the robust public health state will sometimes support the autonomy of nondominated individuals to engage in activities that might increase that public health risk. I have few ideas as to what kind of situation this latter case might entail, but we shouldn't rule out under our contractarian scheme that some potential future public health emergencies, even with a motivated, informed, rationally self-interested population, will be tolerated by that population. A key component of the rights theory that undergirds this contractarian scheme is that while other values can at times override civil, social, political, and economic rights, those rights are at least somewhat insensitive to consequences. The mere possibility that a certain set of acts could lead to a public health threat large enough to motivate a public health emergency is not in itself a reason to declare a public health emergency as a means of prevention.

Proportionality

Proportionality is a critical condition of declaring a public health emergency, and like the declaration of war is part of paired, parallel conditions.

In *ad bellum* considerations in war, this pair takes the form of proportionality and last resort; in *in bello*, proportionality and necessity.[19]

These conditions are paralleled in an account of just health security that takes seriously the role of the public health state. Proportionality and last resort are partly independent. One could imagine a public health emergency where the benefits of intervening through an emergency declaration outweigh the costs, but where the presence of other options violates the last resort condition. Alternatively, an emergency of last resort may conceivably be one in which the benefits of action are disproportionately outweighed by the costs.

At the same time, the last resort condition is related to the proportionality criterion through our decision process. This is because to assess last resort, we need to have a sense of our options and their relative costs and benefits. Not all those potential trade-offs will be permissible under a principle of last resort, but we have to know our options to establish it.

A perennial problem for public health ethics is that the benefits and harms of a public health action are not always indexable against each other, or indexable at all. There is an obvious sense in which we can weigh potential lives lost, or saved, against each other; or life years, adjusted for quality or disability. But these measures may not be able to be compared against rights in a way that is easily computable, such as *X* deaths are sufficient to justify *Y* rights infringements.[20] Likewise, the economic impacts of pandemics and responses are important, and some economic calculations may be especially important in terms of diseases that do not kill but may temporarily or even permanently impair those infected at the cost of productivity in a state—which can, in turn, affect everything from employment to food productivity to health service provision. But it is unlikely that indexing lives against dollars is advisable as the only strategy in thinking about the balance of benefits and harms in declaring a public health emergency.

Likewise, the mainstay proxies for value in public health, such as excess deaths, may be outweighed by other considerations such as the values of community integrity and autonomy. Consider a disease epidemic that threatens indigenous communities. While the morbidity and mortality of tribal members is obviously important, we should be wary if this is only thing that matters to the state. Long-standing norms around tribal sovereignty and a commitment to solving a public health issue, even a very serious one, using the values integral to the community might outweigh even an

increase in lives saved through an emergency regime. This is the case even though in practice I suspect respecting indigenous sovereignty is likely to be the most effective as a public health measure. While tribal nations worldwide have suffered grievously from COVID-19, they have also produced responses to the pandemic that have matched and at times exceeded state and federal responses, and lent credence to claims that their comparatively high death tolls are in the main due to the long-standing injustices they have endured and in which they began the pandemic, and not the quality of their immediate response.[21]

Just war theory includes a separate criterion for a reasonable chance for success. In the context of public health, however, I think this criterion would be better served as a procedural component of proportionality. Assessing the risks and benefits requires not only their magnitude and kind, but the likelihood of certain kinds of benefits/harms coming to pass if we choose to make or refrain from making an emergency declaration. In war, there is a possibility that an invading enemy might be so powerful that resisting them, so long as they are not waging a war of extermination, might be so futile that it may be better to lose one's sovereignty—even if only temporarily—than endure the catastrophe of a war.

But the kinds of crises to which health security responds do not work in quite the same way. It is hard to imagine the following: a disease exigent and harmful to the extent it presents a just cause, a proportionate response, and a last resort; but one for which we have no chance of resisting and should rely solely on the means of conventional public health to respond. I take it that should this occur, it is *because* responding to the disease will be outlandishly harmful to the public. But either that is justified under the proportionality requirement (some kind of "zombie apocalypse" or other existential threat) or it isn't (because it isn't that serious). Viruses don't accept surrender, so the idea that there is a conditional threat in which there is a proportionate capitulation is not on the table like it is in war.

Force Short of (Public Health) War

One obvious objection to the structure provided here is why we *shouldn't* be radically preemptive. After all, in public health of all fields an ounce of prevention beats a pound of cure. Why not defeat the microbial enemy before it even has a chance to reveal itself?

The simple answer to this is grounded in a thoroughgoing appreciation of the doctrine of last resort, and to recanvas the impacts of public health emergencies on the citizenry. Public health emergencies can be devastating, ripping apart families and destroying communities as nonpharmaceutical interventions are deployed to break the transmission of disease; depressing economies for years; placing others at risk through high-stakes healthcare; and destroying the mental and physical health of first responders. It is true that we should do as much as we can to prevent an emergency from arising but utilizing the logic of emergencies to prevent other emergencies is dangerous in its own right. It erodes trust in authorities, and its measures can backfire in the process.

Here too, just war theory can provide guidance. In recent years, just war theory has developed, in response to low-level armed engagements, a theory of *jus ad vim*, or "force short of war." The theory emerged with the fourth edition of Walzer's *Just and Unjust Wars* which, in 2006, attempted to address the war in and occupation of Iraq. Walzer's addition to his canonical account of theory is intended to think through the role of decisive, lethal force in preventing war, though it has in virtue of its applied subject matter caused considerable controversy.[22]

Much of *jus ad vim* is developed along the same lines as *jus in bello*, which as we have seen is broadly homologous with the orthodox view of public health ethics. A critical difference is that *jus ad vim* includes a criterion of last resort, and a unique criterion: probability of de-escalation.[23] Using force short of war, like a drone strike, is a risky affair. The history of the drone war is one in which entire regions of the world have been destabilized and thrown into further conflict as a result of the use of force by America and its allies.[24] While Peter Daszak may have been right in that we do send out the drones in response to terrorism, he is much too cavalier on the wisdom of doing so. We often make things much worse. This is why de-escalation is so important: the purpose of *jus ad vim* is to prevent the horrors of war, not drive nations toward them.

This is the crucial issue in prevention through executive or unrestrained government power in public health. For a public health emergency response to occur outside a formal declaration of emergency, there would have to be a reasonable expectation that our actions would lead us to avoid having to declare a public health emergency in the future. But, because of the connected world of global health governance, we would also have to be

sure that de-escalation was not simply for a particular threat but that it did not compromise our ability to respond to public health threats in future. There's no use borrowing from Peter to pay Paul in public health; stopping one outbreak at the cost of all future outbreaks is not de-escalation in any sense when dealing with the so-called ultimate bioterrorist.

Two cases illustrate this. In the first, failure of de-escalation is proximate. We might think of a jurisdiction whose emergency powers include eminent domain if contaminated structures needed to be destroyed in an emergency.[25] We could imagine a situation in which an environment thought to harbor animals that are vectors for a dangerous pathogen is destroyed. A predictable result of this is the displacement of just those animals, potentially into towns. The public health measure is both preventative because there's no imminent threat, but it is also self-defeating: it drives the carriers of the emerging threat into other locations and makes them harder to deal with in future. There may be ways to slowly remove this threat through other means such as catch and release, selective culling, or even animal vaccination programs.

A longer, more complex issue is the issue of vaccines. A small number of scholars have suggested vaccine mandates as a way to solve vaccine-preventable illnesses, especially with recent spikes in vaccine resistance and denial, and especially during pandemics that threaten to overwhelm health systems.[26] From the quasi-realist health security perspective, there seems to be an in-principle reason to do so: mandating vaccines would give better coverage, and would prevent the onset of pandemic diseases. One way to counter this might be to appeal to the ineffectiveness of mandates in nonsecuritized settings such as childhood vaccinations.[27] Yet a reason why this might fail, even if it were to be found to be effective in preventing the resurgence of a vaccine-preventable disease or an immediate pandemic, is that it would almost certainly undermine pandemic preparedness writ large. Vaccine resistance is driven, in no small part, by broader mistrust of government.[28] Trust is a resource and at times might be spent to gain something else. But there's no need to fetishize trust to see that increasing distrust through vaccine mandates will make it more difficult to secure trust at a later stage and will deplete a scarce resource that might be needed for coercive means during future public health emergencies. Broad vaccine mandates pursued by a public health authority absent just cause and in the absence of a sound public engagement project may seem attractive on their face, but they fail to satisfy basic "peacetime" public health ethics and make public health

emergencies harder to declare and act on. There is a role for mandates, but it is not through the democratic and not through the emergency process.

There may be a role for liberty-limiting measures outside of a public health emergency. They, however, must be consistent with the principle of last resort, and further with a principle of de-escalation that bridges the gap between public health ethics outside an emergency, and within it. The aim must be to pull a community back from a potential crisis, and further not to endanger their future readiness against future emergencies. This is a demanding principle, but it is one that views liberty-limiting measures as part of a broader strategy of securing communities against infectious disease.

Conclusion: Balancing Principles

In this chapter, I described normative principles for the declaration of a public health emergency. This provides a scheme around which future or reformed emergency powers could be designed: a criterion for declaring emergencies and assessing the use of emergency declarations. It also completes our comparison between the classic *ad bellum* tenets of just war theory and resolves some outstanding issues with the orthodox view (table 6.2).

One outstanding issue here is the degree to which all these principles must be fulfilled for an emergency to be just. But merely fulfilling them all is not the end of the story. Recalling the previous chapter, it may be the case

Table 6.2
Correspondence between just war theory and public health ethics (update 2)

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

that declaring an emergency is indeed a last resort, but a last resort borne of some political failing. Here, an emergency may still be unjust. But it is unjust in the sense that an emergency that is a last resort but disproportionately harmful, or was engaged in when other alternatives were plentiful, is not.

A strict consequentialist might say that it is not as bad: it is unclear here whether one thing can be less unjust than another if both are unjust. What can clearly be said is that they are different in that what we ought to do about those injustices will be qualitatively different.[29] Least worst choices in the moment can still, ultimately, be unjust. One particularly critical case is raised by Daniel Schwartz and others in the case of self-defense: responses that are unjust because we fail to adequately prepare for an expected threat in a way that provides us a way out other than our last resort.[30] While a full exploration of Schwartz's work is beyond the scope of this work, if its major conclusion is true, it would make one of the starkest failures of the realist model of modern health security. That is, health security avoids the broader, structural questions of preventing a pandemic that arguably would obviate the need for as many crisis declarations and use of emergency powers, and in doing so leads us into emergency declarations that need not happen.

Some outstanding issues must remain until later chapters. Importantly, detail is needed regarding the end of an emergency. How we reform our institutions to reflect this demanding account, moreover, will remain for the final chapter in which the larger political concerns around securitization must be returned to.

With this in mind, we can now turn to the ethics of liberty-limiting measures. Because this is the most developed part of the orthodox view, I will do less to develop these ideas individually as I have here. Rather, the purpose is to show that military ethics has important insights into how we might permissibly pursue liberty-limiting measures during health emergencies, and what scope of those measures can be justified.

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