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War on All Fronts

A Theory of Health Security Justice

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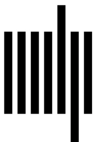

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10 Whose War? Policy and Public Health Politics

The “war on COVID-19” we wanted was mobilization, resources, common goals, political legitimacy, and bold action. The “war on COVID-19” we got was early and transparently false declarations of victory, large numbers of civilian deaths, political suppression, profiteering, and conspiracy, dwindling into defeat. Despite this, I have advocated for a reading of the war metaphor, the analogy between security and health, in fairly close terms. How might we proceed and develop health security—and a series of practices as individuals, groups, nations, and a global community—so that it achieves a set of just ends?

One possibility, obviously, is to abandon the analogy altogether. That, I hope obviously, is not the purpose of this book. Not only is the idea of health as security embedded in our consciousness but it is also consonant with a series of principles that can guide us to just action. As a rhetorical device, the analogy tends to fail. But interpreted as the beginning of a philosophical inquiry, it can be useful.

The theory I have described in this book, as a theory of health security, is demanding. It is based on a position that is ancient, historically grounded, and supported by contemporary moral reasoning. It is demanding, however, because it does not start from a realist position around security and attempt to salvage justice from within that. Rather, it starts from the position of what a just state ought to look like, and then works back from that. Public health is an issue of individual and collective security, but acting on this requires from us a commitment to justice that envisages a robust, rights-respecting public health state; an impersonal account of disease; and commitment to just, brief, and limited emergency acts in those cases where we are threatened, despite our best efforts, by communicable disease, natural disaster, or biological war.

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As a philosophical position, it is my hope that this first entry will prompt discussion—there are additional controversies to be explored, the limits of my account to be tested, and so on. My experience with practitioners in the field is that they are practical to a fault: they will pose the question "so what?" This chapter is a reply to them, and it is about health security itself, and what we might do to bring about a just health security. In philosophical parlance, this is a chapter about a kind of non-ideal theory: how we get from where we are today, to where we ought to be. Though my colleagues in philosophy and my colleagues in health security are more or less disjunctive groups, this conclusion, as a reflection, should be applicable for both.

The Poison of Naive Neutrality

Just health security is morally demanding, but it is deliberately morally thin. I described this in chapter 5. As we have seen over the last two years, health security can be apolitical to the point of cruelty: a form of naive neutrality that sees the instrumental value of staying "in the room"—where those rooms are usually rich or powerful spaces in national capitals—as more important than mobilizing political power and running the risk of being shut out of the discussion, even if only temporarily.

By "naive neutrality," I reference "liberal neutrality," a foundational element of political liberalism: governments ought to maintain an attitude of neutrality toward the many conceptions of the good life that are held by the members of society. Health security as it stands has a form of neutrality, but one that is not truly neutral over the potential range of what constitutes the good life. Rather, it is neutral over the political terrain of the current world—which is, itself, far from neutral about substantive ideals of morality. This makes it risk averse over a range of issues that might be construed as partisan within contemporary politics. There is a reason, for example, why in the US health security's position on medical countermeasures is reflected better in the FDA's Animal Rule that allows emergency use of pharmaceuticals without human testing, than in pharmaceutical benefit access to guarantee essential medicines in the US are free at the point of sale to citizens. It is why the dismantling of *Roe v. Wade,* which will almost certainly result in worse maternal outcomes and a loss of essential healthcare facilities that cater to poor women, has not been taken up by the community. There is, fundamentally, a reason why global health security reform "lessons learned" documents often include the need for improved

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surveillance networks, but rarely universal access to healthcare. There is a reason why health security usually cares more about terrorists securing Ebola than about the lasting disability that results from infectious disease.

As I outlined in chapter 2, this isn't itself surprising. Health security as a discipline is more firmly associated with national security than it is with public health, despite the increasing number of members in the community with backgrounds in public health. It is more at home with the US Department of Defense, in some ways, than with the Department of Health and Human Services. And even when it is affiliated with the latter, it is almost certainly through the National Institutes of Health, which, according to Stobbe, through the 1960s and 1970s was an accomplice in dismantling the power of the US public health service through the surgeon general;[1] or with the American Medical Association, which has itself been an enemy of public health and long opposed substantive reforms in public health and healthcare access.[2] Health security has a fractured identity not just because it is interdisciplinary, but because its practitioners have wildly divergent priorities.

What it means is that the politics in the field have been largely tailored to supporting the status quo, even when that status quo runs counter to the aim of health security itself—preventing pandemics. This is the kind of neutrality I call naive because it takes the political world as it is, as simply the background truth on which health security rests. But the weight of history means that this neutrality is really a form of conservatism. In the US it is true this conservativism is bipartisan in a sense, but that does not fulfill the demands of liberal neutrality, much less the demands of a just health security. Elsewhere in the world, this pattern is mirrored, and health security largely serves prevailing normative trends in society, rather than interact with and, at times, challenge them.

So, what should the findings of this book entail, given the state of the field? I think that depends on how seriously we take the philosophical commitments of just health security, and how closely we tack to this naive neutrality. In what follows, I present three vignettes, each corresponding to a different view of how practical action according to just health security might evolve.

Health Hawks, War Doves

One possible story we could tell that comes out of this is that just health security is taken up robustly by the health security community, or at least a

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segment of it. Even if practitioners disagree with the details of my account (such as, for example, the epidemiological details of when and where we should declare a public health emergency), they buy into the central premise: that public health is an issue of national security; that this conception of national security is grounded in a vision of a legitimate state that serves the interests of its citizens; and that it takes those citizens' rights as paramount in setting priorities and pursuing public health goals. What comes next is health security that is hawkish on the status of public health in society, but considerably more pacifistic in terms of its national security aspects. Let's call this "health hawks, war doves."

Such a view of health security would see the protection of human welfare as rooted in the institutions of the state, and that health security is best promoted through diverse avenues. It would take, for example, the idea that labor rights are in fact a health security issue, remarking that paid time-off laws have been demonstrated to prevent the spread of infectious disease, and guaranteeing them with the force of law would design a certain number of stay-at-home days in the event of the need for a public health emergency into the basic structure of our institutions. They would advocate for national policies that ensure—if not basic income—then robust unemployment insurance, noting that the temporary collapse of certain key industries such as tourism is guaranteed in event of a pandemic, because these are industries whose constituent feature is the movement of people. It would view a broad set of measures that increase social distance as grounded in essential functions of the state and seek to establish those arms of the state as part of—to borrow a defense phrase—"preparing the battlespace" against a potential emergency. These features would include the modernization of communications to deal with widespread remote work and telehealth; restructuring of educational services to reduce class sizes and prepare teachers for transitions to and from remote education; alternative working conditions that benefit individuals with disabilities and individuals under quarantine alike; and many more.

Centrally, this kind of health security would start from the perspective of advocating for a robust moral vision of the state that is well financed, well prepared, and coordinated in a way that fits its purpose, rather than merely touting individual policies. In this, it would follow national security, which frequently touts a robust vision of the state geared to responding to external armed threats—doing so is neither unexpected nor undesirable when the continuing stability of the state is on the line. This vision of the public

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health state would promote the claims, already placed by some of my colleagues but in a full-throated and unified way, that access to affordable healthcare is not just a right: it is pandemic preparedness. Responding to climate change is not simply a matter of preserving our environment: it is pandemic preparedness.

Health security practitioners will obviously disagree over the precise contours of which and by how much these statements are true. But critically, and like their national security cousins who disagree on the relative balance of the branches of the armed forces in securing national security, members of the field of health security would take the *existence* of these institutional changes to be fundamental to securing lasting protection from communicable diseases to be uncontroversial. They would not be divided by these differences; and they would not countenance attempts to divide them on these issues.

Moreover, and like their national security cousins, health security hawks of this kind would understand that this cohesion is a political move that advances a shared goal. They would understand that achieving this vision relies on improved bargaining power, and that comes from a unified front that views its mission as partly political. It will not simply describe what it thinks will be the most acceptable vision of health security to those in power, but it will put together what is truly needed to protect the country and then build the political capital to make that happen.

These revisions would mark a sharp change for a wide segment of health security, and in particular the wealthier and more powerful segment of that community. In some nations such as the US, but increasingly Australia and the United Kingdom as well, it would undoubtedly cast health security at least initially in what elements of the political class describe pejoratively as "political" speech, engaging with issues that are subject to partisan conflict. But the choice to avoid those issues is itself a political decision. Revising that decision will create tension, but tension is often necessary to achieve the aims of justice. Either—to use Moehler's terminology—others interact based on mutual interest in long-term cooperation, or they do not. If they do not, things may escalate, but this is a process that politics at times requires.

Beyond this, advocating for stronger international development of global health infrastructure using this approach will take a view to empowering individual countries to govern their own health affairs, and commit to the principle of last resort (as described in chapter 4) by seeking to change the material conditions of public health determinants in a way that respects

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human rights. Improving healthcare capabilities, education, transit, and basic welfare around the world under this framework becomes essential to a lasting peace against the causative agents of disease. Along the way, access to the relevant scientific knowledge and capacities for individual nations to rapidly screen and detect pathogens would follow, in addition to reforms in trade law to rapidly share life sciences developments that aid in the deployment of technologies to prevent, and respond to, pandemic pathogens. Unlike in conventional national security, in which international relationships are strained between friends and foes, alliances in health are in principle much easier because, in keeping with the findings of this book, the real threat is the causative agent of disease itself.

This will sound like, in addition to health security, a militant view of health writ large. Indeed, it is. But it is militant in the way of collectivist movements worldwide that seek to promote democratic engagement and utilize the state as the means to improve both individual welfare and national productivity. These movements have a long history, and while the Cold War was unkind to them within the US and elsewhere, their modern instantiations still exist. They need not be strictly socialist movements, though some of them are. But any framework of health security that takes seriously the idea that securitized health must respect individual rights will necessarily take the view that the best way to secure ongoing stability in public health is to radically reform our institutions. And it will not tolerate a view of health security that takes human rights to be secondary, or easily forfeited.

Business as Usual, with a Twist

Say that a reader takes this first, optimistic account to be too much. There are reasons to do so: after all, there are many people with substantive moral views that will find my account of the public health state to be too expansive, even if I have argued that this expansiveness is instrumentally rational. What might be done if one takes the main thrust of my argument, but thinks that rather than push for the broadest account of reform we should continue to remain in some sense neutral over larger social questions?

In this case, a number of easy lifts exist that I think would do considerable work, which have received some attention but not as much as they deserve. The first is the focus on refinancing local government health departments. The COVID-19 outbreak has made clear that the level of staffing and resources

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in local public health departments has led to a dearth of expertise, energy, and time to deal with a major public health outbreak. It is unlikely that COVID-19 is the minimal amount of stress needed to overwhelm this system; a moderate cluster of another communicable disease is likely to do the same to any single health department and threaten the others. (We may find out, with the emergence of monkeypox in 2022.) Refinancing the health departments of local governments, acting in concert with state organizations, would be an easy first lift. It would also be relatively inexpensive: funding contact tracing and basic IT services to keep records would go a long way to harmonizing public health departments countrywide in nations like the United States. Importantly, in countries like the US, new bills to better prepare for pandemics have not taken this option as central to their asks, though the machinery of government is slow and there is still time for change.[3]

The next would be to invest in scientific research into materials and manufacturing for personal protective equipment, nonpharmaceutical public health interventions, and public health decision-making. These topics have been understudied: to the last of them, Francis Collins, the outgoing director of the National Institutes of Health, in a recent exit interview stated in response to what he might have done differently with his time was to fund more social science research.[4] What COVID-19—and Ebola virus disease, and flu, and Zika—show us is that even the most rapid research into vaccines can be fatally undermined unless suppression measures can be achieved, held, and instituted in the most efficient and least invasive way possible, giving time not just for vaccine discovery but manufacture, distribution, and deployment. The unsung heroes of the current pandemic are the public health researchers conducting careful analysis of the broad and varied social distancing measures applied not only nationally but globally in an attempt to parse their relative effectiveness and cost effectiveness. Adding to this, new materials engineering collaborations to come up with cost effective and reusable masks and gowns, and human factors research to make them easier to don and doff, would provide a basis for masking that reduces the load on the public during crisis points.

The core of these aims is to find the largest bang for the limited bucks we will likely have as this pandemic fades. There is a sense in which this is prudent: crises like this can usher in an appetite for austerity. There is nothing that says this need be the case, and certainly other crises have created the space for broad social changes. But knowing where the most good can

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be done with the smallest amount of effort is a tactic that may be better suited to elements of health security that are for various reasons more risk averse, or lack the knowledge to organize in a way that generates the kind of popular will needed to make broad changes.

The Breakdown

The final option I wish to entertain is what happens if nothing changes. Already, an interminable number of "lessons" have been learned through COVID-19. But these were lessons that arguably should have been learned during H1N1 2009, or SARS, or the Ebola crises of the 1970s and 1980s, or AIDS. The robust changes suggested in the first vignette are hardly different in kind from the demands of the ACT UP movement, albeit framed through a different lens and with the looming and imminent threat of a major climate disaster. Anyone who has spent time working in health security should be moved to tears by the number of lessons we have should have learned but failed to. So, what then?

One troubling thought is that rather than demonstrate the legitimacy of the public health state, the ultimate lesson here is that the current nation-state is by and large incapable of achieving the kinds of institutional goals required of it to secure its own legitimacy. This is most obvious in the US, where I am writing, but it is also likely true in the United Kingdom, potentially in Australia as cases begin to skyrocket there as well, and in many others. Following Moehler's understanding of long-term cooperation, the state—as it is today—might well be run by and for people who do not meet that important fourth criterion of a commitment to long-term cooperation with others. They will deceive, undermine, and even kill those they cannot control. They will allow disabled and poor people to die for their own convenience. And they will mount campaigns to avoid even the most basic changes to a society to prevent the next pandemic—and will do so even if they claim to be working to prevent just that.

If this is true, then a just health security that does not take as its foundation the legitimacy of the state would be needed. The project I have constructed here still has weight: the last resort principle is still applicable because it is grounded primarily in risk, as would be those on liberty-limiting measures. But the architecture of the public health emergency grounded in state declarations would need to be redesigned. I confess I am

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someone who still holds out hope for a legitimate state, but conversations with friends who hold the opposite view over this pandemic have, if not convinced me, then made me much more sympathetic to their views.

Health security built on this foundation would look profoundly different from its current architecture, but it is not implausible or unanticipated. Radical movements of the 1960s such as the Black Panther Party were liberatory movements whose work included, among other things, the coordination of community health. While the most common images of the Black Panthers are men with guns, Alondra Nelson reminds us, in her book *Body and Soul*, of the critical role the Panthers played in promoting public health within their community.[5] The revised ten-point party platform first drafted by Huey Newton and Bobby Seale came to include explicit mention of the promotion of black health, and requirements that each chapter of the party include the provision of free health clinics. This combined with the Panthers' health activism to insert themselves into the politics of clinical research, and in particular the inclusion of black health needs into the national research agenda and pushback against medicalized racism through the burgeoning genetics movement.

Bobby Seale, in describing the Panthers' development of their platform, describes the division between "what we want" and "what we believe," and the connection between these things. Health security, I contend, frequently lists the former, but omits the latter. This can make our asks at best idiosyncratic—why ask for better and more testing if no one can afford it—and at worst misleading about what it is that matters. Grounding our asks in values—no member of society should be left outside the protective umbrella of pandemic preparedness—situates our policy proposals in ways that can draw attention to and bring diverse groups to the table. The Panthers, in particular, believed in community self-defense and in mutual aid and care in the form, among other things, of school lunches and community medical clinic programs. We tend to remember the former but forget the latter; a health security founded on those ideals would be different from what we see today but is not beyond the realm of political imagination.

The principles of those movements could still be drawn from the work of this book. What would change is the locus of authority and its basis to form an institution of public health within an autonomous community. I don't have the space here to investigate what that change would mean, but the principles of last resort, and of discrimination as it is defined here, would

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continue to be vital. This is because communities of this kind would have considerably less power to compel their members and would need to adopt strategies that are strongly rights preserving to maintain themselves. I consider this a benefit of these movements, not a drawback. And if that is what it really takes to protect ourselves against the next pandemic, then so be it.

In communities that have survived COVID-19, this may become an increasingly important move as the dominant message that comes from Washington continues to be "you are on your own." Justin Feldman, in one of the only detailed histories of the Biden COVID-19 response to date, noted that around May 2021, when all adults became eligible for the COVID vaccine, the US response changed.[6] As vaccine rates have increased, even with massive case counts and deaths, other countries have followed suit. I suspect that for the most vulnerable, and including many individuals described in chapter 5, there is a sense in which that legitimacy is already gone. How we utilize our bargaining power to make change is thus an open question.

Future Visions of (Public Health) War and Peace

This book is not about COVID-19, but it is singularly inspired by the emergence of that disease and its global spread. What this book seeks to establish is that determining that health is a security issue is a political act. Far from being an attempt to depoliticize health security or public health, it is in fact the opposite, drawing these fields into a set of normative questions that desperately require answering, and are as fundamental as the nature of the state. I have answered them and suggested that a thoroughgoing reading of the ethics of armed conflict tells us something quite different than we might expect from popular depictions of the way security and war are used as metaphors in public health. The ethics of war teaches us that lasting peace is the goal, and that war is at best a tragedy but usually a crime. A contingent pacifist interpretation of health security establishes that human rights and public health are rarely at odds, and that achieving the latter necessarily requires establishing the former.

This provides a series of visions for the future of public health. It is my hope that this book provides an account people will take seriously and operates in good faith in providing a critique of the dominant analysis of health

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security to date. What comes after is strongly determined by our political will. In the middle of a crisis, it is often hard to see what that might be once we have the space to do anything but survive. Yet it is crucial that we begin discussing what the world should look like when we have counted up the dead. I do not believe for a moment that the world can, or should, go back to normal. Normal is what got us here. The future demands more of us.

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