Pondering The Next Pandemic: Liberty, Justice, and Democracy in the COVID-19 Pandemic

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(Forthcoming in *Pandemic Ethics*, eds. Julian Savulescu and Dominic Wilkinson, Oxford: Oxford University Press.)

ABSTRACT

The contributions in this collection discuss some of the fundamental debates that emerged during the pandemic. Our aim is to reflect on some of these contributions, offer our own perspective on several debates they engage in, and identify areas that will benefit from further attention by both scholars and policy makers. We focus on two broad issues: personal liberty and global justice. Regarding the former, we take a more sympathetic view of liberty-restricting measures than some of the authors do. We also evaluate the proposal of using selective liberty-restricting measures and encourage a distinction between different kinds of freedom when balancing liberty protection and harm reduction. Regarding global justice, we propose a human-rights framework as a possible alternative or supplement to a duty-of-easy-rescue framework. We end by mentioning some areas not much discussed in the current collection and which should, we believe, engage future theoretical thinking about pandemics ethics: the challenge to democracy posed by public health crises, public-health governance, and the interests of children.

Keywords: equality; global justice; harm prevention; human rights; liberty; selective restrictions, pandemic preparedness, children.

Introduction

Policy decisions taken during the COVID-19 pandemic have engaged difficult ethical questions. These decisions have proved to be challenging to implement as well as politically polarizing. The contributions in this collection address many of these questions, though not in one voice. They take different sides on some of the fundamental debates in the pandemic. One of the questions that arises from reading such a wide variety of views is how to move forward in the face of lingering and fundamental social and philosophical disagreements. Our aim in this chapter is to reflect on the contributions made to this collection, offer our own perspective on some of the debates they engage in, and identify some areas that will benefit from further attention by both scholars and policy makers.

The chapter is divided into three parts. The first concerns state interference with individual liberty in response to COVID-19. The second discusses global justice challenges in the context of responding to the pandemic. In the third part, we consider several issues that, though not much discussed in this volume, are important to pandemic preparedness, going forward.

1. Liberty-Restricting Measures

1.1 The debate

In response to COVID-19, governments as well as private organizations issued various mandates and prohibitions, such as lockdowns, social distancing requirements, restrictions on gatherings,

vaccine mandates, mask-wearing mandates, travel restrictions, border closures, mandates on factories to produce medical equipment, restrictions on the exportation of medical resources, and various restrictive regulations on businesses such as bars and restaurants.

These restrictions were undertaken as effective public health policies. However, they also interfere with people's freedom. These interferences deprive citizens of the intrinsic value of freedom, and cause other harms, such as losses of income and education and other constitutive elements of well-being. How should we evaluate liberty-restricting measures in a time of a pandemic?

As an example of analysis of liberty-restricting measures, Kamm defends what might be regarded as the mainstream position in public health ethics, that liberty-restricting measures are often morally justified during a pandemic.[1] Kamm's preferred justification (and the one she recommends public health officials communicate to the public) is that some liberty-restricting measures prevent individuals from harming others. Kamm considers three significant risks of harm that individuals may pose to others if they do not wear masks, get vaccinated, or follow social distancing practices: 1) infecting others; 2) being a "host" for a virus to mutate, and 3) depleting health resources and overcrowding hospitals.[2]

According to Kamm, the risks individuals pose to others in terms of these harms justify certain restrictions on liberty. Since even libertarians recognize a duty to avoid harming others,

[1] Frances M. Kamm, 'Handling Future Pandemics: Harming, Not Aiding, and Liberty', in this volume.

[2] Kamm, as we understand her, does not intend the list to be exhaustive. We could mention other harms that individuals who do not take certain measures may pose to others, such as harms to the well-being of healthcare workers in overcrowded hospitals. See, for example, Galanis, P. *et* (2021) and Pappa, S. *et al.* (2020).

Kamm argues that they should recognize the moral legitimacy of certain restrictions on liberty. This point is valid whether we think of posing a risk of harm as itself a kind of harm or whether we simply wish to reduce the probability of the occurrence of harm. A useful analogy in this respect is that of a neighbor shooting a rifle in their backyard.[3] It seems permissible, even from a libertarian perspective, to require the neighbor to stop. There can be no certainty that the neighbor's action will result in anyone being shot; yet restricting the neighbor's conduct is justified because there is a plausible risk of this happening if the neighbor persists in shooting a rifle in their backyard.

Other authors, however, are more hesitant. While no author in this collection categorically objects to liberty-restricting measures, several authors argue we should employ them less widely than has been done in the US and other countries during the COVID-19 pandemic. Blumenathal-Barby and Flanigan, for example, point out that we tolerate, as a society, many behaviors that have some non-negligible probability of seriously harming others, such as driving automobiles or drinking alcohol. Assuming that this level of toleration is justified, shouldn't we take a similar stance in tolerating behaviors that risk harming others during a pandemic? This question becomes more pressing once vaccines are widely available and individuals can take substantial steps to protect themselves from the more serious harms of being infected.

These disagreements notwithstanding, there is an element of philosophical agreement threading through this volume. Both sides appear to accept something like what has come to be called Mill's harm principle: it is sometimes justifiable to restrict freedom to prevent an

[3] For this analogy, see the papers by Jennifer Blumenthal-Barby ('Bringing Nuance to Autonomy-Based Considerations in Vaccine Mandate Debates') and Jessica Flanigan ('Prohibition and Pandemic') in this collection.

agent from harming or posing a risk of harm to others. This broad agreement can be utilized in a conciliatory spirit in an attempt to devise policies in which both sides of the debate are asked to make some concessions. These policies will aim to give public expression to the shared idea that both harm-reduction and freedom-protection are important guiding values for public health decision making. We will discuss two broad philosophical approaches for devising such policies, one suggested by several authors in this collection, and another not discussed in this volume and that we believe deserves further scholarly attention.

1.2. Selective Restrictions

The first approach is to introduce selective liberty-limiting policies, for example, lockdowns for only older persons, as suggested by Savulescu,[4] or denying the unvaccinated access to public spaces, as suggested by Persad and Emanuel.[5] By restricting the liberties of only a subset of the population, selective policies sacrifice some freedom for the prevention of some significant harm and sacrifice some harm-reduction for more freedom-protection.

Liberty restriction for harm prevention or reduction can be justified on paternalistic or non-paternalistic grounds. Society may wish to restrict citizens' liberty at least in part for their own good, but there are non-paternalistic justifications, as well. Kamm's argument is a case in point, as it centers on preventing individuals from harming others. The justification of selective restrictions may be paternalistic if it is intended to secure the health of older people or the unvaccinated. However, when defending selective restrictions, Savulescu as well as Persad and

[4] See Julian Savulescu, 'Selective Restriction of Liberty in a Pandemic', in this volume.
[5] See Govind Persad and Ezekiel Emanuel, 'Against Procrustean Public Health: Two Vignettes', in this volume.

Emanuel do not compare them with a policy of no restrictions, but with a policy of universal restrictions, that is, restrictions applying to the great majority of society. When this is the comparison under discussion, paternalistic reasons cannot be invoked in favor of selective restrictions, since universal restrictions and selective restrictions would have similar health benefits for those whose liberty is restricted. What has to be assessed, then, is the non-paternalistic merit of these proposals.

In the case of older persons, a non-paternalistic defense of selective restrictions rests on the disproportionate impact COVID-19 illness has in this population on health care capacity and health care staff, and on the possibility of improving societal functioning more generally for the rest of the population without causing much more harm. In the case of unvaccinated individuals, this sort of justification could be motivated if they pose greater risks of infecting others or of overcrowding hospitals compared to vaccinated individuals. Compared with universal restrictions, selective restrictions offer much more freedom and minimal increases in harm, and so offer a better balance of freedom-protection and harm-reduction. However, many of the benefits of these restrictions will redound to people other than those whose freedom will be restricted. If we wish to respect the *separateness* of persons, this feature of selective preferences makes their justification difficult. Nonetheless, large enough benefits to society could possibly justify these selective measures, and Savulescu, as well as Persad and Emanuel, may be correct in taking the potential benefits of these measures to outweigh this kind of moral concern.

The separateness of persons, however, is not the only relevant ethical concern here. By definition, selective restrictions apply only to a particular subset of society, and thus appear to

raise egalitarian concerns. However, Savulescu, as well as Persad and Emanuel, argue that selective restrictions raise no serious egalitarian concerns, as there are morally relevant differences between the groups whose liberty would be restricted and other groups.

We are skeptical that there is a morally relevant difference between the elderly and the young that could dispel egalitarian worries about selective restrictions. In the case of the unvaccinated, the idea that selective restrictions do not violate an important precept of equality seems more plausible. Let us elaborate on these claims.

Liberals want people to have as much freedom as possible, consistent with certain constraints. They differ with regards to how these constraints should be specified. In Mill's case, people should have as much of certain freedoms as possible consistent with not harming others. Rawls (1971: 60), however, argues that people should have the most extensive basic liberty that is consistent with others having equal basic liberty.[6] Rawls's view implies an *egalitarian constraint* on the goal of providing people with as much basic liberty as possible. Any quarantine would restrict a basic liberty (assuming freedom of movement is a basic liberty), but a universal quarantine would equally restrict everyone's basic liberty and so would not violate the egalitarian constraint. In contrast, a selective lockdown for the elderly would restrict a basic liberty (freedom of movement) of some people but not others, and would thus violate the egalitarian constraint.

Perhaps an egalitarian *constraint* is too extreme. However, we think that at the very least there should be a strong *presumption* in favor of an equal distribution of basic liberties. If so,

[6] Note that even when applied narrowly to basic liberties, Rawls's point may be relevant to various liberty-restricting measures enacted during the pandemic as well as certain selective liberty-restricting measures (such as selective lockdowns) that may be up for consideration.

while a morally relevant difference could in principle justify the unequal distribution of even basic liberties, the threshold for what counts as a morally relevant difference should be quite high. It is against such a high threshold that we must assess the claim that there is a morally relevant difference between the elderly and the young, and it is in relation to a high threshold of justification that we are skeptical about the existence of a morally relevant difference between the elderly and the young that is significant enough to justify selective restrictions of the elderly.[7]

There is another egalitarian concern that is applicable to selective restrictions. To bring this concern into view, it is worthwhile to bring to mind the different ways in which the value of equality can be violated in selective and universal restrictions. Regarding universal restrictions, Nakazawa and Akabayashi point out that universal physical distancing policies in Japan disproportionately harm older people and foreigners.[8] Subramanian describes the special harms that universal lockdowns cause to women, people belonging to lower castes, and

[7] Advocates of selective restrictions may reject this egalitarian constraint or presumption for various reasons. For example, like other egalitarian principles, an egalitarian constraint or presumption would be vulnerable to the famous levelling-down argument (Savulescu and Cameron 2020). However, the levelling-down argument may not be generally decisive against egalitarian principles (Temkin 2002). Furthermore, selective restrictions may not be Pareto superior to universal restrictions. When everyone is in mandatory lockdown, restaurants, theaters, libraries and resorts are also closed down. There is, generally, less to do outside. The point of selective restrictions is precisely to allow all such activities to resume. But then the burden (or the alternative cost) on the select groups being forced to stay at home also arguably increases. Finally, if we replace an egalitarian constraint with a strong egalitarian presumption, we can resist leveling down by arguing that it defeats the relevant presumption.

[8] See Eisuke Nakazawa and Akira Akabayashi, "Public health ethical and human rights considerations with regard to physical distancing during the 2019 coronavirus pandemic", in this volume.

Muslims in India.[9] Dias and Oliveira offer similar observations about Brazil.[10] Indeed, a universal lockdown does not affect everyone equally, giving rise to a concern about disproportionate impact. Selective mandates, however, raise a set of egalitarian concerns in addition to disproportionate impact: unequal treatment by the state and inequality before the law. This should not be taken lightly. We need to be quite certain, then, that the difference we identify between groups is morally significant enough to dispel this egalitarian concern as well.

Older and younger persons clearly differ on various health-related measures, which explain why selective restrictions would be effective. Effectiveness, however, does not guarantee that the health-related differences are also morally relevant in the sense that they can dispel egalitarian concerns about selective restrictions. While effectiveness rationalizes a policy, it may not justify it morally.

This is not to deny that for some decisions, health-related differences are morally relevant. However, we need to be careful not to take a difference that is morally relevant in one context (and, in that context, this difference dispels egalitarian concerns) and use it to justify unequal treatment in a different context, one for which the difference in question has less justificatory power. For example, the risks of becoming seriously ill and of dying increase exponentially after about age 60, and are most dramatic in those in their 70s, 80s and 90s. For *distributive* purposes, this health-related difference is a reasonable basis for prioritizing older people in vaccination programs when supplies are constrained.[11] Prioritizing older people to receive

[9] S. Subramanian, 'COVID-19: An Unequal and Disequalizing Pandemic', in this volume.
[10] Maria Clara Dias and Fabio A.G. Oliveira, 'Pandemic and structural comorbidity: Lasting social injustices', in this volume.
[11] As has been done in many countries. See Beaumont (2020).

vaccines also follows the ethical maxim of protecting the vulnerable (Goodin 1985). But it is more difficult to see how health-related differences between older and younger people could justify restricting basic liberties of some people but not others or violating some people's equality before the law.

One could argue that there is a reciprocity argument for a selective restriction: it is fair for those who benefit from a policy to be those who bear the burdens of the policy. The argument would be that it is unfair to burden younger people for the sake of older people, since younger people do not benefit as much as older people from a restriction.[12] But in a universal restriction, younger people are not asked to restrict their liberty for the sake of older people. Rather, they are asked to restrict their liberty for the sake of equal distribution of basic liberties. Note also that the relevant comparison is between selective restriction and a universal restriction, and older people do not benefit from a selective restriction more than they would benefit from a universal restriction. Indeed, a selective restriction may be worse for older people. Restrictions on movement bring about harms of loneliness and isolation, which may be worse under a selective restriction. Since there is not added benefit to older people in a selective restriction, they should not be asked to carry its burden.

It may be argued that the elderly *need* certain freedoms less than younger people do, such as freedoms related to attending work and school. But these claims should be made with care, for the freedom of movement (which may be necessary for the young to work and to study) may also be necessary for the elderly to experience less social isolation and loneliness, and in

[12] We thank Dominic Wilkinson for helpful comments on this section.

these respects the elderly may even need these freedoms *more*.[13] It is questionable, then, whether the differences that exist between the elderly and the young are sufficient to remove egalitarian concerns about placing legal restrictions on the basic liberties of one group that are not placed on the other.

The most compelling argument for a selective restriction would focus on the worry that older people, but not younger people, risk overwhelming health systems. But there are two ways to approach this difference. One is to count the special risk older people pose as part of a consequentialist calculation that could *override* the requirement to distribute liberties equally. Another is to regard the difference as morally relevant, so that there would be no requirement, in this case, to distribute basic liberties equally. We believe that the former approach is appropriate. For a fundamental liberty, what counts as a morally relevant difference should not be contingent and context dependent. Suppose that country A and country B have the same proportion of young and old people, but country A has many more hospitals per capita, so it does not run a risk of its hospitals being overwhelmed. It would be odd to suggest that in country B there is a morally relevant difference between the young and the old in virtue of which they do not deserve the same basic liberties, but in country A there is no such difference.

To be clear, we do not wish to deny that restrictions imposed selectively on older people could be justified. But we need to be confident that the benefits to younger people and to society overall would be big enough to justify such restrictions. In calculating these benefits, we should also count the fact that older people, but not younger people, are likely to overwhelm

[13] For the effects of social isolation on older people in Japan, see the contribution of Nakazawa and Akabayashi.

hospitals. But even if there is a strong consequentialist argument in favor of selective restrictions, valid egalitarian concerns regarding such policies are likely to persist.[14] When assessing reasons for and against selective restrictions on the elderly, equality should weigh against them.

The case of selective restrictions for the unvaccinated is somewhat different, especially where vaccines are widely available and individuals who are unvaccinated exercise a choice. Unequal choices have been regarded by several egalitarians as a morally significant difference that justifies inequality.[15] And arguably, one central function of law is to incentivize behavior by imposing burdens and conferring benefits on individuals who act or do not act in certain ways. Imposing sanctions that limit the liberty of those who do not abide by a certain policy is not typically seen as a violation of the ideal of equal treatment under the law. Indeed, we can regard a selective restriction on the unvaccinated not as a selective restriction at all, but as a universal conditional restriction, which says "if you get vaccinated, you will enjoy certain liberties that otherwise you would not." The conditional form is apt here because it is in a person's power to make its antecedent true. The same cannot be said of the elderly and the young. If a state justifies a selective restriction by saying, "if you are young, you will enjoy certain liberties that otherwise you would not," the universality of this conditional formulation would ring hollow, because there is nothing an older person can do to be young. In justifying selective restrictions for the unvaccinated, then, perhaps we do not need to point to any morally-relevant health-related, need-related or even choice-related difference between them

[14] The case for selective restrictions can be further strengthened if they also help society protect other vulnerable populations (for example, by allowing the opening of schools).
[15] See Arneson (1989), Cohen (1989), and Dworkin (1981).

and the vaccinated. Even if unvaccinated people do not infect others at higher rates than vaccinated people, selective restrictions could be justified in their case if a state is justified in using public policy to encourage vaccination at the population level.[16]

To sum up, selective restrictions offer one approach to aligning freedom-protection and harm prevention and reduction. They do so by distinguishing between *groups of people*, protecting certain freedoms for some while denying these freedoms to others. Our concern about this approach, at least when applied to some groups, is that it may not protect freedom in the *right way*, one that accepts an egalitarian presumption if not constraint, or a sufficiently robust ideal of equality before the law. There is, however, another approach, not explored in this collection: rather than distinguishing groups of people, we can distinguish between different kinds of freedom.

1.3 Different Freedoms

There is a common tendency in public debates to suppose that one should have some general view about liberty-restricting measures. An implication is that one must take a side: either be pro-mandates or anti-mandates. But if something like Mill's harm principle is appealed to as a shared normative commitment, a more nuanced approach is called for. Powers, Faden and Saghai (2012), for example, reject the view that liberties of all kinds should enjoy an equal

[16] Another issue could be relevant here. Allen (2022: 89) argues that we need a response to the pandemic that fosters a sense of social solidarity. Burdening the elderly may be counterproductive in this respect, but burdening the unvaccinated may be supported. An argument can be made that people who *refuse* to get vaccinated fail to show the kind of solidarity we expect of citizens at a time of crisis, and that society is justified in asking them to bear the burdens of the failure to show this kind of solidarity.

presumption in their favor in the formulation of public policies. They argue for an interpretation of Mill that emphasizes a distinction between three kinds of liberty interests: interests that are immune from state interference, interests that enjoy a presumption in favor of liberty, and interests that enjoy no such presumption.

The core insight for public health policy is that all liberties are not on a moral par and thus that the degree of justification required to support restrictive interventions turns not only on considerations of harm to others but also on the moral importance of the specific kind of liberty at issue. Lockdowns, vaccine mandates and mask-wearing mandates affect liberties of varying importance and should not be lumped together when thinking about the state's legitimacy to interfere. Thus, one may consistently object to lockdowns while supporting mask-wearing mandates. One can also object to lockdowns under certain risks of harm while allowing them under more serious risks of harm. What we need is a careful investigation of particular liberty-restricting measures and their expected harm-reducing effects. Disagreements will surely arise here too, but such inquiry may result in nuanced policies that restrict certain freedoms but not others, in certain circumstances but not others. These policies will have the virtue of being a compromise between extremes. If adopted, we would be asked to tolerate more harm and risk than some people might find acceptable, but less freedom than others think must be protected.

Note that this general proposal is not a version of weak paternalism. A weakly paternalistic justification of vaccine mandates could proceed from arguing that the choice to not get vaccinated is based on misinformation and so frustrates the agent's own ends. Blumenthal-Barby argues convincingly against such weakly paternalistic defenses of vaccine mandates (and other mandates). As a society, she points out, we often respect individual choices that are

based on misinformation. Furthermore, some people refuse vaccination, say, for deep personal convictions. The proposal we outline here does not question people's decision-making processes, but rather distinguishes between different kinds of freedom. It concerns what is chosen, not how it is chosen. The idea is that the freedom to not wear a mask, even if some people take it very seriously, is a less important freedom than freedom of movement, even if some people do not attribute much importance to it.

That all freedoms are not on a moral par may already be presupposed in judgments people make about liberty-restricting measures.[17] The idea that a mask mandate and a lockdown violate freedoms of different importance may seem obvious, yet one hears little about it in public discussions, or, for that matter, in this collection of papers. Philosophers and bioethicists can contribute to public debates by offering a principled way of thinking about such distinctions, by encouraging their use in public decision-making, and by encouraging their use in communication between public-health officials and the public.

In sum, moving forward in the face of disagreement may require some compromise. One option is to proceed with selective restrictions, as some authors propose. Another option is to assess the moral importance of different kinds of freedoms, as we propose. There may be other ways to construe the right balance between freedom-protection and harm prevention and reduction. The right balance may require seeking concessions from people who tend to support liberty-restricting measures and people who tend to object to them. Such compromise is justified not only because of its consensus-building potential, but also because it takes both

[17] One could argue, for example, that closing places of worship infringes on a more fundamental freedom compared with closing bars (say), and so requires a higher threshold of justification in terms of preventing harm to others.

freedom-protection and harm-prevention seriously. Ethically, that appears to be the right thing to do.

1.4 Taking Harm-Prevention Seriously

At least two obstacles can derail us from striking the right balance between freedom-protection and harm prevention and reduction. One is a misguided understanding of each of the values at stake. As mentioned, a correct understanding of the value of freedom-protection may require some egalitarian constraint on the goal of offering people as much freedom as possible. This constraint may be integral to the value of freedom that we seek to promote, such that violations of it that increase aggregate freedom should not count as improvement in terms of freedom. The second is a failure to take one of these values seriously enough. It is our impression that some objections to liberty-restricting measures included in this collection do not take harm prevention and reduction seriously enough or do not have a rich enough understanding of the ethical requirement to prevent harm.

Flanigan, for example, objects to liberty restrictions partly because they are politically polarizing and because they erode public trust in institutions. Her claim requires more empirical substantiation, for it may well be the case that failure to enforce restrictions early on in a pandemic would cause great harm and would also erode trust in institutions. However, we would like to highlight a normative point made by Flanigan. She argues that authorities failed the public in different ways during the early days of the pandemic, so they lost the *standing* to issue coercive mandates later on. Flanigan argues that the tension between harm-prevention

and freedom-protection should be resolved in favor of freedom-protection because there is no one who may legitimately restrict the relevant freedoms.

We agree with Flanigan that a catastrophic, careless or persistent failure to secure public-health goods would erode the legitimacy of public-health authorities. However, provided past failures were made in good faith and were reasonable at the time, we do not think that such failures alone are sufficient to undermine the legitimate authority of public-health institutions. Moreover, although global and national public health authorities made numerous mistakes in their pandemic policy responses, any judgments about the implications of these mistakes for the legitimacy of these authorities during the course of the emergency must take account of the pressures to operate quickly in a rapidly evolving, ominous pandemic of a novel pathogen characterized by uncertainty. This does not mean that these authorities should not be held accountable for their failures, or that it is not critically important to understand how and why things went wrong in preparing for the next pandemic. Our point is simply that we find the inference from the recognition that failures occurred to lack of present authority to be too harsh. In saying this we do not mean to imply that harm-prevention is more important than freedom-protection. Rather, we reject tilting policies too much in the freedom-protecting direction based on these kinds of considerations.

Flanigan allows liberty-restricting measures only where there is clear evidence that a less restrictive measure will not be effective in preventing serious harm. The problem, again, is that we often lack the relevant evidence and may have to make decisions in the face of uncertainty. In such cases, Flanigan advocates for a presumption of protecting rather than restricting liberty. This approach, we think, also fails to take harm-prevention seriously enough. In the face of

uncertainty, it may sometimes be extremely risky to *not* employ liberty-restriction on a wide scale early on. In the case of COVID-19, it may have been sensible to begin with more restrictive measures even in the absence of solid evidence to the effect that no other measure would be less effective, and gradually loosen restrictions while continuing to monitor spikes in morbidity and mortality, health system functioning and so on. Again, in saying this we do not prefer harm-prevention to freedom-protection. Rather, we take it to be a more reasonable balance between harm-prevention and freedom-protection under conditions of considerable uncertainty about both the magnitude and nature of the pandemic's harms and the likelihood that liberty-limiting interventions will contain these harms.

Flanigan and Blumenthal-Barby also argue that many liberty-restricting measures used during the pandemic are more like prohibiting a sober driver from driving than prohibiting a drunk driver from driving. In other words, the restrictions were excessive and society should have tolerated a greater level of risk to protect certain freedoms. In support of this claim, they argue that once vaccines are available, the risk unvaccinated or unmasked individuals pose on others is low, as these other individuals can protect themselves through vaccination.

In one sense, this point is clearly right, and governments generally loosened liberty-restricting measures as the situation improved. That said, it is quite possible that, even in the presence of vaccine availability, rates of severe disease and death will remain high enough for a while, and will continue to overtax health workers and health systems. Until rates steadily decline, it may or may not be justified to maintain mask mandates or other liberty-restricting measures to contain these harms. This is just another instance of a policy judgment that

requires an assessment of the moral importance of liberties at issue and the public health, justice and other non-liberty interests that are at stake.

There is another important ethical issue here, concerning the special duty we have to protect the vulnerable in particular from being harmed.[18] Goodin (1985) has persuasively argued that we have a special ethical duty to protect those who are particularly vulnerable. In the case of this pandemic, the particularly vulnerable include persons with compromised immune systems who remain at significant risk of succumbing to severe COVID-19 disease even after vaccination, as well as elderly persons for whom waning of vaccine protection against severe outcomes overtime is particularly worrisome. These individuals may remain vulnerable even when vaccinated. The elderly and individuals with compromised immune systems (and possibly health-care workers) have a *special* claim on others to take measures not to infect them. This claim is more ethically weighty than garden-variety claims not to engage in behaviors that are risky to others, and it can arguably justify some restrictions on freedom that ordinarily will not be justified by considerations of harm-prevention. Even when a driver is sober, her liberty to drive at the ordinary speed limit may be justifiably restricted when children are playing in the street. Assuming selective restrictions are not placed on vulnerable individuals, we should expect to interact with them in our daily lives. We may thus have a special duty to ensure that we do not impose health risks on them. We worry that, in generally siding with freedom-protection, Flanigan (and perhaps Blumenthal-Barby) do not take possible harm to vulnerable populations seriously enough.

[18] In several places, vulnerable populations expressed concerns about lifting restrictions. See, for example, BBC West (2022), and Mays *et al.* (2022).

These comments help refine the general proposal made above to distinguish different kinds of freedom. When assessing any liberty-restricting measure, several considerations must be taken into account: 1) the value or importance of the liberty/freedom in question; 2) the probability and severity of the harm to others threatened by the liberty/freedom in question; 3) the likelihood that liberty-restricting measures will reduce this harm; 4) whether disadvantaged groups are disproportionately burdened by the liberty-restricting measures, and thus whether precepts of equality are respected; and 5) the extent to which vulnerable individuals will be affected by *not* implementing a certain liberty-restricting measure. Weighing these considerations in relation to particular liberty-restricting policies—and updating these assessments with the latest relevant empirical evidence as scientific knowledge accumulates—will allow public health officials to balance freedom-protection and harm-prevention in ways that may not appeal to everyone, but will offer a sound public justification for certain liberty-restricting measures.

2. Global Justice

Questions of justice loomed large over this pandemic. In many parts of the world, health care systems had to make difficult decisions to suspend services to some patients to make room for COVID patients. Available treatments for COVID patients were in short supply, as were diagnostic tests. These distributive dilemmas were largely addressed within countries. However, as Tasiolas and Wilkinson both point out, distributive principles formulated before the pandemic were often neglected during the pandemic by national public officials, and public

officials did not want to be seen as practicing any form of explicit triage.[19] There is much to discuss regarding domestic distributive justice during COVID-19.[20] But as important as these domestic issues are, questions of global justice were more often taken up by the authors of this volume, so we concentrate on these issues in what follows.

It is the advent of COVID-19 vaccines that brought questions of global justice most dramatically into focus. Initial supplies of the vaccine were severely constrained. During this time, the wealthier nations of the world secured access for their populations through a series of pre- and post- market mechanisms that left poorer nations with limited to no vaccine (So and Woo 2020). Their conduct was completely in line with the global track record on access to medical countermeasures for epidemic threats; consider, for example, antiretroviral therapies for HIV-AIDS (Giuliano and Vella 2007). This conduct was also anticipated. In the early days of the COVID pandemic, an international consortium, ACT-A, and its vaccine arm, COVAX, were established expressly to bring about equitable global access to medical countermeasures this time around. And although COVAX did succeed in securing more doses of vaccine for LMICs compared to previous global experience, it failed to meet its overall objective, in part because of the conduct of HICs.[21]

Considerations of medical need should play an important role in assessing global distributions, and they point in a cosmopolitan direction, as ordinary citizens and national policy makers cannot assume that their co-nationals are the most needy. Following Schaefer,

[19] See Dominic Wilkinson 'Pluralism and Allocation of Limited Resources: Vaccines and Ventilators', in this volume.
[20] See Kristina Orfali, 'Tragic Choices During the COVID-19 Pandemic: The Past and the Future', in this volume.
[21] For discussion of COVAX, see Schaefer's and Gostin's contributions to this volume.

we can say that distributing medical resources by medical need realizes three ethical values: benefitting people and reducing harm, prioritizing the medically worse-off (as people with greater medical needs would have prior access to medical resources), and showing equal concern to individuals (as people with similar medical needs would have equal access to resources).[22] When vaccines first became available it was already clear that older persons were at far greater risk of succumbing to SARS Cov-2 infection than younger persons. That much of the world's population above the age of 60 live in high or middle income countries offers *some* justification for prioritizing these countries. However, even allowing for differential demography, initial global vaccine distributions were a far cry from any reasonable need-based distributive principle.

Could national partiality justify the distributive inequalities observed in the epidemic? Political philosophers disagree whether states are allowed to be partial to their own citizens and residents, or the extent to which they should be. Buchanan, who accepts the view that states may prioritize the interests of their own citizens and residents over those of foreigners, argues that there are limits to legitimate partiality, and that these limits were not respected during COVID-19.[23] We concur. Indeed, among the contributors to this collection, there appears to be consensus that governments of wealthy countries obtained and controlled more vaccines and other needed medical resources than they were justified to obtain and control. The

[22] G. Owen Schaefer, 'Fairly and Pragmatically Prioritizing Global Allocation of Scarce Vaccines During a Pandemic', in this volume.
[23] Allen Buchanan, 'Institutionalizing the Duty to Rescue in a Global Health Emergency', in this volume.

medical needs of foreigners were excessively and unjustly discounted. Our view aligns with this broad consensus.

As several authors point out, it is not necessary to rely on any comprehensive *distributive* ideal or comprehensive account of global justice to defend the view that wealthier nations obtained and controlled more medical countermeasures than they were justified to obtain and control. Buchanan and Savulescu, for example, appeal to *a collective duty of easy rescue* to justify this charge: if wealthy countries can help poor countries to obtain life-saving medical resources with relatively little sacrifice to themselves, they morally ought to do so. According to Buchanan, wealthy countries could do much for poorer countries with little sacrifice to themselves, especially after the initial alarming phase of a pandemic has passed. Therefore, they are morally criticizable for not doing so.[24] We cannot always determine when a society is past its "alarming phase" because we cannot always know when the worst of a pandemic is indeed over, but the overall reasonableness of Buchanan's general position stands.

This way of arguing for a moral duty on the part of wealthy states to help poorer states is appealing because it invokes a widely held moral outlook that recognizes a moral duty of easy rescue. This duty does not presuppose further commitments to cosmopolitan egalitarian ideals or to distribution according to need. Moreover, it can be supported by both consequentialist and nonconsequentialist ethical theories. Its intuitive appeal can be teased out by considering a variation on the famous child-drowning-in-a pond case.[25] If a collective effort is needed to save a drowning child with little sacrifice to the collective and its members, the collective has a moral

[24] See also Gostin, 'The Great Coronavirus Pandemic: An Unparalleled Collapse in Global Solidarity', in this volume.

[25] The thought experiment was popularized by Singer (1972).

duty to save the child. We believe that a duty of collective easy rescue (with its institutional implications) has a secure ethical footing.

However, the duty of collective easy rescue also has its limitations. Consider vaccines or PPE (Personal Protective Equipment). These are not intended to rescue someone who is in danger, but to prevent one from getting into danger in the first place. If there is a pond in which children often drown, we may have a collective moral duty to build a fence around it, but that is not helpfully construed as a duty of *rescue*. The issue here may be merely semantic, but in thinking about global obligations, it may be useful to supplement the duty of easy rescue with other ethical perspectives while remaining neutral regarding comprehensive views of global justice.

One way of doing so is to appeal to human rights. Human rights are already recognized in international affairs as a source of political duties of states and international organizations. Canonical lists of human rights do not mention a human right to be rescued, so a human-rights perspective would presumably be distinct from a collective-duty-to-rescue perspective. Importantly, a human-rights perspective can be used to justify a duty to provide vaccines (say) to people living in LMICs. Suppose that wealthy countries enter bilateral agreements with pharmaceutical companies, "cornering" a large number of vaccine doses and raising their prices. This will put vaccines out of reach for poorer countries. How is that a human rights violation? First, it risks putting people in poorer countries below a minimal level of well-being. Second, it puts people in poorer countries in a state of vulnerability and dependency. Third, the behaviors of wealthy countries during the pandemic suggests that they pose *standard threats*

against which human rights are intended to protect.[26] Wealthy countries pose *threats* because they make much needed medical resources less available to poorer countries, and they pose *standard* threats because, unless prevented, these aggressive market-place practices by wealthier nations are to be expected in a global market economy with actors who hold unequal resources and bargaining power.

Powers and Faden (2019: 146-86) put forward another way to think about human rights and nationalism in global interactions that can be useful in this regard. Their view takes seriously both the moral responsibility of nation-states to secure human rights and structural justice domestically, *and* their responsibility to address impediments to human rights fulfillment elsewhere in the world that result from unfair differentials in interstate and global institutional power. Powers and Faden defend what they call the Principle of Interstate Reciprocity that establishes conditions under which the pursuit of national interests and global advantage is constrained. This principle prohibits a nation from pressing advantage for its own residents when this pursuit 1) undermines the human rights of residents of other nations and 2) foregoing the pursuit of advantage does not thereby put its own residents' basic human rights at substantial risk. Assuming a human-rights case for access to vaccines during a pandemic can be made, at minimum, the Principle of Interstate Reciprocity provides a foundation for a human-rights argument against leaving access to vaccines entirely to the global market economy.

We should note that neither the Principle of Interstate Reciprocity nor the duty of collective easy rescue requires a system of global vaccine allocation based solely on a moral principle like

[26] Following Shue (1996: 18, 29-32), these three points suggest a human-rights violation.

medical need, let alone cosmopolitan egalitarianism. A duty of easy rescue as well as a human-rights perspective allow nationalism to play some role in access to medical resources while providing justification for global restrictions on certain kinds of market practices, for example some kinds of bilateral agreements, as well as for global obligations to strengthen initiatives like COVAX.

3. Going Forward

Finally, we would like to flag three issues that have not been addressed much by the authors in this collection and which we believe deserve greater scholarly attention as we prepare for the next pandemic.

Democracy

The first set of issues concerns democracy and the particular challenges democracies have faced during this pandemic and that they are likely to face in future pandemics. Pandemics pose a legitimacy challenge to all political regimes, because all political regimes must work to secure the health of their populations (Allen 2022: 9–10). But pandemics like COVID-19 pose particular challenges to democracies, as democracies move slower than autocracies (Allen 2022: 101). Democratic deliberation takes time, and democracies tend to respect certain side-constraints on government action that limit their ability to implement some effective public-health measures. When democratic governments implement such measures, they are accused of overreaching, and when they do not implement such measures, they are accused of not doing enough.

Disagreement has always been a virtue of democracy and a challenge to it. But the current epidemic exposes an acute epistemic concern that democracies face given their tendency to encourage epistemic tolerance. In liberal democracies, we value the free expression of different opinions and do not censor the media. The result is that citizens may be deeply divided on questions of fact, not just on questions of value. Furthermore, a society with free speech should expect not just reasonable disagreements about these matters, but also a fair amount of epistemic confusion, from unsubstantiated rumors to full-out conspiracy theories. The ethical challenges this poses for pandemic preparedness and response, particularly when appealing to scientific evidence in justifying certain policies is seen as taking an ideological stance, need to be squarely confronted.

We have seen two concerning trends during the pandemic. One involves politicians who say they seek to simply "follow the science." This approach is misguided.[27] Scientists and other experts aim to tell us what the best available scientific evidence in their field is and may offer advice about the implications of that evidence for policy, but democracy is not the rule of experts. Politicians must make all-things-considered judgments (Allen 2022: 23). Politicians cannot evade making hard decisions about values and should not pretend to do so.

The second worrying trend is that of politicians with no scientific background who dismiss, ridicule, or simply ignore public-health experts, including those who work for their government. While we certainly do not want political leaders or the citizenry to sheepishly and uncritically accept the views of experts, it would be impossible for democracies to effectively respond to

[27] See John Tasioulas, 'The Uneasy Relationship Between Human Rights and Public Health: Lessons from Covid-19', in this volume.

pandemics without some reasonable regard for and reliance on the assessments of experts. The same normative point applies, of course, to experts in ethics and bioethics. They too should not be sheepishly followed in a democratic society. However, we know of no politician who declared to simply "follow the ethics." Indeed, as mentioned, in several countries certain principles of triage were formulated and endorsed before the pandemic, and then ignored during the pandemic.[28] Politicians did not want to be seen to be following any value-laden principle of triage and to engage in explicit ethical deliberation. *That* is worrying, and something for bioethicists to think about. Going forward, the fact that pandemics pose a predictable threat to democratic governance should be a central part of bioethical discourse.

Public Health and Government Overreach

Another democracy-related problem requires attention. In the past, public-health authorities were criticized for not having enough "teeth." This criticism is in some contexts still valid, but in many countries public-health authorities were able during the pandemic to issue or influence significant liberty-restricting measures. That gives them a non-negligible amount of power. The problem, however, is that public health officials, like many officials in ministry-level positions, are not elected. Instead, they are appointed to their jobs by a democratically elected executive or by a ministry head whom the executive selected. Except for top public health leadership, elected bodies like parliaments or congresses play no role in these appointments, though they may have some oversight responsibility. When public-health authorities are able to exercise significant power over the lives of the citizenry they face a challenge to their legitimate

[28] See also Wilkinson's and Tasioulas's contributions in this volume.

authority that goes beyond the legitimacy of particular liberty-restricting measures.[29] In other words, the pandemic calls for a closer examination of the role public health authorities play in a democratic society. This issue is perhaps unique to public-health authorities; it applies to many agencies of government. But some aspects of this problem may be particularly problematic for public health authorities because of the kind of public good that they promote. Thinking about how best to prepare for the next pandemic, this is another area for bioethicists to examine.

Children

Finally, we note with concern the absence of specific attention to children in a volume devoted to the ethical dimensions of pandemic preparedness and response. Unlike with adults, ethical tensions between state intervention and individual liberty are not a central issue in the case of children. Instead, what matters most in the case of children is the impact of pandemic policies on their overall well-being. This point is underscored by the recognition that children have special justice claims, for two reasons. First, children are completely dependent on others and the social order to secure their well-being. Second, as a developmental matter, setbacks to interests in childhood not only harm children at the time they are experienced; these setbacks can reverberate over the whole of their lives, frustrating their interests well into adulthood (Powers and Faden 2006: 92-95). "Unlike a tainted sports event," Jonathan Kozol reminds us, "a childhood cannot be played again" (Kozol 1991: 217). If a childhood does not include the securing of critical milestones in knowledge and understanding, social and emotional

[29] Although, in some places, elected officials can veto (or are needed to approve) certain measures.

development, and mental as well as physical health, prospects for a decent adult life can be profoundly undermined. We thus agree with Allen (2022: 46–49, 99) that we should think of schools somewhat like we think of hospitals. They should be the last to close and the first to reopen. However, we do not wish to downplay the health risks this may expose teachers to, and the other burdens that teachers will face if they are deemed "essential workers." There are ethical dilemmas here, that is, material for bioethical discussion.

It is becoming increasingly clear that children across the globe have suffered significantly during the COVID-19 pandemic, and that children from poor or otherwise marginalized communities have suffered the most.[30] Although the full impact of disrupted schooling, in some cases for almost two years, is yet to be calculated, learning loss, developmental delay, and compromised mental health are already in evidence. Some of the world's most disadvantaged children will never return to school, erasing decades of advancements in education, especially for girls (Frohn (2021), Cameron (2021).

Going forward, children must figure prominently in the ethics of pandemic preparedness. How the interests of children should be taken into account in pandemic planning raise questions about intergenerational justice that go beyond standard debates about whether lives saved or life-years saved is the correct measure in assessing the allocation of vaccines or ICU beds. Even when children are spared much of a pandemic's burden of disease, as is the case with SARS-CoV-2, other critical interests can be significantly harmed by policies designed to contain it (for example, schools closure). The global experience of the COVID-19 pandemic has

[30] For example, it has been estimated that in low-income countries, lockdowns resulted in increased mortality among children. See Ma *et al*. (2021).

been punctuated by a repeated failure to find morally acceptable trade-offs or alignments across different dimensions of well-being. Children in particular suffered from this failure, resulting in profound injustices to our youngest generation. How to prevent that from happening in the next pandemic will require careful integration of expertise in ethics with expertise in education, child development and child health, and should be a top priority for pandemic planning.

Conclusion

A single chapter cannot do justice to all the intriguing and valuable contributions made in this collection. Our aim was more modest: to offer an (opinionated) presentation of some recurring themes and to begin a conversation about the various questions and answers discussed in this collection, with the hope that the conversation will continue beyond the pages of this book. We have also pointed out some areas for further consideration.

At the time of writing this paper, the pandemic is still with us. We do not yet have a complete historical perspective on it or the full benefit of hindsight. But as the various contributions in this collection make all too clear, that does not mean we should wait. Valuable ethical lessons can already be learned from the experience of the last two years. Democracies move slowly. To allow for proper democratic deliberation, time is needed. Somewhat paradoxically, the patience required for proper democratic decision-making makes the task of reflection more urgent. Both nationally and globally, after-action analyses and planning for the next pandemic are already well underway. These efforts must include a careful consideration of the ethics of pandemic preparedness and response. The global and national institutional

reforms that follow should benefit from continued, on-point, scholarship in political and moral philosophy responsive to the experience of this pandemic, as exemplified by the essays in this volume.

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