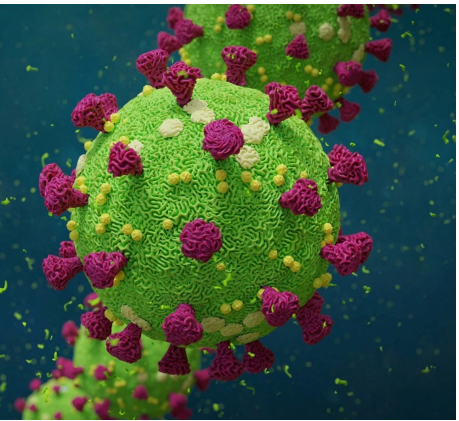


# A Pro-Freedom Approach to Infectious Disease

## Preparing for the Next Pandemic

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### Executive Summary

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Our nation's ongoing response to the SARS-CoV-2 pandemic is not worthy of the leader of the free world. It is not an American response. We can do better in the future by changing our laws to assign government its only proper role in fighting the danger posed by infectious disease.

*We need laws that focus government with laser-like precision on its proper goal: to remove the active threat posed by carriers of severe infectious diseases.*

Government's public health goal in the face of a novel respiratory virus like SARS-CoV-2 is to remove the threat posed by carriers of the virus—primarily by testing, isolating and tracking those carriers. Trying to save every life from a novel virus whatever the cost, or to balance some people's lives against other people's livelihoods, is not a valid public health goal. Apart from testing, isolating and tracking, government should issue only voluntary guidelines and then leave us each free to take the countermeasures we individually think necessary in the face of the new reality.

To accomplish its proper public health goal, the government must catalog the severity of various infectious diseases and then, for severe infectious diseases, it must have the ability to test, isolate and track contagious individuals. *All of this can and needs to be carefully codified into law.*

Here are at least some of the (interrelated) factors that are relevant to defining whether an infectious disease warrants legal intervention.

- *How contagious is the disease?*
- *By what means is the disease transmitted?*
- *What kind of damage can it do when a person contracts it?*
- *How much immunity exists in the population?*
- *What preventive countermeasures are known and easy to implement?*

The basic issue is to define when coercive action against the carrier of an infectious disease is warranted because the threat he poses to others is significant enough. To focus our federal and state governments on the task of isolating carriers of dangerous infectious diseases, the first step to codify into law, therefore, is government's responsibility to use objective legal criteria to determine which existing and new infectious diseases warrant coercive legal intervention.

And then governments must execute these laws. In the presence of a potential outbreak of a sufficiently severe infectious disease, governments must purchase or build the capabilities that enable effective testing, isolating and tracking. But this emphatically does not mean that they control testing across the country, or prohibit private labs from deploying their own tests, or decide who can and cannot purchase tests, and the law must make this clear.

*We need laws that strip federal and state governments of the power to lock down entire states or even just cities in the name of public health.*

Because our existing laws do not prohibit coercive statewide lockdowns, they were too easy a “solution” for our governments to adopt during the SARS-CoV-2 pandemic. If we really believe, as many state governors seemed to believe during this pandemic, that government’s lawful goal is to minimize at all cost the number of deaths from a new infectious disease, or to somehow “balance” the destruction the infectious disease may cause to people’s lives and livelihoods, then government *needs* the coercive power to close everything and quarantine everyone. It needs near *absolute* power. But this goal is illegitimate.

The government’s proper public health goal is, fundamentally, no different from its goal in any other area: to protect *the right of each of us to the pursuit of health, as an aspect of our right to the pursuit of happiness.*

There is no such thing as “our” *collective* health or “our” *collective* wealth. There is only the specific health and wealth—the specific lives and livelihoods—of separate individuals. To ask government to “balance” these two is a euphemism for asking it to decide who will be sacrificed to whom, whose livelihood it decides takes precedence over whose life, and whose life it decides takes precedence over whose livelihood. *These are not government’s decisions to make.*

If our governments know that they do not possess the power of coercive lockdowns, they will be even more focused on their proper role: to effectively test, isolate and track carriers.

The law should also suspend the controls on healthcare that most cripple doctors, hospitals, laboratories and pharmaceutical companies during a pandemic. Remove, for example, the barriers to deploying private tests and the permissions required that prevent hospitals from quickly increasing their capacity.

However, because our governments control so much of the nation’s healthcare, they must be transparent and honest about what they are and are not able to manage.

An infectious disease pandemic should rapidly change governments’ priorities. Just as during a pandemic they must quickly reprioritize budgets to spend more on testing, isolating and tracking, so they must quickly reprioritize budgets to spend more on hospital capacity. Redirect the wealth we have already surrendered in taxes to now fight the pandemic. Draw on government stockpiles and make use of the medical resources of the military. That this only started to happen late into this pandemic contributed to the atmosphere of panic.

More importantly, our governments must acknowledge that government-controlled healthcare means *rationed* healthcare. When production, prices and profits are not the principles directing people’s actions, something else must be. That something else is the decisions made by government bureaucrats. Our governments must discard the fantasy that government-controlled healthcare is free—that, somehow, healthcare doesn’t have to be produced by anyone. It is our governments’ responsibility to explain clearly how healthcare will be rationed in a pandemic. Doing this will allow us as individuals to make better-informed, rational decisions.

If elderly individuals and their loved ones knew, for instance, that they would go to the back of the line for a ventilator or an ICU bed, they would have more reason to socially distance and to

isolate at home. Or if young people knew they would be the lowest priority for being admitted to the ICU, more young people would consider the need to socially distance.

The more we as individuals understand that government healthcare is rationed healthcare, the more reason we have to voluntarily take countermeasures like social distancing. By contrast, the more we are taught that healthcare is free and ours by right—that, magically, there will always be a nurse and an ICU bed when we get Covid-19—the less seriously we will take the need for voluntary countermeasures—and the more it will seem that the coercive hammer of government is necessary.

In sum, what we need and what is realistically achievable is an approach to infectious disease that codifies into law the best aspects of what Taiwan, South Korea and Sweden have implemented in this pandemic. Taiwan and South Korea have learned from their past failures; we can learn from our present failure.

## Table of Contents

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<b>I. WE MUST DEMAND BETTER FROM GOVERNMENT.</b>	<b>5</b>
Our response to SARS-CoV-2 was un-American.	5
The alternative to coercive, statewide lockdowns was not two million dead.	6
A truly American response requires new laws.	7
<b>II. THE LAW SHOULD FOCUS GOVERNMENT ON STOPPING THE THREAT POSED BY CARRIERS OF INFECTIOUS DISEASE.</b>	<b>9</b>
We need to legally specify a threshold for when infectious diseases qualify as active threats.	9
We need to legally delimit appropriate coercive interventions.	12
Proper laws would focus government on one task: to test, isolate and track carriers of infectious disease.	13
<b>III. IN PRACTICE, PROPER LAWS WOULD HAVE ENSURED GOVERNMENT WAS PREPARED TO TEST AND ISOLATE CARRIERS OF SARS-CoV-2.</b>	<b>13</b>
With better laws we would have had Taiwan's level of readiness.	13
With better laws we would have had South Korea's widespread, strategic ability to test.	14
<b>IV. WHEN GOVERNMENT IS UNABLE TO ISOLATE MOST CARRIERS OF AN INFECTIOUS DISEASE, THE LAW MUST LEAVE US FREE TO ACT.</b>	<b>17</b>
If government is unable to isolate most of the infected, the law should grant it few additional powers.	17
An improper public health goal led to coercive statewide lockdowns.	18
The proper public health goal is for government to protect our right to the pursuit of health.	20
This means government's public health goal is not to coercively "flatten the curve."	21
But during a pandemic, government must be transparent and explain how government- controlled healthcare will be rationed.	23
The law should prohibit statewide lockdowns and require governmental transparency.	25
<b>V. IN PRACTICE, IF GOVERNMENT HAD NOT POSSESSED THE POWER OF STATEWIDE LOCKDOWNS, THE RESPONSE TO THE UNCONTAINED SPREAD OF SARS-CoV-2 WOULD HAVE BEEN FAR BETTER.</b>	<b>27</b>
Governmental action would have been more strategic, targeted and effective.	27
Private action would have been more strategic, targeted and effective.	28
<b>VI. WHAT YOU CAN DO</b>	<b>31</b>
Write your representatives in government.	31

## I. WE MUST DEMAND BETTER FROM GOVERNMENT.

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### Our response to SARS-CoV-2 was un-American.

In the words of one expert, the SARS-CoV-2 pandemic presents “the most pressing infectious disease challenge we have faced in over a century.”<sup>1</sup> Our federal and state governments have so far failed the challenge. We dare not meet a second wave of infections, let alone the emergence of another novel disease, with the governmental attitudes and policies that have presently been guiding us.

When a new, deadly disease appears, we expect both illness and death. But who expected that for months our federal and state governments would be unable to test for and then isolate contagious individuals? Who expected the chaos and delays in purchasing ventilators and other supplies, or simply procuring them from federal stockpiles and the U.S. military? Who expected that emergency responders, nurses, doctors and other brave healthcare workers would be exhausted, infected, sick and even dead, unable to obtain adequate personal protective equipment and desperately trying to supply their own makeshifts, homemade masks and repurposed rain gear not excluded?

A March 26 video from an emergency room physician at the center of the outbreak in New York City, featured in a *New York Times* story and now approaching 8 million views, gave voice to what many of us were feeling. “Everything is not fine,” the doctor said. “I don’t have the support that I need, and even just the materials that I need, physically, to take care of my patients. And it’s America, and we’re supposed to be a first-world country.”<sup>2</sup>

America is not only supposed to be a first-world country, we’re supposed to be a free country. Who of us expected that the response from our governments to *their* failure in January, February and March to test for and isolate contagious individuals and to expand healthcare capacity would be to coercively and indefinitely lock *us* down in our homes, with the consequent destruction to our production, incomes, jobs, and freedom?

GDP for the first quarter of 2020 fell 5%, consumer spending fell 7.6% and spending on durable goods fell 16.2%. Since the pandemic well over 40 million Americans have applied for initial jobless claims.<sup>3</sup> Many people’s businesses and livelihoods have been wiped out, their lives shattered.

In response to the economic devastation caused in significant part by the lockdowns, the federal government passed over 2 trillion dollars’ worth of spending bills, which obviously is not taxpayer money it had saved for an emergency. Rather, the spending schemes ultimately represent an immense seizure of wealth from some of us (who already are less wealthy) to transfer it to others; often we will be both victim and profiteer, unable to compute the net result, though for most of us it will be negative. Jockeying predictably ensued among individuals, businesses and state and local governments over who counts, politically, as a have and who as a have-not.<sup>4</sup>

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<sup>1</sup> Amesh Adalja, “COVID-19: A Path Forward,” Medium.com, March 22, 2020.

<sup>2</sup> “‘People Are Dying’: Battling Coronavirus Inside a N.Y.C. Hospital,” *New York Times* YouTube video, March 26, 2020.

<sup>3</sup> Bureau of Economic Analysis, “Gross Domestic Product,” 1st Quarter 2020, updated May 28, 2020; Jeff Cox, “US GDP shrank 4.8% in the first quarter amid biggest contraction since the financial crisis,” CNBC, April 29, 2020; Paul Davidson, “Layoffs: About 1.3M more workers likely filed jobless claims even while states reopen economies,” *USA Today*, June 17, 2020.

<sup>4</sup> Jon Coupal, “The Dark Side of Stimulus,” *Orange County Register*, April 26, 2020.

The economic destruction will play out for years. And of course, the long-range damage from the lockdowns is not only economic. Schools and universities have been closed, affecting the education of millions of children. Cancer treatments, hip replacements, colonoscopies, and other medical tests and elective procedures have been canceled across the country, downgrading the long-term health of thousands and thousands of Americans.

Our nation's response to the SARS-CoV-2 pandemic is not worthy of the leader of the free world. It is not an American response. But too many of our elected officials, unwilling to face the massive governmental failures involved, are pretending that it is.

Instead of admitting that their lockdowns were panicked reactions to months of inaction, when the needs to test and isolate possible carriers of the virus and to increase hospital capacity were being ignored, our elected officials continued to order us around through statewide, phased plans for "re-opening"—as though the economy and the entire country were the government's property, which it could choose to open and close at its discretion.

Our current federal and state governments may be unwilling to admit their failures, but we as Americans need to identify those failures. We need to consider what led to the failures and what principles must be instituted to avoid a repeat. We need to think what a more effective, pro-freedom approach is and then demand that our representatives in government implement it.

### **The alternative to coercive, statewide lockdowns was not two million dead.**

It's common to dismiss opponents of the statewide lockdowns by charging us with the moral crime of evading the 2.2 million Americans who, absent any mitigation efforts, were projected to die by the Imperial College epidemiological model.<sup>5</sup>

And it is true that too many people who are purportedly on the side of freedom, and who were dismayed by the prospect of statewide lockdowns, did react by dismissing or downplaying the threat. Armchair virologists and epidemiologists quickly sprung up to declare that SARS-CoV-2 is just like the seasonal influenza virus, which we should let wash over us as we continued to live our lives as usual. Others stated that there likely would be fewer than five thousand deaths in the U.S. from COVID-19. Unexplained of course was how any of them were in a position to know any of this. Like the initial reactions of too many government officials, this sort of counterreaction is also an evasion.

But you can be pro-freedom and anti-lockdowns while simultaneously recognizing that the threat from SARS-CoV-2 is real and that new thought and action are required to reduce the damage and death from the novel virus. To advocate the continued protection of the individual's freedom to think and act when faced with a threat like SARS-CoV-2 is not necessarily code for ignoring the threat.

In envisioning an American approach to an infectious disease pandemic, in other words, we must not commit the error of assuming the only form of effective action is coercive, governmental action. That assumption is un-American: it is prejudiced against freedom. The American experiment is that only free individuals can pursue and achieve their happiness, including their own health.

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<sup>5</sup> Neil M. Ferguson et al. on behalf of Imperial College COVID-19 Response Team, "Report 9: Impact of non-pharmaceutical interventions (NPIs) to reduce COVID-19 mortality and healthcare demand," March 16, 2020.



This presumably is why the 2017 guidelines from the Centers for Disease Control and Prevention (CDC) for an influenza pandemic as severe even as the 1918 pandemic contain largely *voluntary* measures.<sup>6</sup> The CDC guidelines respect our rights and freedoms as Americans. Apart from localized school closures and bans on (unmodified) mass gatherings, the nonpharmaceutical interventions (NPIs) contained in the guidelines, NPIs which in part are aimed at reducing the patient load on local hospitals (i.e., to “flatten the curve”), are voluntary.

When in late February the CDC warned the country about the seriousness of the novel coronavirus and recommended that we heed its 2017 voluntary guidelines for an influenza pandemic, such as increasing the frequency of hand washing and of disinfecting often-touched surfaces, we should have taken note.<sup>7</sup> And many of us did.

Prior to the coercive, statewide lockdowns, many of us were already implementing voluntary NPIs, like washing our hands more thoroughly and socially distancing. Restaurants, for example, notified patrons of the steps they were choosing to implement, like spacing out tables and disinfecting them after every use, to reduce the chance of infection.

This kind of voluntary action is what has taken place in Sweden. Its governments did not coercively lock down their citizens, but of course that has not meant that life goes on in Sweden as before. Many Swedes are voluntarily choosing to engage in some social distancing, restaurants and other businesses have fewer customers, more people are working from home, and so on. Sweden’s hospitals have not been overwhelmed and as of the middle of June its reported deaths per 1 million residents, though higher than that of its neighbors, Finland and Norway, is in the middle of the range of what locked-down European countries like France, Italy, the Netherlands, Ireland, the UK and Belgium are experiencing.<sup>8</sup>

But Sweden should *not* be our full model for how a first-world, free country meets the challenge from a novel infectious disease.

To emphasize that an American approach to the threat of SARS-CoV-2 would recognize the need for individuals to remain free to think and act, to continue to work and to live as they judge best, does not mean government therefore should do nothing, that it has no function to perform. That assumption too is un-American. In the American system, government has a vital role.

In defining that role our model should be the best aspects of what Taiwan and South Korea have done. In neither country did government focus its coercive power on locking down most of its residents. Instead, in both countries the focus was on detecting carriers of the virus early, by testing and tracking, in order to isolate them. Sweden, by contrast, has lacked this vital focus on testing, isolating and tracking.

### **A truly American response requires new laws.**

Think of it this way: the alternatives to the emergence of a novel respiratory virus are not (a) for government to do nothing and then watch as residents inexplicably resign themselves to the new disease, continuing to live their lives unchanged or (b) for government to coercively lock down almost everyone in their homes. We must not allow our thinking to be trapped by this obviously false alternative.

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<sup>6</sup> U.S. Centers for Disease Control and Prevention, “Community Mitigation Guidelines to Prevent Pandemic Influenza—United States, 2017,” *Morbidity and Mortality Weekly Report*, April 21, 2017.

<sup>7</sup> U.S. Centers for Disease Control and Prevention, “Transcript for the CDC Telebriefing Update on COVID-19,” February 26, 2020.

<sup>8</sup> “COVID-19 Coronavirus Pandemic,” *Worldometers.info*, updated June 19, 2020.

The path that a first-world and free country should take, the truly American path, is for government to test and track the infectious in order to isolate them and quarantine those they might have exposed, and for noninfectious individuals to voluntarily take the actions and countermeasures they judge appropriate for their lives and circumstances.

In other words, a proper government should secure our freedom. This means that it must simultaneously strive to isolate carriers of an infectious disease severe enough to present a threat to the rights of the noninfected and work to preserve the freedom of the noninfected (or those for whom there is no specific evidence that they may be infected) to continue to live their lives. *The government of a free society should have been laser focused on isolating the infectious and, insofar as that was impossible, given us the freedom to deal with the risk of the virus as rationally as possible.*

But tragically this is not what happened. What should strike us as one of the most un-American aspects of our current failed response to the pandemic is how lawless it has been. We have laws that simultaneously require government to apprehend criminals while meticulously curtailing the government's coercive power to arbitrarily search a home for contraband, but apparently no laws that require government to track carriers of infectious disease while curtailing the government's coercive power to lock us down indefinitely in our own homes. Such enormous, unchecked power in the hands of government might be the norm in China, but it should never become acceptable in America.

As a nation, we must not meet a second wave of SARS-CoV-2 infections in the summer or fall of 2020, let alone the emergence of another novel virus, with limited ability to test, isolate and track, with hospitals undersupplied, and with many of us again under coercive lockdowns.

*To ensure a different response, we must enact it into law.* What the architects of the American form of government understood is that to fix and hold government to its proper role, its powers must be carefully specified and circumscribed by law. That is why they wrote federal and state constitutions.

To enshrine into law government's proper response to infectious disease, we must do two things. We must specify government's responsibility, as well as the principles that would govern its powers, to test, isolate and track carriers of infectious disease. And we must delimit its power to lock down residents, depriving it of the power to lock down a state or even only an entire city.

If these two were codified into law, namely, the responsibilities government has to combat infectious diseases and the powers it does and does not possess to carry out these responsibilities, we would ensure a truly American response to further outbreaks of SARS-CoV-2 or to another novel infectious disease. And had such laws been on the books, our existing response to the pandemic would not have been the failure it has been.<sup>9</sup>

Let's see why.

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<sup>9</sup> My field of expertise is not infectious disease or epidemiology, but political philosophy and the foundational principles of the American form of government. But as should become clear from my argument, I think it is vital that proper law be formulated both by consulting expert medical guidance about infectious disease and by implementing the foundational principles of the American form of government: individual rights. As individuals and informed citizens who value our freedom, we each need to think carefully about what the government's powers should and should not be to combat the threat posed by infectious diseases.



## II. THE LAW SHOULD FOCUS GOVERNMENT ON STOPPING THE THREAT POSED BY CARRIERS OF INFECTIOUS DISEASE.

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**We need to legally specify a threshold for when infectious diseases qualify as active threats.**

Infectious disease of course is an ongoing aspect of human existence. Chickenpox, polio, smallpox, the common cold, cholera, malaria, yellow fever, tuberculosis, influenza and, more recently, AIDS, Ebola, Zika, and now COVID-19 are illnesses with which we must contend.

For noninfectious diseases like cancer or diabetes, government has no part to play. Each of us, in consultation with doctors and other chosen experts, must decide what treatments, if any, to pursue and whether to take preventive measures to reduce our chances of developing the disease in the first place, such as changes in diet and exercise. The costs, the risks, and the rewards are ours to assume.

Infectious diseases are different. Because one person can play an active role, knowingly or unknowingly, in transmitting Ebola or malaria to another person, these diseases fall under the purview of government. If a carrier of an infectious disease poses an active threat to the individual rights of other people, to their freedom to pursue their own lives and happiness, government should coercively intervene to end that threat. *This is government's fundamental role in combatting the threat from infectious disease.*

Government's responsibilities of course do not end there. Since the military must maintain a level of readiness, which an outbreak of an infectious disease can jeopardize, this must be monitored. U.S. navy ships, for instance, were partially incapacitated because of outbreaks of SARS-CoV-2. In April the defense secretary said that it was "hard to say" whether Iran and Russia were probing for U.S. military vulnerabilities caused by the pandemic.<sup>10</sup>

Militarily, we must also be prepared for bioterrorism and biological warfare, for the deliberate engineering and release of deadly substances and novel infectious pathogens. This requires the capabilities to test, track and mount appropriate countermeasures, like the use of masks and other personal protective equipment and the ability to treat exposed individuals. A disturbing aspect of this pandemic is that our federal government's chaotic, under-resourced response suggests that as a nation we are not well prepared for biological attack.

But let's leave the military issues aside to focus on naturally occurring (or accidentally created) infectious pathogens like SARS-CoV-2. Here government has two basic responsibilities. It must specify when an infectious disease rises to a level severe enough to warrant coercive intervention. And when the threat from an infectious disease is severe enough, it must act to end the threat posed by carriers.

Not every carrier of an infectious disease should in law be considered an active threat to the rights of others. Those who spread the common cold viruses in restaurants and grocery stores, for example, harm other people. The result of catching a cold is often temporary loss of productivity and reduced enjoyment of life. But we don't coercively restrict the movements or activities of people carrying these viruses. The threat they pose is correctly judged not of sufficient severity to warrant legal intervention.

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<sup>10</sup> Kim Hjelmgaard and Tom Vanden Brook, "Iran, North Korea, Russia: America's adversaries emboldened to flex their muscles amid coronavirus," *USA Today*, April 22, 2020.

Being infected by other people with a common cold virus is one of the risks of living among other people, with the risk obviously higher in more densely populated areas like Manhattan. For the common cold, the burden of action falls on those of us seeking to avoid getting sick. We can take preventive measures like washing our hands more often or banning patrons from our store or restaurant because they seem ill. But the carrier of the common cold is not legally obligated to self-isolate until no longer contagious.

Even for an infectious disease like influenza, the normal, seasonal variety of the virus is not judged severe enough to legally restrict the activities of carriers, even though it results in significant hospitalizations and deaths each year. Noncarriers again bear the responsibility for taking countermeasures. We can, for instance, choose to avoid people in the winter months who seem feverish and we can choose to get the flu vaccine. The burden of action falls on us, and this is so despite the fact that countermeasures like the flu shot are not one hundred percent effective.

In order properly to delimit government's coercive powers to combat the threat from existing and novel infectious diseases, therefore, the first step is to define, with the aid of medical experts, the criteria for when an infectious disease is of sufficient severity to warrant legal intervention. The common cold obviously falls well below the threshold. Ebola obviously lies far above it. There will no doubt be some borderline cases, as there are with most legal criteria, but those don't erase the fact that there will be many clear-cut cases.

Here are at least some of the (interrelated) factors that are relevant to defining whether an infectious disease warrants legal intervention.

*How contagious is the disease?* Does it require, for instance, prolonged contact with the carrier before risk of transmission? Or is it more like chickenpox or the measles, which transmit more or much more readily?

*By what means is the disease transmitted?* Is it a respiratory virus like influenza or SARS-CoV-2, or transmitted through human waste like cholera, or sexually transmitted like HIV, or transmitted by animal vectors such as rats or mosquitos, like the plague, malaria and Zika?

*What kind of damage can it do when a person contracts it?* How destructive and deadly is it on average and in the worst cases? Does treatment often require hospitalization or pharmaceutical interventions? For how long? And with what degree of success and side effects? When a person recovers, is it normally a full recovery or are there long-lasting impairments?

*How much immunity exists in the population?* Relevant to how we view the seasonal flu, for instance, is the fact that we build immunity over time, which is why children get the seasonal flu more often than do adults. By contrast, part of the threat of a novel influenza virus is that there would not be as much immunity to it.

*What preventive countermeasures are known and easy to implement?* Obviously, this is a scientific, technological and economic issue, the details of which will change over time and to which the law should adjust. Does something inexpensive and easy to implement like handwashing with soap, for example, kill the pathogen? Is it relatively easy for people to identify a carrier of the infectious disease? Are there many asymptomatic carriers? It is relatively easy to spot someone with (bacterial) pinkeye, for instance; it is relatively hard to identify someone with HIV. Is it easy to avoid risky interaction with a carrier? It is relatively difficult to avoid interaction with someone with measles, because the virus can linger in the air; you may not know someone with measles was in the restaurant fifteen minutes before you arrived. By contrast, it is relatively easy to avoid risky interaction with someone you know is a carrier of HIV because the disease is sexually transmitted. Or, to take another relevant factor, are there vaccines or preventive drugs like malaria pills available for purchase? How effective are they and with what side effects? Or, say, can the animal vector, like rats or mosquitos, be easily avoided or killed?

These are some of the main considerations that would go into formulating the criteria by which infectious diseases will be judged to warrant or not warrant coercive legal intervention. *The basic issue is to define when coercive action against the carrier of an infectious disease is warranted because the threat he poses to others is severe enough.*

This will allow government officials to know whether it is, say, appropriate coercively to require the individual carrier of influenza to isolate at home until no longer contagious, or to ban containers of standing water that are potential breeding grounds for Zika-transmitting mosquitos, or to quarantine an entire household when a member has been exposed to someone infected with SARS-CoV-2.

In formulating these criteria, the law should catalog *existing* infectious diseases like the common cold, seasonal influenza, chicken pox, HIV, malaria, measles, cholera, Ebola, and Zika. It should explain which rise above the threshold for coercive legal interventions, which do not, and why. When a new infectious pathogen and disease emerges, like SARS-CoV-2 and COVID-19, this catalog will serve as a crucial frame of reference.

This kind of catalog is what the 2017 CDC guidelines offer for different strands of the influenza virus, all the way to the most severe known case, the 1918 flu pandemic.<sup>11</sup> Depending on the existing evidence for the severity of this season's flu strains in comparison to past strains, the CDC recommends different NPIs.

*So, in the case of SARS-CoV-2 and COVID-19, legally the first responsibility of government would have been to determine, using the scientific data available, what the novel pathogen and novel disease are most like.* This in turn will help government determine whether the novel coronavirus falls below or above the legal threshold for being an active threat that requires coercive legal intervention.

Using the criteria sketched above, SARS-CoV-2 of course appears sufficiently contagious, damaging and difficult to avoid, with at present not much existing immunity in the population and no known effective pharmaceutical interventions, to be placed *above* the threshold for legal intervention. Once this determination is made, government would have the responsibility to act to neutralize the threat posed by carriers.

It is this kind of determinization for a new infectious pathogen like SARS-CoV-2 that Sweden has enacted into law. When a novel infectious disease arises, Sweden's public health department must first consider the scientific evidence in order to classify the disease's severity in comparison to existing infectious diseases. There are three (overlapping) categories, each justifying different coercive legal interventions. In the category of medium severity have been placed diseases like tuberculosis and typhoid fever. In the highest category are smallpox and Ebola—and now COVID-19.<sup>12</sup>

By contrast, in the U.S. the existence and threat of SARS-CoV-2 were easy to evade for political (and other) reasons, because an approach like Sweden's has not been enacted into law.

*But the government of a free society has the responsibility to monitor the threat from infectious diseases, to be actively on the lookout for new ones like Ebola or Zika or COVID-19.* It must do this because carriers may threaten the rights and freedoms of the noninfected.

To focus our federal and state governments on the task of isolating carriers of dangerous infectious diseases, *the first step to codify into law, therefore, is government's responsibility to use objective legal criteria to determine which existing and new infectious diseases warrant coercive legal intervention.*

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<sup>11</sup> Centers for Disease Control, "Community Mitigation Guidelines," 13.

<sup>12</sup> U.S. Library of Congress, "Sweden: Legal Responses to Health Emergencies"; Folkhalsomyndigheten Public Health Agency of Sweden, "FAQ About COVID-19," updated June 15, 2020.

## **We need to legally delimit appropriate coercive interventions.**

When an infectious pathogen like SARS-CoV-2 has been judged severe enough to require legal action, the law must then specify what coercive interventions—what controls, bans, fines or imprisonment terms—are legally justified against individual carriers and potential transmitters of the virus.

*Broadly, the coercive interventions should be both proportional and appropriate to the threat.* A carrier of chickenpox (pre-vaccine), for instance, may be required to isolate at home until no longer contagious. A carrier of measles may not only be required to isolate at home, but the members of his household who have been exposed may be placed under quarantine until none of them is even potentially contagious. A carrier of a sexually transmitted virus like HIV may be required to inform prospective partners of this fact before engaging in consensual sexual activity—and be imprisoned for failure to do so. In malaria-infested regions, owners of private property may be banned from having standing water on their property or be required to spray at regular intervals against mosquitos—and be fined for failure to do so.

*The law must also specify the means by which the various coercive interventions will be enforced.* For comparatively less severe infectious diseases, like chickenpox, the requirement to isolate at home may basically be on the honor system. The authorities will not monitor the whereabouts of the carrier but will fine him if they spot him away from home. For comparatively more severe infectious diseases, like Ebola, the authorities will actively monitor that the carrier's entire household stays quarantined at home, perhaps by the use of electronic ankle bracelets, or will place the carrier in isolation in a monitored medical facility until no longer infectious.

*And crucially, for all these coercive interventions and their mechanisms of enforcement, the law must specify what type and amount of evidence is required to wield them.* This is like requiring authorities to demonstrate probable cause to obtain a search warrant or to provide proof beyond a reasonable doubt to convict someone of first-degree murder.

What evidence, for instance, is required to test individuals as potential carriers of a specific infectious disease? Must they appear symptomatic? Or is it enough that the individuals are traveling from a region in which there is an active outbreak? Or perhaps it's sufficient that they're traveling from a region in which the disease is simply present? Or, to take a different kind of issue, if doctors or commercial laboratories test a patient and the test is positive, are they required to inform the authorities? And when governments test individuals, how accurate do the tests need to be to authorize specific coercive legal interventions, such as requiring the individual to self-isolate or the entire household to be quarantined?

Here too, as in criminal law, the type and amount of evidence necessary should be appropriate and proportional to the threat and the punishment. Just as less evidence is needed to obtain a search warrant than to incarcerate someone for life, so less evidence is needed to test someone for an infectious disease than to place an entire household under quarantine.

*Only when all of this is codified into law*—the coercive interventions justified for various infectious diseases, the mechanisms of enforcement, and the evidence required for the authorities to act—will government's powers be known and constrained, its responsibilities clear.

Whatever the details, those responsibilities amount to, in essence, *one* task.

## **Proper laws would focus government on one task: to test, isolate and track carriers of infectious disease.**

Whatever the differences in the particulars of infectious diseases like malaria, HIV and COVID-19, government's essential power and responsibility remain the same: to *detect* the carriers of severe infectious pathogens, to *neutralize* their ability to transmit the pathogen to others, and to *identify* whom the carriers might have exposed.

Test, isolate and track would therefore be government's mantra.

It must *test* to detect who is actually a carrier of SARS-CoV-2. It must *isolate* carriers in order to neutralize the active threat they present to the rights of others. It must *track* the people that have been exposed, first to notify them that they have been exposed (as the police notify potential victims of identity theft when credit card numbers have been stolen) and, second, to test whether those that have been exposed are now carriers who represent threats to others or to quarantine them if it cannot be determined that they are not carriers.

This, according to experts, is standard protocol in dealing with outbreaks of an infectious disease. These are the coercive powers—the *only coercive powers*—government should legally possess to address the threat from a novel respiratory virus.

The fact that our federal and state governments were not laser-focused on widely testing for potential carriers of SARS-CoV-2, isolating those who tested positive, and tracking the people the existing carriers had exposed, reveals just how inadequate existing U.S. law is. Months into the pandemic and with trillions of dollars being spent, our federal and state governments are still unable to perform this, their essential responsibility.

The basic solution is straightforward. In the American system of government, the government's motive power is and should be the law. It has one fundamental task: execute the law. *Only when we have codified into law the government's goal in combatting infectious disease—to neutralize the active carriers of sufficiently threatening diseases—and the government's delimited powers in fulfilling this responsibility—the power to test, isolate and track—will we get an American response to an infectious disease pandemic.*

Consider what such a focus would have looked like during this pandemic, had such laws already been on the books.

## **III. IN PRACTICE, PROPER LAWS WOULD HAVE ENSURED GOVERNMENT WAS PREPARED TO TEST AND ISOLATE CARRIERS OF SARS-CoV-2.**

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### **With better laws we would have had Taiwan's level of readiness.**

Just as the nations of Taiwan and South Korea learned from their past failures to address novel respiratory viruses, so we in the U.S. can learn similar lessons from our current failure.

Taiwan implemented new laws and strategies after nationwide disappointment with its government's handling of the SARS-CoV-1 outbreak in 2003, which killed 37 people there. Among the most important steps implemented was that it is government's responsibility to *actively monitor* for possible outbreaks of new infectious diseases, including of a novel respiratory

virus, in order to be prepared as quickly as possible to test for carriers and isolate them. This pandemic offers striking evidence of the importance of doing so.

In December 2019, *weeks* before the World Health Organization (WHO) declared SARS-CoV-2 a global health emergency, Taiwan had sent doctors from its CDC to investigate some of the strange medical reports coming out of Wuhan, China, which suggested the possible emergence of a new respiratory virus. Taiwan rightly did not trust China's dictatorial government nor did it trust corrupt or easy-to-corrupt international organizations like the United Nations and the WHO, which at the time were saying there was nothing to see.

The consequence of Taiwan's early and independent investigation?

*By January 1, 2020, Taiwan was testing individuals arriving from China for symptoms of a possible new respiratory disease, and it has maintained this rigorous focus on testing throughout the pandemic.*

In addition to early and active monitoring of outbreaks of infectious disease, another important step that was better implemented after the 2003 failure is procedures and policies to carefully isolate individual carriers and to track the people they may have exposed.

The results of this focus on testing, isolating and tracking are dramatic. As of June 18, Taiwan reports 446 coronavirus cases and 7 deaths. Restaurants and shops are open, and schools were closed for only two weeks in February.<sup>13</sup>

In the U.S., by contrast, we did not act quickly. And this was true despite detailed, repeated warnings from infectious disease experts to our governments that they needed to implement the kinds of steps that had been implemented in Taiwan. To highlight how pathetic was the level of attention and resources devoted to the threat from infectious pathogens, one expert summarized it this way: "The unprecedented challenge we face with COVID-19 is the predictable result of years of neglect when the biosecurity budget was less than that for military marching bands."<sup>14</sup>

Thus, one vital lesson we must learn from our failures during this pandemic is that when no laws focus government on its responsibility to actively monitor for infectious disease outbreaks and to quickly begin to test, the threat is too easy for our federal and state governments to ignore.

### **With better laws we would have had South Korea's widespread, strategic ability to test.**

Like Taiwan, South Korea instituted legal reforms and new policies after nationwide disappointment in its government's handling of an outbreak of infectious disease, this time the 2015 Middle East Respiratory Syndrome (MERS) outbreak, which killed 38 people in that country.

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<sup>13</sup> On Taiwan see "How Taiwan Contained COVID-19: Early Action, Technology & Millions of Face Masks," Democracy Now! YouTube video, April 3, 2020; "Taiwan's aggressive efforts are paying off in fight against COVID-19," PBS NewsHour YouTube video, April 2, 2020; "Coronavirus: Taiwan," Worldometers.info, updated June 18, 2020; Holly Williams, "How Taiwan was coronavirus-ready while the U.S. got caught with its 'pants down,'" CBS News, May 26, 2020; Roy Chiang, "COVID-19: Effective infection control strategies implemented in Taiwan," HealthcareIT News, May 8, 2020. Perversely, because of worldwide appeasement of China, Taiwan is banned from membership in the UN and the WHO.

<sup>14</sup> Adalja, "COVID-19: A Path Forward."



South Korea did not act as early as did Taiwan during the initial stages of the emergence of SARS-CoV-2, and as a result as of June 18 it has had more reported cases and deaths, 12,257 cases and 280 dead.<sup>15</sup> But its focus on widespread testing has enabled it to contain local outbreaks.

Vital to South Korea's success is that it appreciates the need to test widely but *does not assume this means government must control all aspects of testing*.

From the outset of the crisis, therefore, it sought the active participation of private companies to develop tests and worked to remove bureaucratic obstacles that might hamper rapid development and deployment. This is how the South Korean governmental agencies explain the approach:

A COVID-19 diagnostic kit was developed by a Korean biotech company using ICT [Information and Communication Technology], AI and high-performance computing technology. It quickly became widely available and played a major role in eliminating uncertainties in the early stages of the viral spread. In Korea, five diagnostic reagent companies (Companies KogeneBiotech, Seegene, Solgent, SD Biosensor, and BioSewoom) have obtained emergency use approval as of now and are producing RT-PCR reagents, which are the chemical substance used in COVID-19 testing.

KogeneBiotech swiftly developed its product and became the first company to obtain approval on February 4, only about three weeks after the release of the COVID-19 genetic sequence on January 12. This was possible thanks to the companies that promptly started product development and the "emergency use approval" system, which enables swift approval of diagnostic reagents in a simplified process.

Diagnostic companies that acquired technological capabilities through infectious disease R&D have also contributed to such swift product development. . . .

One of the reasons behind Korea's rapid development of diagnostic kits is because companies invest in fostering an R&D environment based on ICT such as big data and AI, which allowed the use of research resources available on global online platforms of the WHO and other international organizations. Seegene uses high-performance computing and AI algorithms to dramatically shorten the process of developing a virus diagnostic kit from several months of expert dedication to around two weeks. The COVID-19 diagnostic kit developed using AI obtained a European certification (CE-IVD) (February 7, 2020), proving its excellence, and the Korean government has quickly approved emergency use of the diagnostic kit (February 12, 2020).<sup>16</sup>

In the U.S., by contrast, government sought to develop its own test and *actively prevented* university research labs and private companies from developing and deploying their own tests. The paucity of tests meant our governments were blind to how the virus was spreading and unable to isolate carriers or track those who had been exposed. By early March, the U.S. had conducted 5 coronavirus tests per million people, whereas South Korea had conducted 3,692 tests per million, a more than seven hundred-fold difference.<sup>17</sup>

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<sup>15</sup> "Coronavirus: South Korea," Worldometers.info, updated June 18, 2020.

<sup>16</sup> "Flattening the curve on COVID-19: How Korea responded to a pandemic using ICT," Government of the Republic of Korea, April 15, 2020, p. 21.

<sup>17</sup> Sheri Fink and Mike Baker, "'It's Just Everywhere Already': How Delays in Testing Set Back the U.S. Coronavirus Response," *New York Times*, March 10, 2020; By Michael D. Shear, Abby Goodnough, Sheila Kaplan, Sheri Fink, Katie Thomas and Noah Weiland, "The Lost Month: How a Failure to Test Blinded the U.S. to Covid-19," *New York Times*, March 28, 2020; Stephen Engelberg, Lisa Song, and Lydia DePillis, ProPublica, "How South Korea skillfully scaled nationwide coronavirus testing while the US fell behind," *Business Insider*, March 17, 2020; Suzy Khimm, Laura Strickler and Brenda Breslauer, "Many private labs want to do coronavirus tests. But they're still facing obstacles and delays," *NBC News*, March 11, 2020.

As both South Korea's and Taiwan's reforms demonstrate, because testing is the necessary condition for government to be able to isolate carriers and track those people they may have infected, *it must be a special focus of government*. But what this should mean is that our governments would *buy* the tests they need to execute their responsibilities under the law. Governments would *not* have the legal power to control, manage or run all testing in the nation. If there is *one* failure during the pandemic, this is it.

Governments of course must evaluate the effectiveness of the tests they are purchasing. But so must businesses and individuals who also are buying tests for their private use. Commercial labs, independent research centers and testing organizations would evolve to issue their own seals of approval. It is a learning and creative process to discover and develop effective tests. A variety of factors are relevant, such as how long it takes to get test results, how many false negatives and false positives occur on average, and how efficiently a particular test can be manufactured and sold at scale. *We want a market in tests to develop.*

This will not only help governments, but also individuals and business owners, who want to buy tests for private use. And the companies that can produce and sell tests at scale should be making sizeable profits, just as Zoom and Netflix are making sizeable profits from helping so many of us cope with statewide lockdowns.

But it is not just the number of tests that matters, it is whether government is *strategically* deploying them to detect and isolate the most carriers of the virus that it can—one consequence of which will be to stop or at least slow down the spread of the virus and thereby reduce the load on local hospitals and healthcare producers.

This means the law should require our public health departments to treat the threat of infectious disease as experts say it should be treated: as a local phenomenon, which can spread. One sign that our coercive statewide lockdowns were panicked reactions is that their implication was that, suddenly, SARS-CoV-2 was everywhere and that all of us, including hospitals across the country, were equally in danger of being imminently overwhelmed.

In the next outbreak of infectious disease, our governments would direct their testing, isolating and tracking capabilities toward locations experiencing an outbreak, as New York City was during this pandemic. This is one of the lessons to learn from South Korea. The issue is not simply how many tests government is administering per million inhabitants. The issue is whether and how its testing is *targeted*. South Korea's first outbreak was at a church 150 miles south of Seoul, and therefore attention was directed to that location.<sup>18</sup> This is one of the main reasons the country has kept its cases relatively low, despite implementing countermeasures only weeks after Taiwan did.

In contrast, even when the U.S. started to be able to test for SARS-CoV-2, there was no stated or discernable strategy of how testing would proceed or how isolation of carriers would work in order to contain outbreaks. As a consequence, our federal and state governments were able to do little containment (prior to ordering coercive statewide lockdowns).

Only if we create new laws, as did Taiwan and South Korea after their earlier failures, laws that define and delimit government's responsibility to test, isolate and track carriers of infectious disease, will our government's response to infectious disease outbreaks look anything like Taiwan's or South Korea's during this pandemic. With such laws, our number of cases and of

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<sup>18</sup> Charlie Campbell, "South Korea's Health Minister on How His Country Is Beating Coronavirus Without a Lockdown," *Time*, April 30, 2020.

deaths would have been much lower. As of June 18, South Korea reports 5 deaths per million population, the U.S. reports *seventy times* more: 362 deaths per million population.<sup>19</sup>

But no laws, however well crafted, can ensure that government will be able in practice to contain an infectious disease outbreak, which means that laws are also necessary to specify what powers government does and does not possess when the spread of an infectious disease is widespread and uncontained, as it was in the U.S. during this pandemic.

#### **IV. WHEN GOVERNMENT IS UNABLE TO ISOLATE MOST CARRIERS OF AN INFECTIOUS DISEASE, THE LAW MUST LEAVE US FREE TO ACT.**

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**If government is unable to isolate most of the infected, the law should grant it few additional powers.**

There is no guarantee that government will succeed in testing, isolating and tracking a sufficient number of individual carriers to contain an infectious disease outbreak. Even if government is trying to detect carriers from the outset, it may fail. The desire to test for a novel infectious disease does not conjure the knowledge needed to create a reliable test. During the 1918 flu pandemic, for instance, researchers did not know the pathogen responsible was a virus and not a bacterium. Millions of dollars were spent to test and treat the suspected bacterial culprit, to no avail.<sup>20</sup>

Thus, there is no guarantee that the spread of an infectious disease will not reach the level of a pandemic as it has for SARS-CoV-2. What should government's powers be in such a scenario?

Perhaps the most important factor guiding the proper formulation of the law here is recognition of the fact that in a pandemic much is unknown. The envisioned situation is precisely one in which government is unable to identify many carriers of the disease. *This drastically restricts the scope of legitimate coercive action.*

Some coercive actions might still be legitimate. For instance, even if government cannot *conclusively* test for the presence of SARS-CoV-2, it still might have the power to require individuals to isolate or the power to quarantine whole households when a person is experiencing symptoms like a dry cough or loss of the sense of smell that may indicate active infection. Or government might be empowered to require everyone to wear a facemask when entering government property if the pathogen is known to be a respiratory virus, as it was during this pandemic. (Private individuals and organizations can make this a condition of entry too.) Very large gatherings like sporting events and business trade shows, especially when no mitigation measures have been instituted, such as screening people for symptoms or enabling social distancing within the venue, might be prohibited because the evidence indicates these events enormously accelerate the spread of the virus and so the threat posed by undetected carriers of the pathogen.

In formulating such laws, the input of experts is again crucial, as is the specific evidence about the nature of the pathogen and its mechanisms of transmission. And the *goal* of such laws, it is

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<sup>19</sup> "Reported Cases and Deaths by Country, Territory, or Conveyance," Worldometers.info, updated June 18, 2020.

<sup>20</sup> Dave Roos, "Why the Second Wave of the 1918 Spanish Flu Was So Deadly," History.com, March 3, 2020, updated April 29, 2020.

important to note, remains the same: to neutralize the *carriers* of the infectious disease. What is different is that government is unable to test suspected carriers in order to isolate or quarantine *only* those individuals it *knows* to be carriers. This means that government's powers here must be highly circumscribed. It certainly should not possess anything resembling the power to order coercive statewide lockdowns.

*The guiding principle is that when government lacks specific evidence about a threat, it cannot act.*

Consider an analogy to crime. Suppose a crime wave breaks out over the summer in Denver. Law enforcement has not yet been able to identify and arrest the perpetrators. Government is not thereby empowered to arrest without evidence the people it guesses are responsible or to impose on everyone in the city, innocent and criminal alike, a 10 p.m. to 6 a.m. curfew to attempt to reduce future crimes. Such coercive action against people for whom there is no specific evidence of guilt is illegitimate; it is a violation of their rights and freedoms. Instead, the government is empowered only to share the information it does possess, such as that the crimes have mostly occurred in certain neighborhoods at certain times of day, and that they have consisted largely of, say, automobile or home breaks-ins. Individual residents can then freely choose to take countermeasures they think appropriate, given the threat. In response to information provided by law enforcement, they might install brighter outdoor lighting or a home-alarm system or set up a neighborhood watch.

Similarly, in the case of an infectious disease pandemic, when many people are potential carriers of a virus but our governments are (mostly) unable to detect who in fact is and who is not, coercive action is illegitimate. Government does not legitimately possess the coercive power to impose a 24-hour curfew on the infected and uninfected alike. It does not legitimately possess the coercive power to lock us all down in our homes.

Rather, government should share the information it does have about the pathogen and its spread, including how much about the virus and the resulting disease is still unknown, in order to help individuals take appropriate countermeasures for their situations, such as increasing the number of times they wash their hands, engaging in social distancing, and disinfecting regularly. Some people, especially if vulnerable, may choose to self-isolate at home for weeks or months, even quitting their jobs when they have the financial means to do so, as they await more information about the disease and more effective courses of treatment. Others will choose different courses of action.

*This—voluntary countermeasures not coercive statewide lockdowns—is what the 2017 CDC guidelines for an influenza pandemic as severe as that of 1918 recommend, and this approach should be codified into the law for all similar pandemics.*

## **An improper public health goal led to coercive statewide lockdowns.**

Even though infectious disease experts like the CDC did not recommend coercive lockdowns for influenza pandemics, because our existing laws do not prohibit coercive statewide lockdowns, they were too easy a “solution” for our governments to adopt during the SARS-CoV-2 pandemic.

The governor of New York has had the candor to admit that he is wielding enormous coercive power without really knowing what he is doing.

What we did was we closed everything down. That was our public health strategy. Just close everything. All businesses, all workers, young people, old people, short people, tall people, every school—close everything. If you re-thought that, or had time to analyze that

public health strategy, I don't know that you would say, 'quarantine everyone.' I don't even know that that was the best public health policy. Young people then quarantined with older people was probably not the best public health strategy, because the younger people could have been exposing the older people to an infection.<sup>21</sup>

Translation: "Close everything and quarantine everyone" is not a public health strategy; it's a panicked reaction by our governments.

And who of us imagined that if panicked governors dared to close everything and quarantine everyone, the national debate would not be whether such vast coercive power has been or *could ever legitimately be* delegated to any American government, federal, state or local—but instead whether it is the president or the governors who possess the power to lock us all down indefinitely?

Why then did the panicked use of such enormous, unchecked coercive power seem legitimate, even necessary, to so many of us?

The governor of New York is again helpful here. He articulated the lockdown's *goal*: the "first order of business is save lives. Period. Whatever it costs."<sup>22</sup>

If we believe that when a new infectious disease emerges, government's lawful goal is to minimize at all cost the number of deaths from the disease, then government *needs* the coercive power to close everything and quarantine everyone. It needs near *absolute* power.

But this goal is illegitimate.

To see that this is so, consider existing infectious diseases. For these, none of us thinks the government's legitimate goal is to minimize the number of deaths whatever the cost.

SARS-CoV-2 of course is not an influenza virus, and glib comparisons of the two—which ignore such facts as that there is some immunity in the population to the seasonal flu, that physicians know of effective anti-viral treatments for influenza, that scientists know how to develop flu vaccines, and that pharmaceutical companies have built manufacturing capacity to produce these vaccines in large quantities—are dangerous. But despite these important differences, it remains true that the seasonal flu results in a considerable number of hospitalizations and deaths each year. The CDC estimates that from the 2010–11 through the 2018–19 flu seasons, the average number of U.S. influenza deaths was over 37,000 annually, with a low of 12,000 deaths in 2011–12 and a high of 61,000 deaths in 2017–18.<sup>23</sup>

Yet we don't charge government with the goal of doing whatever it can to minimize the number of deaths from the seasonal flu. We don't urge it to shutdown large gatherings like rock concerts and NBA games during flu season. We don't urge it to move the governmental school year so that children are in school during the summer months and off in the winter, when influenza transmission is highest. We certainly don't grant it the power during a bad flu season to close everything and quarantine everyone.

*In a free society the government's public health goal is and must be different from minimizing at all costs the number of deaths from an infectious disease.*

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<sup>21</sup> Jennifer Smith, "Cuomo admits his decision to quarantine everyone at once was 'not the best strategy' and that he is 'working on' release of coronavirus antibody test that will allow people to go back to work," DailyMail.com, March 26, 2020.

<sup>22</sup> John Haltiwanger, "'Job one has to be save lives': Cuomo implores Trump not to rush toward reopening the economy at the expense of human life," Business Insider, March 24, 2020.

<sup>23</sup> U.S. Centers for Disease Control and Prevention, "Disease Burden of Influenza," April 17, 2020. For the 2017–18 and 2018–19 seasons, the CDC states that the data from which its estimates are drawn are not yet finalized.

## **The proper public health goal is for government to protect our right to the pursuit of health.**

In a free society the steps taken to mitigate the risk of contracting an infectious disease like the seasonal flu are properly regarded as individual, private decisions, not governmental ones. During flu season we as individuals can choose to avoid large venues like sports stadiums, we can choose to home school our children (though that would be easier if we received a tax break when doing so), and we can choose to stop shaking people's hands and to wash our own more frequently. If we run a business, we can choose to perform temperature checks during flu season and send home employees running a fever (unless of course government controls prevent us from doing so). If we are an employee, we can seek a job that lets us work from home, at least in the winter months. But as individuals we can also choose to do none of these things, and the number of deaths from the flu will be *higher* than it otherwise could have been.

*The existence of an uncontained, severe infectious disease does not alter this.*

The government's goal does not become minimizing the number of deaths from a novel coronavirus, any more than the discovery of a new form of cancer renders the government's goal to minimize the number of deaths from that cancer. A novel coronavirus does not suddenly bestow upon government the coercive power to lock *all of us* down in our homes indefinitely, for our own supposed good. Each of us can of course choose to self-isolate. But none of us has the right to coercively lock down other people in their homes, unless the government has determined that they are carriers of the infectious disease. In an uncontained pandemic, when this is precisely what government cannot determine, it must leave each of us free to pursue our health as we judge best.

If we widen our perspective from infectious diseases to non-infectious diseases and to health more generally, the issue is even more clear. Government has no goal of minimizing deaths from cancer or heart disease or maximizing average life expectancy or ensuring that everyone is physically fit. Only you and I can figure out what is best for our health and happiness, and we should each have the freedom to do so.

America is the land of self-responsibility. We regard freedom as the highest political goal because freedom enables us each to *live* our lives. In the case of the value of health and the threat of disease, we each must think how health is best achieved and disease best avoided in our individual circumstances, and we must decide how important in our lives this issue is to us.

What, for instance, do you think are the components of health, mental and physical? What roles do diet and exercise play and what evidence is there for this? What about the role of friendships or a fulfilling career? Should you become a vegetarian or take up meditation? And how does physical health, in particular, fit with your other goals? Might it make sense to deprioritize it for a few years as you launch your new business? How should you assess the issues of quality of life and quantity? Even if evidence points to a calorie-restricted diet extending your lifespan, do you want to live that way? If you're diagnosed with Type-2 diabetes, what should you do? How serious a condition is it, what are the different treatment options, what is the evidence on their behalf, and, given each treatment's likelihood of success, are any of them worth the time and expense?

*Such decisions are but a sampling of what the pursuit of happiness looks like with respect to health.* Unless incapacitated, no one who values his life will cede authority for these decisions to another person. We consult with trainers, doctors, and therapists, to be sure, but we don't let them run our lives. We certainly don't have the moral right to delegate to government the authority collectively and coercively to make such decisions for us all. No one has the right to delegate to government the power to enforce on everyone a vegetarian diet or a two-hour-a-day exercise regime.



In public health the government's proper goal is, fundamentally, no different from its goal in any other area: to protect our freedom. Its goal is to secure the rights of each of us to make the kinds of decisions listed above and then to act on the decisions we've made. *Its goal is to secure the right of each of us to the pursuit of health, as an aspect of our right to the pursuit of happiness.*

As we have seen, when an infectious disease rises to a certain level of severity, the government is charged with the task of isolating the carriers of the disease from those whom they are endangering. That is its basic goal and responsibility. If it is unable to achieve this goal, if an infectious disease becomes widespread and reaches pandemic levels, the government does not acquire the goal of minimizing at all costs the number of deaths from the disease. Rather, it must continue to test and isolate as best it can. And we as individuals must voluntarily assume the responsibility to implement the countermeasures we think appropriate, given the new conditions and level of danger.

### **This means government's public health goal is not to coercively "flatten the curve."**

As governors across the country decide to "re-open" their states despite the fact that new infections of SARS-CoV-2 continue to occur, it's arguable that their goal has changed from "save every life from COVID-19 whatever the cost" to "balance two opposing factors," whether those factors are conceived as personal safety versus saving the economy, health versus wealth, or lives versus livelihoods.

This strikes many of us as a more valid public health goal. And indeed, it's arguable that for some governors this was always the goal. They weren't aiming to reduce deaths from COVID-19 to as near zero as possible whatever the cost, as the governor of New York said he was doing. Rather, they were trying to reduce the number of new cases to lighten the load on hospitals. Their goal was to "flatten the curve." They were always trying to balance health and wealth, but they (somehow) decided that at the beginning of the pandemic health far outweighed the destruction of people's freedom to produce wealth. Hence their initial imposition of coercive, statewide lockdowns, despite the economic devastation they knew these would cause.

There is of course a compelling objection to the idea that this was the initial goal of most governors. For if this was their goal, if they were really trying to reduce the load on hospitals while preserving as many people's livelihoods as possible, why did they impose not *targeted* lockdowns but universal lockdowns? They could have coercively locked down the vulnerable. Had the police and national guards been instructed to lock down nursing homes and similar facilities, for instance, and control who entered and left the facilities, and had testing been prioritized for the homes' residents and staff, the load on hospitals and the death count would have been significantly lower and the loss of our freedoms significantly less.<sup>24</sup> Yet there was no focused effort to do this.

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<sup>24</sup> Adelina Comas-Herrera et al., "Mortality associated with COVID-19 outbreaks in care homes: early international evidence," International Long-Term Care Policy Network, April 12, 2020, updated May 21, 2020; Deborah Schoch, "Nursing Homes Balk at COVID Patient Transfers From Hospitals," AARP.org, April 21, 2020; Suzy Khimm, "New York will no longer require nursing homes to take COVID-19 patients from hospitals," NBC News, May 11, 2020. According to the CDC's provisional data for the week ending June 13, 2020, of the 103,339 individuals who have died in the U.S. from COVID-19, 33% were 85 years or older, 60% were 75 years or older, and 81% were 65 years or older.

But even if we accept the idea that balancing lives and livelihoods has now become for most governors the goal, and always was for some, the crucial question is: Is this a legitimate public health goal?

It is not.

There is a fundamental difference between individuals *voluntarily* choosing to implement NPIs in the presence of a novel coronavirus, and government *coercively* imposing on everyone the countermeasures it deems appropriate for our health.

There is a fundamental difference between these two because there is no such thing as “our” health or “our” wealth. There is only the specific health and wealth—the specific lives and livelihoods—of separate individuals. To ask government to “balance” these two is a euphemism for asking it to decide who will be sacrificed to whom, whose livelihood it decides takes precedence over whose life, and whose life it decides takes precedence over whose livelihood. *These are not government’s decisions to make.*

No American government should have the power to engage in a utilitarian or collectivist “calculus” by which it somehow attempts to determine what will achieve the optimal “balance” between our individual lives and livelihoods. All such calculations entail that government is charged with the task of picking winners and losers, of deciding who counts as the saved and who the damned. Government must then possess near absolute power to enforce its “calculations” on everyone. All of this is profoundly un-American.

*The American ideal of equality before the law means that each one of us possesses the same rights and the same freedoms, and that government’s goal is to secure and protect these, equally. This principle strips government of any power to decide which innocent life takes priority—and which innocent life, therefore, takes a backseat. Government has no legitimate power to declare that this person’s life takes precedence over that person’s livelihood or vice versa.*

During a pandemic, therefore, no attempt should be made to calculate whether it is “better” to cancel preventive tests and elective surgeries in favor of patients infected with SARS-CoV-2, or whether it is “better” to extend by one or two years the life of an 85-year-old who may die from COVID-19 by forcing other individuals to lose their livelihoods as, confined to their homes, they watch their restaurants and shops go bankrupt.

For in all such cases, the question is: Better for whom? The coercive government decrees issued during this pandemic were not better for the woman whose breast cancer went undiagnosed or who can no longer afford to send her daughter to university. In the American system of government, our individual lives and livelihoods are not the government’s to dispose of. Each of us possesses the same rights and freedoms and each of us must learn to pursue our lives, health and happiness as best we can.

This is why, as we have seen, the CDC guidelines for an influenza pandemic are correct in recommending essentially voluntary NPIs like disinfecting and social distancing. Each of us must decide, in our own circumstances, which countermeasures are worth implementing and to what extent. Some of us, for instance, might choose to socially distance to such a degree as to work from home and not go out unless truly necessary, while others may decide that they need to go to and from work but will otherwise mostly stay home. Americans during the pandemic had already voluntarily started to implement such measures, even with the contradictory messages emanating from Washington about whether SARS-CoV-2 posed a threat. Imagine what voluntary actions would have taken place had a consistent message been emanating from Washington.

Moreover, most of us will not welcome the sight of nurses, doctors and other medical staff exhausted and ill. We have ample reason to voluntarily help prevent hospitals from being overwhelmed. When Americans learned of the shortages of equipment at their local hospitals, for

instance, donations predictably started to pour in. This is precisely what happened at the New York City hospital when the emergency room physician's YouTube video went viral.

The proper goal of government in an infectious disease pandemic, therefore, is neither *coercively* to save every life it can at all cost nor *coercively* to balance lives and livelihoods and "flatten the curve." *The proper goal remains as previously defined: to preserve each individual's freedom to think and act by removing the threat posed by carriers of the disease.* If it is unable to test, isolate and track carriers, it doesn't acquire a new goal or new powers.

### **But during a pandemic, government must be transparent and explain how government-controlled healthcare will be rationed.**

Not only should the law restrict government to the continuing task of testing, isolating and tracking individual carriers of an infectious disease during an uncontained pandemic, it should require that our public health departments and our governments more generally operate with *full transparency*.

Another aspect of the lawlessness of our failed response to SARS-CoV-2 was the lack of information and evidence offered when the statewide lockdowns were ordered. The data and models supposedly justifying such extreme coercive actions were often not provided, even to researchers and other experts. What the lockdowns were meant to accomplish was unclear, and therefore how long they would actually last was unknown, as were the criteria by which they would be lifted. How testing would be ramped up and strategically deployed was not specified, beyond a few broad and false general statements. What the evidence was that hospitals across an entire state or the entire country would be overwhelmed was not presented. Yet if we leave aside biosecurity issues, *there are no grounds for such governmental secrecy.*

A novel coronavirus is not consciously plotting against us. SARS-CoV-2 won't mutate or otherwise adapt because government releases the information it possesses about the virus's source, nature, location and transmission. And as free individuals, we need this information to make voluntary, rational decisions. If people with existing respiratory conditions have special reason to be concerned with the novel virus, they need to know this as soon as possible. If there is worry that hospitals in a particular region, say parts of New York City, will be overwhelmed because the hospitals lack equipment or are at the center of a suspected outbreak and in an area where it is difficult for residents to socially distance, residents need to know this as soon as possible. *Most people will take voluntary countermeasures if they are given reason to do so.*

Part of operating with full transparency is that our governments should be open not only about what they currently know, but also about what they don't know and what they are hoping to learn and by what means (e.g., by doing random sampling of a region of the country to see how widespread the virus already is there). All this information, including all the raw data, should be public and easily accessible. Our governments should invite experts to offer competing analyses and data-based counterarguments. If, for example, our governments are relying on models to predict localized outbreaks, the models, including all their formulas and assumptions as well as the data being fed into them, should be publicly available. Critiques of the models from outside experts should be welcome. If, for instance, some outside experts argue that the data show that the infectious disease is not as contagious or as deadly as first thought, our governments and public health officials should want to know this.

A pandemic is neither a time for secrecy nor for groupthink.

It is also not a time for politics. Part of full transparency is requiring that our public health departments be, insofar as possible, independent and apolitical, on the model of the Federal Bureau of Investigation or the Federal Reserve. Decisions about criminal prosecutions, the

relative soundness of our fiat monetary system or the threat posed by an infectious disease should *not* depend on hidden political calculations, on whether, say, it is considered politically wise so close to a presidential election to investigate a senator, to raise an interest rate—or to admit the existence of a novel coronavirus spreading from human to human, because admitting this might drive the stock market lower.

There is one final, crucial aspect of governmental transparency. When the government controls so much of a nation's healthcare—as most governments do throughout the developed world—government must be transparent and honest about what it is and is not able to manage.

If healthcare were not so controlled by government, the profit motive would drive activity in this realm as it drives activity in our country's most vibrant sectors, like high tech. To appreciate how distorted operation of the profit motive is in the U.S. healthcare system, consider what happened and did not happen during this pandemic.

We have all seen the “flatten the curve” graphs that almost always plotted healthcare capacity as a flat, horizontal line over time. This means that despite the obvious increase in demand a pandemic represents, the supply of healthcare is projected to remain stagnant. Why? If nurses, doctors, hospitals, manufacturers of personal protective gear, and emergency responders could profit from being able to meet the increase in demand, no one would think of healthcare capacity as a flat line. Instead, we would expect what we saw in the world of video conferencing, where the supply surged to meet the increase in demand. Zoom and Microsoft rapidly scaled up their capacity. Facebook and Google tried to become bigger players in the market, with both companies rolling out new or upgraded services. No governmental orders were necessary. Leave people free to produce and profit, and the results are amazing. By contrast, during this pandemic we worry that doctors and hospitals will go bankrupt, since preventive tests and elective procedures were forbidden at many hospitals that were not experiencing an overwhelming number of COVID-19 patients. And even hospitals that have seen a surge in COVID-19 patients are struggling financially. This is not what a normal market looks like.

The fact that healthcare is so heavily controlled by government and that consequently the profit motive is so distorted, does not, as we have already seen, justify government locking us down indefinitely in our homes because the healthcare system might get overwhelmed. But it does impose two different responsibilities on government.

First, an infectious disease pandemic should rapidly change government's priorities. Just as it must quickly reprioritize budgets to spend more on testing, isolating and tracking, so it must quickly reprioritize budgets to spend more on hospital capacity. Redirect the wealth we have already surrendered in taxes to now fight the pandemic. Draw on government stockpiles and make use of the medical resources of the military. That this only started to happen late into the pandemic contributed to the atmosphere of panic. Because government controls so much of healthcare, in a potential pandemic it should *immediately* begin directing money and resources to increase the needed hospital capacity.

Second, government must acknowledge that government-controlled healthcare means *rationed* healthcare. When production, prices and profits are not the principles governing people's actions, something else must be. That something else is the decisions made by government bureaucrats. Our governments must discard the fantasy that government-controlled healthcare is free—that, somehow, healthcare doesn't have to be produced by anyone. Nothing is free in this world. *It is our government's responsibility to explain clearly how healthcare will be rationed in a pandemic. Doing this will allow us as individuals to make better-informed, rational decisions.*

For instance, when government forbids the manufacture and sale of tests as it did at the beginning of this pandemic, instead of government saying that whoever wants a test can get a test, it must explain clearly how the severely limited number of tests will be administered. First responders will have highest priority, for example, with more general healthcare workers next, and young

people at the very back of the line. Or, instead of saying that we have more ventilators in federal stockpiles than we need, it must explain clearly how ventilators and ICU beds will be rationed. It would state, for example, that the elderly and vulnerable will have highest priority—or that they will have lowest priority because they are the least likely to survive COVID-19. In Italy, an even worse government-controlled healthcare system, there were whispers about how doctors were rationing ventilators. Stop the whispering and make the rationing public and explicit. Only this will allow truly informed, individual decision-making.

If elderly individuals and their loved ones knew, for instance, that they would go to the back of the line for a ventilator or an ICU bed, they would have more reason to socially distance and to isolate at home. Or if young people knew they would be the lowest priority for being admitted to the ICU, more young people would consider the need to socially distance.

A pandemic is not the time to indulge the fantasy that “free” healthcare magically means healthcare for everyone.

Also vital in a government-controlled healthcare system is to allow medical staff—doctors, nurses, emergency responders and so on—to opt out. When we declare that healthcare is a right and thereby covertly make medical personnel our servants, obligated to provide us with what is ours by right, we are doing them wrong. Doctors, nurses and emergency responders are not our servants; they don’t owe us healthcare. It is perverse to expect them to continue to work without gowns, masks, tests and adequate hospital equipment, thereby risking their own lives and the lives of their loved ones—all because we have declared healthcare our right. Instead, we should allow them to say that enough is enough. Allow them to decide that their hospital is not accepting more patients, that one nurse will not somehow try to work five different ICU beds, that their own lives also matter.

Admitting this is one more aspect of admitting the fact that government-controlled healthcare is rationed healthcare. And the more we as individuals understand that government healthcare is rationed healthcare and that medical staff have a right to refuse us care when hospitals are overwhelmed, the more reason we have to voluntarily take countermeasures like social distancing. By contrast, the more we are taught that healthcare is free and ours by right, the more we are taught that, magically, there will always be a nurse and an ICU bed when we get COVID-19, the less seriously we will take the need for voluntary countermeasures—and the more it will seem that the coercive hammer of government is necessary.

In sum, government should not have the power to lock us down in our homes even during a widespread, uncontained outbreak of an infectious disease, even in order to reduce the load on the healthcare system. But there are valid steps our government should take to increase the capacity of our government-controlled healthcare system and to transparently provide information that will encourage voluntary NPIs during a pandemic, both of which will help reduce the load on hospitals.

### **The law should prohibit statewide lockdowns and require governmental transparency.**

This, in effect, is the approach Sweden has codified into law by establishing a (relatively) independent and transparent public health department and by prohibiting to government the power to order statewide, indefinite lockdowns during a pandemic. As we have said, it is a dangerous myth that the only effective action in slowing the spread of an infectious disease is coercive action. Life is not normal in Sweden: people are socially distancing, restaurants and other businesses have fewer customers, and people are more often working from home. But in another sense life is normal in Sweden, because without coercive lockdowns individuals there remain free to think and act. Unlike Taiwan and South Korea but like the U.S., Sweden did not extensively or

strategically test for carriers of SARS-CoV-2, though its not doing so seems to have been a conscious decision not a failed attempt to test, as in the case of our federal and state governments. *But unlike the U.S., this does not give the Swedish government power “to close everything and quarantine everyone.”*

Swedish law limits the scope of lockdowns to, at most, a neighborhood of a city and only for a short period of time. The goal of such lockdowns is to assess the situation, separate the carriers of the infectious disease from everyone else in the neighborhood, and then to allow life in a free society to go on. If government is unable to detect and isolate the carriers from the non-carriers in the neighborhood, it should not lock it down in the first place.

Because the Public Health Agency of Sweden has classified SARS-CoV-2 as the highest level of threat from infectious disease, the law grants the Swedish government the power not only to isolate carriers of the virus but also to quarantine in their homes healthy individuals who may have been exposed. But if government does not test, isolate and quarantine enough individuals to contain an outbreak—and unlike our government, the Swedish government never pretended that there were only a few cases and that “it’s going to be just fine”—it cannot substitute the last-ditch, but surprisingly easy-to-wield, weapon of lockdowns. By law it cannot lock down even a city.

In answer to the question “Can a whole town or city be placed in quarantine?” the Public Health Agency of Sweden answers on its website, “No. According to the Swedish Communicable Diseases Act (2004:168), individuals can be put in quarantine but not towns or cities.”

It then goes on to explain the power it does possess to lock down smaller geographical areas, a power focused on testing, isolating and quarantining.

Under the Swedish Communicable Diseases Act (2004:168), an area corresponding to a few blocks may be put in lockdown. This means, among other things, that it becomes prohibited to access or leave the area. A lockdown can be used when one or more people have fallen ill with a life-threatening disease within a particular geographical area. The lockdown then serves to make it possible to find the source, and to identify any more cases of disease or transmission.

The aim with this intervention is to create a zone where an investigation can take place without risk of people entering or leaving and risking further transmission of disease. When the investigation is finished and anyone exposed has received the appropriate care or waited through the incubation period, the lockdown should be lifted. . . .

A lockdown is a temporary intervention in order to investigate cases of disease or disease transmission. Hence, it cannot be used in order to prevent people from travelling in or out of an area for a longer period of time.<sup>25</sup>

What Sweden has recognized and codified into law is that in the case of an infectious disease outbreak like SARS-CoV-2, there may be a situation where it is appropriate to lockdown part of a city experiencing an acute outbreak, say part of New York City. Such a localized lockdown would have to be for a short duration, not months, and certainly not indefinitely. And it would have to have a clear goal, sanctioned by law: the goal of detecting and isolating the carriers in the affected region, tracking those they have exposed, and allowing residents to get back as much as possible to normal life. This, and the government’s primary power and responsibility to test, isolate and track carriers are the only governmental powers compatible with a free society.

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<sup>25</sup> Public Health Agency of Sweden, “FAQ About COVID-19.”



## V. IN PRACTICE, IF GOVERNMENT HAD NOT POSSESSED THE POWER OF STATEWIDE LOCKDOWNS, THE RESPONSE TO THE UNCONTAINED SPREAD OF SARS-CoV-2 WOULD HAVE BEEN FAR BETTER.

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### **Governmental action would have been more strategic, targeted and effective.**

If our federal and state governments knew—because codified into law—that theirs was the responsibility to test, isolate and track individual carriers of SARS-CoV-2, and that they could not resort to the easy but devastating solution of locking down a whole state if the spread of the virus were uncontained, their actions would have been more focused and effective.

First and foremost, they would have continued to focus on the need to test, isolate and track. There is no other way in a free society to prevent or contain an uncontained outbreak than to ramp up the ability to test and isolate. This is precisely what South Korea did when they learned of their first uncontained outbreak. This, however, is not what our governments did when there were outbreaks in Washington State, Northern California and New York City. Once the initial effort to develop testing capacity was botched, they too easily closed everything and quarantined everyone. But deprived of this option by law, they would have had to devote most of their efforts to developing and deploying tests, such as by purchasing them from Taiwan and South Korea (or licensing their technology) and freeing U.S. companies to manufacture and sell their own tests. They also would have increased government's capacity to effectively isolate carriers.

And even if, in contrast to the case of South Korea, our governments' focused attention on testing, isolating and tracking carriers had proved insufficient to contain the initial uncontained outbreaks, the result would still have been enormously positive. The greater the number of individual carriers of SARS-CoV-2 our governments were able to detect and isolate in March, April and May of 2020, the slower the spread of the virus, and the less likely that any local hospitals would have been overwhelmed.

Just as it is not an argument that the police shouldn't arrest the criminals they are able to because they are unable to catch *every* criminal, so it is not an argument that our public health departments should have stopped trying to detect and isolate individual carriers of SARS-CoV-2 because they were unable to identify *all* carriers. Instead of "flattening the curve" by coercively locking us all down, the law would have directed our governments to coercively isolate as many carriers as they could and quarantine their households. The byproduct of such actions would have been a flattened curve *without* all the innocent victims.

Second, because the law would prevent state governments from trying to "save" all hospitals by coercively locking down their entire state, our governments would have had to think carefully about how properly to prioritize their healthcare spending during a pandemic. For instance, it is much more likely that they would have heeded the advice of infectious disease experts that outbreaks are localized and must be treated as such. The governor of New York, for instance, could have worked to surge the capacity of hospitals and healthcare providers in New York City while leaving hospitals in the rest of the state free to continue to attend to their wide array of patients, while simultaneously planning for the possibility that their localities would experience an outbreak later on.

Deprived by law of the power to order statewide lockdowns, our governments would instead have had to focus on increasing testing, reprioritizing government spending and, if necessary, locking down geographically small areas to test and isolate carriers. As already mentioned, if the governor of New York had locked down nursing homes, assisted living facilities and the like, and directed testing resources there in order to assess the situation and separate the infected from the uninfected, the death count in the state would likely have been far lower.

And finally, unable coercively to lock us all down, government would have had much more reason and urgency to identify and eliminate the governmental controls that were preventing swift action on the part of private actors, from the controls prohibiting private laboratories from developing tests to the controls interfering with companies' ability to produce drugs, masks, hand sanitizers and physical barriers like plastic dividers. Lifting these controls would have made it easier for private actors to take effective countermeasures early in the pandemic.

*In short, had the government been forced to adopt a more surgical approach because the use of the blunt instrument of statewide lockdowns was prohibited, its actions would have been both less destructive and more effective.*

### **Private action would have been more strategic, targeted and effective.**

It is difficult for any of us to mount effective countermeasures to SARS-CoV-2 when most businesses are closed and most of us are coercively locked in our homes. No one can predict precisely what free people will do with their freedom, but one lesson this country has amply demonstrated is that both private businesses and private individuals will prove adaptive and innovative. This is what would have happened absent statewide lockdowns.

This, for instance, is one of the reasons why, if it had been allowed to, a huge market for tests would likely have quickly developed. Not only would U.S. companies have been competing to manufacture tests that our governments would purchase to fulfil their responsibility to test, isolate and track, but many more companies would also have had cause to do their own testing for SARS-CoV-2. And this would include both types of test, testing for the active presence of the virus and for the antibodies to it, the latter of which may indicate that a person is currently not in danger of being infected.

Consider for instance companies whose line of business involves large gatherings. No doubt some organizations would have closed their doors, as did the NBA and the NHL, without coercive lockdowns or bans on large gatherings. If these organizations had not prepared in advance for SARS-CoV-2, they would need time to prepare for the new reality of a novel coronavirus circulating in the population and people worried about attending events with large crowds. *But these businesses would have worked to reopen as quickly as they could.*

Many different companies had tremendous financial reason to fund research to develop effective, rapid tests, to purchase the tests in large quantities, and then to screen customers before they gained admittance to the gathering. Think for instance of the many travel and tourism companies like Delta and American Airlines, Hilton Hotels and the Walt Disney Company, the many business and trade shows like South by Southwest, to say nothing of the major sports leagues like the NBA, MLB, NHL and NFL—think of what they would have been willing to spend on testing if doing so helped them keep their organizations in operation. What is now happening at Vienna's international airport, where you can purchase a test for 190 euros and skip the 14-day isolation period if the result is negative, would have been common practice far sooner at large gatherings

in the U.S., had businesses been free to create a market in testing and to be inventive and innovative.<sup>26</sup>

More generally, a whole host of products and services would be created during an uncontained outbreak of a new respiratory virus. Money would be invested not just in creating and manufacturing tests, not just in the production of masks and other medical equipment, not just in the development of antiviral drugs and vaccines, but in the vast array of goods and services that help during a pandemic, from improved online ordering to the installation of plastic partitions to helping students and workers not infect one another to delivery by drones as people are quarantined at home. No one can anticipate in detail what free individuals will invent and produce to address their own problems and improve their own lives—but we can know in general that this is what many of us will choose to do in light of a new infectious disease. Such adaptation is precisely what Zoom and many other online businesses have done during the government-created reality of indefinite lockdowns, because these businesses were left free to operate. Imagine this same kind of activity occurring on a much larger scale, because all businesses would have been free to operate (with appropriate modifications).

Absent the statewide lockdowns, there of course would still have been significant economic disruption. Demand for services like air travel and in-person dining would and did drop as many people chose to social distance, and demand for other services would and did surge as many people chose to work from home, to communicate via video conferencing software, and to shop online. But all these business disruptions would have been caused by the new reality of an uncontained novel coronavirus, not by the artificial reality created by coercive lockdowns.

Indeed, instead of forcing businesses to close, our governments, as already mentioned, would and should have worked to liberate businesses by lifting controls and restrictions on, say, developing tests and antiviral drugs, so that companies were free to rapidly deploy the best countermeasures they could invent.

Private and public schools, like other businesses, would have faced similar decisions and would have learned from each other what were the best ways to cope, as the virus spread from location to location. One factor that each would individually have had to consider is the evidence about this particular respiratory virus and the desirability of closing or keeping a school open. How susceptible were school-age children to COVID-19 and how significant was transmission of the virus by the young? Another factor each school would have considered is the changes in demand they were experiencing: if many parents were choosing to keep their children out of school, a particular school might decide to shift to online classes. And still another factor each school would have considered is the localized nature of infectious disease outbreaks: Is there any reason to close my school in my region of the country? Perhaps there would be in a month or two as the virus spread, but that would give individual schools time to prepare for a possible closure. *If individual schools and parents had been free to make these decisions, rather than state governors, the disruption to students' education would have been far less.*

And just as businesses and schools would have learned to adapt to the uncontained spread of SARS-CoV-2 (and should be free to do so now), so would we have as individuals. We each would have been responsible to decide how best to cope with our unique situation and risk profile, and in doing so most of us would have considered the impact of our decisions on our *entire* lives.

Do I, for instance, have reason to think that because of my age or existing health conditions, I'm especially vulnerable to this virus? Or am I likely to be one of the people little affected by it? What about the people I am regularly in contact with? Is there evidence that the virus is widespread in the region of the country in which I live? Do my current job and my career allow me to work from home or otherwise socially distance while working? Can I afford to take a lower-paying job that

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<sup>26</sup> Vienna International Airport, "Coronavirus PCR Tests Now Possible at Vienna Airport."

entails less interaction with strangers? And even if I'm especially vulnerable, should I nevertheless take the risk of interacting with other people?

*There are no obvious or easy answers to these questions.* Some people will think about them more, some people less; but as we have seen, no one legitimately has the power to make these decisions for other people.

For example, I personally know several individuals in their eighties who are still relatively mobile and healthy. Most would have preferred to continue to live their lives as they had been, going out, meeting loved ones, and overall continuing to enjoy what time they have left. If this results in a shorter lifespan, they willingly accept that outcome. Unlike what has happened because of the coercive statewide lockdowns, the choice would have been theirs to make.

And all of us would have enjoyed the same freedom and the same need to thoughtfully make decisions about our health and the kind of life we want to lead. One hypothesis, for instance, is that a low vitamin D level represents a significant vulnerability to COVID-19 because it often leads to a compromised immune system. If that is the case, is cocooning inside really the best countermeasure? Or how much, if any, does the amount of initial exposure to the virus—the initial viral load—matter for the negative health effects it produces? If there is no quick prospect for a vaccine, might it make sense to expose yourself to a low dose of the virus, as people had chickenpox parties to expose their children before a vaccine had been developed?

Or consider decisions about children and their education. Even if you do decide to engage in more social distancing, should that include your children, and to what extent? Should you take them out of school, with the resulting disruption to their education? Is it good for them to spend so much time at home with you or with your elderly parents who also live with you? For a flu pandemic, the CDC guidelines recommend that we consider educating our children at home during severe outbreaks, with perhaps only the teachers still physically at school, broadcasting their online lessons from there. This is recommended in part because children are especially susceptible to the flu and are active spreaders of the virus. But in the case of SARS-CoV-2, there was evidence, as the governor of New York has admitted, that it may have been better for college and university students, for example, to remain in school and consequently have less interaction with elderly relatives. With the freedom to make such decisions, we could have figured out what is good for us in our particular situations.

The bottom line is that if we are truly to pursue our own health and happiness, we must have the freedom to think and act for ourselves. If we codify into law both the government's proper goal and its legitimate powers in execution of that goal during an uncontained outbreak of infectious disease—if the law still focuses government on the task of testing, isolating and tracking carriers as best it can and removes government's power to order statewide lockdowns—we will have that freedom. There is every reason to think the result will be superior.<sup>27</sup>

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<sup>27</sup> A number of individuals have helped improve this paper. But I'm especially grateful to Alex Epstein for detailed discussion of many of the issues and for extensive comments on how better to structure the overall argument of the paper as well as to formulate specific points. For an earlier take on some of the material discussed in this paper, please see our discussion in April, "State Lockdowns Were Never Justified." None of this is of course meant to imply that Alex agrees with every point or formulation in the paper.

## VI. WHAT YOU CAN DO

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### **Write your representatives in government.**

Federal and state governments do have a crucial role to play against the threat posed by infectious diseases. But for governments to perform their proper role, we need to change federal and state laws to accomplish two things.

*On the positive side, we need the law to focus government with laser-like precision on its proper goal: to remove the active threat posed by carriers of severe infectious diseases.*

To be able to accomplish this goal, the government must properly catalog the severity of various infectious diseases and then, for severe infectious diseases, it must have the ability to test, isolate and track contagious individuals. All of this can and needs to be carefully codified into law. And then governments must execute these laws. To do so, they must purchase or build the capabilities that enable effective testing, isolating and tracking. But this emphatically does not mean that they control testing across the country, or prohibit private labs from deploying their own tests, or decide who can and cannot purchase tests, and the law must make this clear.

*Second, on the negative side, the law must strip federal and state governments of the power to lock down entire states or even just cities in the name of public health.*

The government's public health goal is not to save every life from an infectious disease whatever the cost, but to protect our individual right to the pursuit of health, as one crucial aspect of protecting our right to the pursuit of happiness. And if our governments know that they do not possess the power of coercive lockdowns, they will be even more focused on the need to effectively test, isolate, and track carriers and to expand capacity in the government-controlled healthcare system.

It is not just the power of lockdowns during a pandemic that must be removed. The law should also suspend the controls on healthcare that most cripple doctors, hospitals, laboratories and pharmaceutical companies during a pandemic. Remove, for example, the barriers to deploying private tests and the permissions required that prevent hospitals from quickly increasing their capacity.

*What we need and what is realistically achievable is an approach to infectious disease that codifies into law the best aspects of what Taiwan, South Korea and Sweden have implemented. Taiwan and South Korea have learned from their past failures; we can learn from our present failure.*

How can you help make this new approach a reality?

*Write to your representatives in state and federal governments.*

Tell them that government's public health goal in the face of a novel respiratory virus like SARS-CoV-2 is to remove the threat posed by carriers of the virus and that its role, therefore, is to test, isolate and track carriers. Tell them that trying to save every life from a novel virus whatever the cost, or to balance some people's lives against other people's livelihoods, is not a valid public health goal. Tell them that apart from testing, isolating and tracking, government should issue only voluntary guidelines and then leave us free to take the countermeasures we individually think necessary in the face of the new reality. Tell them that they must change our laws.

*And then keep contacting your representatives until they make the necessary legislative changes.*

If America is to remain the free country that it is, we cannot afford to respond to another outbreak of SARS-CoV-2 or another novel respiratory virus in the way that we have. We cannot afford future rolling lockdowns, as we await a vaccine. We cannot allow to stand the precedent that in an infectious disease pandemic, government's public health goal is to try to minimize the number

of deaths from the disease whatever the cost, and that in pursuing this goal, government can coercively lock us down in our homes indefinitely.

There is a better, more American way to confront the threat of infectious disease. We only need to enact it into law.

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