Ethics of U.S. government policy responses to the COVID-19 pandemic: A utilitarianism perspective

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Abstract
COVID-19 hit the United States in January 2020, quickly resulting in stay-at-home orders that sent the U.S. economy into a major recession. The federal government leveraged fiscal, regulatory, and monetary policies to provide relief. Decisions had to be made in a complex environment wrought with difficult choices, complicated by the federalist governing system in the United States. Myers (2016, p. 202) asserted, “If an event like the [1918 influenza] pandemic were to occur in the United States, it is important that the government be prepared, not only in terms of material, but ethically.” We analyze the ethical choices of the initial responses by reviewing early U.S. government responses and the impact of culture, federalism, and justice. We conclude that utilitarian analyses of balancing infection rates and economic impacts must be supplemented with Kantian principles of not treating people as means to an end, balancing the protection of individual freedoms with the good of society, and protecting vulnerable groups. As governments prepare for future crises, ethical considerations should be built into those plans as guardrails to guide decision-makers.
1 | INTRODUCTION

The global coronavirus disease 2019 (COVID-19) pandemic hit the United States swiftly, and governments at all levels found themselves in a major public health crisis not seen since the 1918 influenza pandemic and an economic crisis not seen since the Great Recession in 2008. Pandemics in the United States are rare, requiring expedient decisions in a context with which decision-makers have little experience. It is important for ethics to guide decisions that impact the public’s health and livelihood. Public health and medical professionals advise those with federal policy power, but the extent to which the advice is followed depends on political partisanship in relationships between states and the central government that shape policy in the federalist system used in the United States.

The Centers for Disease Control and Prevention (CDC) confirmed the first case in the United States on January 21, 2020, less than a month after the World Health Organization (WHO) suspected a novel coronavirus (CDC, 2020a; WHO, 2020). Only 50 days later, COVID-19 had created a national public health emergency and threat to the economy. Not since the 1918 Spanish flu had the United States seen a public health emergency interrupt the economy in such a pervasive way. The U.S. government rapidly deployed many public health and economic policy actions in response to the pandemic. Table 1 outlines major timeline milestones of the early pandemic actions and responses.

The purpose of this paper is to review the initial federal economic policy actions taken in response to the pandemic with an ethical and historical lens, recognizing the constraints that our federalist system imposes on managing a national public health crisis. We review government actions and consider relevant literature to critically evaluate U.S. economic policy and public health actions taken in the early stages of the pandemic. Our primary research question is whether these initial responses were consistent with utilitarianism and appropriate in the circumstances. First, we frame our perspectives by reviewing relevant ethical traditions, followed by responses to the 1918 influenza pandemic and other recent public health crises. Next, we discuss the initial major U.S. policy responses to the pandemic as well as potential long-term U.S. consequences of these responses, considering ethical approaches likely used. We close with thoughts and questions for future policy responses.

2 | PERSPECTIVES ON ETHICAL TRADITIONS AND PRIOR CRISIS RESPONSES

2.1 | Relevant ethical traditions

Pandemics force governments to make ethically challenging decisions where they must balance public and economic health (“Between Tragedy and Statistics. The Hard Choices COVID Policymakers Face,” 2020). In 2016, Myers stated, “If an event like the [1918 influenza] pandemic were to occur in the United States, it is important that the government be prepared, not
only in terms of material, but ethically” (Myers, 2016, p. 202). If officials do not act in the public’s best interest in principled ways, public cooperation necessary to minimize health impacts and maintain order are likely to be materially hurt. We review four of the broad ethical traditions that may influence responses.

### 2.1.1 Deontology

Deontology is a normative duty-based approach to decision-making that does not allow humans to be considered as means to an end, but instead focuses on doing what is right or following a moral code regardless of the result (Jeanes, 2019). Moral philosopher Immanuel Kant promoted deontology as an approach that focuses not on outcomes but rather what is right and wrong. Managing a pandemic requires balancing two principles, personal freedoms to act in one’s own best interest and obeying government restrictions on freedoms that limit the risk of the spread of contagion. With competing principles in play, actions must also consider the consequences and/or the virtue of the choices made.
2.1.2 | Utilitarianism and communitarianism

Consequentialism calls for evaluating actions by their ability to produce the most intrinsic good. The utilitarian ethical philosophy guides choices by evaluating their outcomes, with actions that produce the highest utility or net positive outcome for those impacted being the preferred alternative. In these decisions, the choices must involve a careful cost–benefit analysis. These decisions are made much more difficult when there is limited and imperfect information about the consequences of choices (Savulescu et al., 2020; Trevino & Nelson, 2017). Group consequentialism, or communitarianism, implies that the net benefit to one’s group (e.g., nation, religion, and economic class) should receive a higher weight than the impact to other groups in evaluating the consequences (Zürn & de Wilde, 2016).

The philosopher John Rawls argued that to be moral or just, ethical choices must not harm the least well off or the most vulnerable (Rawls, 1958). Thus, a utilitarian or communitarian cost–benefit analysis must be tempered by two principles. First, choices must limit the potential harm to more vulnerable groups. Second, the actions must ensure that the gains are worth limiting personal liberties (Myers, 2016). Many in the United States still cherish their history of individualism and self-reliance with limited government interference in their daily lives (Rosenbaum, 2018). To overcome these tendencies, leaders must foster a sense of national unity that encourages their citizens to set aside personal rights and political differences. This has always been the function of effective leadership in a crisis (Cox & Seawright, 2017). This requires understanding the culture of society as well as discussed below.

2.1.3 | Egoism

Ethical egoism focuses on positive outcomes for the self, with little consideration for impacts on others (Burgess-Jackson, 2013; Cummiskey, 1989). Government leaders, especially elected or appointed officials, may allow their self-interested egoism to override other principles as they face pressure from various groups of constituents. Decision-makers relying on egoism risk losing the trust and confidence that people must place in government leaders to effectively manage the crisis.

2.2 | Cultural factors

Ethical traditions can guide policy decisions, but cultural factors may influence the effectiveness of those policies. The United States is a country with a low power distance index (Pop-Flanja, 2020). Such countries lack a large separation between decision-makers (authority figures) and the public. Authorities are not automatically obeyed, and the public must be convinced of the need to modify their behavior for effective mitigation. In countries with a high-power distance index such as China, the public generally obeys authority figures and is accustomed to the government having a large say in their lives, whether they trust their government leaders or not. As such, adherence to public health mandates to mitigate disease spread is generally high.

The United States is also an individualistic society as opposed to a collectivistic one (Pop-Flanja, 2020). In the former, actions tend to be evaluated based on their impact on the individual rather than on a larger group (a more egoistic viewpoint). Consistent, scientifically backed
**communitarian** appeals to consider the interests of the group are more necessary in individualistic societies such as the United States. To be effective, the message should match the relationship between the public and the government. In the United States, the public must be persuaded it is in their best interest to obey a public health mandate, particularly when the risk and the outcomes are uncertain and actions limit individual freedoms (Ferrier & Haque, 2003; Shen et al., 2021). This requires a consistent, scientific-based message with a high degree of transparency. The public must also believe the messengers are largely free of egoistic (self-interested) intent (Bernstein et al., 2020; Kinlaw & Levine, 2007).

### 2.3 Prior crisis responses

Does the U.S. government have a history of making good ethical choices during earlier public health crises, demonstrating they are trustworthy? Government responses to prior public health crises may help inform the answer to this question. Though the current pandemic is occurring in different political and economic circumstances than prior crises, there are lessons to be learned from prior health events. A summary of these events is presented in Table 2, Panel A.

#### 2.3.1 1918 influenza pandemic

The 1918 Spanish influenza pandemic came in three waves in the United States between March 1918 and summer of 1919 (Institute of Medicine (US) Forum on Microbial Threats, 2005; Wheelock, 2020). The medical establishment of the day failed to create a vaccine or any particularly effective treatments (Institute of Medicine (US) Forum on Microbial Threats, 2005). The federal government was preoccupied with World War I and was concerned that fear of the virus spreads.

| Health event | Primary ethical response of government |
|--------------|---------------------------------------|
| Spanish flu  | Egoistic, placing other interests ahead of public welfare, lack of institutional structures |
| H5N1         | Deontological with respect to planning for future pandemic, but within federalist framework |
| H1N1         | Deontological with long-term view with respect to preparation for future pandemics, preparation not updated for future events as needed |
| COVID-19     | Mixed, affected by federalism |

| U.S. decision-makers | Primary ethical tradition used |
|----------------------|--------------------------------|
| Executive branch     | Egoistic or utilitarian with priority on economy |
| Congress             | Utilitarian and deontological |
| Federal Reserve      | Utilitarian |
| Regulatory authorities| Utilitarian |
| State and local      | Utilitarian and deontological, impacted by partisanship and federalism |
would weaken morale and hurt the war effort; thus, they downplayed the danger of the virus. When the death toll began climbing rapidly despite government assurances that there was nothing to fear from the virus, the credibility of government officials collapsed and panic ensued in some cities (Institute of Medicine (US) Forum on Microbial Threats, 2005). About 675,000 people are believed to have died in the United States and 50 million or more worldwide as a result of the Spanish flu pandemic (CDC, 2019). In comparison, work by *The Economist* estimates the global death toll from the COVID-19 pandemic at between 7 and 12 million and still rising, although official statistics are lower (“Modelling Covid-19’s Death Toll. There Have Been 7m-13m Excess Deaths Worldwide During the Pandemic,” 2021).

Little is known about the national economic impact of the 1918 pandemic. The federal government's health response was very limited. Soldiers returning from World War I helped spread the virus throughout the United States. Roughly 30% of doctors were on active duty in the military at the time, and the government did try to recruit additional doctors (Schulze, 2020). The virus disproportionately impacted working-age individuals between 20 and 40 years old, and the impact was greater on urban workers than rural. We do know that many small businesses failed, and there were localized labor shortages in areas that suffered higher infection and mortality rates (Wheelock, 2020).

The government's public health response can best be described as *egoistic*, as it did not place the welfare of others ahead of government concerns. Government officials were reluctant to inform people of the true risks of the virus and lost credibility with their constituents as they tried to maintain normal activities for as long as possible. This is consistent with the laissez-faire approach of government policy doing nothing or very little that was prevalent at the time (Desvars-Larrive et al., 2020). Indeed, the infrastructure to manage health issues on a national scale would not be in place for decades. The organization that would become the CDC was created in 1946, the WHO in 1948, and the Department of Health and Human Services (DHHS) in 1953 (Edwards, n.d.; Satanovsky, n.d.). The limited evidence available indicates that the economic impact of the 1918–1919 outbreak was probably short-lived, but the death toll was very high (Wheelock, 2020). In contrast, the current pandemic is likely to have a much lower mortality rate, but a longer-lasting negative economic impact, including increases in inequality, poverty, and government debt-to-GDP ratios (Emmerling et al., 2021; Jordà et al., 2020).

2.3.2 | 2003 H5N1 influenza

The COVID-19 pandemic is not the first viral public health event in recent years. In the late 1990s, avian (H5N1) influenza was first detected in Asia, with a more widespread reemergence in 2003. Though no cases were detected in the United States and community spread never reached pandemic levels elsewhere, this outbreak caught the attention of U.S. public health officials due to its high contagion. As a result, in 2005, DHHS adopted a Pandemic Influenza Plan, and the Department of Homeland Security issued a companion Implementation Plan for the preparation, response, and recovery from a virus with potential to grow to pandemic levels. These plans align with the WHO pandemic guidance grounded in pandemic phases, originally issued in 1999 and updated in 2005 (U.S. Department of Health and Human Services, 2005; U.S. Department of Homeland Security, 2005). This act of planning was primarily *deontological* in nature within the framework of federalism described below. Much of the implementation of this plan was the responsibility of state and local governments. The government failed to adequately consider that a health crisis would require a national response to coordinate between...
Thomas et al. (2007) asserted that a lack of preparation for an ethically appropriate decision-making process in pandemic planning at state and local levels would deleteriously affect many people in the event of a pandemic. “History will judge our generation’s response to the next pandemic in large part by our ability to act ethically” (Thomas et al., 2007, p. S31).

2.3.3 | 2009 H1N1 influenza pandemic

In April 2009, a unique H1N1 influenza virus (originally mislabeled “swine flu”) hit the United States with a new strain, appearing in limited clusters (CDC, 2010). The U.S. government declared a public health emergency on April 26, 2009, and began releasing supplies from stockpiles, including antiviral drugs and personal protective equipment (PPE). This was followed by Emergency Use Authorizations for certain new antiviral drugs and warnings issued about traveling to Mexico where there were outbreaks. Within two weeks, the CDC had developed and approved a test to detect the virus. By the end of April, the United States was implementing its pandemic response plan, and on June 11, 2009, the WHO declared a global pandemic. By mid-June 2009, the virus was in all 50 states, and the United States had the largest number of cases of any country. Ultimately, the flu waned, and the following flu season’s vaccine had been developed to protect against it. Overall, the U.S. government’s approach was more deontological by spending funds beforehand to develop a response plan and build a stockpile of supplies and medicine, so that the benefit of the preparedness could be realized in the future when a public health emergency materialized as it did in 2009. The 2009 pandemic was not severe enough to mandate public health actions with widespread economic impact (e.g., stay-at-home and social distancing orders). But as time went on, federal funding waned amid other competing priorities, and the preparedness for a future pandemic declined, reflecting short-term utilitarian cost/benefit thinking (McKay & Dvorak, 2020).

3 | INITIAL U.S. GOVERNMENT COVID-19 PANDEMIC ECONOMIC POLICY RESPONSES

The U.S. government did not take major economic policy actions in response to the 1918 and 2009 pandemics. However, the COVID-19 pandemic was a more serious blow to both the United States and the global economy. In early 2020, the United States found itself in an even sharper downturn than the Great Recession of 2007–2008, resulting from COVID-19 closures and record declines in growth (Bartash, 2020; World Economic Outlook, April 2020: The Great Lockdown, 2020). The impact of closures erased the job gains of the latter part of the prior decade in a matter of weeks. In May and June 2020, however, jobs rebounded as states allowed many businesses to reopen; nevertheless, job growth declined in succeeding months in 2020, and the unemployment rate did not fall to pre-pandemic levels that year (Ettlinger & Hensley, 2020). In a June 20, 2020, report, the Organization for Economic and Cooperation Development (OECD) concluded, “The global economy is now experiencing the deepest recession since the Great Depression of the 1930s” (OECD, 2020, p. 12). U.S. policy responses focused on assisting both individuals and entities during these turbulent events. Major fiscal, regulatory, and monetary responses are listed in Table 3. The ethical considerations of these are discussed below.
Decision-makers initially responded from a public health perspective, closing down states to protect citizens from a fast-spreading and potentially deadly virus. These hard choices involved a cost/benefit analysis rooted in utilitarianism, which presents challenges. The Economist noted, “a government trying to privilege the health of its economy over the health of its citizenry would likely end up with neither ... This is one reason why, in the acute phase of the epidemic, a comparison of costs and benefits comes down clearly on the side of action along the lines being taken in many countries” to minimize the spread of the virus (“Between Tragedy and
Statistics. The Hard Choices COVID Policymakers Face,” 2020). As expected, this required bringing many sectors of the economy to an abrupt halt (Martin, 2020). In April 2020 alone, approximately 20.5 million jobs were lost, and the unemployment rate rose swiftly, increasing from 3.5% in 2019 to 14.7% in April before declining to about 10% in July and 7% in October, with over 11 million people still unemployed at the end of October (U.S. Bureau of Labor Statistics, 2020; Petrosky-Nadeau & Valletta, 2020).

Initial government actions to limit the economic damage were swift and widespread and included fiscal, regulatory, and monetary policy responses (see Table 3). The government website https://www.usa.gov/coronavirus contains links to the full range of federal government actions excluding financial regulatory and reporting changes. Flores et al. (2020) provide a summary of regulatory relief actions.

### 3.1.1 Initial fiscal responses

The government’s fiscal responses to temper the financial impact were extensive and quickly implemented. Congress passed the Coronavirus Aid, Relief, and Economic Security Act, Public Law 116–136 (2020), or CARES Act (the Act) on March 27, 2020, and extended many expiring provisions of the Act in December. A succinct summary of the Act is found in LaBrecque (2020). The general notion was to keep as many entities and individuals financially afloat until the virus infection rate declined and reopening was more feasible. The CARES Act initially authorized a $454 billion fund for industries hurt by the shutdown and provided additional funding to assist state and local governments with COVID-19 spending. The CARES Act was broad-reaching and was built on the logic that providing financial assistance early would soften the economic blow, even with a huge government price tag. The Act increased unemployment insurance by $600 per week for up to 4 months and created the Paycheck Protection Program (PPP) for business and nonprofit entities with fewer than 500 employees. The PPP allowed these entities to apply for loans to retain employees on the payroll, although some of the funds could be used for other purposes as well. The loans are forgivable if the funds were used for these allowable purposes. The CARES Act also included help for especially hard-hit industries. For example, certain taxes normally levied on aviation businesses were suspended for the remainder of 2020.

### 3.1.2 Initial regulatory responses

The federal government and states changed many regulations and deadlines to assist businesses and individuals. Employers were allowed to defer the payment of Social Security taxes until January 1, 2021, as a cash flow relief. Other examples include extending tax filing and payment deadlines, reducing banks’ reserve requirements, viewing loan modifications less punitively, allowing delayed information filings with regulators such as the SEC, and allowing online annual shareholder and board meetings (see Federal Reserve [Fed] and SEC press releases found at https://www.federalreserve.gov/newsevents/pressreleases.htm and https://www.sec.gov/news/pressreleases, respectively). Scheduled implementation of new, complex accounting standards and strict reporting requirements were also delayed, giving firms more time to meet the additional requirements (Kiernan et al., 2020). After the passage of the Act, Congress and regulators continued to be responsive to requests to minimize financial hardships, while clarifying and
adjusting relief program requirements in reasonable ways. For instance, the Fed issued a series of regulatory guidance statements to encourage banks to extend credit to businesses and other financial institutions during the shutdown, an action they might not have ordinarily done for fear of violating regulations to limit lending risk. California and many other states also implemented anti-foreclosure regulations and forbearance for missed loan and rent payments for both individuals and businesses (Parker, 2020a, 2020b). These actions were utilitarian, giving economic participants the benefits of reduced costs of compliance, even if such actions cost the federal government money.

3.1.3 | Initial monetary policy responses

The Fed's monetary policy response was very proactive in the crisis. In early March, the Fed issued guidance to encourage banks to borrow as needed from the Fed's Discount Window and to work with loan customers in creative ways to limit loan defaults. In mid-March, the Fed broadened the list of securities that could be used as collateral for Discount Window loans. The Fed then went on to create lending facilities for Paycheck Protection loans and other financial market participants. The Fed also shifted its monetary policy goals to focus more on achieving maximum employment across sectors and agreed to do so even when inflation moves above its traditional 2% target to provide more economic support to the economy (Brainard, 2020). These monetary policy responses are communitarian, with a focus on the financial industry, but downstream effects impact a wide array of entities, making these responses utilitarian in nature.

4 | DISCUSSION AND ANALYSIS

A pandemic presents an ethical choices paradigm. The government's deontological imperative to protect physical and financial well-being is complicated in a fast-moving pandemic situation, bringing utilitarianism to the forefront. Applying utilitarianism during the novel COVID-19 pandemic was very difficult given the uncertainty of policy actions and inactions, cultural features of the United States, and the federalist system. Pandemics are widespread but do not impact the same populations in the same way at the same time. The potential health impacts can have second order effects on whole economies or subsections of economies. These justice concerns are important. These ethical choices are summarized in Figure 1. In the next sections, we discuss these intricacies with a focus on decisions in the United States.

4.1 | Utilitarianism in a pandemic

Much has been written about the ethics of public health decisions before and during a health crisis such as a pandemic (Bernstein et al., 2020; Kinlaw & Levine, 2007; Myers, 2016). Democratic societies expect their governments to respond to major threats impacting its citizens, including public health threats (Comfort, 2005). Governments have a deontological imperative to protect its citizens. Governments may take various actions, including intervening to allocate resources (e.g., vaccines and medical equipment) or mandating restrictive interventions such as social distancing, quarantines, and international travel restrictions (Myers, 2016). Nihlén
FIGURE 1  Outline of ethical choices paradigm [Color figure can be viewed at wileyonlinelibrary.com]
Fahlquist (2021) discussed the trade-off between protecting the collective good and upholding ethical values such as beneficence, non-maleficence, individual autonomy, and distributional justice. These ethical values intertwine with ethical approaches of deontology, utilitarianism, communitarianism, and egoism in driving policy choices. Utilitarianism is a common framework for evaluating the consequences of decisions before acting.

When applied in a public health crisis, the utilitarian ethical philosophy's focus on net positive outcomes attempts to balance rights and responsibility to both individual and group welfare. Mandating social distancing or requiring businesses to shut down temporarily imposes costs on individuals and values the group over the individual. Libertarians such as Nozick would argue that regardless of the societal or community good resulting from a government policy such as a shutdown order, individual rights must be considered paramount (Salahuddin, 2018). Others maintain that the rights of the individual are limited when granting those rights may negatively impact the community. In deciding whether to obey government mandates that restrict personal rights, individuals assess the personal health and economic risk they face and the extent they trust what their leaders are telling them.

How does one arrive at a utilitarian decision when the consequences can have serious impacts on the health of individuals? Decision-makers must evaluate health interventions by comparing the benefit of the treatment to the cost. Health professionals often consider the cost in terms of the additional number of years of life patients will gain from the treatment adjusted by the quality of the life gained from the treatment (Institute for Clinical and Economic Review [ICER], 2020; van den Broek-Altenburg & Atherly, 2020). The resulting quality of life years gained, or QALYs, from the treatment is then compared to the cost of the treatment. Health administrators in the United States often consider a cost of $100,000 per QALY to be a reasonable cost for many new treatments (ICER, 2020; Savulescu et al., 2020; van den Broek-Altenburg & Atherly, 2020). The CARES Act and other fiscal spending in 2020 may have been as high as $4 trillion. van den Broek-Altenburg and Atherly (2020) estimate that the cost per QALY gained may range from $300,000 to as high as $2.4 million. This is well above what is normally considered a cost-effective medical treatment. The analysis implies that there may be other less costly methods to limit the spread, such as lockdowns of selected vulnerable populations, contact tracing, extensive testing, and/or distribution of PPE. However, the behavior of the COVID-19 pathogen, including its projected persistence and mutation velocity, was largely unknown at the time the lockdown and resultant fiscal spending decisions were being made. Moreover, the $100,000 per QALY standard used to determine the cost-effectiveness of treatments may not be particularly relevant to a pandemic with potentially large and unevenly distributed economic impacts. Taking a triage approach to government spending, more targeted spending may be needed for vulnerable groups rather than providing extra money to the general populace in the CARES Act.

The PPP of the CARES Act is an example of the triage concept. Preliminary work by Autor et al. (2020) finds that the PPP did succeed at boosting employment by around 3.25% in mid-2020. However, another study by Granja et al. (2020) did not find that additional PPP funds were available in areas where there were more business shutdowns and declines in working hours, so the effectiveness of the PPP program in the United States is debatable. Over one-third of the funds were distributed by a few large banks. Initially, not all small businesses could access PPP loans, with lenders giving preference for access to the finite pool of funds to current customers (Simon & Rudegeair, 2020). This was eventually resolved but may have contributed to the negative findings of Granja et al. (2020).
4.2 Limitations of utilitarianism

Utilitarian calculations are made much more difficult when there is limited and imperfect information about the consequences of choices (Savulescu et al., 2020; Trevino & Nelson, 2017). In early 2020, given limited information on the potential health consequences of COVID-19, it would seem the greater risk lay in promoting economic over public health by not intervening (“Between Tragedy and Statistics. The Hard Choices COVID Policymakers Face,” 2020). It appeared that U.S. decision-makers chose the risk of economic overspending rather than suffer the potential economic consequences of under-spending and provided broad spending rather than more targeted spending to protect the most vulnerable groups.

Moving forward, it behooves governments to consider the cost–benefit of their actions more carefully via utilitarianism to engage in the most efficacious and cost-effective practices to protect public health. This is not guaranteed. As Gerber (2007) and Congleton (2006) argue, officials do not always act on knowledge gained from prior events. Learning from prior events should inform the utilitarian actions in response to future events, examining expected future consequences from choices made today (Savulescu et al., 2020). However, from a cost–benefit perspective, policymakers tend to overweight the cost of preparation in relation to the impact of a future event, particularly if the event is of low probability. This occurs because there is often a bias in utilitarian thinking that underweights outcomes that are further away in time. The tendency to underweight future consequences can also cause decision-makers to exclude potential future outcomes that result from a social distancing requirement such as a lockdown. For instance, lockdowns have resulted in postponement of elective and required surgeries, increased isolation, unemployment, depression, and so forth (Savulescu et al., 2020). These can have both near-term and long-lasting impacts that decision-makers in 2020 may not have adequately considered. Election cycles exacerbate this tendency because the spending to prepare occurs at least in part in the current election period, but the benefit may not be realized for many years. There is an underlying deontological imperative to prepare for potential future disasters such as another pandemic or a climate event. The lack of preparedness due to shifting priorities and funding leading up to this pandemic provides a lesson that policymakers should learn from as they prepare for future pandemics.

4.3 The impact of federalism

The United States employs a federalist system with government powers delineated by the U.S. Constitution. In this system, authority is shared between federal, state, and local governments. This scheme allows for national policy when appropriate, while also allowing state and local authorities a large degree of self-government that can be tailored to local conditions (Bulman-Pozen, 2016; Elazar, 1997). A series of crises, including the 1918 flu pandemic, revealed the need for greater federal guidance and assistance for state programs. As a result of the Great Depression of the 1930s, the federal government instituted Social Security and government works programs and began assisting state and local governments in implementing these programs. This led to an era of cooperative federalism that preserved the ability for state and local governments to tailor programs to their local needs while following federal guidelines. Over time, Congress reduced its administrative oversight of the administration of many federal programs, and executive branches of federal, state, and local governments have stepped into the administrative role. Power struggles and a lack of cooperation can impede the deontological
imperative to consider the will of Congress and meet their constituent’s needs. The increased polarization of the electorate and lack of cooperation between the political parties has resulted in cooperative federalism only in cases where state and federal executives are like-minded members of the same political party. In the next two sections, we discuss the role of federalism in public health responses and fiscal responses during the current pandemic.

4.3.1 | The role of federalism in public health policy responses

Inconsistent public health mandates and uneven enforcement have arisen from the executive federalist system employed by the United States, which is colored by partisanship, a polarized electorate, and a lack of clear national leadership (Downey & Myers, 2020; Kettl, 2020; Rozell & Wilcox, 2020). In the United States, initial responsibility for disaster relief is at the state level under the Stafford Act (Bulman-Pozen, 2016; Elazar, 1997; Stafford Act, 1988). States first request federal assistance when a disaster is beyond their capacity to manage. Thirty-two states declared emergencies before President Trump declared COVID-19 a national emergency, and this was two days after the WHO declared the coronavirus a global pandemic on March 11 (Trump, 2020). The national emergency declaration is important because it allows states to request disaster relief from the Federal Emergency Management Agency (FEMA).

The Oxford COVID-19 Government Response Tracker (https://covidtracker.bsg.ox.ac.uk/) shows that beginning in March 2020, U.S. efforts to limit the virus’ spread, such as contact tracing, restrictions on gatherings and public events, testing availability, public transport restrictions, and other policies lagged much of Europe, China, and Australia. Norway and Finland were able to avoid as severe breakouts without lockdowns because of their application of consistent national testing and mandatory quarantining of individuals testing positive for the virus (Pancevski, 2020). In the United States, the CDC failed to quickly develop a viable test that could be broadly distributed during the early stages of U.S. exposure, and testing distribution and policy was left to the states. The result was wide disparities in the ability to identify clusters that could have led to earlier quarantining to limit the spread. President Trump and the CDC did not agree on the efficacy of mask wearing, social distancing, and vaccinations (“U.S. Health, Trump Administration Officials Send Mixed Messages on Americans’ Coronavirus Risk; CDC Official Warns Residents to Prepare for Spread of Virus,” 2020). National leaders failed to lead and take ownership to manage the crisis rather than use the pandemic to pursue political gains (Downey & Myers, 2020; Rozell & Wilcox, 2020). This egoistic ethical approach also resulted in state-level competition in procuring testing supplies, medical equipment, and PPE (Kettl, 2020; Rozell & Wilcox, 2020).

4.3.2 | The role of federalism in fiscal responses to the pandemic

While the Stafford Act places disaster response in the states’ purview, it is less clear where responsibilities for economic assistance lie. Fiscal federalism’s decentralized approach is generally asserted to be more efficient and effective than more centralized fiscal approaches and has allowed some state and local governments to build reserves that can be tapped in emergencies. The CARES Act introduced a myriad of programs, most but not all, administered at the federal level. For example, COVID-19 health providers received payments from the CARES Act based on rules and priorities developed by DHHS. Unfortunately, in the end, these payments
disproportionately went to more financially healthy providers (Grogan et al., 2021). The PPP rules were determined at the federal level, but there were issues concerning equitable access to that program that were not well thought out. The CARES Act included $150 billion in assistance for state, local, and tribal governments. While the federal government issued guidelines for states to follow, the money was spent differently in each state, with healthcare costs and funding for small businesses being common uses (Maher, 2020). This state-centric communitarian approach is inherent in federalism, as decentralized leaders make decisions to benefit their constituent communities.

4.3.3 | Utilitarianism in a federalist system

When utilitarianism is applied by states in a federalist system, this may result in less consistent responses between states. The aforementioned evidence of differing effectiveness of government interventions to control the virus and limit the economic damage implies that varied local responses can be effective, so federalism itself is not necessarily to blame. For instance, the United States led the world in its response to prior health threats such as H1N1 and Ebola (Lewis, 2020; McKay & Dvorak, 2020; Rozell & Wilcox, 2020). Also, other federalist systems such as Australia, Canada, and Germany had more coordinated and more effective initial responses to the pandemic than the United States (Rozell & Wilcox, 2020). The United States faces bigger challenges in administering federal rules and programs as it is larger, more diverse, and more varied in states’ abilities to respond to emergencies than subunit governments in other federalist countries (Congleton, 2006; Rozell & Wilcox, 2020). Although we believe a federalist system can be effective in a pandemic, it requires a high degree of coordination at the national level, and it requires state leaders to act in view of national interests. Partisanship led to inconsistent efforts to limit the spread of the contagion. Two other federalist systems, Germany and Australia, created national councils to ensure that coherent national policies were followed. Both countries had more success at limiting the spread of the virus than the United States (Downey & Myers, 2020; Rozell & Wilcox, 2020).

4.4 | Cultural factors that influenced policy effectiveness

Civil obedience to policies that limit individual freedom but help protect society is critical for recovery and mitigation from a crisis (Bernstein et al., 2020). The best scientific evidence from today (and from studying the 1918 pandemic) has identified large-scale widespread testing, early intervention, contact tracing, wearing masks, social distancing, and regular handwashing as effective means of limiting the spread of the virus (CDC, 2020b; Hsiang et al., 2020). Because policies requiring these measures restrict individual freedoms, they are often met with public resistance in cultures like the United States with low power distance and individualism, limiting their effectiveness. In 2020, countries with higher levels of civil obedience to government mandates designed to limit the spread of the virus and protect the vulnerable initially experienced shorter outbreaks with fewer spikes in infection rates (Lewis-Kraus, 2020). Throughout much of the summer and fall of 2020, the United States faced rising infection rates, but policies in other parts of the world such as China, Korea, and parts of Europe appeared to better contain the virus (Stancati & Panceveski, 2020). In 2020, the federal administration did not provide a consistent message about best practices. This reduced the effectiveness of the utilitarian policies
that imposed a temporary curtailment of individual liberties. Even with a more coherent national message, adherence to these policies would have been more challenging for the United States than, for example, Norway or Finland, where social cohesion and trust in authority is greater (Pancevski, 2020).

4.5 Justice and distributional impacts of policies

The health crisis highlighted the ethical tension between minimizing harm to physical health and financial health. This tension is heightened due to some groups being more severely impacted than others. This should have been anticipated by the federal government when designing their economic relief plans. For instance, theoretical and empirical modeling by economists at the St. Louis Federal Reserve had previously shown that during the financial crisis of 2007–2008, low-income households that had some preexisting financial difficulties were more heavily impacted by downturns, experienced greater job losses, and faced greater forced reduction in consumption (Mills, 2020; Sanchez et al., 2020). Because these individuals generally lack savings, they may be required to borrow more heavily to maintain spending. This has proven to be true in the pandemic-induced recession as well, as job losses were greater in sectors that employ lower-income individuals (Harrison, 2020). Negative health impacts were greater for lower-income individuals as well. The number of cases and deaths in 2020 was greater for lower-income individuals, with 40% of individuals who were the most financially stressed having the most cases and deaths through August 2020 (Athreya et al., 2020).

While many small businesses were hurt by the pandemic, businesses owned by black and other minorities were impacted more severely, and fewer black-owned businesses were able to access government aid programs (Brainard, 2020; Leatherby, 2020). Ravikumar and Vandenburgoucke (2020) find that after controlling for county size, the dispersion in death rates among U.S. counties with COVID-19 infections is predominantly explained by the proportion of African Americans in the counties. The differences were not fully explained by type of job and living conditions, so the results indicate that differences in availability and utilization of health care contributed to higher mortality rates (Oppel et al., 2020). Women were also disproportionately impacted (Grittayaphone & Retrepo-Echavarria, 2020; Tappe, 2020; United Nations, 2020). Lifetime earning losses of women who had to leave the workforce or could only work reduced hours during the pandemic may add up to six figures (Peck, 2021). These are areas that U.S. policy must seek to rectify.

The CDC’s National Center for Health Statistics (NCHS) constructs a Social Vulnerability Index for U.S. counties and groups the results into low, moderate, and high vulnerability (Agency for Toxic Substances and Disease Registry, 2021). Social vulnerability attempts to measure the degree to which a community is at risk from external events such as hurricanes, floods, disease, and so forth. The metric measures the extent of poverty, transportation access, and housing density, among other factors, to assess community vulnerability. COVID-19-related deaths in high vulnerability areas were well over 100% greater than in low vulnerability areas in all but one of the peak monthly periods of COVID-19 deaths which occurred (August 2020, January 2021, August 2021, and September 2021). This suggests that lockdowns or other proven methods such as testing, quarantines, and so forth, along with targeted economic assistance, should be focused on high vulnerability areas. These are the areas where policy can save the greatest number of QALYs for the money spent. These decisions fit into a utilitarian framework, especially with justice considerations supplementing the decision process.
5 | PREPARATION FOR THE NEXT CRISIS

If the United States had been adequately prepared from a public health perspective, the disease spread could have been tempered and the economic impacts perhaps lessened, which many would consider a deontological imperative function of government. As discussed above, this is complicated by cultural and political structures inherent in the U.S. system. In the next section, we address this preparedness aspect in more detail, including the role of federalism.

5.1 | The U.S. approach to health emergency disaster responses

Comfort (2005) notes that one of the basic functions of government is to protect its people, including protection from disasters, natural or otherwise. Crisis management consists of four stages: (a) preparedness, (b) response, (c) recovery, and (d) mitigation (Birnbaum et al., 2015; Congleton, 2006; Gerber, 2007). These phases are largely distinguished by their intent and timing. Preparedness refers to the pre-event planning actions, while response refers to taking actions that directly save lives during the event. Recovery actions occur post-event, while mitigation can occur during or before an event to minimize the event's impacts. In the United States, disaster emergency management starts locally and becomes a national crisis when national resources are required for any of these stages (Birnbaum et al., 2015; Gerber, 2007). Effectively managing each of these stages in a national emergency requires vertical integration of government resources in a consistent nonpartisan manner, as well as horizontal integration across local governments (Gerber, 2007). As of July 25, 2021, the United States ranked 16th in number of deaths per million (104,000) (One World Data, 2021a), despite having the seventh highest GDP per capita (Investopedia, 2021). The United States was more successful on the vaccine front at the time, with 48.75% of the country fully vaccinated as of July 25, 2021, ranking fifth out of 39 countries (One World Data, 2021b).

Government has a deontological imperative to protect both its citizens' health and financial well-being. The U.S. government took a largely utilitarian approach to minimizing the economic impact, showing a willingness to incur costs for near- and long-term benefits to the economy. The CARES Act was not perfect, but it provided timely assistance when it was required. In total, U.S. fiscal and other spending related to COVID-19 was almost $4 trillion in 2020. This is a large number, representing about 18% of GDP. However, Japan, Sweden, Finland, and Germany had all spent a greater percent of GDP on COVID-19 relief as of December 2020 (Barone, 2020). The U.S. programs were a combination of extra income to individuals and relief to businesses. The United States attempted to ‘triage’ parts of the economy that would suffer most from lockdowns, particularly small businesses and the aviation industry. Other countries such as Germany and Norway provided more targeted assistance to individuals, provided large-scale testing and contact tracing, and enforced policies to ensure that quarantines of individuals did not disrupt their income and their ability to return to work. U.S. firms that received PPP loans do not have to repay them if they were used for approved expenses, primarily payroll. Loans to businesses in many other countries must be repaid to keep government debt levels down. We do not know enough about which of these policies will be more effective in the long term, and there are many complicating factors to be considered in these comparisons.

Experiences in other countries show that less drastic measures than full lockdowns can be effective and more targeted spending to protect vulnerable groups is warranted rather than providing money to all. The utilitarian calculations of the need for lockdowns should be modified.
by the experiences of other countries. Modeling work by Tsay et al. (2020) finds that testing and quarantining infected individuals can quickly reduce the extent that broader and more expensive social distancing measures such as lockdowns are needed. Their results indicate that optimal interventions are indicative of act-based utilitarian processes that are tailored to individual states and updated over time.

We must identify weaknesses of the U.S. system that came to light in the pandemic to better assist low-income groups with healthcare disparities and greater financial vulnerability. Targeting assistance to high vulnerability communities may be a start. Considering these disparities as future policies are crafted is crucial and is at the heart of what Rawls would have considered just, ethical policy responses. As indicated above, some countries with stronger welfare systems focused relief efforts on direct payments to individuals rather than assistance to firms to maintain employment. This difference is important because the U.S. lending programs were administered through banks, and banks—at least initially—disproportionately made loans available to current customers (Simon & Rudegeair, 2020). As a result, minority-owned small businesses with fewer banking ties were often unintentionally excluded from these programs, and a large number of both minority-owned and women-owned businesses failed during the shutdown and after (Mills, 2020). This violates the spirit of protecting the most vulnerable groups in society (Rawls, 1958).

Utilitarian calculations are typically focused on providing the greatest good rather than focusing on justice concerns. In their defense of utilitarian decision-making in the current crisis, Savulescu et al. (2020) state that, “There are no egalitarians in a pandemic” (p. 620). This implies that policies should be strictly focused on doing the greatest good to preserve the maximum number of lives (or QALYs). They also note that utilitarian thought is not necessarily the only basis for decisions. There are two ways to approach this issue. First, we can note that it is probable that including justice concerns is likely to increase the effectiveness of policies designed to help preserve physical and financial health, thereby maximizing the good obtained. Secondly, similar to Savulescu, we can note that actions that improve the plight of the vulnerable are morally correct actions that improve the long-run welfare of society as a whole but may require some creative thinking such as creating a government digital payments system to provide non-banked individuals quick access to government funds.8

The federal government and the U.S. federalist system were not prepared to handle a national crisis on the scale of COVID-19. The United States was clearly not prepared for the pandemic in terms of materials and supplies. This undoubtedly led to preventable infections and deaths. Human and political factors imply that governments often do not adequately prepare for future crises that are not imminent. The lack of preparedness due to shifting priorities and funding leading up to this pandemic provides a lesson that policymakers should learn from as they prepare for future pandemics. It is time for the federal government’s role to evolve beyond relying on federalism in crisis management that has the potential to impact multiple states. It must more effectively plan and prepare for future events that states will not be able to manage on their own. This includes delineating clear lines of authority to handle emergencies with national consequences. This may mean expanding the role of the CDC or creating a new national health authority. The experience in Australia may be illustrative.

Federal funding priorities are often dominated by current events rather than long-term planning for potential future crises that are unlikely to happen before the next election cycle. This is a weakness of utilitarian calculations that overweight near-term needs and tend to underweight the need to prepare for future low probability events. This too must change. McLaughlin (2021) estimates that the COVID-19 pandemic will result in a cost of $16 trillion
globally. By spending $357 billion over the next 10 years on increased surveillance of potential pathogens and stockpiling medical equipment, the impact of the next pandemic can be greatly reduced. Stressing the deontological imperative of preparing now to save lives in the future must be stressed to overcome the tendency to underprepare. Better policies to protect people when they cannot work would allow selective quarantining rather than having to impose very costly lockdowns.

6 | CONCLUSION

The United States is a diverse and politically divided country. This makes it vitally important for decision-makers to be cognizant of the need to maintain the legitimacy of authority as Bernstein et al. (2020) term it. To do so, leaders must manage future crises along nonpartisan lines with the goal of managing public interests first and setting aside any egoistic motivations. In an individualistic, low power index country like the United States, managing crises requires including the public in the decision process whenever possible, with leaders clearly communicating their reasoning and the science that informs their choices. They must also provide citizens with a voice to appeal decisions that adversely impact their lives and livelihood (Kinlaw & Levine, 2007; Pop-Flanja, 2020). Leaders will also have to remain flexible and realize that policies must be adapted to different locations and circumstances. This is especially important because crises differentially impact different groups (Leatherby, 2020; Oppel et al., 2020; Peck, 2021). The United States failed at this during the COVID-19 pandemic. In the future, relief efforts must be designed to benefit the more vulnerable groups, although to do so effectively may require some creative thinking such as creating a government digital payments system or using an existing private sector mechanism like PayPal to make payments available to lower-income individuals who do not have banking relationships.

The inconsistencies of the early U.S. responses rising from partisanship and executive federalism almost assuredly led to higher infection and mortality rates than should have occurred (Abutaleb et al., 2020; Sebenius & Sebenius, 2020). Before the pandemic, trust in government and the media was already low and the lack of a consistent national policy in response to the public health emergency contributed to low compliance with scientifically backed practices to limit the spread of the contagion.

The pandemic revealed the need for cooperation between governments globally (Hale, 2021). As governments prepare for future crises, ethical considerations should be built into these plans as guardrails to guide decision-makers. The United States must develop a national emergency response plan to any future widespread health threat whether it relates to viral, nuclear, or climate causes. In these situations, time of response is crucial, and a consistent, coordinated national response is required. Drawing on Kinlaw and Levine (2007) and Bernstein et al. (2020), we conclude that utilitarian or communitarian analyses of balancing health risks and economic impacts must be supplemented with Kantian principles of not treating people as means to an end, balancing the protection of individual freedoms with the good of society, and, as Rawls suggests, protecting vulnerable groups. In particular, support programs for individuals and small businesses must be modified to ensure financial and health assistance is made available to vulnerable groups.

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ENDNOTES

1 Decision-makers in this paper are the federal, state, tribal, and local government officials making policy and decisions. Who the decision-maker is changes with the locus of the decision authority and context.

2 Significant epidemiological differences between this pandemic and the current pandemic include (a) the earlier virus was much more prevalent and serious in the youth and young adults rather than the elderly, and (b) the virus was rarely fatal.

3 This site also contains a link for individual state responses. Major federal regulatory changes are found at the Federal Reserve website, https://www.federalreserve.gov/newsevents/pressreleases.htm; the FDIC website, https://www.fdic.gov; and the SEC website, https://www.sec.gov/sec-coronavirus-covid-19-response.

4 Prior to the 20th century, dual federalism prevailed. In this system, each level of government largely operated in its own sphere with little cooperation among different levels of government (Bulman-Pozen, 2016; Downey & Myers, 2020).

5 As the United States entered the pandemic, increased tax revenue and state savings had generated a record $75 billion in rainy day funds across 50 states (Rosewicz et al., 2020). During the pandemic, many states tapped into those emergency reserves for public health and fiscal responses within the state.

6 The Bureau of Labor Statistics job category Leisure and Hospitality was particularly hard-hit experiencing job losses of 47% in April 2020, more than double the next closest job category (Mendez-Carbajo, 2020). Workers in these job categories generally earn lower incomes. Households making under $40,000 per year were three times more likely to experience a job loss during this pandemic compared to those earning between $40,000 and $100,000 (40% vs. 13%, respectively) (Harrison & Overberg, 2020).

7 The other peak death period was during the lockdown period in April 2020. In this case, high vulnerability deaths were approximately 32% greater than in low vulnerability areas.

8 Elsewhere, payment systems such as Mercado Pago in South America and Alipay in Asia make it easier for low-income groups to obtain banking type services that could be used to quickly provide supplemental income to groups that do not have access to traditional, and expensive, banking services (“Digital Money: Ant Group and Fintech Come of Age,” 2020).

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