

Mandatory Vaccination and the Limits of Emergency Power

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Abstract. This paper critically examines the ethical and legal boundaries of compulsory vaccination during public health emergencies, arguing that mandates are not simply a clash between science and liberty but a fundamental exercise of state power over bodily autonomy. Drawing on Mill's harm principle, herd immunity, and the precautionary principle, I contend that coercion is justified only when four stringent conditions are met: an imminent, well-evidenced threat; a vaccine that substantially reduces transmission; the exhaustion of voluntary measures; and robust procedural safeguards, including medical exemptions, fixed review dates, and democratic oversight. Empirical evidence from European COVID-19 certification policies—which raised uptake but bred resentment—and Austria's failed blanket mandate demonstrates that effectiveness does not equate to legitimacy. Historical injustices such as the Tuskegee syphilis study and Henrietta Lacks's case reveal a deep epistemic deficit among marginalized communities, where justified distrust cannot be remedied by scientific facts alone. Thus, a morally defensible mandate must be preceded by active trust-repair, transparent dialogue, and acknowledgment of past wrongs. The conclusion rejects both absolute libertarianism and unchecked state coercion, insisting that emergency powers remain exceptional, proportional, and accountable. Ultimately, mandatory vaccination may be permissible in rare, severe crises, but only when the state bears a heavy burden of proof and respects individual dignity through institutional honesty and time-bound limitations.

Keywords: Mandatory Vaccination, Public Health Emergency, Bodily Autonomy, Harm Principle and Herd Immunity, Institutional Trust and Historical Injustice

1. Introduction

The question of whether the state may compel vaccination has become one of the most contested issues in contemporary public health ethics. Making vaccinations mandatory is often portrayed as a battle between two sides, one of which "believes in science," while the other "believes in freedom." However, once vaccination becomes mandatory, it goes beyond being a simple health tool and becomes an assertion of state control over the individual's body, which violates a person's bodily autonomy. This tension is not merely theoretical; it has played out in real world policies during the COVID 19 pandemic, from vaccine passports in France and Italy to the abortive general mandate in Austria, revealing deep disagreements about the proper scope of governmental authority in times of crisis [1].

At the same time, infections create complications for this principle. A refusal to take a vaccine during a pandemic does not automatically mean that its effect will be limited to the one refusing it; the refusal can increase risks for elders, immunosuppressed patients, doctors and nurses, or those whose treatments are hindered by a lack of space in the intensive care unit. Therefore, according to international health law, a public health emergency of international concern is recognized as an "extraordinary event," thus potentially justifying extraordinary measures [1]. Yet this recognition does not settle the ethical question—it merely opens the door to a more demanding analysis of when, and under what constraints, coercion becomes permissible.

The central problem, then, is to specify the threshold that transforms a health hazard into a genuine emergency, the degree of scientific uncertainty that society should tolerate, and the weight of historical memory in communities that have suffered under medical authority. This paper argues that vaccination can become mandatory in a real public health emergency only when the danger is imminent, the threat is well evidenced, and voluntary measures are no longer sufficient. To build this case, the paper proceeds in four parts. First, it analyses how infectious diseases reshape the moral framework of liberalism, drawing on Mill's harm principle and the concept of herd immunity. Second, it reviews historical and empirical evidence—from smallpox eradication to COVID 19 certification policies—to assess both the effectiveness and the political feasibility of mandates. Third, it examines the critical role of trust, highlighting how past abuses such as Tuskegee and Henrietta Lacks undermine institutional legitimacy, especially among historically marginalised groups. Finally, it proposes a set of substantive conditions that must be met for any mandate to be ethically and politically defensible. The conclusion reaffirms that while emergency powers are sometimes necessary, they must remain exceptional, transparent, and strictly bounded to prevent the erosion of democratic accountability and individual dignity.

2. Infectious diseases change the moral framework for vaccination

The problem of infectious diseases raises a certain challenge for liberalism. Under normal circumstances, any health-related choice made by a person is primarily relevant only to that person. For example, if a person refuses to take medication for a non-transmissible disease, his choice might be a bad one, but it will not usually bring immediate social harm. However, in a pandemic, even an individual choice not to vaccinate can raise infection risk for others.

In *On Liberty*, Mill argues that power may only be used against someone's will in order "to prevent harm to others" [2]. In other words, Mill's harm principle suggests the argument for personal freedom is weaker when the choice creates danger for other people. A refusal to vaccinate isn't the same as directly injuring another person, since the harm may be indirect and uncertain. Still, in the context of a contagious disease, it cannot be treated as a completely private decision.

The idea of herd immunity also supports this point. According to the Centers for Disease Control and Prevention, herd immunity exists when enough people are protected against a disease that its spread becomes unlikely, giving some protection even to those who are not vaccinated [3]. Therefore, vaccination has a social function. It protects the individual, but it can also reduce transmission. This scenario leads to a case of free-riding where an individual who chooses not to take the vaccine can receive protection from others who have taken the vaccine without having to accept the risks or costs himself. However, the ethical weight of mandatory vaccination does not rest solely on preventing free-riding. It rests more fundamentally on the state's duty to prevent serious, probabilistic harm to vulnerable third parties. This aligns with the precautionary principle, which holds that in the face of a potentially severe and irreversible threat to public health, the lack of full scientific certainty should not delay proportionate preventive action. Yet, this principle also places a

heavy burden of proof on the state: it must demonstrate that the probability and severity of harm are sufficiently high to justify overriding individual bodily autonomy. The protection of those who cannot be vaccinated—due to age, medical conditions, or immunosuppression—adds a further moral imperative, transforming the mandate from a mere restriction into a collective obligation to safeguard the most vulnerable members of society.

Mandates cannot be used on this basis alone. This reasoning makes sense only if the vaccine reduces transmission and if there is a real danger posed by the disease to the public. It is weaker when the vaccine mainly protects the individual from severe illness. However, infectious disease shows why absolute bodily freedom cannot be the only principle in a pandemic. A person's body may belong to himself, but the effects of contagion do not stop at the boundary of his body.

3. Historical and empirical evidence for vaccine mandates

The historical example most used to justify vaccine mandates is smallpox. Vaccination was instrumental in eradicating smallpox, and in 1980, the World Health Organization announced that the disease had been eradicated [4]. Smallpox was particularly dangerous for society and the vaccine had a clear public purpose, which is why the example is appropriate only in exceptional cases.

Another American case that can be used in support of mandatory vaccinations is *Jacobson v. Massachusetts*. It is commonly argued that this case proves that the government has powers to order vaccination during epidemics, but, again, what is more crucial is that these orders were justified because the situation required a response. Thus, the decision means that mandatory vaccination will be permitted when the government faces real danger from a virus and its action is proportional [5]. Nevertheless, it is historically naive to treat a 1905 ruling as a timeless blank check for state power. The *Jacobson* court applied a highly deferential standard of review, operating in an era before the modern framework of human rights, informed consent, and bioethics. Its ruling establishes a floor for state authority, not a ceiling for contemporary democratic legitimacy. Today, any mandate must meet a far more demanding standard of proportionality, scientific transparency, and individual exemption than that court ever envisioned.

A comparative analysis of the European experience reveals a critical distinction that is often blurred in policy debates: the difference between policy effectiveness and normative legitimacy. The French and Italian certification policies achieved measurable increases in vaccination rates, but they also generated significant social resentment, particularly among younger populations and ethnic minorities, and failed to resolve underlying vaccine hesitancy [6, 7]. In contrast, Austria's sweeping general mandate was legally passed but politically and practically abandoned [8]. This contrast suggests a crucial insight: mandates that are conditional, targeted, and framed as crisis-specific measures are both more effective and more publicly tolerable than blanket, open-ended obligations. The failure of the Austrian mandate is not a refutation of all mandates, but a powerful illustration that legitimacy, not just legal authority, is the true precondition for sustainable public health coercion.

The case of COVID-19 shows an even more complicated picture. Some data suggest that vaccine certification and mandates were helpful in increasing the rate of vaccinations. For example, the study conducted in a number of European countries revealed that certification had positive impacts on people's willingness to get vaccinated both before its introduction and afterward [9]. In the case of France, health passes were able to increase vaccine rates, yet were ineffective with regard to specific groups of people and did not contribute to addressing concerns about getting the vaccine [6]. This is an important point: a mandate does not need to change people's minds, yet can still make them get vaccinated without dealing with their concerns.

Another country where a similar process occurred was Italy with the introduction of Green Pass. Studies have shown that the announcement of the green certificate motivated some hesitant individuals to get their first shot, particularly in regions where vaccination rates were lower [7]. In particular, it was shown that such actions can evoke resentment, as they can exclude people from participation in normal activities of society. However, it does not mean that such policy fails; rather, it is necessary to assess its success in different ways.

The example of Austria further highlights the risks associated with taking the other extreme approach. Austria passed comprehensive mandatory COVID-19 vaccination legislation for adults, which was immediately shelved and eventually scrapped. Reuters reported that the Austrian government gave up the initiative following its shelving because there were doubts that the measure would yield enough benefits in terms of increased vaccine uptake [8]. Thus, it shows that having legislation mandating vaccinations can indeed prove to be politically unfeasible.

It is necessary to take into account scientific uncertainty. After all, the COVID-19 vaccines were developed and authorized quickly, given the urgency of the situation. However, such speed did not entail irresponsibility per se – after all, rare risks may only become clearer through wide-scale application. For example, the Centers for Disease Control and Prevention states that myocarditis and pericarditis have rarely been observed after COVID-19 vaccination and that evidence supports a causal association with mRNA COVID-19 vaccines [10]. Indeed, when a government suggests vaccination, its residents can decide by themselves whether the risks outweigh the benefits or vice versa. In contrast, a mandate will impose on the government a much larger burden of proof, especially when the advantages are mostly personal. It shows that mandates can work, but only when the disease is severe, the vaccine's public benefit is clear, and the public can still believe that the state is acting within limits.

4. Trust, historical abuse, and institutional legitimacy

The subject of vaccination is inseparable from the question of trust. Even when a health care policy might be technically correct, it can still politically and morally fall flat when affected people lack trust in the institutions carrying it out. This aspect is important to consider because trust does not exist equally within all segments of society; certain groups have valid reasons to question whether their concerns and interests will be treated fairly by the medical community.

One example was the Tuskegee Syphilis Study. Conducted by the U.S. Public Health Service starting in 1932, the study involved observation of 600 Black men from Alabama, 399 of whom had syphilis, without properly collecting informed consent [11]. The real importance of the Tuskegee case lies in explaining why some segments of the population could not just take government promises at face value.

This is similar to the Henrietta Lacks story. Lacks' cancerous cells were harvested in 1951 without her knowledge or consent, resulting in the HeLa cell line which proved highly valuable to scientific inquiry into medicine [12]. The objective here is certainly not to cast doubt on medical science, but to show that medical research has historically been very powerful. At the same time, it has also revealed the darker side of medical progress, where scientific advancement was achieved by exploiting those treated as less than fully human.

In this regard, it must be recognized that the state's imposition of mandatory vaccinations exists against this background. What may seem like a benign policy initiative to health officials may appear much different considering a group's past experiences with coercion, manipulation, or even neglect. This explains in part why people may harbor doubts about vaccines not due to ignorance but, rather, historical memory, though potentially also mixed with misinformation.

This historical context does not merely provide a sociological footnote to public health policy; it fundamentally alters the ethical terms of the debate. It transforms the question from "Is the mandate scientifically justified?" to "Is the state epistemically trustworthy enough to issue such a mandate?" In communities bearing the historical memory of Tuskegee, a government call to "trust the science" is not heard neutrally; it is heard against a chorus of broken promises and unpunished wrongdoing. This creates an "epistemic deficit"—a justified skepticism that cannot be overcome by simply repeating scientific facts. Consequently, a morally legitimate mandate is not merely one that is based on good evidence; it is one that is preceded by a demonstrable and sustained effort by the state to repair damaged trust through transparent dialogue, community partnership, and acknowledgment of past injustices. Without this prior work of trust-building, even a scientifically sound mandate risks being not only ineffective but morally and politically corrosive.

The coronavirus pandemic showed this. Health organizations modified their advice according to the accumulating evidence. However, too many people who gave advice started talking about it with excessive certainty, only to be proven wrong later, showing a lack of appropriate humility. In such conditions, orders become controversial rather than supportive.

This is important ethically, since there is a difference between power and legitimacy. While governments have the legal right to mandate vaccination for the population, whether they can justify doing this from the perspective of ethics depends on whether they have demonstrated honesty and integrity when doing this. Orders can be counterproductive in the case of alienated populations, which do not trust the scientific community.

5. Conditions to legitimize mandates

Mandatory vaccination may be used only under certain circumstances. A government should not be able to call something an emergency unless the disease creates a serious public danger, such as high death rates, rapid spread, or pressure on hospitals. Otherwise, the language of emergency becomes too easy to abuse.

The vaccine itself must also reduce collective harm. This is central to the justification for compulsory vaccination. If vaccination clearly reduces transmission, the case for a mandate is stronger. If it mainly lowers an individual's own chance of severe illness, then the argument becomes weaker.

Before reaching compulsion, the government should also try less restrictive measures. Education, better access, honest communication, and voluntary campaigns should come before punishment or exclusion from society. Mandates may increase vaccination rates, but they can also create resentment, especially among people who already doubt the safety of vaccines or the motives of public institutions.

Finally, any mandate must have limits. There should be medical exemptions, clear review dates, democratic oversight, and honest information about possible risks. Physical mandatory vaccination would be extremely hard to justify. Conditional measures in higher-risk environments, such as hospitals, are more defensible because the danger to others is more direct. They are rare moments when some limits on freedom may become justified, but only if the state can give stronger reasons than usual.

6. Conclusion

Vaccination mandates should not be applied universally, as this would overextend state power and undermine bodily autonomy. Yet during a severe outbreak, the choice to vaccinate is never purely

personal, given its direct bearing on communal transmission and the protection of the vulnerable.

European policy experiences reveal a crucial distinction: effectiveness does not equal legitimacy. While certification policies raised uptake in France and Italy, they also bred resentment and failed to resolve hesitancy [6, 7]; Austria's blanket mandate, though legally enacted, proved politically unworkable [8]. Moreover, historical abuses like Tuskegee and Henrietta Lacks create an epistemic deficit—a justified distrust among marginalized groups that cannot be overcome by scientific facts alone [11, 12]. Legitimate coercion thus demands prior trust-repair, institutional honesty, and community engagement, not merely legal authority.

Consequently, mandates are defensible only under strict, time-limited conditions: an imminent and well-evidenced threat, a transmission-reducing vaccine, the exhaustion of voluntary measures, and robust procedural safeguards—including medical exemptions, fixed review dates, and democratic oversight. In the end, neither absolute liberty nor unchecked state power serves democracy; emergency powers must remain proportional, transparent, and publicly accountable.

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