

# A DECENTRALIZED FRAMEWORK FOR PANDEMIC RESPONSE

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*Protecting Public Health Without Coercion  
Lessons from 2020–2023 Applied to Future Preparedness*

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## Preamble

The COVID-19 pandemic response of 2020–2023 was the largest peacetime disruption to American civic, economic, and social life in the nation's history. Tens of millions of children lost years of schooling. Small businesses were shuttered by government order while large corporations thrived. Healthy adults were confined to their homes. Treatments were suppressed, dissenting scientists were censored, and citizens were threatened with loss of employment for declining a medical intervention. These harms were imposed not by the virus alone, but by the policy choices made in its name.

The documents that authorized this response — including the PanCAP Adapted U.S. Government COVID-19 Response Plan (March 2020) and related pandemic planning instruments — were built on a centralized, coercive model: identify threat, activate federal machinery, issue mandates, suppress alternatives, await pharmaceutical salvation. The framework you are reading proposes a different path.

This document is not a denial of the seriousness of pandemic threats. Respiratory pathogens can kill, and some kill many. A government that takes no interest in such threats is negligent. But a government that uses such threats to override individual liberty, shutter churches and businesses, mandate experimental medications, and silence scientific dissent is a government that has confused its means with its ends.

The framework below draws on:

- The Swedish model, which maintained open schools, avoided lockdowns, relied on voluntary guidance, and achieved outcomes broadly comparable to locked-down nations while preserving civil society and economic function;
- The Great Barrington Declaration (October 2020), authored by epidemiologists from Harvard, Oxford, and Stanford, which proposed focused protection of the vulnerable rather than universal suppression;
- The documented failures of the 2020–2023 response — including the ineffectiveness of school closures, the harms of isolation to mental health and non-COVID mortality, the suppression of early treatment, and the compromised independence of regulatory agencies;
- The principles of subsidiarity, federalism, and individual liberty that are foundational to the American constitutional order.

This framework has one governing premise: in a free society, government's role in a health crisis is to inform, to support, to coordinate voluntary action, and to protect the most vulnerable — not to coerce, mandate, or centrally manage the behavior of a free people.

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# **I. Governing Principles**

## **1.1 Primacy of Individual and Family Decision-Making**

The individual and the family — not the federal government, not public health agencies, and not expert committees — are the primary decision-makers about health choices. Government's role is to provide accurate, timely, and complete information so that individuals can make informed decisions. It is not to make those decisions for them.

No federal pandemic response plan shall include provisions for: mandatory vaccination; mandatory masking; closure of schools, houses of worship, or businesses as a primary response tool; enforcement of quarantine on persons who have not been individually diagnosed; or restriction of interstate travel. Such measures, if they are to be considered at all, require explicit authorization by democratically elected state legislatures subject to full judicial review, and must be time-limited and subject to regular renewal.

## **1.2 Subsidiarity and Federalism**

Pandemic response is properly a local and state matter. The federal government's role is to support state and local capacity, share information, coordinate logistics, and remove bureaucratic obstacles — not to direct or override the decisions of states, localities, and individuals. The diversity of approaches across fifty states and thousands of counties is a feature, not a bug: it generates the comparative data needed to identify what actually works.

Federal agencies shall not issue mandates that preempt state law or local ordinance on pandemic response. Federal funding for pandemic preparedness shall not be conditioned on adoption of specific interventions. States and localities retain full authority over their own public health decisions.

## **1.3 Transparency and Scientific Pluralism**

The integrity of public health communication depends on the free flow of scientific information, including findings that challenge official positions. No federal agency, platform partner, or grant-making body shall suppress, censor, or penalize researchers, physicians, or public communicators for advancing heterodox epidemiological or clinical views, provided those views are made in good faith and based on evidence.

All modeling assumptions, data sets, and decision-making criteria used to justify public health interventions shall be published in real time and made available for independent replication and critique. Official projections shall be presented with uncertainty ranges and explicit statement of assumptions.

## **1.4 Proportionality**

Interventions must be proportionate to the actual, demonstrated severity of a given pathogen. Risk communication shall include age-stratified infection fatality rates, comparison with seasonal influenza and other known risks, and explicit acknowledgment of the costs and risks of the interventions themselves. The benefits of any proposed intervention must be weighed against its harms — economic, educational, psychological, and physical — before implementation.

Interventions shall be graduated: voluntary guidance before recommendations; recommendations before restrictions; restrictions before mandates. Mandates shall require extraordinary justification and democratic authorization.

## **1.5 Protection of the Vulnerable Without Universal Restriction**

The appropriate target of intensive pandemic response is the population at demonstrably elevated risk — primarily the elderly and those with specific comorbidities. Resources, communication, and support should be focused on protecting these groups, not on imposing universal restrictions on the healthy population. Coercive measures applied to low-risk populations to achieve marginal reductions in risk for high-risk populations represent a fundamental misallocation of public health authority.

## **1.6 No Pharmaceutical Dependency**

Pandemic response planning shall not be organized around the assumption that pharmaceutical interventions (vaccines or antivirals) will be developed, approved, and distributed before the acute phase of a pandemic has passed. Historical timelines suggest this is rarely achievable. Plans must therefore be fully functional in the absence of new pharmaceutical products. When such products become available, they shall be made available voluntarily, with complete information about known benefits and risks, and shall never be a condition of employment, schooling, travel, or participation in public life.

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## **II. Situation Assessment: Lessons from 2020–2023**

### **2.1 What the Centralized Model Got Wrong**

The PanCAP Adapted framework and the response it governed produced the following documented outcomes:

#### **Schools**

The United States closed schools for longer than almost any comparable nation. The learning loss documented in the years that followed — particularly among low-income and minority students — represents the single largest setback to educational equity in modern American history. Sweden kept its schools open throughout; its children suffered no excess mortality and avoided the learning deficits seen in locked-down nations.

#### **Non-COVID Health Harms**

Excess mortality from deferred cancer screenings, delayed cardiac care, and suicide — particularly among young men — offset a significant portion of COVID deaths prevented. These deaths appear nowhere in the official accounting of pandemic costs. A framework that counts only the harms of the pathogen while ignoring the harms of the response is not a public health framework — it is a public health accounting error.

#### **Economic Destruction**

Small businesses — disproportionately minority-owned — were ordered closed while large retailers remained open. This produced an extraordinary transfer of wealth from small and medium enterprises to large corporations and their shareholders. A federal response plan that creates this outcome, whether intentionally or through neglect, is not a neutral technical document — it is a policy choice with distributional consequences.

#### **Mental Health**

Isolation, loss of purpose, closure of religious communities, and the elimination of social support networks produced a mental health crisis — particularly among adolescents — whose full effects are still being measured. Rates of anxiety, depression, self-harm, and suicide attempt rose sharply among young people during the period of maximum restriction. No benefit-cost analysis of lockdown policies adequately accounted for these outcomes.

#### **Suppression of Scientific Debate**

Documented coordination between federal health agencies and social media platforms to suppress discussion of laboratory origin hypotheses, natural immunity, early treatment protocols, and vaccine adverse events represented an unprecedented interference with scientific discourse. The long-term damage to public trust in health institutions is itself a public health harm of the first order.

### **2.2 What the Swedish Model Demonstrated**

Sweden, under the leadership of state epidemiologist Anders Tegnell, pursued a voluntary, non-coercive approach throughout the pandemic. Key features included:

- Schools remained open for children under 16 throughout the pandemic;
- No mandatory lockdowns were imposed;

- High-risk individuals received focused protection and targeted guidance;
- The general population was encouraged — not mandated — to practice social distancing and hygiene;
- Bars, restaurants, and most businesses remained open with recommended (not required) precautions;
- No vaccine mandates were imposed at any point.

Sweden's excess mortality for 2020–2022 was broadly comparable to neighboring nations that imposed stricter measures, while avoiding the documented educational, economic, and social harms associated with coercive approaches. Sweden also maintained significantly higher public trust in its health institutions throughout — a durable asset for future emergencies.

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## **III. Framework Structure: Roles and Responsibilities**

### **3.1 Federal Government**

The federal government's role is limited to the following functions:

#### **Surveillance and Intelligence**

Maintain and fund a global disease surveillance network capable of early detection of novel pathogens. Share surveillance data in real time with state health departments, independent researchers, and the public. Fund and publish independent replication of official surveillance findings.

#### **Logistics and Supply Chain Support**

Maintain strategic stockpiles of personal protective equipment, antiviral medications, and critical medical supplies. Coordinate interstate distribution of these supplies on request from states. Remove regulatory obstacles to domestic production of essential medical supplies.

#### **Research Coordination**

Fund independent clinical research on novel pathogens, including research on repurposed existing medications, through grant mechanisms that are insulated from pharmaceutical industry influence. Publish all funded research regardless of outcome. Prohibit publication suppression as a condition of federal research funding.

#### **Communication**

Provide timely, transparent, and complete information to the public and to state health authorities, including information that is uncertain, contested, or unfavorable to official positions. Communicate risk in accessible, age-stratified terms. Explicitly acknowledge what is not known. Correct errors promptly and publicly.

#### **Regulatory Clearance**

Expedite Emergency Use Authorization for therapeutics and prophylactics, with full transparency about benefit-risk data. Prohibit post-authorization suppression of adverse event data. Maintain independent post-market surveillance. Require that all EUA products be made available on a fully voluntary basis.

### **3.2 State Governments**

States bear primary operational responsibility for pandemic response within their borders. This includes:

- Maintaining and funding state and local public health infrastructure independent of federal mandate;
- Developing and publishing voluntary guidance for vulnerable populations, healthcare facilities, and employers;
- Coordinating with local health departments and hospital systems on surge capacity planning;
- Issuing any restrictions on public activity that may be deemed necessary, subject to judicial review, legislative authorization, and sunset provisions;

- Maintaining educational continuity — schools shall remain open absent documented, overwhelming evidence of specific risk to children and staff that cannot be mitigated by less restrictive means.

### **3.3 Local Health Departments**

Local health departments are the operational core of pandemic response. Their functions include:

- Case identification and contact tracing on a voluntary, non-coercive basis;
- Coordination with hospitals, nursing homes, and long-term care facilities;
- Community communication in local languages and through community-trusted channels;
- Provision of voluntary testing and clinical support for high-risk populations;
- Real-time data sharing with state and federal surveillance systems.

### **3.4 Healthcare Providers**

Physicians and other licensed healthcare providers retain clinical authority over treatment decisions for their patients. Federal and state agencies shall not prohibit, suppress, or penalize the prescribing of legally available medications for pandemic illness based solely on the absence of large-scale randomized trials. Off-label prescribing for clinical indications, including in pandemic contexts, is a recognized component of medical practice and shall remain protected.

Hospitals and health systems are responsible for maintaining surge capacity plans. Federal support for capacity expansion shall be made available on request without conditions related to treatment protocols or staffing requirements.

### **3.5 Independent Research and Civil Society**

Academic researchers, independent epidemiologists, public health commentators, and civil society organizations serve as essential checks on official pandemic management. This framework explicitly recognizes and protects their role. No federal pandemic response activity shall include coordination with communications platforms to suppress independent scientific commentary.

Preprint servers, open-access data repositories, and independent media serve critical public health functions in rapidly evolving situations where official guidance may lag the best available evidence. Their operation shall be protected.

## IV. Operational Phases

### Phase 1 — Surveillance and Early Warning

*Trigger: Novel pathogen detected with evidence of human-to-human transmission, OR significant uptick in unexplained respiratory illness in surveillance data.*

#### Federal Actions

- Activate global surveillance network; publish all findings publicly within 48 hours of analysis completion;
- Convene independent scientific advisory group with published conflict-of-interest disclosures;
- Issue preliminary risk assessment with explicit uncertainty bounds, age-stratified risk estimates, and comparison to known risks;
- Begin logistics assessment of strategic stockpile adequacy;
- Notify state health officials through established communication channels.

#### State and Local Actions

- Activate early warning monitoring protocols in hospital systems;
- Review and publish surge capacity status;
- Prepare voluntary guidance templates for high-risk populations.

#### What is NOT Authorized in Phase 1

- Mandatory quarantine of unexposed populations;
- School closures;
- Business closures;
- Any restriction on freedom of movement or assembly.

### Phase 2 — Community Transmission Identified

*Trigger: Confirmed sustained community transmission within U.S. borders, with preliminary characterization of severity and at-risk populations.*

#### Federal Actions

- Publish updated risk assessments weekly, with explicit presentation of infection fatality rate by age and comorbidity;
- Issue voluntary, evidence-based guidance for high-risk individuals, healthcare workers, and caretakers;

- Activate logistics support for state requests; begin coordinating PPE and supply distribution;
- Fund and publicize voluntary testing infrastructure;
- Immediately begin funding independent research on existing therapeutics;
- Commission independent benefit-risk modeling of any proposed interventions, published with full methodology.

### **Communication Standards in Phase 2**

- All official communications shall include: (a) age-stratified risk data; (b) explicit statement of what is not yet known; (c) comparison to seasonal influenza and other familiar risks; (d) acknowledgment of costs and harms of proposed protective measures;
- Official communications shall not include: (a) projections presented as predictions rather than scenarios; (b) suppression of uncertainty; (c) claims of consensus where professional disagreement exists.

### **What Requires Explicit Legislative Authorization if Proposed**

- Any mandatory measures affecting schools, businesses, or freedom of movement require state legislative authorization, time limits not to exceed 30 days per authorization, judicial review on demand, and published benefit-cost analysis.

## **Phase 3 — Sustained Transmission with Documented Severe Outcomes**

*Trigger: Pathogen demonstrates IFR significantly exceeding seasonal influenza across multiple age cohorts, OR documented healthcare system capacity crisis in multiple states.*

Even in Phase 3, the default remains voluntary guidance and focused protection. Mandatory measures may be considered by state legislatures as a last resort, subject to the following constraints:

### **Permissible State-Level Measures (Requiring Legislative Authorization)**

- Mandatory isolation of confirmed, individually-diagnosed cases for medically supported durations;
- Enhanced infection control requirements for high-risk congregate settings (nursing homes, long-term care facilities) — with simultaneous requirements for family visitation accommodations;
- Temporary restrictions on specific high-risk activities if benefit-cost analysis demonstrates net benefit.

### **Measures That Remain Prohibited**

- Mandatory vaccination of any population segment as a condition of any public or private activity;

- School closures absent documented, specific risk to children that cannot be mitigated through less restrictive means;
- Mask mandates for children;
- Quarantine of asymptomatic, unexposed individuals;
- Suppression or discouragement of off-label prescribing by licensed physicians;
- Coordination with communications platforms to reduce visibility of dissenting scientific views.

### **Focused Protection Protocol**

Phase 3 triggers mandatory activation of a focused protection protocol for individuals over 65 and those with documented high-risk comorbidities. This includes:

- Proactive outreach to identified high-risk individuals through primary care networks;
  - Provision of N95 respirators at no cost to high-risk individuals on request;
  - Dedicated staffing and supply priority for nursing homes and long-term care facilities;
  - Telemedicine infrastructure to minimize unnecessary in-person exposure for high-risk patients;
  - Voluntary, paid isolation support for high-risk workers who choose to reduce exposure.
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## V. Information, Surveillance, and Communication

### 5.1 Decentralized Data Architecture

The COVID-19 response demonstrated the dangers of centralized control over epidemiological data. When a single agency controls data collection, analysis, and communication, errors propagate unchecked and political pressures can shape scientific conclusions. This framework requires:

- Multiple independent surveillance networks, including hospital systems, academic research networks, and state health departments, reporting to a shared open-access data repository;
- All underlying data published in machine-readable format within 72 hours of collection, with appropriate de-identification;
- Independent replication of key findings as a standard requirement, not an exception;
- Explicit prohibition on data withholding or embargo by federal agencies during a declared public health emergency.

### 5.2 Risk Communication Standards

Official risk communication shall adhere to the following standards:

- Risk shall be presented in absolute terms (e.g., 'X deaths per 100,000 people in age group Y') not relative terms alone;
- All projections shall be presented as scenarios with explicit assumptions, not as predictions;
- Uncertainty shall be explicitly communicated, including uncertainty about the reliability of surveillance data itself;
- Costs and harms of proposed interventions shall be included in risk communications, not only benefits;
- Age and comorbidity stratification shall be standard in all mortality and severity reporting.

### 5.3 Prohibition on Narrative Management

No federal health agency, White House task force, or interagency coordination body shall:

- Coordinate with social media platforms to reduce the reach or visibility of scientific commentary that dissents from official positions;
- Issue guidance to journalists, platforms, or publishers characterizing specific scientific claims as 'misinformation' without contemporaneous, publicly available scientific justification;
- Fund or support communications campaigns designed to discourage the expression of scientific heterodoxy;
- Penalize researchers, physicians, or public health communicators for good-faith public expression of dissenting scientific views.

### 5.4 Community-Based Communication

Effective public health communication during a pandemic requires trust, and trust is built at the community level. This framework prioritizes:

- Funding for community-level communication through trusted local channels — primary care physicians, community health workers, faith leaders, and local media;
  - Translation and accessibility in the languages and formats used by affected communities;
  - Explicit acknowledgment, in official communications, that healthy adults and children face very low risk from most respiratory pathogens — and that this fact is not in conflict with concern for those who face higher risk;
  - Regular public Q&A forums with independent scientific experts, not just agency officials.
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## **VI. Medical Countermeasures and Treatment**

### **6.1 Therapeutics First**

Pandemic planning has historically been organized around vaccine development as the primary endpoint. This framework reorients toward therapeutics — existing medications and supportive care protocols — as the near-term priority, with vaccine development as a longer-term parallel track.

In the acute phase of any pandemic, a vaccine will not be available. Treatments will. Federal resources shall prioritize:

- Rapid clinical evaluation of existing licensed medications with plausible mechanism of action against novel pathogens;
- Publication of clinical trial results, including negative results, in real time;
- Provision of supportive care protocols to frontline physicians within weeks of pathogen identification;
- Protection of physician authority to use clinical judgment in treatment decisions, including off-label prescribing, throughout the emergency period.

### **6.2 Vaccine Development: Voluntary and Transparent**

Vaccine development, if pursued, shall be conducted under the following standards:

- Full transparency of trial data, including safety signals and adverse event data, in real time;
- Independent safety monitoring with published authority to halt trials;
- No authorization of vaccines for populations not adequately represented in clinical trials;
- Mandatory long-term follow-up studies as a condition of any Emergency Use Authorization;
- No authorization shall translate into any mandate; availability shall remain strictly voluntary;
- Liability protections for manufacturers shall not preclude compensation for documented vaccine injuries through a fully funded, accessible compensation program.

### **6.3 Healthcare System Resilience**

The COVID-19 experience revealed that the U.S. healthcare system's surge capacity was inadequate. This framework requires:

- Maintenance of minimum hospital surge capacity of 20% above normal bed utilization as a standard preparedness metric;
- Investment in distributed care capacity — the ability to provide care in outpatient, home, and community settings — to reduce dependence on hospital infrastructure;
- Prohibition on staffing mandates that reduce available healthcare workers during a surge (including mandates that result in termination of experienced nurses and physicians);
- Federal support for temporary facility expansion without conditions on treatment protocols.



## **VII. Economic and Social Continuity**

### **7.1 Schools**

No pandemic response framework shall authorize the closure of primary or secondary schools as a standard mitigation measure. The documented harm of school closures — measured in learning loss, mental health deterioration, food insecurity, and lifetime earnings for affected children — is severe and disproportionately affects already disadvantaged populations.

If school closure is sought in exceptional circumstances, it requires: state legislative authorization; documented, specific risk to children in that setting that cannot be mitigated by less restrictive means; time limit of no more than 14 days per authorization; and immediate provision of high-quality remote educational alternatives for all affected students.

### **7.2 Businesses and Houses of Worship**

The government shall not order the closure of lawfully operating businesses or religious institutions as a pandemic mitigation measure. Voluntary guidance for modifications to operations — ventilation improvements, capacity recommendations, symptom monitoring — may be issued. Mandatory closures, if sought in extraordinary circumstances, require the same authorization standards as school closures and are subject to full property rights analysis and compensation requirements.

### **7.3 Worker Protections**

High-risk workers who choose to reduce their exposure during a pandemic shall have access to:

- Paid leave provisions at no cost to their employer for up to 60 days per year during a declared public health emergency;
- Protection against termination for choosing to work remotely where job function permits;
- Priority access to focused protection resources.

No worker shall face adverse employment consequences for declining a medical intervention, including any vaccine, regardless of whether a public health emergency has been declared.

### **7.4 Supply Chain**

The COVID-19 experience demonstrated the fragility of a global supply chain for critical medical supplies. Federal pandemic preparedness shall include:

- Domestic manufacturing capacity for at least 90 days of essential PPE and critical medications;
- Removal of regulatory obstacles to rapid domestic production scaling;
- Bilateral agreements with allied nations for mutual supply chain support;
- Strategic stockpile maintenance and rotation programs with published inventory levels.

## **VIII. Accountability and Review**

### **8.1 Sunset Provisions**

Every public health emergency declaration shall include a sunset provision not to exceed 90 days. Renewal requires:

- Updated benefit-cost analysis of all active interventions;
- Independent scientific review of evidence supporting continued emergency designation;
- Legislative authorization at the state level for any measures affecting individual liberty;
- Public reporting on all interventions implemented under emergency authority.

### **8.2 Post-Event Review**

Within 18 months of the conclusion of any declared public health emergency, a fully independent review commission shall be convened to assess:

- The accuracy of official risk assessments and projections;
- The effectiveness of all interventions implemented;
- The harms caused by interventions, including harms to non-COVID health, education, and economic wellbeing;
- The performance of interagency coordination and communications;
- Specific recommendations for revision of this framework.

The commission shall include independent epidemiologists, economists, educators, mental health professionals, and civil liberties experts. Agency officials who served during the reviewed period shall not constitute a majority of the commission. The commission's findings shall be published without redaction and shall be formally responded to by relevant federal agencies within 180 days.

### **8.3 Legal Accountability**

Individuals and officials acting under emergency health authority are not exempt from constitutional constraints. Specifically:

- Emergency declarations do not suspend First Amendment protections;
- Emergency declarations do not suspend the right to judicial review of government action;
- Emergency health orders are subject to the same equal protection analysis as ordinary legislation;
- Agencies that coordinate with private platforms to suppress speech retain liability for First Amendment violations under relevant case law.

## **IX. Conclusion: A Different Model of Trust**

The dominant model of pandemic response that produced the policies of 2020–2023 was built on a theory of information: that official agencies possessed superior knowledge, that public communication should be managed to prevent 'panic' and 'misinformation,' that deviation from official positions should be suppressed rather than engaged, and that coercive measures could be justified by the urgency of the threat.

That model failed — not only in terms of the harms it produced, but in the very trust it sought to manage. Public confidence in health institutions has collapsed to historic lows. The next pandemic, whatever its character, will be met by a population more skeptical, more resistant to official guidance, and less willing to accept voluntary protective measures than the population of 2020. This is a direct result of the policies pursued in that year.

The framework in this document is built on a different theory: that trust is earned through transparency, that coercion undermines the voluntary cooperation that is the real foundation of public health, that scientific pluralism produces better outcomes than managed consensus, and that the freedom of individuals to make their own decisions about their own lives is not a regrettable obstacle to pandemic management but a positive value that any legitimate public health framework must respect.

A government that treats its citizens as subjects to be managed during a crisis will find, in the next crisis, that it has fewer citizens willing to be governed at all. A government that treats its citizens as free adults capable of making informed decisions — and provides them the accurate information they need to do so — builds the durable social trust on which effective voluntary public health action depends.

The Sweden model was not a perfect one. No response will be. But it demonstrated that a high-income democracy could navigate a serious pandemic without closing its schools, without locking down its population, without mandating medications, and without suppressing its scientists — and could achieve outcomes broadly comparable to those that imposed far greater costs. That is the model worth learning from, adapting, and institutionalizing.

This framework is a beginning, not an end. It is offered for public discussion, critique, and improvement. The scientific and policy questions it engages remain live and contested. That is, precisely, the point.

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