FACULTY OF PUBLIC HEALTH

The Nanny State Debate: A Place Where Words Don't Do Justice

A report for the UK Faculty of Public Health on the nanny state debate and its implications for policy and practice

The Challenge from Nanny State Critics

Nanny state accusations represent a perennial challenge to public health agendas; a constant, negative point of reference in debates on the measures that we, as a society, should take to provide conditions in which people can enjoy and benefit from good health. Large parts of the popular press routinely identify and castigate the nanny state when reporting on public health policies and interventions. We see attacks under headlines such as:

A Nanny State that Dictates What We Drink Will Soon Be Telling Us How To Think (Daily Mail, 28th November, 2012)

Why Are We Paying £3.9bn for 5,000 Nannying Civil Servants to Patronise Us? (The Sun, 6th March, 2018)

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In what might be described as its most 'threatening' form, the nanny state refers to governmental interventions that philosophers call hard paternalism. Hard paternalism refers to measures that force, or coerce, competent adults to act in a particular way to promote their well-being, regardless of their own will, values, beliefs, or preferences. 'Hard' refers to the coercive nature of the measure. 'Paternalism' refers to its comparability to persons with parental responsibility knowing what is best for their children.

We might think here, for example, of laws that require us to wear seat belts even if we would not wish to do so. In these instances, the law is based on a policy that holds that, whatever we may think, our interests are served by using a seatbelt. And if we act against that view by not wearing a seatbelt, the government is justified in criminalising our conduct. The state uses criminal law to 'nanny' us: it tells us what is good for us and forces us to act accordingly.

In legal and political philosophy, hard paternalism is often treated as a uniquely challenging problem. What right, it is asked, does the government have to force autonomous adults to live their lives in particular ways? Special justifications are said to be needed if we are to accept laws that will force people to protect their own health. The arguments run that we might be able to compel healthy choices to protect other people from harm (for instance smoking bans to protect people who share our workplace or other members of the public from 'second hand smoke'). Equally, we might be able to defend measures designed to protect and promote the health of children and adults who lack decision-making capacity (for instance by limiting the environments that they might enter). But the state has no right, the arguments suggest, [illegible] force [illegible] competent adults to live healthy lives for their own good.

So, in philosophical discourse, we might think of nannying by reference to this idea of 'hard paternalism'. However, it is clear from representations in public debate that nanny state accusations are also made against policies that are 'softly' paternalistic. We would say 'softly' here either because a measure does not force a healthy choice, or because it is aimed at persons who are not autonomous adults.

In regard to the former, consider how criticisms are made of policies that advise people on healthy choices: of measures that explain to people the evidence about what will serve their health, as contrasted with policies that would force them to make healthy choices. A good example is Public Health England (PHE)'s recommendations on alcohol intake. This is advisory, with no question of government coercion. In its report on PHE's guidelines, The Sun newspaper notes that they are just recommendations, but nevertheless characterises them as '"nanny state" plans', with the article's headline reading:

SUP YOURS: Fury at government's killjoy health ruling that sets new booze limit at just SIX pints a week In regard to measures that are aimed at persons who are not competent, autonomous adults; consider the following example of a response to a policy to improve the diets of children. The Daily Mail carried a report that categorises this as "an intrusion by a 'nanny state'", under the headline:

Parents' fury after primary school becomes first in the UK to ban packed lunches because fewer than 1% of them were healthy enough

In sum, when politicians and members of the public health community are confronted with accusations of 'nannying', the concern in practice is not just with 'hard paternalism'. 'Soft paternalism' may also be characterised as 'nannying'. And things are additionally complicated because sometimes it is suggested that accepting a 'soft' measure places us on a dangerous 'slippery slope' to becoming a nanny state.

At the level of principle, accusations of nanny statism can therefore be seen to refer to a range of philosophical concerns about policy and paternalism:

'Hard paternalistic' concerns that the state should not coerce competent adults to be healthy;

Similar concerns about non-coercive paternalistic policy, such that it is wrong for government agencies such as Public Health England to advise on healthy choices; and

Concerns that non-coercive health policy may problematically be the 'thin end of the wedge'.

These important principled concerns should be taken seriously in debates on health policy. However, it must also be recognised that in practice we find references to [illegible]

nanny statism that appear, on any terms, to be arbitrary or otherwise incoherent.

Arbitrary or incoherent references to a measure being nanny statist arise because we find claims that just do not make sense. In theory, this means the nanny state accusation should not stick, but in practice we know that it can do. Such nanny state accusations close down debate, rather than allow a sensible discussion of the merits (or otherwise) of the measure under issue.

Instances of arbitrariness or incoherence in the use of nanny state accusations are found where:

Some measures of health promotion are supported, whilst others are derided as being 'nanny statist', notwithstanding that they are no less paternalistic in their aims or methods; or

A measure may have implications in terms of its impact on health, but as a policy has no rational connection whatever to hard or soft paternalism.

An example of the first is found in an article published by The Sun in August 2016 under the apparently public health friendly headline:

The Sun Says: Britain must get its act together as the obesity crisis is not only killing our NHS but us too

The article explicitly welcomes the government's anti-obesity strategy. But in presenting its opposition to some measures and support of others, it says:

We remain opposed to the sugar tax—a regressive measure targeted at the poorest—but are pleased to see the PM ditch intrusive nanny state proposals aimed at branding and advertising.

And we fully endorse clearer food labelling, which the Government is now free to implement having previously been banned by Brussels.

The solution to Britain's expanding waistlines isn't pushing people into poverty or food companies out of business.

It's getting kids and adults off the sofa and exercising outdoors.

We might challenge the substantive claims made here: for example, [illegible] ight ask what the evid[illegible] that the 'sugar tax' pushes people into poverty. Beyond that, what we see here is the apparently arbitrary application of the term 'nanny state'. From the perspective of nanny state concerns, it is not clear why some of the measures are supported and others attacked. There is no sound reason to suggest that it would be nannying to prevent people from seeing adverts but not nannying to promote exercise. In logic, either both are nannying or neither is, and the material difference between the two seems in reality to relate to the former representing an interference with commercial freedoms.

Regarding arbitrary or incoherent references to nanny statism where a policy would not be rooted in hard or soft paternalism at all, we might refer to a story published on BBC News in October 2018 under the following headline:

Is meat's climate impact too hot for politicians?

This article concerns the impact of the meat industry on carbon emissions, and consequent arguments that we ought to reduce meat consumption to mitigate the problem. In an interview about the role of government in advising on a 'climate-friendly diet', and in response specifically to whether Cabinet members should lead by example, the climate minister is quoted as saying:

I think you're describing the worst sort of Nanny State ever. Who would I be to sit there advising people in the country coming home after a hard day of work not to have steak and chips?... Please…

There may be good reasons for government not to act or interfere in the ways asked about. But it is unclear how or why the question is related to the nanny state (less still 'the worst sort of Nanny State'). The policy would be based on concerns about conservation of the environment; not about promoting individuals' health, coercively or otherwise. We see here a nanny state accusation that is potentially effective at closing down debate, but which has no logical relationship with the policy that it is levelled against. It is comparable to saying that efforts to reduce the use of plastics, given environmental concerns, is nanny statism.

Overall, therefore, the different uses of the nanny state in public debate and discourse suggest a need more systematically to break down what lies beneath or motivates nanny state accusations. This permits an understanding of the merits—or otherwise—of nanny [illegible] claims, and of how we might [illegible] on-

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FACULTY OF
PUBLIC HEALTH

Published by

Faculty of Public Health
4 St Andrews Place
London
NW1 4LB

www.fph.org.uk

ISBN 978-1-900273-76-3

November 2018

Suggested citation: John Coggon, *The Nanny State Debate: A Place Where Words Don't Do Justice* (London: Faculty of Public Health, 2018)

The nanny state debate

This report looks critically at the nanny state debate. It has been produced under the coordination of Dr Farhang Tahzib, Chair of the Public Health Ethics Special Interest Group of the UK Faculty of Public Health. It is intended as a resource for members of the public health community whose own reflections or practice are affected by nanny state concerns, and for other readers who may be interested in the ethical legitimacy of public health practice and policy.

The nanny state is a frequent point of reference in academic, public, and political debates on public health policy. As with many political slurs, it refers at once both to valid and invalid concerns. It reduces these to hard-hitting and often logically-incoherent rhetoric; rhetoric that obscures meaningful discussion and obstructs pathways (whatever one's political leanings) to a fairer, healthier society.

At its best, the nanny state is intended to represent a political-philosophical position; a view on public health ethics and on the source and constraints of politically legitimate actions and agendas of government. At its worst, it is an incoherent slogan that is lazily or cynically made against policies that a person, group, or organisation wants to shout down without explaining why. Either way, nanny state accusations require to be scrutinised because the nanny state debate directly impacts policies that may protect or promote the public's health, as well as people's views on such policies.

Accordingly, this report aims to summarise and explain key points implied by and related to the nanny state in practice: it aims to make clear what people 'do' with nanny state accusations, and how we might respond to their claims. It discusses these matters as part of broader political debates that impact on efforts ethically to protect and promote the public's health. It does so too with regard to a social context in which damage is done—in the form of harms and injustices—by questionable arguments that are based on nanny state accusations.

An earlier draft of this report was circulated to colleagues working in public health ethics, leadership, practice, and training. The author gratefully acknowledges the comments, observations, and questions that were provided consequent to that consultation exercise.

Responsibility for the final drafting and the views expressed is the author's own.

About the author

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This paper is based on research for the following articles and books:

- John Coggon, 'Harmful rights-doing: The perceived problem of liberal paradigms and public health,' Journal of Medical Ethics (2008) 34, 798-801
- John Coggon, *What Makes Health Public? A Critical Evaluation of Moral, Legal, and Political Claims in Public Health* (Cambridge University Press, 2012)
- John Coggon, 'What Help is a Steward? Stewardship, Political Theory and Public Health Law and Ethics,' Northern Ireland Legal Quarterly (2012) 62:5, 599-616
- John Coggon, Keith Syrett, A.M. Viens, *Public Health Law: Ethics, Governance, and Regulation* (Routledge, 2017)
- John Coggon, 'Smoke Free? Public Health Policy and the Ethics of the Long Game,' (2018, unpublished manuscript)
- John Coggon, 'Persuasion, Paternalism, and "Public Health Politicking": A critique of evolutions in public health promotion and advocacy,' (2018, unpublished manuscript)

Foreword

For some, the role of the state should be to do as little as possible. It should not meddle in the affairs of its private citizens and it should leave business unfettered in its pursuit of the wealth it creates for the benefit of us all. I've heard it suggested that the role of the state was to provide the military and the roads – protect the borders, secure the peace, and oversee free access… We have always had rules though. It's always been a good idea to agree which side of the road to drive our chariots. It's always been a good idea not to drop our waste products in our neighbour's garden. We follow rules for our common good, and to avoid wearying disputes and unnecessary conflicts. But what about the butcher who sells us bad meat? What happens to the individual who refuses treatment for a communicable disease? What happens to the drunk driver? What happens when we don't follow the rules? We didn't know about them? Or we just deliberately broke them? How do we ensure a common understanding of rules we think we have? And where is the sanction when we break rules knowingly?

Bit by bit, we have evolved laws to protect the health of our citizens and our environments. And little by little we have come to appreciate that good laws for our protection have our consent and our confidence. Sometimes these laws are for the general good; sometimes for the protection of vulnerable groups and individuals.

In this era of the unbridled greed of multinational corporations, we cannot presume that everyone knows where they can safely dispose of their waste and whether they will choose to do it or not. We cannot assume there will be fair use of natural resources and we cannot assume these corporations will not be butchers selling us bad meat.

I am not sure what the people who came up with the term 'nanny state' have against nannies. I didn't have one. I have always thought of them as something very much for the wealthier classes, and parents who didn't want to spend a lot of time with their children. I have always thought of nannies as people charged with keeping their children safe and able to grow up strong, wise and healthy. I would think those would be no bad aims for our governments. I imagine that, as in all walks of life, there are nannies who are caring or overbearing, kindly or cruel. Likewise, there will be law-making that can be all of these things too.

We live in an unequal world; there is economic inequality between and within countries and not everyone benefits from the economic adventure. There is environmental injustice; the poorest people live in the poorest environments and suffer the double jeopardy of poor social and economic opportunity and the added stressors of pollution in all its forms. The health of the planet is also suffering; we are threatening the health of future generations by living unsustainably, by destroying natural habitats, ecosystems, our food sources and the soil beneath our feet. There must be some agreed controls. This report is a contribution to the debate about what those controls should and should not be.

Professor John Middleton
President, UK Faculty of Public Health
October 23rd 2018

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1. Introduction

The term 'nanny state', like other popular political slurs, has contestable historical origins. It is widely attributed to Iain Macleod (1913-70), a Conservative Member of Parliament whose government roles included serving as Minister of Health. Mr Macleod famously used the phrase in his 'Quoodle' column in *The Spectator* in 1965.[1] Over half a century later, the nanny state remains a frequent and forceful presence in debates on health policy.

At the core of nanny state accusations is the following line of reasoning:

- We are competent, autonomous individuals;
- This means that we always know best our own interests and how to protect them;
- And that means that government has no business in 'nannying' us into living healthy lives.

The idea of a *nanny* state necessarily carries connotations of an infantilising vision of politics; of a government treating competent adults as if they were children. However, in practice, nanny state accusations are made against all sorts of measures that would protect and promote health, whether or not they might be 'nannying' in this sense. The negative traction that is gained by criticising a measure as nanny statist means that the term is applied, for example, to redistributive measures, to interventions that serve the well-being of disadvantaged or vulnerable persons or groups, and policies that impact entities that cannot in any sense be 'nannyed', such as commercial corporations. In other words, nanny state accusations are often made arbitrarily or incoherently. Nevertheless, they stick. They impact policy and practice. And ultimately, they impact people's opportunities to achieve and enjoy good health. This is problematic.

Problems of the nanny state debate are not, furthermore, limited to instances of logical incoherence or arbitrariness. We have reasons at least to question the strength of the premises of nanny state critiques. Are we truly *always* competent, autonomous individuals who may best judge and protect our own interests? There is convincing evidence that our autonomy—our capacity for free choice and self-determination—is not always promoted by an absence of regulation. Web-based algorithms, social media, and false representation of news stories all represent examples of threats to autonomous decision-making through insidious methods of manipulation. Equally, studies demonstrate how, at times, people make decisions that they themselves would consider harmful to their interests: for instance, by prioritising short term benefits at longer term cost.

Governments have responsibilities to protect and promote the public's health, and address the injustices represented by health inequalities within our society.[2] To exercise these responsibilities, policies must be implemented. And inevitably nanny state accusations will be made. Practice tells us as much. Practice also tells us that such accusations can be overcome, albeit that this is not necessarily straightforward. Consider, for example, historical and ongoing efforts to regulate and diminish tobacco smoking. These may be seen as a model of public health success. But change has come more slowly than it might have done.[3] The nanny state debate has had its part to play in this, representing views on interferences with people's 'right' to smoke: sometimes such claims reflect a principled concern; sometimes they may be a smokescreen to hide and protect other, less principled interests.

In many regards, the nanny state debate is a tiresome distraction that interferes with meaningful public discussion of health policy. Professor Mike Daube, Julia Stafford, and Laura Bond wrote ten years ago:

> " There are legitimate debates to be had about legislation, taxation, public education and other approaches to protecting the public's health. But they should focus on the issues, not on slogans and clichés. It's time for nanny to retire."[4]

Ironically (given that nanny state claims essentially purport to have respect for rationality at their core), it seems optimistic to hope for legitimate public debates unhampered by simplistic nanny state rhetoric. Those who are given to making nanny state accusations in place of reasoned argument do not seem to be retiring types. This report therefore aims to open up the nanny state debate. It explains what it means philosophically, as well as how it is used incoherently or arbitrarily as a weapon in argument. It then relates nanny state concerns to debates in public health ethics. Finally, it looks to the ways that those who are concerned about the harms of flawed nanny state accusations might respond to the challenges of a public debate in which the effect of this political slur translates into significant harms and injustices.

Aims

In order to understand and engage with the nanny state debate, it is crucial to think about:

- **Principled concerns:**
  - What theoretical claims are made when a measure is criticised for being nannying?
  - Are these claims sound?
- **Hidden concerns:**
  - Is the use of a nanny state accusation in a given instance a genuine concern, or does it seem to be a cover for unstated reasons (for example, the protection of entrenched commercial interests)?
- **Practical methods of response**:
  - How should we answer nanny state accusations in a way that is at once principled, coherent, and effective in a public debate that is often characterised by over-simplification and cynical argumentation?

2. The Nanny State: What does it mean, and why do we care?

Section Summary

2.1 The Challenge from Nanny State Critics

Nanny state accusations may be based on ranging *principled* concerns, but may also be based on *arbitrary* or *incoherent* arguments.

- Principled concerns:
  - Classically, claims of nanny statism relate to 'hard paternalism'. This means government measures that force autonomous adults to make healthy choices.
  - In the nanny state debate, we often also find claims about 'softer' measures: 'softer' either because they do not refer to coercive policies, but rather, for example, government advice; or 'softer' because they would apply to vulnerable groups, such as children.
  - Some participants in the nanny state debate cite concerns about 'slippery slopes' from softer to harder measures.

- Arbitrary or incoherent arguments:
  - The rhetorical strength of nanny state accusations allows powerful arguments to be made that are, on analysis, arbitrary or incoherent.
  - This may be because they contradict themselves, for example by saying that some policies are 'nannying' whilst others are not, when all of them appear equal in terms of government paternalism.
  - Or this may be because particular policies are not about government paternalism at all, but some other policy goal.

2.2 Categorising Nanny State Arguments

To make sense of and participate in the nanny state debate, we need to be able to recognise and critique nanny state accusations.

- Three distinct foundations to nanny state arguments are identified:
  - Claims based on economics: these suggest that the market will be more successful than government regulation;
  - Claims based on philosophical libertarianism: these suggest that persons' individual autonomy should be respected, and that accordingly we may only justify 'small government';
  - Claims that frame health policy as ideology: these suggest that the government should not define health because it is a subjective concept.

2.3 The Healthy Response to the Nanny State

The different sorts of rationale implied by the different types of nanny state critique are explained, in particular noting the distinction between responding to empirical and theoretical claims (see also section 4.3).

2.1 The Challenge from Nanny State Critics

Nanny state accusations represent a perennial challenge to public health agendas; a constant, negative point of reference in debates on the measures that we, as a society, should take to provide conditions in which people can enjoy and benefit from good health.[5] Large parts of the popular press routinely identify and castigate the nanny state when reporting on public health policies and interventions.[6] We see attacks under headlines such as:

A Nanny State that Dictates What We Drink Will Soon Be Telling Us How To Think

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In what might be described as its most 'threatening' form, the nanny state refers to governmental interventions that philosophers call *hard paternalism*.[10] Hard paternalism refers to measures that *force*, or *coerce*, competent adults to act in a particular way to promote their well-being, regardless of their own will, values, beliefs, or preferences. 'Hard' refers to the coercive nature of the measure. 'Paternalism' refers to its comparability to persons with parental responsibility knowing what is best for their children.

We might think here, for example, of laws that require us to wear seat belts even if we would not wish to do so.[11] In these instances, the law is based on a policy that holds that, whatever we may think, our interests are served by using a seatbelt. And if we act against that view by not wearing a seatbelt, the government is justified in criminalising our conduct. The state uses criminal law to 'nanny' us: it tells us what is good for us and forces us to act accordingly.

In legal and political philosophy, hard paternalism is often treated as a uniquely challenging problem. What right, it is asked, does the government have to force autonomous adults to live their lives in particular ways? Special justifications are said to be needed if we are to accept laws that will force people to protect their own health. The arguments run that we might be able to compel healthy choices to protect *other people* from harm (for instance smoking bans to protect people who share our workplace or other members of the public from 'second hand smoke'). Equally, we might be able to defend measures designed to protect and promote the health of children and adults who lack decision-making capacity (for instance by limiting the environments that they might enter). But the state has no right, the arguments suggest, to force competent adults to live healthy lives for their own good.[12]

So, in philosophical discourse, we might think of nannying by reference to this idea of 'hard paternalism'. However, it is clear from representations in public debate that nanny state accusations are also made against policies that are 'softly' paternalistic. We would say 'softly' here either because a measure does not *force* a healthy choice, or because it is aimed at persons who are not autonomous adults.

In regard to the former, consider how criticisms are made of policies that advise people on healthy choices: of measures that *explain* to people the evidence about what will serve their health, as contrasted with policies that would *force* them to make healthy choices. A good example is Public Health England (PHE)'s recommendations on alcohol

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In sum, when politicians and members of the public health community are confronted with accusations of 'nannying', the concern in practice is not just with 'hard paternalism'. 'Soft paternalism' may also be characterised as 'nannying'. And things are additionally complicated because sometimes it is suggested that accepting a 'soft' measure places us on a dangerous 'slippery slope' to becoming a nanny state.[16]

At the level of principle, accusations of nanny statism can therefore be seen to refer to a range of philosophical concerns about policy and paternalism:

1. 'Hard paternalistic' concerns that the state should not coerce competent adults to be healthy;
2. Similar concerns about non-coercive paternalistic policy, such that it is wrong for government agencies such as PHE to advise on healthy choices; and
3. Concerns that non-coercive health policy may problematically be the 'thin end of the wedge'.

These important principled concerns should be taken seriously in debates on health policy. However, it must also be recognised that in practice we find references to nanny statism that appear, on any terms, to be *arbitrary* or otherwise *incoherent*.

Arbitrary or incoherent references to a measure being nanny statist arise because we find claims that just do not make sense. In theory, this means the nanny state accusation should not stick, but in practice we know that it can do. Such nanny state accusations close down debate, rather than allow a sensible discussion of the merits (or otherwise) of the measure under issue.

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2. A measure may have implications in terms of its impact on health, but as a policy has no rational connection whatever to hard or soft paternalism.

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The Sun Says: Britain must get its act together as the obesity crisis is not only killing our NHS but us too [17]

The article explicitly welcomes the government's anti-obesity strategy. But in presenting its opposition to some measures and support of others, it says:

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We might challenge the substantive claims made here: for example, we might ask what the evidence base is that the 'sugar tax' pushes people into poverty. Beyond that, what we see here is the apparently arbitrary application of the term 'nanny state'. From the perspective of nanny state concerns, it is not clear why some of the measures are supported and others attacked. There is no sound reason to suggest that it would be nannying to prevent people from seeing adverts but not nannying to promote exercise. In logic, either both are nannying or neither is, and the material difference between the two seems in reality to relate to the former representing an interference with commercial freedoms. [18]

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There may be good reasons for government not to act or interfere in the ways asked about. But it is unclear how or why the question is related to the nanny state (less still 'the worst sort of Nanny State'). The policy would be based on concerns about conservation of the environment; not about promoting individuals' health, coercively or otherwise. We see here a nanny state accusation that is potentially effective at closing down debate, but which has no logical relationship with the policy that it is levelled against. It is comparable to saying that efforts to reduce the use of plastics, given environmental concerns, is nanny statism.

Overall, therefore, the different uses of the nanny state in public debate and discourse suggest a need more systematically to break down what lies beneath or motivates nanny state accusations. This permits an understanding of the merits—or otherwise—of nanny state claims, and of how we might respond to concerns about the nanny state.

2.2 Categorising Nanny State Arguments

Section 2.1 of this paper demonstrates how and why the challenge of the nanny state debate is extremely broad and varied. On their face, nanny state allegations suggest either a pervasive cynicism of health promotion or a label that is applied questionably to specific policies that an author or speaker finds objectionable. Looking beyond face value, questions therefore arise about *why* nanny state accusations are made. In the nanny state debate more widely, this includes a need to look at the *principled* arguments in defence of (say) individual freedom. And it includes a need to consider whether arguments may sometimes be mistaken. In the extreme, we may even go on to ask if arguments really serve (intentionally or otherwise) to protect alternative (say commercial) interests. As Professor Roger Magnusson suggests in an analysis of different contexts in which nanny state critiques arise:

> " The nanny state is not, therefore, simply a philosophical critique, but a weapon that assists tobacco, alcohol and processed food businesses, and their allies, to resist regulatory threats." [20]

Given concerns such as those expressed by Professor Magnusson, and the complexities explained above in the use of the term nanny state, we do well to ask how much any given accusation of nanny statism is based on principle (and what sort of principle), and how much it is based on underlying agendas to advance other interests. Such scepticism is warranted in particular if we consider that dominant voices in legal and political philosophy suggest that paternalistic interventions can be justified to protect vulnerable persons (for example, children, adults who lack decision-making capacity), and that paternalistic measures that are not coercive can be permissible where 'hard' coercion would not be (for example, warning labels, fiscal (dis)incentives). As we have seen, in popular discourse nanny state accusations are directed at health promotion agendas in general. And they are presented as something that is inherently problematic.

We may summarise the most prevalent principled bases of arguments against the legitimacy of 'nanny statism' under three headings. In its most simple terms, the nanny state critique may be framed as a conflict between paternalism and individual autonomy (or liberty or freedom). However, distinct rationales can be identified to support such an argument. These are summarised here, and developed further in section 4,[21] where it is explained how the main principled sources of nanny state critique rest on, and are thus as strong or as weak as, one or a combination of the following.

1 The *economic libertarian* voice in the nanny state debate:

According to this view, government interference in the name of health is economically inefficient: this means that, as a matter of fact, we achieve better health (and other) outcomes in society if the market rules and people take individual responsibility for their health.

2 The *philosophical libertarian* voice in the nanny state debate:

According to this view, people should always be the judges of their own interests: this can mean both that competent adults are always best placed to judge how to balance protection of their health against other values, and be extended to include claims, for example, that parents always know best what serves their children's interests.

3 The *coercive healthism* voice in the nanny state debate:

According to this view, the state has no business defining, less still promoting, health: this reflects the idea that health itself is an entirely subjective concept, and that the government should have no role in favouring particular lifestyles.

The first challenge for the public health community in the nanny state debate is to be able to recognise and appropriately categorise

these distinct sorts of principled argument, and thereby be able to respond to them on appropriate terms given the differences between them.

The second is to identify the overall coherence of arguments made in the name of nanny state objections: to ask whether it really makes sense, on the argument's own terms, to level an accusation of nanny statism, or if there is some sort of incoherence or arbitrariness in the distinctions drawn.

The third, if doubt is raised by the second, is to consider whether the incoherence is just an error, as it may well be, or if possibly it masks an unspoken agenda, using rhetoric in place of reason. In practice we know that nanny state arguments have proven powerful. But we might ask whether, when scrutinised, they are really very persuasive.

2.3 The Healthy Response to the Nanny State: Simplistic Slogans Cause Injustice

When the premises and coherence of nanny state assertions go unchallenged, the accusations can prove to be effective bars to better policies for the public's health, as well as possibly an interference with other sound policy goals (such as environmental sustainability). It is for this reason that claims of nanny statism have the potential to promote and perpetuate harms and injustices. This is a long-standing source of concern to the public health community, many of whose members perceive entrenched interests (particularly economic and commercial interests) being advanced cynically in the name of defending individuals' rights.[22] Whilst some participants in the nanny state debate sincerely hold principled commitments to economic or political libertarianism, or opposition to 'healthist' agendas, for many others these ideas are just convenient reference points that may cynically be deployed.

In considering how to respond to nanny state accusations (a matter that is expanded upon in section 4), we should think about:

- The *empirical* claims that the accusations rest on: is there a sound evidence base to support the practical claims about, for example, the strength of people's individual choices, the neutrality and influence of 'non-political' actors, the distribution of burdens of disease, or the effectiveness of the market?
- The *philosophical* claims that are made: is a libertarian concept of justice a fair one, or should society promote an alternative, more collectivist concept of justice (for example, a concept of justice that is concerned with individual autonomy *as well as* other values, such as well-being, happiness, equal opportunity to achieve good health)?

Public health thrives on its status as a field committed to *evidence-based* practice. But to criticise policy (positively or negatively), and to advocate for reforms, we require values-based arguments too. Demonstrating, for example, that rates of child obesity are rising requires a scientific evidence base. But other forms of evidence are required to show:

- That rising rates of obesity should be considered a problem, whether for individuals or for the community as a whole: to make this claim we cannot just refer to scientific evidence; values-based reasons are also required.
- That there are further problems if, within the community as a whole, particular populations are particularly affected by rising rates of obesity: again, evidence of inequalities is not alone enough to establish that they are unfair; values-based reasons are needed.
- How, through policy and practice, we might effectively and fairly respond to the problem: here we need to refer to ethical and political values to understand what would be proportionate and justified policies.

Overall, there is a wealth of evidence, for example based on the social determinants of health, that demonstrates that a commitment to libertarian ideologies is harmful to the public's health. By framing health as a matter that should primarily be viewed as an individual responsibility, rates of mortality and morbidity are higher than they are in political systems that show greater commitment to social solidarity.[23] And this empirical reality impacts most heavily the most disadvantaged groups.

This is the rationale for public health responses to the nanny state. At the heart of public health is a commitment to the ethical achievement of two moral mandates: promoting better overall health, and reducing unfair health inequalities.[24] If the harms and injustices perpetuated by nanny state rhetoric are to be reduced, we require effective means of making the arguments for these moral mandates and the measures that might soundly be used to realise them. This requires engagement in the field of *public health ethics*.

3. How does the Nanny State relate to debates in Public Health Ethics?

Section Summary

3.1 The Political Context of Public Health Ethics

It is essential to appreciate the inherently political nature of public health if we are to engage well in debates on public health ethics:

- Within public health such political significance has long been recognised.
- As an academic field, however, public health ethics has only recently emerged.
- Public health ethics involves understanding of political philosophy, with a concern both for:
  - The ethics of the public health community;
  - Theories of social justice.

3.2 The Nanny State in Public Health Ethics

- Works in public health ethics have sought to distinguish and respond to nanny state critiques.
- Such efforts are exemplified through the Nuffield Council on Bioethics' denial of the nanny state through its 'stewardship' framework and use of the intervention ladder.

3.3 Insidious Philosophical Values in Public Health Ethics?

We can learn from critiques of public health ethics approaches such as the Nuffield Council's. Notably, they invite criticism from advocates of less, and of more, government intervention for the public's health:

- From one side, we see challenges that stewardship is just nannying by another name.
- From the other side, we see challenges that too much emphasis is given to the value of individual liberty (or autonomy/freedom).

3.1 The Political Context of Public Health Ethics

As we have seen, the nanny state debate reflects *political* concerns: concerns about what government should and should not be doing. As a field and a vocation, public health has a long history of political and legal advocacy, activism, and engagement.[25] Dr Richard Horton, editor of the medical journal *The Lancet*, describes public health as 'the science of social justice'.[26] Yet whilst a political mission has long been identified and acted on by persons *within* public health, the attention of wider academic communities in ethics, politics, and law has historically been more limited.[27] With the exception of a small number of notable individuals (such as Professors Angus Dawson and Robyn Martin), and exceptions related to a small number of specific areas of concern (such as resource allocation and HIV/AIDS), it was not until very recently that significant numbers of scholars in bioethics and political and legal theory could be seen to be concertedly addressing and contributing to public health ethics as a field of inquiry and practice.[28]

In its influential report *Public Health—Ethical Issues*, published in 2007,[30] the Nuffield Council on Bioethics explains why public health raises questions that are best explored through political analysis:

> " Public health measures raise complex questions about the relationship between the state and individuals and organisations that are affected by its policies. They also raise questions about the duties that individuals have towards each other. A substantial body of literature in political philosophy examines these relationships of duties and entitlements."

The Nuffield Council goes on to say:

> " The central issue in public health is the extent to which it is acceptable for the state to establish policies that will influence population health." [31]

The references to *the state* in these points are of critical importance. Public health activities of course include non-governmental actors and agencies (such as charities, industry, academia). But at the heart of questions of what can and should be done in the name of public health are arguments about what government is for. In particular, there are questions of what policy aims governments should have (what are the proper goals of government?) and what means might be used to see these effected (what sorts of measures or interventions are justified to achieve governmental goals?).

Interest in public health and ethics, as addressed to governmental agendas, can be said to focus on two important points of concern, which are usefully distinguished.[32] Perhaps of more familiarity within the public health community, we may consider professional ethics: here, we are interested in the ethical codes and norms that govern and guide public health practice. Professional codes, such as the *Public Health Skills and Knowledge Framework*,[33] help direct the practice specifically of those working in public health roles. Their function is to guide a particular group who have followed a particular vocation.

A second focus of public health ethics looks to society as a whole, and asks what health responsibilities are held by different 'stakeholders'—from public institutions and agencies, through non-governmental bodies, industry and community organisations, to individuals. This face of public health ethics reflects on the value of health, including population health. But it does not end with simply the ethics that should govern the public health community: it rather is concerned with overall questions of social justice, and what makes a fair society.

3.2 The Nanny State in Public Health Ethics

Framing the debate in its political context allows us to see the nature and scope of discussion of the nanny state. If we are to promote a society whose commitments to fairness include recognition of the ethical mandates of public health—to improve health and reduce unfair inequalities—then we must be able to identify and categorise the different components of *dominant narratives* and seek to respond to these. Furthermore, we must do this while understanding that scientific developments mean that public health is a very wide field: it includes, for example, concerns across the lifecourse, epigenetics, addressing socio-economic inequalities, health in all sectors and policies, and health and global justice. Perhaps unsurprisingly, prominent efforts to develop an ethically rigorous public health show the strength of nanny state narratives and how they impede agendas to promote the public's health through public health ethics. For the purpose of this paper, we might take the Nuffield Council report to exemplify the point.

Building on the idea of stewardship promulgated by the World Health Organization[34] and the King's Fund paper on the same topic by Dr Karen Jochelson,[35] the Nuffield Council on Bioethics seeks to distance itself from charges of promoting a nanny state ideology: rather than embrace or seek to defend 'nannying', it denies it. It does this in particular by highlighting as one of its principles that public health programmes should 'not attempt to coerce adults to lead healthy lives'.[36]

Overall, the Nuffield Council's report advocates for a public health ethics that is concerned with promoting better population health, ameliorating health inequalities, and paying attention to vulnerable and disadvantaged groups. To account further for nanny state concerns, the Nuffield Council advances the idea of an 'intervention ladder'. This regulatory model describes different levels of possible government intervention for public health programmes. These range from the 'lower', less engaged levels of intervention, such as monitoring behaviour or providing information, to the 'higher', more interfering levels such as providing fiscal (dis)incentives (for example introducing a 'sugar tax'), limiting choices (such as by banning transfats in foods), and restricting choice altogether (for instance by isolating people who are carrying contagious disease).[37] To avoid nanny state allegations, the Nuffield Council suggests that we should always start at the bottom of the ladder, and work up through more restrictive or prescriptive interventions always with an increasingly demanding level of justification.

3.3 Insidious Philosophical Values in Public Health Ethics?

The dominance and force of nanny state critiques is clear from the way that the Nuffield Council presents its position. We may, however, question it from two conflicting directions. Interestingly, both of these contradictory angles suggest that the approach to framing public health ethics is insidious, and thus should give us pause for reflection.

First, we can look at public discourse and ask how the framing of 'liberty friendly' public health ethics is received. Two headlines from the reporting of the Nuffield Council report in *The Times* indicate a cynicism in line with the points raised earlier in this report:

No to the Nanny State, But Yes to Telling Us All What to Do Through 'Stewardship'

(*The Times*, 13th November, 2007)

Higher Alcohol Tax and No Smoking at Home—Beware of the New Nanny State

(*The Times*, 13th November, 2007)

Such framing shows, consistently with the analysis in section 2, how nanny state accusations are not circumvented by avoiding hard paternalism (that is, measures that force

autonomous adults to make healthy choices). From the perspective of a nanny state critique, public health values and methods are insidious, and even 'soft' measures of regulation or measures targeted at vulnerable groups amount to 'nannying' under another name.

From a philosophical public health ethics perspective, the self-imposed nanny state constraints in ethical frameworks such as the Nuffield Council's are also problematic. This represents a different sort of insidiousness. Professor Angus Dawson has been a consistent and forceful critic of the Nuffield Council report.[38] Amongst other things, he suggests that the presentation of the 'Intervention Ladder' and the mandate always to start at the bottom means that we wrongly *double* the value of liberty: it ceases to be *one* value to consider, and becomes a value that is counted twice in any given assessment of possible public health measures.[39] Whilst liberty is, of course, an essential value to protect in a liberal democracy, it should not be double-weighted when balanced against other important values, such as health or the reduction of unfair inequalities. By overemphasising the value of liberty, the Nuffield Council, on this view, falls prey to insidious and unwarranted libertarian principles. If this is accepted, it follows that it provides an inadequate public health ethics. This is because public health ethics *perpetuates* rather than challenges or diminishes the individualism that compounds threats to the public's health. Theories and frameworks in public health ethics are problematic, on this view, if they work with questionable libertarian constraints that overstate the strength of individual choice and responsibility.

Overall, these points have significant implications for how we participate in and respond to the nanny state debate. Ethical concerns go to the heart of our understanding of what constitutes a *legitimate* or *justified* public health policy. We need to consider, therefore, the structure and assumptions of arguments about how we should advance public health policy. And we need to anticipate and account for the reception of our proposals in public discourse.

4. Responding to the Nanny State in Public Health Advocacy

Section Summary

4.1 Reflections on the Here and Now

- To have an effect, ethical policy aims need to account for the dominance of the existing social and political climate.
  - An example is given of a public health strategy that aims to move towards a 'culture of health' through progressive means.
  - The acceptance of the need to progress policy simply through 'nudge' type measures is questioned.

4.2 Reflective Public Health

- At the level of theory, it is instructive to revisit and expand on the principled positions outlined in brief in section 2. This involves:
  - An explanation of what is meant by 'economic libertarianism', 'philosophical libertarianism', and 'coercive healthism';
  - An account of how reasoned responses to each of these might be made.

4.3 Healthy Strategies for Promoting Better Public Debate

- In practice, philosophical reasoning is not enough. The nature of public debate is therefore considered.
  - Three forms of response to nanny state accusations are evaluated: denying nannying; taking on and responding to health-harming organisations and policies; and 'owning' or 'reclaiming' nannying.
  - Considerations are raised that might inform our decisions on how to respond to the nanny state debate, and policy debates more widely.

4.1 Reflections on the Here and Now: Public Ethics, Status Quo Bias, and Nudging Around the Edges of the Nanny State Debate

In recent history we have seen an increasing role for experts in ethics and law in matters of health practice and policy.[40] In part because of this, there has emerged a scholarly literature that examines 'public ethics'. Public ethics describes the points of connection between academic philosophical inquiry, public debate, and practical social and political change.[41] Within this literature we find compelling arguments about the relevance of '*status quo* bias'.[42] *Status quo* bias refers to the need to accept that 'we are starting from here'. We are not in some abstract philosophical society, but operating in the here and now.

This means that we need to account for the dominance of the existing social and political climate within which a particular policy or practice sits. *Status quo* bias means that we take and relate to the society that we live in. To recognise a *status quo* bias does not mean that we accept the world as it is. Rather, it means that whilst we should aim towards a better, fairer society, if we are realistically going to make a difference, we must push for reforms building from where we are.[43]

Prominent public health agendas seem to accord with this view, combining ethical reasons and agendas with an acknowledgment of real world constraints. Professor Dame Sally Davies and colleagues, for example, argue for what is an ethical mission for public health: promoting a healthier society and reducing unfair health inequalities. They advocate that this is best achieved through progressive moves that would create a cultural shift. The methods of such moves explicitly recognise and fit themselves within a political climate of liberal individualism. Professor Davies and colleagues say:

> " Commitment to strengthen community action as promoted by the Ottawa Charter can be seen to be countered by a rise in individualism in modern society, undermining health and wellbeing at individual and social levels."[44]

In response to this dominant political ideology, they aim to move in steps towards a society that embraces a 'culture of health':

> " [A] cultural shift that emphasises a society characterised by individual dependence and social interdependence, and which embeds engagement so that personal and social goals can be achieved justly." [45]

This sort of vision, and the approach to reach it, brings us into policy debates that aim at once to respect libertarian concerns—concerns that people should be free to make their own choices—and paternalistic concerns—concerns that people do not always promote their own health and well-being, and that regulatory interventions may help them to do so without *forcing* healthy options. As we have seen in the previous sections, even 'liberty friendly' public health measures may face nanny state accusations. But some scholars and policy makers have sought to overcome the concerns through methods of 'nudging', or 'libertarian paternalism': ideas advocated by Professors Cass Sunstein and Richard Thaler.[46] We may thus explore whether nudge, or nudge-type theory, represents an appropriate basis of public health policy.

Professors Sunstein and Thaler's nudge theory rests on the idea that people are not rational economic actors: we make decisions (even by our own account) unwisely. Given this, it is argued that we should re-design our social and regulatory environments so that the easier choices are those that best promote our welfare, whilst leaving it open to us to make harmful choices if we so wish. For instance, a 'nudge' approach would mean having salad as the side dish that automatically comes with a food order, but leave open the option to choose chips instead. Professor Davies and colleagues' approach essentially looks to the use of nudges: we create a healthier environment without laws that directly coerce healthy choices.

The dominance of the individualism that

Professor Davies and colleagues describe represents a clear, political *status quo*. It is apparent, then, why nudge-type approaches might be seen as the most fitting. Recourse to nudge-type reasoning has, furthermore, proven politically popular. However, we should not accept it uncritically: it presents various problems. These include concerns from a public health perspective that there is little novel in the idea of policies that nudge, and that there are limits to the good that nudges can do.[47] Relevant questions also include more philosophical concerns, such as the question: if people are not properly treated as the rational actors of classical economic theory, why treat them as if they are the rational, self-reliant actors of philosophical libertarianism?[48] Nudge theory, and agendas that (explicitly or implicitly) use nudge-type reasoning in developing health policy, seem to fall prey to the double commitment to liberty as just one important value, in the way discussed above in section 3.3.

This indicates that whilst we need to account for and start from the *status quo*, public health agendas should be more direct in confronting the challenges of individualism. They ought to consider how to defend themselves as paternalistic, explaining the weaknesses of the arguments entailed within nanny state accusations and justifying themselves by reference to clear and persuasive reasons. This is done, for example, by the British Medical Association in its advocacy on public health ethics.[49] Although individual policies that 'nudge' are crucial parts of the overall regulatory environment, nudge as an overall philosophy or agenda cannot provide the answer in the nanny state debate. We cannot straightforwardly nudge our way around the contours of nanny state accusations. It is therefore necessary to consider first the critical responses that might be made in the nanny state debate, and then to look at practical approaches that might be suggested.

4.2 Reflective Public Health: Marrying Theory and Practice

This report has emphasised the importance of recognising that ethical values to direct public health policy cannot be established just by reference to the ethics of public health professionals. Rather, we need to consider questions of social justice and policy in the round (section 3.1). Accordingly, the key to ethical public health is not persuading other members of the public health community that the public's health and health equalities are values of significant importance. Through a public ethics approach, we rather need to be able to advocate for health as a value that should be promoted all things considered: we need to be able to explain how and why health matters to everyone.

Although this may not be a welcome message, there is no politically neutral ground in—no 'third way' around— the nanny state debate. It is crucial in public health to be able to advocate to all communities about the special importance of health (again as one amongst various values including but not limited to liberty). And it is crucial to be able to explain the reasons why improving health and reducing health inequalities are important not just from a 'public health perspective', but for the general good of a fair and successful society.

In public debates and discourse, respondents to nanny state critiques need to be able to reply to contrary political, commercial, and social interests and reasoning. Commitment to nanny state ideals causes injustices, in terms of harms to individual and population health, and in terms of the perpetuation and exacerbation of unfair health inequalities. To respond to these, we need, as explained in section 2, to be able to recognise *the nature* of arguments that are implied in a nanny state accusation. And part of this means identifying and explaining their underpinning rationales.[50]

To help demonstrate how this might be done, we may revisit and build on the three areas of principled arguments outlined in section 2. These present distinct sorts of rationales for a nanny state accusation. Accordingly, they also invite different forms of reasoning in response.

Economic Libertarianism

One category of argument against the nanny state holds that, as a matter of practical reality, health outcomes and opportunities are best realised through market freedoms and individual choice.

On this reasoning, most public health measures are economically inefficient. Furthermore, such arguments may hold that health promotion measures and campaigns (for example the provision of a publicly-funded healthcare system; anti-obesity programmes) are *harmful* to population health as they reduce personal responsibility for health: by providing a 'safety net', it is suggested, such policies encourage people to become *less* healthy by incentivising unhealthy behaviours and attitudes.

From the perspective of economic libertarianism, health protection and promotion are nannying because they infantilise: they leave people who would in fact be able best to take care of their health unable to do so.[51]

Responding to Economic Libertarianism

The arguments here rest on *empirical* claims; arguments (putatively) based on facts about the world. Responding to them therefore relies on *evidence-based* public health.

This is where members of the public health community likely feel most comfortable responding to nanny state arguments. Arguments devised in response to economic libertarian accusations of nanny statism should be guided by the best interpretation of the scientific evidence: where public health science (e.g. on commercial, political, or social determinants of health) shows that interventions would (likely) improve health or reduce health inequalities, this will rebut economic libertarian arguments.[52]

Philosophical Libertarianism

According to a second category of argument, it may be claimed that to respect persons as moral agents the government must always respect their rights to make their own decisions for themselves unless their choices cause unjustified harm to other people or other people's property. This holds where a person's decision seems unwise to other people, or even where a person's decision seems unwise on her own terms (for example when a person prioritises short-term interests over long-term happiness and security, such as by opting out of a pension scheme that she wants to be in).

If we accept philosophical libertarianism, we hold that the government and public health community have no right to interfere with people's right to smoke cigarettes, to treat activities such as gambling as public health concerns, or more generally to prioritise values other than autonomy (or liberty/freedom). On this view, the great majority of public health activities and agendas are nannying because, *regardless of whether in fact they promote better health*, they are unjustifiably *paternalistic*: people have a natural right (on some counts even a *duty*[53]) to make their own choices without the influence of the state or the public health community.

Responding to Philosophical Libertarianism

Nanny state accusations that are based on *philosophical* libertarianism rest on ethical claims; arguments based on what it means to be respected morally as a person. As indicated in the discussion above of libertarian paternalism/nudge, there may be some empirical claims here that can be responded to on empirical terms. For example, claims that persons are inherently self-reliant, or able to judge best their own interests, have been criticised for being too abstract, and

not reflective of what persons are like in the real world.[54] Such points are all the stronger in relation to decisions made on behalf of children, given the special duty of care that the state owes to children.

There is much weight to such views, yet arguments from philosophical libertarianism often treat it as a self-evident truth that the government has no right to intervene in people's choices about their own health and well-being.[55] In this instance, ethical advocacy requires fundamental challenges to libertarian theory itself. This means combining the sorts of empirical claims just described with a clear defence of the importance of further political values to liberty, such as health and well-being, solidarity, fairness/equity, community, and happiness. In other words, a political vision must be presented that accounts for and explains the value of autonomy and other things that matter. To respond to philosophical libertarianism, arguments must be produced that explain why good government is not limited to the protection of narrowly conceived libertarian rights. This may include, for example, claims that sometimes protection of autonomy is best achieved through government regulation, for instance to negate the undue influence of enormously powerful non-governmental (e.g. commercial) actors.

'Coercive Healthism'/Health as a Political Ideology

A third, distinct category of arguments states that the government and public health agencies and actors have no business even defining health, less still promoting it as a value to underpin policy.

This view raises challenges that differ from those in the previous two because it rejects any place for arguments based on public health promotion. Economic libertarians do not (of necessity) claim that health is unimportant; rather, they claim that health is best achieved without public health interventions. Philosophical libertarians do not challenge the idea that health might be a value to pursue; rather, they claim that it is a value that should not be placed above liberty, and that health interventions are therefore only justified with persons' consent.

Claims about 'coercive healthism' are more radically sceptical. They hold that health is too abstract a concept to be defined in the first place; health on this view is a subjective concept that differs for different people, and thus is not something that can or should be measured at a population (or other aggregated) level, or be the basis of policy. One person's health is another person's hell, so people's well-being is purely to be defined by them. Where measures are instituted to protect health or promote 'healthy lifestyles' this is political ideology. From the perspective of 'coercive healthism', public health activities are problematic because they pretend to a beneficial agenda (promoting people's interests) when in reality they take an undefinable subjective value (health) and use this to push an ideological position on what it means to live well: by purporting to define well-being, the government destroys well-being.[56]

Responding to 'Coercive Healthism'/Health as a Political Ideology

The arguments here again rest on *philosophical* reasons and require to be responded to accordingly. The role of empirical reasoning is very limited precisely because the claims are about values. There are two points in particular whereby responses to the challenges of claims of 'coercive healthism' require to be developed.

First, we might respond in terms to the claim that well-being cannot be defined other than by the individual. Here, we might argue that some things are simply, quite regardless of the individual person's perspective, harmful.[57] For example, to characterise conditions such as heart disease or lung cancer as harmful is not ideology. Of course, political arguments are

required to establish how we should *address* the causes of disease. But in formulating these we can argue forcefully that health harms are uncontroversially harms, and there are thus reasons to address them.

Second, we might look at our practical, social environment. The political ideology arguments rest on a view that public actors and institutions control people's choices and lives in a way that is not matched by private actors (for example, large corporations, media organisations). Where this is falsifiable, we may also suggest that the arguments may require regulation precisely to protect people's autonomy and well-being. Whether at an individual or a population level, it might be argued that attention must be given to the influences on our lives and health, whether these come from government agencies or organisations such as the food industry, social media, or news media. This includes the need for a platform for public health advocacy to serve as a corrective where our social and commercial environments themselves are doing damage in the ways feared by the manner of philosophical reason described here.[58]

This all makes clear that there are qualitatively distinct arguments to address in different instances if we want to ameliorate the harms and wrongs caused by acceptance and perpetuation of nanny state critiques. It is crucial to be able to distinguish the different sorts of arguments: economic/empirical claims about how an optimally healthy society is achieved, and philosophical arguments about the proper roles of government. Necessarily, all of these require engaged discussion of values and principles: what is optimal health?; and what values should be protected politically?

And of course, as demonstrated in section 2.1, there are nanny state accusations that are not the product of different sorts of principled reasoning. We must also keep an eye on the possibility that particular nanny state accusations may be *arbitrary* or *incoherent*.

Overall, this means intellectually there are two key tasks for responding to the nanny state debate:

- First, building capacity to identify the different sorts of reasons that arise in the debate, and thus being able to respond to them on appropriate terms, asking such questions as:
  - Where an empirical claim is made, for example that plain packaging will not reduce tobacco use, what is the scientific evidence base?
  - Where a philosophical claim is made, for example that society is fairest when government does not promote health, is it a claim that can be sustained when we reflect on the values as a whole that society should promote?
  - Within the structure of an argument, is a person or organisation making claims that hold together, or do they contradict themselves, for example by saying that one health promotion measure is to be recommended but that another measure that is no more interventionist is unjustified nannying?
  - Is it the case that in fact a nanny state accusation is irrelevant to the policy or measure under discussion, for example because the policy is about environmental protection rather than health promotion?
- Second, building capacity to present in positive terms an account of how and why public health priorities should be accepted as guiding overall social and political priorities. This requires the development of more than a 'public health perspective':
  - Account must be given of how health corresponds to other (sometimes conflicting or competing) values: we need to establish substantive values; establish what matters.
  - This will include health and well-being, solidarity, fairness/equity, community, happiness.

- Importantly, we are looking here not at the professional values of the public health workforce (though these may overlap), but the political values of our society as a whole.
- As well as substantive values, we need to consider procedural values; establish the ethical means to achieve policy ends.
- This will include values such as democratic methods of decision-making, proportionality, transparency and accountability, cycles of planning and responsiveness in regulation, and respect for human rights.

These principled underpinnings should serve to ensure that the messages and methods of public health advocacy are ethically robust. However, when looking at the nanny state debate, we might ask not just how to understand the arguments, but also how practically to formulate a response. Policy requires public understanding and support. We need to be able to 'translate' philosophical messages into language that is accessible and clear. And we need to recognise that the nanny state debate takes place in an arena wherein simply winning the philosophical argument is not enough. Section 4.3 therefore looks at some of the positions on practical advocacy from within the public health literature.

4.3 Healthy Strategies for Promoting Better Public Debate

This report has explained how nanny state critiques are formulated. We have seen that in practice they may apply to any public health measure: they are not limited to coercive interventions. And we have seen too that in practice nanny state accusations may be applied arbitrarily or incoherently to demonise some health promotion measures and not others. We have also seen nanny state accusations made against policy proposals that are not even about promoting individual or population health.

This report has explained how nanny state ideas and ideals have impacted on public health ethics, and how a robustly ethical public health might allow us to recognise and respond to different sorts of nanny state argument. Throughout the discussion it has been clear that the nanny state debate is a public debate, and one that provokes political disagreement.

Given this real world context, we must remain constantly aware that the nanny state cannot simply be debated according to the 'rules' of a university seminar discussion. In unpicking the rationales and reasoning that support a nanny state accusation we do require skills in critical reasoning (reflected in the discussion in section 4.2). But in advocating publicly in defence of public health policies and agendas, we need to consider how to frame the points we make given how nanny state accusations are made in practice. Ideas about the best sorts of strategies vary, and members of the public health community may be guided by the voices of different public health leaders. To illustrate how this might work, we can consider the benefits and challenges of three different sorts of approach.

Strategy 1: Deny Nannying

One way to try to avoid or overcome nanny state accusations is to try to refute them. Consider how, for example, in 2017 *The Sun* reported that Duncan Selbie, Chief Executive of Public Health England, denied nanny state accusations. He did so by reference to the idea at the core of nanny statism: namely that nanny states *coerce* healthy behaviour (see section 2.1):

> ***What Nanny State? Top Health Boss Says He's Not Running a Nanny State and Doesn't Care if Brits Smoke, Drink or Die***
> Duncan Selbie claims he only gives people information to make the right decisions and it is up to them how they act (*The Sun*, 13th July, 2017)*

The strengths of this approach are clear: they aim to defuse the charges levelled against public health policy, and explain that the role of Public Health England is to advise rather than coerce.

Dr Stacy Carter, Professor Vikki Entwistle, and Professor Miles Little have provided their own insightful analysis of nanny state accusations. In it, they explore the concept of freedom, and open up means of identifying how public health advocates might respond to nanny state accusations. This comes in their analysis by engaging in debate and in particular: challenging the accuser's claims about why an intervention is an unacceptable interference with freedom; and highlighting that government measures are in fact crucial to the protection and promotion of freedoms that we enjoy.**

Again, such an approach has the benefit of aiming to defuse charges against the nanny state, and aims to promote a broader public discourse on what justifies the scope and limits of government policy.

One challenge, however, for an approach of denying nannying is, as we have seen, that nanny state accusations are widely made against 'soft' modes of intervention, arbitrarily, or in instances where there is no 'nannying' in any sense. As such, this method of responding to nanny state accusations looks apt for consideration in points of principled debate, but may be a message that is lost in the context of more fraught or cynical public and political discourse. However fair the point may be, it risks being undermined by participants who shout the loudest in the public debate, who may simply continue to cry nanny.

A second possible challenge, in reference to the first example here, is that this sort of framing may perpetuate the view that government should never use 'harder' measures of intervention. As discussed above in relation to the Nuffield Council on Bioethics' report, and the use of nudging, this is possibly not an ethical position that should be accepted.

* https://www.thesun.co.uk/living/4014078/top-health-boss-says-hes-not-running-a-nanny-state-and-doesnt-care-if-brits-smoke-or-drink/

** See Stacy M. Carter, Vikki A. Entwistle, Miles Little, 'Relational Conceptions of Paternalism: A way to rebut nanny-state accusations and evaluate public health interventions,' Public Health (2015) 129:8, 1021-1029; Vikki Entwistle, Stacy Carter, and Miles Little, 'Defending Public Health Against 'Nanny State' Accusations: We Need To Talk About Freedom,' (November 28, 2016), available at https://chpi.org.uk/blog/defending-public-health-nanny-state-accusations-need-talk-freedom/

Strategy 2: Take on and respond to health-harming organisations and policies

A second approach that might be taken is more 'combative'. Rather than deny or try to circumvent a charge of nanny statism, this strategy looks to throwing challenges back at those who attack public health policy.

Professor Martin McKee and colleagues, for instance, publish papers that identify the techniques used by actors including commercial organisations, and recommend commensurate methods of engagement by the public health workforce with politicians, the media, and different publics. This form of advocacy may be characterised as almost aggressively pro-health, in response to aggressive tactics by actors such as corporations who are protecting interests that are harmful to the public's health. Writing with Pascal Diethelm, Professor McKee contrasts scientific scepticism with 'denialism'. Denialism involves:

- Identification of conspiracies [where they do not exist];
- Use of fake experts;
- Selectivity of citation;
- Creation of impossible expectations of research;
- Misrepresentation and logical fallacies;
- Manufacture of doubt.*

It is clear how 'denialist' agendas might feed into and perpetuate nanny state narratives. McKee and Diethelm argue that public health professionals must be able to identify and respond to denialists, 'exposing the tactics they use and the flaws in their arguments to a wide audience.' This requires speedy responses and effective methods of communication; for example through use of narrative and analogy. Writing more recently, this time with Professor David Stuckler, Professor McKee proposes four methods that may be taken to advance public health messages:

1. 'Challenge dominant narratives': here, we might expose how (for example) the exercise of corporate power leads to health impacts that are beyond individuals' control.
2. 'Shape norms for healthy policymaking': here, we might expose and challenge the place at the policy table of corporations with vested interests in health-harming products.
3. 'Support communities that have stood up to powerful corporations and won': this entails evaluation and communication of health successes.
4. 'Align with other social movements': here, alliances are formed with other fields that have shared or consistent policy agendas.**

The advantage of this sort of strategy is that it may be seen as levelling the playing field. It promotes the use of narratives that will be well understood in public debates, and aims to ensure that health messages are not lost. Such an approach aims to expose the sorts of values that are often harmful and lead to social injustices; values that may be hidden behind the cover, for example, of nanny state accusations. And such an approach aims to speak in positive terms to the value of health promoting measures.

The main challenge of such an approach is its scale and ambition. As Professors McKee and Stuckler acknowledge, 'we are not so naïve as to believe that public health professionals can put right all of the problems we have described'. Their advocacy here nevertheless is for impacts that can be made notwithstanding the size of the challenge.

* Martin McKee and Pascal Diethelm, 'How the growth of denialism undermines public health,' BMJ 2010;341:c6950.
** Martin McKee and David Stuckler, 'Revisiting the Corporate and Commercial Determinants of Health,' American Journal of Public Health (2018) 108, 1167-1170.

Strategy 3: 'Own' or 'reclaim' nannying

A third alternative is to 'own' nanny state claims. On this view, it may be more effective or fitting to 'reclaim' nannying, as in the headline of the following opinion piece by Barbara Ellen, published in *The Guardian* in 2018:

> ***Bring on the Nanny State if it Stops Our Children's Teeth from Falling Out***
> (*The Guardian*, 8th April, 2018)*

Professor Simon Capewell's advocacy may be seen also to represent a 'reclaiming' of the nanny state:

> " The nanny state means ensuring a healthy environment for us all. […] The nanny state is not a luxury or a naïve socialist aspiration. It is essential for the optimal health of every person on this planet."**

An advantage of this sort of approach is that it challenges the perceived need to deny nanny state accusations. It may be seen as empowering in the nanny state debate, and a means to inviting more serious consideration of a policy rather than an assumption that it must be rejected simply on the basis of a nanny state slur.

A challenge that it presents is that it may alienate those who 'know' that nannying is necessarily wrong. It will appeal to some people, and persuade others. But it may also keep some ears closed to policy debates.

* https://www.theguardian.com/commentisfree/2018/apr/08/bring-on-nanny-state-if-it-stops-childrens-teeth-falling-out
** Simon Capewell, 'Are Nanny States Healthier States? Yes' BMJ 2016;355:i6341

These three approaches—deny nannying, take on and respond to health-harming organisations and policies, or 'own nannying'—are not exhaustive of methods of engagement in the nanny state debate, less still public policy debates more widely. For practical guidance, practitioners would do well to refer to existing tools: for example, the *Oxford Handbook on Public Health* contains practical guidance in a series of chapters on 'policy arenas'. [59]

When considering on what terms to engage in and respond to the nanny state debate, there are various points that we might consider. These include advantages and disadvantages summarised in the above boxes. In reality, there is of course more nuance in health policy debates than sharp choices between the sorts of approaches listed here. Equally, the methods of advocacy taken by specific members of the public health community will necessarily vary depending both on personal ethics and the specific nature of different roles that people hold. Professor Johan Mackenbach has noted that: 'Politics is a struggle between conflicting ideologies and interests, in which health provides only one of the many types of argument.'[60] In addition, he explains:

> " Politics operates on a timescale governed by elections and media attention, which is at odds with the greater timescale at which population health and its determinants can be expected to change. An emphatically political approach to public health may also in the long run prove to be a self-defeating strategy, because of the dangers of politicisation. Politics is divisive, and long-term support for public health can be eroded as well as strengthened by recurrent political debates."[61]

In Professor Mackenbach's analysis, there is a recognition that members of the public health community may engage in public and political debates at different levels. At base, we have a passive position of simple dissemination within the sector itself, only engaging with politicians when approached. One step up from this, political engagement is limited to methods such as submission of scientific reports to politicians and the media. A step up again entails active efforts of lobbying. And at the top, Professor Mackenbach looks to members of the public health community becoming politicians.

In considering the rationales for operating at these different levels, we may refer to members of the public health community and the roles and rationales that they express for different methods of political debate and advocacy. We may contrast, for example, the advocacy methods of Professor Martin McKee, discussed above, with those of Professor Judith MacKay.[62]

Whatever methods and levels of engagement we might choose when formulating arguments in the nanny state debate, what is essential is having an understanding of claims being made. Does the argument itself make sense, or is it incoherent or arbitrary? Where an apparently coherent principled claim is being made, is it an economic argument inviting an empirically-informed response, or a philosophical argument inviting a challenge to basic premises or logic? In responding, effective argument must be well communicated and not itself become hollow rhetoric. It is essential to be able to advance a sound, reasoned response to nanny state accusations that can be understood and accepted without recourse to the cynical or obstructive methods too often found in the nanny state debate.

5. Useful Resources on the Nanny State Debate

Please note that some of the following resources are behind paywalls.

The special issue of Public Health (2015) 129:8, available at **https://www.publichealthjrnl.com/issue/S0033-3506(15)X0008-4**

Sudhir Anand, Fabienne Peter, and Amartya Sen (eds), *Public Health, Ethics, and Equity* (Oxford University Press, 2006)

British Medical Association, Behaviour Change, *Public Health and the Role of the State—BMA Position Statement*, (BMA Ethics Department, 2012)

Simon Capewell and Richard Lilford, 'Are Nanny States Healthier States?' BMJ 2016;355:i6341

John Coggon, *What Makes Health Public? A Critical Evaluation of Moral, Legal, and Political Claims in Public Health* (Cambridge University Press, 2012)

John Coggon, Keith Syrett, A.M. Viens, *Public Health Law: Ethics, Governance, and Regulation* (Routledge, 2017)

John Coggon and A.M. Viens, *Public Health Ethics in Practice: An Overview of Public Health Ethics for the UK Public Health Skills and Knowledge Framework* (Department of Health, 2017), available at **https://www.gov.uk/government/publications/public-health-ethics-in-practice**

Sarah Conly, *Against Autonomy: Justifying Coercive Paternalism*, (Cambridge University Press, 2013)

M Daube, J Safford, L Bond, 'No need for nanny,' Tobacco Control 2008 17, 426-427

Sally C. Davies, Eleanor Winpenny, Sarah Ball, et al., 'For debate: a new wave in public health improvement,' The Lancet (2014) 384; 1889-1895

Angus Dawson, 'Snakes and Ladders: State Interventions and the Place of Liberty in Public Health Policy,' Journal of Medical Ethics (2016) 42, 510-513

Gerald Dworkin, 'Paternalism,' in Edward N. Zalta (ed), The Standford Encyclopedia of Philosophy (2017), available at **https://plato.stanford.edu/entries/paternalism/**

Vikki Entwistle, Stacy Carter, and Miles Little, 'Defending Public Health Against 'Nanny State' Accusations: We Need To Talk About Freedom,' (November 28, 2016), available at **https://chpi.org.uk/blog/defending-public-health-nanny-state-accusations-need-talk-freedom/**

Kalle Grill and Jason Hanna, *The Routledge Handbook of the Philosophy of Paternalism* (Routledge, 2018)

Lawrence O. Gostin and Keiran G. Gostin, 'A broader liberty: J.S. Mill, Paternalism, and the Public's Health,' Public Health (2009) 123, 214-222

Charles Guest, Walter Ricciardi, Ichiro Kawachi, Iain Lang (eds), *The Oxford Handbook of Public Health Practice*, (3rd edn, Oxford University Press, 2013), Part 4.

Bruce Jennings, 'Frameworks for Ethics in Public Health,' Acta Bioethica (2003) 9:2, 165-176

Karen Jochelson, *Nanny or Steward: The Role of Government in Public Health* (King's Fund, 2005)

Julian Le Grand and Bill New, *Government Paternalism: Nanny State or Helpful Friend?* (Princeton University Press, 2015)

Johan Mackenbach, 'Politics is nothing but medicine at a larger scale: reflections on public health's biggest idea,' Journal of Epidemiology and Community Health (2009) 63:3, 181-184

Theresa M. Marteau, David Ogilvie, Martin Roland, Marc Suhrcke, Michael P. Kelly, 'Judging Nudging: Can Nudging Improve Population Health?' BMJ (2011) 342, 228-231.

Martin McKee and Pascal Diethelm, 'How the growth of denialism undermines public health,' BMJ 2010;341:c6950

Martin McKee and David Stuckler, 'Responding to the Corporate and Commercial Determinants of Health,' American Journal of Public Health (2018) (online advance access, July 19, 2018, e1-e4).

Thomas R. V. Nys, 'Paternalism in Public Health Care,' Public Health Ethics 1(2008): 64–72

Nuffield Council on Bioethics, *Public Health—Ethical Issues* (Nuffield, 2007)

Public Health England, *Public Health Skills and Knowledge Framework 2016*, (PHE, 2016), available at **https://www.gov.uk/government/publications/public-health-skills-and-knowledge-framework-phskf**

Thomas Schramme (ed.), *New Perspectives on Paternalism and Health Care* (Springer, 2015)

Jonathan Wolff, 'Harm and Hypocrisy: Have We Got It Wrong on Drugs?' Public Policy Research (2007) 14:2, 126-135.

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1 M Daube, J Safford, L Bond, 'No need for nanny,' Tobacco Control 2008 17, 426-427.

2 See John Coggon and A.M. Viens, *Public Health Ethics in Practice: An Overview of Public Health Ethics for the UK Public Health Skills and Knowledge Framework* (Department of Health, 2017), available at **https://www.gov.uk/government/publications/public-health-ethics-in-practice**

3 See Conrad Keating, *Smoking Kills: The Revolutionary Life of Richard Doll* (Signal Books, 2009); Naomi Oreskes and Erik Conway, *Merchants of Doubt* (Bloomsbury, 2011).

4 Daube, Safford, Bond, 'No need for nanny,' p. 427.

5 Karen Jochelson, Nanny or Steward: *The Role of Government in Public Health* (King's Fund, 2005); British Medical Association, *Behaviour Change, Public Health and the Role of the State—BMA Position Statement*, (BMA Ethics Department, 2012); Roger S. Magnusson and Paul E. Griffiths, 'Who's afraid of the nanny state? Introduction to a symposium,' Public Health (2015) 129, 1017-1020.

6 It should be noted that there are also instances in commentary and editorial lines within the popular press where the idea of the nanny state is explicitly embraced and promoted. This of course does not undermine the negative connotations of the term, but rather aims to 'reclaim' it. See further section 4.3, below.

7 http://www.dailymail.co.uk/debate/article-2240118/A-nanny-state-dictates-drink-soon-telling-think.html

8 https://www.thesun.co.uk/news/5742802/why-are-we-paying-3-9bn-for-5000-nannying-civil-servants-to-patronise-us/

9 https://www.express.co.uk/news/politics/891612/BBC-Newsnight-UK-nanny-state-elite-lower-classes-Christopher-Snowden-IEA-liberty-latest

10 See Gerald Dworkin, 'Paternalism,' in Edward N. Zalta (ed), The Standford Encyclopedia of Philosophy (2017), available at https://plato.stanford.edu/entries/paternalism/ ; Gerald Dworkin, 'Paternalism,' The Monist (1972) 56, 64-84; Joel Feinberg, *Harm to Self*, (Oxford University Press, 1986).

11 Some theorists argue for defences of such laws on the basis of their impact on third parties: e.g., noting that if a person is harmed in a car crash, the consequent healthcare costs necessarily have an effect on other persons and not just the person who has been injured. Even granted such reasoning, there is a clear, paternalistic rationale that must be accepted in regard to seatbelt laws: Lawrence O. Gostin and Keiran G. Gostin, 'A broader liberty: J.S. Mill, Paternalism, and the Public's Health,' Public Health (2009) 123, 214-222; Sarah Conly, *Against Autonomy: Justifying Coercive Paternalism*, (Cambridge University Press, 2013).

12 On the complexities of critiquing paternalism in law and policy, as contrasted with interpersonal relationships (e.g. between a doctor and a patient), see Douglas N. Husak, 'Legal Paternalism,' in Hugh LaFollette (ed), *The Oxford Handbook of Practical Ethics*, (Oxford University Press, 2005).

13 Department of Health, *UK Chief Medical Officers' Low Risk Drinking Guidelines* (DoH, 2016), available at **https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/545937/UK_CMOs__report.pdf**

14 https://www.thesun.co.uk/news/1675437/fury-at-governments-killjoy-heath-ruling-that-sets-new-booze-limit-at-just-six-pints-a-week/

15 http://www.dailymail.co.uk/news/article-2687241/Parents-fury-primary-school-bans-packed-lunches-fewer-1-healthy-enough.html

16 See e.g. the TaxPayers' Alliance, 'A Sugar Tax Would Send Us Down A Slippery Slope,' (July 13, 2015), available at **https://www.taxpayersalliance.com/a_sugar_tax_would_send_us_down_a_slippery_slope**

17 https://www.thesun.co.uk/news/1630382/britain-must-get-its-act-together-as-the-obesity-crisis-is-not-only-killing-our-nhs-but-us-too/

18 See also Michael Moore, Heether Yeatman, Rachel Davey, 'Which Nanny—The State or Industry? Wowsers, Teetotallers and the Fun Police in Public Health Advocacy', Public Health (2015) 129, 1030-1037.

19 https://www.bbc.co.uk/news/science-environment-45838997

20 Roger S. Magnusson, 'Case Studies in Nanny State Name-Calling: What Can We Learn?' Public Health (2015) 129:8, 1074-1982.

21 See also Magnusson, 'Case Studies in Nanny State Name-Calling'; Stacy M. Carter, Vikki A. Entwistle, Miles Little, 'Relational Conceptions of Paternalism: A way to rebut nanny-state accusations and evaluate public health interventions,' Public Health (2015) 129:8, 1021-1029.

22 Carter, Entwistle, Little, 'Relational Conceptions of Paternalism'. See also the blog post by these authors: Vikki Entwistle, Stacy Carter, and Miles Little, 'Defending Public Health Against 'Nanny State' Accusations: We Need To Talk About Freedom,' (November 28, 2016), available at **https://chpi.org.uk/blog/defending-public-health-nanny-state-accusations-need-talk-freedom/**

23 Michael Marmot, *Status Syndrome: How Your Social Standing Directly Affects Your Health*, (Bloomsbury, 2004); Michael Marmot, *The Health Gap: The Challenge of an Unequal World*, (Bloomsbury, 2015); Norman Daniels, *Just Health*, (Cambridge University Press, 2007); Sridhar Venkatapuram, *Health Justice: An Argument from the Capabilities Approach*, (Wiley, 2011).

24 See John Coggon and A.M. Viens, Public Health Ethics in Practice: An Overview of Public Health Ethics for the UK Public Health Skills and Knowledge Framework (Department of Health, 2017), available at **https://www.gov.uk/government/publications/public-health-ethics-in-practice**

25 Jochelson, *Nanny or Steward*.

26 Richard Horton, 'Offline: Where Is Public Health Leadership in England,' The Lancet (2011) 378, 1060.

27 Ruth Chadwick and Duncan Wilson, 'The Emergence and Development of Bioethics in the UK,' Medical Law Review (2018) 26:2, 183-201.

28 See Nancy Kass, 'Public Health Ethics: From Foundations and Frameworks to Justice and Global Public Health,' Journal of Law, Medicine and Ethics (2004) 32:2, 232-42.

29 Nuffield Council on Bioethics, *Public Health—Ethical Issues* (Nuffield, 2007); see also Kenneth Calman, 'Beyond the 'Nanny State': Stewardship and Public Health,' Public Health (2009) 123:1, 6-10.

30 Nuffield Council on Bioethics, *Public Health—Ethical Issues,* p. xv.

31 Ibid., p. xvi.

32 For a more comprehensive of ethics and public health, see John Coggon, Keith Syrett, A.M. Viens, Public *Health Law: Ethics, Governance, and Regulation* (Routledge, 2017), chapter 2. See also Bruce Jennings, 'Frameworks for Ethics in Public Health,' Acta Bioethica (2003) 9:2, 165-176.

33 Public Health England, *Public Health Skills and Knowledge Framework 2016*, (PHE, 2016), available at **https://www.gov.uk/government/publications/public-health-skills-and-knowledge-framework-phskf**

34 World Health Organization, *World Health Report 2000*, (WHO, 2000).

35 Jochelson, Nanny or Steward.

36 Nuffield Council, *Public Health—Ethical Issues*, p. 26.

37 Ibid., chapter 3.

38 See e.g. Angus Dawson and Marcel Verweij, 'The Steward of the Millian State,' Public Health Ethics (2008) 1:3, 193-195.

39 Angus Dawson, 'Snakes and Ladders: State Interventions and the Place of Liberty in Public Health Policy,' Journal of Medical Ethics (2016) 42, 510-513. See also British Medical Association, Behaviour Change, Public health and the Role of the State; Paul Griffiths and Caroline West, 'A Balanced Intervention Ladder: Promoting Autonomy Through Public Health Action,' Public Health (2015) 129, 1092-1098.

40 Duncan Wilson, *The Making of British Bioethics*, (Manchester University Press, 2014).

41 See James Wilson, 'Towards a Normative Framework for Public Health Ethics and Policy,' Public Health Ethics (2009) 2:1, 184-194; Jonathan Montgomery, 'Reflections on the Nature of Public Ethics,' Cambridge Quarterly of Healthcare Ethics (2013) 22:1, 9-21.

42 Jonathan Wolff, *Ethics and Public Policy: A Philosophical Inquiry*, (Routledge, 2011); Jonathan Wolff, 'Harm and Hypocrisy: Have We Got It Wrong on Drugs?' Public Policy Research (2007) 14:2, 126-135.

43 Ibid..

44 Sally C. Davies, Eleanor Winpenny, Sarah Ball, et al., 'For debate: a new wave in public health improvement,' The Lancet (2014) 384; 1889-1895, p. 1891. See also the *Academy of Medical Sciences, Improving the Health of the Public by 2040: Optimising the research environment for a healthier, fairer future*, (AMS, 2016).

45 Davies et al., ibid..

46 Cass Sunstein and Richard Thaler, 'Libertarian Paternalism is not an Oxymoron,' The University of Chicago Law Review (2003) 70:4, 1159-1202; Richard Thaler and Cass Sunstein, *Nudge: Improving decisions about health, wealth, and happiness*, (London: Penguin, 2009).

47 Chris Bonell, Adam Fletcher, and Andy Haines, 'One Nudge Forward, Two Steps Back,' BMJ (2011) 342, 401; Theresa M. Marteau, David Ogilvie, Martin Roland, Marc Suhrcke, Michael P. Kelly, 'Judging Nudging: Can Nudging Improve Population Health?' BMJ (2011) 342, 228-231; C Knai, M Pettircrew, MA Durand, et al., 'The Public Health Responsibiltiy Deal: Has a public-private partnership brought about action on alcohol reduction?' Addiction (2015) 110:8, 1217-1125..

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49 British Medical Association, *Behaviour Change, Public Health and the Role of the State*.

50 See also Lawrence O. Gostin and Gregg Bloche, 'The politics of public health: a response to Epstein,' Perspectives in Biology and Medicine (2003) 46:3, S160-S175

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52 See e.g. Marmot, *Status Syndrome*.

53 Cf Robert Paul Wolff, *In Defense of Anarchism*, (Harper and Row, 1970).

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55 See Robert Nozick, *Anarchy, State, and Utopia*, (Basic Books, 1974).

56 See e.g. Petr Skrabanek, *The Death of Humane Medicine and the Rise of Coercive Healthism*, (Bury St Edmunds: St Edmundsbury Press, 1994).

57 Cf Amartya Sen, 'Health Achievement and Equity: External and Internal Perspectives,' in Sudhir Anand, Fabienne Peter, and Amartya Sen (eds), *Public Health, Ethics, and Equity* (Oxford University Press, 2006).

58 See also Moore, Yeatman, Davey, 'Which Nanny—The State or Industry?'.

59 See Charles Guest, Walter Ricciardi, Ichiro Kawachi, Iain Lang (eds), *The Oxford Handbook of Public Health Practice*, (3rd edn, Oxford University Press, 2013), Part 4. See also *British Medical Association, Behaviour Change, Public health* and the Role of the State.

60 Johan Mackenbach, 'Politics is nothing but medicine at a larger scale: reflections on public health's biggest idea,' Journal of Epidemiology and Community Health (2009) 63:3, 181-184, p. 183.

61 Ibid., emphasis added.

62 Contrast Priya Shetty, 'Martin McKee: champion of public health in Europe,' The Lancet (2013) 381, 1089; David Holmes, 'Judith MacKay: self-made scourge of the tobacco industry,' The Lancet (2013) 381, 1531.

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