Perspectives on Paternalism and Public Health

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Contents

Foreword

Public health measures raise complex questions around the relationships between the state and individuals and organisations that are affected by its policies and activities. There are issues around the nature, extent and legitimacy on the part of people in authority of restricting the freedom and responsibilities of those subordinate to (or otherwise dependent on) them in their supposed interest and to promote their own good.

There is debate and disagreement on whether and why health should be the business of the state. Libertarian critics deride the so-called nanny state or meddling paternalistic public health doctors and professionals for interfering with personal choice, by legislating on such behaviours as smoking, alcohol or wearing seat belts, which may infringe on the individual's freedom.

It is important to note though that public health policies around migration, vaccination, alcohol, tobacco, food policies and other issues are not merely based on empirical evidence, facts and science but also on norms and values of the politicians and policy makers making such decisions and their views on the role of the state. To be explicitly aware of the different world views, their assumptions, intentions and operation is key to good public health practice.

Libertarians accuse public health practitioners and policy makers of infantilisation, treating competent adults as if they were children. Citizens, it is said, are made out to be unfit to make their own decisions, who must be told what to do by those who think themselves in the know. They are accused of arrogant finger wagging and trampling on the right of sovereign individuals to make their own decisions and to do what they know is best for them, often irrespective of consequences to themselves or others.

Nanny state accusations are however made against all sorts of measures that would protect or promote health, whether or not they are nannying in this sense. The negative traction gained by criticising a measure as nanny statist means that the term is applied, for example, to redistributive measures, to interventions that serve the wellbeing of disadvantaged or vulnerable persons or groups, and policies that impact entities that can't in any sense be "nannied", such as commercial corporations. Nanny state accusations therefore are often made arbitrarily or incoherently.[1]

There are also issues around duties and responsibilities of governments to protect and promote the public's health and address health inequalities in society. It is argued that "public health is a right of citizens, alongside more familiar rights such as liberty and security. Public health should not be thought of merely as interference with the rights that individuals have, but as necessary to protect these rights."[2] It is suggested that the state could be considered as negligent if it does not fulfil its duties and responsibility to protect health of the population.

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1.   John Coggon, 'The Nanny State Debate: A Pace Where Words Don't Do Justice'. Faculty of Public Health, November, 2018.
     Available at: https://www.fph.org.uk/media/1972/fph-nannystatedebate-report-final.pdf
2.   James Wilson, *Philosophy for Public Health and Public Policy: Beyond the Neglectful State* (Oxford: Oxford University Press, 2021)

There has been a tendency to create false dichotomies between considering the individual versus the collective, or the institutions of society as giving us mutually-exclusive alternative choices between promoting health and social justice. The idea of a divide between, on the one hand, individual freedoms and personal choice and, on the other hand, the state and authority demanding submission has led to polarization, conflict and continuance of outdated ideologies and approaches to achieving the potential of society. Yet there is growing recognition that the individual, the community and the institutions of society which serve us are all key protagonists and chief stewards for health, from whose mutually-enriching values and interactions the future emerges. It is through understanding the interdependence, interactions and relationships between these key protagonists that we can create healthy communities, served by just institutions, in which individuals and families can flourish.

Public health practitioners and policy makers often encounter some version of the 'nanny state' accusation. Does this accusation ever track anything ethically significant (or is it merely ideological hot air)? If so, what exactly? Without an answer to these questions, it is hard to evaluate whether the accusation is ever warranted (and, if so, when) and implications for practice.

The essays collected here aim to help us gain some clarity on these questions, by reflecting on the role (if any) of *paternalism* in public health practice and policy. The contributors include ethicists, philosophers, practitioners and legal scholars, all with an interest in public health ethics. The collection covers a diverse range of topics and presents a range of contrasting positions within the debate. The essay by Begon and Parry aims to provide an accessible overview of theoretical perspectives on paternalism, and explains why public health is a particularly important and interesting case study for better understanding its nature and ethical significance. The essays by Coggon, Da Silva, Dawson, Flanigan, Laurence, McKay, and Wilson each explore specific sub-questions within the broad topic.

The essays are a useful timely resource. They provide insights about why we find accusations of nanny-statism; it examines different philosophical perspectives on what governments and public health organisations and actors are permitted to do; and it gives voice to different framings of critical concerns. Public health readers can learn from this how better to engage in ethically-rigorous practice; to understand and be able to respond to critics of their jobs.

The essay collection continues the longstanding interest of the Faculty in exploring and encouraging debate within public health ethics and building capacity and understanding of the public health workforce around such issues. In particular, the collection complements the Faculty's 2018 report 'The Nanny State Debate: A Place Where Words Don't Do Justice' authored by Professor John Coggon. The essays that follow are presented in the spirit of open enquiry, with the goal of helping us better articulate our views and better understand the source of our disagreements and options in finding common ground.

The collection has its origins in a workshop held in September 2021, on the theme of *'Paternalism and Public Health'*. The workshop was hosted by the UK Faculty of Public Health, in collaboration with the 'Paternalism, Health and Public Policy' project, exploring the tension between the state's duty to protect the health of its citizens and the common worry that such policies may take important decisions out of the hands of those affected by them, undermining their autonomy and agency. The project is organised by Dr Jessica Begon (The University of Durham) and Dr Jonathan Parry (London School of Economics) and funded by the Wellcome Trust. Their partnership with the Faculty provides opportunity to further advance the discourse and scholarship around the issue and promote good public health practice. Particular thanks to Dr Jonathan Parry for his collaboration and support in development of the report (Dr Parry's work on this report is also supported by a UKRI grant, reference EP/X01598X/1).

At the start of the pandemic in 2020 people went onto their balconies and front doorsteps to applaud and convey their admiration and thanks to health care and public health workers for their service and expertise. But by 2021 there were reports of public health practitioners being abused, at times even their lives threatened and attacked for simply trying to do their jobs in devising and advocating policies around vaccination, masks and other public health interventions to protect and promote the health of the people who they were serving. Nanny state slurs and accusations continue to be regularly used to attack health groups and governments, as cliches and slogans to discredit us while avoiding discussion, debate and facts. There is evidence of growing moral distress and injury of the UK public health workforce. There is nothing new about demonising and slogans in opposing public health measures. In 1854, when Edwin Chadwick pressed for basic sanitation, the London Times noted that, *"we prefer to take our chances of cholera and the rest than be bullied into health by Mr Chadwick."*[3] As highlighted by Daube, "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 cliches"[4] and political ideologies. It is hoped that this report will provide some thoughts and ideas to support the ongoing discourse around the judgements required for good public health practice and policy making.

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3.   Cited in Annabel Ferriman, 'Vilified for tackling tobacco', *British Medical Journal* 320 (2000): 1482-1482.
4.   Michael Daube et al, 'No need for nanny', *Tobacco Control* 16, No.6 (2008): 426-427.

Paternalism and Public Health: Mapping the Terrain

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1. Introduction

Public health policies are often accused – rightly or wrongly – of being objectionably paternalistic. And public health practitioners are keen to defend themselves from these 'nanny state' criticisms. But what, exactly, does it mean to label an action paternalistic? And why, exactly, is paternalism supposed to be a bad thing? Without answers these questions, it is hard to adjudicate debates about public health.

In this short essay, we aim to do two things. First, we will provide an accessible overview of how theorists of paternalism have tried to make sense of these fundamental questions.[1] We hope that this will give the reader some analytical tools to aid their own thinking. But, second, we also aim to explain why reflection on the practice of public health can help us make progress on these more abstract issues. This is because most theorising about paternalism focuses on small scale interactions between individuals. By contrast, the domain of public health focuses on policies that target *groups* or *populations*. By testing how our theories of paternalism fare in this specific context, we can learn a great deal about the nature and ethical significance of paternalism in general. So, we hope to show that both practitioners and theorists stand to gain from careful reflection on the relationship between paternalism and public health.

2. What is Paternalism? And What's Wrong with It?

Consider the following case:

Doctor/Patient: An adult patient is seriously ill, but competently refuses a safe and effective medical treatment. Out of concern for his health, his doctor gives him the treatment while he is asleep. The patient never learns that he received the treatment and attributes his recovery to good fortune.

We assume most people will agree that the doctor clearly acts morally wrongly in this case. Why is this? For one thing, the doctor *assaults* the patient. For another, the doctor deceives the patient. But, crucially, this doesn't seem to capture the whole story. In addition, the doctor's behaviour seems objectionable because she treats her patient *as though he is a child,* in some sense. Theories of paternalism aim to explain this distinctive ethical phenomena.

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1. For more detailed introductory discussions, see Jessica Begon, 'Paternalism', *Analysis* 76, No.3 (2016): 355-373; Daniel Groll, 'Medical Paternalism. Part 1', *Philosophy Compass* 9, No.4 (2014): 186-193; Daniel Groll, 'Medical Paternalism. Part 2', *Philosophy Compass* 9, No.4 (2014): 194-203; Christopher Coons and Michael Weber, 'Introduction: Paternalism – Issues and Trends' in Michael Weber and Christopher Coons (eds), *Paternalism: Theory and Practice* (Oxford: Oxford University Press, 2013): 1-24; Jason Hanna and Kalle Grill, 'Introduction' in Jason Hanna and Kalle Grill (eds), *The Routledge Handbook of the Philosophy of Paternalism* (Abingdon: Routledge, 2018): 1-8; Gerald Dworkin, 'Paternalism' in Edward N. Zalta (ed), *Stanford Encyclopedia of Philosophy* (Fall 2020 Edition), Edward N. Zalta (ed.). Available at: https://plato.stanford.edu/archives/fall2020/entries/paternalism/

What does paternalism involve, exactly? Paternalism is standardly taken to have three core components. As Kalle Grill nicely summarises, "For there to be paternalism... an action must be unwelcome, interfering, and benevolent".[2] Let's break these three parts down a bit more precisely:

1. Act Component: A's act interferes with B (or otherwise 'affects' B in some way).

2. Will Component: A's act is done against B's will (or without consulting B's will).

3. Reason Component: A's act is justified or motivated by the belief it will promote B's well-being (A's act is done 'for B's sake').

Note that this tripartite model – Act, Will, Reason – is morally neutral. It simply identifies instances of paternalism, but does not take a stand on whether paternalism is morally objectionable or innocuous. This is advantageous, since many paradigm cases of paternalism seem entirely unobjectionable. While it may be inappropriate to treat an adult like a child, treating children paternalistically is typically fine. The same is true of adults who lack – either permanently or temporarily – the capacity to make informed choices.

But many cases of paternalism – such as *Doctor/Patient* – do seem intuitively objectionable. What explains this? Identifying the wrong of paternalism is somewhat puzzling. After all, improving individuals' health and wellbeing is normally a good thing. How can it be wrong to do something good? In what follows, we set out three broad accounts of the problem with paternalism.

The Wellbeing View

One explanation is straightforward: Paternalism is wrong because it *doesn't work*. Paternalistic actions and policies typically fail to improve the overall wellbeing of their targets. There are various ways in which paternalism might be self-defeating. First, one might think that individuals are best placed to know what their interests are and to determine what is best for themselves. Outsiders (and bureaucratic governments in particular) lack this special insight. Hence, outside interference, even if well-meaning, will tend to be misdirected. Second, even if a paternaliser does manage to accurately identify and promote aspects of the target's well-being, the *harms* of intervention might outweigh any benefits bestowed. If this is so, paternalistic interference will still fail to promote wellbeing overall. A third possibility emphasises the connection between a person's wellbeing and their choices. On this view, the fact that we autonomously choose an option renders that option good for us. As J.S. Mill famously puts it, a person's "own mode of laying out his existence is best, not because it is best in itself but because it is his own mode."[3] Hence, interfering with people's choices is unlikely to make them better off.

It certainly seems true that, before intervening in someone's life, we should consider whether we really do know best, and whether our intervention might do more harm than good. Nonetheless, these arguments are somewhat unsatisfactory.[4] The first and second considerations only provide rather half-hearted opposition to paternalism, since they do not rule out paternalism if it were better informed and more sensitively imposed. The third consideration relies on the controversial assumption that persons' choices seldom set back their own wellbeing. But this seems implausible given all we know about people's tendency to irrationality, short-sightedness, and weakness of will, as well as our propensity to prioritise things other than our own well-being. When we know that people often choose imprudently, and that minor interferences can generate big welfare gains, it seems a stretch to insist that paternalism will never work. If we think that paternalism might still be objectionable in these cases, we need to go beyond the Wellbeing View and identify some value external to wellbeing that explains this. Let's turn to two views which aim to do this.

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2. Kalle Grill, 'Paternalism By and Towards Groups', in in Jason Hanna and Kalle Grill (eds), *The Routledge Handbook of the Philosophy of Paternalism* (Abingdon: Routledge, 2018): 46-58, at p.54.

3. John Stuart Mill, *On Liberty,* reprinted in Mark Philp and Frederick Rosen (eds), *On Liberty, Utilitarianism, and Other Essays* (Oxford: Oxford University Press, 2005), p.66.

4. For a helpful critical discussion of wellbeing-based objections to paternalism, see Jason Raibley, 'Paternalism and Wellbeing' in Jason Hanna and Kalle Grill (eds), *The Routledge Handbook of the Philosophy of Paternalism* (Abingdon: Routledge, 2018): 69-84.

The Insult View

One of the most popular contemporary accounts of the wrong of paternalism holds that paternalistic action conveys a *special kind of insult* to the target, even if it successfully promotes the target's wellbeing.[5] The central thought is that when we act paternalistically towards others, we act on the basis of a negative judgement about their ability to lead their lives well. We treat them as though they cannot be trusted to run their own affairs and promote their own welfare successfully. This seems like an insultingly superior attitude to hold, one which is incompatible with treating others as equals. This view captures the core idea that the problem with paternalism is that adults should not be treated like dependent and incompetent children, and that doing so demonstrates an insulting lack of respect.

The Authority View

A different view locates the distinctive wrong of paternalism not in the insult of forming a negative judgement about another's competence, but the lack of respect demonstrated by acting on it. On this view, each person should be regarded as having ultimate authority over their own life and wellbeing. Paternalism is objectionable because it offends against this self-sovereignty. We do not need to believe that individuals will choose well, but we must nonetheless treat their will as authoritative in matters concerning their own interests. Respect for persons sometimes requires refraining from promoting their wellbeing and instead deferring to their will.[6] This view provides a different interpretation of the idea that paternalism objectionably treats adults like children: adults, unlike children, have authority over their lives and wellbeing. While it may be appropriate to relate to children primarily in terms of their wellbeing, respect for adults requires we defer to their choices.

Needless to say, the foregoing discussion only begins to scratch the surface. Each of these views is subject to criticism and many sophisticated defences have been offered. But we hope this gives a sense of the general landscape. Moreover, the foregoing also hopefully provides some tools for evaluating and responding to accusations of paternalism, in two ways. First, we can evaluate whether an action or policy satisfies the intuitive criteria for paternalism. Second, we can reflect on how the action or policy fares in light of the values captured by the Wellbeing, Insult and Authority views.

3. Some Puzzles for The Standard Model

Earlier we introduced the standard tripartite model of paternalism. On this model, paternalism involves interfering with a person (Act Component), against their will (Will Component), for their own good (Reason Component). However, a variety of challenges and complications have been raised for each component. We will briefly outline three contested issues, each of which bears on public health. In the next section, we will consider some further puzzles raised by public health specifically.

What counts as interference?

Our first puzzle concerns the extent to which paternalistic actions or policies must be restrictive or intrusive. The most clear-cut cases of paternalism involve direct coercion or restrictions on liberty. But these are relatively rare in practice, especially when it comes to public health interventions. More commonly, governments attempt to promote health and wellbeing by influencing individuals' option sets. For example, by making options cheaper – such as subsidising gym memberships – or more

5. For versions of this view, see Seana Shiffrin, 'Paternalism, Unconscionability, and Accommodation', *Philosophy and Public Affairs* 29, No.2 (2000), 205-250; Jonathan Quong, *Liberalism Without Perfection* (Oxford: Oxford University Press, 2011), Ch.3; Michael Cholbi, 'Paternalism and Our Rational Powers' *Mind* 126, No.501 (2017), 123-153; Nicholas Cornell, 'A Third Theory of Paternalism', *Michigan Law Review* 133, No.5 (2015): 1295-1336; Elizabeth Anderson, 'What's the Point of Equality?', *Ethics* 109, No.2 (1999): 287-337.
6. For versions of this view see, for example, Daniel Groll, Paternalism, Respect, and the Will', *Ethics* 122, No.4 (2012), 692-720; Daniel Groll, 'Paternalism and Rights', in Jason Hanna and Kalle Grill (eds), *The Routledge Handbook of the Philosophy of Paternalism* (Abingdon: Routledge, 2018): 119-130; Joel Feinberg, *The Moral Limits of the Criminal Law. Vol. 3: Harm to Self* (Oxford: Oxford University Press, 1986): Ch.19. Shiffrin's discussion suggests she also endorse aspects of the Authority View, as well as the Insult View. Shiffrin, 'Paternalism, Unconscionability, and Accommodation'.

expensive – such as placing additional taxes on high-sugar or high-fat foods and drinks. Even if we grant that such policies are not coercive, it seems implausible that they are thereby automatically exempt from the charge of paternalism.[7] To illustrate, consider the Insult View and the Authority View discussed above. On these views, paternalism is objectionable because it is based on insulting judgements about the target or because it fails to appropriately defer to the target's will. Even if a policy is entirely non-coercive, it may nonetheless still manifest insulting judgements or insufficient deference to individuals' self-regarding authority.

What this shows us is that we may need to understand 'interference' broadly, so as to include any attempt to influence behaviour, and not only polices that involve a 'hard hand'. This also implies, more controversially, that even providing extra options might constitute interference in the relevant sense – for example, requiring cafeterias to offer at least one healthy option, which some may then feel pressured to choose. One important upshot is that it may be a mistake to defend public health policies from the charge of paternalism merely by showing that they are non-coercive or minimally invasive. Of course, a policy may well be less objectionable if it is less coercive. But coercion and paternalism are distinct objections.

Second, some have suggested that merely providing information or engaging in rational persuasion may qualify as (potentially paternalist) intervention.[8] This might seem surprising. Even committed anti-paternalists tend to assume that we can intervene when someone is ignorant of the risk of their choices, if only to make them aware. And engaging in reasoned persuasion seems like a paradigmatically respectful way of influencing others' choices. Nonetheless, choosing not to gather information is a choice like any other, and providing information seems to clearly interfere with that choice. Foisting unwanted information on people, or even pushing them to carefully consider their decisions, is also plausibly a form of interference. Thus, contrary to the standard

assumption that education and persuasion simply cannot be paternalist, it might be argued that, for example, requiring individuals to attend road safety courses, having mandatory cooling-off periods for contracts and purchases, or placing health warnings on cigarette packets might all qualify as paternalistic if carried out for the sake of the target's own good.

Third, paternalism might not even involve doing anything. Consider, for example, a person who refuses to lend a friend £50, because they believe their friend will spend the money imprudently on unhealthy snacks. Or a government that refuses to enforce certain contracts, in order to protect contractors from suffering the consequences of their choice.[9] These cases suggest that omissions can be paternalistic, as well as actions. If this is right, then we may need to further broaden our conception of paternalism's Act Component.

Must paternalism be against our will?

Our next set of puzzles focuses on how we should interpret the requirement that paternalism be against the target's will (Will Component). First, we need to clarify which of the target's preferences or choices count as 'their will' in the relevant sense.[10] Sometimes paternalism aims to promote ends that the target does not recognise as valuable. These seem like clear-cut cases in which an intervention is against the will of the target. However, often paternalism does not attempt to promote 'alien' goals, but rather aims to help individuals meet their own ends. Many of us fail to achieve goals we set for ourselves, due to weakness of will, competing pressures on our time and resources, or the inability to identify appropriate means to achieve them. For example, we may want to quit smoking but cannot resist when a friend offers a cigarette. Or we may wish to eat more healthily but lack the energy after a long day to do more than order a takeaway. When it comes to interventions that aim to get us to adopt the means to our own ends, it is not clear whether we should label these as 'against our

7.   For the view that such polices are in fact objectionably coercive, see Jessica Flanigan, 'Public Bioethics', *Public Health Ethics* 6, No.2 (2013): 170-184.

8.   See, for example, George Tsai, 'Rational Persuasion as Paternalism', *Philosophy and Public Affairs* 42, No.1 (2014): 78-112.

9.   For discussion of omissions cases, see Quong, Liberalism Without Perfection, Ch.3 and Shiffrin, 'Paternalism, Unconscionability, and Accommodation'.

10.   This also suggests a further difficulty, which we will not discuss here: determining the extent to which an individual's expressed preferences or choices actually reflect their underlying will. When faced with constrained options individuals may choose – and even come to prefer – some option as the best available, though we may not think this reflects their will in a deeper sense. For example, imagine a homeless person choosing to get drunk every night to enable them to sleep in cold, noisy, and uncomfortable circumstances. Though they prefer and choose this course of action given their current options, their preferences may change if better sleeping quarters were available, and we may think these new preferences would be more reflective of their will. (For discussion of adaptive preferences, see: Serene Khader, *Adaptive Preferences and Women's Empowerment* (Oxford: Oxford University Press, 2011); Rosa Terlazzo,'Conceptualizing Adaptive Preferences Respectfully: An Indirectly Substantive Account', *Journal of Political Philosophy* 24, No.2 (2016): 206-226; Jessica Begon, 'Disability, Rationality, and Justice: Disambiguating Adaptive Preferences', in David Wasserman and Adam Cureton (eds.) *The Oxford Handbook of Philosophy and Disability* (Oxford: Oxford University Press, 2020), pp.343-359.)

will' in the relevant sense.[11] Nonetheless, intervening to help people meet their own goals might be paternalist if they do not (or, perhaps, would not) consent to the means that are employed to achieve them – for example, increasing tax on cigarettes or unhealthy food – even if they would consent to another form of intervention – for example, subsidising vaping or shortening the working day.

Second, an intervention might fail to properly consult the target's will even if it coincides with what they would choose. In order to genuinely respect a person's will, their wishes need to play the right kind of role in our decision-making. Rather than merely doing what the target wants, respect also requires that we do what they want solely *because they want it.* We must be guided by the target's will in the appropriate way.

Some concrete examples will help to illustrate this point. To begin, imagine a patient who refuses a beneficial medical treatment. Their doctor responds by saying, "After carefully considering your refusal, alongside all the other relevant considerations, I have decided not to give you the treatment." There remains something disrespectful about the doctor's decision, despite the fact that she does what the patient wants. The problem seems to be that she is guided by the patient's will in the wrong way. She shouldn't merely take the patient's refusal as one consideration to be weighed against others. Rather, she ought to treat the patient's will as *settling the question* of what should be done.[12]

Let's now consider a different kind of case, in which we cannot directly discover what someone wants or would consent to. Even in these cases, it still seems important to try to be *guided* by their wishes, rather than simply *conform* with their wishes. For example, imagine a patient is admitted to hospital unconscious following a car accident. A doctor can reasonably assume they would wish to receive life-saving treatment (in the absence of a reason to think otherwise). Treating the patient shows appropriate respect for the patient's will, even though they are not in a position to give consent. However, if the doctor also took it upon themselves to perform cosmetic surgery on the unconscious patient, then this *would* fail to respect the patient's will, even if it turned out that this is exactly what the patient wanted. In the former case the doctor makes an effort to ensure she acts according to the patient's will. In the latter, she makes no such effort, but 'gets lucky'. Again, this highlights that it matters not just that we get what we want, but that we get it for the right reasons.

Must paternalism be motivated by our interests?
Finally, let's consider the Reason Component of paternalism. We will assume that paternalism must, in some sense, aim to benefit its target.[13] Thus, cases in which we interfere with someone for the sake of a third-party – for example, interfering with a parent for the sake of their children's wellbeing – are not paternalistic. Nonetheless, actions rarely have simple and single motives or justifications. We do things for many reasons, and it is often hard to determine what roles these multiple motives play in causing us to act. For example, imagine a doctor who overrides their patient's wishes both for sake of the patient's wellbeing *and* in order to improve their mortality statistics. Is it enough that wellbeing is one of their motives? Or should the paternalistic motive be decisive in determining whether they act? As we will see, these questions become even harder when the intervening agent is not an individual but a group or institution.

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11. For example, Thaler and Sunstein's argue that their brand of 'libertarian paternalism' is unobjectionable because it aims to "make chooser's better off, *as judged by themselves.*" Richard Thaler and Cass R. Sunstein, *Nudge: Improving Decisions about Health, Wealth and Happiness* (New Haven: Yale University Press, 2008), p.5 (our emphasis). For another statement of 'means' paternalism, see Julian Le Grand and Bill New, *Government Paternalism: Nanny State or Helpful Friend?* (Princeton, NJ.: Princeton University Press, 2015), pp.27-30; 101-104.

12. For discussion, see Groll, 'Paternalism, Respect and the Will'.

13. For minority dissent on this point. Shiffrin, 'Paternalism, Unconscionability, and Accommodation'.

4. Why Public Health is Distinctively Puzzling

In the discussion so far, we have set out the standard tripartite model of paternalism, outlined three theories of why paternalism might be objectionable, and discussed some complications and challenges for the standard model. In this section, we will raise some further puzzles and complications that arise from reflection on public health specifically. As we have already seen, public health policies raise interesting questions about how to understand the Act Component of paternalism, since public health polices influence behaviour via a wide variety of mechanisms, many of which do not seem to involve direct interference or coercion. But we want to focus specifically on complications arising from the fact that public health policies target *groups* or *populations*. As many public health ethicists have pointed out, this is the key morally distinctive feature of public health.[14] Moral theories developed in the context of debates within medical ethics – which tend to focus on interactions between individuals – may need to be revised (or even jettisoned) when we shift to the population-level.[15] As we will now explain, we encounter particular puzzles when we try to interpret the Will and Reason components of paternalism in the context of public health policy.

Public Health and the Will Component
As discussed earlier, a key feature of paternalistic action is that it takes places against the will of its target (or without adequately consulting the target's will). In the case of paternalistic action by one individual against another, this component is relatively straightforward. Whilst it is sometimes difficult to determine whether a person's will qualifies as authoritative – what if they are ignorant of the risks? what if they are drunk? what if they are emotionally distressed? – we at least have a sense of what we are trying to evaluate. By contrast, when it comes to assessing interventions that target groups or populations, it is not obvious what it even

means to say that an intervention is carried out against (or in accordance with) the group's will. This is because groups are not simply individuals 'writ large'. Rather, they are composed of individuals, each with a will of their own. Moreover, in any realistic population-level intervention, there will be disagreement among the population members as to whether they accept or reject the intervention. In order to evaluate whether the intervention qualifies as paternalistic, we need some principled way of determining what counts as the 'will of the people' in the relevant sense.

We think this is an extremely difficult task, for at least two reasons. First, we need some way of identifying what counts as the relevant group or population in the first place: whose wills count as the relevant ones for consultation? Should we consult all citizens within a state? All those affected by a policy (excluding non-affected citizens and including affected non-citizens)? Or some other principle? Since the question of *who* we consult largely determines the *results* of the consultation, this is a very important question.[16] Second, once we have identified the relevant class of consultees, we still need some way of aggregating or combining the wills of the population-members in order to tell us whether the intervention counts as for or against their will. There are many possibilities – majoritarianism, super-majoritarianism, veto systems, non-proportional thresholds, etc. But which is the relevant one *for evaluating paternalism* specifically?[17] It seems implausible to simply tell a dissenting minority that they have consented to some public health tax, fine, or subsidy because the majority favour it. Without answers to these questions, the task of evaluating whether a public policy qualifies as paternalistic seems likely to be indeterminate.

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14. See e.g. Ruth Faden, Sirine Shebaya, and Andrew W. Siegel, 'Distinctive Challenges of Public Health Ethics', in Anna C. Mastroianni, Jeffrey P. Kahn, and Nancy E. Kass (eds), *The Oxford Handbook of Public Health Ethics* (Oxford: Oxford University Press, 2019): 12-21.

15. Angus Dawson, 'Resetting the Parameters: Public Health as the Foundation for Public Health Ethics' in Angus Dawson (ed), *Public Health Ethics: Key Concepts and Issues in Policy and Practice* (Cambridge: Cambridge University Press, 2011): 1-19.

16. This issue is analogous to the well-known 'demos problem' in democratic theory. The literature here is vast, but see e.g. Robert E. Goodin, 'Enfranchising All Affected Interests, and its Alternatives', *Philosophy and Public Affairs* 35, No.1 (2007), 40-68; Harry Brighouse and Marc Fleurbaey, 'Democracy and Proportionality', *Journal of Political Philosophy* 18, No.2 (2010), 137-155. As an example of how this issue may arise in the context of public health, consider the case o the controversial New York 'soda ban'. As Ruth Faden and Sirine Shebaya point out, the overall majority of New Yorker disapproved of the ban, but levels of approval varied considerably by district. Ruth Faden and Sirine Shebaya, 'Public Health Programs and Policies: Ethical Justifications', in Anna C. Mastroianni, Jeffrey P. Kahn, and Nancy E. Kass (eds), *The Oxford Handbook of Public Health Ethics* (Oxford: Oxford University Press, 2019): 21-32, at p.22.

17. On this question, see Kalle Grill, 'Liberalism, Altruism, and Group Consent', *Public Health Ethics* 2, No.2 (2009), 146-157: Kalle Grill, 'Paternalism By and Towards Groups', in in Jason Hanna and Kalle Grill (eds), *The Routledge Handbook of the Philosophy of Paternalism* (Abingdon: Routledge, 2018): 46-58; Jonathan Parry, 'Defensive Harm, Consent and Intervention', *Philosophy and Public Affairs* 45, No.4 (2017): 356-396.

A further puzzle is whether a population's self-regarding decisions can *themselves* be evaluated in terms of paternalism. When it comes to individuals, this issue rarely arises: there doesn't seem anything objectionable about a person deciding to limit their own choices for the sake of their own good (for example, if I hire a personal trainer to cajole me out of bed each morning).[18] But, of course, population-level choices are not like this. Imagine, for example, that a community holds a referendum on whether to impose an additional tax on sugary drinks. If a majority votes in favour, each member of the majority is not simply acceding to a restriction on their own choices, but also imposing that restriction on others too. Would the majority be acting objectionably paternalistically if they cast their votes altruistically (not for their own sake but instead with the intention of improving the health of the dissenting minority)?[19] As we can see, once we recognise that groups are not analogous to individuals, the standard model of paternalism does not provide much guidance.

Public Health and the Reason Component

A further key feature of paternalistic action is that it has a certain motive or justification: it aims at benefitting its target (improving their wellbeing in some respect). When it comes to actions that target specific individuals, this seems relatively uncontroversial. But when it comes to polices that target groups or populations, things are far more complicated. In the same way that it is difficult to identify the *will* of a group or population, it is also unclear what it means to *benefit a group* or to *promote a population's wellbeing,* in the relevant sense. Just as populations are made up of individuals with heterogenous goals and preferences, so too will they include people with a variety of needs and interests. In our view, this raises at least two puzzles.

The first challenge is what, exactly, we are referring to when we talk about 'benefitting a group'. Is there such a thing as group wellbeing? And, if so, what does it consist in? Surprisingly, while philosophers have devoted much thought to questions of individual wellbeing, there

are few detailed treatments of the group case.[20] On one way of understanding it, a group's wellbeing is purely a function of the wellbeing of its members. But just as there are multiple ways of aggregating individuals' wills, so too there many different ways of aggregating individual wellbeing. Which is the relevant one for evaluating a policy in terms of paternalism? A second view is that it is possible to distinguish the wellbeing of the group itself from the wellbeing of its members. For example, we might describe a football team as flourishing, even if we would not say the same about its players taken individually.[21] So, to determine whether a particular population-level policy is backed by a paternalistic reason we will have to think hard about the relevant conception of group wellbeing.

A related problem arises from the fact that the benefits and burdens of population-level policies are not uniformly distributed.[22] Public health policies are often evaluated by their overall impact on a population – for example, lowering rates of mortality, obesity, or heart disease. But even policies that provide clear net benefits are unlikely to be universally beneficial. In some cases, the costs the policy imposes simply will not be counteracted by a corresponding benefit for some group members. For example, a smoker who would not have developed ill-health as a result of their habit will nonetheless have to bear the costs of a tax on tobacco products. In other cases, population-level interventions not only impose costs, but also create new risks that will result in direct and serious harms to some individuals. For example, a decision to make seat belt use mandatory will reduce overall death and injury from road accidents. However, in a few cases, wearing a seat belt may cause injury that would have been avoided by its absence. Thus, should we say that smoking reduction programmes or mandatory seat belt policies benefit the population, or rather that they benefit a sub-population within it? The case of population-level policies thus not only make it difficult to determine who the relevant beneficiaries are, but also raises distinct questions about the fair distribution of benefits and burdens within a population.[23]

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18. On the possibility of acting paternalistically towards oneself, see Chrisoula Andreou, 'Self-Paternalism', in Jason Hanna and Kalle Grill (eds), *The Routledge Handbook of the Philosophy of Paternalism* (Abingdon: Routledge, 2018): 59-66.

19. On this issue, see Grill, 'Paternalism By and Towards Groups'.

20. For one notable (and very recent) exception, see Eric Wilard, 'What is Group Wellbeing?', *Journal of Ethics and Social Philosophy* 21, No.1 (2022): 1-23.

21. Wilard, 'What is Group Wellbeing?'.

22. This point is emphasised in Tom Walker, 'Paternalism and Populations', *Public Health Ethics* 9, No.1 (2016): 46-54. See also, Dawson, 'Resetting the Parameters: Public Health as the Foundation for Public Health Ethics'.

23. Ruth Faden and Sirine Shebaya, 'Public Health Programs and Policies: Ethical Justifications', p.24.

Yet even if a satisfactory conception of group wellbeing can be identified, this is not the end of the difficulties for the Reason Component. A second important puzzle arises from the fact that public health policies are not merely enacted *on* groups, but enacted *by* groups – of politicians, civil servants, and health professionals. Thus, to determine whether a policy is paternalistic we must ascertain whether it is *justified or motivated* by the belief it will promote the target's wellbeing. And this will entail the difficult task of disentangling mixed motives and multiple justifications. As discussed earlier, this is tricky even in individual cases. More layers of complexity are added when dealing with institutions, which are composed of (and influenced by) many individuals, with many different motivations and objectives. In most cases, we simply cannot identify *the* motive or reason behind government decisions. Consider, for example, a government decision to impose an additional tax on alcohol. There are many different reasons for endorsing this policy, only some of which are paternalistic. In addition to the paternalistic goal of improving the health of alcohol consumers, policymakers might be motivated by: reducing crime and anti-social behaviour, reducing NHS costs, fulfilling electoral promises, raising tax revenue, responding to religious objections to alcohol, or reducing the power of industry lobbyists. Given the multitude of reasons that may support a policy, how should we evaluate whether a policy is objectionable in virtue of being supported by *paternalistic* reasons?[24]

As with the other puzzles we have discussed, there are many options here. Maybe a policy counts as paternalistic if *any* of the reasons cited by public officials to justify the policy is paternalistic. Or perhaps we should assess the motivations driving *some proportion* of the individuals who make the decision? But, if so, what proportion? More broadly still, we might look to the motivations behind *the public* who elected the government and influence its policy decisions. More radically, one might argue that a policy counts as paternalistic just in case it *could* have been justified by appeal to paternalistic reasons, even if it was neither the motive of, nor justification given by, those who choose to impose the policy?[25] However, this view runs the risk of labelling nearly every policy as paternalistic, since the vast majority of policies have at least some paternalistic reasons in their favour. We should therefore be cautious of assuming that any policy that *could* be paternalistically motivated is an instance of paternalism. But there are no obvious answers here.

5. Conclusion

Debates about public health and paternalism often seem intractable. But, as we have tried to explain, the issues here are subtle and complex. The difficulties with assessing public health policies in terms of the standard model of paternalism are often under-recognised and under-explored. Given the lack of attention paid to these issues, perhaps we should not be overly pessimistic that progress is possible. When it comes to public health policy and practice, we should avoid trying to take a pre-made theory and simply applying it. Instead, we should carefully reflect on the case of public health to help us improve our theorising about the nature and ethical significance of paternalism in general.

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24. Faden and Shebaya, 'Public Health Programs and Policies: Ethical Justifications', p.26.In light of this problem, James Wilson concludes that no public health policy is likely to qualify paternalistic and so we should 'stop worrying' about paternalism in public health. See Wilson, 'Why It's Time to Stop Worrying About Paternalism in Health Policy'.

25. For a detailed discussion of the 'mixed reasons' issue, see Peter de Marneffe, 'Avoiding Paternalism', *Philosophy and Public Affairs* 34, No.1 (2006), 68-94; Kalle Grill, 'The Normative Core of Paternalism', *Res Publica* 13:441-458; Kalle Grill, 'Anti-Paternalism as a Filter on Reasons', in T. Schramme (ed.), *New Perspectives on Paternalism and Health Care* (Dordrecht: Springer, 2015): 47-63. See also, Cornell, 'A Third Theory of Paternalism.'

Long-Game Regulation and Public Health Policy-Making: The Ethics of Eradicating Choices without Eradicating Choice

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Would it be ethically justifiable to implement an immediate legal prohibition on smoking tobacco? Faced with this question, some would not only answer "yes", but also claim that governments have a duty to do so. Others might say "in principle, yes, but there would be too many practical problems with doing so." However, many would argue that such a ban would be morally unjustified as a matter of principle. Among these voices, we would expect to hear the full-blooded libertarian view: "Of course it would be unethical: a ban on smoking would be nanny-statism. The government has no business interfering with people's choices about how they live their own lives: that is *paternalism*. We know that smoking harms people, but that's a decision and risk for them to make and take."[1]

Moral objections to smoking bans, or bans and restrictions on other targets of public health policy, such as fatty or sugary foods, alcohol, and so on, are based on deeply-held commitments to individual freedom; a fundamental value in liberal democracies. This value stands in tension with any right of governments to exercise their coercive powers to intervene in (what tend to get framed as) individuals' self-regarding choices. Legitimate government intervention, on this view, is limited to matters such as protecting others from unwelcome harm (my right to harm myself does not give me a right to harm you) and to providing the basic infrastructure for us to co-exist in a shared society (so for instance I may be compelled to pay taxation to support the civil and criminal justice systems that are essential to upholding the rights of all).[2]

In what follows, my interest is not in who is right in zero-sum debates about paternalism, where individual rights are pitted against health benefits.[3] Rather, I am interested in how public health policy in the UK (and elsewhere) gets framed in a way that aims to please (or at least appease) everyone. Using the regulation of smoking as an example, we see policy agendas that have the paternalistic aims of health protection and promotion, yet which are presented as morally permissible because they give due respect to individual liberty. This public health policy landscape has two key features: it relies on the ethics of so-called nudge theory; and it is implemented practically through *long-game regulation.*[4]

1. John Coggon, *The Nanny State Debate: A place where words don't do justice,* (London: Faculty of Public Health, 2018). Available at <https://www.fph.org.uk/media/1972/fph-nannystatedebate-report-final.pdf>.
2. Richard A. Epstein, 'Let the Shoemaker Stick to his Last: A defense of the "old" public health,' *Perspectives in Biology and Medicine* 46, No.3 (2003): S138-159; Jessica Flanigan, 'Public Bioethics,' *Public Health Ethics* 6, No.2 (2013): 170-184.
3. John Coggon, 'Lord Sumption and the Values of Life, Liberty and Security: Before and since the COVID-19 Outbreak,' *Journal of Medical Ethics* 48, No.10 (2021): 779-784.
4. John Coggon, 'Smoke Free? Public health policy, coercive paternalism, and the ethics of long-game regulation,' *Journal of Law and Society* 47, No. 1(2020): 121-148.

Nudge theory holds that governments should generally avoid using law to force people into making healthier decisions, in light of the importance of individual autonomy and liberty. However, nudge theory provides that this is consistent with implementing 'softer' interventions which are shown to have positive effects on people's health.[5] On this view, while people should legally be allowed to smoke, the government could, for example, justify 'nudges' that steer people away from smoking. These may come, for example, through public information campaigns, bans on the public display of tobacco products in shops, health warnings on and plain packaging of tobacco products, and so on. While these interventions leave (potential) smokers free from government coercion, they also have demonstrable, positive health impacts and are thus to be welcomed. Concerns about protecting health can be satisfied without problematically interfering with liberty.

So far so good. But each and all such nudges are *not* just isolated policy measures to be assessed one by one. They are designed to act in combination. The government's tobacco strategy is built to work through the combined weight of an increasing aggregation of nudges. This pattern is an example of *long-game regulation*.[6] While the government upholds a commitment to people's freedom to smoke, it is—openly and based on ethical reasons regarding the avoidable harms of smoking and health inequalities—committed to realising a smoke-free agenda. Through wide-ranging, piece-by-piece policy measures, the aim is to reduce and eventually eradicate smoking.[7] Nudge theory appears attractive in relation to such an agenda because it purports to show how health interventions can be morally innocuous. However, for this to work, tobacco strategies rest on the idea that if there is no complaint about individual interventions, there can be no complaint about their aggregate force.

That is a controversial assumption. It is controversial where it is justified through nudge theory because nudge theory simply does not allow us to examine the ethics of an overall policy agenda. It is designed only to provide a means to evaluate specific, individual interventions. Standard nudge theory does not equip us to examine whether there is a moral difference between the "aggressive" coercion of an immediate, paternalistic criminal prohibition and a slow-burn, if still paternalistic, progression towards what is, in effect, a ban. Yet if the end point is equivalent to a prohibition—effectively and by design—this invites the question: if the government cannot justify an overnight smoking ban, why is it okay to eradicate smoking over (say) a thirty-year period?[8] This calls for a renewed engagement with the ethics that underpin governmental public health agendas.[9] Rather than try to *avoid* the moral questions by lazily appealing to the idea of nudging, we need to engage with them directly. We can and should flip the question on its head: why, if it is okay to implement a ban over thirty years, would it be wrong to bring about the same outcome immediately?

In the context of a large-scale public health policy there are all sorts of practical points that raise ethical barriers to *immediate*, wholesale change. The rapid enactment and implementation of the Coronavirus Act 2020 and related secondary legislation (including restrictions regulations) have been held up as showing what can be done to protect the public's health if the circumstances press hard enough. However, they have also shown what ethically-damaging unintended consequences may follow: for example, in worsening social inequity, generating health harms, or in threatening basic human rights.[10] So there can be wisdom in taking long-game approaches in health policy where that is possible.

5. Richard Thaler and Cass Sunstein, *Nudge: Improving decisions about health, wealth, and happiness,* (London: Penguin, 2009).
6. Coggon, 'Smoke Free?' above n. 4.
7. Department of Health, *Towards a Smokefree Generation: A tobacco control plan for England,* (London: Department of Health, 2017), available at <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/630217/Towards_a_Smoke_free_Generation_-_A_Tobacco_Control_Plan_for_England_2017-2022__2_.pdf>; Department of Health and Social Care, Tobacco Control Plan: Delivery Plan 2017-2022, (London: Department of Health and Social Care, 2018), available at <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/714365/tobacco-control-delivery-plan-2017-to-2022.pdf>.
8. Coggon, 'Smoke Free?, above n. 4.
9. John Coggon, *What Makes Health Public? A critical evaluation of moral, legal, and political claims in public health,* (Cambridge: Cambridge University Press, 2012).
10. Beth W. Kamunge, *Which Inequalities Should We Focus on in Evaluating Health Policy Before, During, and Following COVID-19?* (London: UK Pandemic Ethics Accelerator, 2021), available at <https://ukpandemicethics.org/wp-content/uploads/2021/12/Intersectionality-Framework.pdf>.

But if it is right that government should have a crucial role in promoting health as a shared social value—as is accepted by those who support long-game regulatory strategies to eradicate tobacco use—we see that liberty is not the only value under issue. This raises significant points for how we ethically evaluate public health policy, and social policy more widely. We do not automatically see a mandate for 'big government', or heavy-handed coercive measures in the pursuit of assuring better population health. But we do see mandates, in principle, for interventions that are coercive in effect, and which are not embarrassed by or objectionable simply because of libertarian charges of paternalism or 'nanny statism'.

What this all suggests is that we may go one of two ways. Either we need to embrace a more consistent libertarian position that speaks not just against an immediate ban on smoking (or fatty foods, etc.), but which also condemns long-game policy agendas that have the same effect. Or we should recognise that legitimate government can include a mandate to implement health protection and health promotion measures that do interfere with individual liberty. In so doing, we do not need to push for or accept coercive legal and policy changes brought in at the pace seen in the COVID-19 pandemic. But we may at the same time accept that policy changes to promote health are permissible, and that they may be implemented more rapidly and using 'heavier' interventions than a nudge-oriented government strategy suggests.

Nudge theory invites us to look at interventions one-by-one in the immediate moment, rather than to look at long-game regulatory agendas that work through the combination of multiple interventions across time. By treating nudges as morally innocuous, we are in fact closing down ethical debate without having addressed the crucial questions. This may have the strategic advantage of appealing to and apparently honouring deeply-held moral intuitions. But it has the disadvantage of perpetuating them where their validity may be better called into question. Without doubt, good public policy requires the use of nudges: regulatory interventions are not exhausted by a binary of either legal coercion or individual freedom. But we should not confuse nudges' having a place with the idea that nudges should be the only forms of regulation. Nor should we act as if nudge theory provides a helpful measure for assessing how ethical a public health policy agenda may be. By design, in the context of long-game regulation, it just is not equipped to do so, and leaves open the point that some instances of legal paternalism may well be justified after all.

Public Health Rights, Liberty, and Paternalism: Continuing Challenges

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Introduction

Public health policies often face two kinds of criticisms. The first holds that public health policies infringe our rights to *liberty*: by preventing us from purchasing super-sized sodas, drinking alcohol, smoking cigarettes, or running our businesses without requiring mask-wearing, public health policies leave us unable to freely pursue our interests. The second objection holds that public health policies are *paternalistic*: they not only infringe our liberty but do *so for our own sake.* Public health experts treat us like children, by justifying restrictive policies in terms of interests they think we should have, rather than what we actually desire.

These debates are often framed in terms of conflicts between individual rights and other kinds of goods: Public health policies, it is alleged, infringe our rights in the name of the *public good* and *our own good.* This way of framing things seems to leave public health advocates at a disadvantage. It is natural to think that rights generally 'trump' other considerations. Indeed, some people think that this is the very point of individual rights, including liberty rights.

Over several decades, a lot of important work has attempted (with some success) to shift the terms of these debates. Several scholars suggest that we should understand any potential tensions between public health and, for example, liberty in terms of conflicts *between different kinds of rights,* rather than between rights and other moral considerations. In particular, many have argued that there is a right to *public health* (RTPH). A RTPH makes it easier to defend public health policies from the charge that they infringe our liberty and treat us paternalistically. Take, for example, a mandatory mask policy. This policy can be understood as restricting one right (the liberty right not to wear a mask) in the name of fulfilling another right (a right to a health-conducive environment). The latter right arguably takes priority over the former. On this view, public health officials have as much claim to be rights-defenders as their libertarian critics.

Recognising a RTPH has important practical upshots. There may be good reasons to do so. However, I will argue it does not allow us to sidestep the liberty and paternalism objections.

A Right to Public Health as a Potential Solution to the Liberty v. Public Health Debates

The basic idea behind a RTPH is that there are strong moral reasons which require governments to enact certain public health policies. Indeed, these reasons are so strong that governments who fail to do so *wrong* their citizens. While advocates disagree on precisely which policies are required by the right, they share a commitment to the idea that health is sufficiently important to trigger duties to safeguard it through public health programs.[1] The RTPH raises many theoretical and practical issues.[2] But the basic idea seems plausible. Public health *does* looks like a very important moral good – either in its own right or for its ability to secure other moral goods (such as dignity or human flourishing) – and so worthy of recognition as a right. Absent seatbelt laws or nutrition programs, people will generally fare much worse. This not only undermines their interest in health, but also leaves them unable to enjoy other, uncontroversial 'rights,' including liberty-related ones. The victims of morbidity and mortality are less able to enjoy liberties of movement, speech, ownership, and commerce. So, while a plausible conception of the RTPH requires far greater specification, the general impetus behind RTPH advocacy seems sensible.

Importantly, RTPHs also offer responses to the liberty- and paternalism-based challenges outlined above. If we recognize public health as a right, this gives public health policies a measure of protection against being overridden by other values, including liberty. If tensions between public health and liberty are conflicts of rights, advocates suggest, liberty will not always 'win' simply because it is a right. To put it in simpler terms, if there is a right to anti-obesity measures, then the fact that there is also a right to liberty does not tell us whether a particular soda ban is justified. Liberty is not always more important than public health. Both are objects of rights.

At minimum, this places public health advocates in a better rhetorical position in the debate. Critics of public health need to explain why, for example, a right to smoke is stronger than a right to protection from tobacco-related harms. This makes it easier to justify public health programs and protect health generally. Legal recognition of a RTPH could provide even better protections. In some jurisdictions, constitutional rights can be justifiably infringed. Governments bear the burden of justifying these infringements. The necessity of an action to fulfill another right is one of the more plausible potential justifications that a government could present.

A RTPH may also have the resources to address the paternalism objection. For instance, James Wilson's RTPH is a right to *proportionate* public health policies that minimally infringe other rights. This conception purports to avoid paternalism critiques. Any 'right to anti-obesity measures' on this view is better understood as a right to particular measures that only infringe other rights to the extent necessary. One cannot have a right to a ban on fatty foods as that would unduly infringe upon rights, but one could have a right to a narrower ban on large sodas. That ban would be morally required since governments (at least) are obligated to take action to fulfill rights. If the relevant right is in any way still paternalistic, Wilson claims that it is unobjectionably so: "Anything that is morally required is either not paternalistic at all, or paternalist but not morally wrong".[3] A ban on large sodas is, in other words, best understood as fulfilling your rights – and if it is paternalistic to pass that law in the name of your rights but against your interests, so be it. Any paternalism here is not wrongful as it is already designed to be proportionate.

On this rosy picture, apparent tensions between valid public health measures and liberty interests, are either illusory or actually favour public health.

1. Compare, e.g., the public health policies included in rights in Lawrence O. Gostin, 'Public Health, Ethics, and Human Rights: A Tribute to the Late Jonathan Mann,' *Journal of Law, Medicine & Ethics* 29, No.2 (2001): 121-30; Lawrence O. Gostin, *Global Health Law* (Cambridge: Harvard University Press, 2014); Matthew S. Liao, 'Human Rights and Public Health Ethics.' In A.C. Mastroianni, J.P. Kahn, and N.E. Kass (eds), *The Oxford Handbook of Public Health Ethics* (Oxford: Oxford University Press, 2019), 47-56; and Benjamin Mason Meier, 'Advancing Health Rights in a Globalized World: Responding to Globalization through a Collective Human Right to Health,' *Journal of Law, Medicine, and Ethics* 35, No.4 (2007): 545-55. Note further that James Wilson ("The Right to Public Health." *Journal of Medical Ethics* 42, No.6 (2016): 367-75; *Philosophy for Public Health and Public Policy: Beyond the Neglectful State* (Oxford: Oxford University Press, 2021) largely leaves specification of his RTPH up to fair procedures.

2. Wilson offers a strong defense in both texts in the previous note. I critique the notion in a forthcoming chapter in the *Routledge Handbook on the Philosophy of Public Health*. For another critique of moral health rights in general, see Gopal Sreenivasan, 'A Human Right to Health? Some Inconclusive Scepticism,' *Proceedings of the Aristotelian Society Supplementary Volumes* 86, No.1 (2012): 239-65. For a good overview of health rights debates, see Benedict E. Rumbold, "The Moral Right to Health: A Survey of Available Conceptions,' *Critical Review of International Social and Political Philosophy* 20, No.4 (2017): 508-28.

3. Wilson, *Philosophy for Public Health and Public Policy,* p.124. All analyses here build on articulations of the right in note 1 sources.

The Continuing Challenges

Unfortunately, even if we think a RTPH is justified, this does not help resolve the key tensions at issue. Let's start with the paternalism objection to public health. At heart, paternalism involves interfering with people, against their will, in order to benefit them. The problem is that it is hard to see why a person having a right to that benefit makes any real difference to whether paternalistic treatment is morally objectionable. Here's an example to help illustrate the problem. Imagine that I decide to fast for religious reasons, and somebody forces me to eat (or fines me for not eating) because they are concerned for my health. This looks like a clear case of objectionable paternalism. But let's now add the assumption that I have a strong *right* to the means of subsistence, including food. Does the fact that I have a right to the benefit of food make a difference to the moral permissibility of paternalist forcing me to eat? I think not. It seems equally objectionable to force benefits on me regardless of whether I have a right to the benefits. This basic point can be applied to the case of public health: the fact that people have a right to public health does not automatically remove the sting of paternalism from public health policies.

Now let's consider the liberty objection to public health policies. Appealing to a RTPH was meant to help us make progress on resolving the conflict between liberty rights and public health interests. The problem is that it is not clear why re-describing this tension as a conflict of rights makes any significant difference to our views about what public policies are morally justified. The issue is that when we assign rights, this is a way of signalling which things we think are morally weighty. But, if so, the fact that we call something a 'right' doesn't give us new reasons to extra moral weight to that thing. Doing so is just a way of redescribing our moral commitments. In the present context, RTPHs only 'protect' public health policies against liberty-based objections where one accepts pre-existing views on the relative moral importance of health and liberty. If so, rights add little to the debate. We have simply imported our pre-existing views about when the importance of public health can 'trump' individual rights to non-interference.

To illustrate, take the classic case of bans on large soda drinks. Some people think these policies are justified because they think health is really morally important. Other disagree because they think liberty is really morally important. Redescribing these bans as fulfilling people's rights does not itself tell us anything new about which party to this debate is correct. It just tells us what we already knew: some people think health is a morally weighty value, capable of outweighing the importance of liberty. Indeed, rights talk may distort our moral analysis, by making bans appear more compelling, leading us to uncritically resolve conflicts in its favour.

Adding proportionality constraints to our conception of a RTPH simply moves discussions of how to weigh competing interests into the characterization of the right. Even if one agreed with Wilson about whether soda bans are proportionate (which I deny) we would still need to address liberty and anti-paternalism interests at some stage. Soda bans proponents would still need to explain why they do not unduly restrict rights and are not objectionably paternalistic. We would simply be making those decisions when specifying the RTPH, rather than when weighing that right against competing interests. I think we would be better off explicitly and openly weighing the competing interests against one another, rather than hiding these tensions behind a controversial right.

Conclusion

Recognizing a RTPH does not help us defuse longstanding tensions between the value of public health policies and our aversion to restricting choices and to paternalism. Many cases will present as conflicts between public health and liberty interests. Describing these as conflicts of rights is unlikely to provide new justifications for necessary public health policies.

Public Health and Ideology

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Over the twentieth century, practitioners and scholars in the field of public health have expanded their conception of the field, from the study of things like sanitation and contagion to domains that are not as straightforwardly related to promoting population health. For example, The American Public Health Association lists political issues such as gun violence, high school graduation, housing, transportation, and climate change as public health issues.[1] This broader conception of public health characterizes the field in a way that is clearly aligned with the priorities of more left-leaning political parties.

Though public health authorities, including scholars and public officials, are generally committed to a broadly progressive or leftist political ideology, they should not aim to advance this ideology through their work in public health. In this post, I argue that it is wrong for public health officials to impose this ideology on people for three reasons. First, this imposition is often unfairly coercive. Second, public health officials who adopt an ideological approach to public health lack legitimacy with the people they aim to serve. A third, related, reason to reject an ideological approach to public health is that pairing health with ideology makes it harder for officials to effectively promote public health.

Coercion

Expanding the scope of public health policy to domains like high school graduation rates and gun violence expands the harms associated with public health ideology by widening the scope of officials' power to interfere with people's choices by threatening them with punishment. Even governmental interventions that don't seem coercive, like taxes, truancy laws, and consumer safety regulations, are ultimately enforced through the coercive power of the government. If a policy is legally enforceable, then this means it carries with it a threat of punishment for violating that law.

And while public health authorities profess to be egalitarian, taxes and policies that are backed by legal penalties and punishment are more harmful to lower-income people, who have less money to spare. Prohibition is not equitably enforced, so people who are more likely to be targeted by law enforcement and people with less access to legal resources are more likely to be affected by prohibitive public health policies. In this way, policies that may appear at first glance to be egalitarian, can make inequality worse in practice.

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1.   APHA website, 'Topics & Issues', (2022). Available at: https://www.apha.org/topics-and-issues.

Legitimacy and Social Control

Public health officials often conceive of their work as part of the implementation of a broader political ideology. We see this when public health agencies publicly support and advance progressive policies, such as consumer protection legislation and debt cancellation, which are not directly related to health policy.[2] This is a problem because people are becoming more politically polarized, and political polarization increasingly aligns with people's educational attainment.[3] The fact that educated public health authorities overwhelmingly endorse a political ideology that less educated people do not hold means that risk imposing elite values on people who do not accept those values.

Additionally, public health officials also impose a perfectionist view of diet, exercise, education, productivity, wellness, parenting, sexuality, and mental health, on people who may have a very different conception of what makes a good life. Characterizing these aspects of life as health problems provide a justification for political intervention, which then happens by way of a public health agencies that are largely part of an unelected administrative state

Public health officials also contribute to the medicalization of deviance when they conceive of their field in this broad, comprehensive way. By this I mean that public officials reconceive non-medical aspects of life in medical terms. As McGann and Conrad argue, "Constructing deviance as illness confers a moral status different from crime or sin."[4] This medicalization re-conceives of things like sexuality, birth, death, and substance use as forms of sickness.[5] By reframing behavior in this way, public officials have a pretext to criticize and control behavior while dodging charges of moralism.

In all these ways, public health officials risk stigmatizing or alienating the populations they aim to serve. They do this by using public health policy to advance controversial values, while the people who are subject to their policies do not accept or endorse those values.

Effective Health Promotion

These ideological dynamics in public health are not only disrespectful to those who are subject to coercive public health policies, and they're also counterproductive. For example, the state enforcement of soda taxes or menthol cigarette bans impose a view of health and wellness that soda drinkers and menthol smokers do not accept—people who drink soda and smoke menthols generally don't value the health benefits of quitting as much as the people who are taxing and banning these behaviors. So even if these policies did promote health on balance, they wouldn't necessarily promote wellbeing on balance.

The enforcement of public health restrictions also imposes perfectionistic ideals on people in ways that undermine people's health in practice. For example, public health officials may advocate for retractions on e-cigarettes out of a belief that no one should use nicotine, but such a policy could discourage people from switching from cigarettes to e-cigarettes, which are safer. Or public health officials may argue that no one should engage in sex work, and therefore support criminal penalties for sex buyers that end up making sex workers' jobs more dangerous. In these cases, moralistic public health policies can backfire. They not only fail to improve people's lives; they make people's lives harder.

2. APHA Policy Statements, 'The Impacts of Individual and Household Debt on Health and Well-Being,' (October 26, 2021). Available at: https://apha.org/Policies-and-Advocacy/Public-Health-Policy-Statements/Policy-Database/2022/01/07/The-Impacts-of-Individual-and-Household-Debt-on-Health-and-Well-Being.
3. Pew Research Center Report - U.S. Politics & Policy Blog, 'Ideological Gap Widens Between More, Less Educated Adults,' (April 26, 2016). Available at: https://www.pewresearch.org/politics/2016/04/26/a-wider-ideological-gap-between-more-and-less-educated-adults/.
4. PJ McGann and Peter Conrad, 'Medicalization of Deviance,' in George Ritzer, J. Michael Ryan and Betsy Thorn (eds), *The Blackwell Encyclopedia of Sociology* (Hoboken, NJ: John Wiley & Sons, 2007). DOI: 10.1002/9781405165518.
5. Joseph Schneider, 'The Medicalization of Deviance: From Badness to Sickness,' in Erich Goode (ed), *The Handbook of Deviance* (Hoboken, NJ: John Wiley & Sons, 2015), 137-153.

Conclusion

In response to these observations, I imagine that some public health authorities may be tempted to point out that people with conservative, libertarian, and Republican ideologies have also undermined trust in public health and science. That is true, but it's a non sequitur. Political elites on all sides have failed to earn people's trust on matters of public health because they put ideology before health. For example, in the US, Republicans downplay risks of Covid in the service of their political agenda, while Democrats exaggerate Covid risk.[6] Neither side is morally authorized to engage in messaging that misleads the public on the grounds that their ideological opponents do the same.

Instead of viewing public health agencies as mechanisms to advance a more general political ideology, public health officials should instead focus on the basics. By this I mean that they should focus on protecting people from the contagious transmission of illness, and reducing environmental harms that unavoidably and non-consensually diminish wellbeing. They should not aim to prevent people from making unhealthy choices. Maybe if public health officials narrowed their focus and abandoned some of their political ambitions, they'd have more resources to effectively promote public health, narrowly understood, in ways that people welcomed and valued.

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6.   Jonathan Rothwell and Sonal Desai, 'How Misinformation Is Distorting COVID Policies and Behaviors,' Brookings Institute (blog) (December 22, 2020).
     Available at: https://www.brookings.edu/research/how-misinformation-is-distorting-covid-policies-and-behaviors/.

Health, Paternalism, and the 'Nanny State': A View from the Front Line

Bruce Laurence, retired public health physician, formerly Director of public health for
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Public health policies are often accused of paternalism and 'nanny statism' For some, particularly in the media and some political circles, the mere use of the term is considered a powerful objection to public health initiatives. Some political theorists and ethicists construct more reasoned arguments, that focus on the importance of liberty and autonomy and the dangers, in theory and in practice, of undermining these principles, even if with the intention of improving the health of the public or protecting the vulnerable.

As a recently retired director of public health (DPH), having spent many years as one of the front-line workers in the NHS and local government, I am keenly aware of the nanny state accusation. My contribution to this debate is therefore practical rather than academic, and based on my experiences of promoting health, in the widest sense, with people and communities, through the state system.

In this short article, I will expand on four broad conclusions.

1. The accusation that public health practice is paternalistic is based on a distorted view of what most public health work actually entails.

2. The "nanny state" accusation is itself representative of a partisan and self-serving political view that presents itself as a fact of nature or "just common sense".

3. The practice of shaping people's choices should not be seen as state overreach or as disrespectful of individual autonomy, when it is used to support those whose choices are restricted by their social and economic circumstances or driven by powerful cultural and commercial forces.

4. In the future, powerful new technologies that will further manipulate individual choice and also major new challenges to individual and population health will need even stronger and more targeted interventions to counter threats to individual and population health.

1. The nature and scope of public health work at locality level

In practice, the work of the average public health official and their teams are little focused on coercing people's behavior and finger wagging, and much more on providing essential support services to populations and people in need. We should therefore resist the implication that public health work is all about paternalist approaches. Instead, we should explain what it is we actually do. Some examples of the services we commission are health visiting and school nursing, sexual health services, drug and alcohol treatments, smoking cessation, and obesity management. We play a key role in protecting the public from infectious and environmental

hazards including having been among those at the forefront of the local response to the COVID-19 pandemic. We also work with many council departments and partner organisations to help ensure that others' work utilizes detailed local understanding of people's health and wellbeing to increase the sphere of choice for those living in the most unfavourable circumstances and to best target support to those in most need.

There is certainly a part of our work that presents to our local communities information and evidence that can be used to guide healthy and positive behavioural choices, but this is always done in a way that seeks to understand the reality of how people in these communities live and work.

In relation to the appropriate scope of public health work, I would differentiate theory and practice. Most public health professionals would surely agree that anything that has a significant influence on health (which is almost any major area of human organization or behaviour)

potentials falls within the legitimate scope of public health action of some sort. However, the decision about where to intervene and make efforts in any particular place and time will be a strategic and tactical decision, based on the need and capacity to play a useful role in the system, whether through use of data, advocacy or more direct planning and provision of services. That depends on many considerations: the nature of the problem at hand, the authority and ability of other actors in the arena and the capacity and authority of local bodies. It is one of the most important "soft" skills of public health officials to understand when, where and how to intervene in ways that are impactful and make effective and efficient use of our own scarce resources. In other words, the practical scope of public health work is heavily limited by a wide range of factors. Thus, from the perspective of front line health work, the nanny state accusation targets a rather distorted and exaggerated "straw man" view of public health practice.

2. Public health inevitably involves politics…and the nanny state accusation equally so

Public health seeks to understand the causes and distribution of good and poor health in communities. Insofar as this is impacted by choices that are made about the distribution of society's resources and opportunities, public health is partly a politically driven discipline. Public health workers generally do have a progressive political perspective, at least in the UK, with a strong leaning towards equity and social justice (difficult though those things are to define). As far as public health workers are engaged in a discussion of the just and equitable society, this is nothing to be ashamed of and need not be hidden. However public health workers do need to understand that this is a political view that is not shared by everyone. The move of local public health teams into local government has brought this to the fore, but encouragingly it has been found that when these discussions are had with Councillors, based on shared local understanding of communities needs and circumstances, most DsPH have found that they are supported well by administrations across the political spectrum, and there has generally been a high level of support for public health work.

A more libertarian perspective which is suspicious of public health work as inappropriately paternalistic, does reflect a view held by many, and that cannot just be disregarded. We need to be prepared to listen to this view, reflect on it, and be prepared to challenge it where necessary. In particular, we should acknowledge that we need to be very mindful of avoiding doing anything that disrespects or further oppresses those who are already struggling against inequality and disadvantage in what is already a very unequal society.

Part of my refutation of this counter-view, is that it itself comes from a highly political perspective and one that has been driven by strongly in recent times in the US and UK by powerful and self-serving forces in the media, business and politics. This view is allied to one which sees all human activity and organization through the prism of "the market" which must not be constrained and asserts the primacy of individual autonomy over other ethical or social considerations. It is sometimes presented as akin to a law of nature and as the "common sense" view, and it is also the view that has underpinned great social inequality and an increasingly "winner takes all" world that is undermining social cohesiveness and creating dangerous political and cultural polarization.

As part of the practical response to this, I suggest that making detailed philosophical arguments against the nanny state accusation will in practice just help to keep the term in the public mind and nothing will be gained by continually fighting the battle on the opponents' ground and therefore on the back foot. We should rather get onto the front foot, express our aims positively in terms of striving for social justice, human flourishing, protection of vulnerable people and the protection of social cohesion in the face of our great social and environmental challenges.

3. Shaping choices can increase as well as limit autonomy, but must be done carefully

In its best light, the nanny state objection to public health is based on a concern for respecting individual autonomy and choice. But it is not at all clear that typical public health policies offend against the value of autonomy. Rather, once we recognise that the ability to live an autonomous life requires an autonomy-conducive environment, public health policies can be viewed enhancing individuals' capacities for choice.

Public health practice is often split between actions that seek to improve people's behaviors within their existing environment (individual level health promotion) and those that see to change that environment through acting on the wider determinants of health, in order to enable people to live in an environment that is favourable to their health and wellbeing.

If one believes (perhaps drawing on recent evidence from neuroscience and behavioural psychology) that our behaviours are highly determined by genetics, upbringing, peer-group cultural influences, advertising, and economic constraints, then some elements of health promotion can look like "victim blaming" and can support the criticism that public health professionals are middle class folk imposing a particular world-view on others.

But equally, if one takes this to an extreme, and treats people as having no ability to improve their health behaviours within their existing constraints, this can be also be disrespectful, and unduly fatalistic, since it treats individuals as lacking any agency. Most public health professionals try to take a pragmatic balance between these two extremes, acting both in wider determinants but also aiming to support individual empowerment and change. People with little resources and few options might make bad health choices rationally from their perspective, and it may be respectful to both support their right to make those choices in their position and to seek to change the status quo so that they are equipped to make different choices in the future.

The proponent of the view that respect for autonomy requires that the state should do little or nothing to restrict or influence individual choice, must meet the challenge that some people have much more power and influence than others. The freedom of choice of the powerful can limit those of the less powerful in so many direct and indirect ways. Furthermore, we have much evidence that the advantages and disadvantages that support or restrict choices and impact on health outcomes are strongly handed down from generation to generation and that social mobility in the UK (even more so in the US) is very limited. If we really care about the value of autonomy, we need a combination of interventionist and non-interventionist approaches.

4. Challenges to individuals' and communities' health wellbeing and freedom are mounting

Finally, in this generation two other major factors have entered public health discussions. One is the opportunities and threats posed by the new technologies or the digital age. For example, the immense power of "big data" and algorithms, to survey, understand, predict and influence the behaviour of all of us. This power – unimaginable to previous generations – is a tool that brings the possibility of major benefit and equally major harm depending on who controls it and how it is used. Secondly, there is the matter of the global climate crisis alongside other developing environmental dangers. In our interconnected and densely populated world, and especially in our modern Anthropocene era, so much common human behaviour (including what we eat, what we buy and throw away, how we travel and power our lives) has profound impacts on others, whether obvious and direct, or indirect through global markets and environments. Thus, the usual caveat to the principle of autonomy that one's actions should do no harm to others needs very careful consideration.

We face the real prospect that the sum of every individual, family and state promoting their own interests will lead to an uninhabitable world in the future. As these two examples show, individuals' choices and fates have never been more interlinked. Only collective action will enable us to respond adequately, and this can only be achieved by coordinating strong actions at local, national and supra-national levels. With this in mind, the easy resort to a nanny state accusation as an argument for untrammeled individual autonomy is more than just a dis-service to public health and social justice, but constitutes an existential threat to humanity.

Public Health and Public Values in Diverse Societies

Kathryn MacKay, Lecturer at Sydney Health Ethics, University of Sydney

Paternalism is a common concern about public health initiatives. We see it discussed in the media as 'nanny state' activity, where public health (particularly as a government agency) is purportedly interfering with the choices of adult citizens in a way that is considered to be inappropriate or insulting.

In this short essay, I will approach the topic of public health paternalism in a slightly different way. I am interested in how the diversity of a society impacts how we understand public health activities as paternalistic or not. Diversity in a society might render initiatives more or less paternalistic, or make public health initiatives paternalistic in one place, but not in another. But let me explain what I mean by paternalism first.

Paternalism & Liberty

Paternalism is typically defined as interfering with a person's freedom in order to benefit that same person. A fairly clear-cut example of paternalism from public health is motorcycle helmet laws. If we set aside that in a universal healthcare system our health-regarding choices have some bearing on everyone else, a motorcycle helmet law can be described as paternalistic when a person really doesn't want to wear a helmet, but is forced to wear one by law (or else suffer penalties). This person experiences the helmet law as trampling upon their freedom to ride a motorcycle without a helmet.

An interesting thing to note about paternalism is its close connection to personal freedom. This isn't just any personal freedom, but in particular it is 'negative liberty' – that is, freedom from interference. This idea is important to public thought in democratic, industrialised Western nations. But, this idea has a history. The notion of personal liberty, and especially freedom from the tyrannical will of others, arose roughly around the times of anti-monarchy revolutions (the Glorious Revolution, French Revolution, and American Revolution), and developed in a tradition under which people in a state wanted to be treated as equal citizens, and not as subjects.

This is important for two reasons: first, because it shows that personal liberty is a value that gained importance in a particular time and place; and second, because there are other times and places in which liberty did not play this important public role, and which hold other values to be central.

Places where liberty is less valued still exist, and in these contexts paternalism is less likely to be an issue. In societies where community decisions about health are made by consensus, there is little opportunity for paternalism. Similarly, when a society desires a particular intervention (like motorcycle helmet laws, perhaps), then that intervention supports their desire, rather than impeding their freedom.

So, whether a public health intervention is seen as paternalistic is partly dependent on where liberty figures in the values of a particular society. Perhaps public health could avoid paternalism by ensuring consensus on an intervention before implementing it. However, public health's ability to operate in a paternalism-free way is limited. There are two reasons for this that I'll discuss in this post: first, since societies are increasingly diverse, it is more likely that public opinions on health will diverge; and second, public health makes value-based decisions that are sometimes at odds with public values.

Values in Diverse Societies

Societies in democratic, industrialised nations are becoming more diverse. Some of these societies, like Australia and Canada, are post-colonial states made up of indigenous groups and various generations of settler/immigrant groups. Others, like the UK, are former colonial powers, made up of various distinct native cultures (e.g. Scottish, Welsh) as well as generations of immigrant groups from former colonies (e.g. the Windrush Generation).

As societies become more diverse, the work of public health becomes more challenging. This is because different groups and cultures frequently hold different values, or similar values but with different estimations of their importance. It may even be the case that some fundamental values about social life differ in their interpretation. For example, different groups within a single society might have very different interpretations of who counts as 'immediate family.' Or, there may be divergent views about who can give consent for screening or biobanking among different groups.[1]

I've noted that liberty is an idea with a history, but this is true of all ideas. Some ideas have longer histories than others. In Australia, which has been continuously populated for 60,000 years, 'individual liberty' has only been present for approximately the last 250. Before the value of personal liberty took centre stage, a variety of other values guided moral thought in this land. Such values included the importance of cooperation, continuity of being through time and space, and custodianship. These ideas are very old and have a deep history.[2] And, such ideas lead to a different understanding of health, which encompasses the person, their family, their ancestors, the land, and the animals.

It would be overly simplistic to suggest that this is merely a difference between individualistic and communitarian cultures, as there can be diversity of views from within these two broad categories as well. In such a context, gaining support for public health interventions might be more complicated or take more time, as there are different groups with different ideas of health and wellbeing to take into account.

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1.   It might interest readers that among some cultures of First Nations people in Australia, an individual is not an owner of their body or their genetic material. Genetic information is a part of the community's inheritance, like knowledge or the land and water, of which they are a custodian for the next generation. Participation in programmes which hold onto biological samples therefore requires community consent – and consensus. For discussion, Michael Dodson and Robert Williamson, 'Indigenous Peoples and the Morality of the Human Genome Diversity Project,' *Journal of Medical Ethics* 25, no. 2 (1999): 204–208.
2.   Aboriginal Dreamtime Stories capture and communicate important values. Interested readers can find a collection of stories here: https://dreamtime.net.au/dreaming/story-list/

Public Health and Public Values

I'll turn now to the interplay between public health and public values. I am based at a school of public health, and I am learning from my colleagues that public health has a bit of a blind spot when it comes to recognising that it occupies a specific historical and ideological position.[3] Public health sees itself as objective and universal, rather than a recent (~200 years) phenomenon with a particular history, culture, and view of the world.

When public health creates an initiative to improve health in a particular domain, it is doing so based on a set of values that are part of the culture of public health as a discipline. These values include what counts as evidence, what counts as harm, what counts as risk and how much risk is acceptable, and what health means.

I've mentioned above that some groups might have a more expansive idea of health, and others might have a more limited idea. Some groups might hold the view that the individual is the main locus of intervention, others might hold that the group or community is the main locus. This will influence the approach that public health can justifiably take toward a health issue among these groups.

The difference between England and New Zealand in approaches to COVID-19 seems like an excellent example of the way that acceptable public health responses to an issue depend upon the interpretation of values in a particular place and time. England is clearly more risk-tolerant than is New Zealand. The English public seems to accept a higher rate of COVID-19 illness at the population level in exchange for a greater amount of freedom (and higher risk) at the individual level. By contrast, New Zealand's public has higher acceptance for a low (or zero) rate of COVID-19 at the population level, even if it costs more in terms of individual freedom. The influence of Maori values in New Zealand's public life and their pandemic planning is one plausible contributor to this difference.[4]

What this means for the discussion of public health paternalism is that the very same public health measure can be experienced as paternalistic in one society but not in another. Consider travel restrictions, for example. In England, these might be experienced as paternalistic, burdensome, and potentially unjustifiable (because they lack public support). In New Zealand, the same measures are experienced as non-paternalistic, reasonable, and justified.

Moreover, within these two diverse societies, there are very likely to be sub-groups that experience the restriction differently. So, within the UK, the Scottish public seems less risk-tolerant than the English, and more accepting of various restrictions. Likewise, in New Zealand, the Maori community is more staunchly supportive of restrictions than some of the Anglo-settler community.

So, as societies around the world are increasingly becoming more diverse, public health is in an increasingly challenging position. Public health may be viewed as acting paternalistically according to one group, but not another. Or, the same public health measure applied to one society may be paternalistic there, but not when applied to a different one.

Rather than hamstring public health practice, I think an awareness of the value-laden nature of health interventions can make public health and its interventions more robust. There likely never was a one-size-fits-all public health approach, but certainly there isn't one now. Public health can limit paternalism or 'nanny state' objections by listening to the different groups within diverse societies, and responding to the values they hold, in respectful dialogue.

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3. It's not the only discipline to do this – philosophy is famously bad at recognizing its historical and ideological position, so I hope readers don't think I'm unfairly pointing the finger. Getting out of our blinkers is very important for philosophers and public health practitioners, alike.

4. National Ethics Advisory Committee, 'Getting through together: ethical values for a pandemic,' (Wellington: Ministry of Health, 2007). Available at: www.moh.govt.nz/notebook/nbbooks.nsf/0/4A5665FA-075FAC7ECC257332006EBA40/$file/getting-through-together-jul07.pdf; Louise Delany, 'Ethics and Indigeneity in Responding to Pandemic Influenza: Māori Values in New Zealand's Emergency Planning. In Michael Selgelid (ed), *Ethics and Security Aspects of Infectious Disease Control* (Abingdon: Routledge, 2016), 179-200.

Beyond the Neglectful State – lessons for the future of public health

James Wilson, Professor of Philosophy, UCL; Co-director of the UCL Health Humanities Centre

Expectations about how states can and should interfere in citizens' daily lives to protect health have been profoundly reshaped over the past two years. Before 2020, even non-intrusive measures such as minimum unit pricing for alcohol, or regulation of wood-burning stoves, were rejected in England for involving too much interference. Since then, vastly more draconian and intrusive measures – including travel restrictions, mask wearing, vaccine mandates, and of course lockdowns – have not only been legislated for but enjoyed widespread compliance.

Rapid and radical change provides an excellent opportunity to reflect on our previous practices with fresh eyes. The progress towards an endemic Covid – in which citizens need to find ways of resuming life and work while living alongside the virus – allows us to examine what should be taken forward from the muscular approach to public health shown over the past two years. Does the pandemic have profound lessons to teach us about the nature and place of public health in society? Or should we treat the pandemic period as a *state of exceptio*n – as a discrete time that was subject to its own set of ethical rules, with few implications for the ethical justifiability of public health practice post-pandemic?

There are some reasons for scepticism that there are straightforward ethical lessons to be drawn. Large stretches of the past two years have seen societies on a public health emergency footing. Many think that the ethical principles which apply to emergencies are different from those that apply to ordinary circumstances. As philosopher Tom Sorell has argued,[1] a situation isn't an emergency unless swift and decisive action is required in order to avert or minimise a large-scale harm. Clearly, there have been times over the past two years when it has been necessary for governments to act quickly and decisively to lockdown. Where they have not, it has been evident (if not admitted by these authorities) that the result has been thousands of additional deaths.

It is often argued that the ethical principles that apply to emergencies are different, or at least that the balance of such principles is different, favouring an approach that is more "utilitarian" as rights and safeguards that might be applied under usual circumstances are temporarily lifted. For example, the Control of Patient Information Regulations[2] in England explicitly allow that in the context of an emergency, patient data can flow much more freely and without the need consent where it is for public health purposes. The ethics of triage after disasters tends to focus on those lives that can be saved, rather than, for example, on those who are worst off.

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1. Tom Sorell, 'Morality and Emergency,' *Proceedings of the Aristotelian Society* 103, No.1 (2003): 21-37.
2. See Cian O'Donovan, 'Debate needed on post-pandemic rules for medical data', *Research Professional News* (2021).
    Available at: https://www.researchprofessionalnews.com/rr-news-political-science-blog-2021-12-debate-needed-on-post-pandemic-rules-for-medical-data/

However, it would be too hasty to think that public health emergencies have nothing to teach us about the ethics of public health in ordinary circumstances. The story of public health responses to Covid has not just been one of bold and decisive strokes by governments (or failure to take such measures). It has also been a story of countless actions by millions that have either slightly reduced or slightly increased risk to others. Sometimes, the effect of a government intervention on population health often just is the sum total of these effects. One person refuses to wear a mask on public transport, another takes daily lateral flow tests to minimise risks to others, a third shifts a meeting outdoors. Even in the context of a public health emergency, each small act of precaution will typically have correspondingly small effects. Nonetheless, the aggregate effect of all these actions may make all the difference in the world.

Large-scale public health emergencies rarely come out of nowhere. The myriad of small actions taken by many that shape environments in ways positive and negative to population health, are not separable from the scale and the severity of the public health problems states face. Population health problems that have socially controllable causes, but have been allowed to fester, and to become part of "business as usual" should not be treated as a baseline from which deviation must be required. It is indefensible both for governments and for citizens to resist measures that are mildly inconvenient, but would prevent things being much worse for many others, and would lead to hundreds or thousands of fewer deaths, regardless of whether the threat to public health is framed as an "emergency" or business as usual.

Moreover, the relationship between precaution, emergency and disaster is thoroughly human mediated. Any policy response to a rapidly worsening threat that is not sufficient to control it creates an obvious risk that politicians will end up enacting an escalating series of interventions, which together fail to bring the disease under control. This was a recurring common theme of the UK response, and culminated in a need for very stringent lockdown measures over a much longer period of time than would have been necessary if decisive action had been taken early on. There is something self-defeating, in other words, in thinking that it would be wrong to impose the public health restrictions now that would prevent a full-blown emergency because these would be disproportionate, where similar or indeed more draconian measures would become necessary if the emergency does predictably ensue.

Pre-pandemic, too many worked with the default assumption that it might be acceptable for the state to do nothing to protect and promote population health, and that whatever the state does do needs to be checked carefully to ensure that it avoids both paternalism and overreach. In my recent book,[3] I argue that this is to get things backwards. We should deploy the idea of the Neglectful State to help rethink the ethical basis for public health. Neglectful States fail to pursue cost-effective and proportionate measures that would make life safer for all, and in so doing show a callous disregard for the lives and well-being of everyone, but especially the vulnerable. Neglectful States are not just ethically problematic in emergencies, but in ordinary circumstances too.

3.   James Wilson, *Philosophy for Public Health and Public Policy: Beyond the Neglectful State* (Oxford: Oxford University Press, 2021).

Why Paternalism is (Largely) Irrelevant to Public Health Policy

Angus Dawson, Formerly Professor of Bioethics and Director of Sydney Health Ethics, University of Sydney; joint Editor-in-Chief of Public Health Ethics; joint coordinator of the International Association of Bioethics' Public Health Ethics Network (InterPHEN)

A focus on paternalism as a problem for public health policy is common but misplaced. I provide four reasons for this view. First, is a conceptual objection to the use of the term 'paternalism' in this context, as most accounts are built around defending individual liberties from encroachment by others. But public health policy is not, primarily, about individuals. Any objection here should instead be focused on the possible lack of legitimacy of public health decision making. For example, in a democratic society policy ought to be formulated on the basis of public support and relevant legal protections. Their absence is not paternalism, even if wrong. Second, is a conceptual objection built around the nature and aims of public health. Public health policy aims to protect us all from threats to our health. Often such threats to individuals and communities can be most efficiently, or in some cases only, tackled through collective action. Solidaristic action is the best way to ensure that individuals (and communities) can pursue their chosen plans. Third, objections to the second reason often focus on a requirement for the state to be neutral in relation to how individuals live their lives. However, such a requirement is deeply implausible and potentially highly costly, particularly for the vulnerable and disadvantaged in society. Fourth, and related to the third reason, any plausible moral and political theory will be pluralist in the values espoused. Unless you are a libertarian, in the sense of holding that liberty is the only relevant or always the most important value, the issue is about how we weigh different relevant considerations against each other when deliberating about policy. Appeal to paternalism, with its pejorative negative associations, defaults to giving priority to the liberty of individuals. Liberty is, of course, an important value and ought to be taken into account in formulating policy. But to prioritise it in all cases is just not compatible with a fair engagement with the aims of public health and is likely to result in poorer and unjust health outcomes. It would, in my view, be welcome if discussion could move on to seeking to establish the basis of formulating legitimate and democratic public health policy rather than continuing to obsess about the P word.

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