Public Health Ethics and Liberalism

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This paper defends a distinctly liberal approach to public health ethics and replies to possible objections. In particular, I look at a set of recent proposals aiming to revise and expand liberalism in light of public health's rationale and epidemiological findings. I argue that they fail to provide a sociologically informed version of liberalism. Instead, they rest on an implicit normative premise about the value of health, which I show to be invalid. I then make explicit the unobvious, republican background of these proposals. Finally, I expand on the liberal understanding of freedom as non-interference and show its advantages over the republican alternative of freedom as non-domination within the context of public health. The views of freedom I discuss in the paper do not overlap with the classical distinction between negative and positive freedom. In addition, my account differentiates the concepts of freedom and autonomy and does not rule out substantive accounts of the latter. Nor does it confine political liberalism to an essentially procedural form.

Introduction

The establishment of public health ethics as a discipline in its own right seems innately related to questioning the suitability of a liberal framework (Dawson and Verweij, 2007: 8). For instance, it is often argued that although liberal approaches are congenial to bioethics and its focus on individual choices and patients' autonomy, liberalism lacks the conceptual tools necessary to tackle the intricacies of public health ethics such as an irreducible concept of public good that a republican or communitarian strategy would be able to offer (Nuffield Council on Bioethics, 2007; Jennings, 2007a, b). Essentially, these proposals contend that if epidemiological findings are taken into proper consideration, liberalism should make room for public health interventions that go beyond standard constraints such as respect for basic liberties and individual choices, the harm principle and the conception of freedom as non-interference.

In this paper, I will argue that these attempts to establish public health ethics on essentially revised liberal grounds are misconceived. My strategy will be as follows. In the opening section, I provide a logical reconstruction of a cluster of views whose constitutive feature is this apparent dissatisfaction with liberalism in public health ethics. The objective is to make explicit an underlying argument that could animate these views and to relate it to broader, initially appealing criticisms against liberalism. I then outline its continuity with some *prima facie* reasons for preferring a republican alternative. In subsequent sections, I critically examine what appear to be the two key premises of the reconstructed argument. The first is normative. It takes health to be an overarching value. The second comprises specific interpretations of epidemiological evidence that presumably expose liberalism as a sociologically naïve approach to public health. The thrust of my analysis in these sections is twofold. First, it purports to show that the prior, normative premise should be rejected because it derives from conflating prudential and moral reasons for valuing health and fails to respect its complex axiological structure. Second, it aims to demonstrate that the posterior, presumably empirical premise builds upon the invalid assumption that health is an overarching value. Hence, this premise cannot be used to support increasingly prescriptive policies as informed extensions of a liberal commitment to public health. This latter point indicates that such proposals effectively disengage with central liberal values and should be conceived as part of a different, republican project. In the final section, I reply to the challenges against liberalism outlined at the beginning of the paper and demonstrate its superiority over the republican alternative in the context of public health. In light of this analysis, I conclude that the liberal commitment to the value of toleration should be paramount within public health ethics.

A major advantage of the proposed strategy consists in its capacity to both explain the popularity of recurrent criticisms against liberalism in public health ethics and show that these concerns are unfounded. Here, 'liberalism' stands primarily for procedural, e.g., Rawlsian liberalism. The rationale is that this strand relies more heavily on the conception of freedom as non-interference and invites a narrower understanding of the harm principle than perfectionist theories, which commit to

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additional values, such as autonomy. However, freedom as non-interference and a restrictive harm principle seem to be the main target of the criticisms mentioned above. In particular, they both are deemed incongruous with standard definitions of public health, which include collective initiatives in the pursuit of irreducibly public goals (Verweij and Dawson, 2007). Thus, my defence of liberalism will focus on these challenged features and aim to deal with ensuing criticisms on their own terms. Nevertheless, it directly applies to more substantive forms of liberalism as long as they intend to eliminate abusive conditions of choice rather than discount some choices as non-autonomous by default (Scanlon, 1988). Joseph Raz's *Morality of Freedom* is an example of such a liberal yet substantive approach. Conceptions that do not satisfy the preceding condition will not be considered as distinctively liberal.

In addition, the following discussion presupposes a distinction between the concepts of freedom and autonomy and focus on the former (Feinberg, 1986; Dworkin, 1988: 3–33). My argument relates to the latter insofar as freedom facilitates personal autonomy, both in its development and exercise. As a result, the issues raised about the value of health do not undermine value-laden conceptions of autonomy, e.g., Oshana (2006), but only suggest that health cannot sustain such a conception.

Finally, the central distinction between freedom as non-interference and freedom as non-domination differs from that between negative and positive freedom (Berlin, 1958). For both strategies of defining freedom share aspects that belong to both sides of the classical divide.

Non-interference and Its Perceived Weaknesses

As stated in the Introduction, this section aims to reconstruct an underlying argument that could sustain the frequent claims that liberalism is an awkward match for public health ethics. A promising starting point would be to maintain that the liberal understanding of freedom as non-interference is at odds with the underpinnings of public health policy. The 'harm principle' stating that one's freedom may be legitimately constrained only in order to prevent harm to others is criticised as an insufficient corrective to the primary focus on individuals. Although its original formulation by Mill (1859) is significantly more complex (Dawson and Verweij, 2008), its rationale is persistently associated with the protection of individuals from potentially interfering powerful institutions (Hart, 1963; Feinberg, 1984; Ripstein, 2006; Bird, 2007). As explained earlier, I shall not elaborate further on the harm principle at this point, but take for granted this narrow interpretation, which is both widely accepted by political philosophers and typically addressed by its critics within public health ethics, e.g., Jennings (2007a,b). I shall though return to this issue in the two final sections and argue that a narrow version of the harm principle is, in fact, apposite to public health matters. For the moment, however, I shall concentrate on making it clear why freedom as non-interference might be considered out of tune.

The standard criticism against liberalism for holding a naïve view of rational agents as 'unencumbered selves' and ignoring the importance of social bonds and interpersonal context seems to hit home (Sandel, 1982). From this perspective, freedom as non-interference would seem prone to uphold the appearance of individual choices, which may conceal the effects of prior, systematic oppression. Subtler forms of coercion remain undetected. Their victims are not identified as such. Nor are the harms inflicted on them countered by the public authorities. Instead, such harms are perceived as the result of free, although perhaps imprudent, choices that are subject to liberal toleration.

Some critiques of cosmetic surgery exemplify this line of reasoning. Their aim is to show that by condoning this practice, liberal democracies fail to protect some of their vulnerable citizens from important physical, psychological and political harms (Marzano, 2002; Chambers, 2008). These critiques point out the persistent gender inequalities that push women towards cosmetic surgery and contest its interpretation as a coincidence of unrelated individual choices to enhance one's looks.

In a similar vein, the Nuffield Council on Bioethics maintains that 'the state has a duty to help everyone lead a healthy life and to reduce health inequalities' (2007: Summary). However, this duty is undermined by the standard formulation of the 'harm principle', which insulates unhealthy choices such as smoking and binge drinking from direct state intervention. Yet, the Nuffield Council argues, these choices largely pertain to disadvantaged strata of the population and therefore should not be presumed free. In fact, citizens' fundamental interest in being healthy is considered as a sufficient reason for discounting harmful individual choices as *prima facie* unfree. They are likely to be either uninformed, or they make such unhealthy choices due to peer pressure and disadvantaged background (2.22–2.33). A 'stewardship model' of public authority is deemed a more appropriate starting point than classical liberalism. This alternative model bestows the state with the objective to enable healthy lifestyles and pays particular attention to the

vulnerable and the disadvantaged (2.41–2.45). To this effect, it proposes an 'intervention ladder' of public health measures, which gradually become more invasive. They start from monitoring the situation and providing information to restricting and eliminating unhealthy individual choices. The Nuffield Council insists that whenever possible, the desired health outcomes should be achieved via the least intrusive measures. Nevertheless, the authors contend that the failure of less restrictive policies should lead to the implementation of more restrictive ones, provided that the expected health benefits still offset the interference with people's lives and financial cost (3.17–3.18).

The Nuffield Council asserts that these underpinnings are not illiberal. On the contrary, they are perceived as a more coherent framework for the liberal commitment to individual freedom. This view finds support in recent epidemiological studies that ascertain the paramount importance of the *social gradient of health* (Marmot, 2004; Wilkinson, 2005; Marmot and Wilkinson, 2006). Their findings suggest that unhealthy behaviours are broadly determined by adverse circumstance and lack of opportunity and contend that individual choices are less significant healthwise than the social environment.

A further objection to the conception of freedom as non-interference points towards its inability to appreciate irreducibly social goods (Taylor, 1995). For instance, Rawlsian primary goods such as liberties, opportunities and income matter because they are essential all-purpose means and could further any particular plan of life (Rawls, 1971: §15; 1993: V, §§3–4). Their worth derives from the pursuit of individual projects and does not transcend the aggregate value that they have for each individual beneficiary. Therefore Rawlsian primary goods are social only in the sense that it is impossible to provide them 'in such a way as to benefit a single individual, but must benefit many or none' (Taylor, 1995: 129). In contrast, a Rawlsian framework does not leave room for irreducibly social goods, the value of which partly depends on the common appreciation that they inspire. For instance, the value of equal social relationships cannot be reduced to that of curtailing each other's oppressive intentions. In fact, it can hardly be realised without a general consideration for the ideal of equality (Scheffler, 2005).

This apparent failure to grasp that some fundamental goods are irreducibly social arguably prompts an unhelpful attitude towards public goals and, *inter alia,* public health. For the pursuit of these might be suspected to collide with individual freedoms. Yet, no individual plan can be meaningfully articulated in the absence of irreducibly social goods (Taylor, 1989). The liberal insistence on non-interference is deemed to be liberty-diminishing in this respect. It reduces the range of opportunities for everybody as it invites people to think of their interests in isolation from public ones. As a result, it brings forward misguided dilemmas between individual freedom and the public good. Debates about public health interventions often seem dominated by these. For instance, it is widely acknowledged that a legal cap on weekly working hours provides important public health benefits and reduces the risk of various conditions associated with overwork, some of which are cardiovascular disease, depression and diabetes. Yet, some persistently oppose the measure claiming that it would interfere with one's freedom to work as long as one pleases. However, this alleged freedom is problematic. It exposes the disadvantaged to economic and managerial pressures and condones the resulting harms (Bunting, 2004; Gillan, 2005).

These perceived weaknesses of freedom as non-interference seem to be avoided by the republican alternative, which conceives freedom as non-domination. Republican philosophers consider interference as irrelevant in itself. Instead, they suggest that individual freedom is undermined by the potential for arbitrary use of power. This power may never be exercised as a matter of fact. The sheer capacity to exercise it at will suffices for complete domination. Its background presence utterly corrupts individual choices and subverts the foundations of autonomous agency. In fact, the dominated habitually commit to extensive self-censorship in order to pre-empt repression (Pettit, 1997; Skinner, 1998). Conversely, legitimate interference does not threaten individual freedom. It is a case of 'friendly coercion', which focuses on the interests of the coerced rather than the coercing party. 'Friendly coercion' engages the coerced in a reasoned discussion and restores their control over future decisions. As a result, legitimate interference is seen as a way to reinstate individual freedom. Unlike abusive power, it is based on reasons and their validity is recognisable by those who experience legitimate interference. The avowable interests of these people are thereby respected (Pettit, 2001: 65–103; 156–160).

The appeal of the preceding argument largely depends on some implicit assumptions. Its conclusion that freedom as non-interference provides an inadequate foundation for public health ethics resonates with the idea that inattention to health results primarily from covert oppression rather than proper choice. This supposition builds on the following two premises. The first premise is, health is an overarching value. It is unlikely that another value can take precedence over it as a result of a defensible choice. The second premise is, once liberalism takes on board empirical findings such as the social

gradient of health, liberal proposals would by and large converge with the preceding communitarian and republican insights. The next two sections will look at each premise in turn.

The Value of Health

In a recent paper, Gostin and Stone assert that 'the public health community takes it as an act of faith that health must be society's overarching value.' (2007: 66). They approvingly quote Franklin Roosevelt according to whom nothing could be more important to a state than its public health and criticise Western governments for failing to appreciate this insight.

In fact, it is rare for this premise to be so explicitly endorsed. Some may even doubt whether the preceding statement should be taken literally rather than scaled down to the uncontroversial and uninteresting claim that health is surely important. Yet, the array of congenial, although less overt observations in the literature suggest that the assertion that health is an overarching value should be taken in earnest. For instance, the popularity of public health rhetoric in political discourse points towards the paramount importance that the general public attributes to health (Massé, 2003). Arguably, it has succeeded eternal salvation in its role as a core societal value (Walzer, 1983). In addition, health's perceived objectivity backs up the idea of its exceptional place (Cribb, 2005: 3–20). The concern for health appears both fundamental and devoid of partisan flavour.

However, this widespread agreement on the value of health is misleading. It comes down to an overlapping consensus that health matters to people and inadvertently conceals the divergence of reasons for valuing health. A cursory look at the existing conceptions of health is sufficient to show that they do not converge towards a shared understanding of its value. For instance, an account of health as absence of disease yields a different evaluative stance that that of health as foundations of achievement (Boorse, 1977; Seedhouse, 2001; Nordenfelt, 2007). Lay perceptions of health, its meaning and relative importance are even more disparate (Blaxter, 2004). This presents health as a likely umbrella concept the ubiquity of which does not suggest unanimous acceptance.

More importantly, no plausible view of health is compatible with the thesis that health is an overarching value. It is improbable that the pursuit of health is what makes other goods worthwhile. On the contrary, the intelligibility of this pursuit is partly sustained by values other than health.[1] Among these, freedom from pain and impairment is of particular importance (Engelhardt, 1981). This points towards a constitutive feature of health as a value, which is to enable further projects and activities. The absence of such commitments effectively undermines the value of health. It takes away an essential part of its foundations and makes the interest in health appear vague and shaky. Conversely, this partial dependence on further values gives a rationale to undertake certain health risks for the sake of these values.

In addition, both achieving and maintaining health are threatened by direct, continuous efforts. The exclusive focus on health is patently self-defeating as it leads to risk aversion, reduced activities and feelings of anxiety and stress (Verweij, 1999, 2007). These factors affect not only the subjective experience of well-being, but quickly translate into serious physical symptoms (Heath, 2005). Thus, the value of health appears to be self-effacing in two complementary ways: it is best realised indirectly and as a part of a comprehensive project capable of remedying its original vagueness and incompleteness. In its ideal circumstance, health gives way to the pursuit of other values. Only in situations imposing a grave threat to one's health and realisation of further constitutive projects that it is reasonable to make health one's primary concern. These kinds of situations have to be considered as exceptional in order to respect the self-effacing structure of the value of health. A public health policy that takes these as representative runs the risk of undermining health and becoming self-defeating.

It might be objected that this analysis does not take into consideration an influential perspective which arguably motivates the idea of health as an overarching value by associating health and well-being (WHO, 2006). However, this association is notoriously loose and creates more difficulties than it is supposed to solve (Cribb, 2005: 21–40, 2007: 550). It does not provide an explicit conception of health as well-being. Instead, it uses the one as a metaphor of the other and makes both ideas even more elusive. Moreover, such a conception would be irreparably flawed since the values of health and well-being are different in kind. Assuming some credible notion of autonomous agency, the latter can be a good candidate for ultimate value, whilst the former, as shown above, cannot (Griffin, 1986). For instance, if one posits a minimal, or instrumental account of practical rationality, well-being can arguably take on the role of an ultimate, or final, end of all intelligible pursuits. In contrast, health cannot satisfy the formal requirements imposed by the concept of a final end. For its value is underdetermined and not self-contained.

The persistent illusion of health as an overarching value can be explained as an upshot of mixing up first- and third-person perspectives on health. The attitude to one's health is essentially prudential. It is as unreasonable

to pay no attention to one's health as it is to single out its preservation as one's main objective. Yet either imprudence differs from a moral failure. It might be regrettable, but not blameworthy in itself. In contrast, carelessness towards other people's health is morally problematic. It often amounts to harming them directly as, for instance, when driving in a drunk condition. This example helps clarify the distinction between the sheer imprudence of a behaviour and its culpability. The former focuses on potentially disastrous consequences for the imprudent agents themselves, whereas the latter reflects prospective harmful effects on third parties. These two aspects are not necessarily related, even though many actions that endanger one's health also happen to endanger other people's health. Smoking in closed spaces is an obvious example. The frequent concurrence of these aspects may lead to the impression that the corresponding actions are made objectionable by the inattention to health they display. In turn, this is likely to prompt the view that health must be an overarching value since its disregard is both imprudent and morally wrong. This conflation of prudential and moral reasons for valuing health seems to animate the reinterpretation of clear-cut cases of harm to others as public health issues. As a result, the health of both victims and perpetrators is perceived as an adequate subject of state protection. Following this logic, domestic violence is perceived as a result of unhealthy behaviour that is by and large socially determined and affects both parties negatively. For instance, it is suggested that violent husbands might be suffering from increased levels of stress at work (Seedhouse, 2001: 10–13). This outlook on domestic violence blurs crucial distinctions between self- and other-regarding aspects of objectionable actions. It effectively undermines the straightforward justification for state interventions that the 'harm principle' provides, and opts for a defence based on a conceptual confusion about the value of health.

The Role of Epidemiological Evidence

As previously outlined, references to epidemiological findings have been crucial in urging both revisions and expansions of distinctly liberal approaches to public health. This section will show that these references cannot establish an inescapable path from the liberal recognition of equal access to healthcare to prescriptive policies aiming at reducing health inequalities. Instead, such interpretations of the social gradient of health have to assume that the latter is an overarching value. This outcome is important for the following two reasons. On the one hand, it confirms the pivotal role of the preceding premise that might be overlooked because it often remains inexplicit. On the other, it clearly indicates that this kind of public health proposals break away from liberalism. In fact, they belong to a distinct political project and understanding of freedom, which is republican.

The argument for expanding the standard liberal framework for public health typically contends that the switch from healthcare to health promotion is unavoidable once this framework is properly linked to a sociologically informed outlook on health. For instance, Cribb explains the essence of health promotion as 'the idea that we might turn our knowledge of the determinants of health into action for health' and asserts that 'the idea of health promotion is thus a kind of logically necessary development in the historical evolution of health care' (2007: 550). However, this development transcends the liberal framework. It requires that the distribution of broader socio-economic determinants of health is essentially oriented towards improving health and decreasing health inequalities. The underlying reasoning can be reconstructed as follows. Disease and disability can be obstacles to full participation in a liberal political community just as race, gender or class. Therefore, a liberal state ought to provide special protection for its citizens' health under the principle of fair equality of opportunity. This obligation includes helping citizens to restore their health via adequate medical provision. Conversely, when this is not possible, affected individuals should be offered a fair compensation for their loss of opportunities. At first glance, universal access to healthcare and the enforcement of proper health and safety measures seem to fulfil the state obligation towards citizens' health (Daniels, 1985). However, recent epidemiological research shows that in affluent countries, social arrangements affect people's health more dramatically than the healthcare services available to them (e.g., Marmot and Wilkinson, 2006). Therefore, a consistent protection of citizens' health cannot be confined to healthcare provision. Instead, it requires that the state mitigates social factors with negative impact on health. Examples are relative poverty and lack of social capital. The conclusion is well summarised by the catchphrase '(social) justice is good for our health' (Daniels *et al.*, 2004; Daniels, 2008: 23). Its moderate interpretation is represented by Daniels's latest monograph *Just Health*. It is meant to revise and expand the author's earlier theory from *Just Health Care* in the light of presently available evidence for the social gradient of health. This moderate interpretation aims to justify the move from healthcare to comprehensive action for health in terms of fair equality of opportunity. In contrast, more radical

versions dismiss equality of opportunity as an inadequate principle and promote its replacement with equality of condition (Marmot, 2004: 248–257; Wilkinson, 2005: 284–287). According to these, social or economic, inequalities that result in unequal health outcomes are unacceptable. Thus, societies are called upon to account for statistically significant health and life expectancy variations among their members. Moreover, the overall achievement of political communities is assessed on public health grounds (Wilkinson, 2005: 1–31).

The apparent inescapability of the conclusion above receives further support from the fact that the moderate version seems unstable as it eventually collapses into the radical one. The reason for this is the extraordinary status it assigns to health. Once it is suggested that the social determinants of health should be allocated in view of health outcomes, it becomes difficult to resist the conclusion that the principle for health distribution should dominate the distribution of other goods such as liberties, education and income (Wilkinson, 2008). In fact, the very idea that a theory of justice is to be recommended for its impact on health is at odds with protecting health under the principle of fair equality of opportunity. For this implies that health is conceived not only as an important resource and therefore has to be preserved on account of social fairness. In addition, health seems employed as a litmus test for the overall quality of individual lives. In this respect, the moderate version assumes a steady association between health and well-being. But in doing so, it has to acknowledge public health and life expectancy as a comprehensive standard of social justice across societies. However, this contradicts the priority of the basic liberties that defines political liberalism. Instead, it expresses the core of a more radical understanding of social justice as conducive to health. This understanding leads us to considering some authoritarian regimes as successful and fair societies. For instance, Marmot commends the popular democracies of Central Europe in terms of public health: 'Under the new communist regimes, in the 1950s and 1960s, people were fed, housed, educated, clothed, employed, and the elderly were looked after. It is not surprising to me that with this set of social arrangements, health should improve. It did.' (2004: 200). The following process of liberalisation from the 1970s on is analysed in terms of a straightforward social disintegration because of the decline in average life expectancy.

This analysis is a logical consequence of the underlying idea that public health is a fair standard of social justice achieved by different states and cannot be avoided by those who find the idea attractive. Yet, it clearly rests on the assumption that health is an overarching value, which, as demonstrated above, is invalid. Unless this assumption is made, it is difficult to see why equal opportunity provisions, let alone basic liberties, should be rated on their public health impact.

The 'stewardship model' proposed by the Nuffield Council presents another argument for revising the standard liberal approach to public health. It relies on a different interpretation of epidemiological evidence. As shown in the first section, it leads to assuming that unhealthy choices are *prima facie* unfree, especially when they belong to underprivileged groups. Thus, prescriptive policies at the higher levels of the 'intervention ladder' are deemed compatible with the liberal commitment to the primary importance of individual choice since the choices that they are meant to curtail, or even eliminate, have already been discounted as unfree. However, this line of thought depends on overstating the significance of epidemiological data such as the association between lower socioeconomic status and certain unhealthy habits, e.g., raised alcohol consumption. Certainly, these findings express statistically important variations and inform hypotheses with considerable predictive power. Nevertheless, their high degree of probability does not amount to a social determination of one's attitude towards health. Yet, this stronger, overstated dependence is necessary in order to read epidemiological data as indicating the lesser importance of certain unhealthy choices. The latter are, therefore, reinterpreted as covert effects of societal pressures. However, this step undermines the moral significance of individual choice in general. For it now seems to be further analysable in terms of external influences. The move marks a radical departure from the liberal commitment to non-interference. It certainly assumes that health must be an overarching value so that choices that fail to match it cannot be both free and informed. In doing so, it fails to acknowledge that persistent life expectancy variations across society are compatible with free choice and thoughtful realisation of one's idea of a good life. Social patterns of health distribution do not rule out the possibility that people are generally in control of their lives. For instance, it seems unconvincing to use the popularity of a certain lifestyle or practice within a particular community or a social strata in order to argue that it has not been freely chosen but imposed on the members. Endorsing this strategy would lead to the absurd conclusion that one exercises proper choice only when one opts for things that most people of a similar background would not consider choiceworthy. Hence, epidemiological findings that correlate disadvantage with specific unhealthy choices do not suffice to write these off as unfree. Such a use is inopportune and motivated by the invalid assumption that health is an overarching value.

More importantly, it eclipses a promising way of articulating the underlying concerns about socially imposed burdens on individual health. In fact, these concerns are defensible insofar as they commit to the value of individual choice and follow a plausible understanding of the harm principle. For instance, distrust about the importance of individual choice makes it difficult to argue that some state interventions are preferable to the *status quo*. If the effects of both on the opportunity to live according to one's choice and judgement are neglected, neither can be preferred without prejudice to some of the affected parties. The objective of improving public health cannot substitute for the missing impartial justification since its open-endedness reflects the underdetermination of health as a value.

In contrast, epidemiological evidence can be helpfully integrated in a valid argument for governmental initiatives provided that it identifies genuinely harmful social arrangements. The defining feature of such arrangements is that they affect non-consenting parties and pre-empt their prospects of retaining or gaining control over relevant aspects of their lives, one of which is caring for one's health. This plausible notion of harm avoids a common misconception, according to which harming somebody necessarily involves making them worse off than they have been beforehand. However, one can also harm another by denying them what is due to them or preventing them from improving their own condition (Raz, 1987: 327–329). Public health interventions justified on this ground are neither intrusive, nor undermining apparently unwise individual choices. Their rationale is not curtailing such choices, but broadening the range of available options. For instance, instead of tackling binge drinking by raising alcohol prices and limiting sales hours as suggested by the Nuffield Council (2007), a policy proposal based on the previous considerations would focus on providing sensible recreational alternatives such as subsidised cultural events, expanding public libraries and affordable access to sport facilities. This understanding of the harm principle is consistent with its standard, narrow interpretation outlined in the opening section. It upholds the distinctly liberal commitments to freedom as non-interference and the protection of individuals from powerful institutions.

Toleration, Justified Interference and 'Friendly Coercion'

The preceding sections showed that neither the special character of health as a value nor its social dimension actually undermines the liberal approach to public health. Furthermore, they clarified that attempts to extend this approach beyond its standard constraints, e.g., respect for basic liberties and individual choice cannot be considered as sociologically informed versions of liberalism. Instead, these proposals imply an alternative, republican view. As previously outlined, republicanism takes state interventions in its citizens' lives to be respectful of their freedom as long as such interventions aim to remedy people's failures to implement their avowable interests. This is a necessary background assumption in order to argue, as observed in the previous section, that the state should correct individual choices or social arrangements whenever they disregard the value of health. This conclusion cannot be reached by merely assuming that these choices and arrangements are deeply problematic because health is an overarching value. An additional supposition is needed to defend this kind of state intervention as congenial to individual freedom instead of exposing it as unduly intrusive. This further step is inconsistent with the liberal conception of freedom as non-interference, but continuous with its republican rival, freedom as non-domination. Therefore, the remainder of the paper will focus on the challenges to liberalism, which seem most applicable to public health and show why a distinctly liberal rather than a republican framework is better suited to this field. As shown in the opening section, these challenges primarily focus on liberalism's alleged hostility to irreducibly social goods and its conception of freedom as non-interference. The latter is deemed shallow and unable to deal with cases where individual freedom is most in need of defence, such as systematic oppression.

The widespread presumption that liberalism cannot cater for irreducibly social goods is closely related to the idea that the harm principle requires the suspension of evaluative judgements, the objects of which are actions or attitudes with no detrimental impact on third parties. Their further appraisal is considered irrelevant because they have been excluded as prospective grounds for interference. Hence, the neutrality of liberal states is assimilated to an evaluative void inherent to liberal societies. However, this association is mistaken. Liberal neutrality at the political level is sustained by toleration at the societal level. The latter is a keystone of liberalism as a political morality. It is best understood as an irreducibly social good since its value transcends the comfort of avoiding censorship and meddling enjoyed by individuals. Furthermore, it cannot be achieved unless toleration is largely regarded as an important value within society (Scanlon, 1996). In fact, the practice of toleration is both intellectually and psychologically demanding. It requires that the objects of toleration are properly identified and do not get distorted in the process of making them

tolerable to a majority (Green, 2008). Lack of opinion, indifference and *laissez-faire* preclude the possibility for toleration, which implies an initial strong disapproval. The principled decision to refrain from acting upon this negative judgement whilst still upholding it defines toleration (McKinnon, 2006: 31). However, such a decision would be unintelligible unless toleration is a valued disposition. Its significance relates to a key motivation for the harm principle, according to which the enforcement of morality can be morally problematic (Hart, 1963: 17). In order to circumvent this eventuality, interference has to be further justified with reference to harm to others or possibly self-harm when the agent's competence is severely undermined. Furthermore, the instances of justified interference are treated as constraints on individual freedom instead of ways of promoting it as implied by the republican concept of 'friendly coercion'. This liberal approach is far from superficial. It rests on a compelling theory of agency that aptly avoids the pitfalls of the alternative view of freedom as non-domination. For instance, the rationale for 'friendly coercion' builds on the intuition that agents may have some good reasons for action, of which they are fully or partially unaware. As a result, agents may not appreciate some of their important, avowable interests. Sometimes, an observer may have a better grasp of these than the agents themselves. This intuition is both uncontroversial and equally compatible with either internalism or externalism about reasons for action. It does not depend on settling the issue of whether prospective reasons should to be traceable to one's actual motivations or not (Williams, 1981, 1995; Johnson, 1999).

However, 'friendly coercion' requires an additional step, according to which an action that promotes somebody's avowable interests by constraining their choice does not in fact diminish their freedom. This step is unconvincing. It enjoys some plausibility on specific occasions such as the original example of 'friendly coercion', in which Ulysses' companions follow his preceding orders, keep him bound to the ship's mast and save him from the spell of the Sirens (Pettit, 2001: 75–77). However, this cannot be used as a model for upholding individual freedoms by the public authorities. For the way of realising one's avowable interests is critical. Failing to act on one's better reasons may indicate suboptimal agency. Yet, if these reasons were implemented by somebody else, this would neither make up for one's inadequate agency, nor suggest a viable route for improvement. 'Friendly coercion' robs one's initiative as an agent and undermines one's authority over one's life. It eventually fosters dependence rather than counterbalance the subtle effects of arbitrary power that the harm principle presumably cannot pick up. Thus, instead of coping with covert forms of oppression, the underlying conception of freedom as non-domination inadvertently provides a channel for these. For instance, it is consistent with an authoritarian approach to citizens' welfare such as improving public health by curtailing public freedoms and making people's lives more secure and predictable. No republican safeguards seem capable of averting this danger as long as the state retains the ultimate task of tracking people's avowable interests (cf. Pettit, 2001: 152–174). Its pervasiveness threatens to absorb and dilute individual agency. This feature categorically sets political trusteeship apart from well-defined instances of entrusting projects and delegating responsibilities to others (Hardin, 1999). The latter strengthen individual agency insofar as they enable the achievement of a wider range of goals and facilitate the development of valuable social skills (Hardin, 1991; Pettit, 1995). Yet, this conclusion cannot be extrapolated towards the former, political case because its open-endedness potentially undermines individual agency. Following this line of thought, it is unclear as to how the state's actively tracking citizens' avowable interests can be prevented from forcefully redefining what is avowable by them.

In contrast, interference based on the harm principle is free from self-defeating consequences. It focuses on sustaining the conditions for autonomous agency rather than trying to make people autonomous. Only in extreme circumstances is one's authority in implementing one's interests questioned. The shared commitment to the value of toleration helps keep at bay temptations to pressure dissident fellow citizens into more conventional lifestyles. This is of special relevance to public health ethics given the paradoxical way in which modern societies express their 'impatience with moral authority', namely by embracing technical expertise in general and medical competence in particular (Elliott, 2003: xxi). Following this trend, intolerant attitudes towards unpopular practices and choices are likely to be articulated as professional concerns about negative health outcomes. In this context, it seems paramount that public health ethics rests on firm liberal grounds and avoids the danger of dissociating health protection from the ability to lead a meaningful and rewarding life of one's choosing.

Conclusion

Concerns about public health are often considered at odds with a liberal outlook on social and political life. The harm principle is criticised for providing an insufficient defence of the vulnerable and prompting unjustified distrust towards public goals. This trend is expressed by

a set of proposals that aim to revise liberalism in light of both public health's rationale and recent epidemiological findings. I argued that these proposals are misconceived in several ways.

First, I demonstrated that they rely on a normative premise according to which health is an overarching value. This premise was then proven untenable since it fails to appreciate the axiological underpinnings of health as a self-effacing value, the choiceworthiness and successful realisation of which partly derive from a commitment to further values.

Second, I clarified that epidemiological evidence such as the social gradient of health or specific covariations between one's status and attitude towards health cannot justify attempts to expand the original liberal framework. These attempts depend on the preceding, flawed normative premise. They fail to provide a sociologically informed extension of liberalism.

Third, I related these proposals to their unobvious theoretical background, which is republican, and showed the advantages of liberalism in the context of public health. In particular, I argued that its conception of freedom as non-interference and a narrow understanding of the harm principle can integrate epidemiological evidence into a sound argument for sufficient state interventions. Their primary focus would be the adverse conditions and limitations prompting unhealthy choices rather than the unhealthy choices themselves. This liberal approach helps avoid the perverse effects of policies that protect the vulnerable by disregarding their choices and substantiates a principled commitment to the value of toleration in public health ethics.

Note

1. See Aristotle, Nicomachean Ethics I, 7, which introduces the notion of goods, which are choiceworthy both in themselves and for the sake of further, superior goods.

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