**Liberalism and Public Health Ethics**

Public health officials do not have generally accepted ethical principles for their profession, and the academic literature is equally unsettled.[[1]](#footnote-1) In light of that, we might try to resolve public health dilemmas using the liberal principles of government that have garnered wide support in other areas of political philosophy.[[2]](#footnote-2) Such principles wouldn’t resolve all the ethical issues in public health, but they could provide help on many.

However, many public health experts claim that liberalism shouldn’t be applied to public health, and they endorse distinct principles instead.[[3]](#footnote-3) This paper surveys their anti-liberal arguments and shows that those arguments don’t provide good reasons for rejecting liberalism in public health. Instead, liberalism remains our best guide to the ethics of public health.

**1 Liberalism**

Liberalism is the view that liberty is a prime value and the state needs strong justification for infringing upon it.[[4]](#footnote-4) So described, liberalism is a large tradition encompassing many classic figures—including Locke, Rousseau, and Mill—and developed by equally diverse modern figures—including Nozick, Rawls, and Dworkin.

My subsequent arguments won’t defend all types of liberalism but will focus instead on a subset of liberalisms that take a common form.[[5]](#footnote-5) First, these varieties of liberalism—henceforth just “liberalism”—allow the state to interfere with some individual actions in order to stop one person from wrongfully harming another. I will understand “wrongful harm” so that, in addition to standard types of harm, one person wrongfully harms another when they fail to fulfill a positive dutyto help the other person improve their situation. These positive duties may include duties of social justice.[[6]](#footnote-6)

Second, liberalism allows the state to sometimes engage in soft paternalism: it may stop individuals from harming themselves when their choices are substantially non-voluntary—e.g., if the choosers are not fully competent (e.g., children), if they are affected by coercion or duress, by subtle manipulation (e.g., post-hypnotic suggestion), if the choosers are significantly uninformed, or if they are affected by emotions or other factors that distort reasoning. All choices are non-voluntary to some degree, and choices only need to be sufficientlyvoluntary to be immune from government interference. Furthermore, one of the most important implications of liberalism is that, while it countenances soft paternalism, it rules out hard paternalism that is intended to prevent people from harming themselves even when they have made a sufficiently voluntary choice.[[7]](#footnote-7)

Liberalism sanctions state interference in some cases, but only if the interference is *appropriate*. This catch-all condition rules out many things. For instance, the appropriateness clause rules out state intervention that carries too great a cost to other values. It also restricts the state to the least intrusive intervention among the feasible options.[[8]](#footnote-8)

The previous principles don’t fully define a specific liberal theory.[[9]](#footnote-9) For instance, a liberal theory could allow other forms of state interference—e.g., to prevent some forms of offense or mental harm. But for my purposes, we don’t need to define liberalism more fully, since my project below will be to show that with only these features of liberalism in hand, we can counter many of the critiques of liberalism in public health.

**2 Methodology**

How can we determine whether liberal principles are right for public health ethics? Like many philosophers, I believe our best method is reflective equilibrium. Roughly speaking, when we use reflective equilibrium, we pull together our considered judgments about specific ethical issues, our considered judgments about abstract principles of justice, and any other information relevant to theory formation. We seek the theory that best reconciles and explains our considered judgments. No theory will perfectly reconcile all of our initial considered judgments, so we will have to abandon some of them, but we should accept the theory that does the best job overall.

A few particulars will be helpful in what follows. First, properly used, our method should be “wide” as opposed to “narrow” reflective equilibrium. A wide equilibrium relies only on *considered* judgments about cases—judgments that, as Rawls said, we have a high degree of confidence, and which are made “in circumstances where the more common excuses and explanations for making a mistake do not obtain.”[[10]](#footnote-10) A wide equilibrium process also considers alterative theoretical outlooks and the arguments for them,[[11]](#footnote-11) always allowing that our considered judgments may need revision.

Second, if our reflective equilibrium arguments are aimed at other people, then those arguments must begin with the *audience’s* considered judgments and then show that the audience members should arrive at liberal principles (or not) in reflective equilibrium. Some authors suggest that all reasonable audience members will arrive at the same political principles in reflective equilibrium.[[12]](#footnote-12) I don’t assume so; all we can do is to rely on the most widely-shared considered judgments we can find. Relatedly, when my arguments appeal to some pro-liberal considered judgments, I don’t assume that people share those judgments for the same reasons. Instead people operate from different comprehensive moral views, and those comprehensive views may incline people to liberalism for what are ultimately different reasons. Some may even embrace liberalism *because of* moral disagreement, believing it to be the most defensible political approach in a world of practically or even theoretically unresolvable moral conflict.[[13]](#footnote-13)

With these remarks on method behind us, let us turn to some anti-liberal arguments in the ethics literature.

**3 Inconsistency with (Purportedly) Acceptable Public Health Practice**

One argument against liberalism in public health is that liberalism allegedly rules out public health interventions that some people regard as appropriate policy.[[14]](#footnote-14) For instance, Jennings says that “We should ask whether [Millian] liberalism…would not place restrictions on the practice of public health so stringent that it would preclude…most of the positive, health promoting, well-being enhancing aspects of the field.”[[15]](#footnote-15) Specifically, in the literature on public health ethics, it has been claimed that liberalism might rule out all of the following:[[16]](#footnote-16) (1) quarantining individuals who pose public health risks,[[17]](#footnote-17) (2) various anti-smoking measures, including increased tobacco taxes, advertising bans and regulations, smoking bans and restrictions, public health campaigns, and publicly funded stop-smoking helplines and other resources, (3) government intrusion into markets for healthful food, safe housing, and so on, and (4) laws requiring people to wear motorcycle helmets and seatbelts.

Such arguments can seem weak if viewed through the lens of reflective equilibrium. In particular, it might *seem* that the objectors are simply alleging that liberal principles require us to revise some considered judgments about public health actions. And yet we know that every political theory will require some revision of our considered judgments, so one can imagine liberals saying that merely citing some considered judgments which are (allegedly) inconsistent with liberalism doesn’t carry much argumentative weight.

But that reply is too quick. Our considered judgments about some issues seem so firm to some of us that, even before we complete the reflective equilibrium process, we can reasonably expect that the right theory must comport with those judgments. To see why, consider an example from outside of public health, Peter Singer’s famous argument for poverty relief in “Famine, Affluence, and Morality.” Singer asks whether we feel we should save a drowning child at the cost of our $100 shoes. Our considered judgment is that we should, and Singer argues that we should therefore give more to global charities. Singer’s argument may work or not, but one can’t reasonably respond to it by claiming that if we undertook a complete reflective equilibrium process, we *might* arrive at a theory that does not require that we save the baby, and thus that our considered judgment about the baby should be viewed with suspicion. Our considered judgment is so firmly held that, in the absence of proof to the contrary, we can reasonably expect that, after a reflective equilibrium process, the right theory will comport with it.

To be clear: I’m not suggesting that anti-liberals should claim that our considered judgments about, say, anti-smoking legislation seem as indubitable as our considered judgment that we shouldn’t let the baby drown. That is implausible. Still, they might reasonably contend that some of the cases cited above (seatbelt legislation, fluoridation, etc) are core cases in public health, and that, absent proof to the contrary, we should reject any ethics of public health that clashes with our considered judgments about a great many of those cases. Seen through that lens of reflective equilibrium, the appeals to cases look stronger than they otherwise would.

So is there another way for liberals to respond to the anti-liberal arguments? Those arguments rely on the idea that the audience will share the considered judgment that the interventions in question are moral and in prima facie conflict with liberalism. Thus liberals could respond by disputing whether the considered judgments are truly widely shared and/or believed to conflict with liberalism. While this liberal response may be sound, I know of no way to verify it, since I know of no data on the beliefs of academics and public health practitioners on these subjects. Thus I leave this argumentative tactic aside.

As a result, the main way for liberals to respond to this anti-liberal argument is by showing that liberalism does not exclude the interventions in question, and thus that liberalism is not in tension with our considered judgments at all. Let us explore this line of reasoning in more detail.

**3.1 Harm to Others**

Liberalism permits some state intervention in order to prevent one person from harming another, and that can justify some of the interventions above. For instance, some regulations on smoking prevent wrongful harm to third parties through second-hand smoke,[[18]](#footnote-18) and some quarantine measures also prevent wrongful harm to third parties.

Bayer and Fairchild are skeptical about this liberal line of argument. They recognize that liberalism comports with some forms of quarantine: “For government to impose restrictions on those who represent a risk to others falls clearly within the broadly accepted exercise of state power in liberal societies….”[[19]](#footnote-19) But they see tension between liberalism and certain quarantines policies when “the risk to others is uncertain.”[[20]](#footnote-20) They say that “It is here that an important divide emerges between the judgments of those committed to autonomy and those whose first priority is to public health.”[[21]](#footnote-21) In a similar vein, Jennings writes that “…public health measures must go beyond infected individuals and interfere with the lives of those not yet infected—limiting their movements, quarantining and destroying their property—and restricting their freedom and interests in many other ways. Such measures are not plausibly justified by appeal to the harm principle put in the future conditional tense.”[[22]](#footnote-22)

However, as Bayer and Fairchild note, liberalism countenances state intervention, not only to prevent harm, but to prevent the *risk* of harm. Given this, there is no particular reason why liberalism should disallow interventions aimed at *uncertain* risks. In fact for hundreds of years liberal governments have issued regulations on the basis of “best guesses” about risks; nothing else is possible, since specific probabilities arise only in philosophers’ hypotheticals.

Now of course nothing in the definition of liberalism tells us whether a risk of a certain type, and of a (perhaps uncertain) likelihood constitutes a “wrongful harm to others,” and this is a well-known and difficult issue within liberal political theory. Moreover, though some discussions of liberalism leave this issue hanging, as a problem to be dealt with downstream, that move risks rendering our theory so abstract as to be useless in the actual practice of public health. So how can we more precisely define “wrongful harm”?

I have discussed this issue elsewhere,[[23]](#footnote-23) and given space limitations, I will only briefly say a few things about it here. When defining “wrongful harm,” one might adopt the view that harm is not wrongful if allowing harms of that sort is most beneficial overall, when compared with other possible policies, taking into account not just obvious negative and positive effects but also effects on autonomy and individual choice. Such a proposal might explain, for instance, why we sanction automobile driving even though cars emit harmful exhaust—we do so because we get the best world overall by allowing driving rather than by banning it. I reject that approach and favor another that can be extracted from Arthur Ripstein’s *Equality, Responsibility and the Law*. Each person has interests in liberty and security—interests in being able to do what one wants and being free from the actions of others. Instead of aggregating costs and benefits *across* populations, one should ask how a hypothetical “reasonable person” might balance the interests in liberty and security.

This proposal is incomplete because no one has offered a concrete proposal for determining how hypothetical reasonable individuals would balance their liberty and security interests. But even without an algorithm or quasi-systematic method, most people can agree that some balancings are manifestly unreasonable. For instance, no reasonable person would embrace a limitless or near-limitless liberty interest which allows citizens to assault each other. And surely no reasonable person would embrace a near-limitless security interest that prevented others from manufacturing any unhealthful food that might possibly tempt us.

Likewise, I would propose (but cannot argue here) that a reasonable person would not prefer the liberty to engage in activities that are the equivalents, in harms and benefits, of smoking in confined spaces with others nearby, or violation of quarantine, knowing that he or she might be infringed upon by others doing the same. And if that is right, then liberalism has the resources to explain why these behaviors constitute wrongful harms to others.

**3.2 Social Justice**

Public health experts often point out other problematic cases for liberalism. For instance, in some areas, nutritional foods are prohibitively expensive for low-income earners and inconvenient to buy.[[24]](#footnote-24) Such markets are unjust, they say, so the government can interfere in those markets. More generally, some anti-liberals may share Jennings’s view that liberalism protects free choice within one’s current society and ignores the fact that state action can make possible “…an entire form of life with other possible ways of living.”[[25]](#footnote-25)

However, state interference in, say, food markets is not incompatible with most forms of liberalism. Liberals countenance enforceable positive duties to promote conditions of social justice. And while liberals understand those conditions differently, many liberalisms countenance strong positive duties. For instance, Rawls would countenance alternations to the basic structure of society that maximize the index position of the least advantaged, within the boundaries of equal basic liberty and fair equality of opportunity.

Of course, the mere fact that liberals believe in duties of social justice doesn’t show us that their theories will sanction specific measures to promote, say, just food markets. I couldn’t make that case without putting forward a detailed liberal theory, so here I will simply note several things. First, contra some communitarian critics,[[26]](#footnote-26) liberalism countenances state intervention into the background conditions of our lives and doesn’t merely protect our freedom to make choices within our current environment. (The most obvious and discussed example is intervention to ensure fair equality of opportunity.) Second, liberal social justice measures are usually aimed at guaranteeing access to certain life prospects and wellbeing. Third, because health affects life prospects and wellbeing, many liberals have argued it is a proper subject for state oversight. Overall, then, we have good reason to suspect that at least some reasonable, defensible liberalisms will support public health measures such as ensuring just food markets.

**3.3 Soft paternalism**

Liberalism countenances soft paternalism, where the state interferes with substantially non-voluntary choices that lead individuals to harm themselves.[[27]](#footnote-27) All choices are non-voluntary to some degree, and a realistic ethics of public health couldn’t plausibly contend that choices must be fully voluntary in order to be immune from state interference. Instead, following Feinberg and others,[[28]](#footnote-28) liberalism contends that choices are immune from government interference so long as they are sufficientlyvoluntary. The line for “sufficiently voluntary” is not fixed. Choices require more voluntariness if the risks are large, probable, or irrevocable, and they require less voluntariness when the opposite things are true.[[29]](#footnote-29) The voluntariness of a choice is diminished if the choosers are uninformed or if they cannot reason well from their information—e.g., if the choosers aren’t fully competent (e.g., children), experience coercion or duress, manipulation (e.g., post-hypnotic suggestion), or are affected by emotions, cognitive biases, or other factors that distort reasoning.

Many public health interventions that are allegedly problematic can in fact be countenanced by liberalism on soft paternalist grounds.[[30]](#footnote-30) Seatbelt and helmet laws may be two examples, though I will focus on one case in particular: legislation aimed at reducing smoking. Liberals need not contend that smokers have no rational will or that their choices are completely non-voluntary. In fact, that would be a *reductio* of the liberal position, since many smokers quit, often without the help of others,[[31]](#footnote-31) and their choices show other clear signs of voluntariness—e.g., by being price-sensitive.[[32]](#footnote-32) (Importantly, many accounts of voluntariness, discussed below, aim to explain how smokers can be responsible for their actions even though their actions are substantially non-voluntary.) The only question is whether their choices are *sufficiently* voluntary, given the implications of the choice.[[33]](#footnote-33)

To judge that, we must start by asking how voluntary smokers’ choices must be in order to be sufficiently voluntary. There is no formula for setting that standard, so liberal theory may seem too abstract to be useful in real-world public health decisions. However, we must be cautious with this criticism. I don’t think philosophy can provide an algorithm or decision procedure for such decisions, in public health or elsewhere. The best we can do is to provide broad but useful guidelines for making ethical decisions, and some of those were given earlier.[[34]](#footnote-34) The more serious the potential negative impact of a choice, the more voluntariness is required. So too when the negative impact is more likely. Finally, if the negative impact is irrevocable, this also raises the bar for voluntariness.

A complete liberal theory might spell out more rules of thumb, but with just these three, we can see there will be a high bar for sufficient voluntariness in the case of smoking. Smoking increases the chance of many diseases and conditions: stroke, blindness, cataracts, periodontitis, aortic aneurysm, coronary heart disease, pneumonia, vascular disease, COPD, asthma, diabetes, reduced fertility (in women), ectopic pregnancy, erectile dysfunction, rheumatoid arthritis, immune function, and cancers of the larynx, esophagus, lung, stomach, liver, pancreas, kidney, cervix, bladder, and rectum.[[35]](#footnote-35) These are serious and often irrevocable risks, with some being seriously debilitating and often leading to death. The risks of these negative outcomes are also substantial.[[36]](#footnote-36) Thus we see that the bar for voluntariness would be about as high as it is for any typical, real-world choice.

The next issue, then, is how voluntary smokers’ choices typically are. To determine that with precision, we would need a more complete account of voluntariness than I provided above, and in fact there is a substantial philosophical debate concerning voluntariness and allied notions such as freedom, autonomy, and so on. But the unsettled nature of this literature does not prevent us from drawing concrete conclusions about smokers, for two reasons.[[37]](#footnote-37)

One is that the philosophical debate often revolves around the question of whether a particular account of voluntariness (autonomy, freedom, etc.) explains why *all* smokers have impaired voluntariness. But even if smoking does not always impair voluntariness in one particular way, it may often do so. For instance, in a much discussed article, Goodin argues that smokers typically fall victim to wishful thinking (and therefore underestimate the negative impact of smoking), anchoring (thus assuming that since smoking hasn’t harmed them yet, it won’t), and time-discounting (where they inappropriately discount future pain and over-weight present pleasure).[[38]](#footnote-38) In contrast, in another much discussed article, Levy argues that factors like these may not always explain why smokers suffer impairments to autonomy, and offers another explanation in its place.[[39]](#footnote-39) But the fact that smokers do not always suffer from Goodin’s list of irrationalities still leaves open the possibility that they sometimes do. And since those factors impair voluntariness on standard liberal accounts, this is at least a partial explanation of why many smokers’ choices are less than fully voluntary.

Moreover, there is a second reason why the disagreement about the proper account of voluntariness need not stand in the way of progress on a concrete issue such as smoking—namely, there is widespread agreement that smoking does impair voluntariness (or some allied notion such as autonomy), and the only real question is *exactly* how it does.[[40]](#footnote-40) One can easily see why that agreement exists. Perhaps the most striking evidence that smokers’ choices are in some way not fully voluntary is their own phenomenological reports, including the fact that between 75-80% of smokers say they want to quit but can’t, indicating that addiction impairs their ability to pursue their all-things-considered goals.[[41]](#footnote-41) The phenomenological reports of smokers are confirmed by empirical science on nicotine and addiction, with the characteristics of addiction (self-damage, damage to others) suggesting impaired voluntariness.[[42]](#footnote-42) Moreover, in addition to impairments in judgment and execution, many smokers may suffer from pure factual ignorance, another factor that impairs voluntariness. For example, though smokers are often aware of the chance of certain diseases like lung cancer and emphysema, they often seem to under-estimate how bad it will be to endure those diseases. On a personal note, I can add that, having shepherded a person with chronic obstructive pulmonary disease (COPD) through the end of their life, and having discussed smoking and public health with numerous people, including smokers (and even public health experts who are smokers), it seems clear to me that almost no smokers have even a rudimentary understanding of how bad their last years might be with COPD, the impact of those years on their family, and so on. The ignorance is substantial.

In sum, then, smoking has serious, probable, and irrevocable negative effects, so the bar for “sufficient voluntariness” will be about as high as it could be for a real-world choice. And though philosophers still disagree about how exactly to characterize voluntariness (autonomy, freedom, etc.), there is no real disagreement that smokers’ choices are typically non-voluntary in significant ways.

None of this is a *definitive* argument,[[43]](#footnote-43) since we still lack any algorithm or formula which tells us precisely how voluntary smokers’ choices are and precisely where the bar for sufficient voluntariness lies. In light of that, later I’ll consider how liberals might defend their theory even if they were unable to make a soft paternalist case for seatbelt, helmet, or anti-smoking legislation. First, though, let’s consider one important objection to the present line of argument that arises out of the recent literature about “nudges,” [[44]](#footnote-44) a debate instigated largely by the work of Thaler and Sunstein*.*[[45]](#footnote-45)

**3.4 A Challenge from the Nudge Debate**

Thaler and Sunstein cite social-science research showing that choices are often less rational than we assume and that we are instead regularly influenced by a variety of cognitive biases. These biases include, for example, framing biases (where choices are affected by the way options are presented) and status quo bias (where choices are influenced by which option is presented as the default).[[46]](#footnote-46) The social-science research leads Thaler and Sunstein to conclude that individuals sometimes fail to make choices that are best by their own lights, decisions that “they would change if they had complete information, unlimited cognitive abilities, and no lack of self-control.”[[47]](#footnote-47)

Many other authors have discussed the positive normative position that Thaler and Sunstein develop out of these observations,[[48]](#footnote-48) a position which they call “libertarian paternalism,” but Thaler and Sunstein’s work also raises several distinct challenges to the presuppositions behind liberalism.[[49]](#footnote-49) Because of space constraints, I will simply focus on the one I find most interesting and compelling: Some might think the social science literature shows that very few choices are rational and “substantially voluntary” in the liberal sense. It is a liberal illusion, they might say, to think that non-interference yields the purported benefit of free, autonomous, individual choice. And since few choices are substantially voluntary, the liberal hard/soft distinction can do no work, and liberalism will countenance interference in all or almost all choices. Perhaps as one author wrote, “Human beings are simply without the sort of decision-making autonomy that advocates of paternalism are accused of violating.”[[50]](#footnote-50)

The right liberal response involves a mix of theoretical, practical, and empirical considerations.[[51]](#footnote-51) Paternalist action aims to further individuals’ good by interfering with their actions. Liberals can maintain that individuals’ goods are, either theoretically or at least practically, defined by what they choose or would choose in a fully voluntary way. (I defend that view below; for now I take it as an assumption.) Thus suppose an individual chooses *in a fully voluntary way*—that is, in full knowledge, and without impairments to her reasoning—to eat a less than ideally healthy diet, perhaps because she believes her enjoyment of the foods outweighs the harm to her health. If so, then eating that diet is, practically or theoretically, the best thing for her, and liberals oppose paternalistic intervention because it would make the individual worse off. Importantly, we see that this liberal rationale for protecting fully voluntary choice is not that liberals care about protecting voluntary choice *per se*, or about preventing non-voluntary choice *per se*, but rather that their ultimate goal is, as Feinberg writes, “to prevent people from suffering harm that they have not truly chosen to suffer.”[[52]](#footnote-52)

Since liberals need not care about preventing nonvoluntary choices *per se*, but only those that impact wellbeing, liberals need not care that cognitive biases render almost all choices less than fully voluntary. For instance, if I buy one brand of aspirin instead of another because of its placement on the shelves, with no real effect on my wellbeing, liberals need not seek to intervene.

Now of course some choices do impact agents’ wellbeing. If we suppose that cognitive biases render all or almost all such choices less than fully voluntary, then anti-liberals might claim that liberalism must endorse state intervention into those choices. But here liberals can appeal to one of their other basic principles. Liberalism only countenances state intervention that is “appropriate,” where this includes the sensible requirement that the intervention not impose a greater cost on other values. And of course having the state constantly monitor all of the little ways in which we imperfectly pursue our wellbeing—and then attempt to correct our errors—would require a hugely imposing state apparatus that would be obviously undesirable.

**3.5 Summary of Section 3**

In sum, some claim that liberalism is inconsistent with certain acceptable public health measures. Presented as mere counter-example production, this argument isn’t terribly impressive, because the right method is reflective equilibrium, and that method will undoubtedly lead to a theory which requires revision of some considered judgments. However, we’ve reconstructed the anti-liberal arguments in as charitable a way as possible, as claims that our considered judgments about at least some examples are so firm that we can reasonably expect any correct theory to accommodate them at the end of a proper reflective equilibrium process. In reply, I’ve argued that liberalism can accommodate most if not all of those considered judgments rather than requiring that we abandon them. The only problem cases would concern hard paternalism, to which I now turn.

**4 Hard Paternalism and State Knowledge of Health**

The previous section focused on considered judgments about specific public health programs that are allegedly incompatible with liberalism. I argued that some can be justified on soft-paternalist grounds, but what about those that seemingly cannot be? For instance, while discussing helmet laws, Jones and Bayer write that “The challenge for public health is to…forthrightly argue in the legislative arena that adults and adolescents need to be protected from their poor judgments about motorcycle helmet use.”[[53]](#footnote-53) They point out that without helmet laws, motorcycle riders often choose not to wear helmets, and then they ask “Need anything more be said to show that motorcyclists have not been able to make sound safety decisions on their own and that mandatory helmet laws are needed to ensure their own safety?”[[54]](#footnote-54)

There is an ambiguity in this notion of “sound decisions.” Some of us agree that helmetless riders don’t make sound decisions, and what we mean is that (we suspect that) helmetless riders don’t understand the enormity of the risks, the devastation an accident would bring, the triviality of wearing a helmet, and so on. But if that is the ground for intervention, then helmet laws are soft paternalist and do not present a problem for liberalism.

However, let’s consider what to do about the rider who is fully informed but rides without a helmet anyway. Anti-liberals might be alleging that even in such cases, we have a firm considered judgment that the state may regulate the behavior. Absent specific reasons to abandon those considered judgments, we should reject any theory that doesn’t comport with them.

I am unsure how many people have firm considered judgments in favor of hardpaternalism, but for the sake of argument, I’ll grant that some do. Moreover, I’ll grant that we must reject liberalism in public health unless we can give some theoretical reason to abandon the considered judgments. What reasons could liberals give? I see two options.

The first would be to claim that there are strong arguments for liberalism as a general approach to political philosophy. I set aside this argumentative strategy earlier by assuming, tacitly, that public health *might* be governed by its own distinctive principles. Furthermore, this appeal to general principles won’t work if the critics of liberalism in public health can explain why hard paternalism is acceptable in some public health cases even though it seems unacceptable at other times. Arguments to that effect are at best latent in the writings on public health, but some are promising, and here is my best reconstruction.

Consider first paternalism outside of public health. Paternalism aims to increase individuals’ welfare by overriding their choices. When the state knows that some factor is distorting individuals’ pursuit of their own welfare (coercion, manipulation, etc.), then sometimes the state will be able to generally, though not indubitably, promote the individual’s good through soft paternalism. But a common argument against hard paternalism is that, when those distorting factors are absent, then even though the individual may still not be making optimal choices, the state lacks the knowledge it needs to promote the individuals’ well-being better than the individuals themselves.

Public health experts might admit that this reasoning is sound when considering such matters as whether to prohibit private sexual conduct or whether to force people to spend their time reading educational books. But they could claim that things are different with health. Everyone agrees that health is a fundamental good. The state therefore knows that individuals should seek it out and place a high value on it. This is why hard paternalism can be effective when directed at matters of health. Individuals who severely impair their health can be known, on general grounds, to be failing to promote their own good.

There are several reasons to think that this argument lies behind the hard paternalism of some public health experts. It explains why they countenance hard paternalism in public health but not anywhere else.[[55]](#footnote-55) It also comports with the public health attitude toward health itself. Public-health experts and others in the medical profession often assume that all people should place a high value on health.[[56]](#footnote-56) (In a notorious and oft-cited passage, the constitution of the World Health Organization assimilates health and well-being, thus making it easy to see health as a master, overarching value.[[57]](#footnote-57)) Given this attitude, it is easy to see how public health experts would be led to the paternalistic argument above. Finally, the interpretation fits with the stated arguments of public health experts. Consider Jones and Bayer’s remark that public health officials know, on the basis of mortality statistics, that motorcyclists who ride without helmets are displaying “poor judgment.” The point is *not* that motorcyclists’ decisions are the result of coercion, manipulation, and so on. Rather, the point seems to be that health is a fundamental good, the state knows this, and it can therefore know that helmetless riders are making unwise decisions about their health and overall wellbeing.

Given the plausibility of this health-focused argument for hard paternalism, let’s examine another liberal argument for abandoning any considered judgments in favor of hard paternalism in public health. Paternalism aims to override individual choices and better promote welfare. Health is definitely a fundamental part of human well-being, and people should perhaps always place a high value on it. Still, absent evidence of factors that distort judgment and render decisions substantially involuntary, the state has no ground for thinking that it generally makes people worse off to trade health for the other things in question. Consider concrete examples. People regularly trade health for other things—when they choose to be professional athletes, when they decide to work in sedentary jobs offering no exercise, and even when they elect to work in hospitals, which increases the risk of disease. Most readers of this paper accept a high risk of colon cancer in exchange for the pleasure of eating red meat.[[58]](#footnote-58) I presume that public health officials would agree that trading away health in these ways can and often does make people better off.

But if so, then on what basis could the state presume that it generally makes people worse off to trade health for such things as a helmetless trek through the windy countryside—especially if we continue to assume that these people are adequately informed? (Remember that that is a key assumption; if they were uninformed or subject to other factors that rendered their decision involuntary, then this would be a case of soft paternalism and wouldn’t present a problem for liberalism.) There is no reason for that presumption, because the evidence in both cases is perfectly parallel. We presume it can and often does make people better off to trade health for red meat because rational people actually do this. But likewise, we are assuming that rational people are willing to trade a risk of death for the pleasure of riding without a helmet.

So hard paternalists would still need some way to show that it generally improves well-being to trade health for jobs, red meat, etc., but not for such things as riding helmetless. For theoretical reasons, though, I don’t think they could, in large part because, like many others, I accept a corrected-preference theory of the good. This theory says that a person’s good is defined by the ends the individual would choose if he or she was rational, well-informed, and acquainted with the possible ends. Since the rational person's choices define their well-being, the fact that seemingly rational and informed people choose to trade health for riding helmetless provides very strong evidence that those trades make them better off. The principal alternative theory of the good is an objective-list theory. This theory holds that certain ends must be adopted by rational individuals,[[59]](#footnote-59) perhaps including the end of avoiding health problems. But while this theory may seem to contrast with the corrected-preference theory, in practice they are quite similar. This happens because any objective list account of the human good that diverged too greatly from what rational, well-informed individuals favor would be regarded by most as implausible. In fact, some objective list theorists judge what should be on the “objective list” simply by looking at the choices of rational, well-informed individuals. And since some rational, well-informed individuals favor riding helmetless, this is again strong evidence that the objective list theory does not exclude those choices.

In sum, perhaps some people have considered judgments in favor of hard paternalism about seatbelts and helmets. However, when we engage in a thorough reflective equilibrium process, one that takes into account important facts about the human good, we find that the initial considered judgments can’t withstand scrutiny, and we should not expect a correct theory of public health ethics to comport with them.

**5 The General Good**

I’ve argued that liberalism can accommodate most of our considered judgments about public health policies and that it can offer reasons for thinking that we should abandon any incompatible considered judgments. But since liberalism’s fit with our considered judgments has not been uncontroversial and unproblematic, opponents might think they can win the debate by producing an alternative theory that more smoothly reconciles and explains our considered judgments. For instance, some public health experts argue that public health ethics must incorporate a value that is (allegedly) absent in liberalism, the public good.[[60]](#footnote-60) Gostin writes that:

As members of a society in which we all share a common bond, we…have an obligation to protect and defend the community against threats to its health, safety, and security. Members of society owe a duty -- one to another and to all -- to promote the common good. A new public-health ethic should advance the idea that individuals benefit from being part of a well-regulated society that reduces risks that all members share.[[61]](#footnote-61)

Or consider Dawson and Verweij, who, while discussing smoking regulations, say that:

Even if we want to limit ourselves to harm, why not think that harm results where a flourishing life is less likely, because we make it easy for tobacco companies to peddle a known dangerous substance? Why do we have to individualize our conception of harm? Where we as a society are threatened, why not see solidarity against such a threat as an important consideration?[[62]](#footnote-62)

And finally, consider Widdows and Cordell, who write that:

It is now being recognized across the spectrum of bioethics, and particularly in genetics and population ethics, that to focus on the individual person, and thereby neglect communities and the goods which accrue to them, is to fail to see all the ethically significant features of a range of ethical issues.[[63]](#footnote-63)

These appeals to “community,” “society,” and the “common good” all need disambiguation. On one interpretation, these authors are merely claiming that individuals should support public health measures that benefit society as a whole, even if the individual would prefer not to or does not herself benefit. For instance, Dawson argues that individuals should accept vaccination and thereby produce a state of “herd immunity” in which communicable diseases cannot spread.[[64]](#footnote-64) But this position is not necessarily distinct from liberalism. We have already seen that liberalism can countenance positive duties to support public health and social justice measures. As Wilkinson says in his critique of communitarian public health positions, the mistake here may be thinking that “the alternative to community is individualism, with an insistence on individual liberty, and individualism would rule out the state coercion needed for public health as an infringement on liberty.”[[65]](#footnote-65) Some authors seem to make this mistake explicitly, as when Brownsword writes that “Liberal principles…presuppose that the basic condition for human well-being are in place.”[[66]](#footnote-66)

So if we want to work the “common good” into a rival theory of public health ethics, we must interpret that notion differently, as it is in an often-cited article from Dan Beauchamp.[[67]](#footnote-67) In “Community: The Neglected Tradition of Public Health,” Beauchamp says that:

… public health and safety are not simply the aggregate of each private individual’s interest in health and safety, interests which can be pursued more effectively through collective action. Public health and safety are community or group interests (often referred to as "state interests" in the law), interests that can transcend and take priority over private interests if the legislature so chooses.[[68]](#footnote-68)

Similar remarks occur throughout the article, and although Beauchamp’s remarks are subject to interpretation, one understanding is that Beauchamp is claiming that the aggregate “community health” can be harmed even when no specific individual has been wronged.[[69]](#footnote-69) He then says that the state may act to prevent community harms:

By ignoring the communitarian language of public health, we risk… undermining the sense in which health and safety are a signal commitment of the common life -- a central *practice* by which the body politic defines itself and affirms its values.[[70]](#footnote-70)

This is similar to other communitarian positions. The basic idea is that the state may take action in order to protect important ways of life.[[71]](#footnote-71)

One problem, though, is whether such reasoning will run amok and allow state intervention where none of us wants it. This problem concerns even sympathetic interpreters such as Bonnie Steinbock. She endorses Beauchamp’s position, but worries that it leads to an unacceptable moralism:

…if [we are] willing to acknowledge collective or communal values, such as health, why not acknowledge that there can be collected or communal *moral* values?[[72]](#footnote-72)

And she points out that

A [liberal] might argue that if it is permissible to infringe individual liberty for the sake of social goals, there is no principled reason for insisting that the goals to be achieved must be of a certain kind. If the majority in a society thinks that homosexuality is bad for society, then why shouldn't it pass laws against homosexuality? What justifies coercion for some social goals, but not others?[[73]](#footnote-73)

Steinbock’s answer is that

The common good should not be understood in terms of whatever the majority values or wants. Such a conception would indeed threaten individual liberty through, in Mill’s phrase, "the tyranny of the majority." Rather, I suggest that we think of the common good in terms of what Rawls calls "primary goods": "things which it is supposed a rational man wants whatever else he wants." Health is an example of a primary good. By restricting our conception of the common good to primary goods, we avoid imposing goals and values on individuals that they do not happen to share.[[74]](#footnote-74)

Now we can reconstruct a complete theory. The key political principle is that the state may act to preserve community goods if doing so (a) helps the body politic maintain solidarity, define itself, and affirm its values; and (b) the communal good is a Rawlsian primary good. This principle could lead us to countenance hard paternalism in the following way. We would begin with the assumption that harmful, voluntary, self-regarding behavior can harm the community good. But health is a Rawlsian primary good, and preserving it helps the body politic maintain solidarity, define itself, and affirm its values. As a result, the state may act to prevent some harmful, voluntary, self-regarding behavior.[[75]](#footnote-75)

This and other communitarian theories are impressive. They can explain many of our considered judgments, just as liberalism can, and so we need to see whether any additional reasons can be offered for favoring liberalism. I see two that work in tandem.[[76]](#footnote-76)

First, the core principle of the communitarian theory is that the state may act to preserve community goods if doing so helps the body politic maintain solidarity, define itself, and affirm its values; and the communal good is a Rawlsian primary good. Both Steinbock and Beauchamp think that one point in favor of this theory is that it, but not liberalism, can make sense of standard public health interventions.[[77]](#footnote-77) But previous sections have shown that public health practice doesn’t conflict with liberalism in the way some people assume. So if we were judging which theory best fits our considered judgments in reflective equilibrium, we would at best have a tie. Both liberalism and communitarianism can do so.

Of course wide reflective equilibrium is not merely about fit with considered judgments about cases; it considers theoretical considerations as well. And on that score, communitarianism suffers from a theoretical drawback that liberalism does not, one that (interestingly) Steinbock herself spots. She hopes to avoid the conclusion that communitarianism leads to an unacceptable moralism by restricting the “common good” to Rawlsian primary goods. But even if she is right, communitarianism still countenances too much state interference, because tyranny of the majority could arise even with respect toprimary goods. For instance, prohibiting the eating of red meat would drastically reduce the incidence of colon cancer, and we can imagine a society in which public opinion has turned against the eating of red meat. The communitarian framework now has no basis on which to oppose regulation of the eating of red meat, since the regulation aims to promote a Rawlsian primary good. In contrast, liberal principles, combined with a theory that restricts enforceable positive duties in an appropriate way, could explain why that regulation was impermissible.

In sum, then, when choosing between rival theories, the method of reflective equilibrium requires that we pick the one that best explains and reconciles our considered judgments. Since earlier sections have shown that liberalism does not suffer the drawbacks it’s often alleged to, including the alleged drawback of restricting state power so much that the theory conflicts with our considered judgments about state action, the main question is whether the rival theories have theoretical drawbacks. Here I obviously have not had the space to consider all rival frameworks, but I’ve examined one oft-cited alternative, and I’ve argued that it over-extends the state’s power.

**6 Conclusions**

We’ve surveyed some anti-liberal arguments and considered responses to them. Although those arguments are not always framed in terms of reflective equilibrium, placing them against that theoretical backdrop has shed light on the debate in several ways.

First, some anti-liberal arguments seem to consist merely of counter-example production—the claim that liberalism will conflict with our considered judgments about specific public health measures. Counter-example production can seem unimpressive, because we know that some considered judgments won’t survive the reflective equilibrium process. However, the objectors can frame their points more powerfully within that theoretical framework as well. Their claim is that some considered judgments about cases are so fundamental that, absent reasons to the contrary, we can reasonably expect the correct theory of public health ethics to comport with them.

Second, once we see the strength of the previous anti-liberal argument, we also see that liberals must argue that their theory does not conflict with (at least most of) those considered judgments. I’ve sketched those liberal replies above. Details aside, the key was to not under-estimate the resources of liberalism. Liberalism countenances soft paternalism, and it can be supplemented with sensible theories about positive duties and about the risks of harm. These resources allow liberalism to comport with our considered judgments about a range of concrete public health cases.

Third, by framing our debate in terms of reflective equilibrium, we’ve been reminded that our goal is to reconcile *all* our considered judgments, not just some of them. And when we do that, we find that our considered judgments in favor of hard paternalism cannot survive reflection, thus eliminating counter-examples to liberalism based in hard paternalism. We also see that communitarian alternatives to liberalism are impressive, but they have theoretical costs that liberal theories do not—costs that must be taken into account during the reflective equilibrium process.

Of course, as I noted at the outset, this paper surveys a range of objections and issues, and I have not had the space to delve into all in detail. Readers of the public health literature will know that there is much more that could be said about each one. But the advantage of a survey is that we can see the general structure of a defense of liberalism in public health. It involves, first, maintaining that some considered judgments would survive reflection and that others would not. After that, we argue that liberalism can be reconciled with the remaining considered judgments, and that it has fewer theoretical costs than other theories which otherwise might fare just as well. Here I have not had the space to consider all alternative theories, but I have pointed toward a general difficulty that will affect the most often-cited rival, and, overall, we have seen that there is a strong case for liberalism in public health.

1. On the underdeveloped state of public health ethics, see R. Bayer & A. Fairchild. The Genesis of Public Health Ethics. *Bioethics* 2004; 18: 473-492: 473; D. Callahan & B. Jennings. Ethics and Public Health: Forging a Strong Relationship. *Am J Public Health* 2002; 92: 169-176: 169; M.J. Roberts & M. R. Reich. Ethical Analysis in Public Health. *Lancet* 2002; 359: 1055-1059: 1055; J.F. Childress, et al. Public Health Ethics: Mapping the Terrain. *J Law Med Ethics* 2002; 30: 170-178; and S.S. Coughlin, W. H. Katz & D. R. Mattison. Ethics Instruction at Schools of Public Health in the United States. Association of Schools of Public Health Education Committee. *Am J Public Health* 1999; 89: 768-770. [↑](#footnote-ref-1)
2. There have been notable attempts to apply liberal principles to public health. The most famous may be N. Daniels. 1985. *Just Health Care*. New York, NY: Cambridge University Press. For more examples, see D. B. Resnik. Food and Beverage Policies and Public Health Ethics. *Health Care Anal* 2013. DOI: 10.1007/s10728-013-0266-z; D.B. Resnik. Trans Fat Bans and Human Freedom.  *Am J Bioeth* 2010; 10: 27-32; L. Radoilska. Public Health Ethics and Liberalism. *Public Health Ethics* 2009; 2: 135-145; and J. Coggon. 2012. *What Makes Health Public?: A Critical Evaluation of Moral, Legal, and Political Claims in Public Health.* Cambridge: Cambridge University Press. [↑](#footnote-ref-2)
3. The discussion below provides numerous examples. For a general discussion of the state of public health ethics, including its often anti-liberal character, see Childress et al., op. cit. note 1; and D.J. Merritt. "The Constitutional Balance between Health and Liberty." *Hastings Cent Rep* 1986; 16: suppl 2-10.Some public health experts see public health ethics as distinct, not only from the principles of liberalism, but from the principles of bioethics. See Bayer & Fairchild, op. cit. note 1; Callahan & Jennings, op. cit. note 1, p. 169; and M. Lappe. 1986. Ethics and Public Health. In *Public Health and Preventive Medicine*. M. J. Roseneau, K. Maxcy & J. Last, eds. Norwalk, CT: Appleton-Century-Crofts: 1867-1877. [↑](#footnote-ref-3)
4. Though for an interesting challenge to the view that the ‘liberty as default’ formulation makes sense, see Coggon, op. cit. note 2, esp. ch. 8. [↑](#footnote-ref-4)
5. Much of what follows, and especially the discussion of soft paternalism, draws on material from J. Feinberg. 1984. *The Moral Limits of the Criminal Law*. New York, NY: Oxford University Press. For a critique of minimal liberalisms in the public health context in particular, see T.M. Wilkinson. Community, Public Health, and Resource Allocation. *Public Health Ethics* 2010; 3: 267-271. [↑](#footnote-ref-5)
6. Though Mill is sometimes alleged to countenance very few public duties, this is not the case. On this, see A. Dawson and M. Verweij. The Steward of the Millian State. *Public Health Ethics* 2008; 1: 193-195. [↑](#footnote-ref-6)
7. It’s interesting to ask whether liberalism can also countenance some *non*-intentional hard paternalism when that paternalism is, in John Coggon’s phrase, a “proportionate collateral effect of necessary blanket policy to protect citizens who require ‘soft paternalist’ measures.” (Coggon, op. cit. note 2, p. 237.) I suspect it can, though I will not use this potential “loophole” against hard paternalism in the arguments to come. Note also that some would not call this paternalism at all since the intervention is not intentionally aimed at improving the person’s wellbeing. On these same subjects, see J. Wilson. Why It’s Time to Stop Worrying about Paternalism in Health Policy. *Public Health Ethics* 2011; 4: 269-279; and F.G. Miller and A. Wertheimer. Facing Up to Paternalism in Research Ethics. *Hastings Cent Rep* 2007; 37: 24-34. [↑](#footnote-ref-7)
8. On degrees of invasiveness, see the Nuffield Council’s ladder of intervention: Nuffield Council on Bioethics. 2007. *Public Health: Ethical Issues*. London: Nuffield Council on Bioethics: xvii and elsewhere. On the potential need for highly intrusive interventions, see S. Conly. 2012. *Against Autonomy: Justifying Coercive Paternalism.* Cambridge: Cambridge University Press;and S. Conly. Coercive Paternalism in Health Care: Against Freedom of Choice. *Public Health Ethics* 2013; 6: 241-245. One response is D.B. Resnik. Paternalistic Food and Beverage Policies: A Response to Conly. *Public Health Ethics* 2014; 7: 170-177; and S. Conly. Response to Resnik. *Public Health Ethics* 2014; 7: 179-179. [↑](#footnote-ref-8)
9. One aspect of liberalism that is often overlooked is its commitment to a political morality that accompanies its principles of state behavior. On this, see Radoilska, op. cit. note 2, p. 141. [↑](#footnote-ref-9)
10. J. Rawls. 1999. *A Theory of Justice.* Cambridge, MA: Belknap Press of Harvard University Press. [↑](#footnote-ref-10)
11. Rawls, op. cit. note 10, p. 43. [↑](#footnote-ref-11)
12. See, e.g., Rawls, op. cit. note 10, p. 44. [↑](#footnote-ref-12)
13. On this, see Coggon, op. cit. note 2; and B. Jennings. 1998. Autonomy and Difference: The Travails of Liberalism in Bioethics. In *Bioethics and Society: Constructing the Ethical Enterprise.* R. DeVries & J. Subedi, eds. Upper Saddle River, NJ: Prentice Hall: 258-69, esp. p. 261ff. [↑](#footnote-ref-13)
14. For example, the Nuffield Council worries that a Millian liberal framework might “[make] impossible a range of important public health measures.” (Nuffield Council, op cit. note 9, p. 19.) See also: (1) A. Dawson. 2011. Resetting the Parameters: Public Health as the Foundation for Public Health Ethics. In *Public Health Ethics: Key Concepts and Issues in Policy and Practice.* A. Dawson, ed. Cambridge: Cambridge University Press: 1-19: esp. p. 3; (2) B. Jennings. 2009. Public Health and Civic Republicanism: Toward an Alternative Framework for Public Health Ethics. In *Ethics, Prevention, and Public Health*. A. Dawson & M. Verweij, eds. Oxford: Oxford University Press: 30-58. [↑](#footnote-ref-14)
15. B. Jennings. 2007. Community in Public Health Ethics. In *Principles of Health Care Ethics.* R.E. Ashcroft, et al., eds. New York, New York: Wiley: 543-348: 544. [↑](#footnote-ref-15)
16. For examples of (1) through (3) see Bayer & Fairchild, op. cit. note 1, esp. p. 479ff., p. 486ff., and p. 491 respectively; for (4) see ibid., p. 485; and L.O. Gostin. Public Health Law in a New Century: Part III: Public Health Regulation: A Systematic Evaluation. *JAMA* 2000; 283: 3118-3122. For a discussion of liberalism and fluoridation, which I do not take up here, see ibid., p. 3319. For a discussion of compulsory vaccination, see A. Dawson. 2007. Vaccination Ethics. In *Principles of Health Care Ethics.* R.E. Ashcroft, et al., eds. New York, New York: Wiley: 617-622; and A. Dawson. 2007. Herd Protection as a Public Good: Vaccination and our Obligations to Others. In *Ethics, Prevention, and Public Health*. A. Dawson & M. Verweij, eds. Oxford: Oxford University Press: 161-178. [↑](#footnote-ref-16)
17. For a discussion of the real-world issues regarding quarantine, see W. Parmet. J.S. Mill and the American Law of Quarantine. *Public Health Ethics* 2008; 1: 210-222; F. Baylis, N.P. Kenny & S. Sherwin. A Relational Account of Public Health Ethics. *Public Health Ethics* 2008; 1: 196-209: 199; M. Selgelid. A Moderate Pluralist Approach to Public Health Policy and Ethics. *Public Health Ethics* 2009; 2: 195-205; S. Gainotti et al. Ethical Models Underpinning Responses to Threats to Public Health: A Comparison of Approaches to Communicable Disease Control in Europe. *Bioethics* 2008; 22: 466-476; and M. Verweij. 2011. Infectious Disease Control. In *Public Health Ethics: Key Concepts and Issues in Policy and Practice.* A. Dawson, ed. Cambridge: Cambridge University Press: 100-117. [↑](#footnote-ref-17)
18. For a more thorough discussion of such arguments, see R. Ashcroft. 2011. Smoking, Health, and Ethics. In *Public Health Ethics: Key Concepts and Issues in Policy and Practice.* A. Dawson, ed. Cambridge: Cambridge University Press: 85-99. [↑](#footnote-ref-18)
19. Bayer & Fairchild, op. cit. note 1, p. 485. [↑](#footnote-ref-19)
20. Ibid. [↑](#footnote-ref-20)
21. Ibid. [↑](#footnote-ref-21)
22. Jennings, op. cit. note 14, p. 34. [↑](#footnote-ref-22)
23. [NYC PUBLIC HEALTH PAPER] , from which the following text is largely taken. [↑](#footnote-ref-23)
24. L.O. Gostin. Fast and Supersized: Is the Answer to Diet by Fiat? *Hastings Cent Rep* 2005; 35: 11-12: 11. [↑](#footnote-ref-24)
25. Jennings, op. cit. note 14, p. 35. [↑](#footnote-ref-25)
26. See, e.g., Nuffield Council, op. cit. note 8, p. 23. [↑](#footnote-ref-26)
27. For an interesting challenge to the idea that we can determine which legislation is paternalistic at all, see Wilson, op. cit. note 7. [↑](#footnote-ref-27)
28. See, e.g., Feinberg, op. cit. note 5, chapter 20 of vol. 3 (*Harm to Self)*. [↑](#footnote-ref-28)
29. The bar may also affected by how central the infringed choice is to the person’s values or identity, although that is more controversial and not something that I will rely on in my arguments. On this point, see Coggon, op. cit. note 2, p. 33; T.R.V. Nys. Paternalism in Public Health Care. *Public Health Ethics* 2008; 1: 64-72; and also an interesting discussion of a related point in Mill in M. Powers, R. Faden & Y. Saghai . Liberty, Mill and the Framework of Public Health Ethics. *Public Health Ethics* 2012; 5: 6-15. Wilson argues that most public health interventions do not infringe significantly on people’s important interests; see Wilson, op. cit. note 7. [↑](#footnote-ref-29)
30. There are some liberal justifications of seatbelt and helmet laws that appeal to the need to prevent harm to others. See M.M. Jones & R. Bayer. Paternalism and Its Discontents: Motorcycle Helmet Laws, Libertarian Values, and Public Health. *Am J Public Health* 2007; 97: 208-217; and especially Feinberg*,* op. cit. note 5, p. 134ff of *Harm to Self*. In addition, for an alternative liberal justification for some paternalist interventions, see Nys, op. cit. note 29; as well as responses in S. Holland. Public Health Paternalism—A Response to Nys. *Public Health Ethics* 2009; 2: 285-293. Finally, note that to justify ordinary seatbelt, helmet, and anti-smoking legislation, liberals would need to show that there is no way to reduce the impairments to choice discussed below and then allow individuals to make voluntary choices. On this, see Feinberg, op. cit. note 5, p. 134ff of *Harm to Self*. [↑](#footnote-ref-30)
31. N. Levy. Autonomy and Addiction. *Can J Philos* 2006; 36: 427-227: 431. See also the discussion in F. Koopmans & S. Sremac. Addiction and Autonomy: Are Addicts Autonomous? *Nova Prisutnost* 2011; 9: 171-188: 175ff. [↑](#footnote-ref-31)
32. Levy, op. cit. note 31, p. 431. [↑](#footnote-ref-32)
33. Verweij gives some arguments for thinking that smoking is sufficiently voluntary, though I find them unconvincing. See M. Verweij. Tobacco Discouragement: A Non-Paternalistic Argument. 2007. In *Ethics, Prevention, and Public Health*. A. Dawson & M. Verweij, eds. Oxford: Clarendon Press: 179-197: 184-5. [↑](#footnote-ref-33)
34. These factors are borrowed from Feinberg, op. cit. note 5, chapter 20 of *Harm to Self*. [↑](#footnote-ref-34)
35. U.S. Department of Health and Human Services. 2014. The Health Consequences of Smoking —50 Years of Progress: A Report of the Surgeon General: Executive Summary. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention

    and Health Promotion, Office on Smoking and Health: 2. [↑](#footnote-ref-35)
36. U.S. Department of Health and Human Services. 2014. The Health Consequences of Smoking —50 Years of Progress: A Report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention

    and Health Promotion, Office on Smoking and Health. Cf. K. Voigt. Smoking and Social Justice. *Public Health Ethics* 2010; 3: 91-106. [↑](#footnote-ref-36)
37. Cf. D.I. Wikler. Coercive Measures in Health Promotion: Can They Be Justified? *Health Educ Monogr* 1978; 6: 223-241; and Voigt, op. cit. note 36, p. 97ff. [↑](#footnote-ref-37)
38. R.E. Goodin. The Ethics of Smoking. *Ethics* 1989; 99: 574-624: 582ff. These remarks are discussed in Conly, op. cit. note 8, p. 169. [↑](#footnote-ref-38)
39. Levy, op. cit. note 31. [↑](#footnote-ref-39)
40. For surveys of this debate, see ibid.; and Koopmans & Sremac, op. cit. note 31. For a somewhat dissenting view, see, e.g., G. Heyman. 2010. *Addiction: A Disorder of Choice.* Cambridge, MA: Harvard University Press, though it’s important to note that even Heyman believes that addiction results from sub-optimal choices. [↑](#footnote-ref-40)
41. F. Newport. 2013. Most U.S. Smokers Want to Quit, Have Tried Multiple Times. Washington, DC: Gallup. Available at: <http://www.gallup.com/poll/163763/smokers-quit-tried-multiple-times.aspx> [Accessed 17 September 2014]. Polls are historically consistent about this: Gallup. 2014. Tobacco and Smoking. Washington, DC: Gallup. <http://www.gallup.com/poll/1717/tobacco-smoking.aspx> [Accessed 17 September 2014]. [↑](#footnote-ref-41)
42. For an overview of this debate, see G. Felsen & P.B. Reiner. How the Neuroscience of Decision Making Informs Our Conception of Autonomy. *AJOB Neurosci* 2011; 2: 3-14; and Koopmans & Sremac, op. cit. note 31. [↑](#footnote-ref-42)
43. For contrary views see R. Scruton. 1998. A Snort of Derision at Society. *Times of London* 19 October; and R. Scruton. 2000. *WHO, What and Why? Transnational Government, Legitimacy and the World Health Organization.* London: Institute of Economic Affairs. [↑](#footnote-ref-43)
44. For a more extensive review than I give below, see J. Menard. A “Nudge” for Public Health Ethics: Libertarian Paternalism as a Framework for Ethical Analysis of Public Health Interventions? *Public Health Ethics* 2010; 3: 229-238, whose presentation I follow below. [↑](#footnote-ref-44)
45. R. Thaler & C. Sunstein. 2009. *Nudge: Improving Decisions About Health, Wealth, and Happiness.* New York: Penguin Books. [↑](#footnote-ref-45)
46. For a review of these factors, see Felsen & Reiner, op. cit. note 42. [↑](#footnote-ref-46)
47. R. Thaler & C. Sunstein. Libertarian Paternalism is not an Oxymoron. *Univ Chic Law Rev* 2003; 70: 1159-1202: 1162. [↑](#footnote-ref-47)
48. For one useful critique, see D.M. Hausman & B. Welch. Debate: To Nudge or Not to Nudge. *J Polit Philos* 2010; 18: 123-136. [↑](#footnote-ref-48)
49. For a good discussion of these general issues, see Hausman and Welch, op. cit. note 48. [↑](#footnote-ref-49)
50. R.A. Skipper. Obesity: Towards a System of Libertarian Paternalist Public Health Interventions. *Public Health Ethics* 2012; 5: 181-191: 182; and see similar argumentative strands in Felsen and Reiner, op. cit. note 42. [↑](#footnote-ref-50)
51. This and the following paragraphs draw on some of the central arguments from Feinberg, op. cit. note 5, ch. 20, p. 98ff, and especially 118ff , in *Harm to Self.* [↑](#footnote-ref-51)
52. Feinberg, op. cit. note 5, p. 119, in *Harm to Self.* This is not to say that liberals may only *oppose* paternalism only because of its effects on welfare. Instead, they may have other reasons for opposing it. The most commonly-cited rationale is the need to prevent violation of a right to autonomy, irrespective of whether doing so protects the agent’s well-being or not. A related reason against paternalism is Shiffrin’s notion that when A acts paternalistically toward another competent adult B, it can seem that this manifests a failure to respect B’s ability to judge or act, or to respect B’s legitimate sphere of personal control. (See S.V. Shiffrin. Paternalism, Unconscionability Doctrine, and Accommodation. *Philos Public Aff*  2000; 29: 205-250: 220.) [↑](#footnote-ref-52)
53. Jones and Bayer, op. cit. note 30, p. 216. [↑](#footnote-ref-53)
54. Ibid. [↑](#footnote-ref-54)
55. Cf. Wikler’s discussion of the same general argument, op. cit. note 37, p. 228; and Verweij’s comments on health as a fundamental good, op. cit. note 33, p. 195. [↑](#footnote-ref-55)
56. Cf. R.F. Meenan. “Sounding Board. Improving the Public’s Health: Some Further Reflections.” *N Engl J Med* 1976; 294: 45-47. Compare a discussion in R. Crawford. Healthism and the Medicalization of Everyday Life. *Int J Health Serv* 1980; 10: 365-388 10; Wikler, op. cit. note 37, p. 230; and Radoilska, op. cit. note 2, p. 138. [↑](#footnote-ref-56)
57. See World Health Organization (WHO). 2006. *Constitution of the World Health Organization*. New York, NY: World Health Organization: 1. Available at: http://www.who.int/governance/eb/who\_constitution\_en.pdf [Accessed 18 September 2014]. For criticism, see A. Cribb. 2005. *Health and the Good Society: Setting Healthcare Ethics in Social Context.* Oxford: Oxford University Press;and A. Cribb. 2007. Health Promotion, Society and Health Care Ethics. In *Principles of Health Care Ethics.* R.E. Ashcroft, et al., eds. New York, New York: Wiley: 549-556. [↑](#footnote-ref-57)
58. A. Chao et al. Meat Consumption and Risk of Colorectal Cancer. *JAMA* 2005; 293: 172-182. [↑](#footnote-ref-58)
59. For evidence that this theory is sometimes implicit in public health work, see P. Allmark. *Choosing Health* and the Inner Citadel. *J Med Ethics* 2006; 32: 3-6. [↑](#footnote-ref-59)
60. In addition to the sources cited below, see Radoilska, op. cit. note 2; and J.E. Ataguba & G. Mooney. A Communitarian Approach to Public Health. *Health Care Anal* 2011; 19: 154-164. [↑](#footnote-ref-60)
61. L.O. Gostin. Public Health, Ethics, and Human Rights: A Tribute to the Late Jonathan Mann. *J Law Med Ethics* 2001; 121-130: 125. Cf. Wikler’s description (but not endorsement) in D. Wikler. 1987. Personal Responsibility for Illness. D. VanDeVeer & T. Regan, eds. Philadelphia: Temple University Press: 326-358: 353. One might expand Gostin’s remark by including the qualification that the individual sacrifices would be small and the gains to society large. On this see Lappe, op. cit. note 3, p. 1875. [↑](#footnote-ref-61)
62. A. Dawson & M. Verweij. Smoke Gets in Your Eyes: Offence, Harm and the Good Life. *Public Health Ethics* 2010; 3: 89-90. [↑](#footnote-ref-62)
63. H. Widdows & S. Cordell. Why Communities and Their Goods Matter: Illustrated with the Example of Biobanks. *Public Health Ethics* 2011; 4: 14-25: 14. [↑](#footnote-ref-63)
64. Dawson, op. cit. note 16, p. 161. For other remarks on positive duties in the public health sphere, see J. Harris & S. Holm. Is there a Moral Obligation Not to Infect Others? *BMJ* 1995; 311: 1215-1217;

    Childress et al., op. cit. note 1, p. 173 (where the “proportionality requirement” may be an appeal to positive duties, though it is hard to be sure); and also M. Verweij, Obligatory Precautions against Infection. *Bioethics* 2005; 19: 323-35 (although Verweij’s outlook is ultimately utilitarian). [↑](#footnote-ref-64)
65. Wilkinson, op. cit. note 5, p. 269. [↑](#footnote-ref-65)
66. R. Brownsword. Public Health Interventions: Liberal Limits and Stewardship Responsibilities. *Public Health Ethics.* 2013; 6: 235-240: 235-6. In Brownsword’s defense, he seems to have in mind a fairly minimalist liberalism which might have the implication he names. [↑](#footnote-ref-66)
67. For an alternative way of appealing to community, see Widdows and Cordell, op. cit. note 63. [↑](#footnote-ref-67)
68. D. Beauchamp. Community: The Neglected Tradition of Public Health. *Hastings Cent Rep* 1985; 15: 28-36: 29. [↑](#footnote-ref-68)
69. Ibid., pp. 33 and 35. [↑](#footnote-ref-69)
70. Ibid., p. 34. [↑](#footnote-ref-70)
71. Cf. W. Kymlicka. 1989. *Liberalism, Community, and Culture.* Oxford: Clarendon Press: ch. 4. [↑](#footnote-ref-71)
72. B. Steinbock. 1994. Drug Prohibition: A Public Health Perspective. In *Drugs, Morality, and the Law*. S. Luper-Foy & C. Brown, eds. New York: Garland Publishing: 217-239: 224. [↑](#footnote-ref-72)
73. Ibid., p. 224. [↑](#footnote-ref-73)
74. Ibid., p. 224. [↑](#footnote-ref-74)
75. Although I won’t pause to digress about it, it is worth noting a gap in this reasoning: the argument says that the government may act to preserve Rawlsian primary goods, and yet liberty is a Rawlsian primary good, and nothing in the argument tells us why we should act to protect one primary good, health, at the expense of another, liberty. [↑](#footnote-ref-75)
76. For another critique of the use of “community” in public health ethics, see Wilkinson, op. cit. note 5. [↑](#footnote-ref-76)
77. See Steinbock, op. cit. note 72, p. 223, where she seems to assume that a liberal outlook would lead to drug legalization. See also the opening pages of Beauchamp, op. cit. note 68. Beauchamp discusses the various actions that public health has undertaken. Among the modern, reasonable ones he discusses, only helmet laws may be unjustifiable under liberalism. And of course they may be justified as well, for reasons given above. [↑](#footnote-ref-77)