The Ethics of Public Health Paternalism

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To the memory of my father, Robert James 'Tim' Wilkinson
20 April 1934–17 February 2024

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Preface and Acknowledgements

For thirty years now I have been interested in whether third parties (governments, the law, ethics committees, doctors, families) could or should stop people harming themselves. My interest was initially abstract, probably typical of a young political philosopher; but it became more practical after joining my university's research ethics committee. There the question came up of whether researchers should be allowed to pay their research subjects. The committee had a rule saying 'no'. No one on the committee knew why. I was told to see why and found that one reason often given was that the subjects would supposedly be lured by money into acting against their interests. This did not strike me then, and does not strike me now, as a very good reason; and so I began thinking about paternalism in practice.

Some years later, I moved from the Politics Department to what became the School of Population Health. We in the School were all supposed to be proud of being called 'Population Health' because it meant, for some reason I never understood, that we were superior to 'public health'. My first staff meeting was taken up with a surreal discussion of whether to remove cans of sugary drinks from the School's vending machines. These drinks, it appeared, made children fat and so were bad. I was new and had a background in politics rather than public health, so naturally I was puzzled. Were a lot of children working in the School of Population Health? It turned out they were not, and this meeting gave me my first insight to how my colleagues in public health think.

I worked in Population Health for six years. I learned from my colleagues about the importance of empirical evidence in public health, how to find it, and how to evaluate it. These were lessons of inestimable value and I am glad I worked there. I am glad for a further reason too. For a political philosopher with an interest in paternalism, working in public health was gold. The prime aim of paternalism in practice is trying to make people be healthy (stopping them losing their money is the second aim). I could now apply theoretical ideas about the ethics of paternalism to arguments used by real people arguing for real policies. In fact, as you will see in this book, I think workers in public health make some big assumptions about the importance of health and its place in well-being, and about why people make unhealthy choices, and I think these assumptions are often wrong.

Then I moved back to Politics, where I am most suited. I have been there ever since. I have thought and written about public health ethics for most of the last fifteen years and used my sabbatical leave in 2021 to write the first draft of this book. This was the period of Covid lockdowns, which had its drawbacks but did mean I focused on writing. Since then, I have been reworking the manuscript and here it is.

During the period of writing, I have talked about the ideas with many friends and colleagues, and I want to thank Lynley Anderson, Paul Brown, Linda Cameron, Annette Dufner, Elizabeth Fenton, Stephen Holland, Mike King, John McMillan, Ana Marià Fonseca Moreno, Neil Pickering, Paul Snowdon, Philipp Wichardt, Stephen Wilkinson, and James Wilson. I have given talks on the topics of this book to audiences at Aarhus, Auckland, Dunedin, Durham, Keele, Lancaster, Rostock, Warwick, Washington, DC, and York. I like giving talks and listening to audiences, but, apart from the pleasure I get, this process undoubtedly makes for better arguments and a clearer book. I have been lucky to have at my university Geoff Kemp, Monique Jonas, Kathy Smits, and Stephen Winter, four friends who have given me detailed comments and advice on every part of this book. I have talked for hours with Kathy in particular, but all of them slip me references, news articles, and suggestions from time to time. No fewer than four anonymous readers for Oxford University Press kindly gave me their suggestions and their enthusiasm for what I have written. And my thanks to Annie Kang, a clever graduate student, who helped me with the research work on self-binding in Chapter 8. I also want to thank the University of Auckland for the two periods of research leave that bookend this project, and for not crushing me with teaching or administration in the interim. And thanks to the Bioethics Centre at the University of Otago, which has become something of a home from home for me.

Some parts of this book have been adapted from articles and I wish to acknowledge their first places of publication. These were:

T. M. Wilkinson. 'Nudging and Manipulation'. *Political Studies* 61.2 (2013): 341.
T. M. Wilkinson. 'Libertarian Paternalism: A Review Essay'. *Political Science* 67.1 (2015): 73.
T. M. Wilkinson. 'Counter-Manipulation and Health Promotion'. *Public Health Ethics* 10.3 (2017): 257.
T. M. Wilkinson. 'Nudging'. In *International Encyclopedia of Ethics*, edited by Hugh LaFollette (John Wiley & Sons Ltd., 2018).
T. M. Wilkinson. 'Obesity Policy and Welfare'. *Public Affairs Quarterly* 33.2 (2019): 115.
T. M. Wilkinson. 'Smokers' Regrets and the Case for Public Health Paternalism'. *Public Health Ethics* 14.1 (2021): 90.
T. M. Wilkinson, 'Review of A. Barnhill and M. Bonotti, "Healthy Eating Policy and Political Philosophy: A Public Reason Approach"'. *Ethics* 133.3 (2023): 415.

Finally, I want to thank my family. Sticking only to their contributions to this project, as opposed to my life, my grown-up children are a rich fund of historical stories about misguided policies. My wife, a wheel of formidable importance in her own university, has often been happy to stop what she was doing and talk about

my book, and even happier to come up with ideas for the cover. My mother, who worked in health for years, gave me many insights, as well as telling me about a public health triumph in an almost totally forgotten smallpox outbreak in Brighton in 1950. Lastly, I dedicate this book to the memory of my father, who died a few months ago. Again sticking only to his contribution to this project, he taught me from an early age by example and discussion how important it is to be clear, not to bluff, and not to take refuge in obscurity when it comes to something one cares about (as opposed to when working on a mission statement, writing a promotion application, or discussing institutional values, when the bluffing and obscurity come into their own). These lessons, I am pleased to say in the preface to a book on public health, were most vividly taught me in the pubs of North Yorkshire.

Auckland, July 2024

1
Introduction
Public Health and Paternalism

This book is about the ethics of policies that try to stop people damaging their health. Call these public health interventions. One reason to intervene is because people would, if left to their own devices, make unhealthy choices that are bad for them. It is this reason that we focus on in this book. Trying to stop people harming themselves sounds paternalistic, and paternalism in public health raises two main questions. Why think that getting people to make healthier choices would make them better off? And should people not be free to choose for themselves? The first is a question about well-being and the second is about autonomy. These questions are harder to think through for adults than for children and, unless otherwise specified, we shall be thinking about adults in this book.

To the question about well-being, I argue that many, perhaps most, adults look as if they would not benefit by being steered into making healthier choices, except when they are discouraged from smoking. To the question about autonomy, I argue that adults ought to be free to run their own lives, and that some, but not all, public health interventions would infringe on their autonomy. As one might gather from these answers, I shall disagree with a great deal of what public health advocates say, and I am doubtful about the merits of many of the interventions they want.

The interventions we shall consider can be categorized according to whether they make it harder to be unhealthy, or make it easier to be healthy, or influence beliefs, or nudge people. It always helps to have some concrete detail, so here I list the sorts of interventions we shall discuss. Into the category of making unhealthy choices harder fall:

1. Bans on products, such as electronic cigarettes, or on ingredients, such as trans fats in food or menthol in cigarettes.
2. Taxes to raise prices, such as taxes on cigarettes, dietary fat, and sugary drinks.
3. Restrictions on availability, such as planning regulations to limit the density and siting of fast food or liquor outlets.
4. State ownership and monopolies that raise price and reduce availability, for instance by allowing only state-owned shops to sell alcohol and then closing them at weekends.

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5. Age limits, such as selling alcohol and cigarettes only to those over 18 or over 21.

Into the category of making healthier choices easier fall:

1. Subsidies to individuals, such as giving discounts for gymnasiums or paying money to pregnant women to give up smoking.
2. Collective provision or subsidy, such as for public transport or to install cycle lanes and pavements for walking.
3. Tax reductions, for instance removing sales tax on fruit and vegetables.

Into the category of influencing beliefs fall:

1. Providing information, as in warning that smoking causes lung cancer or that a cinnamon roll has 500 calories.
2. Bans or restrictions on marketing, for instance a ban on marketing for cigarettes or on advertising junk food to children.

Into the category of nudging fall:

1. Product placement, such as making fruit and vegetables conspicuous while hiding the unhealthy options.
2. Quantity limits, for instance setting a maximum size for sugary drinks or banning multibuys of junk food (such as 'buy one, get one free').
3. Exhortation, as in the 'Eat Five a Day' campaigns to encourage eating more vegetables and fruit.

I should say that we can distinguish these methods only approximately. Quantity limits, for instance, might count as a form of nudging, but they can shade into making unhealthy choices harder. I should also say that this list is not complete; one can always come up with more regulations, influences, nudges, and so on. And the items on it need not be mutually exclusive; for example, the government could tax unhealthy options while subsidizing the healthy ones.

The interventions I just listed often cause political controversy. Probably the most striking example is the prohibition of alcohol in the United States (1920–33), the subject of two amendments to the US Constitution (out of only twenty-seven). Other cases tend not to be quite so prominent, but it would be rare to attend to the news and not come across disagreements about them. We shall get a sense, in Chapter 2, of what people are arguing about, when we try to see things from the contrasting points of view of advocates for public health and critics of the 'nanny state'.

Although this is a book on public health paternalism, we do not want to get too caught up in the problems of defining paternalism. Readers who have a background

in political philosophy, as I do, will probably know we have no shortage of elaborate definitions of paternalism because writers either do not agree on what cases ought to count as paternalistic, or they pick holes in other writers' definitions.[1] For our needs, we can use this basic definition: paternalism involves limiting people's liberty or autonomy because one thinks doing so would make them better off. Notice that, by this definition, paternalism need not be wrong; perhaps limiting people's liberty or autonomy for their benefit could be justified. However, when we apply this definition to public health interventions, we will ask some important questions. Why think that these interventions would make people better off? When do these interventions limit autonomy? And what about the reasons for the interventions besides trying to make their targets better off?

In trying to answer these questions, I have used many sources but in particular I have engaged with the ideas that writers and advocates in public health have offered. These ideas may be found not only in books and academic articles, but in blogs, pamphlets, interviews, and health promotion campaigns. Of course, when I refer to the ideas of the writers or advocates, I do not mean that everybody in public health agrees with these ideas, only that they are commonly put forward.

The public health advocates who want to steer people into healthier behaviour have not been good at giving reasons to think that their targets would benefit. They generally assume that to be healthier is to be better off, but this assumption is often wrong because health is neither the only value nor the supreme value. To decide when people would benefit from being healthier, we must consider the value of health in their lives, how their unhealthy behaviour might be mistaken, and the evidence about whether it is or not. These are the tasks of Chapters 3–6. We shall see why paternalistic public health interventions are likely to be against the interests of many of those they affect, with the striking exception of those that aim to reduce smoking. As for whether public health interventions infringe on autonomy, we have to know what autonomy is, what sort of interventions we are asking about, and whether and when unhealthy behaviour is autonomous. These are the tasks of Chapters 7–10. We shall see why restrictions on choice do generally infringe on autonomy while nudges and health promotion generally do not. The arguments in all these chapters involve a mix of the normative and the empirical. The normative tells us the evidence we need and the empirical describes the evidence we have, especially the evidence offered by public health advocates. As I explain, their evidence is often of the wrong sort and the paternalistic case for public health interventions is generally weak.

[1] Two surveys will give a sense of some of the problems: Gerald Dworkin, 'Paternalism', in *The Stanford Encyclopedia of Philosophy* (Fall 2020 Edition), edited by Edward N. Zalta, https://plato.stanford.edu/archives/fall2020/entries/paternalism/; Søren Flinch Midtgaard, 'Paternalism', *Oxford Research Encyclopedia of Politics*, 29 September 2021, https://doi.org/10.1093/acrefore/9780190228637.013.201.

Now, much of what public health does is not done for paternalistic reasons. The most obvious example involves controlling contagious diseases, which primarily aims to stop some people infecting other people. But some of the interventions listed above also have non-paternalistic reasons. Banning smoking in aircraft saves passengers from suffering the effects of second-hand smoke. Taxing alcohol heavily might reduce or defray the social costs of weekend trips to the emergency departments of hospitals. One might then wonder whether we need paternalism at all to make the case for public health interventions and indeed some writers on public health do think arguments about paternalism miss their point. They say that public health is not paternalistic; it is instead a collective effort to improve the health of populations in the face of market failure and an attempt to promote social justice and reduce inequities in health. However, I shall be arguing, in Chapters 11–12, that if modern public health wants to fulfil its ambitions, it cannot avoid being paternalistic. And then it must face the problems I set out in Chapters 2–10.

I will be concluding that many public health interventions would probably make people worse off, and would infringe on their autonomy, and would not have a compensating benefit to others. This conclusion is, then, obviously critical of public health. As we shall see, some supporters of public health are too quick to write off ethical criticism as the product of a doctrinaire, anti-paternalistic, free market, minimal state libertarianism. Let me say now, then, that the position I take in this book is neither libertarian nor free market: it takes no view about the size of the government, its role in the economy, or its duties to redistribute or to support a welfare state. Nor do I believe that paternalism towards adults is always wrong, only that it is questionable. Perhaps paternalistic influences on people's choices would make them better off; perhaps they would not infringe upon people's autonomy after all, or perhaps the infringement is justified. I doubt these contingencies obtain, but a persistent theme of the book is that we often do not have very good evidence. Because the absence of evidence is not evidence of absence, I do not conclude that public health interventions are unjustifiable, only that they have not been justified.

I have only introduced the subject of this book briefly. In the next chapter, I shall describe more fully the field of public health and its aims, and then analyse the criticism that public health acts as a 'nanny state'.

2
Public Health and the Nanny State

Introduction

States can be corrupt, despotic, incompetent, biased, unrepresentative, and vaulting in their ambitions. Compared with these defects, acting like a nanny is not the worst a state might have; but it is generally a defect nonetheless. Nanny states treat adults like children, they get too worked up about supposed threats to health and safety, and they like being controlling. Many of us do not want what Angela Ince, a UK columnist, called 'the whole irritating, complacent, smug, Nanny-knows-best, eat-up-your-nice-spinach-or-your-hair-won't-curl of today's Nanny State'.[1] But many of us want to be healthy rather than ill, and alive rather than dead. Does a state really nanny us when it uses its power to make us healthier? If it does, should it stop? My aim in this chapter is to give us the background we will need to answer these questions.

We start with an overview of public health, understood as the collective effort to improve the health of a population. We are introduced to the nanny state criticism and the often ill-tempered and uncharitable rhetoric of both those who say that the efforts of public health resemble the behaviour of a nanny and those who dismiss this criticism as dishonest, or incoherent, or doctrinaire. I say the nanny state criticism should be taken seriously and I bring out three strands within it. The first is what I call 'healthism', which says that the nanny state overvalues health and safety. The second is autonomy, which objects to the state's imposing health on people. The third I call 'scepticism', which expresses doubt that the state or public health practitioners know what they are doing or else, if they do know, that they can be trusted to do it. Much of the book will be about healthism and autonomy and in this chapter I aim only for us to understand why some people might accept and others deny that they are problems for public health. I also explain why I think we ought to have an attitude of what one might call 'healthy scepticism' towards public health, but not an attitude of outright disbelief.

[1] In *Menace of the Watchdogs*, published in the short-lived magazine *London Life*, 15 October 1966, quoted in Pascal Tréguer, 'Nanny State', https://wordhistories.net/2020/10/03/nanny-state/ (last accessed 14 May 2024).

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An Overview of Public Health

When I started writing this book, we were living through the Covid-19 pandemic, and we became only too familiar with one key aim of public health, the control of contagious disease, and with its methods of enforced social distancing, mandatory mask wearing, quarantine, isolation, and vaccination. Other public health measures to control contagious disease include providing safe drinking water and keeping people away from their sewage to prevent cholera, typhoid, and dysentery, and reducing overcrowded living to prevent the spread of diseases such as tuberculosis and rheumatic fever.

Public health measures also try to control the spread of non-communicable diseases. In rich countries, the biggest killers have for years been heart diseases, strokes, and cancers. In one way it is not a bad thing that so many people die from non-communicable diseases. Everyone who dies has to die of something—'old age' rarely appears on modern death certificates[2]—and the alternative to dying of a non-communicable disease is not living forever but dying of something else. Still, many people do die prematurely or live with avoidable illness. If they did not smoke, or drank less alcohol, or kept off the junk food and sugary liquids, they would be healthier. Hence those public health tactics mentioned in the Introduction, such as taxing tobacco, restricting the sale of alcohol, and limiting the density of fast-food outlets. However, the concerns of public health are broader than just smoking, drinking, and diet. Addictive gambling is often treated as a public health problem to be dealt with like tobacco and alcohol, for instance by limiting slot machines or casinos and offering quit services.[3] Clean air legislation has reduced respiratory diseases and poisoning from burning coal and wood, or from fuelling cars with diesel and leaded petrol. Health and safety laws help prevent industrial accidents, for instance by making employers provide safety gear such as hard hats and high-visibility vests. Public health campaigners have agitated against free trade agreements, which they blame for allowing rich countries to dump cheap unhealthy food on poor ones.[4] As we can see, public health is not just about stopping people having fun so they avoid 'lifestyle diseases'.

[2] Queen Elizabeth II's is an exception. See Sean Coughlan, 'Queen's Cause of Death Given as "Old Age" on Death Certificate', *BBC News*, 29 September 2022 https://www.bbc.com/news/uk-63078676 (last accessed 17 June 2024).

[3] In New Zealand, the Ministry of Health is responsible for 'developing and implementing the "integrated problem gambling strategy focused on public health" that is described in section 317 of the Gambling Act 2003'. See Ministry of Health, *Strategy to Prevent and Minimise Gambling Harm 2022/3 to 2024/25*, https://www.health.govt.nz/publication/strategy-prevent-and-minimise-gambling-harm-2022-23-2024-25#:~:text=The%20Strategy%20to%20Prevent%20and,period%20starting%201%20July%202022 (last accessed 14 May 2024).

[4] New Zealand has pressured Samoa to take its wildly unhealthy mutton flaps, a cut of meat of up to 50 per cent fat. See Robyn Toomath, *Fat Science: Why Diets and Exercise Don't Work—and What Does* (Auckland: Auckland University Press, 2016), pp. 101–4.

What makes some health-promoting activity fall into the category of 'public health'? We do not need to define public health by setting out precise necessary and sufficient conditions, even if it were possible to do so. We just need some clarity. The first step is to realize that we are not talking about 'public health' in the sense of a 'public health system' such as the National Health Service (NHS) in the United Kingdom's constituent nations. We are talking of public health in the sense that Marcel Verweij and Angus Dawson have in mind, 'as collective interventions to promote or protect the health of the population'.[5] Public health systems such as the NHS largely treat individual patients whereas public health in our sense usually targets groups of people or even the whole population. A breast screening programme for women aged 40 to 70 is aimed at a population and is typical of public health, whereas chemotherapy for breast cancer is for a specific patient and is not a public health intervention, even when it occurs in a public hospital. Public health is collective in a second sense too, in being an organized enterprise. The state is central to this organization. It sets up such public health services as surveillance and vaccination, it funds NGOs, and it uses its coercive power to try to control threats to health.

Some areas of public health are collective in the further sense of solving collective action problems. A problem is a collective action problem when people who are individually rational freely interact in such a way as to make themselves worse off than if they had acted differently. It might be individually rational to throw one's sewage out of the window where it is someone else's problem, but we are all the 'someone else' when the sewage hits us. It might be individually rational not to contribute to the cost of watching out for novel diseases since one would get any benefits of protection whether one paid or not, but then no one might watch out. Public health authorities can enforce sanitation rules or spot disease outbreaks, to take two examples of how they might solve collective action problems. Even quarantine and isolation can be thought of as solving collective action problems because people have an interest in not being infected and they cannot protect this interest adequately in a private tort system.[6] It is simply not feasible for us to take out injunctions against the disease vectors or sue them for infecting us. We, and the vectors themselves, often do not know who they are.

Quite a bit of public health activity might count as a response to genuine collective action problems; but not all.[7] A substantial element in modern public health tries to prevent harms that people incur not through rational interaction but

[5] M. F. Verweij and A. J. Dawson, 'Public Health Ethics', in *The International Encyclopedia of Ethics*, edited by Hugh LaFollette (Wiley-Blackwell, 2013), p. 4421. See also the Nuffield Council on Bioethics, *Public Health: Ethical Issues* (London: Nuffield Council, 2007).

[6] Richard A. Epstein, 'Let the Shoemaker Stick to His Last: A Defense of the "Old" Public Health', *Perspectives in Biology and Medicine* 46 (2003): 138.

[7] James Wilson, *Philosophy for Public Health: Beyond the Neglectful State* (Oxford: Oxford University Press, 2021), pp. 11–12.

through their voluntary, although possibly irrational, actions. This element cannot be described as 'collective' in the sense of solving a collective action problem. Now some writers say that the only proper task for the collective efforts of public health is to solve proper collective action problems, and they argue that the 'Old Public Health' of contagious disease control is defensible but the 'New Public Health', with its focus on lifestyle and social justice, is not.[8] However, when I say that not everything public health does tries to solve a collective action problem, I am only making a conceptual point, not starting a criticism.

Public health is not just collective but also typically preventative. Public health practitioners in New Zealand, as I have heard many a time, regard clinical medicine as 'the ambulance at the bottom of the cliff', treating illness and injuries that have already happened. By contrast, the aim of public health is to stop us falling off the cliff in the first place. (To continue the metaphor, a question for this book is how far away from the edge we should be kept.) Not all prevention is public health, though. Prevention can be specific to a patient, for instance when a woman has her ovaries removed because she is at high risk of ovarian or breast cancer, whereas public health prevention typically targets 'the population'. One highly influential approach is Geoffrey Rose's in *The Strategy of Preventive Medicine*. Rose's distinctive strategy is to intervene on a wide scale rather than target only people who are at high risk, following 'one of the most fundamental axioms in preventive medicine: *a large number of people exposed to a small risk may generate many more cases than a small number exposed to a high risk*'.[9] For example, a 'population strategy' to reduce coronary heart disease would be to reduce everyone's or most people's cholesterol rather than targeting the people most likely to develop the disease. A much greater reduction in coronary heart disease could come from the population strategy because most of the disease would occur in the bulk of the population.

One final element I want to bring out in this overview is the drive in modern public health to reduce inequality. Leading public health bodies and scholars emphasize the great differences in mortality and morbidity between people who differ in, for instance, ethnicity, gender, income, education, and occupation, and they regard these inequalities as substantially unjust and inequitable. They often argue that their interventions would reduce health inequity and we shall consider in later chapters how good their arguments are.

[8] Epstein, 'Let the Shoemaker Stick to His Last'; Christopher Snowdon, *Killjoys: A Critique of Paternalism* (London: Institute of Economic Affairs, 2017), pp. 62–5. 'Old' and 'New' cannot be taken that seriously historically. The Old is what we have been subject to in the response to Covid-19 and elements of the New can be found years ago. For example eleven states in the United States passed prohibition laws against alcohol in the 1850s. See W. J. Rorabaugh, *Prohibition: A Very Short Introduction* (New York: Oxford University Press, 2020), pp. 2–3.

[9] G. A. Rose, K.-T. Khaw, and M. Marmot (eds), *Rose's Strategy of Preventive Medicine: The Complete Original Text* (New York: Oxford University Press, 2008), p. 59 (italics in original).

In sum, we can take public health to be a highly varied set of collectively organized efforts to reduce death, disease, and injury in a population in some sort of equitable way. These efforts sometimes include trying to stop people damaging their own health, and it is these that prompt the nanny state criticism.

The Nanny State

The term 'nanny state' is often attributed to Iain Macleod, a British Conservative politician. Macleod was, as it happens, the Minister of Health who in 1954 announced the link between smoking and lung cancer (in a press conference at which he and the journalists present chain-smoked).[10] Writing in *The Spectator* magazine in 1965, Macleod criticized a government proposal to ban cigarette advertising on commercial television. He said he regarded 'the proof of a causal link between heavy cigarette-smoking and the incidence of lung cancer as overwhelming'. Even so, he wrote of the proposal:

> This new victory for the Nanny State represents the wrong approach. It is certainly the duty of ministers to make sure that there is full knowledge of the risks thought to be involved in heavy cigarette-smoking. . . . If this is done, the decision to smoke or not is for the individual, and it should be left to him.[11]

Later that year, Macleod opposed a ban on smoking in London cinemas and criticized the Ministry of Transport's 'perishing nonsense of a plan for a 70 m.p.h. speed limit even on motorways'. Times change and not many people in Britain nowadays defend tobacco advertising on television, smoking in cinemas, or unlimited speed on motorways. However, Macleod described the government's finally overturning the BBC's monopoly on radio, and allowing the pirate station Radio Caroline to broadcast, as 'a victory against the Nursemaid State',[12] which shows both that the opposition to the nanny state is not just to its public health role and that public opinion would now in some cases be on his side.

As a first approximation, the term 'nanny state' describes bossy intrusion in people's lives by a government that thinks it knows better what is good for them than they do. The term picks out only a subset of government actions. States are not generally called 'nannying' when they bail out banks or airlines, or try to control the money supply, even by those who criticize the policies as government

[10] Virginia Berridge, 'The Policy Response to the Smoking and Lung Cancer Connection in the 1950s and 1960s', *Historical Journal* 49 (2006): 1194.

[11] Quoted in Robert Shepherd, *Iain Macleod: A Biography* (London: Hutchinson, 1994), p. 490. See also Tréguer, 'Nanny State'.

[12] Quoted in Shepherd, *Iain Macleod*, p. 356.

overreach. Nor are states considered to be acting as nannies when they threaten people with gaol for violence. And if they tried to stop 11-year-olds smoking, they might be nannying but the criticism does not apply because most people accept that children ought to be nannied. As one critic of modern public health paternalism writes: 'It goes without saying that paternalism is appropriate in the case of children.'[13]

Macleod was both a Conservative and from the British middle class so his use of 'nanny' has led to plenty of jeering over the years as the sort of term that would occur to someone of his politics and background.[14] The jeering is misplaced. The first person to use 'nanny state' in print was an American journalist, Dorothy Thompson, and, ironically, she was criticizing Britain under the very Conservative government which Macleod had joined as Minister of Health one month earlier.[15] While 'nanny state' is probably mainly a British term, it has currency in the United States. When the then-Mayor of New York City, Michael Bloomberg, tried to limit the size of soft drinks, the Centre for Consumer Freedom's hostile advertisement had him dressed in a nanny costume.[16] Australia too has the term, along with the Australianism, 'wowser', which applies not just to the state but to individuals who are both too frightened of dangers to health and who love meddling in other people's lives.[17] It is easy to find uses of 'nanny state' in other English-speaking countries, such as India, Ireland, New Zealand, and Canada.[18] However, I get the impression the term is hardly used elsewhere. Dutch, Farsi, Italian, Spanish, and Catalan seem to have no word for it, and while German has 'Kindermädchenstaat', Danish has 'barnepigestaten', Norwegian has 'barnepikestat', and French has 'état de nounou', I am advised that these are rarely used.[19]

[13] Snowdon, *Killjoys*, p. 13.

[14] Macleod, as Minister of Health, brought family planning out of the shadows and tried unsuccessfully to ban heroin, so he did not neatly fit into the slot of an anti-public-health critic of the nanny state. See Shepherd, *Iain Macleod*, pp. 63–5.

[15] Tréguer quotes a column in which Thompson uses 'nanny state' in 'Nanny State'.

[16] The advertisement is reprinted on p. 77 of Cass R. Sunstein, *Why Nudge?: The Politics of Libertarian Paternalism* (New Haven: Yale University Press, 2013).

[17] See e.g. the art collective, Wowser Nation, some of whose work can be seen in Gary Nunn, 'It's Telling That People Are Convinced They Are Real', *The Guardian*, 23 June 2020, https://www.theguardian.com/artanddesign/2020/jan/23/its-telling-that-people-are-convinced-theyre-real-the-satirical-signs-of-sydneys-nanny-state (last accessed 14 May 2024).

[18] For India: Pritish Nandy, 'Why India Should Stop Being a Nanny State and Ban the Ban', *The Times of India*, 23 February 2021, https://timesofindia.indiatimes.com/india/why-india-should-stop-being-a-nanny-state-and-ban-the-ban/articleshow/81175151.cms (last accessed 14 May 2024); Ireland: Oliver Callan, 'Indoor and Outdoor Mixed Messages So Hot Right Now as Nanny State Remains in Full Force', *The Irish Sun*, 21 July 2021, https://www.thesun.ie/news/7320898/indoor-and-outdoor-mixed-messages-nanny-state-ireland/ (last accessed 17 June 2024); New Zealand: 'Brian Tamaki to Defy Nanny State Government, Says He Will Hold Sunday Service', *New Zealand Herald*, 12 May 2020; Canada: Ron Corbett 'Welcome to the Nanny State', *Ottawa Sun*, 29 July 2015, https://ottawasun.com/2015/07/29/welcome-to-the-nanny-state (last accessed 17 June 2024).

[19] My advisers are Govert den Hartogh, Mostafa Babaeian Jelodar, Serena Piccolo, Ruggiero Lovreglio, Nadia Huertas López, Annette Dufner, Andreas Albertsen, Lars Moen, and Stephen Winter.

Nanny state critics often assert that our lives are subject to a vast and ever-growing number of regulations used to control people's lives.[20] Since the critics do not agree with these regulations, they do not explain them as a reasonable response to genuine problems. Instead, they explain them by psychology or with cynicism. Take Rory Sutherland's reasons for what he thinks has been a closed-minded clamour by the World Health Organization and anti-smoking organizations to ban electronic cigarettes:

> If you have spent the last 20 years as a public health advisor promoting policies designed to create shame, alongside colleagues who will believe the same thing, the last thing you want to hear is: 'Don't worry about that, because a bloke in China has come up with a gadget that means that the problem to which you have dedicated your life and from which your social status derives is no longer a problem anymore.' Even worse, the inventor was a businessman rather than a health professional.[21]

He also says that the campaign against electronic cigarettes was partly financed by pharmaceutical companies with the deliberate aim of protecting their sales of nicotine patches and gum. He takes the campaign to be an example of a Bootleggers and Baptists coalition, named after an unlikely shared interest in restricting legal alcohol sales in the United States. The Baptists wanted it because they disapproved of alcohol; the bootleggers to prevent legal competition to their illegal supply.[22]

Public health advocates, on the other hand, think governments are too much under the sway of excessively powerful corporations and that nanny state critics help perpetuate injustice by holding back the interventions which are clearly needed to make people healthier and improve health equity.[23] The advocates have their own cynical explanations of nanny state criticisms. The criticisms are, they say, just a convenient pseudo-principled way to try to oppose regulations and policies that are going to come at the expense of corporations and other interested parties; and it is no accident either that tobacco firms have funded freedom-touting smokers' rights organizations or that conservative politicians attack the nanny state in the name of a principle of freedom they abandon when it comes

[20] The nanny state index is a league table of how easy it is in the European Union to 'eat, drink, smoke and vape'. Turkey came top in its debut entry, beating previous winner, Norway, as the least free in 2023. See http://nannystateindex.org/ (last accessed 14 May 2024).

[21] Rory Sutherland, *Alchemy: The Surprising Power of Ideas That Don't Make Sense* (London: W. H. Allen, 2019), pp. 64–5.

[22] For the original idea, see B. Yandle, 'Bootleggers and Baptists: The Education of a Regulatory Economist', *Regulation* 7 (1983). See also the wine lobby's campaign to ban absinthe, a competitor alcoholic drink, in early twentieth-century Europe. See M. Huisman, J. Brug, and J. Mackenbach, 'Absinthe—Is Its History Relevant for Current Public Health?', *International Journal of Epidemiology* 36 (2007): 738.

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

to legalizing gay marriage or prostitution.[24] Many writers in public health think that the nanny state criticism is nothing more than a slur, a conversation stopper to obscure the benefits of public health, and that '[u]se of the term "nanny state" is no more than a lazy rhetorical device denying the responsibility of the state for the health of its citizens'.[25] 'Nanny state' has certainly held the rhetorical advantage over public health. None of the counter-alternatives suggested, such as 'stewardship', has really caught on, and nor has the attempt to 'reclaim' the term.[26] 'We are nannies and proud' has not yet proved politically appealing.

I believe that the nanny state criticism should be taken seriously, for all the hyperbole, selective application, and cynicism of some of the people who make it. Public health has a case to answer. Indeed, this book will argue that it can answer the case for some, although not all, of its interventions. I am therefore disagreeing with writers in public health who dismiss 'nanny state' as expressing dishonest, doctrinaire, or incoherent opposition to sensible regulations. To make my point and theirs, consider this move by numerous public health writers in political argument. They list laws, policies, and regulations that seem open to the nanny state criticism, usually beginning with sanitation measures in the middle of the nineteenth century.[27] For example, Simon Chapman lists 150 regulations, including bans on asbestos and child pornography.[28] The point of these lists seems to be that we accept these regulations, indeed accept them as obviously justified. It is then supposed to follow that the nanny state criticism must either be selectively applied so as not to reject them, in which case the critics are incoherent or dishonest, or else that a coherent criticism would reject these sensible regulations and so be doctrinaire and implausible. The lists also make the point that regulations have been regarded as infringing on liberty in a way we now think hysterical. The list-writers often quote *The Times* newspaper's attack on the 1848 Public Health Act as a grave threat to liberty: 'We prefer to take our chance with cholera and the rest than be bullied into health. There is nothing a man hates so much as being cleansed against his will, or having his floors swept, his walls whitewashed, his pet dung heaps cleared away.'[29] The implication is that the nanny state criticisms of

[24] M. Moore, H. Yeatman, and R. Davey, 'Which Nanny: The State or Industry? Wowsers, Teetotallers and the Fun Police in Public Health Advocacy', *Public Health* 129 (2015): 1030.

[25] John Kemm, *Health Promotion: Ideology, Discipline, and Specialism* (Oxford: Oxford University Press, 2014), p. 5.

[26] 'Stewardship' is at the heart of the Nuffield Council on Bioethics' report, *Public Health: The Ethical Issues*. For the idea of reclaiming 'nanny state' see e.g. Rogan Kersh, 'Of Nannies and Nudges: The Current State of US Obesity Policymaking', *Public Health* 129 (2015): 1088.

[27] See, amongst many writers, Karen Jochelson, *Nanny or Steward? The Role of Government in Public Health* (London: King's Fund, 2005); R. S. Magnusson, 'Case Studies in Nanny State Name-Calling: What Can We Learn?', *Public Health* 129 (2015): 1074.

[28] Simon Chapman, 'One Hundred and Fifty Ways the Nanny State Is Good for Us', *The Conversation*, 2 July 2013, https://theconversation.com/one-hundred-and-fifty-ways-the-nanny-state-is-good-for-us-15587 (last accessed 14 May 2024).

[29] Chapman, 'One Hundred and Fifty Ways'.

sugar taxes, or plain packaging of cigarettes, or of whatever public health proposal is currently up for debate, will later come to seem just as hysterical as the quotation from *The Times*.

As against the lessons we are supposed to derive from these lists, one could point out the selection bias in their compilation. These lists include only items that have actually succeeded in the sense that they have endured. Where, one might ask, is the prohibition of alcohol in the United States or the hastily repealed Danish fat tax (on which more below)? It is not much of a response to critics of state overreach to give a list consisting only of successes. Furthermore, some nanny state critics worry about shifting social attitudes and creeping regulation. They say that if we have come to accept all these restrictions on our liberty, we should not have done. Not every opponent of seatbelt laws in the United Kingdom thought they would be a major infringement on liberty; they worried that once the principle of interfering with self-regarding liberty was conceded more and more regulation would follow.[30] It would not be unreasonable to criticize even sensible regulations if good grounds could be given for thinking they were up a slippery slope.

In any case, the primary question for the writers of these lists is why nanny state critics are supposed to be inconsistent if they do not want asbestos or child pornography made legal. When they develop their ideas, nanny state critics often distinguish between acts that affect only or primarily the actor, which should not be interfered with, and acts that harm other people, which may in principle be interfered with.[31] Since producing child pornography and scattering asbestos around do harm others, these nanny state critics would not in principle oppose banning both. The distinction between affecting self and others has its difficulties, but it is unfair to assert that a critic of the nanny state must in all consistency oppose every state regulation.

Some of the writers who would discredit the nanny state criticism say that it is 'unhelpful', by which they sometimes seem to mean that one cannot wring out an entire theory of the role of the state from the two words 'nanny state' or from the criticism. That is not much of an objection. It would be just as unreasonable to expect a whole theory out of the two words 'public health' or from a criticism of nanny state rhetoric. Other writers seem to envisage some doctrinaire libertarian minimal state theory to be the only coherent basis for the nanny state criticism. But as I understand the nanny state criticism, it does not presuppose libertarianism or any other ideological *-ism*. One could be a command economy socialist who hopes to end the anarchy of market competition so as to allow the springs of cooperative wealth to flow more abundantly—and still consistently think the state has no

[30] Snowdon, *Killjoys*, pp. 38–40. The 'where will it all end?' concern was also expressed in the context of smoking regulation by senior politicians and civil servants in the United Kingdom. See Berridge, 'The Policy Response to Smoking'.

[31] Snowdon, *Killjoys*, ch. 1.

business trying to make people live healthier lives whether they like it or not. The nanny state criticism certainly needs to be sharpened up—that is one lesson from those lists of regulations—but it can be.

Before I try to sharpen up the criticism, I want to point out two pitfalls in thinking about the role of the state in public health. The first is getting bogged down in the big *-isms*. When people write about state, society, and public health, they often talk of individualism, collectivism, (neo)liberalism, libertarianism, and the like. Since these *-isms* are understood in many different ways, people often talk past each other.[32] The second pitfall is taking ideas to come ready-packaged together, which is a further risk of thinking in *-isms*. I have in mind the sort of argument that goes like this: 'You say the state should not tax unhealthy food, so you must be a libertarian who wants to close down the welfare state and since we do not want to close down the welfare state we can reject what you say about the food taxes.'[33] Ideas do not have to be ready-packaged; as I said, you could be a command economy socialist and still endorse the nanny state criticism.

The Core Elements of the Nanny State Criticism: Healthism, Autonomy, and Scepticism

The core elements of the nanny state criticism that should be taken seriously are healthism, autonomy, and scepticism. 'Healthism', as I mean it, is overvaluing health and safety (which I shall shorten to 'health' from now on). The autonomy element says that we ought to be free to run our own lives, and the nanny state stops us running our own lives. The scepticism is about the ability of the nanny state to make us healthier at all and about whether the state can be trusted not to abuse its power. Let me explain these in more detail.

A healthistic criticism of a state policy would say that it gives too much weight to some aspects of health, such as avoiding diabetes, when compared with other values, such as the cheap pleasures of sugary drinks. How might we decide whether the criticism is justified? I can see several reasons that might be given for thinking that a pro-health policy is not healthistic. In outline, these reasons are that the state's actions might promote health, but for reasons besides its value in people's

[32] When the British political theorist, Steven Lukes, told Isaiah Berlin that he had found no fewer than eleven different meanings of 'individualism', Berlin replied, 'So few?'. Quoted in Edmund Fawcett, *Liberalism: The Life of an Idea*, 2nd ed. (Princeton: Princeton University Press, 2018), p. 124.

[33] Another example of thinking in packages is R. Magnusson: 'Ultimately, nanny state critics pedal (*sic*) a neoliberal philosophy that wants the state to be agnostic about the health of the population allowing market forces to dominate.' R. Magnusson and P. E. Griffiths, 'Who's Afraid of the Nanny State? Introduction to a Symposium', *Public Health* 129 (2015): 1017. Magnusson might have meant that nanny state critics are in fact neoliberals rather than that neoliberalism is the only coherent basis for what they say. If so, he would still be wrong. Neither Iain Macleod nor Christopher Hitchens, both of whom Magnusson presents as nanny state critics, held anything like 'a neoliberal philosophy'.

lives; that the state just gives people what they want; that better health does not conflict with other values, so it is not overvalued; and that, while the state does impose a value of health, it is the right value. Let me explain these reasons in a little more detail and describe how they fit into the rest of this book.

Health promoting policies can be adopted for many reasons. Perhaps they aim to reduce the social costs of healthcare, appease noisy lobby groups, or keep a nation fighting fit.[34] These reasons do not rest on the view that health is especially important in people's lives, so they are not healthistic. We shall consider the social cost argument in Chapter 11 but leave aside the other, less ethically respectable, reasons.

A clear democratic mandate could mean that a state's public health policies should not be stigmatized as healthistic because the policies would be the will of the people rather than expressing the values of the state. Of course, this defence relies on the people happening to want the policies or the gain in public health they try to achieve, and the people might not. But suppose they all do. Even then, though, a healthism criticism might be justified, if it shifted from the state to society. Imagine everyone in society votes for very low speed limits on all roads, the modern equivalent of a man with a red flag walking in front of a car, and suppose the state enforces them so as to implement the collective will rather than because it has a position of its own.[35] While the state might not be acting as a nanny, the society seems open to the criticism of healthism.

If overvaluing health can be understood as giving too little weight to values that compete with health, then health would not be overvalued if it did not compete with other values. Take, now, the lessons that Sir Michael Marmot recommends policymakers should draw from research on the social determinants of health. He and the commissions he has chaired want policies to improve early childhood development, education and lifelong learning, and employment and working conditions; to provide at least the minimum income needed for healthy living; and to achieve communities that are healthy and sustainable.[36] According to Marmot, the outcomes of these policies would be not only good in themselves but also promote health. Leave aside the questions of how far these outcomes are causally important in health, and how far we know what policies would achieve them.[37] Marmot's idea is that better health does not compete with many other values. That said, it seems

[34] An example of this last reason is the national efficiency movement in Britain, galvanized by the poor physical state of the Army's recruits in the Boer War. See e.g. Maj.-Gen. Sir Frederick Maurice, 'National Health: A Soldier's Study', *Contemporary Review* 83 (1903): 41.

[35] I stipulate a unanimous vote to avoid the problem of a majority's imposing its view on a minority. The problem of imposing views is more a matter of autonomy than healthism.

[36] Michael Marmot, *The Health Gap: The Challenge of an Unequal World* (London: Bloomsbury, 2015), p. 243.

[37] For some doubts, see A. Lleras-Muney, 'Mind the Gap: A Review of *The Health Gap: The Challenge of an Unequal World* by Sir Michael Marmot', *Journal of Economic Literature* 56 (2018): 1080.

most unlikely that nothing of value is lost in becoming more healthy, and the next chapter provides plenty of examples where health comes at a cost.

Some costs are worth it, of course, and the final reply to the complaint of healthism says that while the state does impose a value of health, it is the right value. But what is the right value for health? An obvious answer is whatever people think it is for them. The nanny state criticism often takes the form of attacking the fun police, the implication being that people prefer the fun of some activity to the health they would be risking. Health is not so valuable, in their view, for it to be worth giving up the fun. Put like this, people's preferences are the measure of the value of health. But why accept people's preferences? Can they not undervalue health? Or overvalue it? What should we make of George Orwell's attack on food cranks (he had socialist vegetarians in mind)? The 'food-crank is by definition a person willing to cut himself off from human society in hopes of adding five years on to the life of his carcase; that is, a person out of touch with common humanity'.[38] Food cranks might be odd, but are they in some way mistaken about the value of health?[39] Working out the value of health is central to evaluating public health and the nanny state criticism, more central than many writers have realized, and we consider it in Chapters 3 and 4.

I now want to contrast healthism with the second element in the nanny state criticism, autonomy. Whereas the healthism objection is that the nanny state takes a view of the value of health that is faulty, the autonomy objection is to imposing health, whether based on a faulty or a justified view. The objection draws on the ideas that people should be able to run their own lives in matters that concern only, or primarily, themselves without being interfered with by others, and that they should not be treated like children. If people's health is primarily their own business, it is not hard to see why nagging them or making them be healthier is thought by many to intrude into a personal sphere even if people really ought, rationally speaking, to take better care of themselves. Still, not everything that the state does in the way of protecting and promoting public health interferes in the personal sphere. In developing the autonomy objection in later chapters, we will have to think about what counts as an interference, and about what matters concern people themselves and what is properly a matter of public concern.

When it comes to interfering with people for their own sake, we do not always object. Children are people and we tend not to object to treating them like children. The obvious reason is that they do not usually have the same capacity for autonomy as typical adults. We can draw out two implications. First, some public health measures, such as childproof caps on medicine bottles, are designed

[38] George Orwell, *The Road to Wigan Pier* (Harmondsworth: Penguin, 1962), p. 153.

[39] Would we think they were mistaken if we diagnosed them with orthorexia? See 'What Is Orthorexia?', *Eating Disorders Victoria*, https://www.eatingdisorders.org.au/eating-disorders-a-z/orthorexia/#:~:text=Orthorexia%20is%20a%20term%20that,food%20to%20an%20excessive%20degree (last accessed 18 June 2024).

primarily for the benefit of children and only incidentally affect adults as a by-product. These measures may not wrongly treat adults as children. Second, the contrast between children and adults may not be sharp. Some of the features that make children tempted to act in unhealthy ways can equally apply to adults who may well not count as autonomous in some cases, such as when they are subject to manipulative marketing or addicted to a substance. Again, these are ideas to be developed and assessed in later chapters.

The third element in the nanny state criticism is what I called 'scepticism', which holds that attempts to make people healthier will not do any good. One reason to be sceptical is a sense that the supposed threats to health are exaggerated. Another is that, whether or not the threats to health are genuine, the government would not be able to do anything much about them. A third reason is that the state could misuse its public health power. I shall describe these sceptical ideas in more detail now than I did with healthism and autonomy, which have several chapters devoted to them later. Scepticism will be largely assumed away after this chapter, and I want us to see how provisional the later conclusions must therefore be.

Public health advocates say they want to intervene for the common good and part of the nanny state criticism has been that the supposed 'common good may be illusory'.[40] We are supposed to be in the middle of an obesity epidemic, but being obese or overweight may not be as unhealthy as public health advocates say. Activists in the field of Fat Studies, amongst others, think the dangers of body fat have been exaggerated. They claim that the mortality statistics do not have the same clarity as, say, those for smoking tobacco, and they argue that the extra ill health that the obese suffer is due to being discriminated against and stigmatized in healthcare and society rather than due to their body fat directly.[41] As for alcohol, many of us are said to be drinking at dangerous levels. But what are those levels? Public health recommendations for maximum consumption vary from place to place and fluctuate over time. They have now fallen to 9.33 small glasses of wine per week in the United Kingdom, whether for a small woman or a large man.[42] These conflicting recommendations cannot all have been right. Nutrition is an even more obvious example of changing fashion. In the 1980s, all sorts of foods were said to cause cancer, eggs were blamed for heart disease, and supposedly healthier sugar was substituted for fat. Again, opinions have changed. Having ulcers definitely is unhealthy; but the public health advice to reduce stress and alcohol turned out not to be the right way to treat them. Ulcers are caused by the helicobacter

[40] Virginia Berridge, *Public Health: A Very Short Introduction* (Oxford: Oxford University Press, 2016), p. 9.

[41] See numerous entries in *Routledge Handbook of Critical Obesity Studies*, edited by M. Gard, D. Powell, and J. Tenorio (London: Routledge, 2021).

[42] National Health Service, 'Alcohol Misuse', https://www.nhs.uk/conditions/alcohol-misuse/ (last accessed 14 May 2024).

bacterium and can be treated with antibiotics.[43] The United States, Australia, and Singapore have restricted or banned electronic cigarettes while other jurisdictions, such as New Zealand, are encouraging electronic cigarettes to try to reduce the harms from smoking tobacco. Who is right? Even some writers in public health concede that the further one goes into 'the cause of the causes', the less certainty one has about what those causes are and how to deal with them. Double-blind randomized controlled trials are not possible for many social policies.[44]

The case for a public health intervention could not get off the ground unless there was a good reason to think it would make people healthier in some way. If it did not, we would not need to discuss whether health is being overvalued or people's autonomy disrespected. If the condition intervened in is not unhealthy, then a public health attempt to change their condition would not be justified. If the condition is unhealthy, but the public health attempt to change it would fail, then again the attempt would not be justified. This book is about the ethical problems that would arise only if public health interventions do achieve their aims, so I shall just assume that they would, purely for the sake of argument. Of course, at least some behaviour is unequivocally unhealthy, such as smoking tobacco, and people who behave in these ways would generally be healthier if they did something less dangerous. Total scepticism about public health recommendations is not justified, although we ought to watch out for health panics.

Scepticism about public health differs from but could supplement scepticism about political control. Political scepticism, as I shall call it, can come in the form of a cock-up theory and a conspiracy theory of public health control. A cock-up theory says that government action will have unintended and undesired consequences. A conspiracy theory takes the more cynical view that people try to use power for their own ends, and government should not be trusted with unnecessary power.

Cock-up theories can be elaborated along the lines, suggested in Albert Hirschman's analysis of conservative rhetoric, of futility, perversity, and jeopardy.[45] A policy is futile if it does not change behaviour, is perverse if it produces worse consequences, and falls under jeopardy if it threatens other values that are more important. Let us apply these ideas to the national prohibition of alcohol in the United States from 1920 to 1933.[46] 'Prohibition' of alcohol was in fact a

[43] Berridge, *Public Health*, p. 75; James Le Fanu, *The Rise and Fall of Modern Medicine* (London: Abacus, 2000), ch. 12.

[44] K.-T. Khaw and M. Marmot, 'Commentary', in Rose, Khaw, and Marmot, *Rose's Strategy*, pp. 23–5.

[45] A. O. Hirschman, *The Rhetoric of Reaction: Perversity, Futility, Jeopardy* (Cambridge, MA: Belknap, 1991).

[46] For another example of a disastrous anti-alcohol campaign in a very different system, see the Soviet Union of 1985–8. The full and fascinating story is in Stephen White, *Russia Goes Dry: Alcohol, State and Society* (Cambridge: Cambridge University Press, 1996), in which p. 131 reprints a cartoon from the Soviet satirical magazine, *Krokodil*, illustrating one problem with the campaign. A policeman hands over a sheet to a superior and tells him, 'Here's the list of people in our district who aren't homebrewing'. The list has just three names. However, what is sometimes wrongly cited as an example of the lengths to which people would go to get drink during the campaign turns out instead to show the problems of

decriminalization policy.[47] It was legal to possess alcohol for private consumption but it was illegal to manufacture, sell, transport, or import it.[48] Americans carried on drinking alcohol nonetheless so, to a considerable degree, prohibition was futile (although rates of cirrhosis of the liver did fall early on).[49] Americans also switched to distilled spirits so that prohibition had the perverse effect of bringing back 'the very hard liquor that the original temperance movement had despised'.[50] As for jeopardy, the enforcement of prohibition came at a cost in liberty and citizens' respect for the law. A value that was also jeopardized was the value of not deliberately poisoning citizens. Alcohol was needed for industrial purposes as well as drinking, and the government wanted to stop it being diverted. But instead of making it unpalatable with a harmless nasty taste, the alcohol was laced with strychnine or mercury at the urging of temperance lobbyists so as to punish the people who drank it.[51]

A less-storied example was the Danish fat tax of 2011–12. In an attempt to control obesity (and raise money), the Danish parliament unanimously passed a tax on dietary fat in 2011. In response to this tax, Danes drove to Germany to buy cheaper products with fat, small artisans struggled to comply with the rules, and Denmark found itself entangled in European competition law. The policy was repealed a year later by a large majority.[52]

Of course, one can expect to find an element of 'they would say that, wouldn't they?' in arguments against public health policies. All sorts of vested interests want to cast doubt on whether the policies would do what they are supposed to do. A nice example was British American Tobacco's thriller-style video, *Illegal Cigarettes: Who's in Control?*[53] The video cuts between well-meaning health officials and particularly sinister criminals. As the officials propose to tax cigarettes

alcoholism and drunkenness the campaign tried to end. Soviet ground crews would drink the 60 litres of pure alcohol from the hydraulic and fuel stores of the MiG-25 'Foxbat' fighter, which became known as the 'Flying Restaurant'. But the Flying Restaurant predated the campaign. See White, *Russia Goes Dry*, p. 53.

[47] M. A. R. Kleiman, J. P. Caulkins, and A. Hawken, *Drugs and Drug Policy: What Everyone Needs to Know* (New York: Oxford University Press, 2011), p. 27.

[48] But with widely abused exceptions, such as home production of communion wine and prescriptions for medicinal purposes. See Rorabaugh, *Prohibition*, p. 61.

[49] Kleiman, Caulkins, and Hawken, *Drugs and Drug Policy*, p. 23.

[50] Rorabaugh, *Prohibition*, p. 65.

[51] Bill Bryson, *One Summer: America, 1927* (London: Doubleday, 2013), pp. 182–3. Bryson says that estimates of the number killed vary wildly. What Bryson considers an authoritative source estimates, at the high end, that 11,700 people were killed in 1927 alone.

[52] M. Bødker, C. Pisinger, U. Toft, and T. Jørgensen, 'The Rise and Fall of the World's First Fat Tax', *Health Policy* 119 (2015): 737. See also Euractiv, 'Danish Fat Tax a Feast for German Border Shops', https://www.euractiv.com/section/agriculture-food/news/danish-fat-tax-a-feast-for-german-border-shops/, updated February 2016 (last accessed 14 May 2024).

[53] British American Tobacco, 'Illegal Cigarettes: Who's in Control?'. This video does not seem to be available on the BAT website anymore, but it appears on YouTube in different places, such as here: https://www.youtube.com/watch?v=Ra2PHP7CksU (last accessed 14 May 2024).

heavily, or to require plain packaging, or to ban cigarettes from public display, the criminals gloat about how these regulations make their illegal products cheaper and easier to counterfeit, all the better to fund their criminal and terrorist lifestyles. The video's style of reasoning is the classic obstructionist tactic of saying 'I agree with your ends [in this case reduced smoking] but doubt that you are going the right way about it'.

As for the conspiracy theory version of political scepticism, public health powers certainly can be abused. The threat of spreading Covid-19 was used by governments in Belarus to prevent its citizens from leaving, in Hong Kong to ban commemorations of the Tiananmen Square massacre, and in Malaysia to prevent the recall of a Parliament that might deprive the government of its majority.[54] A deep distrust of state power is entirely justified for some states. On the other hand, public health advocates say the governments have done little to, as they see it, curb the power of corporations or, in other words, interfere in markets for unhealthy food, drink, and alcohol. That does not suggest governments are always so hungry for power that they would use any excuse to acquire it.

A tremendous amount has been written on regulation and on the conservative case for not doing much and I will largely leave this case aside.[55] A full consideration of any proposed public health regulation needs to consider the warnings in this literature, but I do not believe that public health regulation would as a result be entirely ruled out.[56] To take one example, the prohibition of smoking in bars and restaurants may have its ethical drawbacks in discriminating against smokers, but it has been a policy success in many countries in the sense that it has been substantially complied with despite all the predictions that the rules would be largely ignored.[57] In general, I shall make one large simplifying assumption that public health regulations would generally be complied with and would achieve their aims of making people healthier in some respect and another large simplifying assumption that states would not abuse their public health powers. My question will be about whether and when regulations would nonetheless be unjustified.

[54] 'Belarus, Citing COVID-19 Fears, to Close Land Borders as Brain Drain Bites', *Reuters*, 10 December 2020, https://www.reuters.com/article/health-coronavirus-belarus-idUSKBN28K0VR (last accessed 14 May 2024); 'Hong Kong Bans Tiananmen Vigil Again', *DW*, 29 May 2021, https://www.dw.com/en/hong-kong-authorities-ban-tiananmen-vigil-again/a-57711432 (last accessed 14 May 2024); 'Malaysia's Democracy Gets a Boost from an Unlikely Quarter', *The Economist*, 3 July 2021.

[55] I have found particularly helpful Jim Leitzel's book, *Regulating Vice: Misguided Prohibitions and Realistic Controls* (Cambridge: Cambridge University Press, 2007).

[56] As Hirschman says, the futility part of conservative rhetoric assumes that policymakers cannot or will not learn from their mistakes, something not borne out by the evidence. See *Rhetoric of Reaction*, pp. 67–8.

[57] The rules were followed even by Italians, who have a complicated relation to the law. See John Hooper, *The Italians* (London: Penguin, 2015), p. 248.

Conclusion

Public health consists of collective efforts to make people healthier, often by trying to prevent people becoming ill or injured. Public health interventions might not work, always something to bear in mind, although I largely leave it aside in this book. The interventions might go too far in infringing on people's autonomy, a possibility discussed at length later by thinking about what autonomy means, whether public health interventions might conflict with it, and about how important a value autonomy is anyway. And the interventions might be healthistic, that is, based on overvaluing health. Health is not the only important thing in life and we usually cannot have every good thing, so it is an open question whether to be healthier is to be better off. I develop this point in the next chapter. Later chapters have an account of the value of health and explain what might lead us to think that people who act in unhealthy ways act against their interests.

3
The Limited and Variable Value of Health

Introduction

Lawrence Gostin and Lesley Stone write that: 'The public health community takes it as an act of faith that health must be society's overarching value.'[1] Whether faith or not, one can think of various reasons why one might value health highly. Perhaps healthy people are a social benefit. Perhaps health is a perfectionist excellence.[2] This chapter is about the most obvious reason, that people are better off overall with more health than less.

I begin this chapter with some claims I regard as obviously correct: that health is one good amongst many in people's lives; that the value of health is not so great that it always outweighs other values; and that how valuable more health would be varies from person to person. I shall show how these claims relate to what writers in public health have said, or omitted to say, about the value of health, and at this point it will become clear why I have spent so much time supporting claims that I think no one could seriously reject. I will give examples where writers jump to conclusions in favour of public health, forgetting to ask whether making people healthier might make them worse off; where writers talk down the benefits of unhealthy behaviour and talk up the benefits of health, in some cases by saying things about health that a moment's reflection would show to be wrong; and where writers, who have not kept in view the limited and variable value of health, have been misled into framing the main problems of public health ethics as health versus liberty or the individual versus the community, or into framing the very project of public health as a 'prevention paradox'.

By the end of this chapter, we will have reached the interim conclusion that it is an open question whether a policy or intervention that makes someone healthier would make them better off. It could make them better off, worse off, or leave their overall well-being unchanged. The next chapter is where we will turn to the

[1] Lawrence O. Gostin and Lesley Stone, 'Health of the People: The Highest Law?', in *Ethics, Prevention, and Public Health*, edited by Angus Dawson and Marcel Verweij (Oxford: Oxford University Press, 2007), p. 66.

[2] Susan Hurley, 'The "What" and the "How" of Distributive Justice and Health', in *Egalitarianism: New Essays on the Nature and Value of Equality*, edited by N. Holtug and K. Lippert-Rasmussen (Oxford: Clarendon Press, 2006). I do not discuss perfectionism because, although Hurley thinks it is the most immediately intuitive basis for the value of health (p. 332), I have never come across anything like it in arguments by public health advocates. I discuss the social benefits of health in Chapter 11.

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difficult task of coming up with the right, or at least a good enough, account of the value of health.

Health and the Tradeoff with Other Values

Health is not the only value in a life; it does not have absolute priority over other things that are good; and the value of some component of health in a life varies from person to person. I want in this section to show why these claims, or ones like them, are right. These claims can be understood as expressing the limited and variable value of health in people's lives, and the reference to 'value in people's lives' can be understood as being captured by the concept of 'well-being'. Let me acknowledge immediately that the meaning of 'health' and its relation to 'well-being' are subject to extensive dispute. It does not go too far to say that one enters a quagmire, which, unfortunately, we will not be entirely able to avoid doing. At this stage, though, it is more helpful to proceed with examples than with theories or conceptual analysis.

I could begin with such classic targets of public health as smoking, drinking alcohol, eating too much unhealthy food, having unsafe sex, and not exercising enough. Many people like smoking, drinking, or non-monogamous sex without condoms, and lots dislike exercise. Why think they would be better off if a public health intervention steers them away from doing what they like? It is a good question, and we will come back to these targets throughout the book, but I want to start with examples outside the usual field of public health to show how wide a sphere it is in which people might reasonably risk or sacrifice at least some of their health.

Eddie Hall was the first person to deadlift 500 kg and he won the World's Strongest Man competition in 2017. Of the many sacrifices he had to make to achieve his goals, one was eating 12,500 calories per day. He had to eat meals in the middle of the night, which is ghastly enough, but he also believed that if he carried on, he would not have a long life. For that reason, he retired immediately after he won the world title and promptly lost a large amount of weight.[3] Tevita Ngalu is a New Zealand weightlifter. At the Oceania Championships in 2012, he tore his left quadricep and was advised by competition doctors to withdraw. Instead, he lifted (primarily on one leg) while in excruciating pain so as to help a teammate qualify for the London Olympics.[4] These two athletes are striking examples of a dictum

[3] See 'Eddie "The Beast" Hall Discusses His 12,500 Calorie Strongman Diet!', https://www.youtube.com/watch?v = i80jEU-IGEc (last accessed 20 June 2024). You can see the 500 kg deadlift, itself a staggeringly impressive but most unhealthy feat, here: '1102lb/500kg Deadlift World Record ft Eddie Hall', https://www.youtube.com/watch?v = IGaN66dcZEs (last accessed 20 June 2024).

[4] David Legatt, 'Harrowing Lift Is Ngalu's Greatest Gift', *The New Zealand Herald*, 12 June 2012, available at https://www.nzherald.co.nz/sport/weightlifting-harrowing-lift-is-ngalus-greatest-gift/XU6IJNSY3HEPHJ3GDDVR3TTRYE/ (last accessed 21 May 2024).

about elite sport: it is about winning, not about being healthy.[5] Lynley Anderson gives five more representative cases: a professional rugby player who wants to play with a fractured forearm; a top endurance runner who wants to race although it would damage his arthritic hip; another runner who wants to race, despite having gastro-enteritis, in what is his last chance to make the world championships; a cricketer, hit on the head by a ball in a test match, who might be concussed but wants to play on; and a boxer who wants to fight a few days after being concussed in a motorcycle accident.[6] With the possible exception of the cricketer, who may be unable to think clearly, these athletes voluntarily want to risk their health.[7] To be sure, athletes can train or be coached foolishly, and sports' governing bodies have a reason to make their sports safer, but the fact is that, at the highest levels, sport damages bodies. In any case, the point is that it is understandable why athletes damage their health. They are getting something out of it that they think is worth more.[8]

Consider now a friend of mine who likes mountain biking.[9] She cycles the Old Ghost Road, a track through bush and mountains on the West Coast of New Zealand's South Island. If you watch the video linked here, you can see this track is not only beautiful but dangerous.[10] At some points, the track is narrow and steep, it winds sharply round hairpin bends, and it has sheer drops on either side. Cyclists can die. And yet my friend thinks the risk is worth it. BASE jumpers certainly do die. A BASE jumper is someone who jumps with a parachute or gliding suit from a Bridge, Antenna, Span, or the Earth (presumably an elevated part). Over 300 have died in the twenty years to 2021. But no one makes the jumpers take the risk and the sport does not even attract much money or fame. They jump because they like to jump.[11]

[5] In the 'Goldman Dilemma', athletes are asked if they would take a drug that would guarantee them Olympic success but also cause them to die after five years. Some would, although not, it appears, many. See J. Connor, J. Woolf, and J. Mazanov, 'Would They Dope? Revisiting the Goldman Dilemma', *British Journal of Sports Medicine* 47 (2013): 697. The thought experiment is not perfect given that any such drug would be banned by anti-doping agencies. Athletes might be willing to risk their health to win but not to win by cheating.

[6] Lynley Anderson, 'Doctoring Risk: Responding to Risk-Taking in Athletes', *Sports, Ethics and Philosophy* 1 (2007): 119.

[7] The case of the professional rugby player is, as Anderson points out, not clearly voluntary because of pressures from team, coaches, and fans and because of the ambiguous role of team doctors. However, a similar case minus the pressures could easily be constructed.

[8] Amateur athletes get injured too, of course. The New Zealand state insurer, ACC, reports 452, 768 sporting injury claims, in a population of five million, for 2023. See ACC, 'Sport and Recreation Injury Statistics', https://www.acc.co.nz/newsroom/media-resources/sport-and-recreation-injury-statistics/ (last accessed 20 June 2024). Only a small number of these claims involve injuries to top athletes.

[9] This friend is none other than Lynley Anderson.

[10] 'Mountain Biking NZ "The Old Ghost Road"', https://vimeo.com/201613662 (last accessed 20 June 2024).

[11] 'Last of the Daredevils', *The Economist*, 30 January 2021. The article does not say how many people are BASE jumpers so we do not know what the 300 is out of; but BASE jumping is often called the world's deadliest sport.

Finally, consider this story, adapted from one told me by a colleague about her relation. A man has suffered for many years from heart disease and eventually has a heart transplant. He now feels energetic enough to play with his grandchildren, something he has wanted to do for a long time. Because he has had a transplant, he must take drugs that suppress his immune system so as not to reject his new heart. As a result, he is vulnerable to catching nasty infections from his grandchildren. And yet he decides to take the risk and play with them anyway.

Here are some observations about these stories. First, people's health is not their only concern. Some value sporting performance and competition, either in themselves, or as an aspect of teamwork, or because of the glory and riches they lead to; for many reasons, really, besides their own health. Some value thrills and beauty for their own sake, again not because of the health-promoting benefits of exercise. Some value family life as family life, rather than because of whatever contribution it makes to their health. Second, people not only have values besides health, but they are willing to give up some health for the sake of achieving these other values. Third, their tradeoffs seem quite reasonable.[12] And, fourth, none of the tradeoffs in these cases involves addictive substances or capitalist-marketed-illness-promoted products, to pick two usual suspect categories in public health.

We can further observe that the tradeoffs in these examples are not ones everyone would make. If you do not like sport, or would find the cycling terrifying rather than exhilarating, or get annoyed by your grandchildren, you may well choose health if you were in something like the position of the people in the examples above. But you need not, and should not, universalize your tradeoff. When it comes to deciding how much health, if any, to give up, no universal right answer is to be found. In certain cases, one might criticize someone's tradeoff as being based on manipulated preferences or false beliefs—and that could include criticizing the tradeoffs made by people who over-value health—but no one who accepts that health is tradeable can seriously believe in a universally right rate of exchange.

Let me make three points about tradeoffs. First, I have so far spoken as if health were an undifferentiated lump, but it is not. One has less than perfect health if one has any or all of fractures, depression, boils, cluster headaches, end stage renal disease, and hayfever. Obviously countless things can go wrong with our bodies and minds. Most of us are at different points between perfect health and dreadful health and different aspects of ill health vary in how bad they are.

[12] A reader for this book was not persuaded that the tradeoffs made by BASE jumpers are reasonable. I do not insist on it; whether they are reasonable is in the end a matter for judgement. However, after reading 'Last of the Daredevils', they seem reasonable to me and might to you. On the telling of that article, BASE jumpers tend not to be daft young men showing off, but older and monk-like in their preparation and dedication, mitigating the risks as far as possible, but finding the joy and control of BASE jumping to be worth the residual high risk of death.

Second, health or, more strictly, aspects of health, can be instrumentally valuable in the sense that they help someone to achieve what they want. Physical mobility and eyesight help people with leading independent lives, working, raising children, and so on. Aspects of health can also be desirable in themselves, for instance in the pleasure of motion or the absence of pain.

Third, I have glossed over the difference between giving up health and risking health. Some of the examples I gave involve taking risks or, put another way, not giving up health for certain. My friend would probably not fall off the Old Ghost Road. The grandfather might not catch a nasty disease from his grandchildren. My friend might not be willing to cycle or the grandfather play with the children if they believed they certainly would suffer the health consequences. Obviously, the certainty of a bad thing happening is worse than the risk of its happening. Even then, some people are willing to give up some health for certain, as with athletes who train through injuries knowing that doing so will delay recovery.

To conclude so far: as the examples are designed to show, people are quite reasonably willing to give up some health for the sake of other values and they vary in the tradeoffs they make. It is therefore possible that people could be made healthier and yet worse off overall because they would lose more of what is valuable besides health than they would gain in the value of health. Because tradeoffs in value vary from person to person, it is also possible that a policy that made everyone healthier would be on-balance good for some but on-balance bad for others. Thus it is an open question whether a public health policy that made people healthier would make enough people better off for it to be justified. Having made these points, health is valuable. It would be worth a great deal to most people not to have heart disease or psychosis. So I am not closing the question I just declared open: a public health policy could make all or most people better off.

I regard these conclusions as obviously correct. People who are anti-paternalist or sceptical of paternalism accept them but so too do many paternalists.[13] I do not know of any writer who comes out and says: 'Health is the only good' or 'Health is so valuable that the smallest loss of it must make someone worse off no matter what else they gain'. The reader might wonder why I have taken so long to state what I regard as obvious and uncontroversial. The reason is that, as I now explain, many writers about public health do not fully appreciate the force of these conclusions.

[13] These paternalists are examples: Robert Goodin, *No Smoking: The Ethical Issues* (Chicago: Chicago University Press, 1989), pp. 33–4; and Kalle Grill and Kristin Voigt, 'The Case for Banning Cigarettes', *Journal of Medical Ethics* 42 (2016): 294.

Omissions and Errors in Thinking about the Value of Health

Suppose the question comes up of whether a policy should try to discourage some type of unhealthy behaviour. Now we are sensitized to ask about the value of health, we might expect a serious discussion of this question to consider what people would lose if they behaved differently and to offer some way to compare the losses against the gains in health. Sometimes one finds these serious discussions.[14] But, as we shall see in this section, often one does not. Advocates for public health measures frequently commit the fallacy of counting the costs and ignoring the benefits.[15] On occasions when they do not ignore the benefits, advocates often wrongly denigrate them. And sometimes their theories of the nature or value of health lead them to forget the basic fact that ill health is a matter of degree.

Over and over, one finds in writings on public health policy an argument with this structure: 'This behaviour (such as smoking, drinking alcohol, eating sugar) causes ill health. Therefore, policymakers should discourage this behaviour.' As we can see, this argument omits any benefits people might get when they behave in the unhealthy way.[16] Here is an example, about alcohol, from an article in *The Lancet*. In this article, the authors try to show, amongst other things, that drinking any amount of alcohol poses a risk to health and that people in richer countries drink more than people in poorer ones. They then draw their policy conclusion:

> Given that most low and low-to-middle SDI [socio-demographic index] settings currently have lower average alcohol consumption than high-to-middle SDI settings, it is crucial for decision makers and government agencies to enact or maintain strong alcohol control policies today to prevent the potential for rising alcohol use in the future. Effective policies now could yield substantial population health benefits for years to come.[17]

[14] Such as T. F. Pechacek, P. Nayak, P. Slovic, S. R. Weaver, J. Huang, and M. P. Eriksen, 'Reassessing the Importance of "Lost Pleasure" Associated with Smoking Cessation: Implications for Social Welfare and Policy', *Tobacco Control* 27 (2018): 143. I discuss this article in Chapter 6.

[15] A fallacy named by Joseph Heath, *Filthy Lucre: Economics for People Who Hate Capitalism* (Toronto: HarperCollins Publishers, 2009), p. 8 and passim.

[16] Cost-benefit analyses of policies to reduce unhealthy consumption also regularly omit to count the 'monetized utility associated with the foregone consumption activity' thus 'almost certainly producing substantial overestimates of policy-induced net benefits'. See E. M. Ashley, N. Clark, and R. A. Lavaty, 'Estimating the Benefits of Public Health Policies that Reduce Harmful Consumption', *Health Economics* 24 (2015): 618.

[17] M. G. Griswold, N. Fullman, C. Hawley, N. Arian, S. R. Zimsen, H. D. Tymeson, V. Venkateswaran, A. D. Tapp, M. H. Forouzanfar, J. S. Salama, K. H. Abate et al., 'Alcohol Use and Burden for 195 Countries and Territories, 1990–2016: A Systematic Analysis for the Global Burden of Disease Study 2016', *The Lancet* 392 (2018): 1025.

Notice that their conclusion in favour of 'strong alcohol control policies' is based only on the benefits to health. They do not consider that people might want to drink alcohol for good reasons, such as that they like it.

To be clear, my criticism of the argument is not that advocates of public health measures are blind to all the potential drawbacks. In the case of the article quoted, the authors say that 'Governments should consider how these recommendations can be implemented within their local contexts and broader policy platforms'.[18] They do not explain what they mean, but virtually every worker in alcohol control must be aware that policies such as prohibition can backfire, so perhaps that is what they had in mind. Advocates for public health are also aware that policies could be ineffective or stigmatize people, with consequent bad effects on their well-being.[19] They also see that policies can genuinely infringe on liberty, or at least be politically objectionable because they are thought to infringe on liberty.[20] All these are typical ways to qualify the basic argument that runs: 'this behaviour is unhealthy so it should be discouraged.' What is so often missing is the point that unhealthy behaviour can have its own benefits which ought to be considered when deciding whether changing the behaviour would make people better or worse off.

One can forget to ask about the benefits of unhealthy behaviour if one gets distracted by the question of whether we make rational choices. Public health advocates often say that we do not choose in fully rational ways because we are manipulated by marketing, or because our rationality is 'bounded' and our choices are the outcome of biases.[21] These are important ideas. They can indeed be part of a case for public health measures and they will be discussed at length later. But they are not enough. The advocates' point can be summarized as saying that, contrary to a model of rational economic choice, people make mistakes in how they choose and these mistakes occur when what they choose is unhealthy. The conclusion is then drawn, at least implicitly, that their choices must be bad for their well-being.[22] That conclusion does not follow. Procedure is one thing, substance another. You

[18] Griswold et al., 'Alcohol Use', p. 1026.

[19] Robyn Toomath claims, quite likely correctly, that taxing and regulating are more effective and less stigmatizing than many other anti-obesity interventions, such as healthy eating campaigns. See her *Fat Science: Why Diets and Exercise Don't Work—and What Does* (Auckland: Auckland University Press, 2016), chs. 8 and 9.

[20] See the discussion of health versus liberty later in the chapter, pp. 34–6.

[21] Here are two examples (from many) for obesity: Avner Offer, *The Challenge of Affluence: Self-Control and Well-Being in the United States and Britain since 1950* (New York: Oxford University Press, 2006); Robert A. Skipper, 'Obesity: Towards a System of Libertarian Paternalistic Public Health Interventions', *Public Health Ethics* 5 (2012): 181; and here are two examples (from many) for smoking: Goodin, *No Smoking*, §2.2; and Sarah Conly, *Against Autonomy: Justifying Coercive Paternalism* (Cambridge: Cambridge University Press, 2013), p. 169.

[22] Conly, *Against Autonomy*, pp. 166–8 is one example (although Goodin, *No Smoking*, §2.2, does not make this mistaken inference). Richard Thaler and Cass Sunstein simply cite obesity as an example of people's mistaken choice of diet without showing that it is a mistake in their *Nudge: Improving Decisions about Health, Wealth, and Happiness* (New Haven: Yale University Press, 2008), p. 7. See the critical comment in Robert Sugden, 'Do People Really Want to Be Nudged Towards Healthy Lifestyles?', *International Review of Economics* 64 (2017): 117.

might be irrational to bet on your lucky numbers, but you can still win; you might be wrong to judge a book by its cover, but a book with a bad cover can be a bad book. In general, one can get the right answer from procedurally problematic decisions and perhaps being less than maximally healthy is the right answer.[23] If the argument for changing unhealthy behaviour consists only of denigrating people's choosing, it is another way of failing to consider the benefits.

When advocates of public health policy do consider the benefits of unhealthy behaviour, they are prone to dismiss them. One example is in Sarah Conly's argument for banning cigarettes. Her argument hinges on denying that 'smokers get sufficient benefit from smoking to make this a rational choice'.[24] Conly thinks that smoking becomes most enjoyable after smokers have become addicted and for her an addictive drive is 'the desire to extinguish an unpleasant feeling of craving'.[25] The physical pleasure smoking brings is largely negative, eliminating something like a pain rather than being enjoyable in itself:

> This is not to say it isn't pleasant—it's been said that the greatest pleasure is the alleviation of pain. We don't normally think it is worth it to undergo pain for such pleasures, though—while having someone step on your foot causes a great surge of relief when they get off, we don't seek out heavy people to stomp on us just so we can enjoy their departure.[26]

Having minimized the benefit from smoking, she then says, 'it's a dangerous expensive habit that doesn't advance anyone's goals'.[27]

A version of Conly's argument is made by many writers, although hers is set out more carefully than most. It is an argument worth spending some time on because smoking is such a central case in public health and we will be better able to understand the appeal—indeed, benefit—of this quintessentially unhealthy habit if we approach it with more sympathy than usual.[28] We will be able to see why smoking should not be regarded as an unreasonable choice for everyone.

To return to Conly's argument, she is right that smoking is dangerous. She is also right that smoking is expensive in some countries, although she does not mention that it is only expensive because of the high taxes that are designed to discourage

[23] Robert Frank describes the fallacy of inferring bad decision-making from a bad outcome. See his *Passions Within Reason: The Strategic Role of the Emotions* (New York: Norton, 1988), pp. 72–5. This fallacy would be at work if people thought that unhealthy choices are bad choices, so whatever decision process led to those choices must be bad. However, I am describing the fallacy of inferring a bad outcome from bad decision-making.

[24] Conly, *Against Autonomy*, p. 170.

[25] Conly, *Against Autonomy*, p. 158.

[26] Conly, *Against Autonomy*, p. 171.

[27] Conly, *Against Autonomy*, p. 172.

[28] An epidemiologist colleague once told me he thought that the public health workers employed to encourage smokers to quit often did not really understand the people they were trying to help because they had never smoked.

smoking. But does smoking really advance no goal at all? Even if she were right that the only pleasure from smoking comes from alleviating a pain, she is wrong to say that we would not seek out pains to alleviate them. Some people go for walks to build up hunger which they can enjoy alleviating; some people's idea of a good time is to go back and forth between saunas and icy water. People want stimulation as well as comfort and sometimes that desirable stimulation involves creating discomfort.[29]

In any case, smoking does more than alleviate a pain. It provides structure and a sense of community for many smokers. Robert Goodin, who is well known in the field of public health ethics for attacking smoking, also wrote a less well-known article called 'Banana Time in British Politics'.[30] We can ignore the British politics of decades past; what matters here is 'Banana Time', which was the name given by factory workers to the time in their shifts when they would eat a banana: 'Time tended to drag, and to help it pass they devised little rituals and benchmarks: coffee time, peach time, banana time, window time, fish time, coke time and, at long last, quitting time.'[31] The workers' shifts were unstructured and they could have eaten their bananas when they wanted, but people like structure and the workers created it by setting their time to eat. Smoking has played the same role for many. Unlike alcohol and many other drugs, smoking is not intoxicating and historically has lent itself to breaking up the working day with what in New Zealand is still called a 'smoko'.[32]

Smoking has also been a communal activity.[33] Nowadays one thinks of small groups huddled in doorways or outside pubs where they have been banished by smoke-free legislation, and some evidence is to be found that such smokers identify as an oppressed group.[34] Even without that sense of oppression, smoking has often been shared. Smokers have cadged cigarettes off each other or swapped to try new brands. And having something to do with your hands when smoking can help nervous people overcome some of their anxiety from being in a group.[35]

[29] Tibor Scitovsy, *The Joyless Economy: An Inquiry into Human Satisfaction and Consumer Dissatisfaction* (Oxford: Oxford University Press, 1976).

[30] R. E. Goodin, 'Banana Time in British Politics', *Political Studies* 30 (1982): 42. His source was Donald Roy, '"Banana Time": Job Satisfaction and Informal Interaction', *Human Organization* 18 (1959): 158. In *No Smoking*, Goodin describes the benefits of smoking only as '"relaxation" or whatever' (p. 23, n. 20) and asserts, with no grounds given, that cigarettes have easily available substitutes. However, e-cigarettes might be a good substitute now.

[31] Goodin, 'Banana Time', p. 43.

[32] See also Gene M. Heyman, *Addiction: A Disorder of Choice* (Cambridge, MA: Harvard University Press, 2009), pp. 148–9 on the role of cigarettes in filling a niche.

[33] Lucy McCullough, 'The Sociality of Smoking in the Face of Anti-Smoking Policies', in *Alcohol, Tobacco and Obesity: Morality, Mortality and the New Public Health*, edited by K. Bell, D. McNaughton, and A. Salmon (Abingdon: Routledge, 2011).

[34] McCullough, 'Sociality of Smoking', pp. 141–2.

[35] My thanks to Monique Jonas for this observation. As she also observed to me, social relationships are a massive source of well-being.

In short, smoking lends itself to structure, ritual, and community, as well as pleasure. What is true of smoking is true of many of the activities that can cause ill health, including taking other addictive drugs such as alcohol or even heroin.[36] One leading researcher into addiction, Bruce Alexander, takes addiction to be an adaptive response to a fragmented world caused by modernism. He thinks consuming addictive drugs or engaging in addictive activities help provide the purpose, identity, and social connections missing in modern lives.[37] While I do not accept all of what he says about history and economics, he is clearly right that consumption by addicts, let alone by other users, is not simply to be understood in terms of giving in to the short-term pleasure of relief of stress.

As it happens, Conly is more sensitive to the benefits of unhealthy behaviour other than smoking, such as when she criticizes attempts in the United States to stop people spending state assistance on sugary soft drinks.[38] Americans, she says, care about their sodas. But she just does not see the benefits of smoking. To be clear, I am not saying that the benefits of smoking outweigh the costs. In fact, as we shall later see, smoking is one of the cases where public health interventions probably do make most of their targets better off. What I am saying here is that advocates for public health often either overlook the benefits of unhealthy behaviour, in this case smoking, or dismiss them as trivial, and they should do neither.

While some writers wrongly talk down the benefits of unhealthy behaviour, others exaggerate the benefits of health. For example, Lawrence Gostin writes: 'Health is a necessary condition for just about all aspects of human endeavour', such as pursuing a livelihood, exercising rights, or achieving personal satisfaction.[39] And Thomas Nys thinks that the capacity to revise one's ends requires health.[40]

These arguments might work if health were binary: in other words, you must be either completely healthy or else completely unhealthy, say, by being dead or in a coma. Obviously, if you are dead or in a coma you cannot do anything. But, as we saw, health is not binary. People need not be maximally healthy to pursue a livelihood, exercise a right, achieve satisfaction, or revise their ends. People can go to work, for instance, even if they have a cold, or hypertension, or are obese. I wrote this book while having intermittent knee tendinopathy and permanent

[36] Hanna Pickard, 'The Puzzle of Addiction', in *The Routledge Handbook of Philosophy and Science of Addiction*, edited by Hanna Pickard and Serge H. Ahmed (Abingdon: Routledge, 2019), pp. 18–19.

[37] Bruce K. Alexander, 'Addiction: A Structural Problem of Modern Global Society', in Pickard and Ahmed (eds.), *The Routledge Handbook of Philosophy and Science of Addiction*. Alexander developed his ideas in a book, *The Globalization of Addiction: A Study in Poverty of the Spirit* (Oxford: Oxford University Press, 2008).

[38] Conly, *Against Autonomy*, pp. 157–8.

[39] Lawrence O. Gostin, 'Securing Health or Just Health Care: The Effect of the Health Care System on the Health of America', *Louis University Law Journal* 39 (1994): 13.

[40] Thomas Nys, 'Paternalism in Public Health Care', *Public Health Ethics* 1 (2008): 67–8; see also Thomas Nys and Bart Engelen, 'Judging Nudging: Answering the Manipulation Objection', *Political Studies* 65 (2017): 199.

tooth decay. Franklin D. Roosevelt won four presidential elections despite being scarcely able to use his legs after contracting polio.[41] The elderly have worse health than young adults but are more likely to exercise their right to vote in every democracy I know. People can even exercise their rights to veto medical treatment when they are in the very unhealthy state of being severely paralyzed, so long as they can communicate in some way.

Health is obviously not binary and the writers who make these claims about the importance of health know that. But it is as if they forget it when trying to make their case for the importance of health. Gostin himself says that only a certain level of health is necessary for livelihoods, rights, and satisfactions. But then it is open whether health should be traded off against other goods above whatever level he had in mind.

Another view starts by saying that health is valuable in part because it is an all-purpose means to our ends. Subject to the qualification that health is a matter of degree and the instrumental value of its components will vary, that starting point seems fair enough. The trouble lies in the conclusions drawn. In discussion, I have heard it said that because health is so generally useful, people should not give it up. Obviously, this argument is hopeless. One could run a parallel argument for money: money is an all-purpose means for achieving one's ends. Would one then want to say that people should never spend any money on consumption? Or that they should earn as much money as they can no matter how boring, unpleasant, or family-disrupting the job? One criticism of market societies' supposed obsession with economic growth is that goods and services are just means and not ultimately valuable; one could make a similar point about the instrumental argument for health. If the argument for providing health is that it is a means to our ends, it would be perverse to have more means at the expense of the ends they are supposed to serve.[42]

Even one of the most sophisticated recent writers on public health ethics, James Wilson, seems to forget to take account of the potential costs of being healthier. Wilson argues that because health is instrumentally valuable for nearly everyone, we have a right to health; that the right to health entails a right to public health; and the right to public health imposes a duty on the government to reduce risks to health.[43] He asserts that the right to public health requires governments to plan to include what the World Health Organization (WHO) calls 'best buys', which are cheap, effective, and feasible interventions. These best buys include immunizing

[41] Or possibly Guillain-Barré Syndrome. See Armond S. Goldman et al., 'Franklin Delano Roosevelt's (FDR's) (1882–1945) 1921 Neurological Disease Revisited: The Most Likely Diagnosis Remains Guillain-Barré Syndrome', *Journal of Medical Biography* 24 (2016): 452.

[42] Goodin makes the same point against those who oppose smoking because health is an interest not a mere want. See *No Smoking*, pp. 33–4.

[43] James Wilson, *Philosophy for Public Health: Beyond the Neglectful State* (Oxford: Oxford University Press, 2021), ch. 6. This duty can be overridden, he thinks, for instance if the gain to health would be small and the loss in liberty great.

children, taxing alcohol and tobacco, making it harder to buy alcohol, banning alcohol and tobacco advertising, and taking trans fats out of the food chain.[44] I will not consider whether we do have a right to health, or public health, and I certainly would not want to deny that governments have a duty to organize children's immunizations. The puzzle is how we got to the policies on tobacco and alcohol, which mainly apply to adults.

Earlier I criticized writers who argue from 'this behaviour is unhealthy' to 'this behaviour ought to be discouraged' without considering the value of the unhealthy behaviour. In one way, Wilson is not one of these writers because he acknowledges that people care about their overall well-being and are willing to trade off health for other goods.[45] But in another way, he is an example because he does not then take account of his own point when he recommends the WHO's 'best buys'. The taxes on alcohol and tobacco, the restrictions on their availability, and the bans on their advertising are supposed to cause a big gain in health but would likely lead to the loss of at least some of the non-health benefits of smoking and drinking, and Wilson does not mention these foregone benefits. He considers only the gain in health, which he thinks is large, and the loss in liberty, which he thinks is small. Wilson's implicit assumption is that alcohol and tobacco are not just bad for health but for well-being. Perhaps they are, but it is a mistake to assume they are and another mistake not to notice that one is assuming it.

Lastly, we enter the quagmire of defining health. If we think of the earlier examples, of the 500 kg deadlift and the rest, a common-sense way to describe what the people involved do is as trading off health for the sake of goods besides health. Does this description of the tradeoffs presuppose a controversial or narrow definition of what health is? I do not think so. The description is consistent with different views of what health is.[46] To illustrate, suppose health is defined in terms of biological dysfunction. It is quite understandable why one might want to behave in ways that cause biological dysfunction, as some people do when they seek infertility. (Infertility is another example of how evaluations vary, since other people are desperate to overcome their problems with fertility.) Suppose instead ill health is defined not just, or at all, in biological terms but instead in an evaluative way so that it becomes true by definition that ill health must be bad. Even then, it is left open that the badness of some aspect of ill health, such as an episode of hayfever, is worth it for its benefits, such as seeing the flowers in a summer meadow.

What are we to make of the WHO's definition of health as 'complete mental, physical, and social well-being and not just the absence of disease and infirmity'?[47]

[44] Wilson, *Philosophy for Public Health*, p. 119.
[45] Wilson, *Philosophy for Public Health*, p. 118.
[46] For a brief and accessible discussion of the options, see Wilson, *Philosophy for Public Health*, ch. 1, §2.
[47] From the Constitution of the World Health Organization. See https://www.who.int/about/governance/constitution (last accessed 20 June 2024).

On this definition, health cannot be conceptually separated from the rest of well-being. One might then say that the people in the examples that opened this chapter were not giving up health. Rather, the athletes, cyclists, BASE jumpers, and grandfather were giving up one aspect of health for the sake of other aspects of health.

The WHO has not, in my opinion, defined health. It has instead taken an ordinary concept and given it a radically different meaning.[48] However, even if we use the WHO definition, the tradeoffs described so far are still there; they just need to be redescribed as tradeoffs within health. The point of substance can then be put like this: suppose a public health policy makes a population healthier in a specific way, say by preventing some of them getting lung infections or Type 2 diabetes or chlamydia. It is still possible that, although people are likely to gain in these aspects of health, they lose more in something else that the WHO might call 'health', such as playing with their grandchildren, improving their strongman performance from putting on body mass, or having casual sex. In other words, public health policies that do what they aim to do could make people worse off overall in health, as the WHO defines health. Put more clearly, public health policies could make people healthier but worse off.

Community and Collective Benefits

Grant the claim that it is possible for people to behave in healthier ways but be worse off for it. I now want to show how this claim causes difficulties for common ways to think of the main ethical problems of public health interventions, and for an influential analysis of the project of preventative health itself. To begin with the ethics, Virginia Berridge frames the 'nanny state' debate as being about 'the tension between the collective benefits to society of public health interventions contrasted with the liberty of individuals'.[49] Dan Beauchamp writes that 'We are not only individuals, we are also a community and the body politic' and he says that 'By ignoring the communitarian language of public health, we risk shrinking its claims'.[50] Lawrence Gostin and Lesley Stone take a leading question in public health ethics to be: 'Who gets to decide in a given case which value is more important—freedom or health?', as if freedom and health were the only or main potentially competing

[48] Unfortunately, a WHO-style expansion of the concept of health seems to be catching on in New Zealand, according to my colleague, Susanna Trnka. Thanks to her for showing me her draft book, *Healthization: Turning Life into Health*. The expansion is fostered by failing to distinguish between the factors that affect health causally, which can be all sorts of things, and the thing that is supposed to be affected, which is where we need the concept of health.

[49] Virginia Berridge, *Public Health: A Very Short Introduction* (Oxford: Oxford University Press, 2016), p. 9. For Berridge, the nanny state debates are also about fairness and whether public health brings about a genuine common good.

[50] Dan Beauchamp, 'Community: The Neglected Tradition of Public Health', *Hastings Center Report* 15 (1985): 34.

values.[51] Putting these together,[52] critics of the nanny state might be said to have wrongly taken the side of the liberty of individuals rather than the benefits of public health to the community. On this framing, the issue between the advocates of public health and the critics of the nanny state is not over whether adults should be made to be healthier and treated like children, it is whether to choose individual liberty or the common good. I think this framing is misleading. The critics, as we saw, object to the healthism that they think underlies public health measures. Their objection, I shall argue, cannot be avoided by framing public health ethics as a choice between the common good and individual liberty.

One way to understand the slippery term, 'the common good', derives from community understood as more than an aggregate of the interests of private individuals. This is the sense preferred by Dan Beauchamp and Bruce Jennings.[53] Community is built out of practices that are 'shared activities that are not purely instrumental and that help shape and affirm the common life'.[54] Both Beauchamp and Jennings think that public health ought to invoke community in its support. However, upholding communal practices need not promote health. All sorts of traditions, from getting communally drunk, to eating at large feasts, to shaking hands, to an honour code of vendetta, can get in the way of promoting health. Cigarette smoking played an important role in British cultural life for decades: widows kept the stubs of the cigarettes smoked by their dead husbands as mementos of 'his last cigarette'; Sir Austin Bradford Hill, the legendary figure in demonstrating the link between smoking and lung cancer, kept a box of cigarettes on his desk because offering one to a visitor was the way to show hospitality;[55] my father told me that, in the Royal Air Force of the 1950s, it was customary to offer cigarettes even in formal interviews, such as commissioning boards. When workers in public health discouraged smoking, they were not respecting these community traditions. They were trying to overturn them. As I hope is obvious, my point in this paragraph has nothing to do with the merits of communitarian thinking; it is only that, contrary to Beauchamp's aim, taking communitarian ideas seriously could shrink the claims of public health. Indeed, public health activities could be objected to precisely because they would cause, to quote Jennings, '[t]he eroding of traditions and institutions that sustain communitarian values' and therefore be 'a significant social "cost"'.[56]

[51] Gostin and Stone, 'Health of the People: The Highest Law?', p. 65.

[52] As Bruce Jennings does in 'Community in Public Health Ethics', in *Principles of Health Care Ethics*, 2nd ed., edited by R. Ashcroft, A. Dawson, H. Draper, and J. McMillan (Chichester: John Wiley and Sons, 2007).

[53] Beauchamp, 'Community', p. 29. See also Jennings, 'Community in Public Health Ethics', p. 548.

[54] Beauchamp, 'Community', p. 34. See also Jennings, 'Community in Public Health Ethics', where community is said to involve 'particular, localized modes of cultural and symbolic expression', p. 547.

[55] Both these stories can be found in Virginia Berridge, 'The Policy Response to the Smoking and Lung Cancer Connection in the 1950s and 1960s', *Historical Journal* 49 (2006): 1200.

[56] Jennings, 'Community in Public Health Ethics', p. 548.

Leaving aside unhealthy communal practices, it is misleading to frame public health ethics as a tension between individual liberty and the collective or common good because it draws our attention away from the possibility that what promotes health might reduce well-being. As we saw, the price of health can be less pleasure, not playing with one's grandchildren, losing in sporting competitions, and not seeing interesting places and, as we will see in later chapters, the price can also be less money or time. Thus trying to make people healthier against their wishes might not just infringe on their liberty: it could make them worse off as well. This possibility is further obscured by casually putting 'health and well-being' together in a text block, as commonly happens. Contrary to the framing, the choice may not be health and well-being versus individual liberty but health versus well-being and individual liberty.

Let me state some points that I think are obvious on reflection. Health, as a benefit, is good in one way; but a gain in health might come at too high a cost. And so a community could gain the benefits of more health and yet become worse off. These obvious points are not only often overlooked in discussions of public health ethics, they are also overlooked in an influential analysis of public health, the prevention paradox.

Recall from the previous chapter what Geoffrey Rose called 'one of the most fundamental axioms in preventive medicine: *a large number of people exposed to a small risk may generate many more cases than a small number exposed to a high risk*'.[57] One example might be reducing blood pressure in a large population, such as those over 40. Although many in that group would not otherwise develop cardiovascular disease, targeting all of them, and not just those at high risk, could be most effective at reducing the disease in the population.

In Rose's view, a paradox then arises:

> It is a common irony of preventive medicine that many people must take precautions in order to prevent illness in only a few. This common phenomenon has been expressed as the 'prevention paradox' . . . *a preventive measure that brings large benefits to the community offers little to each participating individual.*[58]

The prevention paradox is often cited by writers in public health when they think about the choice between the individual and the community. But it is puzzling why anyone would think the phenomenon described as the prevention paradox is a paradox at all. I shall speculate that it seems paradoxical only to those who lose sight of the possibility that a community could be healthier but worse off and I shall point out two important omissions in the usual discussions of prevention.

[57] G. A. Rose, K.-T. Khaw, and M. Marmot, *Rose's Strategy of Preventive Medicine: The Complete Original Text* (Oxford: Oxford University Press, 2008), p. 60.
[58] Rose, Khaw, and Marmot, *Rose's Strategy*, p. 47. Emphasis in original.

We do not really have a paradox if what offers 'little' to each of many individuals sums to a large aggregate benefit.[59] Take an example outside health: if a cup of coffee costs $3.90 but is worth $4 to each consumer, the consumer gains a net benefit worth ten cents every time they buy; and in a large population of coffee drinkers, the consumer surplus would be considerable. A 'little' here, a 'little' there, it all adds up. Drinking coffee differs from typical preventive health, of course, but not in ways that affect the point. Drinking coffee has a benefit that is both small and immediate whereas, as Rose points out, many people might get no benefit from preventive health measures, while the ones who as a result avoid illness or injury do so only in the relatively distant future. To use Rose's example, most drivers would not be saved by their seatbelts because they would not crash. On the other hand, the few who are saved gain a lot. Suppose we take account of the points about time and probability and interpret Rose's statement that preventive measures offer 'little' to each participating individual as meaning that each individual would acquire a very small chance of a very high benefit from participating, and that the 'little' it amounts to is a small but positive expected benefit after costs are counted. Still, it would not be paradoxical if the result of each person acting so as to get a small net expected benefit were to be a large community benefit.

What would be closer to being paradoxical would be if each person were to act against their expected interests and yet the result be collectively better. Preventive health measures, even measures that make people healthier, could certainly have people acting against their interests. Rose agrees. Participating in preventive health is something that most people would not otherwise want to do, which is why getting them to do it is hard. Rose himself says he would not adopt the Japanese diet even though the Japanese lived longer than anyone else because 'as I do not live in Japan, the cost to my domestic and social life would be high, and I do not value health as much as that!'.[60] And when Rose considers an alcohol strategy that aims to mitigate alcoholism by reducing population mean levels of drinking, for instance by raising the price of drink and reducing its availability, he writes that 'This is hard on Mr and Mrs Average, who presumably enjoy their moderate drinking'.[61] As Rose makes clear, Mr and Mrs Average would have to lose overall so that the people who would otherwise be alcoholics would gain. In sum, for an individual, an expected gain in health can not only come at a cost but be outweighed by that cost. So if a preventive health measure is, from the point of view of the individual, against their expected interests, how can the result of applying it on a large scale be a large collective gain?

An answer can be found for the subset of public health measures that deal with collective action problems. Achieving herd immunity to measles or reducing

[59] Perhaps, as Geoff Kemp suggested to me, we should speak instead of the 'prevention platitude'.
[60] Rose, Khaw, and Marmot, *Rose's Strategy*, p. 39.
[61] Rose, Khaw, and Marmot, *Rose's Strategy*, p. 144.

noxious fumes could be a net benefit to society even without its being on balance in any individual's interests to contribute to these collective goods (although some reason would have to be given for why the collective goods are a net benefit once one takes into account the cost of contributing). However, to restate a point from the previous chapter, many public health measures do not address collective action problems. Reducing cholesterol for the sake of lower rates of coronary heart disease does not address a collective action problem because lower cholesterol is not the equivalent of herd immunity.[62] My cholesterol does not cause heart disease in you.[63] Leaving aside collective action problems, why does Rose, and those who follow him, think that the result of prevention that is against each person's interests would be a collective gain?

I speculate that Rose and others have made a mistake because they do not see how a large gain in public health could be anything other than a major net benefit, that is, after taking account of costs. Assured, in their own minds, that successful prevention has large community benefits but accepting that individuals could be worse off for participating, they think they have a paradox rather than realizing they might have a large collective loss. Whether or not that speculation is on to something, observe that Rose does not establish that the benefits of prevention are net benefits, only that they might be benefits in health. He provides evidence and theory to show how a population strategy would lead to the greatest reduction in disease or injury, but what he provides does not show whether the strategy would make people better or worse off overall.

Once we realize that the benefits of prevention to individuals can be outweighed by the costs to them, we can see two important omissions in the usual discussions of the prevention paradox. The first is about motivation. Rose and other writers in public health say that the people will often not be motivated to follow a preventive population strategy because the health benefits to them are distant and uncertain and people are not powerfully motivated by distant uncertain benefits.[64] On the face of it, that is a value-neutral psychological claim, but Rose treats the lack of motivation as a problem, and he immediately goes on to say that it is a good thing that social norms have pressured smokers into quitting or cutting down when the prospective health benefits alone are not enough to change their behaviour. What he omits, and what the usual discussion of the paradox omits, is to consider whether people are right not to be powerfully motivated by the distant and uncertain benefits in health that a preventive strategy might bring. Perhaps the problem is with the prevention and not the people.

[62] As Khaw and Marmot make clear in their commentary on Rose's text. See Rose, Khaw, and Marmot, *Rose's Strategy*, p. 19.

[63] Might my heart disease cause me to use up more health care resources than I otherwise would? It might, and then again it might not. Rose himself refuses to rest his case on saving resources. The social costs of ill health, and Rose's reason not to rely on them, are discussed in Chapter 11.

[64] Rose, Khaw, and Marmot, *Rose's Strategy*, p. 47.

The other omission is this: the population prevention strategy can have large net costs even if it does what it is supposed to do. To be clear, the point is not that a strategy can backfire or fail, a point made by Rose and others. They have in mind such possibilities as getting people to drink less alcohol, and thereby removing a protection against coronary heart disease, or encouraging exercise that regrettably causes injuries, or over-diagnosing diseases leading to unnecessary and risky treatment.[65] My point, by contrast, is that preventive strategies could increase health and still make people worse off. We saw earlier that if each person gains a small net benefit, it could add up to a large collective benefit. But equally many small net losses can add up to a large accumulation of net costs. Thus another version of the prevention paradox, also omitted in the usual presentations, is this: *a preventive measure that offers a little loss to each participating individual brings large losses to the community.*

Conclusion

Because health is not so overwhelmingly important in our lives that we should never give it up, a public health policy could make people worse off even when it succeeds in making them healthier. And because people vary in how they would trade off health against other benefits, and vary for good reasons, a public health policy could be good for some people but bad for others. These two points seem clear enough but they are, as we saw in this chapter, often overlooked by public health advocates when they argue for their policies. The upshot is that it is an open question whether even successful public health policies would be ethically justifiable.

As far as that statement goes, it could turn out that even highly interventionist health policies could succeed in making people not only healthier but better off in overall well-being. That is what follows from being an open question. In this chapter, I did not defend laissez faire or anti-paternalism, nor did I recommend what might be stigmatized as 'the neglectful state'.[66] I took no stand on whether the conclusions of public health advocates were correct; I only pointed out errors and omissions in their reasoning.

That policies can benefit some while being against the interests of others raises questions of distributive ethics. When do the gains to the winners from being made

[65] Anne H. Outwater, Sebalda C. Leshabari, and Ellen Nolte, 'Disease Prevention: An Overview', in *International Encyclopedia of Public Health* (2nd ed.), edited by Stella R. Quah (Kidlington, Oxford: Academic Press, 2017), p. 342, for the examples of heart disease and exercise; and Wilson, *Philosophy for Public Health*, p. 149, for the example of over-diagnosis. The authors are not asserting that reducing alcohol, encouraging exercise, or screening would in fact have these side effects. They are just examples to show how a strategy could backfire.

[66] Wilson's term in his subtitle to *Philosophy for Public Health.*

to be healthier outweigh the losses to those who would have been better off without the public health policy? We will consider some answers later in the book, especially in Chapter 12. The prior task is to work out a way to decide whether and when a gain in health is a gain in well-being. For that, we need an account of the value of health, and I offer one in the next chapter.

4
The Value of Health and a Challenge to Public Health

Introduction

If it is an open question whether even successful public health policies would make people better off, how can we close it? The obvious place to start, given what I said in the previous chapter, is with how people value their own health. In this chapter, I put forward a preference-based account that takes the value of some component of health to be measured by the extent to which it gives people what they ultimately prefer. I say I put this account forward rather than that I endorse it because, although I think a lot can be said for it and it is good enough for the purposes of this book, I cannot fully accept it.

Our interest in this book is primarily in public health policies that are paternalistic, and paternalism generally presupposes that people make mistakes about their interests. The preference-based account does allow that people could make mistakes about their interests, for instance if their beliefs are false or their motivation is weak. But it rules out counting someone's ultimate ends as being mistaken. If someone's beliefs were correct and if they steadfastly acted so as to fulfil their ultimate ends, they could not be said to have made a mistake about their interests no matter how unhealthy they might become.

Should we really say that if people ultimately do not prefer to be healthy then making them healthier could not be good for them? I consider two arguments against a preference-based account: that value is objective, not subjective, and that preferences may be adaptive. I do not think either of these arguments is persuasive. But as I said above, I cannot fully accept the preference-based account. Some ultimate preferences do seem as if they could be mistaken, as I believe we can see by considering the awful decisions of patients with advanced anorexia nervosa. Even so, I argue that the preference-based account is good enough to assess typical public health interventions.

We then come to a challenge to public health interventions: when people choose to behave in unhealthy ways, they do what they prefer; and given that preferences measure value for them, public health interventions that steer them towards health would make them worse off, not better off. This is an important challenge and the answers to it will take up the next two chapters. In this chapter, we see only what the challenge is, what it applies to, and why it ought not to be dismissed as ignoring

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the problems with unhealthy choices that are caused by poverty, manipulation, or addiction.

Preferences as the Measure of the Value of Health

Suppose someone's chronic liver disease makes them ill tempered and depressed. They might regard being ill tempered and depressed as bad because these states damage their relationships with their family. If so, the benefit of not having chronic liver disease would be good as a means to their end, the end of getting on with their family. They might regard feeling ill tempered and depressed as bad states in themselves. If so, the benefit of not being in these states would be an end in itself; and if depression is a form of ill health, then not being depressed would be a health benefit that was an end in itself. Thus avoiding disease could be good both as a means and as an end. To use terms of art, we might say that when a health benefit is a means to an end, it has derivative value; and when it is an end in itself, it has ultimate value. The 'ultimate' in 'ultimate value' means that it is last or final, as in David Hume's example:

> Ask a man why he uses exercise; he will answer, because he desires to keep his health. If you then enquire, why he desires his health, he will readily reply, because sickness is painful. If you push your enquiries farther, and desire a reason why he hates pain, it is impossible he can ever give any. This is an ultimate end, and is never referred to any other object.[1]

The 'ultimate' in 'ultimate value' does not mean 'very important'. The small pleasure of a cheeseburger could be ultimately valuable, in this sense of ultimate.

The idea I am putting forward here is that the value of health for a person depends on the extent to which that person values it in itself—its ultimate value—or to which being healthy really does promote other ends they have.[2] Since people vary in how they value the different components of health, as with an athlete willing to risk injuries that other people would not, the value of these components varies from person to person.

[1] David Hume, *An Enquiry Concerning Human Understanding and Concerning the Principles of Morals*, ed. L. A. Selby-Bigge, rev. ed. P. H. Nidditch (Oxford: Clarendon Press, 1986), p. 293. I agree with Hume when he goes on to say, 'Something must be desirable on its own account' (i.e. not everything can have only derivative value), but I do not endorse what follows, 'and because of its immediate accord or agreement with human sentiment and affection'.

[2] Because this is not a book about well-being, I shall largely ignore the difficult question of disentangling means from ends, or derivative ends from ultimate ends. For discussion, see Cass R. Sunstein, *Why Nudge? The Politics of Libertarian Paternalism* (New Haven: Yale University Press, 2013), pp. 63–71.

So far, I have talked about what people value, and what is good or bad. But people value lots of things and they cannot have them all. We need the idea of what people prefer—the equivalent of better and worse rather than good or bad. Whether it is better to be healthy in some way does not depend on whether it would be good but whether it would be better than the alternative. Although this idea is a tautology, it is sometimes overlooked. To take one example, Karen Jochelson, in making her case for public health regulation and taxation, points out that many overweight people 'would like to be thinner'.[3] Her argument commits the mistake, the opposite of the one usually attributed to economists, of knowing the value of everything and the price of nothing.[4] People might in the abstract want to be thinner, as they might in the abstract want a tennis court. But just as they might not want a tennis court if they have to pay the $90,000 bill, so they might not want to be thin if they have to eat less and exercise more. To use a term of art again, I will write of what fulfils a person's ultimate preferences, where 'ultimate preferences' is supposed to capture the way in which they trade off the fulfilment of their ultimate ends. The same idea is sometimes expressed as their 'balance' of ends.[5]

The idea that the value of health for someone is measured by their preferences differs from the idea that the value of health depends on its contribution to a person's well-being. A person might value their health relatively low not because they want something else that would be better for them but because they care about other people, or even have impersonal goals, such as preserving an ecosystem. Thus some people might, for the sake of their families, eat badly to save money or take risky jobs to earn more. Some of them might sacrifice not only their health but their overall well-being. If so, fulfilling their ultimate preferences would not promote their well-being. Quite possibly, if we had to choose between fulfilling someone's preferences or promoting their well-being, we should choose their preferences. Be that as it may, I shall simplify what I say here so, except where I say otherwise, the view I am setting out is that ultimate preferences measure well-being. This simplification seems reasonable to me for the common targets of public health because I think that people do not typically smoke, drink alcohol or sugar, take drugs, skip exercise, or have unprotected sex for the sake of other people or for noble ideals. They do it for themselves.

Paternalism, including public health paternalism, aims to make people better off. But we might wonder how interfering with unhealthy people's behaviour could make them better off if their preferences measure the value of health for them. Would public health paternalism be self-defeating by making people worse off?

[3] Karen Jochelson, *Nanny or Steward: The Role of Government in Public Health* (London: King's Fund, 2005), p. 32.

[4] Francis Spufford, *Red Plenty* (London: Faber and Faber, 2010), p. 106.

[5] e.g. by Julian Le Grand and Bill New, *Government Paternalism: Nanny State or Helpful Friend?* (Princeton: Princeton University Press, 2015), p. 29.

Quite possibly, as we will be seeing, but not simply because ultimate preferences are the measure of value. We might not be mistaken about our ultimate ends, but we can make mistakes in how we pursue them. These are the sorts of mistakes pointed out by 'means paternalists', who take preferences to be the measure of value but still recommend paternalism.[6] Means paternalists aim to make people better off 'as judged by themselves'.[7] Means paternalists stress that they do not impose values but merely help people achieve what they themselves prefer. In their usual jargon, means paternalists want to close the 'gap between behaviour and preferences'.[8] We shall evaluate, over the next two chapters, their ideas and the mistakes they think they detect in our behaviour.

We shall also consider, in the next chapter, the difficult problem of time. I have been writing about preferences between health and other goods, for instance between athletic achievement and health or excitement and health. In many cases, these are not just choices between different goods but different goods at different times. Smoking, overeating, drinking alcohol, and being inactive often lead to ill health in the future rather than at the time. From the point of view of someone in 2024, good health in 2024 might be better than smoking in 2024, but smoking in 2024 might be better than good health in 2064. Could such preferences be mistaken? As I said, it is a difficult question and I put off answering it until later.

The view we are considering in this chapter says that ultimate preferences cannot be mistaken. I want to discuss three objections to the idea that ultimate preferences measure well-being: that the correct account of well-being is objective, not subjective; that preferences can be 'adaptive'; and that some ultimate preferences are harmful. Needless to say, a lot more can be and has been said on whether ultimate preferences can be wrong but, for reasons of space, I am concentrating on those that tend to come up in discussions of unhealthy preferences.

Objective Well-Being

One might think that getting what one ultimately prefers is not sufficient for one's well-being because one might fail to prefer what is objectively more valuable. Some such thought is often expressed in discussion by philosophers who say they do not accept preference-satisfaction theories of well-being. They favour an apparent alternative, the objective conception of well-being. Objective conceptions, as they

[6] 'Means paternalism' is the term used by Le Grand and New, *Government Paternalism*, ch. 3. Means paternalism is also endorsed by, amongst many others, Sarah Conly, *Against Autonomy: Justifying Coercive Paternalism* (Cambridge: Cambridge University Press, 2013); and Sunstein, *Why Nudge?*

[7] Richard Thaler and Cass R. Sunstein, *Nudge: Improving Decisions about Health, Wealth, and Happiness* (New Haven: Yale University Press, 2008), p. 8.

[8] D. M. Cutler, A. I., Jessup, D. S., Kenkel, and M. A. Starr, 'Economic Approaches to Estimating Benefits of Regulations Affecting Addictive Goods', *American Journal of Preventive Medicine* 50 (2016): 25.

are understood in philosophical writings, often list various valuable components of a life.[9] A list might include health or pleasure, and these and other items on it could be described as objectively valuable in that their value does not depend fully on people's attitudes to them.

Applied ethics must often sit on fences and this is one of several occasions where I would like to avoid taking a stand on a highly controversial philosophical problem. With that remark, let us contrast the account I am setting out with the points typically made by pro-objectivist philosophers. The account says that a person's ultimate ends measure the value of health for them. Objectivists often say that the perception of value is prior to the preference and people want things, at least for the most part, because they think they are good;[10] and they say that preferences do not give reasons for action or, if they do, only unimportant ones.[11] What the account says and what objectivists say are different; but they are not opposed. Objectivists would not accept that what makes something best for someone is that it fulfils the ultimate desires that underlie their preferences, but they could accept that what people prefer is what is best for them. Perhaps people's ultimate desires are a very reliable guide to what is objectively best for them, a possibility that becomes more likely to the extent that objective value is supposed to depend on a person's own commitments and wholeheartedness.[12]

An objectivist might think that people's ultimate preferences are not a very reliable guide to what is valuable for them, but I doubt whether, in the context of health policy, objective views can give us a criterion for judging value that is an alternative to one based on preferences.[13] How, without drawing on someone's own preferences, are objective views to answer the question: 'is this person all-things-considered better off for being healthier?' Of course, objectivists can say that people are better off in one way for being healthier because health is on their objective list but, as we saw in Chapter 3, health cannot credibly be held to be of such overwhelming importance that any health benefits must outweigh all other non-health benefits. So just being healthier would not on its own settle the all-things-considered question. Nor would we get out of objectivism anything like this: 'Your ultimate ends would support giving up four units of health for three units of playing with grandchildren, but in fact the correct rate of exchange is two units of health for three units of playing with grandchildren; therefore your risking

[9] James Griffin, *Well-Being: Meaning, Measurement, and Moral Importance* (Oxford: Clarendon Press, 1986), p. 33.

[10] Derek Parfit, *Reasons and Persons* (Oxford: Oxford University Press, 1984), p. 499. George Sher, *Beyond Neutrality: Perfectionism and Politics* (Cambridge: Cambridge University Press, 1997), p. 109.

[11] T. M. Scanlon, *What We Owe to Each Other* (Cambridge, MA: Belknap Press, 1999), ch. 1.

[12] As in Joseph Raz's account of well-being in *The Morality of Freedom* (Oxford: Clarendon Press, 1986), ch. 12.

[13] Alex Rajczi believes that objective list accounts of the value of health will end up being similar to the preference-account offered here. See Rajczi's 'Liberalism and Public Health Ethics', *Bioethics* 30 (2016): 96. I agree with much of Rajczi's article.

your health as you are is a mistake.' We do not have a book of value with the answer at the back.[14]

This is one of those occasions where I cannot close off every possibility. So I can say that I have left it open for someone to argue for an objective account of well-being in which health has a very high or dominant value. I do not know of any plausible versions of such an argument.[15]

Adaptive Preferences

One can criticize the idea that the value of health depends on ultimate preferences by asking, 'What if people adapt their preferences in response to their unfortunate circumstances?' To take a well-known example from Amartya Sen, think of a subdued housewife. Suppose she values her own health as less important than her family's health or than men's health generally. If this valuation is due to adapting to her unjust circumstances, it should not be taken as the measure of the moral importance of making her healthier.

I propose not to specify in detail what it means for a preference to be adaptive. Different writers——sometimes the same writer at different times——have different phenomena in mind.[16] Let the idea be that when preferences about health or competing goods adapt, they do so because they are manipulated, or inauthentic, or shaped by having hardly any desirable options.[17] Adaptive preferences would be

[14] One might also argue that to base policies on an objective view of value is perfectionist, which fails the requirements of public reason and thereby makes the policies illegitimate. This argument is developed in a public health context by Anne Barnhill and Matteo Bonotti, *Healthy Eating Policy and Political Philosophy: A Public Reason Approach* (New York: Oxford University Press, 2022), esp. chs. 2 and 5. I only mention this argument rather than endorse it.

[15] But I do know an implausible one. Plato, who at various points in *The Republic* sounds like a public health advocate, put this argument into the mouth of Socrates in Book VIII (559): the only food necessary for health and condition is bread and meat; the desire to eat more than what is needed for health and condition is an unnecessary desire; it is unnecessary because (a) satisfying the desire is bad for the body and the insight and temperance of the soul and (b) the desire could be avoided with early training and discipline. As against Plato's Socrates, many people would not be attracted to a diet consisting solely of bread and meat, or to its modern pro-health equivalent, and I see no reason to think they thereby risk the temperance and insight of their soul. And even on Socrates' terms, the people who have not had his early training may be worse off on his Spartan diet. See Plato, *The Republic* (trans. A. D. Lindsay) (London: Heron Books, no date).

[16] Sen uses the subdued housewife example, and others, in many places, often in different ways. In *Inequality Reexamined* (Cambridge, MA: Harvard University Press, 1992), pp. 54–5, the adapters seem to be concentrating their desires on what they can realistically achieve; but in *Development as Freedom* (New York: Anchor Books, 2000), pp. 62–3, they are said to lack courage and be unambitious; in *The Idea of Justice* (Cambridge, MA: Belknap Press, 2009), pp. 284–6, Sen gives the example of people misperceiving their own health, which seems a point about the accuracy of their beliefs, rather than the merits of their desires. Put another way, Sen, like other writers on adaptive preferences, does not describe a single phenomenon.

[17] Sen explains at one point that his remarks about preferences adapting to deprivation should be understood not as a paternalistic criticism of those preferences but as asking that people have the chance to form their preferences with reasonable opportunities. See *The Idea of Justice*, p. 275. I take

a problem for the thesis that our ultimate ends measure the value of our health only if these three conditions were all met: (1) some people's health-related preferences are adaptive, (2) it is their ultimate ends that have adapted, and (3) the adaptation is a good reason to think their ultimate ends do not measure what is valuable for them. As we now see, these conditions may well not be fulfilled and I do not think we should give up the ultimate preference account because of a concern about adaptive preferences. As we shall also see, this conclusion offers some support to the argument that public health interventions could make people better off through causing their preferences to adapt.

The first condition is that adapting preferences are health-related. It would not be a problem for the preference-based account of the value of health if the only preferences that adapt do not bear on health behaviour. Are people's health-related preferences adaptive? We should not assume they are. As we see later in this chapter, not all unhealthy behaviour is down to the poverty or manipulation one might cite as causes of adaptation. Too many people who are neither poor nor manipulated behave in unhealthy ways. Moreover, we should not infer that people have something wrong with their preferences just because we do not share them. That is an obvious point to make, but cultural critics who ask 'why don't people want what I want?' have been prone to explain away other people's preferences as the result of some psychological defects or regrettable socialization. Many of their criticisms now seem absurd, such as sneering at two speed windscreen wipers on cars.[18]

Still, even if not all unhealthy behaviour can be criticized as down to adaptive preferences, perhaps some can. Even when it can, the second condition may not be met because the problem may not be with ultimate ends. Perhaps the problem is with beliefs. Beliefs can be false and the desires that derive from combining those beliefs and higher-order ends can therefore be criticized. If manipulation or adaptation cause you to have false beliefs which cause you to want what in fact sets back your ultimate ends, then you have made a mistake. If you want cocaine but only because you do not know cocaine is dangerous, then your desire for cocaine is mistaken. Thus if one's concern about manipulation or adaptive preferences is a concern about people's beliefs, one need not give up the view that their ultimate ends measure the value of their health.

Even if some people's ultimate ends have adapted, a question still arises over what is wrong with them. Perhaps the third condition is not met since adapting

it that he would not then criticize as adaptive the preferences of someone for being unhealthy (with its benefits) over being healthy if they had the reasonable opportunity to be either.

[18] The windscreen wipers were Jean Baudrillard's example, cited in Joseph Heath and Andrew Potter, *The Rebel Sell: How the Counterculture Became Consumer Culture* (Chichester: Capstone, 2006), p. 107. Barnhill and Bonotti recommend caution before treating preferences as adaptive in *Healthy Eating Policy and Political Philosophy*, pp. 47–8.

what we want to what we can have is in many cases a perfectly normal and healthy response. It is what many of us do as we grow up and realize we will not drive in Formula 1 or marry a pop star.

If a good reason can be given to think that some people's ultimate ends have been shaped by a bad adaptive process (and it will not be easy to come up with a good reason), that leaves all those people whose health-related preferences are not objectionably adaptive. For them it could still be correct to think of the value of health being measured by their ultimate ends.

If we should not generally reject health-related preferences on the grounds that they are adaptive, one perhaps unexpected implication is that we should not, in principle, reject an adaptability argument that supports public health. The argument, while not put this way, can be derived from much public health advice about eating and drinking. The argument is that our tastes can be changed. People who, for instance, like sugary drinks can learn to like tap water which is, in countries with a safe supply,[19] both cheaper and healthier than sugary drinks. Water drinkers would thus get no less pleasure and have more health and money than if they drank sugary drinks. Since we can assume they like pleasure, money, and health, they would get more of what they prefer in two dimensions and no less in another, so they would be better off for having adapted their tastes.[20] If we thought adaptation always undercut autonomy or authenticity or was otherwise bad, we would reject the adaptability argument in principle, but, as I said, we should not.

Although we are getting diverted from thinking about whether ultimate preferences can be mistaken, we might as well finish with this public health adaptability argument. How far does our capacity to adapt our preferences support public health interventions? Assuming adaptation works as stated, we can distinguish two groups. One group consists of those who have not yet developed unhealthy tastes and the other consists of those who have already developed unhealthy tastes. If the first group learns to like tap water, then plausibly they would be better off. What of people who have already formed unhealthy tastes? Why do they not spontaneously transform their tastes given the supposed advantages? The answer could be that, before they adapt, they would have to pay transition costs. Two weeks of irritability and a fuzzy mind might be too high a price to pay for the slender benefits of adapting to life without coffee. When transition costs are not worth paying, people would not be better off for being forced to adapt. On the other hand, they might

[19] Surprisingly, the United States is not one of these: 'Nearly 21m Americans drank water from communal systems (including schools, hospitals and other public places) that did not meet safety standards in 2015, the latest year for which data are available.' 'High and Dry', *The Economist*, 10 September 2022.

[20] I am here applying to well-being what John Rawls names the 'principle of inclusivity' for rational choice. See Rawls, *A Theory of Justice*, rev. ed. (Oxford: Oxford University Press, 1999), p. 362. If Plan A would achieve everything desirable that Plan B would, and Plan A achieves other desired ends too, Plan A should be chosen. Here, water (cheaper, healthier, no less pleasurable) is better than a sugary drink (equally pleasurable, but more expensive and unhealthy). We will see the principle of inclusivity again at work in an argument for why anorexia nervosa is bad for the people who have it.

be worth paying and yet left to themselves people would not change for reasons of shortsightedness, in which case making them adapt could make them better off. It is, however, easy to assert shortsightedness but harder to establish its existence, as we see in the next chapter.

How far could people adapt out of unhealthy activities? Sugary drinks have a ready alternative in water but the alternatives to cheap and convenient food and drink are often expensive or inconvenient. Some people dutifully exercise their bodies without ever coming to like it. Intoxicants might be substitutable with each other but heavy drinkers are unlikely to find that 'lime juice and soda has a pleasant little kick to it'.[21] The adaptation argument thus probably has a scope limit. In sum, public health interventions could improve some people's well-being through adaptive preference change but it would be a complex task to establish how many people would actually benefit.

To get back to well-being, on the account I have put forward, how well off someone is depends on how far their ultimate ends are fulfilled no matter what those ends are. I have tried to make this account appealing by showing some of the difficulties in criticizing someone's ultimate ends. However, I must admit that I do not wholeheartedly support this account. The account allows some ultimate ends that I and, I am sure, many readers, cannot believe would make someone better off for being fulfilled. Put another way, I feel the opposing pull of two sides: the side that says we should not impose our ends on others because they are like tastes and tastes are beyond dispute, and the side that says, what about crazy and harmful ends? I would like to explain why I am torn by reporting the value judgements of people with anorexia nervosa.[22] Although it may seem as if we are getting a little too detailed, I think that the example of anorexia nervosa not only tests the ultimate preference account, but also that working through it introduces some important problems in deciding what counts as a mistake about one's interests.

Harmful Ends and Anorexia Nervosa

Anorexia nervosa is characterized by fasting or purging or both, and often a great deal of exercise. The motive is an intense fear of being fat and the effect is low, or

[21] The main character replies, 'The kick of a mouse, I should imagine. In carpet slippers.' The quotations are from a dialogue about whether to warn a heavy drinker that he must stop drinking or die. 'Rumpole and the Alternative Society', in John Mortimer, *Rumpole of the Bailey* (London: Penguin, 1978), p. 53.

[22] We might also have considered people with Munchausen's Syndrome or Factitious Disorder Imposed on Self, some of whom will swallow razor blades, stab themselves, infect their wounds, or undergo frequent abdominal surgery because they so badly want the attention in 'medical attention'. For vivid case descriptions, and the original naming of the phenomenon, see Richard Asher, 'Munchausen's Syndrome', *The Lancet* 257 (1951): 339.

very low, body weight.[23] Emaciation due to anorexia can, amongst other things, weaken bones, shrink the heart, cause electrolyte imbalances, and damage the oesophagus, which in turn can cause fractures, epileptic attacks, cardiac arrest, an inflamed pancreas, and death.[24] Although the health consequences are obviously very bad for anorexics, they are the result of their deliberate actions. The energy shortfall of someone with anorexia is not like the shortfall of an elderly person with dementia who forgets to eat. Nor is it due to the absence of hunger; unlike someone on chemotherapy who is too nauseated to eat food, people with anorexia nervosa do struggle with hunger.[25] Their refusal to eat enough is a refusal in the service of a goal, on some views the goal of self-mastery or self-control, that takes the form of control over an inferior body; and this is a goal valued higher than health.[26] Anorexia nervosa seems a powerful counterexample to the account of well-being given in this chapter because it looks as if it involves actions in pursuit of a balance of ends that is obviously against anorexics' interests.

I can see several reasons why anorexia might not turn out to be a counterexample after all. However, we shall see that these reasons are not fully persuasive. We are thus left with a choice: we can either give up the claim that anorexic behaviour is harmful or we can give up the claim that ultimate preferences cannot be mistaken. To avoid irrelevant complications, suppose we are considering adults only and remember that we are discussing the well-being of anorexics and not whether they are competent, or autonomous, or should be forcibly treated.

Perhaps anorexia involves faulty perception, such as wrongly seeing one's body as being much larger than it really is. Or perhaps anorexia involves faulty cognition, such as not understanding the consequences of one's actions. Exactly when and why faulty perception or beliefs might cause mistakes is something we shall go into in the next chapter but, for either reason, the actions of anorexics might be against their interests even when their interests are taken as given by their own ends. If anorexia were always due to these mistakes, it would not be a counterexample to the ultimate preference account. However, it looks as if anorexia cannot be said always to involve such mistakes.[27] Indeed, one problem, raised by Jacinta

[23] Simona Giordano, *Exercise and Eating Disorders: An Ethical and Legal Analysis* (Abingdon: Routledge, 2010), ch. 1. When I write about 'anorexia' and 'anorexics', I am referring to anorexia nervosa and people with it and not to another condition, called 'anorexia athletica'. Also, I use the pronouns 'she' and 'her' for an anorexic because anorexics are predominantly young women.

[24] Giordano, *Exercise and Eating Disorders*, ch. 2.

[25] Giordano, *Exercise and Eating Disorders*, p. 11.

[26] Giordano, *Exercise and Eating Disorders*, pp. 67–73.

[27] Giordano, *Exercise and Eating Disorders*, p. 164. The American Psychiatric Association's *Diagnostic and Statistical Manual* (DSM-5) lists under Criterion C for anorexia nervosa: 'Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.' The disturbance and the lack of recognition might be perceptual and cognitive problems, but 'undue influence' is a value judgement. See American Psychiatric Association, *Diagnostic and Statistical Manual*, 5th ed. (Arlington, VA: American Psychiatric Association Publishing, 2013), p. 339.

Tan and her colleagues, is that anorexics will often pass tests of competency that are designed to pick up mistakes in perception and beliefs.[28] And yet, even so, anorexics still seem to be clearly acting against their interests. If so, it looks as if their values must be criticized.

Tan et al. say that anorexics have '"pathological values"'.[29] The scare quotes are theirs. They shrink from the most obvious criticism one could make of people who value self-mastery and thinness over life itself, which is that their value judgement is wrong and self-mastery and thinness are not so important. Tan et al. would like to find some other way to reject the values of the anorexic without calling some values right and others wrong. They suggest that the anorexic's value judgements are pathological because they are caused by a mental disorder and ones she makes only because she is anorexic. The viewpoint from which the anorexic's actions may be criticized, then, is not a supposedly objective one but the viewpoint the anorexic herself would take if not anorexic. Tan et al. do not say why the counterfactual non-anorexic viewpoint is the right one but they probably have something like this in mind: the anorexic's actions are bad for her as judged by her true values, not the values that are the result of her disorder. If Tan et al. were right, anorexia would not be a counterexample to taking ultimate preferences as the measure of well-being.

We should not write off the anorexic's values as the product of a disorder. As Simona Giordano points out, these values are conceptually part of what it is to have anorexia nervosa.[30] The disorder is therefore not separate from the values, and so it is not a cause of these value judgements. Put another way, to call these value judgements a disorder is to say that they have something wrong with them, but it is not to give a reason why they are wrong. What of the idea that the true self would have an opposing value judgement and prefer health to thinness? Once we realize we are no further ahead by labelling anorexia a disorder, we can see that the claim amounts to saying that, if the person were not anorexic, they would have different value judgements, and then asserting that the non-existent person is the true one. But why think that?

Perhaps the point is that the anorexic in some sense does prefer to be healthy and their anorexic behaviour is contrary to their actual preferences rather than the preferences of some idealized self. In the first place, some anorexics are profoundly ambivalent, wanting both to eat and to not eat.[31] In the second, an anorexic might now prefer being thinner to being healthier but, if she is made to eat, she would

[28] Jacinta O. A. Tan, Tony Hope, Anne Stewart, and Raymond Fitzpatrick, 'Competence to Make Treatment Decisions in Anorexia Nervosa: Thinking Processes and Values', *Philosophy, Psychiatry, & Psychology* 13 (2006): 267.

[29] Tan et al., 'Competence to Make Decision Treatments', p. 278. The interest of Tan and her colleagues is in competence, especially to refuse treatment, but their ideas seem readily adaptable to a judgement of well-being.

[30] Giordano, *Eating and Exercise Disorders*, pp. 161–3.

[31] Tony Hope, Jacinta Tan, Anne Stewart, and Ray Fitzpatrick, 'Anorexia Nervosa and the Language of Authenticity', *Hastings Center Report* 41 (2011): 24.

later be grateful. Later gratitude is not valid retrospective consent so, insofar as we are concerned with competence to refuse treatment, later gratitude might be of limited importance.[32] But it might be relevant to a judgement of interests. Neither of these ideas is without its problems. When desires conflict, whether at the same time or over time, the question will arise of which one determines interests. In any case, would we not want to say that an anorexic chooses against her interests even if she is in no way ambivalent and would not have different preferences later?

Here is another way in which we might be able to argue that the anorexic acts against her interests as given by her own preferences. Often, anorexics want both self-control and health. They do not value ill health as such, they are just willing to give up their health. If they could find a less damaging way to achieve self-control than self-starving, then they could get self-control and more health. One life is better than another if it has more of what is valuable in one respect and no less of what is valuable in any other respects.[33] The anorexic therefore acts against her interests because her chosen life is worse, judged by her own preferences, than an alternative.

Self-control and health are no doubt better than self-control and no health but we cannot conclude that the anorexic acts against her interests unless she really could exercise self-control in a less harmful way. Perhaps she cannot, given the person she is and the kind of situation she is in. The alternative object of self-control might not be a perfect substitute, or self-control over her weight might have a particular value for her that cannot simply be replaced. Some anorexics report that anorexia is part of their identity,[34] and we are not always willing to change our identity by acquiring different goals that are easier to fulfil. Or perhaps anorexia is a response to a difficult situation. It might have been better not to be in that situation, but given that one is in it, perhaps it is not possible to have self-control and health.

We have considered arguments that try to show that anorexics act against their interests while avoiding a criticism of their ultimate preferences. I do not want to say that these arguments must all fail but we can see that they have problems. Suppose then that we must choose. We can either continue to say that well-being is measured by the fulfilment of ultimate preferences, or we can say that the anorexic acts against her interests, but we cannot say both. I am inclined to give up the theoretical claim and stick with what I see as the common-sense view that the anorexic is making a mistake in her ultimate preferences. To avoid misunderstanding, to describe an anorexic's preferences as mistaken does not entail 'imposing values', if that means forcibly treating them. As we see in Chapter 7, well-being is one value

[32] Jennifer Radden makes this point in Jennifer H. Radden, 'Food Refusal, Anorexia and Soft Paternalism: What's at Stake?', *Philosophy, Psychiatry, & Psychology* 28 (2021): 146–7.

[33] This is the principle of inclusivity that we saw in discussing adaptation.

[34] Tan et al., 'Competence to Make Treatment Decisions', pp. 278–9.

and autonomy is another and perhaps anorexics should be allowed to act against their interests. Nonetheless, acting against their interests is, so I think, what they would be doing.

Suppose you disagree with me and deny that ultimate preferences can be mistaken. When you come to the challenge in the next section, which asks why we should think unhealthy behaviour is mistaken, you might think of false beliefs or weak motivation, but you would not say that the ultimate preferences are wrong. But suppose you do agree with me that ultimate preferences could be mistaken. Do you and I then have to say that Chapter 3's smokers, drinkers, overeaters, injured athletes, and grandparents all act against their interests? I think not, because their tradeoffs seemed reasonable. The costs in health were small, or of low risk or uncertain, or were distant in time, whereas someone with severe anorexia who is not stopped would definitely do major damage to their health, and possibly die, in the near future. Without being able to specify exactly what counts as reasonable,[35] the best I can do is to say that interests depend on fulfilling reasonable ends, or a reasonable balance of ends. That move seems both ad hoc and, pending a specification of what is reasonable, incomplete. It is not a tidy theory of well-being. But we should feel the pull of two ideas: that the value of health is limited, variable, and not the sort of thing with a precise objective tradeoff; and that some ultimate preferences, are, like the anorexic's, mistaken and not where a person's interests lie. We might produce a tidy theory of well-being by ignoring one of these ideas, but it would be a faulty theory.

I suggest, then, that when it comes to the common public health targets—smoking, drinking, and so on—that we proceed as if people's ultimate preferences are not mistaken. That leads us to the challenge to public health.

A Challenge: Public Health Stops People Doing What They Want

Public health interventions aim to make people healthier. However, if people are to be paternalistically guided or forced to drink less, eat less, avoid unprotected sex, and so on, the benefits must outweigh what they have to give up. As this chapter has argued, the value of more health to someone (generally) depends on their own ultimate preferences. To the extent that the reason to make them healthier is because of the benefits of health to them, the case for public health interventions must give reasons to think that, in making people healthier, they also make people better off as judged by their own preferences.

[35] Not for want of trying. But I have come to believe it very difficult to say exactly what is wrong with the preferences involved in mental disorders such as anorexia nervosa and Munchausen's. I hope to write on this problem once I have finished this book.

Here now is the challenge to public health interventions. When people act in an unhealthy way, they do what they want to do. No one makes them smoke, drink alcohol, or eat junk food. If a public health intervention tries to stop them or even discourage them by raising the costs of unhealthy activity, it will make them worse off, not better off.

Let me develop this challenge. The causal path to many public health problems has to pass through people's decisions, such as the decision to smoke or eat. Smoking and eating are unlike non-voluntary movements, so unlike the functioning of the kidney, and they do not merely befall people, so unlike being hit by a meteorite. Even writers who believe unhealthy decisions are in some way flawed accept that they are still decisions. For instance, Swinburn et al. write in the context of obesity: 'Undoubtedly the final decision to consume a particular food or beverage, or to exercise or not, is an individual decision.'[36]

People's decisions are motivated. As we saw in Chapter 3, people have smoked for many reasons, besides the relief from an artificially induced craving. Alcohol as a drug makes people less inhibited and so it often acts as a social lubricant; and, in specific forms, such as wine, beer, gin, and whisky, alcohol has its fanatical enthusiasts, collectors, and lyricists. Some—probably a lot—of people hate exercising; Margaret Thatcher, the work-driven former British Prime Minister, did as little exercise as possible, apparently because she thought it a waste of time.[37] The leading cause of the rise in obesity is often held by economists and obesity researchers to be the much greater availability of cheap and convenient processed food and drink, and it is understandable why people want to consume what is cheap and convenient.[38] Unhealthy food may have cultural value too.[39] As for unprotected sex, I shall leave its advantages to the memory or imagination of the reader. In sum, unhealthy behaviour can have understandable benefits. Thus the challenge: people must be getting something out of what they choose, otherwise they would choose differently. The risk of disease or death is a cost of unhealthy behaviour but why believe the costs to them outweigh the benefits they get?

What does the challenge apply to? Most obviously, it applies to public health interventions that reduce choice by banning, taxing, limiting outlets, and the like. Why think that reducing choice and thereby causing people to choose differently

[36] Boyd A. Swinburn, Gary Sacks, Kevin D. Hall, Klim McPherson, Diane T. Finegood, Marjory L. Moodie, and Steven L. Gortmaker, 'The Global Obesity Pandemic: Shaped by Global Drivers and Local Environments', *The Lancet* 378 (2011): 809.

[37] John Campbell, *Margaret Thatcher*, Vol. 2: *The Iron Lady* (London: Pimlico, 2004), pp. 479–80.

[38] David M. Cutler, Edward L. Glaeser, and Jesse M. Shapiro, 'Why Have Americans Become More Obese?', *Journal of Economic Perspectives* 17 (2003): 93; Avner Offer, *The Challenge of Affluence: Self-Control and Well-Being in the United States and Britain since 1950* (Oxford: Clarendon Press, 2006), ch. 7.

[39] Barnhill and Bonotti, *Healthy Eating and Political Philosophy*, p. 25. See also Peter Kay's sketch about the North of England, 'Friday Night Chippy Tea', https://www.facebook.com/thepeterkay/videos/friday-night-chippy-tea-peter-kay-live-at-the-bolton-albert-halls/2646566422327982/ (last accessed 21 May 2024).

would make them better off? Why would, for instance, getting people to eat more vegetables make them better off when the cause is only making other options more expensive in money or time? However, the challenge can be extended beyond cost-raising and restrictions to include expanding options and reducing costs through subsidies, in-kind goods, and collective provision. Health-promoting subsidies could be an inefficient way to make people better off. Why subsidize gym memberships or healthy food when people could be given the money to spend as they please? At the collective level, policies might be able to achieve outcomes beyond individual action, such as reducing local pollution or providing cycle tracks, but what if people do not want the pollution reduced if it comes at the price of closing off streets to traffic, thereby causing shops to close, or what if they would rather not have the expense and nuisance of cycle tracks? If the argument goes, 'you must have these because they are good for your health', then that is open to the challenge.

One way to understand the challenge is as saying that people act to fulfil their preferences and thereby make themselves as well off as possible given the options they face; and the reply we will be focusing on in the next two chapters says they do not because they make mistakes. I think the question of whether people make mistakes is central to justifying many public health interventions and it cannot be avoided. That said, many other reasons have been given for public health interventions. Take sin taxes: their point might not be to benefit the people who become healthier but to offset the social costs of unhealthy behaviour (although the benefits of unhealthy behaviour should still be accounted for). As for subsidy and in-kind provision, they might avoid problems with markets that do not rest on the thesis that people make mistakes about their interests, although again, as we saw above with the gym subsidies and cycle tracks, some account must be taken of how much people want the subsidy or in-kind provision.[40] Nor need the challenge apply to public health interventions that give information.[41] Truthfully telling people, for instance about the risk of cancer or heart disease from smoking, might put people in a better position to realize their aims. As we can see, numerous reasons can be given for public health interventions that do not presuppose that people make mistakes about their interests. But, as we will see in Chapter 11, these reasons are limited in that they do not support many of the interventions public health advocates recommend. That is why I say the question of whether people make mistakes

[40] For problems that do not depend on mistaken consumers, see the example of the market for health care in Nicholas Barr, *The Economics of the Welfare State*, 6th ed. (Oxford: Oxford University Press, 2020). For an example of an over-provided public good, see the bear patrol in 'Much Apu about Nothing', Episode 23, Season 7 of *The Simpsons*.

[41] That said, giving information can be controversial. Mandating information, such as ordering restaurants to display calorie information, may have a cost passed on to consumers who do not think it worth paying. Perhaps consumers do not even want to know, because, for instance, seeing calorie counts triggers an eating disorder. See Annabel Rackham, 'What's the Problem with Calories on Restaurant Menus?', *BBC News*, 16 April 2022, https://www.bbc.com/news/health-61078447 (last accessed 18 June 2024).

about their interests is so central and why it is so important for public health advocates to respond properly to the challenge.

As against the challenge, it might be said that people often act in unhealthy ways because they are poor, or manipulated, or addicted, and these are not cases where they freely choose to do what they want. People without much money have no choice but to buy cheap unhealthy food and drink and, whether or not poverty is a form of coercion, it would be disingenuous to say a choice made in poverty is a fully free choice. As for manipulation, people do not make their decisions in an environment free from influence: unhealthy products are heavily marketed or would be unless, as is the case with tobacco, marketing were restricted or banned. Furthermore, advocates for public health interventions often say that what they want banned, taxed, or regulated is addictive. Alcohol and tobacco are obvious examples, but 'food addiction' (including to non-alcoholic drinks as well as food) is cited too. In the words of the pressure group Fizz, which campaigns for New Zealand to be free of sugary drinks: 'We believe that sugary drinks are likely to be addictive, like coffee, alcohol and cigarettes.'[42] It has also been said that people can be addicted to certain behaviour, especially gambling, as well as substances.

Poverty, manipulation, and addiction are important in thinking through the challenge, and we consider them in detail later. Still, important though they are, they do not justify dismissing the challenge or refusing to engage with it. Let me explain why not. In the first place, we can be manipulated into acting in our own interests; we can be poor and still do what is best for us. If manipulation or poverty are to be relevant to the challenge, it is in explaining why people make mistakes. But some ground must then be given, besides saying that they are manipulated or poor, for thinking that they act against their interests. A similar point can be made about addicts (on some conceptions of addiction): it is logically possible that what they are addicted to is best for them in their circumstances. To say that someone drinks coffee or exercises because they are addicted does not settle the question of whether drinking coffee or exercising are worse for them than their alternatives.[43]

In any case not all the unhealthy actions of people could plausibly be ascribed to poverty, manipulation, or addiction. Here are some figures from England for unhealthy behaviour by people who are well-off. 'The proportion of men and women who reported drinking over 14 units of alcohol weekly increased with household income.'[44] 22 per cent of men and 22 per cent of women in the 'least deprived

[42] *Fizz: Fighting Sugar in Soft Drinks*, https://www.fizz.org.nz/ (last accessed 20 June 2024). As against their claim, see M. L. Westwater, P. C. Fletcher, and H. Ziauddeen, 'Sugar Addiction: The State of the Science', *European Journal of Nutrition* 55 (2016). They conclude: 'In summary, the science of sugar addiction at present is not compelling' (p. 65).

[43] However, some conceptions of addiction do specify difficulty in controlling behaviour, which would make addictive behaviour close to being necessarily against the addict's interest. See Chapter 5.

[44] Urszula Bankiewicz and Chloe Robinson, 'Health Survey for England 2019 Adults' Health-Related Behaviours', 15 December 2020, https://files.digital.nhs.uk/D4/93337C/HSE19-Adult-health-behaviours-rep.pdf (last accessed 21 May 2024), p. 22.

quintile' were obese.[45] Even smoking is not purely a habit of the poor: 10 per cent of adults in the highest income quintile smoked (compared with 27 per cent of adults in the lowest income quintile).[46]

I do not know of figures for manipulation, so let me try age as a proxy, inspired by a criticism H. L. A. Hart made of John Stuart Mill's *On Liberty*. According to Hart, Mill opposed paternalism because he wrongly thought of all adults as having 'the psychology of a middle-aged man whose desires are relatively fixed, not liable to be artificially stimulated by external influences; who knows what he wants and what gives him satisfaction or happiness, and who pursues these things when he can'.[47] By implication, Mill was right to oppose paternalism towards people who do have the psychology of 'a middle-aged man', in part because they would not be open to the manipulation Hart describes. Notice then that plenty of middle-aged people behave in ways that public health advice warns against. In England, 36 per cent of people aged 65 to 74 are obese;[48] 55- to 74-year-olds are the age group most likely to say that they drank alcohol in the last week (62 per cent of them);[49] and 20 per cent of 45- to 54-year-old men and 12 per cent of 45- to 54-year-old women smoke cigarettes.[50] If these middle-aged people are like Hart's middle-aged man, why think they are making a mistake with their unhealthy behaviour?

We can make the same point about addiction as was made about poverty and manipulation: many or most consumers are not addicted. Estimating how many consumers are addicted is not straightforward, partly because addiction is understood in quite different ways, but also because, as Joel Paris points out, the line between normality and disorder is blurry and so the number of addicts may be exaggerated as a result.[51] Nonetheless, here are some indicative figures. In the UK, only 0.5–0.6 per cent of the adult population were estimated to have a serious gambling disorder, although 47 per cent of the adult population were estimated to have gambled over a four-week period.[52] For cocaine, 15–16 per cent of users become

[45] Alison Moody, 'Health Survey for England 2019 Overweight and Obesity in Adults and Children', https://files.digital.nhs.uk/9D/4195D5/HSE19-Overweight-obesity-rep.pdf (last accessed 21 May 2024), p. 15.

[46] Bankiewicz and Robinson, 'Health Survey for England 2019 Adults' Health-Related Behaviours', p. 12.

[47] H. L. A. Hart, *Law, Liberty, and Morality* (Stanford: Stanford University Press, 1963), p. 33.

[48] Moody, 'Health Survey for England 2019 Overweight and Obesity in Adults and Children', p. 13.

[49] Bankiewicz and Robinson, 'Health Survey for England 2019 Adults' Health-Related Behaviours', p. 23. The UK's Office of National Statistics (ONS) says 'Social surveys consistently produce estimates of alcohol consumption that are lower than the levels indicated by sales data. This is likely to be because people either knowingly or unknowingly underestimate their alcohol consumption.' See ONS, 'Adult Drinking Habits in Great Britain: 2017', https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/drugusealcoholandsmoking/bulletins/opinionsandlifestylesurveyadultdrinkinghabitsingreatbritain/2017 (last accessed 21 May 2024).

[50] Bankiewicz and Robinson, 'Health Survey for England 2019 Adults' Health-Related Behaviours', p. 11.

[51] Joel Paris, *The Intelligent Clinician's Guide to the DSM-5®*, 2nd ed. (New York: Oxford University Press, 2015), p. 153.

[52] House of Lords Select Committee on the Social and Economic Impact of the Gambling Industry, *Gambling Harm—Time for Action Report of Session 2019-21—published 2 July 2020—HL Paper 79*,

addicted within ten years of use.[53] For alcohol, 10 per cent of users are estimated to have a substance-use disorder.[54] Food addiction prevalence is about 19.9 per cent based on a meta-analysis.[55] The highest figures by far are for smoking. For instance, 84.7 per cent of a nationwide US sample of smokers considered themselves addicted.[56] It is unsurprising that the people still smoking are mainly addicts given how much more strongly policy discourages smoking than gambling, eating, or drinking.

Can we expand the number of addicts? Certainly, if we expand our definition of addiction. In their article on food addiction, Gearhardt et al. show us how. They write, 'addiction does not just impact people who have a clinical disorder. Generally, addictive responses to a substance occur on a spectrum and widespread sub-clinical response can lead to major public health consequences.'[57] The addictive behaviour they have in mind is 'increased craving, high impulsivity and a greater motivation to use in response to negative affect' or as I interpret them, to strongly want some food, typically food high in carbohydrate or fat, to eat or drink in an unplanned way, and to eat and drink for comfort or to relieve stress.[58] We probably all fit this description at some time, so redefining addiction in this way certainly gets the numbers up. But of course it is another question whether our behaviour would be either unfree or against our interests, even if the aggregate result is worse public health. Someone with a severe personality disorder who drinks alcohol heavily seems worlds apart from what many of us do when we eat more cashews than we wanted.[59]

Plenty of unhealthy behaviour cannot be explained away as the result of poverty, manipulation, or addiction; and even when it can, the explaining away needs more thought since unhealthy behaviour need not be against the interests of the poor, manipulated, or addicted. People make unhealthy choices for reasons which are often understandable because they secure benefits. To restate the challenge, why think the costs of unhealthy choices must outweigh the benefits when the people

§§70 and 262–5, https://publications.parliament.uk/pa/ld5801/ldselect/ldgamb/79/7902.htm (last accessed 21 May 2024).

[53] Ashley Gearhardt, Michelle Joyner, and Erica Schulte, 'Food Addiction', in *The Routledge Handbook of Philosophy and Science of Addiction*, edited by Hanna Pickard and Serge H. Ahmed (Abingdon: Routledge, 2019), p. 185.

[54] Gearhardt, Joyner, and Schulte, 'Food Addiction', p. 185.

[55] Gearhardt, Joyner, and Schulte, 'Food Addiction', p. 185. In Chapter 6, we will see that this figure exaggerates the extent of food addiction in the general population.

[56] T. F. Pechacek, P. Nayak, P. Slovic, S. R. Weaver, J. Huang, and M. P. Eriksen, 'Reassessing the Importance of "Lost Pleasure" Associated with Smoking Cessation: Implications for Social Welfare and Policy', *Tobacco Control*, 27(e2) (2018), table 1, p. 146.

[57] Gearhardt, Joyner, and Schulte, 'Food Addiction', p. 188.

[58] Gearhardt, Joyner, and Schulte, 'Food Addiction', p. 185.

[59] I shall make this point again in Chapter 6, when we come to an attempt to lump together people who are alcoholics with men who have three drinks a day and women who have two.

who make the choices do not think so and when they are the ones who will experience the costs and benefits?

Conclusion

I see the challenge as serious but not decisive against public health. When people act in an unhealthy way, they might be doing what in a sense they want, and yet they could be mistaken. Now, the mistake they might be making cannot be simply that health is best for everyone and they chose not to be healthy; we saw in Chapter 3 that health is of limited and variable value. We have seen in this chapter that the value of some aspect of health to an individual depends on how it serves their ends. That gives us a high-level criterion to assess whether unhealthy behaviour is bad for someone: does it make them worse off in terms of their ultimate preferences? Unhealthy behaviour certainly could be worse for people. They can make factual mistakes about what would best serve their ends, and perhaps choosing in an unhealthy way is due to such a factual mistake. Or perhaps they do not really want to smoke, drink, or eat in an unhealthy way but find they cannot control themselves. The next chapter evaluates some general arguments about choices, such as that people are the best judges of their own interests or that they are weak-willed. These arguments will not settle the question of whether and when public health interventions would make people better off, but we can use them to derive clues about what to look for in Chapter 6. Does the evidence show that people are ignorant of the dangers of their behaviour? What sort of evidence could show that people had a self-control problem rather than that they do exactly what they really want, and what does the evidence show?

5
Mistakes and Unhealthy Behaviour

Introduction

To restate the challenge to public health from the previous chapter, when people act in an unhealthy way, they do what they want to do. No one makes them, for example, smoke, drink alcohol, or eat junk food. Public health interventions that steer people away from unhealthy behaviour would therefore make people worse off, not better off.

A key part of the case for public health interventions is showing, as against this challenge, that unhealthy behaviour is mistaken. As Chapter 3 showed, one cannot say that unhealthy behaviour is harmful on the grounds that health is a value of such importance that sacrificing any of it must be a mistake. Even so, we can make mistakes. In a way, that claim is obvious; we are hardly infallible. That said, establishing when we make mistakes is not as obvious as some think. Writers on public health say that people do not know the dangers of unhealthy behaviour, or are seduced by marketing, or act impulsively, or cannot delay gratification, or are addicted, or copy others in their social group, or indulge the tastes they formed in childhood. But as we shall see, these claims, even when true and even though relevant, do not show people's unhealthy behaviour to be a mistake that harms their well-being. To show that unhealthy behaviour is a mistake, we need to explain what it is to be a mistake, and then give reasons to think that a mistake caused the unhealthy behaviour.

We shall see how people could fail to fulfil their ends, whether because they make mistakes about fact, such as being wrong about what would best serve their ends, or mistakes in their motivation, such as being tempted to act against their better judgement. It is fairly straightforward to see how unhealthy behaviour might be mistakes in these senses. Where we shall come to a difficulty is with unhealthy behaviour, such as smoking or eating junk food, that has its ill effects only after a long time. Where is the mistake in preferring the short-term benefits of unhealthy behaviour to the long-term benefits of healthy behaviour? The answers could be ignorance or temptation again. Another, but more controversial, answer is that people who make unhealthy choices do not give enough weight to their later preferences.

Having explained what it is to be a mistake, we must then consider whether these mistakes cause unhealthy behaviour. The problem here is one of interpretation. We know that smoking, say, is unhealthy, but how can we tell whether a person smokes because they are ignorant or weak-willed, which would be a mistake, rather than

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because they value the pleasures of smoking more highly than health, which would not? We consider some general ideas to be found in discussions of paternalism, such as that people are the best judges of their own interests, or that they are swayed by biases, or that in working out what people prefer, we should look at what they do rather than say. I shall argue that, while we can learn from these general ideas, we shall in the end have to get down to details.

How Unhealthy Behaviour Can Be Bad for Us

Public health advocates often say they have evidence that people make mistakes due to biases or addiction, and their critics often counter by saying that these features of choosing are less widespread or have less effect than the advocates would have us believe. My opening point is different. I think the advocates have not clearly spelt out why what they suppose to be mistakes are mistakes at all. I shall explain where the gaps are in their claims before trying to fill them in with an account of mistakes as due to factual error or motivational weaknesses.

Here is a typical example of not spelling out the link to mistakes, from a recent book by Anne Barnhill and Matteo Bonotti on unhealthy eating and drinking.[1] In this book, Barnhill and Bonotti say what a mistake is, which is that one's behaviour does not align with one's life plans. They rightly accept that some people might not be better off for a healthier diet given the other ends they have in their lives, so they do not think that unhealthy behaviour just must be mistaken.[2] Nonetheless, they write, 'It is plausible that many people adopt unhealthy dietary patterns that really are not consistent with their life plans and conceptions of the good'[3] and it is plausible because 'there is evidence that dietary patterns reflect various influences and factors, including early childhood eating patterns, social norms, food marketing, and the neurophysiology of eating.'[4] Consequently, they believe: '[I]t is reasonable for public health policymakers—as a general matter—to assume that many people's unhealthy dietary patterns are misaligned with their life plans, and to assume that making dietary patterns healthier would make many people better off by their own lights . . . .'[5]

The problem is that Barnhill and Bonotti do not tell us how 'early childhood eating patterns, social norms, food marketing, and the neurophysiology of eating' connect to misaligned diets. The total of the authors' explanation is (a) people value health and so their unhealthy diets can be misaligned with what they value,

[1] Anne Barnhill and Matteo Bonotti, *Healthy Eating Policy and Political Philosophy: A Public Reason Approach* (New York: Oxford University Press, 2022).
[2] Barnhill and Bonotti, *Healthy Eating Policy*, pp. 25, 27–9.
[3] Barnhill and Bonotti, *Healthy Eating Policy*, p. 34.
[4] Barnhill and Bonotti, *Healthy Eating Policy*, pp. 34–5.
[5] Barnhill and Bonotti, *Healthy Eating Policy*, p. 36.

and (b) 'We do not have reason to believe that these various influences would work to systematically align people's dietary patterns with their life plans and conceptions of the good'.[6] That people value health is obviously inconclusive since, as the authors correctly stress throughout their book, the value of health can be outweighed. And why should we think the influences would cause a misalignment? The influences do not affect behaviour alone; they also affect life plans and conceptions of the good. Contrary to the authors, that is a reason to believe the influences would cause diet to align with plans and conceptions.[7] As for the specific influences, suppose eating reflects our habits; can we not have habits that are both good and economize on mental effort? Suppose we buy food that is cheap and quick; is saving money and time not a benefit? Suppose we like sugar, fat, and salt; should we eat things we do not like instead? Suppose eating is not fully under my control; neither is my breathing, and my breathing is not misaligned with my goals. And what is wrong with having our eating and drinking shaped by our childhood and by social norms? If, as Barnhill and Bonotti elsewhere say they believe,[8] food and drink are culturally important and valuable, how else is culture supposed to be transmitted? To be clear, I am not saying that the influences mentioned by Barnhill and Bonotti are irrelevant to whether people make mistakes, only that how they are relevant needs spelling out. Let me make the same point at greater length about addiction.

As we saw in Chapter 4, public health advocates say that people are addicted to unhealthy products. Suppose they are right. The advocates obviously think that consuming these unhealthy products is bad for people, that is, against their interests. But how is the claim about addiction connected to the claim that consumption is harmful?

If addicts are supposed to be unable to abstain, one could see how their being unable to abstain might explain why they would act against their interests; but an inability to abstain does not entail that they act against their interests. Perhaps the addicts are addicted to something they reflectively value highly.[9] That said, many addicts have awful lives so one might reasonably think they would be better off for consuming less or not at all. But we have to get the well-being test right. The test is not whether non-addicts are better off than addicts but whether addicts are better off not consuming than consuming. Some people in unfortunate circumstances

[6] Barnhill and Bonotti, *Healthy Eating Policy*, p. 35.
[7] My thanks to Kathy Smits for suggesting this point.
[8] Barnhill and Bonotti, *Healthy Eating Policy*, e.g. pp. 25, 128.
[9] See the willing addict in Harry Frankfurt, 'Freedom of the Will and the Concept of a Person' in his *The Importance of What We Care About* (Cambridge: Cambridge University Press, 1988), p. 24. William Palmer's story of the life and drinking of the novelist, Kingsley Amis, makes him sound like a happy addict: 'To Amis, drinking was a pleasure, providing a haven from the very real terrors that affected him, and enabling him to continue working at a high level. He had established a style of living that enabled him to survive; if this meant the ingestion of large amounts of alcohol that was just tough luck.' William Palmer, *In Love with Hell: Drink in the Lives and Work of Eleven Writers* (London: Robinson, 2021), p. 211.

may be better off for consuming. Chris Middendorp reports the words of Robbie, a homeless man in Melbourne: 'Despite spending a week getting sober in a detox unit every year or two, Robbie felt there was not much merit in abstinence. "It's easier living in the park when you're sloshed," was Robbie's standard justification.'[10]

Some accounts of addiction describe addictive consumption as maximizing behaviour, so in a sense picking the best option, but only because the addiction has destroyed the value of the competing alternatives.[11] For example, a heroin addict whose consumption has caused them to lose their job and their family may now be better off continuing to take heroin, not because taking heroin is good, but because it is better than their remaining alternatives. In such cases, it might seem reasonable to say that they would have been better off never having gone down the path of addiction in the first place. In other cases, though, people's lives may be grim independent of drugs, and beyond fixing. For them, addictive consumption might be the best response.[12]

Suppose we take a view of addiction based on the diagnostic criteria for a substance use disorder in the American Diagnostic and Statistical Manual—5 (DSM5).[13] DSM5 scores people against eleven criteria grouped into four categories: impaired control, social impairment, risky use, and pharmacological. Again, one can see how addictive behaviour, thus characterized, could be against the addict's interests: social impairment, risky use, and pharmacological dependence can all show drug taking has some costs. But they do not entail that the behaviour is bad for the addict because they do not show that the costs outweigh the benefits. Impaired control, by contrast, seems the most obviously connected to a mistake. The addicts at least demonstrate some ambivalence about their consumption when, for example, they try to quit, and so their own preferences give some basis to say that consuming is against their interests. However, impaired control is not necessary to being diagnosed with the disorder.

As with Barnhill and Bonotti's list of influences on eating, addiction is relevant and important to showing that unhealthy behaviour can be mistaken but its connection to mistakes needs to be made more explicit. Let me try to make the

[10] Chris Middendorp, 'Being Homeless Does Not Mean Being Hopeless', *The Age*, 4 August 2009, quoted in Jeanette Kennett, 'Just Say No', in *Addiction and Self-Control*, edited by Neil Levy (New York: Oxford University Press, 2013), p. 161. Kennett goes on to say that Robbie did later get into a home and 'his need to drink was reduced' (p. 62).

[11] Gene M. Heyman, *Addiction: A Disorder of Choice* (Cambridge, MA: Harvard University Press, 2009), ch. 6.

[12] Hanna Pickard and Steve Pearce write: 'The stereotype of addiction as a chronic disorder, with little hope of recovery, is not an accurate picture for the general population. It is an accurate picture for psychiatric patients.' See their 'Addiction in Context', in Levy (ed.), *Addiction and Self-Control*, p. 166. I think that, in the absence of a solution to their psychiatric problems, these patients might be better off taking drugs.

[13] American Psychiatric Association, *Diagnostic and Statistical Manual*, 5th ed. (Arlington, VA: American Psychiatric Association Publishing, 2013), pp. 483–4. DSM5 refuses to use the term 'addiction', preferring 'substance abuse disorder', which its writers think does not have the same 'negative connotation' (p. 485).

connections clearer, starting by setting out, in the abstract, what it is to make a mistake. Remember that we are assuming that people have ultimate ends which are not mistaken. Remember too that generally these ends cannot all be maximally fulfilled and how a person trades off these ends against each other also cannot be said to be mistaken. Thus neither the reflective, well-informed, injury-risking athlete of Chapter 3, or Orwell's nut-cutlet-eating, orange juice-drinking socialist of Chapter 2 could be criticized as under- or over-valuing their health. However, while ultimate ends and their tradeoffs might not be the sorts of things that can be mistaken, people can be mistaken in choosing means to those ends. These can be factual or motivational mistakes.

When people invested in Bernie Madoff's Ponzi scheme, or Charles Ponzi's Ponzi scheme come to that, they wanted to make money but they lost their shirts. As for health, people could make a means-ends mistake if they want to be healthy and do not know that what they propose to do is unhealthy or if they do not realize the instrumental value of health in fulfilling their ultimate ends. These are mistakes due to mistaken beliefs.

When it comes to arguing that people are making mistakes about their interests, it is not enough to give grounds to think that their beliefs are in some way defective. One must give grounds to think that the defects in their beliefs have caused their actions. People can have false beliefs or fail to have true beliefs that are causally irrelevant to their behaviour. I might falsely believe that New Zealand is larger than Colombia, but that error would have nothing to do with whether I drink another beer. I might not know everything that is physically damaging about smoking, but knowing everything would make no difference because I do not smoke anyway and I cannot smoke less than zero. I might even deceive myself that I can quit drinking any time, but my false belief might make no difference to my drinking because I would drink the same amount anyway.

While some mistakes are factual, others are motivational. People could know what is healthy, value health correctly given their ultimate ends, and yet still choose unhealthy options because they are not motivated to choose what is healthy. People might judge one course of action better than another but fail to act on their judgement, for instance because they give into temptation.

Belief and motivation need not be separate. Motivational failings can themselves cause false beliefs. An example is denial. Some people who are highly motivated to take drugs do not want to believe that the drugs are dangerous and so they deny to themselves that they are. Denial might cause a false belief which in turn helps cause the consumption of drugs.[14] Coming by more accurate beliefs might lead them to consume less or quit. Or, of course, it might not, such as when the

[14] Hanna Pickard, 'The Puzzle of Addiction', in *The Routledge Handbook of Philosophy and Science of Addiction*, edited by Hanna Pickard and Serge H. Ahmed (Abingdon: Routledge, 2019), pp. 16–18. See also Roy F. Baumeister, 'Addiction, Cigarette Smoking, and Voluntary Control of Action: Do Cigarette Smokers Lose Their Free Will?', *Addictive Behaviors Reports* 5 (2017): 67.

desire for the drug is so great that they would take it even if they saw its danger, or when users intentionally seek out drugs that have caused overdoses because they know them to be especially pure.[15]

To connect in a basic way the account of mistakes to public health, it would be possible for a health-promoting choice-limiting policy to serve people's actual ends if being healthy would serve their ends more than they thought it would, or if it got people to do what they themselves think is better but are too unmotivated to do. Health would not then be imposed as a foreign value on the targets of public health paternalism.[16]

Some public health problems involve choices where the important effects are in the short term, whether gains or losses. For instance, one might choose between a chance of a short-term gain, such as getting high on heroin or not being inconvenienced by wearing a helmet on a motorbike, and a chance of a short-term loss, such as dying from an overdose or a head injury. Using our basic account of mistakes, we can say that people might wrongly risk their health (or wrongly fail to risk their health) because of simple ignorance or an inability to understand probability. Or they might fail to act on their tradeoffs because of a problem with motivation, such an overwhelming desire for the drug. If, however, they understand the probabilities and the outcomes and happen to take risks that others would not (like the BASE jumpers of Chapter 2), they cannot be said to be making a mistake on the account I have given.

However, many public health problems involve behaviour where the benefits of unhealthy behaviour are immediate but the costs are in the distant future. I want to bring out a difficulty in considering this unhealthy behaviour to be a mistake.

Preferences and the Long Term

It is often thought that people act in unhealthy ways because they are more attracted to benefits in the short term than in the long term. This idea is represented in this quotation, which argues for steering choices of food:

> People who have already developed unhealthy preferences struggle to make healthier choices, but . . . these choices can be shifted through changes in the way

[15] In a macabre form of information disclosure, drug dealers have stamped their heroin envelopes with labels such as 'DOA', 'Body Bag', and 'Red Rum' (i.e. 'Murder' backwards). See Humberto Fernandez, *Heroin* (Center City: Hazelden, 1998), p. 48. Fernandez goes on to write: 'Contrary to what one might expect, overdoses are not bad for a particular brand name's business.'

[16] This is essentially Sarah Conly's view: that people do prefer being healthy to unhealthy but do not act on their preferences; and in being pushed to be healthier, they are made better off as judged by their own preferences rather than the preferences of the paternalist. See Sarah Conly, *Against Autonomy: Justifying Coercive Paternalism* (Cambridge: Cambridge University Press, 2013) and 'Coercive Paternalism in Health Care: Against Freedom of Choice', *Public Health Ethics* 6 (2013): 241.

> food is priced and presented [which] can encourage people to make choices that satisfy long-term preferences for health rather than following unhealthy preferences for short-term gratification.[17]

We might ask, of this quotation, in what sense do people with unhealthy preferences 'struggle' to make healthier choices? Is it the same sense in which someone who does not like ballet would 'struggle' to choose to go to *The Nutcracker*? If so, then the obvious question is: why think people with unhealthy preferences have a problem in choosing? Some sort of answer is clearly intended by referring to long-term preferences rather than short-term gratification. But what is going on here?

Any of the following might be called a long-term preference: (1) a preference you now have for the long-term future; (2) a preference you now have and will continue to have, that is, an enduring preference; and (3) a preference you do not now have but will have later. None of these has to be important just because they are long term. I prefer to be cremated rather than buried after I die. That is a long-term preference in the first sense of being a preference about what I hope is my distant future, in the second sense in that I have had it for a long time, and in the third sense in that I did not have it at 18, so it was then a preference I would have later. But I do not much care what happens to my body after I die. I would take burial in exchange for a nice bottle of wine that I could drink now. My preference to be cremated is long term but unimportant. If we are to criticize unhealthy choices as overriding long-term preferences, we need some reason to think the long-term benefits are more important than the short-term benefits.

I think what many advocates of public health have in mind is this: 'you now prefer the long-term benefit, but you find yourself struggling with short-term temptation.'[18] Some of them also mean this: 'you now prefer the short-term benefit, but later on you will think you should have chosen health.'[19] These are different ideas.

Although not without its complications, the idea of temptation is more straightforward than preference change and we will work through it first. We can think of giving into temptation as following a pattern like this: at an earlier time, the person prefers the healthy option; at the current time, the person chooses the unhealthy option; later, the person wishes they had not taken the unhealthy option. This

[17] C. Hawkes, T. G. Smith, J. Jewell, J. Wardle, R. A. Hammond, S. Friel, A. M. Thow, and J. Kain, 'Smart Food Policies for Obesity Prevention', *The Lancet* 385 (2015): 2411–12.

[18] Robyn Toomath is one such advocate. See her *Fat Science: Why Diets and Exercise Don't Work—and What Does* (Auckland: Auckland University Press, 2016), p. 153.

[19] Such as Janet Hoek, describing 'powerful temporal biases that lead people to focus strongly on the short-term, with little acknowledgment or understanding of longer term consequences.' She is thinking of young people who see those in their 60s as decrepit but who will have a different view when they reach their 50s. Janet Hoek, 'Informed Choice and the Nanny State: Learning from the Tobacco Industry', *Public Health* 129 (2015): 1040.

pattern might be repeated many times, as with starting diets and then abandoning them or quitting drugs and relapsing.

The point about temptation, as I just characterized it, is that all along, even when giving into it, the person prefers something else. If I think I should not eat a slab of cake, eat it anyway, and then wish I had not, even when eating it I was acting against my own preference. In this case, it was I who judged the relative importance of gain now versus gain later. It is according to my preferences that cake is not worth it, not someone else's judgements of my interests. This case may be what most people have in mind who cite the long term. They may be thinking of cases where we all agree that we should do more for our long term than we do, and they might see the role of public health interventions as helping us to achieve what it is that we now prefer. That seems to be Conly's view when she describes what she thinks typically happens when we eat cake and regret it:

> It is not that we have changed our minds about what our goals are, and have decided that the taste of cake outweighs the advantages of health and long life. That could happen, but it is a different kind of case. For most of us, once we have wiped the last of the buttercream off our chins, we realize that we made a mistake, and wish we had not acted as we did.[20]

For Conly, when we eat cake, despite previously preferring to be healthy, we have not typically changed our preferences. We prefer to be healthy even while eating the cake; but we do not act so as to achieve what we most prefer. Hence an intervention that stopped us eating cake could make us better off.

As for why we might act against our own preferences, one can give various explanations. One might be that the desire for the cake is more motivating than one's better judgement. In the extreme, perhaps the desire is irresistible. On this explanation, our beliefs about costs and benefits might be accurate, and our judgement well informed, but the judgement is overwhelmed. Or perhaps the desire blots out the costs from our minds so that, although we have some standing judgement that the costs of an unhealthy option are not worth the benefits, our desire causes us to fail to pay attention to what we ourselves think of as its excessive costs.[21] Or perhaps the desire for the unhealthy option distorts our beliefs and causes us to downgrade the costs and upgrade the benefits; we could, for instance, fool ourselves into thinking the cake is healthy or special.[22] Not paying attention or having distorted beliefs is irrational but, more to the point here, they could be said to cause us to make mistakes about our interests as we ourselves judge them at the time of acting.

[20] Conly, 'Coercive Paternalism in Health Care', p. 242.

[21] Baumeister describes a blindness in ignoring health risks, with some evidence smokers have this blindness, in 'Addiction, Cigarette Smoking, and Voluntary Control of Action', p. 69.

[22] Jon Elster, *Strong Feelings: Emotion, Addiction, and Human Behavior* (Cambridge, MA and London: MIT Press, 2000), p. 173 for the contrast between blotting and distorting.

I said that temptation is not without its complications, and here are some. What if our choice was due to a shift in judgement? With a shift in judgement, we earlier judged the healthy option best and later we will judge the healthy option best, but at the time of consumption we, fleetingly, judge the unhealthy option best.[23] We then have a problem for the temptation argument because now the unhealthy behaviour is not contrary to a preference held at the time of acting, although it is contrary to preferences held earlier and later. Could we criticize the fleeting preference just because it is so fleeting?[24] We might say that the earlier and later preferences are the ones that determine a person's interests in this case because they are 'stable', but the fleeting preference is not.[25] On the other hand, not every time where we choose against our earlier and later preferences is a mistake. Suppose I agree to give a talk to an overseas conference in a year. When the time comes, I realize how little I want to do it. If I were to give the talk, I would later on forget what a nuisance it was.[26] In this example, only in the present do I properly appreciate the costs and benefits whereas earlier I did not and later I will not.[27] The 'fleeting' preference is the right one.

The issue is not whether giving into temptation is acting against one's better judgement, because that seems true by definition. The issue is whether to think of some behaviour as temptation or instead as acting to fulfil a fleeting preference. I can see how the issue could in principle be resolved by a mix of empirical and interpretive work. For instance, do people who repeatedly eat more than they said they wanted to eat keep forgetting the pleasure of eating when they say they regret it? If not, that casts doubt on whether it is their judgements that shift rather than their motivation to act on them. I am inclined to think that unhealthy behaviour that follows a pattern of 'earlier preference against, unhealthy behaviour, later preference against' would often be against the person's interests as judged by themselves. So I am inclined to think that these are cases where public health advocates would be right: the unhealthy behaviour is bad for people.

[23] This is Gideon Yaffe's characterization of the behaviour of drug addicts. Yaffe thinks drug addicts do not act against their better judgement at the time they act. See Gideon Yaffe, 'Are Addicts Akratic? Interpreting the Neuroscience of Reward', in Levy (ed.), *Addiction and Self-Control*.

[24] My thanks to Philipp Wichardt for making me address this problem.

[25] Robert Nozick, *The Nature of Rationality* (Princeton: Princeton University Press, 1994), pp. 16–27. Jon Elster says that temptation-like rapid and brief preference change resembles other forms of irrationality enough that it could be said to be irrational (*Strong Feelings*, p. 179). He contrasts rapid reversals of preference with time discounting, which he regards as just another preference, as we shall see.

[26] Christopher Snowdon, *Killjoys: A Critique of Paternalism* (London: Institute of Economic Affairs, 2017), p. 50.

[27] See also Thomas Schelling's story of Ahab (which seems to be a slightly inaccurate retelling of a scene in the 1930 film, *Moby Dick*). In Schelling's version, Ahab's leg has been severed by the whale and his shipmates want to cauterize the wound with a red-hot iron to prevent a fatal infection. Ahab begs them not to. As Schelling says, 'It is hard to claim he didn't understand better than we do what the stakes were'. He adds, in a perhaps unfortunate phrase, that Ahab 'knew exactly what was afoot'. See Schelling, *Choice and Consequence* (Cambridge, MA: Harvard University Press, 1984), pp. 83–4. In the film, Ahab does not beg, it is his right foot only that is gone, and the dubious medical reason given is to 'burn the poison out'.

As we saw, unhealthy behaviour often has short-term benefits but risks ill-health years later. What we have been discussing, in temptation, is seeking short-term benefits despite judging at the time of acting that they are outweighed by the risks of ill-health in the future. However, this description does not fit people who behave in unhealthy ways because, at the time of acting, they think the benefits are worth the risks. If they have accurate enough beliefs and they never change their minds, then it is hard to say that their judgements are mistaken. But what if they do change their minds? Consider someone who:

1. In 2024, regards good health in 2024 as better than smoking in 2024.
2. In 2024, regards smoking in 2024 as better than good health in 2064.
3. In 2064, regards health in 2064 as better than smoking in the past.

Suppose this person smokes in 2024. Why say this smoker is acting against their interests? Remember that the answer must be rooted in the smoker's own preferences. Here is one possible answer, from Gene Heyman's account of addicts who choose drugs despite their net costs. Heyman writes that, 'for drugs, the costs are delayed, indirect, and uncertain. As a result, there is a misleading bias in the relationship between perceived costs and perceived benefits.'[28] On this explanation, the addicts overlook what they themselves should regard as net costs given what they care about at the time of their actions. Here is another possible answer: a smoker who smokes only because they do not appreciate fully the badness of ill health in the future since they have not experienced it.[29] When I was a teenager, I knew smoking caused lung cancer, but it did not mean much more to me than knowing the layout of the port of Fos (in Marseille; we had to memorize the layout for Geography, presumably in case we found ourselves in Fos without a map). My beliefs about smoking and Fos were neither meaningful nor vivid. If the smoker of 2024 is like I was, they would fail to grasp the costs of smoking fully. Thus the smoker of 2024 could be making a mistake in uncontroversial senses of what it is to make a mistake.

However, consider a hypothetical smoker who knows the risks and expects to be unhealthy in forty years' time. The smoker says, 'I do not want to be unhealthy in forty years' time and if I had to choose either smoking now or being healthy now, I would not choose smoking. In that sense I regard the benefits of smoking as smaller than the costs. But at this time, I prefer smoking now to health later.' This smoker is not struggling with temptation and nor does this person fail to see what the costs are. This person might be said instead to have a time preference or a discount rate. Is smoking against this person's interests? Notice that one could say so

[28] Heyman, *Addiction*, pp. 128–9.
[29] Julian Le Grand and Bill New, *Government Paternalism: Nanny State or Helpful Friend?* (Princeton: Princeton University Press, 2015), p. 93.

without being like the anti-smokers of Chapter 3, who denigrated the benefits of smoking. This smoker agrees that the benefits of smoking are less than the costs to health when we abstract from time. In one sense, to say that smoking is against their interests is not to criticize their ultimate preferences.

In another sense, though, it might be. Many writers think we should see a time preference as just another ultimate end, not the sort of thing that can be mistaken. For instance, the means paternalists, Julian Le Grand and Bill New, think that not only is the content and importance of a person's ultimate ends up to that person, but so too is how they are fulfilled over time.[30] They give the example of people who have the end of a comfortable and happy old age and the end of maximizing consumption now. They cannot have both. How they should trade off consumption now against consumption later is a question of ends rather than means. To judge that a person is giving too much weight to the present (or the future) is therefore to judge their ends, which Le Grand and New think we cannot justifiably do. The hypothetical smoker we are considering understands the benefits of both health and smoking but prefers smoking now to being healthy later; for Le Grand and New, this smoker could not be making a mistake.[31]

One could counterclaim that all parts of a person's life matter equally in accounting for their interests and discounting some parts just because of when they occur would, by definition, not treat them equally. The value of a component of health in some time period might depend on a person's own valuation of it, as the preference-based view holds, but it could not depend simply on when it occurs, whatever that person's time preference.[32] This counterclaim may be right. I am myself more confident that respecting a person's autonomy includes respecting how they weigh goods over time than I am that their time preferences determine what is valuable for them. But the line of argument is obviously controversial and this is another of those occasions where I cannot close everything off.[33] It is open to someone to defend an account of well-being over time that would favour public health interventions, for instance by saying that a person's well-being is to be

[30] Le Grand and New, *Government Paternalism*, pp. 29 n. 6, 101. Elster, *Strong Feelings*, p. 179, says that 'a given rate of time discounting cannot in itself be seen as rational or irrational'. However, when discussing temptation-type cases, he does think 'a momentary heightening' of a discount rate is irrational.

[31] See Le Grand and New, *Government Paternalism*, p. 178.

[32] I think this view is implicit in Heyman's discussion of global and local bookkeeping, *Addiction*, ch. 6. When Heyman says that local bookkeeping almost always 'provides a lower rate of overall benefits' than global bookkeeping (p. 137), he means the benefits added up over a period with no weighting for when they occur. The view is also implicit in Richard Thaler's model of irrational choice over time as the actions of more impulsive selves rather than our deliberative selves. The impulsive self cares only about the near term; the deliberative self cares equally about all the parts of its future. For a description of this model, see Richard H. Thaler, *Misbehaving: The Making of Behavioural Economics* (London: Penguin, 2015), ch. 12.

[33] A reading list on well-being over time would go on and on, so let me single out, for those who do not know it, Derek Parfit, *Reasons and Persons* (Oxford: Oxford University Press, 1984), part 2.

assessed over a complete life by adding up the value of its components with no weighting for when in the life these components occur.

What we can say, without being too controversial, is that unhealthy behaviour might be caused by mistakenly seeking short-term benefits due to temptation or some equivalent phenomenon. We can also say that preferring short-term benefits with long-term costs would be a mistake if the preferences were due to ignorance as opposed to being time preferences.

The Problem of Interpreting Behaviour

When people choose to act in unhealthy ways, their unhealthy behaviour could be bad for them in setting back the fulfilment of their ends. But what is possible may not be actual. Suppose someone behaves in an unhealthy way. It might be that:

A. They behave that way because they wrongly think it is healthy. Suppose someone wants to be healthy and believes it advisable to avoid vigorous exercise after early middle age. This person is, according to current thinking, wrong. Exercise is good for health at any age.[34]
B. They know their behaviour is unhealthy but they underrate the importance of health in serving their ends. An example here might be someone who greatly values their work but, by working too long, skimps on their sleep with the result that they underperform.
C. They know their behaviour is unhealthy, and they think that by acting in a healthier way they would better fulfil their ends, but they are not motivated to act on their judgement. An example here might be a smoker who prefers to quit but does not stop.

These three possibilities are hardly outlandish. It is clearly possible, indeed likely in some cases, that unhealthy behaviour is against the person's interests and for explicable reasons. A difficulty is that we can always interpret unhealthy behaviour this way:

D. They know their behaviour is unhealthy but they correctly think that behaving in an unhealthy way would better fulfil their ends. An example here, taken from Chapter 3, might be the endurance runner who competes despite having arthritis of the hip.

[34] National Health Service, 'Benefits of Exercise', https://www.nhs.uk/live-well/exercise/exercise-health-benefits/ (last accessed 27 May 2024).

The problem for public health advocates is to show that the cases in which they wish to intervene fall under A, B, or C and not D.

When it comes to interpreting behaviour, some writers are too quick to spot irrational behaviour.[35] They should be more charitable and follow the advice of Daniel Kahneman, who writes that, 'when we observe people acting in ways that seem odd, we should first examine the possibility that they have a good reason to do what they do. Psychological interpretations should only be invoked when the reasons become implausible.'[36] On the other hand, other writers will give reasons that really are implausible so as to avoid attributing irrationality to anyone. These implausible reasons can be found in a dialogue reported by (a clearly frustrated) Michael Marmot between him and unnamed rational choice theorists. Marmot was thinking of someone who eats a huge slice of chocolate gateau despite being overweight and worried about it. For Marmot, they are obviously acting irrationally, but the rational choice theorists invent implausible rational explanations, such as a rapid change in preferences. Marmot asked, 'Would you ever conclude that someone is not rationally maximising utility?' Rational choice theorists would reply, 'No, why else would they do that behaviour?'[37] To see a problem with the rational choice theorists' reply, take the economists' favourite example of fruit. Suppose someone chooses an apple rather than an orange, an orange rather than a pear, but a pear rather than an apple. The explanation could be that their preferences are intransitive and their choices therefore irrational, according to the standard axiom of transitivity. But their choices could be said to be based on transitive preferences, and so rational after all, if we cite an immaterial difference. We might say they (transitively) prefer apples with a 5 mm stalk to oranges, and oranges to pears, but pears to apples with a 4 mm stalk.[38] Transitivity would be saved, but the explanation would be implausible.

Whether people behave in unhealthy ways for good or bad reasons is not to be decided by an easily applicable test.[39] We could try to interpret their behaviour

[35] Robert Sugden argues that the new behavioural economics is often too quick to see irrationality. To take an example outside health, some writers say that people do not save enough money for their retirements because they lack self-control. But, as Sugden points out, low saving rates might be because 'people are conscious of the huge economic, political, and personal uncertainties involved in planning for a retirement that may be several decades away'. They might also think that, if they need the money later, they can use their voting power to force transfers from people of working age. See Robert Sugden, *The Community of Advantage: A Behavioural Economist's Defence of the Market* (Oxford: Oxford University Press, 2018), p. 155. Forcing transfers may or may not be wrong, but it is not a failure of self-control.

[36] Daniel Kahneman, *Thinking, Fast and Slow* (New York: Farrar, Straus, and Giroux, 2011), p. 412.

[37] Michael Marmot, *The Health Gap: The Challenge of an Unequal World* (London: Bloomsbury Publishing, 2015), p. 58. Marmot goes on to criticize the explanatory value of rational choice by saying that it must explain the rise in obesity by positing a mysterious rise in irresponsibility. Marmot's argument fails. The rational choice theorist could and does explain the rise in obesity by a drop in price for obesogenic food. See e.g. David M. Cutler, Edward L. Glaeser, and Jesse M. Shapiro, 'Why Have Americans Become More Obese?', *Journal of Economic Perspectives* 17 (2003): 93.

[38] Adapted from Susan Hurley, *Natural Reasons: Personality and Polity* (New York: Oxford University Press, 1989), p. 59.

[39] Elster, *Strong Feelings*, p. 142.

with the aid of such general ideas as that people are the best judges of their interests, or that they are swayed by biases, or that what they do is a better guide to what they prefer than what they say. However, these general ideas will not on their own settle the question of whether unhealthy behaviour is a mistake, as we shall now see.

Factual Mistake

We can reasonably infer from some behaviour that people had made a mistake as judged by their ends. Tens of millions of smokers gave up after they were told of the dangers.[40] A large number of people gave up taking patent medicines after the 1906 Pure Food and Drug Act in the United States made it mandatory to disclose that these medicines contained opium and cocaine.[41] In these cases, it is reasonable to conclude that people realized that smoking, or taking opium and cocaine in the form of patent medicines, did not best promote their ends.

It would be no surprise if people make mistakes in ignorance and an obvious role for public health is to provide information. Then people can avoid acting against their interests out of ignorance. One might go further, though, and say that public health should stop there. People are the best judges of their own interests, an argument goes, and they might have good reasons to consume unhealthy products. Giving information does not stop them judging for themselves, but imposing healthy options would either fail to benefit them, because they would choose them anyway, or harm them if they prefer unhealthy options. We shall see that this argument has some force, but so too do counterarguments that describe biases in our reasoning, and we cannot decide whether unhealthy behaviour is factually mistaken by generalizations alone.

To see our way into the question of how far unhealthy behaviour is due to mistaken judgements, let us consider a couple of weak arguments against the value of giving information. First, some public health advocates say that giving information has been shown to be inadequate. Now, they may have forgotten how effective it was in the cases of smoking and addictive patent medicines but put that possibility aside.[42] The problem is when the advocates' test for the adequacy of an intervention is whether it gets people to behave in a healthier way. This test is faulty. It would wrongly count giving information as inadequate even when someone

[40] Heyman, *Addiction*, p. 149.

[41] Jim Leitzel, *Regulating Vice: Misguided Prohibitions and Realistic Controls* (Cambridge: Cambridge University Press, 2007), p. 84.

[42] Janet Hoek writes that 'Comparisons of alternative interventions conclude that education is the weakest tool available to policy makers' but neither she, not the references she cites, mentions these historical examples of high rates of quitting. See Hoek, 'Informed Choice and the Nanny State', p. 1042.

carefully weighed the information and quite reasonably decided they would rather take the unhealthy option.

A different argument is that giving information can be inadequate because transmitting information does not mean that it is received and understood. For instance, nutrition science is complicated. Smoking is associated with numerous diseases, far more than many smokers are aware of. Detecting the effects of drinking a relatively low amount of alcohol requires sifting through conflicting statistics. Thus some advocates for public health interventions say that ordinary people are not fully informed about the dangers of unhealthy behaviour and therefore do not make 'informed choices'.[43]

This argument has two parts: it sets a standard for choices to count as informed, and then it says that people generally do not reach that standard because the information is too complicated for them to understand. A risk with this argument is setting the standard too high. It is a risk familiar to those who advocated informed consent in clinical medicine fifty years ago against sceptical doctors, who said patients could not be as well informed as they were.[44] The reply is that patients do not need to be as well informed as a specialist, they only need to be informed enough. Similarly, in public health, if consumers know that smoking, or drinking, or junk food have health risks, and can sort them into mild, medium, and severe, why do details matter? It does not matter, for instance, if people are unaware of the low risk of excessive hairiness that has been associated with obesity so long as they believe that obesity leads to a substantially higher risk of stroke or heart disease or diabetes and they realize that eating lots of processed sugary or fatty foods tends to promote obesity. Now, how much people know of health risks is an empirical question, but this quotation from Michael Marmot has the ring of plausibility: 'The reasons that people continue to smoke and that obesity continues to spread do not stem from ignorance.'[45]

In any case, people should not consider only the risks to health of their behaviour. They should also consider the benefits. Here public health policymakers and advocates are probably at an informational disadvantage, as we can see if we

[43] Hoek, 'Informed Choice and the Nanny State', p. 1041. Toomath also makes this suggestion in *Fat Science*, pp. 152–3, although to recommend mandatory food labelling. Cécile Meier describes public confusion over the risks of moderate drinking (while in my view contributing to the confusion) in 'A Few Drinks a Day: Good for You or Not?', in *Stuff*, 28 April 2022, https://interactives.stuff.co.nz/2022/the-whole-truth-te-maramatanga/#/1210814033/a-few-drinks-a-day-good-for-you-or-not (last accessed 28 May 2024).

[44] Jay Katz, *The Silent World of Doctor and Patient* (Baltimore and London: Johns Hopkins University Press, 2002), p. 27.

[45] Marmot, *Health Gap*, p. 51. People might, though, be wrong about how easy it is to stop unhealthy behaviour. George Loewenstein says that addicts overestimate how easy it is, because they underestimate the power of visceral urges. See George Loewenstein, 'A Visceral Account of Addiction', in *Smoking: Risk, Perception, and Policy*, edited by Paul Slovic (Thousand Oaks: Sage Publications, 2001). By contrast, smokers underestimate how easy it is to quit, according to Baumeister, 'Addiction, Cigarette Smoking, and Voluntary Control of Action', p. 75.

consider the well-known view that people are the best judges of their interests. In one summary of the best-judge view, David Archard writes: 'When sincere, reasonable but conflicting claims as to what is for somebody's good are made then that person's own claim is (probably) right.'[46] If the best judge view is correct, then we should not interpret people's unhealthy behaviour as involving a mistake about what would best serve their ends. (Remember temptation, though; our judgements might be fine, and yet we might fail to act on them.)

One reason for the best judge view is 'privileged access'. Privileged access is the idea that we have a special knowledge of our own aims and mental states that we do not have about the aims and mental states of others. Privileged access should not be taken to mean that I alone can know my aims and mental states as you alone can know yours, or that we cannot be wrong about our own aims and mental states.[47] The idea is that individuals have an authority about their aims and mental states that others do not.[48] I can tell directly how much pleasure I get from drinking a beer, for example, but I cannot tell directly how much pleasure you would get. Even so, judging our own interests involves more than knowing our aims and mental states, important though they are. It involves working out what would best serve our aims or produce the right mental state, and the answer is not something to which we have privileged access.[49] For instance, I might aim at a loving relationship with someone and yet be wrong about whether that someone is right for me. However, a second reason for the best judge view speaks to this point. It is a job of work to discover what would serve my ends and I am more motivated to find out than anyone else is.

The best judge view is a generalization and it will have its exceptions. Even John Stuart Mill, who seems to affirm a best judge view in *On Liberty*,[50] gave some. Mill excluded those who were 'a lunatic, an idiot, an infant: or though not wholly incapable, may be of immature years and judgment'.[51] He thought that adults have no special advantage in judging the value of what they have not experienced, for instance when the uneducated judge the value of education.[52] He was wary of irrevocable contracts, such as certain marriage contracts, especially when undertaken 'at an early age, and without any real knowledge of what they undertook.[53]

[46] David Archard, 'For Our Own Good', *Australasian Journal of Philosophy* 72 (1994): 285. Archard, however, rejects this view.

[47] Donald Davidson, 'Knowing One's Own Mind', in his *Subjective, Intersubjective, Objective: Philosophical Essays*, vol. 3 (Oxford: Oxford University Press, 2001).

[48] Davidson, 'Knowing One's Own Mind', p. 16.

[49] Archard, 'For Our Own Good', p. 285.

[50] Compare *On Liberty* (Harmondsworth: Penguin, 1982), p. 151 (ch. IV, par. 12) with *Principles of Political Economy, Part II* in *The Collected Works of John Stuart Mill*, vol. 3, ed. John M. Robson (Toronto: University of Toronto Press, 1965), ch. XI.

[51] Mill, *Principles of Political Economy*, p. 957. Mill also excluded barbarians. See *On Liberty*, p. 69 (ch. 1, par. 10).

[52] Mill, *Principles of Political Economy*, book V, ch. XI, §8.

[53] Mill, *Principles of Political Economy*, p. 960.

(Mill's point is that combining immaturity with inexperience made for an unreliable pursuit of self-interest.) One can see how these exceptions could undercut the claim that when people act unhealthily, they are nonetheless the best judges of their interests because they often do not know what it would be like to be ill and because the bad consequences would not occur for many years.[54]

In addition to Mill's exceptions, many writers cite the baleful effects on our judgement of assorted psychological biases, and these ideas have worked their way into public health advocacy.[55] According to these writers, we think bad things will not happen to us because we are in some way special; we botch elementary probability calculations; we are swayed by irrelevant features of a decision problem, such as being more likely to take an option when described as offering a 90 per cent chance of survival than when described as offering a 10 per cent chance of death. The relevant literature in social psychology and behavioural economics is now vast and a list of all the biases in the literature would be very long. However, we should not get carried away into thinking that people are hopeless at judging their interests. First, and this is a reason internal to the literature, it may well be that the influence of biases on our judgement has been too uncritically accepted. In a rather large number of cases, the biases reported in some experiments have turned out not to be replicated in others.[56] And second, the reasons for the best judge view were on to something. People do have privileged access to their own ultimate ends, and they are generally more motivated to find out what would serve them. These are not decisive reasons to think people are right, but they are to be set against their defects.

A third reason to keep a sense of proportion about biases draws on a point made earlier in this chapter: someone might have false beliefs that do not matter to their behaviour because they are causally irrelevant. Writings on public health sometimes assume, rather than establish, the causal influence of the bias. For instance, Robert Goodin considers smokers who deny the dangers of their habit despite having been bombarded with the evidence.[57] They rationalize the dangers away, for instance by saying that if smoking were so dangerous, the government would ban it. Goodin thinks this is a case where people have false beliefs that cause them to act against their own conception of the good and that stopping them smoking is thus relatively easy to justify because it does not impose the paternalist's values. Buried in this claim is the assumption that the false beliefs are causally necessary

[54] Le Grand and New, *Government Paternalism*, pp. 93, 168–9.

[55] Marmot, *Health Gap*, p. 59, like many, says that people do not rationally calculate utility, citing in his support the work of the psychologist Daniel Kahneman (and, by implication, his co-writer, Amos Tversky) as summarized in Kahneman's book, *Thinking, Fast and Slow*.

[56] Tim Harford, 'Rule 5: Get the Back Story', in *How to Make the World Add Up* (London: Bridge Street Press, 2020).

[57] Robert E. Goodin, *No Smoking: The Ethical Issues* (Chicago: University of Chicago Press, 1989), pp. 21–3. However, Goodin's main argument against smoking in private (i.e. setting aside second-hand smoke) is that it is both physically harmful and addictive.

for the smoking. But Goodin's own description makes it clear that such smokers would come up with anything to explain away the dangers. For anything he says, such smokers would smoke even if they were persuaded of the dangers and he offers no reason to think that such smokers 'really' want not to smoke.

My view is that the various plausible generalizations one can make about people's abilities to judge their own interests are far from being exceptionless or decisive when it comes to public health. We cannot be confident either that most people's unhealthy behaviour is due to sound judgement or due to unsound judgement. As I said before, we must get down to details.

Motivation

If we want to see whether unhealthy behaviour is due to temptation or some similar motivational problem, we can see: (1) what people say about what they want; (2) what they do; and (3) what they say about what they do. Take the unhealthy activity of smoking. We might ask: do smokers say they regret it? Do they say they wish they had not started? Do they say they want to stop? About their behaviour, we can ask, do smokers try to stop? Do they pay for cessation treatments or turn up for hypnotherapy? And what do they say about their behaviour? Do they, for instance, say they find it hard or impossible to stop? These sources of evidence can point in different directions. People do not have to smoke so, when they choose to, their choosing suggests that they prefer it. On the other hand, many smokers say they would rather not smoke. Do they really prefer to smoke or not? Their revealed preferences imply 'Yes' but their stated preferences imply 'No'. Which is the better guide to what people really want?

Christopher Snowdon writes: 'Revealed preferences are more reliable than stated preferences as a barometer of a person's desires unless there are compelling reasons to believe that a person's actions are substantially non-voluntary.'[58] He thinks that when people make unhealthy choices, they tend to do what they really prefer. I think that while Snowdon gives reasons to be cautious about taking statements of preferences at face value, reasons we will bear in mind, he does not show that revealed preferences must have priority over stated preferences in interpreting behaviour.

Snowdon says that stated preferences can be cheap virtue signalling.[59] When people say they wish they did not smoke, or want to quit, or want to take more exercise, or eat more healthy food, or drink less alcohol, they could be signalling a cost-free commitment to health to whomever they are talking to. Or they could be

[58] Snowdon, *Killjoys*, p. 138.
[59] Snowdon, *Killjoys*, p. 49.

describing the kind of person they wish they were. They could be trying to deceive whomever they are talking to. They could even be trying to deceive themselves.[60]

I agree with Snowdon that if stated preferences are only virtue signalling or express character aspirations, then they are not a good guide to what is in someone's interests. That is probably obvious in the case of virtue signalling but I think it is also true of wishing one had different preferences. One often sees it said that people have second-order preferences, that is preferences about their preferences, such as wishing they did not want to smoke.[61] I think we cannot infer that something is in a person's interests just because they want to want it, even if they are sincere and not deceiving themselves. Suppose I want to want kale (a second-order desire), but in fact I dislike kale and want not to eat it (a first-order desire). I can also prefer not to have kale given that I do not like it. This thought is not just a restatement of the first-order desire not to eat kale. It is instead to rank 'wanting to want kale, not wanting kale, not eating kale' higher than 'wanting to want kale, not wanting kale, eating kale'. Nor does this thought imply some mind-bending third-order preference such as 'I wish I was not so obsessed with my health that I did not want to want kale'. To prefer not to eat kale given that I do not like it is just to evaluate my interests given what I am really like, that is, someone who, regrettably, dislikes kale.[62]

Snowdon might be right that people who say they want to quit smoking, or that they regret their unhealthy actions, could be merely virtue signalling or reporting their aspirations, and that in these cases their stated preferences do not indicate where their interests lie. However, other interpretations are possible. Perhaps someone does not try to quit because they are fatalistic about their chances of successfully stopping. It is not that they judge the unhealthy behaviour better for them, but that they, rightly or wrongly, think changing it is impossible. Not quitting therefore does not show that they prefer consuming to not consuming. Or someone might sincerely regret starting and regard it as a mistake but now be in a position where, regrettably, the best they can do is to carry on. Or what if temptation is a very plausible interpretation of behaviour? Why must we say that the preferences revealed through choosing the unhealthy option must indicate the person really values? As with trying to decide whether someone is merely virtue signalling, these questions may be answerable with more detail and context. We

[60] Snowdon, *Killjoys*, p. 52.

[61] e.g. C. R. Hooper and C. Agule, who assert, without citing evidence, that 'many smokers have second-order desires not to smoke' in their 'Tobacco Regulation: Autonomy up in Smoke?', *Journal of Medical Ethics* 35 (2009): 366.

[62] Invoking second-order preferences is sometimes just a vague shorthand for this thought: we can stand back from the fulfilment of our desires and evaluate the value of fulfilling them. I agree with this thought and rely on it in this chapter, when talking about motivational problems, and the next, especially when discussing regret and judgement. My doubts in this paragraph are about whether the thought should be expressed in terms of second-order preferences.

will have an extended example in Chapter 6, when we consider the empirical research on smokers' regrets.

Even if we consider behaviour rather than talk, the argument that some people really prefer to be healthy gets support from what they do. Like many drug users, smokers often quit and relapse, quit and relapse. People trying to lose weight see it go up and down, up and down. People spend a lot of money, time, effort, and misery in trying to lose weight through diets, exercise, and surgery.[63] 'Slimming is a repudiation of the prior "eating decision"', says Avner Offer.[64] Bariatric surgery is an even louder repudiation.

Even if we agree that ambivalent actions show that some people prefer to be healthier, Snowdon might still be right to assert that 'the claim that "public health" paternalists are helping people to realise their true selves is at odds with billions of revealed preferences that can be observed daily'.[65] For probably any unhealthy activity, and certainly those involving smoking, diet, alcohol, and immobility, some will, but others will not, regret it, want to quit, be happier for cutting down or stopping, and so on. Any public health intervention is overwhelmingly likely to be good for some people and bad for others, which raises questions about the ethics of distribution we come to in Chapter 12. But we have yet to see who would gain or lose from an intervention, and that is the subject of the next chapter.

Conclusion

Here is where we are up to. If a public health intervention makes someone healthier, it makes them better off only if being healthier would better fulfil their preferences. The challenge was to explain why intervening in their behaviour would make them better off. The possible answers are that people are factually misinformed or have some problem of motivation in acting on their preferences. Such answers need evidence, and the sort of evidence would be from within people's own attitudes and behaviour, such as their regret or attempts to quit. In the next chapter, we shall consider the evidence about smoking, drinking alcohol, and unhealthy food and non-alcoholic drinks. Of these, the evidence is much the strongest for paternalistically discouraging smoking.

[63] Julie S. Downs and George Loewenstein, 'Behavioral Economics and Obesity', in *Oxford Handbook of the Social Science of Obesity*, edited by John Cawley (Oxford: Oxford University Press, 2011), p. 138.

[64] Avner Offer, *The Challenge of Affluence: Self-Control and Well-Being in the United States and Britain since 1950* (New York: Oxford University Press, 2006), p. 163.

[65] Snowdon, *Killjoys*, p. 111. Snowdon writes 'public health' in scare quotes because he thinks its mission has crept beyond controlling contagious disease. See pp. 62–3.

6
Applications
Smoking, Alcohol, Fattening Food, and Drink

Introduction

Public health advocates often favour policies that reduce options for consumers. These policies include special taxes, restricting who may buy or sell products, restricting where products may be consumed, and banning certain ingredients. Such policies have been applied to cigarettes, alcohol, and unhealthy non-alcoholic drinks and food. Advocates recommend these policies for different reasons. A good reason to regulate alcohol in particular is to reduce the harm drinkers do to other people. However, advocates also recommend the policies on the grounds that consumers would benefit from having unhealthy options made harder or impossible to take. Note that those who are to be protected from themselves could be current or potential consumers, or both. It is this paternalistic reason we shall consider in this chapter.

We saw in Chapter 5 that while people can make factual mistakes about how to fulfil their preferences or can be too unmotivated to act on their judgements of their interests, we need evidence about whether people really do make these mistakes and about how widespread they are. We cannot assess every type of unhealthy behaviour, and in this chapter we consider only the evidence about smoking, drinking alcohol, and body weight. I shall present evidence about regrets, addictions, and attempts to quit or otherwise reverse unhealthy behaviour. The evidence gives strong support for thinking that paternalistically regulating smoking can, in principle, make people better off. But the evidence is much weaker when it comes to alcohol and body weight. In part, the reason is an absence of evidence. Although researchers have studied the effects of regulations on behaviour and the effects of behaviour on health, they have not done much to connect people's health to their ultimate preferences. Insofar as we have evidence, it implies that only relatively few eaters and drinkers (whether of alcohol or sugary drinks) make mistakes about their interests. Even if this observation is correct, the paternalistic case for regulation is not lost. But it is in trouble.

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Smoking Cigarettes

While people can also get their nicotine from vaping, smoking cigars, chewing tobacco, and sticking patches on their bodies, this section is about smoking cigarettes, which everyone agrees is especially unhealthy, and which has been widely known to be unhealthy for a long time.[1] Amongst other policies, governments have imposed taxes, sometimes very high taxes, banned advertising and marketing, restricted availability, required hiding cigarettes and putting them in plain packets, and banned smoking in public places. Advocates for these policies say they prevent the harm to others that comes from second-hand smoke, or they reduce social costs, such as to a health system, and, of course, they give the paternalistic reason that we are interested in in this chapter, that smoking is bad not just for smokers' health but for their well-being.[2] Since people choose to smoke, those who want to argue for paternalistic anti-smoking policies must give reasons to think that smokers make mistakes about their interests.

Public health advocates no longer tend to claim that smokers, in developed countries at least, falsely believe smoking to pose no risk to health. Smokers might not be aware of every danger posed by cigarettes, but what they do not know seems unlikely to make a difference to whether they smoke. We do have some evidence that smokers underweigh the risks because they misunderstand probability or think they are mysteriously exempt from dangers, although some evidence points the other way, that smokers overestimate the dangers of smoking.[3] I think we can cut through the disagreements about how much smokers genuinely understand the risks of smoking by bearing in mind the evidence we shall now see, which points towards the conclusion that most smokers see smoking as a mistake.

Many smokers say they want to quit—68 per cent in 2015, according to the US Centers for Disease Control and Prevention, while 55 per cent said they had tried to quit at least once in 2018.[4] Many smokers say they are addicted.[5] Some try cessation counselling or medicines.[6] Now, none of this evidence proves on its own that smoking is a mistake in failing to fulfil smokers' ultimate preferences.

[1] The reader might remember from Chapter 2 that the British Health Minister, Iain Macleod, announced the link between cigarettes and lung cancer to a smoky press conference in 1954.

[2] In Chapter 11, we shall see that the non-paternalistic arguments for the anti-smoking policies either fail or are limited in what they support.

[3] Paul Slovic, 'Smokers: Rational Actors or Rational Fools?', in *Smoking: Risk, Perception, and Policy*, edited by Paul Slovic (Thousand Oaks: Sage Publications, 2001). Slovic thinks smokers are fools.

[4] Centers for Disease Control (CDC), 'Smoking Cessation: Fast Facts', https://www.cdc.gov/tobacco/data_statistics/fact_sheets/cessation/smoking-cessation-fast-facts/index.html (last accessed 31 May 2024).

[5] T. F. Pechacek, P. Nayak, P. Slovic, S. R. Weaver, J. Huang, and M. P. Eriksen, 'Reassessing the Importance of "Lost Pleasure" Associated with Smoking Cessation: Implications for Social Welfare and Policy', *Tobacco Control*, 27(e2) (2018): 143.

[6] But fewer than a third in 2015, according to the CDC, 'Smoking Cessation'.

Neither wanting to quit nor self-reported addiction amounts to admitting a mistake. People who plan their retirements generally want to quit paid work at some point, which does not indicate that they see taking paid work as a mistake. As for self-reported addiction, those who claim to be addicted to exercise or coffee often seem happy about it, even proud. Nor does being willing to pay to stop smoking show it to be a mistake, although it might show that stopping is not that easy,[7] and anyway only a minority are willing to pay to quit.[8] For all these reasons, critics of anti-smoking policies can try to chip away at the evidence. However, interpreting behaviour is unlikely to be a matter of drawing deductive conclusions. We have to come up with the most plausible of the several possible interpretations. In the case of smoking, the desires to quit, the self-reports of addiction, and willingness to pay to stop become more compelling evidence that smoking is a mistake when we add them to the striking and persuasive research on smokers' regrets about starting. It is this research we shall concentrate on in this section.

Numerous studies conclude that a large majority of smokers regret smoking. One massively cited study, by G. T. Fong and colleagues, gives the flavour:

> We present data from the baseline wave (October–December 2002) of the International Tobacco Control Policy Evaluation Survey, a random-digit-dialed telephone survey of a cohort of over 8,000 adult smokers across four countries—Canada, the United States, the United Kingdom, and Australia—to estimate the prevalence of regret and to identify its predictors. The proportion of smokers who agreed or agreed strongly with the statement 'If you had to do it over again, you would not have started smoking' was extremely high—about 90%—and nearly identical across the four countries.[9]

A similar study for New Zealand produced similar results.[10] A study of certain Asian countries found that the prevalence of regret was much the same in South Korea (87 per cent) and Thailand (93 per cent), although somewhat lower—but

[7] Although the CDC, 'Smoking Cessation', say: 'In 2018, 61.7% of adult smokers (55.0 million adults) who ever smoked had quit.' These high quit rates sink an argument against the voluntariness of smoking that goes like this: smokers are mainly children when they start and, by the time they become adults, they are addicted, so they cannot stop. For a relatively sophisticated version of this argument, but one still sunk by the high quit rates, see Robert E. Goodin, *No Smoking: The Ethical Issues* (Chicago: University of Chicago Press, 1990), pp. 29–30.

[8] The number in England using state-funded smoking cessation services has declined in recent years, which might be partly due to disruptions from Covid and partly due to people switching to vaping. See Nuffield Trust, 'Smoking' https://www.nuffieldtrust.org.uk/resource/smoking#backgro und (last accessed 31 May 2024).

[9] G. T. Fong, D. Hammond, F. L. Laux, M. P. Zanna, K. M. Cummings, R. Borland, and H. Ross, 'The Near-Universal Experience of Regret among Smokers in Four Countries: Findings from the International Tobacco Control Policy Evaluation Survey', *Nicotine & Tobacco Research* 6 (2004): 341.

[10] N. Wilson, R. Edwards, and D. Weerasekera, 'High Levels of Smoker Regret by Ethnicity and Socioeconomic Status: National Survey Data', *New Zealand Medical Journal* 122 (2009): 99.

still very high—in Malaysia (77 per cent) and China (74 per cent).[11] A more recent US study, which asks not only about regret but also perceived addiction and intention to quit, again shows high levels of regret.[12]

What follows from these results for paternalistic smoking policies? Fong et al. write: 'this near universality of regret casts doubt on the view of some policy analysts and economists that the decisions to take up and continue smoking are welfare-maximizing for the consumer.'[13] Sansone et al. write: 'the extensiveness of the regret we observe does challenge the notion that "consumers wouldn't smoke unless it was in their best interests to do so".'[14] Wilson et al. say: 'Such high levels of regret help to justify government action to substantially expand existing tobacco control interventions and smoking cessation support.'[15] I agree with the conclusions of these authors, but observe that they did not set out their reasoning. How does their regret show that consumers do not maximize their welfare or act in their best interests? How does regret make the case for further tobacco control? I shall try to answer these questions in the rest of this section.

One false start, in connecting regret to well-being, is interpreting the regret of smokers as grounds for thinking smoking is on-balance unpleasant. Chaloupka et al. write, of regret data from a 2002 survey: 'These data strongly suggest that many smokers do not find smoking pleasurable.'[16] Pechacek et al. treat regret as a component of what they call a 'picture of misery'.[17] These claims would be reasonable if the data they cited reported regret in the ordinary sense. Ordinarily, regret is an unpleasant emotion.[18] So one can see why researchers might think their data shows smoking causes misery as well as ill health. But in the research, the indicator of regret is agreeing to some variant of this statement: 'If I had my time over again, I wouldn't start smoking.' This bare statement lacks the emotional element and it does not entail that one feels bad about what one has done or that one gets so little pleasure from smoking that one finds it on-balance unpleasant. A smoker could coherently say: 'smoking brings me great pleasure but I wish I hadn't started because I think it is bad for me.' Of course, smokers could regret their smoking and feel bad about it, but the results do not prove that they do.

[11] N. Sansone et al., 'Comparing the Experience of Regret and Its Predictors among Smokers in Four Asian Countries: Findings from the ITC Surveys in Thailand, South Korea, Malaysia, and China', *Nicotine & Tobacco Research* 15 (2013): 1663.

[12] Pechacek et al., 'Reassessing the Importance.'

[13] Fong et al., 'Near-Universal Experience', p. 341.

[14] Sansone et al., 'Comparing the Experience of Regret', p. 1670.

[15] Wilson et al., 'High Levels of Smoker Regret', p. 99.

[16] F. J. Chaloupka, J. Gruber, and K. E. Warner, 'Accounting for "Lost Pleasure" in a Cost-Benefit Analysis of Government Regulation: The Case of the Food and Drug Administration's Proposed Cigarette Labeling Regulation', *Annals of Internal Medicine* 162 (2015): 64.

[17] Pechacek et al., 'Reassessing the Importance', p. 147.

[18] Jon Elster, *Alchemies of the Mind: Rationality and the Emotions* (Cambridge: Cambridge University Press, 1999), p. 246.

In my view, the widespread regret amongst smokers matters not because of what it tells us about their pleasure, but because it gives their overall judgement of their interests. In the ordinary sense of regret, it is 'an unusually cognitively-laden or cognitively-determined emotion. . . . Judgment is more central, in other words, to the experience of regret than, say, to the experience of jealousy or anger.'[19] The element of judgement is present in 'If I had my time over again, I wouldn't start smoking'. The smoker's regret is their judgement that they made a mistake on-balance. The person who makes it is not saying they regret that smoking has its downside. They are saying that the upside of smoking is not worth the downside.[20]

One may doubt whether our regrets tell us much about our well-being if our regrets are based on factual mistakes or are biased. However, factual mistakes and biases seem unlikely to undermine the evidence of smoker regret, and this is a strength of the research. The research cited here shows that smokers who regret smoking believe it makes them unhealthy and poorer and infringes on social norms.[21] They are probably right; smoking does make smokers unhealthy, and I see no reason to think they would be deluded about the norms or the effects on their wealth. As for biases, humans appear generally biased towards regretting what they do not do rather than what they do,[22] but then it is especially striking that the smokers regret what they do. Perhaps they think smoking is especially bad for them, otherwise they would have rationalized away what they have done.

The research on smoker regret has a further strength, in avoiding a bias in gathering evidence. Let me illustrate the bias. 'You'll regret it' must have been said tens of thousands of times to people who do not follow public health advice. R. S. Magnusson is one example when he quotes a former Premier of Tasmania, who, after a diagnosis of lung cancer, said: 'I have been a smoker for 35 years. . . . I have been an idiot. I have not listened.'[23] In discussion, clinicians often say that people with cancer or diabetes regret their excessive smoking, eating, and drinking. They seem to think that their observation shows that everyone, or nearly everyone,

[19] T. Gilovich, and V. H. Medvec, 'The Experience of Regret: What, When, and Why', *Psychological Review* 102 (1995): 379.

[20] Here I disagree with G. M. Lucas, Jr, who strangely interprets the expression of regret as a wish to have smoked without risk. See 'Saving Smokers from Themselves: The Paternalistic Use of Cigarette Taxes', *University of Cincinnati Law Review* 80 (2011): 715–16. Lucas also claims that smokers who express negative attitudes to their smoking might be telling what researchers want to hear. Lucas offers no evidence for this claim, and it seems unlikely to explain away (1) such a large majority of expressed regret in (2) so many countries, including China. At the time of Sansone et al.'s survey (in 2005), China had weak tobacco control and weak norms against smoking. See Sansone et al., 'Comparing the Experience of Regret', p. 664.

[21] Fong et al., 'Near-Universal Experience', p. 349; Sansone et al., 'Comparing the Experience of Regret', p. 1669.

[22] Gilovich and Medvec, 'The Experience of Regret'; Daniel Gilbert, *Stumbling on Happiness* (London: HarperCollins, 2006), pp. 178–80.

[23] R. S. Magnusson, 'Case Studies in Nanny State Name-Calling: What Can We Learn?', *Public Health* 129 (2015): 1077. Magnusson also cites Christopher Hitchens as another person who regretted his smoking (and drinking) but in a more 'subtle' way. I think it is questionable whether Hitchens regretted his smoking and drinking.

would be better off if they did not smoke, drink too much, overeat, and so on. Their argument is formally like the one made by believers who tried to convince Diagoras of Melos of the power of the gods. The believers showed Diagoras 'portraits of some worshippers who prayed, then survived a subsequent shipwreck. . . . Diagoras asked, "Where were the pictures of those who prayed, then drowned?"'.[24] Diagoras might ask, of those pointing to the people who did not follow the public health advice and regretted it, 'What of those who smoked, drank, and overate but did not fall ill and did not regret what they had done?' The bias in the regret argument is all the more ironic because it is often to be found in those who themselves cite biases as reasons to think people are not rational maximizers.[25] By contrast, the smoker research cited here avoids the bias because it is based on a representative sample of all smokers, not just those to whom bad things have happened.

The smoker research partly avoids a further problem, the problem of prediction, which arises for the argument that potential smokers should be deterred because they would regret smoking. Suppose an adviser says, 'You'll regret starting smoking' to someone. The potential smoker could reply, 'How do you know?' The adviser in this case is extrapolating from the regrets of different people. The adviser must then say, 'You are like these other people, and they regret it'. The potential smoker might say, 'I am not like these other people'. And they might say, 'I won't regret it because in forty years' time, treatments for heart disease and cancer will be better'. Notice that the potential smoker is also predicting in these replies. As against the first, Daniel Gilbert argues that if we want to know how we will feel about something in the future, we often do better to assume we will be like other people in that position than trying to guess for ourselves.[26] One could add: 'especially in this case, when the vast majority regret their smoking.' As for the second, the potential smoker could of course be correct, but the issue is whether treatment would get so much better. It is a prediction primarily about advances in medicine rather than about future regrets.

Even if we knew someone would regret smoking, obstacles might remain in the way of concluding that smoking would reduce their well-being. The regret judgement in the empirical research is a later judgement about an earlier time. Suppose one says to a 20-year-old 'You'll regret your smoking/drinking/overeating/listening to loud music, when you're 60'; and suppose this person would regret the activity forty years later. The 20-year-old could say: 'why think my later judgement

[24] N. N. Taleb, *The Black Swan: The Impact of the Highly Improbable* (New York: Random House, 2007), p. 100.

[25] Such as Julian Le Grand and Bill New, *Government Paternalism: Nanny State or Helpful Friend?* (Princeton: Princeton University Press, 2015). Like many modern paternalists, they cite the psychological evidence about how our beliefs and decisions are swayed by anchoring, probability mistakes, and so on. Le Grand and New go on to claim (pp. 168–9) that, since health professionals have experience caring for the ill, they have more insight into the interests of smokers than healthy smokers do themselves. Le Grand and New forget that ill smokers are only a subset of all smokers.

[26] Gilbert, *Stumbling on Happiness*, ch. 11.

is the right one? I will have forgotten by then the pleasure I got.' However, I do not think this reply raises a problem for concluding that smoking is against the interests of those who say they regret it. The reply invokes faulty memory or perhaps a failure on the part of the later self to put itself in the shoes of the earlier self. Smokers' regrets do not seem seriously subject to such failures because the research asks current smokers about their regret and they obviously know what it is like to smoke. Moreover, even young smokers regret smoking.[27]

The 20-year-old might say instead: 'What I will want then is not what I value now.' This reply envisages a change in preferences and it is potentially a problem for drawing conclusions about well-being from the regret research. How such a change would affect an agent's well-being overall is a difficult question, as we saw when discussing long-term preferences in Chapter 5. I can say that regret need not represent a change in values; regret could be due to greater knowledge or understanding, for instance. Also, the plausibility of ascribing a change in preferences to a smoker depends partly on how soon after starting they came to regret smoking. Take a parallel case: many winners of auctions immediately feel buyer's remorse but not due to a sudden change in ultimate preferences. Values do not change so fast. More likely they realized that, in winning the auction, they paid more than anyone else was willing to pay and suspected they overpaid.[28] Unfortunately, the research cited in this chapter did not ask smokers about when they first regretted smoking although, as just mentioned, even younger smokers say they would not take it up if they had their time again.

Turning now to the limits of the research on regret, we cannot conclude that smokers who regret starting would be better off if they stopped. It does not follow from 'I regret I am in a state where I do X' that 'I would be better off if I do not do X'. Someone who acquired emphysema due to smoking might regret having to use an oxygen bottle; it does not follow that they would be better off without the bottle. Analogously, current smokers might regret being in a state where their best option is to smoke. How could smokers who regret smoking not be better off for stopping? Perhaps the transition costs to non-smoking are too high due to the symptoms of withdrawal. Perhaps their smoking has irreparably damaged their health so much that they might as well carry on.[29] These possibilities are not supposed to show that smokers should carry on, only the limit to what may be inferred from their regret. In any case, this limit does not apply to deterring potential smokers. If people are put off ever starting to smoke, they would not have to pay the transition

[27] Fong et al., 'Near-Universal Experience', p. 347; Pechacek et al., 'Reassessing the Importance', p. 148.

[28] Why would anyone overpay? Perhaps because auctions create both the fear of missing out and rivalry between bidders. See Robert B. Cialdini, *Influence: The Psychology of Persuasion* (New York: Collins Business, 2007), pp. 264–5.

[29] See Jon Elster, *Strong Feelings: Emotion, Addiction, and Human Behavior* (Cambridge, MA and London: MIT Press, 2000), p. 71. In Elster's terms, the weak desire to quit, 'I wish I had never started', does not entail the strong desire, 'I now want to stop'.

costs from an addiction they have not acquired and nor would they have damaged their health so much they might as well carry on. It may be, then, that paternalistic policies to discourage smoking would benefit the people who might have smoked while being against the interests of current smokers.

Finally, smokers say that they regret smoking for several reasons. The risk to health is obviously one leading reason, but they also regret smoking because it is expensive and stigmatized. That people smoke despite these costs might show them not to be rational maximizers of preferences that are consistent over time. It does not show that adding to these costs would reduce their regret or increase their well-being compared with reducing the costs. Smokers could even regret their smoking only because of the costs in money, time, and social acceptability that have been imposed through public health paternalism. Here is a way to see the point in the case of tax. A packet of twenty-five cigarettes cost $37.48 on average in New Zealand in 2019 (about USD 24.70).[30] The tax component was $20.66 of which the regular Goods and Services Tax was around $2.50 and the rest a special tax on cigarettes. The number of smokers who would regret smoking could be much lower if they did not have to pay the special tax of around $18 a packet. Cutting the tax would then be a way to reduce regret. A limitation of the quantitative research on smoker regret cited in this chapter is that it does not tell us how far the health effects, rather than the financial and social costs, make smokers regret their habits. That said, the health effects do figure prominently in the qualitative data cited.[31] Moreover, as mentioned earlier, 74 per cent of smokers in China said they would not start again even though China had weak tobacco control policies at the time of the survey. Thus it would not be surprising if many, even a large majority, of smokers regretted smoking due to the health effects alone. Still, as far as making the case for paternalism is concerned, more research would be welcome.

The research on smokers' regrets helps us cut through some of the distributional problems of paternalism that will occupy us in Chapter 12. In brief, paternalistic interventions would often be good for some people but bad for others. What might justify policies that impose costs on some while benefiting others? On any plausible view, numbers should count for something. Put another way, policies would be more defensible the greater the proportion who would benefit and less defensible the greater the proportion who would lose. The research on smokers' regrets is important because it shows that such a high proportion regret their smoking and could benefit from regulation. (Whether they would benefit in practice depends on whether the regulations work and avoid excessive side-effects, considerations we are leaving aside.) Some views of distributive ethics also give a special weight to

[30] Statistics New Zealand, 'Cigarette Price Rise Offsets Cheaper Petrol', 17 April 2019, https://www.stats.govt.nz/news/cigarette-price-rise-offsets-cheaper-petrol (last accessed 31 May 2024).

[31] Paul Slovic, 'The "Value" of Smoking: An Editorial', *Health, Risk & Society* 14 (2012); Pechacek et al., 'Reassessing the Importance', Supplementary Material 3.

the effects on the worst off. The regret research is some help here too. Pechacek and colleagues find no difference in regret for highest and lowest income levels (70.6 per cent of smokers for < $30,000 household income and for > $60,000 household income) and they even find that the less educated (high school or less) did express regret in greater proportion than those with a college degree (73.3 per cent compared with 67.6 per cent).[32] Thus we have grounds to think that most of the worse off would, according to their own judgement, benefit from smoking less or quitting.

The research on smoker regret gives a strong reason to think regulation could improve smokers' well-being. Can a similar reason be given for regulating in other areas of public health? Since there appears to be no research on alcohol or food (or e-cigarettes) that is analogous to the research on smoker regret, the answer is 'No'.[33] One therefore cannot argue, on behalf of regulation, that we know that most consumers of unhealthy food and drink regret their activities. However, I see no reason why the research could not be done. Let me offer some suggestions and observations. Pechacek and colleagues define smokers as people who have smoked more than one hundred cigarettes in a lifetime and currently smoke every day or most days. They categorize smokers into those smoking 1–5, 11–15, or over 15 cigarettes\day.[34] By analogy, we might define a drinker of alcohol as someone who has had ten beers or equivalent over a life and drinks every day or most days. We could then categorize them into those who drink 1, 2–5, or over 5 beers per day. We could define and categorize in a similar way the drinkers of soft drinks and eaters of cakes, burgers, and chips. Then we could ask them whether they regret their pattern of consumption.

While one should not anticipate the results of empirical research, I would be surprised if over 70 per cent of current beer, soft drink, cake, burger, or chip consumers regretted their consumption. I would not be surprised if people diagnosed with addictions, or who were seriously ill as a likely result of drinking or eating too much, did regret their activities in high numbers. But asking only them would not be analogous to the smoking research, which asked all current smokers about their regrets. A uniform tax on alcohol or soft drinks, like a cigarette tax, would affect anyone who might buy them and one ought to ask all consumers about any regrets, not just a subset who are addicted or are seriously ill. If it turns out that a majority do not regret their consumption, then the paternalistic case for regulating them is considerably weaker than it is for smoking. Interestingly, some anti-smoking advocates think that the paternalistic case for regulating smoking does not extend

[32] Pechacek et al., 'Reassessing the Importance', table 3, p. 148; see also Fong et al., 'Near-Universal Experience', p. 346.

[33] Some research exists on what is called 'anticipated regret' to try to work out whether, for instance, people exercise in order to avoid later regret, but anticipated hypothetical regret is not the same as actual after-the-events regret.

[34] Pechacek et al., 'Reassessing the Importance', p. 144.

to regulating other 'lifestyle' choices precisely because smokers regret their consumption whereas, by implication, drinkers and junk food eaters do not.[35] Perhaps smoking is a special case of a product whose consumers regret it because it is a rare combination of being very dangerous, highly addictive, and legal.

As I said, we do not have research on regretting other unhealthy behaviour that is comparable to the research on smokers. So let us see what we do have. In the next section, I present research about alcohol, and in the subsequent section, research about bodyweight.

Alcohol

Public health campaigners against alcohol often consider prohibition impractical, at least in countries where most adults drink alcohol. But they would like people to drink less, and less hazardously, and to this end would like to ban the advertising of alcohol and make it less available and more expensive.[36] One cluster of reasons is to prevent harm to others and reduce social costs. Car crashes and violence, for instance, often involve harm to people besides the drinkers and they are expensive to deal with. Another reason, the one we are considering in this chapter, is to prevent harms to drinkers themselves.

Geoffrey Rose, as we saw in Chapter 3, wanted to reduce the mean level of drinking as a way to mitigate alcoholism, but he did not think the average drinker would be better off for drinking less. By contrast, more recent writers seem to favour a population strategy because they think no safe limit for alcohol exists and alcohol causes a great deal of harm in aggregate to light and moderate drinkers, although they think the smaller number of heavy drinkers are individually at much more risk.[37] Quite often, these writers mention, only to criticize, the supposed benefits to health of drinking alcohol, for instance in reducing ischaemic heart disease. They think these benefits are either small or the result of statistical confounding (because the people who drink more alcohol and live longer tend to be richer, and being richer is what makes them live longer, not the drinking).

However, as we saw many times in Chapter 3, health is not the only value, and public health advocates often overlook the benefits of unhealthy behaviour generally, and of drinking alcohol specifically.[38] In fact, some public health writings leave

[35] K. Grill and K. Voigt, 'The Case for Banning Cigarettes', *Journal of Medical Ethics* 42 (2016): 300; R. N. Proctor, 'Why Ban the Sale of Cigarettes? The Case for Abolition', *Tobacco Control* 22 (2013): 27.

[36] See the World Health Organization's 'best buys', discussed in Chapter 3.

[37] Thomas F. Babor et al., *Alcohol: No Ordinary Commodity: Research and Public Policy*, 2nd ed. (Oxford: Oxford University Press, 2010), §4.8; Jennie Connor, 'Alcohol Consumption as a Cause of Cancer', *Addiction* 112 (2017): 226–7.

[38] But certainly not all of them. Devi Sridhar writes, 'But clearly, public health is a constant balance between regulating risk factors that harm our health, and letting individuals leave meaningful lives in the way they want to. For many people, the pleasure and fun of having a glass of wine or a beer with

it a mystery why anyone drinks at all.[39] The non-health benefits of alcohol should be accounted for whether the aim is to see if drinking is on-balance harmful to drinkers or to estimate the overall social benefits of reducing alcohol consumption.

Some writers do attempt to quantify non-health benefits as part of a cost-benefit analysis of alcohol policy. The ones I consider here are Peter Anderson and Ben Baumberg. Their analysis considers the pleasure that drinkers would lose if they consumed less as against the benefits they would get in their health, and in 'jobs and income', which are at risk if they are too sick from alcohol, too drunk, or too hungover to work or work properly. I agree that these effects should be considered, but the way in which they do it is seriously flawed.

Anderson and Baumberg have two main ideas that tend to the conclusion that drinkers would be better off for drinking less.[40] The first is to quantify the dangers of alcohol to health (including the dangers of being injured), to jobs and income through lost productivity, and to education, and claim that these outweigh the 'lost pleasure' of foregone drinking. The second is to attribute some of that lost pleasure to 'irrational demand'.[41] They work through a model of a tax-imposed increase of 10 per cent on the price of alcohol in the United Kingdom and find that the value of pleasure lost would be around $69 million whereas, 'On the benefit side, there are real tangible benefits due to reduced health and welfare costs ($217 million) and reduced labour and productivity losses ($480 million). . . . These benefits do not include benefits to people other than the drinker. . . .'[42] Therefore, in their opinion, the lost pleasure to drinkers from lower consumption would be outweighed by the benefits to them.

friends is worth the harm.' 'Cheers to Getting Through Dry January: Moderation over Bingeing Should Be Our Next Goal', *The Guardian*, 1 February 2023.

[39] The closest Babor et al. come to describing the non-health benefits of drinking is in a sentence, 'Nowadays, alcohol products are mainly used as beverages to serve with meals, as thirst quenchers, as a means of socialization and enjoyment, as instruments of hospitality, and as intoxicants.' Thomas F. Babor et al., *Alcohol: No Ordinary Commodity*, p. 12. But they never attempt to quantify these less than lyrically described benefits or offset them against the costs of alcohol.

[40] Peter Anderson and Ben Baumberg, *Cost Benefit Analyses of Alcohol Policy—a Primer*, Report for the European Commission Health & Consumer Protection Directorate—General Directorate C—Public Health and Risk Assessment, 2010. Anderson and Baumberg make another point, pp. 8–9, which is that a tax raises revenue and so, even though it is a cost to drinkers, it is not a social net cost. However, this point would not apply to policies, such as restricting availability, that do not raise revenue and in any case to the extent that the policy raises revenue, it is not discouraging consumption. Drinkers only pay tax on what they drink. Whether we should want a budget depending on alcohol tax revenue is another matter. The Soviet 'drunken budget', as General Secretary Gorbachev called it, is an unencouraging example. For the quotation, see Mark L. Schrad, *Vodka Politics: Alcohol, Autocracy, and the Secret History of the Russian State* (New York: Oxford University Press, 2014), p. 267.

[41] Peter Anderson, 'Tackling Alcohol-Related Harms', in *Promoting Health, Preventing Disease: The Economic Case*, edited by David McDaid, Franco Sassi, and Sherry Merkur (Berkshire: Open University Press, 2015), p. 93.

[42] Anderson, 'Tackling Alcohol-Related Harms', p. 93. This quotation summarizes (and converts euros into dollars) Anderson and Baumberg, *Cost Benefit Analyses of Alcohol Policy*, p. 47.

Notice, in that last quotation, that the savings in health, welfare, and jobs and productivity costs are explicitly said to be benefits to drinkers. But, confusingly, when they describe these benefits, they all turn out to be benefits in saving social costs, such as in health care, or costs to other people, such as not being victims of crime or accidents. What they describe are not benefits to the drinker. One can see why it would benefit someone not to commit a crime or not to be ill or not to fall asleep at work, but they did not quantify these benefits to the drinker, even though they said they did.

Let us now consider quantifying lost pleasure. The method Anderson and Baumberg use (which is a common method) is to equate the pleasure from drinking with the consumer surplus, and to measure consumer surplus by the difference between how much people do pay for their alcohol with the most they would be willing to pay. To give again the example from Chapter 3, if a cup of coffee costs $3.90 but the consumer would be willing to pay $4, the consumer surplus is 10 cents for each cup. Anderson and Baumberg give all sorts of caveats about the difficulties of estimating willingness to pay, but nonetheless, willingness to pay is their basis for putting a dollar value on the lost pleasure from drinking less alcohol. This dollar value is lower than the health and other costs to the drinker (disregarding the confusion reported in the previous paragraph), so Anderson and Baumberg think these consumers are net better off for drinking less.

What Anderson and Baumberg are explicitly doing is comparing one kind of benefit, pleasure, with other kinds of benefit, such as health, to try to reach an on-balance judgement. But they have therefore made a mistake in using willingness to pay to quantify pleasure. People's willingness to pay is not just willingness to pay for pleasure. It is willingness to pay after taking all costs and benefits into account. If they drink, they have decided that the dangers to their health, educational attainment, and jobs and income are outweighed by the benefits of drinking. A drinker's willingness to pay for their drink expresses an on-balance judgement that takes pleasure into account as just one factor. If $69 million is the real figure for the loss to consumers that can be derived from willingness to pay, then that is the loss overall, even taking into account any health benefits. Thus reducing the consumption of alcohol would be against the interests of drinkers overall.

At this point, we should consider Anderson's and Baumberg's attempt to discount people's actual willingness to pay as being partly based on 'irrational demand'. Anderson and Baumberg do not say explicitly what value they give to fulfilling 'irrational demand', but the strong impression is that they think it has no value. For instance, they compare irrational demand with what they call 'true willingness to pay' (presumably identifying the true self with the rational self).[43] But if they do consider that fulfilling irrational demand has no benefits, they need to give

[43] Anderson and Baumberg, *Cost Benefit Analyses of Alcohol Policy*, p. 9.

a reason. Suppose a book costs $10. Suppose the most I would pay for it if I were rational is $20, but I am irrational and would be willing to pay $30. We might say in this case that the 'true' consumer surplus is $10, rather than $20, but we should not say that the book has no value at all.[44]

What, then, is irrational demand? Anderson and Baumberg write:

> First, some consumers are poorly informed on the delayed impact of alcohol consumption, and there is a perception, especially amongst young drinkers, that whatever the risks 'they don't apply to me'; second, there is a change in preferences and behaviours with age, with alcohol consumption and heavy drinking occasions normally declining with age; third, family and welfare systems that look after people if they become ill, disabled or unemployed create a 'moral hazard', meaning people are likely to take on more risks than if the safety net were unavailable; fourth, the heavy expenditure on the promotion and advertising of alcohol by the industry which stimulates alcohol consumption amongst youth, a strong predictor of lifetime drinking patterns, raises the question in what sense can the preferences of individual consumers be said to be 'sovereign', as distinct from 'manipulated'?; fifth, the evidence suggesting that peer group pressure is strongly influential in individual values, preferences and drinking behaviour, which again raises the question of the sovereignty of the preferences of individual and, finally, sixth, there is neurobiological evidence, that the brain reward circuitries overvalue the pleasure of psychoactive drugs, and thus the consumer puts more effort to obtain them, even if they provide no objective or subjective benefit to the user.[45]

Sensitized to these sorts of list, as we now are after Chapter 5, we can see how peculiar some of these items are. The second item, on drinking changing with age, seems irrelevant; the third item, on moral hazard, seems to cite rational, not irrational, behaviour; and the fourth and fifth items only ask questions and we cannot just assume that it is irrational to drink because of advertising or wanting to fit in with a group, and nor can we just assume that these factors play a major causal role.[46] However, the first and sixth items do seem relevant. If consumers are poorly informed, they could make mistakes, although we are not told how many people are poorly informed or whether their drinking is due to it. As for the sixth item, this seems to connect drinking to addiction. Anderson elsewhere writes of 'alcohol's direct impact in cheating the brain to think that it gives more reward than it does

[44] This point also applies to the Chaloupka et al.'s claim that the 'lost pleasure' from less smoking should be set at zero because smokers are irrational. See Chaloupka et al., 'Accounting for "Lost Pleasure"', p. 64. But they do at least have on their side the substantial evidence of regret by smokers, whereas Anderson and Baumberg have no such evidence of drinkers' regrets.

[45] Anderson and Baumberg, *Cost Benefit Analyses of Alcohol Policy*, pp. 18–19.

[46] See also Chapter 5, on mistakes, and Chapter 9, on manipulation.

regardless of harms',[47] although the ultimate source for this claim is an article that offers a model of addiction and but does not actually mention alcohol.[48]

Suppose addiction does involve some overestimate of the reward from consumption. Anderson and Baumberg give no reason to think the brain cheating happens to drinkers in general. To restate some facts and figures from previous chapters, only 10 per cent of drinkers are estimated to have a substance use disorder.[49] And one can have a substance abuse disorder by fulfilling various criteria, not all of which establish that the disorder is bad for people, as judged by their preferences (see Chapter 5, on the DSM5 criteria). Thus one cannot say that more than a small minority of drinkers have the self-cheating brains of addicts.

However, Anderson and Baumberg, when estimating the quantity of irrational drinking, cite (presumably as a proxy) these figures: 'In the UK, for example, 82% of all alcohol is consumed by men who drink >32 g alcohol per day and women >24g/day, and 64% of all alcohol is consumed by men who drink 64g/day and women more than 48g/day.'[50] According to New Zealand's Health Promotion Agency, one standard drink contains 10 grams of alcohol and equates to a 330 ml can of 4 per cent strength beer.[51] Thus Anderson and Baumberg want to count it as irrational drinking when a man has around three cans of beer per day and a woman has two. For the sake of perspective, let us compare this quantity with the consumption of a genuine alcoholic, the writer Patrick Hamilton. According to his brother, at one stage of his life, Hamilton would drink beer and the equivalent of a bottle of whisky each day when in the country and, when in London, 'his daily consumption can seldom have fallen far below the equivalent of three bottles'.[52] To lump people who drink three cans of beer a day in with genuine alcoholics needs more justification than Anderson and Baumberg give it, which is none.

When we look to see if drinkers fail to fulfil their ultimate preferences, we are looking for motivational problems or false beliefs. The evidence supplied by the advocates of policies to reduce consumption is, when you read it carefully, that most drinkers are happy with their drinking in the sense that they would be willing to pay even more for it than they do now. We do not have evidence of widespread motivational problems. That leaves the possibility that drinkers have false beliefs about the effects of alcohol. Quite likely they have some false beliefs, especially since the science is not completely settled, but I have seen no evidence that if they

[47] Anderson, 'Tackling Alcohol-Related Harms', p. 82.

[48] A. D. Redish, 'Addiction as a Computational Process Gone Awry', *Science* 306 (2004): 1944.

[49] Ashley Gearhardt, Michelle Joyner, and Erica Schulte, 'Food Addiction', in *The Routledge Handbook of Philosophy and Science of Addiction*, edited by Hanna Pickard and Serge H. Ahmed (Abingdon: Routledge, 2019), p. 185.

[50] Anderson and Baumberg, *Cost Benefit Analyses of Alcohol Policies*, p. 20.

[51] Te Hiringa Hauora\Health Promotion Agency, 'Guide to Standard Drinks', https://resources.alcohol.org.nz/resources-research/alcohol-resources/research-and-publications/straight-up-guide-to-standard-drinks-pamphlet (last accessed 31 May 2024).

[52] Bruce Hamilton, quoted in William Palmer, *In Love with Hell: Drink in the Lives and Work of Eleven Writers* (London: Robinson, 2021), p. 31.

were fully informed, most would drink less than they do. Thus the conclusion is that policies that would reduce most drinkers' alcohol consumption would make most of them worse off, not better off.

Fattening Food and Drink

We have discussed cigarettes and alcohol, two examples of substances that tend not to promote health (to put it at its lowest). We now consider food and drink that make us fat.[53] Obesity has causes besides the food and drink (alcoholic or not) that people consume, such as how much they sleep and how little exercise they take. And food and drink can be unhealthy in ways besides making people fatter. Nonetheless, obesity is a major concern for public health and fattening food and drinks are its main target.

In the opinion of some, several countries face an obesity epidemic that could slow or perhaps reverse the rise in life expectancy.[54] Furthermore, 'Obesity rates continue to rise in most OECD countries, with an average of 60% of adults measured as overweight or obese. Obesity rates are highest in Mexico, Chile and the United States.'[55] Governments and local authorities have tried to control obesity by exhortation and education. They have increasingly turned to regulation too. As of March 2022, fifty-four countries have introduced taxes on sugary drinks.[56] Hungary has gone even further, with wide-ranging taxes on sugary, fatty, and salty foods and drinks.[57] Several local authorities in poor areas of England and Los Angeles have used their powers over planning permission to restrict the number

[53] Although 'fat' is a word some may find offensive, it has been reclaimed in the field of Fat Studies. See E. D. Rothblum, 'Fat Studies', in *Oxford Handbook of the Social Science of Obesity*, edited by John Cawley (Oxford: Oxford University Press, 2011), p. 174. From the perspective of Fat Studies, it is 'obesity' which is the offensive term, medicalizing a harmless aspect of some people's identity. To be even-handed, I shall use 'fat' and 'obese' interchangeably. Some further points that deserve to be only in a note: (1) Body Mass Index, the usual basis for obesity statistics, is, as everyone acknowledges, not a wholly reliable measure of body fat; and (2) I do not engage with the question of how bad being obese is for health—I just assume it is. If obesity were not bad for health, reducing obesity would not be a good reason for public health paternalism.

[54] Health Select Committee of House of Commons (UK), 'Obesity—Third Report of Session 2003–04' (London: The Stationery Office Ltd. 2004).

[55] OECD, 'Health at a Glance 2021', executive summary. Available at https://www.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance_19991312 (last accessed 20 June 2024). Rather oddly, the 'Health at a Glance 2023' summary still says that obesity rates continue to rise even though the figure for 2023 is 54 per cent overweight or obese rather than 60 per cent. https://www.oecd-ilibrary.org/sites/7a7afb35-en/index.html?itemId=/content/publication/7a7afb35-en (last accessed 31 May 2024).

[56] Obesity Evidence Hub, 'Countries That Have Implemented Taxes on Sugar-Sweetened Beverages (SSBs)', 17 March 2022, https://www.obesityevidencehub.org.au/collections/prevention/countries-that-have-implemented-taxes-on-sugar-sweetened-beverages-ssbs (last accessed 7 May 2024).

[57] Bettina Kovecses and Fruzsina Nagy, 'Hungarian "Chips-Tax" Now Applicable to All Forms of "Sweet Taste"—Significant Changes Affecting Taxes on Foodstuff and Drinks Effective as of 1 July 2022', https://www.twobirds.com/en/insights/2022/hungary/hungarian-chips-tax-now-applicable-to-all-forms-of-sweet-taste (last accessed 31 May 2024).

of takeaway outlets.[58] New York City tried to limit the size of containers in which sugary soft drinks could be sold.[59] These are all examples of 'preventive regulations to counter obesogenic environments'.[60]

Not every policy to counter obesity is a preventive regulation that limits choice. Subsidizing healthy food is not, for example. Of those that do limit choice, the reason need not be to benefit the people who would otherwise be fatter. The reason could be to save social costs, such as in health care. But, as is obvious from how they argue, advocates for regulations often want to limit people's choices because they think it would make them better off by making them thinner than they would otherwise be. As with smoking and alcohol, those who argue in this way must give us reasons to think that people who want to consume fattening substances are making a mistake, and their evidence must be rooted in these people's ultimate preferences. As with alcohol, but not smoking, the evidence is sparse and what there is suggests that limits on choice will be against people's interests. Unlike preventive regulations against smoking, which primarily affect smokers alone, many of the regulations to reduce obesity are not tailored to affect only the obese. A tax on sugar, for instance, affects everyone who buys sugar.

Supporters of public health are, as we saw in Chapter 3, prone to assume that what makes us healthier makes us better off. In the context of obesity, much of their evidence-gathering is designed to tell us what body fat does to our health, what makes us fat, and what policies might either prevent us becoming so fat or, although this seems harder, make us thinner than we used to be. But what we need as well is evidence that the benefits of being healthier outweigh the costs of higher-priced and harder-to-buy food and drink. I do not think an overall body of evidence exists. As Anne Barnhill and Matteo Bonotti say, 'We (policymakers and the public) may lack knowledge about the range of important social, psychological, and economic effects of healthy eating efforts. Arguably, the public health research community does not have a research programme in place to gather this kind of evidence about healthy eating efforts.'[61] Barnhill and Bonotti hedge what they say with 'arguably', and one can find relevant evidence about people's attitudes to their eating and drinking, but even so this evidence does not seem to me

[58] Patrick Butler, 'Fast Food England: Does Putting a Cap on Takeaways Improve People's Health?', *The Guardian*, 25 July 2017. For Los Angeles, see Roland Sturm and Aiko Hattori, 'Diet and Obesity in Los Angeles County 2007–2012: Is There a Measurable Effect of the 2008 "Fast-Food Ban"?', *Social Science & Medicine* 133 (2015): 205.

[59] Cass R. Sunstein, *Why Nudge? The Politics of Libertarian Paternalism* (New Haven: Yale University Press, 2013), pp. 75–8.

[60] Lucy C. Farrell, Megan J. Warin, Vivienne M. Moore, and Jackie M. Street, 'Socio-Economic Divergence in Public Opinions about Preventive Obesity Regulations: Is the Purpose to "Make Some Things Cheaper, More Affordable" or to "Help Them Get Over Their Own Ignorance"?', *Social Science & Medicine* 154 (2016): 1.

[61] Anne Barnhill and Matteo Bonotti, *Healthy Eating Policy and Political Philosophy: A Public Reason Approach* (New York: Oxford University Press, 2022), p. 170.

to have been properly synthesized and writers rarely even ask how many people's consumption is contrary to their goals, let alone provide any evidence to give us the answer.[62]

As before, we should be looking for evidence that people consume fattening substances either because they make some factual mistake about what would best serve their ends or because they have some motivational problem. I propose to focus on the motivational mistakes. I agree with Michael Marmot when he says, 'The reasons that people continue to smoke and that obesity continues to spread do not stem from ignorance',[63] and in any case it is hard to see how one could argue for limiting adults' choices on the grounds that they are ignorant when public health advocates could give them the information instead. Quite likely, food and drink manufacturers ought to be required to disclose information in an accessible and accurate way, but requiring disclosure differs from taxing the food, banning it, or restricting its availability.

Let us first consider addiction to food and drink. Because people can be addicted to alcoholic drinks, and because alcohol can make us fat, alcohol addiction might have a bit part to play in explaining some people's obesity.[64] It is more controversial whether anyone is addicted to food and non-alcoholic drinks. The Yale Food Addiction Scale tries to apply the criteria in the Diagnostic and Statistical Manual, and these include feeling conflicted and attempting to quit certain foods and drink.[65] These criteria might be taken as a proxy for behaviour that is against a person's ultimate preferences. A systematic review of different studies found that 19.9 per cent of the adult population qualified, with a mean of three out of seven possible symptoms. Of the seven studies that reported the frequency of food addiction criteria, five reported as the most common symptom 'the persistent desire or unsuccessful attempts to cut down foods'.[66] However, 'study populations were predominantly female and obese, limiting the generalizability of findings . . . the majority of studies were conducted in clinical settings of overweight/obese individuals'.[67] Notice all the ways in which we could expect the 19.9 per cent figure to

[62] As an example of almost raising the question and not answering it, see the C. Hawkes, T. G. Smith, J. Jewell, J. Wardle, R. A. Hammond, S. Friel, A. M. Thow, and J. Kain, 'Smart Food Policies for Obesity Prevention', *The Lancet* 385 (2015): 2410. We came across this article in Chapter 5, and its claim that people have a long-term preference for health. But although the writers gave some supporting citations, none shows that people valued the long-term benefits higher than the short-term losses of switching from unhealthy options.

[63] Michael Marmot, *The Health Gap: The Challenge of an Unequal World* (London: Bloomsbury Publishing, 2015), p. 51.

[64] Although the connection between alcohol and body weight is murkier than one might think. See Gregory Traversy and Jean-Philippe Chaput, 'Alcohol Consumption and Obesity: An Update', *Current Obesity Reports* 4 (2015): 122.

[65] See Chapter 5 for more details about addiction and the DSM criteria.

[66] K. M. Pursey, P. Stanwell, A. N. Gearhardt, C. E. Collins, and T. L. Burrows, 'The Prevalence of Food Addiction as Assessed by the Yale Food Addiction Scale: A Systematic Review', *Nutrients* 6 (2104): 4579.

[67] Pursey et al., 'Prevalence of Food Addiction', pp. 4584–5.

overstate the extent of addiction in the general population. The studies are mainly on people who are not only obese but who had gone so far as to seek bariatric surgery (which usually requires both a very high body weight and a very high motivation to reduce body weight), or else who are seeking weight treatment and think they 'eat out of control', which guarantees that they meet the criteria for addiction.[68] Even at 19.9 per cent of the population, only a small minority would count as addicted, and the real figure seems to be much smaller. But a sugar or fat tax affects almost everyone.

Advocates of anti-smoking policies often say that most smokers want to quit and very many try to, and quit attempts show that smokers think they would be better off not smoking. Can we get anything similar for body weight? Obviously, people will not stop eating and drinking altogether, but they sometimes try to stop consuming especially fattening food and drink. However, while some research evaluates attempts to persuade people to quit sugary drinks,[69] and other research explains consumption as an unconscious process,[70] it does not ask, so does not find out, how many people would prefer to consume less than they do.

That some people prefer to lose weight is often taken to be indicated by the fact that they try to lose weight. By implication, the people who try to lose weight are the ones who would benefit from being thinner. I suggest we ask how many people try to lose weight.[71] Obviously, the answer is likely to vary from place to place and perhaps time to time. A brief look at surveys of the US population (the United States being unusual in having good accessible data on weight loss attempts) makes it clear that at any given point, only a minority of people are trying to lose weight. For instance, in Gallup polls since 1990, the percentage who say 'Yes' when asked: 'At this time are you seriously trying to lose weight?' has fluctuated from a low of 18 per cent in 1990 to a high of 30 per cent in 2008.[72] The US National Health and Nutritional Examination Surveys (NHANES) asks whether people have tried to lose weight in the preceding year. The figures here are higher, around 39 per cent in

[68] Pursey et al., 'Prevalence of Food Addiction', table 1.

[69] e.g. M. G. Hall, A. H. Grummon, A. J. Lazard, O. M. Maynard, and L. S. Taillie, 'Reactions to Graphic and Text Health Warnings for Cigarettes, Sugar-Sweetened Beverages, and Alcohol: An Online Randomized Experiment of US Adults', *Preventive Medicine* 137 (2020): 1.

[70] e.g. Robbert Jan Beun, Claire Luiten, Chris Verbeek, and Maartje P. Poelman, 'A Rationale for a Gamified E-Coach Application to Decrease the Consumption of Sugar Sweetened Beverages', *Frontiers in Digital Health* 2 (2021).

[71] Trying to lose weight may not be a good response to obesity since weight falls in the short term and then in the great majority of cases reappears. See Robyn Toomath, *Fat Science: Why Diets and Exercise Don't Work—and What Does* (Auckland: Auckland University Press, 2016), ch. 1. Nonetheless people who are trying to lose weight are showing their preferences for body size and giving some evidence that they wish they had not got so fat.

[72] Gallup, 'Personal Weight Situation', https://news.gallup.com/poll/7264/personal-weight-situation.aspx (last accessed 31 May 2024). Only 23 per cent were trying in November 2020 (during the first year of the Covid-19 pandemic) but 27 per cent were in November 2021 (possibly trying to shed the weight they put on the year before).

the most recent years.[73] Those trying to lose weight have been disproportionately female and\or, highly educated, and\or affluent.[74]

In Gallup's 2011 survey, however, 63 per cent had tried to lose weight at least once. If trying to lose weight at any point in one's life were enough to show being thinner to be a gain in well-being, the majority in the United States could benefit from being thinner.[75] But it is unreasonable to deduce that a 60-year-old would be better off now for being thinner because over forty years earlier she dieted for her high school ball. As it happens, the 63 per cent figure can be broken down into 25 per cent who have tried once or twice, 30 per cent who have tried 3–10 times, and 8 per cent who have tried more than 10 times. People who keep trying (and possibly failing) are perhaps classic cases of being unable to fulfil a stable all-things-considered preference for losing weight. But what should we make of the ones who tried only once or twice? Perhaps they tried losing weight and decided it was not worth it to try again. Perhaps they will try again. Perhaps they lost enough weight and do not need to try again. We do not have sufficient grounds to attribute to them an all-things-considered preference to lose weight that is a basis for their interests now.

The figures for recent years do not differ much from figures for the past. In the late 1950s, one in three people was planning to lose weight. In the 1980s, 23 per cent of American men and 40 per cent of women were trying to lose weight.[76] Possibly, in the future, a much higher percentage of adults will be trying to lose weight at any given time, but there has been no sharp increase in weight loss behaviour that would support extrapolating to this possibility. It might be true that, as Marmot writes, 'in England a majority of people who are obese claim to be on a diet'.[77] But, as with alcohol, if we are considering broad-based policies such as tax, we must take account of everyone who is affected, not just those who are obese.

We have been looking for evidence that people's consumption of weight-promoting food and drink is a mistake judged by their ultimate preferences. The evidence is sparse. Even if food addiction exists, and even if addicts act against their interests, only a small minority of people who eat and drink (which is all of us) count as addicts. Even if dieting implies a mistake, only a minority of people are dieting. Thus the regulation of food and non-alcoholic drink is not like smoking,

[73] Centers for Disease Control (CDC), *National Health and Nutrition Examination Survey 2017–March 2020 Data Documentation, Codebook, and Frequencies Weight History (P_WHQ), November 2021*, available at https://wwwn.cdc.gov/Nchs/Nhanes/2017-2018/P_WHQ.htm#WHQ070 (last accessed 31 May 2024).

[74] Hannah Seward, 'Socioeconomic Status and Weight Loss Behaviors' (MSc Thesis, Virginia Commonwealth University, 2014), pp. 35–6.

[75] 2011 is the last year for which Gallup 'Personal Weight Situation' gives this data.

[76] For the 1950s, see Gary Taubes, *The Case against Sugar* (London: Portobello Books, 2017), p. 133; for the 1980s, see Avner Offer, *The Challenge of Affluence: Self-Control and Well-Being in the United States and Britain since 1950* (New York: Oxford University Press, 2006), p. 163.

[77] Marmot, *Health Gap*, p. 51. One of his supporting citations for England is, however, a Gallup poll of Americans.

where so many smokers regret what they have done, but is more like alcohol, where we do not have evidence that people make mistakes about their interests. The paternalistic case for broad-based policies to regulate food and drink is therefore in trouble.

Conclusion

The first element of the nanny state objection was healthism, which says that public health policies overvalue health. We have worked through this objection for the last four chapters. According to Chapter 4, the test for the value of health to someone is the extent to which it fulfils their ultimate preferences. Public health policies that restrict people's choices for their own good then faced a challenge, that restricting their choices would make them worse off, and the answer to the challenge requires showing that people make mistakes about their interests. In this chapter, we have considered the evidence about whether unhealthy behaviour tends to be mistaken. The evidence points to smoking being a mistake but it does not point to drinking alcohol or consuming fattening food or sugary drinks as being mistakes. Thus the potential case for anti-smoking paternalism is strong whereas the potential case for paternalism about food and drink, alcoholic or not, is weak.

Let me make some comments on these conclusions. First, supporters of public health restrictions might carry out some new research that finds out that most people who drink alcohol or consume fattening food and sugary drinks regard what they do as a mistake. Equally, a critic of public health restrictions might be able to produce evidence missing here that most smokers endorse their smoking. It may also be that research would find contrasting attitudes in different countries.

If we conclude that most eaters and drinkers do not act against their interests, this conclusion is particularly problematic for broad-based paternalistic policies such as taxes on alcohol or sugar. Most people affected by the taxes be worse off. But the conclusion is less problematic for paternalistic policies that are tailored to benefit primarily those people for whom consumption is a mistake without burdening the people for whom it is not. Equally, perhaps paternalistic policies against smoking can be tailored so as to leave relatively unaffected the minority of people for whom smoking is not a mistake. In practice, no doubt, the tailoring of paternalistic policies, while desirable in principle, would not be perfect and a choice would have to be made between having imperfectly tailored policies or not, with some people losing out either way. I have argued in this chapter that broad-based paternalistic policies against alcohol and food and drink would probably make most people they affect worse off. For this reason, the paternalistic case is in trouble. But perhaps the policies could be justified nonetheless even if only a minority benefit, so long as they benefit enough, or they are of especial ethical importance,

for instance on grounds of equity. We will consider these ideas about distributive ethics in Chapter 12.

If I am right about smoking, then the first hurdle for paternalism has been jumped and the healthism objection has been met. That leaves another hurdle, autonomy. Perhaps people should be allowed to run their own lives even when they would make mistakes, and restrictions on smoking would thus violate their autonomy. Perhaps, too, restrictions on alcohol and other food and drink would violate autonomy, and that would be a reason against them which would apply whether or not most eaters and drinkers make mistakes about their interests. The next chapter starts explaining and evaluating this objection from autonomy.

7
Autonomy

Introduction

Paternalistic public health policies might not work and, when they do work, they could make people healthier but worse off, since health is neither the only value nor the supreme value. Sometimes, though, making people be healthier would make them better off. The restrictions on smoking have caused people to smoke less and, as we saw in Chapter 6, quite likely made many of them better off. They also have not backfired or spilled over into general state repression, to refer to a couple of typical objections to paternalism. Even then, one can object to paternalistic limits on choice. The nanny state objection is not just to the 'healthism' of public health or its alleged incompetence or untrustworthiness, but also that its policies make people unfree or violate their autonomy. According to this objection, it should be up to us what we eat, drink, smoke, or otherwise do with our bodies and money.

We have not the slightest chance of being able to discuss freedom or autonomy completely. Both concepts are the subjects of a full and rich literature in which writers try to explain what they are, and whether and when they are valuable. One drawback of full and rich literatures is endless confusion. For instance, 'positive freedom' is sometimes used to mean 'having options' and contrasted with 'negative freedom', taken to mean 'not being coerced'. Sometimes, though, 'positive freedom' is used to mean the quite different idea of self-mastery, meaning freedom from obstacles internal to the person, such as phobias or compulsions, as well as freedom from such external obstacles as being locked up. Nor does turning from freedom to autonomy make life any easier. Gerald Dworkin once gave a long list of what people have meant by autonomy and wrote: 'About the only features held constant from one author to another are that autonomy is a feature of persons and that it is a desirable quality to have.'[1] For Onora O'Neill, these were two features too many for a list of constants; even the ones Dworkin cited were controversial.[2]

To make our task feasible, I shall present one account of autonomy, personal sovereignty, which says that we should be treated as the rulers of our bodies and

[1] Gerald Dworkin, *The Theory and Practice of Autonomy* (Cambridge: Cambridge University Press, 1988), p. 6.
[2] Onora O'Neill, *Autonomy and Trust in Bioethics* (Cambridge: Cambridge University Press, 2002), p. 22.

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minds. With this account, we can think through the criticism that public health policies interfere in the lives of grown-ups. We shall see why even policies that make us better off can conflict with our personal sovereignty. That is not to say that such policies must be wrong. As I explain, when autonomy and well-being conflict, neither invariably has priority and they must be traded off against each other. Some policies may be justified despite interfering with people's autonomy because they benefit them so much; but other policies, even beneficial policies, would interfere too much. How that conclusion applies to public health policies remains to be seen. Writers in public health give all sorts of arguments why their favoured policies would not conflict with autonomy. I summarize their arguments at the end, and we shall consider them in detail in the next few chapters.

This chapter is fairly abstract so, for those readers who would rather get on with the ethics of public health, let me explain what we can get out of it. In the first place, this chapter lays some foundations for later topics, for instance whether unhealthy choices are autonomous or whether nudges infringe on autonomy. In the second, we shall see some of the steps we need to take to think through the nanny state objection. Public health advocates must tell us why their interventions are either of enough benefit to outweigh any loss of autonomy or else do not conflict with autonomy at all. As for those who would criticize public health for violating autonomy, they must do more than show that public health interventions infringe on autonomy. They must also explain why the loss of autonomy is not outweighed by the benefits in well-being.[3]

Autonomy as Personal Sovereignty

Autonomy means self-rule ('auto' and 'nomos'). In one usage, autonomy applies to peoples or states rather than individuals, and it contrasts those that govern themselves with those that came under outside rule.[4] Our interest is, however, in individual persons, and we can summarize their autonomy using the words of Joel Feinberg: 'I am autonomous if I rule me, and no one else rules I.'[5] This statement can be understood as an expression of personal sovereignty.[6] As we can see, it has

[3] To explain terms, 'infringing' on autonomy means in some way interfering with it, but possibly justifiably. 'Violating' autonomy means infringing on it in a way that is, all things considered, wrong. I follow Judith Jarvis Thomson, *The Realm of Rights* (Cambridge, MA: Harvard University Press, 1990), p. 122.

[4] This usage goes back to the ancient Greeks. See Lucas Swaine, 'The Origins of Autonomy', *History of Political Thought* 37 (2016). Swaine reports, p. 228, that using 'autonomy' to apply to individuals may also go back nearly two thousand years.

[5] Joel Feinberg, *Harm to Self* (New York: Oxford University Press, 1986), p. 382, n. 26.

[6] 'Personal sovereignty' is Feinberg's term. He describes various senses of 'autonomy', and personal sovereignty fits into a category he calls 'autonomy as right'. See Feinberg, *Harm to Self*, pp. 47–51. The idea could equally be called 'self-determination'.

two parts: 'I rule me' and 'no one else rules I'.[7] The first requires that the person has the capacity to rule. Compare 'I rule me' with the chaos of failed states: no one ruled Somalia in 2010, not even Somalia. 'No one else rules I' implies that, if someone else is 'ruling' me, for instance by coercing or manipulating me, I am not autonomous. Both parts envisage a sphere of sovereignty or authority: decisions are mine to make when they are about me. From this description, we can say that public health policies would infringe on personal sovereignty if and only if they met these two conditions: they interfere with the behaviour of people who are capable of self-rule and they concern a matter belonging in people's sovereign spheres.

The account of personal sovereignty needs some more explaining, and that is the task in this section. Let me make one preliminary comment: I am not asserting that personal sovereignty is the only or the best way to understand autonomy, only that it is a good way to think through and evaluate some of the criticisms of public health for acting like a nanny. As I said, 'autonomy' is understood in many ways, and they need not coincide. For instance, respecting someone's personal sovereignty by no means guarantees that they will be autonomous in the sense of 'obedience to a law one prescribes to oneself'.[8] Personal sovereignty requires that someone capable of running their lives should be allowed to do so even if they would do it badly, and indeed even if they would fail to live up to the ideal of autonomy by drifting through life or following someone else's 'nomos'.[9] The point of substance is not whether personal sovereignty should be called 'autonomy,' but whether it names something valuable that can conflict with public health interventions.

To explore personal sovereignty, let us consider first the capacities for self-rule. These include (1) some things the person wants, (2) some beliefs about how to get them, (3) some capacity for means-end reasoning, and (4) some capacity to act on judgements.[10] To some extent, these capacities are matters of degree. We can be better or worse at working out what we want, formulating beliefs, reasoning from means to ends, and acting on our judgements. However, when it comes to making decisions about someone's life, it is usually thought that people should decide for themselves if they are at or above a threshold. So long as people are good enough—where what is 'enough' must be specified—at forming beliefs, having coherent desires, connecting them in mean-ends reasoning, and acting on their judgements, then they should decide for themselves. Thus even if you would not

[7] Why the odd grammar in 'no one else rules I'? Possibly, Kathy Smits suggested to me, so as to emphasize that it is the 'I' that is not ruled, the 'I' that is the ruler of me. To be personally autonomous, one cannot be like a governor-general who rules a colony but serves under the rule of the colonizing power.

[8] Rousseau's famous definition of 'moral freedom'. See Jean-Jacques Rousseau, *The Social Contract* (trans. Maurice Cranston) (Harmondsworth: Penguin, 1968), p. 65.

[9] Personal sovereignty equates to what Stanley Benn called 'autarchy', and he contrasts it with autonomy as a character ideal. See Stanley I. Benn, *A Theory of Freedom* (Cambridge: Cambridge University Press, 1988), ch. 8, esp. pp. 155–6.

[10] Allen Buchanan and Dan Brock, *Deciding for Others: The Ethics of Surrogate Decision Making* (Cambridge: Cambridge University Press, 1989), pp. 23–5.

decide as well as I would about some personal matter of yours, you should be the one to decide, not me, if you are good enough.[11] Of course, a normally autonomous person may sometimes fall below the threshold, for instance if severely concussed or blind drunk.

It obviously matters where the threshold is placed. The more that is demanded of people in the way of practical and theoretical reasoning capacities, that is, the higher the threshold, the less that people's decisions would be protected by respect for their autonomy. If you had to be able to 'think like Albert Einstein, store as much memory as IBM's Big Blue, and exercise the willpower of Mahatma Gandhi',[12] then perhaps no one would be autonomous. If such a high threshold is too high, where should it be placed? Worms and young children do not have the capacity for autonomy. Nor are adults likely to be autonomous if they have severe psychosis (hallucinations, delusions of grandeur, delusions of persecution), severe depression that leads them to care about nothing, or rapid swings of the will (as sometimes experienced by the terminally ill).[13] However, in places that respect autonomy, most adults are held to be capable of deciding for themselves whom to have sex with, where to live, what jobs to take, what religion to follow, how to invest their money, and, closest to public health, whether to follow medical advice.

The idea of a threshold for autonomy crops up in later chapters when we consider certain arguments by public health advocates. According to one of these arguments, a public health intervention might not infringe on autonomy because unhealthy behaviour is generally mindless, or caused by addiction, or manipulation, or some other factor that vitiates autonomy. Whether this argument can be made out depends in part on where the threshold for autonomy should be set. According to another argument, public health interventions can make people more autonomous, for instance by getting them to think harder before they act in unhealthy ways. The threshold idea tells us that this argument will have minimal application because, for those who have reached the threshold, being 'more autonomous' is impossible or irrelevant.

We now turn to another element in personal sovereignty, the sovereign sphere. Consider consent in medical decision-making. The element of the sovereign sphere is usually not to the fore in discussions of consent, which tend instead to concentrate on people's capacities to decide and which ask such questions as whether a particular mental disorder makes them incompetent. Nonetheless,

[11] Feinberg endorses this idea of the threshold in *Harm to Self*, pp. 28–30.

[12] These are the capacities of the economic reasoner rather than humans, according to Richard Thaler and Cass Sunstein, *Nudge: Improving Decisions about Health, Wealth, and Happiness* (New Haven: Yale University Press, 2008), p. 6.

[13] Such as, for instance, asking for a treatment, refusing it, then asking for it again, and so on, all over a short time. The phenomenon, while not very common, is not rare. My thanks to Janine Winters, a palliative care doctor, for her advice.

the sovereign sphere is fundamental. My informed rational decision to refuse a nephrectomy would typically be binding if it were my kidney I refused to have removed, but it would not be binding if I were to refuse a nephrectomy for somebody else who is competent to decide for themselves. The difference lies in whose body it is, not in the quality of the decision. Public health policies often intervene in what people do with or put into their bodies so, on the face of it, they intervene in people's sovereign spheres.

To be sure, questions are sometimes raised in medicine about whether patients have the right to make decisions about their bodies that might adversely affect their families, just as questions have been raised about whether people have a right to smoke in enclosed public places. These are boundary questions about what falls within someone's sphere of decision, and they are often difficult to answer. John Stuart Mill's view, in *On Liberty,* was that people should not be interfered with to stop them from harming themselves, although it could be permissible to stop them harming others. He was not only well aware of the objection that no boundary could be drawn between self and others, but he had one of the best and most sophisticated attempts to explain how to draw it.[14] However, the boundary problem does not arise for paternalistic arguments. These are arguments that rely on the benefits people get from being made to be healthier. When we consider paternalistic arguments, we are thinking of preventing harm to self rather than harm to others, and the self is our sovereign sphere.

Fulfilling Our Ultimate Preferences versus Autonomy

People want to be healthy so, if a public health intervention would give people what they want, it could not infringe on their autonomy. Thus goes one argument against the nanny state objection. As I shall explain, this argument must be spruced up to take account of the following points: people want many things, of which health is but one; they might want to decide for themselves; and shielding people from their mistakes might damage their decision-making capacities. The argument can then be altered to take account of these points by saying that public health interventions would make people better off by better fulfilling their ultimate preferences, an idea set out in Chapters 4 and 5. But even a spruced-up argument would not be a complete response to the criticism that public health interventions interfere with autonomy, because autonomy has a value that is independent from, and can outweigh, fulfilling ultimate preferences. Contrary to what some writers think, an intervention could make people healthier, give them what they want, and still wrongly infringe on their autonomy.

[14] J. S. Mill, *On Liberty* (Harmondsworth: Penguin, 1982), ch. V.

One might wonder how an intervention that gets people to do what they want could conflict with autonomy. In defending taxation, regulation, and codes of advertising, Karen Jochelson writes: 'Many smokers want to quit. Many overweight people would like to be thinner. And few would welcome a bout of syphilis or chlamydia from a night of unprotected sex. If government interventions make it easier for individuals to act on these desires, then it is difficult to argue that it undermines their liberty.'[15] Jochelson does not say what she means by 'liberty', but she may think of it as doing what one wants, the view taken by John Stuart Mill at one point.[16] She may also have meant liberty as a synonym for autonomy. Whether she did or not, many writers do define autonomy along the lines of making choices in accordance with one's long-term goals and values.[17]

As mentioned, this argument needs sprucing up. We saw one reason in Chapter 4: we need to know not what people want but what they prefer. People might want to be healthy but not want to pay the price. Put that to one side and suppose smokers prefer to quit, overweight people prefer to be thin, and the frisky prefer not to have unprotected sex, given the danger of infections. Whatever the benefits of smoking, eating, and unprotected sex, these people themselves regard them as smaller than the costs. Therefore, discouraging them from these unhealthy activities would better fulfil their preferences.

Even then, Jochelson and others move too quickly in arguing that interventions that make us healthier do not undermine our liberty (or autonomy). The interventions might damage our capacities to choose. Perhaps we would learn from our mistakes and be better off for doing so. Moreover, we might value making our decisions in a certain way. We might want to be thinner, but not by being coerced into eating less through threats of fines or imprisonment. Smokers might want to quit, but not want to be forcibly hypnotized into doing so. Being able to choose might benefit us in all sorts of ways which are overlooked when the paternalist compares only our desire to be healthy with our desires for unhealthy behaviour and finds that we prefer health. Paternalism that makes us be healthier might therefore be self-defeating.

In response to these points, the argument for public health can be spruced up further. The benefits of choosing are important but by no means decisive against paternalism. People might not learn from their mistakes, or the value of learning

[15] Karen Jochelson, *Nanny or Steward: The Role of Government in Public Health* (London: King's Fund, 2005), p. 32.

[16] Mill writes, of a man unwittingly crossing an unsafe bridge, 'liberty consists in doing what one desires, and he does not desire to fall into the river'. *On Liberty*, p. 166 (ch. V, par. 5).

[17] See e.g. Carissa Véliz, Hannah Maslen, Michael Essman, Lindsey Smith Taillie, and Julian Savulescu, 'Sugar, Taxes, and Choice', *Hastings Center Report* 49 (2019): 24. James Wilson writes, 'I use autonomy . . . to refer to an individual's ability or right to make choices in line with their values', *Philosophy for Public Health: Beyond the Neglectful State* (Oxford: Oxford University Press, 2021), p. 94, n. 8. But as I use autonomy, it also includes the ability and right to make choices not in line with one's values.

or becoming better able to choose might be outweighed by the losses their choices would cause them. People might not care about their self-determination, or at least not much in some of the cases where public health might intervene. Sarah Conly says that people in 'western culture' care about deciding on their marriage partners or careers for themselves but they do not, or at least she does not, mind having the option to eat trans fats removed.[18] I agree with such writers as Sarah Conly, Cass Sunstein, and Simon Clarke that, while the value of learning and our desires to decide for ourselves must be taken into account by paternalists, they do not rule out paternalism.[19]

Suppose then that one takes an appropriately broad view of ultimate preferences so that they include preferences for deciding for oneself and somehow include the benefits of learning and developing the capacity to choose. Suppose that, even after all this complex accounting, some public health intervention pushes people into doing what they prefer overall. Much of what concerns people about paternalism would not arise with such an intervention. In pushing people into doing what they most want, the intervention would not impose 'foreign values' or someone else's conception of the good on them. But should we conclude that the intervention would in no way infringe on their autonomy? I think not. Autonomy does not reduce to fulfilling ultimate preferences.

Imagine that a competent adult Jehovah's Witness refuses a blood transfusion. It is widely thought that imposing a transfusion would wrongly infringe on the Witness's autonomy.[20] However, Jason Hanna argues that forcing a blood transfusion could be justified.[21] His argument involves claiming that the Witness is wrong about what the Bible means and then claiming that we tend to see intervening in a person's self-regarding affairs as justified when 'a person's choice is induced by ignorance or mistaken belief'.[22] Hanna writes: 'If the traditional JW doctrine results from simple textual misinterpretation, and if the JW ultimately desires to live in accordance with the moral injunctions that are *actually* included in the Bible, then it is unclear why intervention to save his life should be thought to impose values on him.'[23] This quotation brings out the point I wish to make. Hanna is not quarrelling here with the Witness's ultimate desire but saying that the Witness is mistaken in

[18] Sarah Conly, *Against Autonomy: Justifying Coercive Paternalism* (Cambridge: Cambridge University Press, 2013), p. 184 for marriage, p. 154 for trans fats.

[19] Although taking them into account is easier said than done. In Sunstein's words, 'the measurement issues are formidable here'. Cass R. Sunstein, *Why Nudge? The Politics of Libertarian Paternalism* (New Haven: Yale University Press, 2013), p. 126. For a thorough argument for why paternalism need not always be self-defeating, see Simon Clarke, *Foundations of Freedom: Welfare-Based Arguments against Paternalism* (New York and London: Routledge, 2012).

[20] Dworkin, *Theory and Practice of Autonomy*, p. 14.

[21] Jason Hanna, *In Our Best Interest: A Defense of Paternalism* (New York: Oxford University Press, 2018), p. 112. Hanna actually says only that a pro-paternalist would support intervening rather than that he would, but then he is a pro-paternalist.

[22] Hanna, *In Our Best Interest*, p. 113.

[23] Hanna, *In Our Best Interest*, p. 113.

how he proposes to act on it. I now want to further stipulate that the Witness does not greatly value self-determination. The Witness values getting the right answer rather than deciding for himself, except insofar as deciding for himself is a means to getting the right answer. Thus, by stipulation, the Witness (a) has the wrong answer in terms of his own values and (b) does not value personal sovereignty for its own sake. So suppose, what is by now plausible, that imposing the transfusion would fulfil the Witness's ultimate preferences better than not imposing it. Even so, I think, and I expect many readers to think, that imposing a blood transfusion on him would not only infringe on his personal sovereignty but would be wrong because it infringes.

In case religious mysteries are in some way too unusual to draw conclusions from, consider choosing a career. Suppose someone wants to take up medicine. She believes she will be good at it and will find it stimulating and worthwhile. Suppose she does not value deciding on her career for its own sake but only as a means to her ends. I now stipulate further that this person is wrong about the value of medicine to her. Like some others before her, if she starts on the long road of medical education, she will have invested too much time and money to pull out by the time she realizes she would have been better off doing philosophy. If some third party sees her mistake and manipulates her into not doing medicine, would that infringe on her autonomy? The answer, as with the previous Witness case, seems clearly 'yes'. She would not be determining her own life if she were manipulated into doing something she really wants to do even if 'really wants to do' takes account of the value she attaches to deciding for herself.

Of course, typical public health interventions are less fundamental than forcing blood transfusions or manipulating people out of careers and, as we will see, one might argue that these interventions do not conflict with autonomy because they are too trivial or not interferences with anything. My point here is only that autonomy does not reduce to fulfilling ultimate preferences.

I think some writers genuinely do not appreciate the value of autonomy once it has been distinguished from the fulfilment of ends. They tend to think, as Cass Sunstein does, that 'the master concept is social welfare'.[24] For them, any value in autonomous choosing derives entirely from its contribution to well-being. On such a view, it would make no sense to sacrifice overall well-being, which includes autonomy, for autonomy; it would be like spending a pound to save a penny. Let me contrast their views with the view of personal sovereignty I am supporting.

Sunstein, despite calling himself a 'libertarian paternalist', tries to debunk the view that autonomy is intrinsically valuable. He says that we only think autonomy is intrinsically valuable because we confuse its intrinsic value (which he thinks is zero) with its instrumental value, which lies in such partial truths as that people

[24] Sunstein, *Why Nudge?*, p. 142. See also p. 18.

are better informed about their own interests than anyone else or that they care about being free to choose. To judge that autonomy is intrinsically valuable is, says Sunstein, to misapprehend 'a rapid, intuitive judgment about welfare'.[25] 'Respect autonomy' is just a moral heuristic, a short-cut piece of advice for promoting welfare that sometimes fails. But Sunstein gives no grounds for his view. Furthermore, as he himself says, many writers have thought long and hard in trying to justify the independent value of autonomy. Whether they are right or wrong about autonomy, it seems most unlikely that they were unwittingly following a heuristic. Are we seriously supposed to conclude that, when Joel Feinberg wrote his 420-page pro-autonomy, anti-paternalism book, *Harm to Self*, he was influenced by an inaccurate heuristic, analogous to betting on red at roulette because black has come up the last five times?[26]

Sarah Conly, to take another leading paternalistic writer, opposes paternalistic interferences with the choice of spouse or career, but only because she thinks that no one is in a better position to choose spouses or careers than the individuals themselves and because she thinks people want to make these choices for themselves.[27] Autonomy, understood as independent of either making accurate choices or a desire to choose for ourselves, is for her never a good reason against paternalistic interference. Conly accepts that many people would see her brand of paternalism as interfering with 'a right to determine what happens to you, as long as that does no harm to others', but she asks why we should have such a right given that 'the point of the action is to help the person achieve what in the long run he wants, and what he would want now if he were not a flawed thinker'.[28] Furthermore, she thinks that the harm principle ('interfere only to prevent harm to others, not harm to self') depends on people being good at deciding for themselves. The principle would therefore be refuted if people were no good at it.

By contrast, many others, including me, think that people's autonomy should be respected because of its non-instrumental value. It does not matter whether some people value their autonomy only as a means to fulfilling their ultimate preferences; their autonomous, but inaccurate, decisions still deserve respect. Generally, whether we have a right does not depend on our individual attitudes to its importance. For instance, people who do not much care about freedom of expression have the same right to freedom of expression as people who do.[29] Moreover, in the cases above, many of us would conclude that it would not only infringe on the autonomy of the Witness and the would-be medical student to coerce or manipulate

[25] Sunstein, *Why Nudge?*, p. 134. See also pp. 128, 134–7.

[26] See Sunstein, *Why Nudge?*, pp. 134–8. Even Sunstein concedes several times that his claim is 'reckless'.

[27] Conly, *Against Autonomy*, p. 185.

[28] Conly, *Against Autonomy*, pp. 35–6.

[29] The issue of tolerating the intolerant is irrelevant to this point. Whether people should be free to advocate the suppression of free speech is a question about what they say and the context in which they say it, not how much they care about advocating suppression.

them, but that it would be wrong to infringe. This conclusion expresses the view that autonomy is independent of fulfilling preferences, can conflict with fulfilling preferences, and can override fulfilling preferences. If we are asked why we would override well-being for the sake of autonomy, we may have no other answer than because we value autonomy highly. We cannot prove that autonomy is valuable because proof is not to be had. As Feinberg says, 'Demonstration of the doctrine is not possible'.[30] But nor, of course, is rejection of the doctrine: try proving that well-being is always more valuable than autonomy. Perhaps this answer is inadequate, but I hope to have said enough to show that a complete defence of public health interventions has somehow got to reckon with the value of autonomy.

Some readers may find personal sovereignty unappealing because they think it is a libertarian conception and they object to libertarianism. The libertarian conception, as presented by some of its enemies, treats any restriction of individual choice as an infringement of autonomy. It is supposed to have three defects: it would oppose any state action, because state action would always alter choices; it would be unable to distinguish between important and trivial interferences; and it is naïve in invoking 'a version of human life in which people are most autonomous when entirely insulated from one another's actions'.[31] I think these objections are unfair to libertarians, but my point is that they do not apply to personal sovereignty as set out in this chapter. Let us run through the supposed problems. First, personal sovereignty does not say the state should never restrict choices. Apart from preventing harm to others, states may restrict choices for the sake of providing collective goods or achieving distributive justice and need not thereby infringe on a person's rule over themselves.[32] Personal sovereignty certainly has some implications for the state's actions in these areas, but not for the libertarian reason that the state should always respect stringent private property rights in the external world.[33] As for distinguishing the trivial from the important, I shall argue that those who accept personal sovereignty can consistently distinguish between them, and need to when deciding whether to give up some autonomy the sake of large gains in well-being. The final criticism seems to be that libertarians want a world in which no one's actions limit others' choices, which is impossible. But I see no basis to think that personal sovereignty (or libertarianism either) requires such a world. If Thidwick the Big-Hearted Moose had told the animals to get out of his antlers, he would have limited their choices by exercising

[30] Feinberg, *Harm to Self*, p. 52.

[31] S. M. Carter, V. A. Entwistle, and M. Little, 'Relational Conceptions of Paternalism: A Way to Rebut Nanny-State Accusations and Evaluate Public Health Interventions', *Public Health* 129 (2015): 1024.

[32] See Joel Feinberg, *Harm to Others* (New York: Oxford University Press, 1984), esp. chs. 4 and 6. Feinberg does not object in principle even to taxes on cigarettes, although he is vague on whether they are justifiable for paternalistic reasons. See pp. 23–5.

[33] To see the important differences between owning oneself and owning bits of the external world, and between self-ownership and self-determination, see G. A. Cohen, *Self-Ownership, Freedom, and Equality* (Cambridge: Cambridge University Press, 1995), chs. 3 and 10, respectively.

his sovereignty, but he does not thereby infringe on the sovereignty of the other animals.[34]

If we were to object to a public health intervention on the grounds that it infringes on autonomy, then we would need to show that the intervention did conflict with autonomy. As we shall see in Chapters 8–10, advocates of public health have many reasons for saying that their favoured interventions would not conflict with autonomy, for instance because people welcome restrictions on their choices. Set these reasons aside for now and suppose that some public health interventions would infringe on autonomy. Whether the infringements are wrong depends on whether the loss in autonomy they cause outweighs or is otherwise ethically more important to avoid than whatever benefits they bring about.

The Tradeoff between Autonomy and Well-Being

How should we choose, when we have to, between autonomy and well-being? Here are three options:

1. When autonomy and the fulfilment of ultimate preferences conflict, respecting autonomy should take absolute priority.
2. When autonomy and the fulfilment of ultimate preferences conflict, fulfilling the preferences should take absolute priority.
3. When autonomy and the fulfilment of ultimate preferences conflict, neither should take absolute priority over the other.

The third option covers the widest range, from high, but not absolute, priority for autonomy to high, but not absolute, priority for fulfilling ultimate preferences. I think the best answer will lie here. I do not think that giving absolute priority to either autonomy or fulfilling ultimate preferences can be refuted, but reflecting a little shows how implausible it would be.

The view that autonomy always beats fulfilling ultimate preferences seems implausibly doctrinaire when we remember that the preferences are ones people really do have, not ones imposed by the paternalist, and include the value people attach to deciding for themselves.[35] Many jurisdictions require passengers in vehicles to wear seatbelts. Suppose, as is plausible, that being required to wear a

[34] Dr Seuss, *Thidwick the Big-Hearted Moose* (New York: Random House, 1948). This example was used to make a similar point by the libertarian writer, Robert Nozick, in *Anarchy, State, and Utopia* (Oxford: Basil Blackwell, 1974), p. 269.

[35] Feinberg looks at various points as if he would give absolute priority to personal sovereignty over avoiding harm to self. See e.g. Feinberg, *Harm to Self*, p. 94. But his explicit topic is the moral limits to the criminal law, so his apparent restriction on giving up personal sovereignty may apply only to paternalism that uses the criminal law rather than, say, taxes.

seatbelt is a small infringement on autonomy because most passengers do not care much about travelling with one and because the fines for not wearing a seatbelt are small; and suppose, as is also plausible, that the expected benefit of wearing a seatbelt is quite high. Mandatory seatbelts then looks like a plausible example of where autonomy could be outweighed.

Consider now whether fulfilling ultimate preferences should take absolute priority over autonomy. To give absolute priority to one value over another is most plausible when the inferior value is trivial. Suppose we accept the argument of the previous section and agree that autonomy is valuable independent of whether it leads to a person fulfilling their ends. While something could be both independently valuable and relatively trivial, it is hard to see that autonomy could be trivial given the language in which it is often couched—dignity, respect, sovereignty. Both Sunstein, who doubts that autonomy is independently valuable, and Feinberg, who affirms a view of autonomy as personal sovereignty, assume that if autonomy were independently valuable, it would not be trivial.[36] If and when respecting a person's autonomy would lead them to do less well by their own lights, it is implausible to think that it must always be autonomy that yields. In any case, if the reader accepts that it would be wrong to coerce the Witness or the would-be medical doctor of the previous section, they must agree that autonomy can take priority over fulfilling ends.

If we should not give absolute priority to autonomy over fulfilling ultimate preferences or the other way around, then some sort of tradeoff must be justified.[37] Exactly what sort of tradeoff would be justified in what circumstances is beyond this book, but I can sketch a few aspects of tradeoffs in the rest of this section. We shall consider what makes infringements on autonomy major or minor; why minor infringements on autonomy may produce only small benefits; how, when trading off, smaller infringements on autonomy are better for a given benefit than larger infringements and how some infringements might not be justified at all; how making children better off can combine with making adults better off to justify public health interventions that infringe on autonomy; and lastly how we might sort tradeoffs into ones that are easy and ones that are hard.

The idea of a tradeoff presupposes a way to compare interventions so as to determine how much they interfere with autonomy and how far they promote people's ends. Only then would it be possible to say, for instance, such things as 'this given intervention is only a minor infringement on someone's autonomy but it would make them much better off'. One factor that affects how far autonomy is infringed upon is the nature of the interference. Intuitively, it seems obvious that the threat of a hundred lashes for drinking alcohol infringes more on autonomy than a

[36] See Sunstein, *Why Nudge?*, pp. 127, 133; Feinberg, *Harm to Self*, ch. 19, esp. pp. 54–5, 61–2.

[37] Many writers agree that autonomy and welfare may be traded off against each other, including Julian Le Grand and Bill New, who also cite many others in their *Government Paternalism: Nanny State or Helpful Friend?* (Princeton: Princeton University Press, 2015), pp. 129–30.

frightening advertisement or a small tax.[38] A full account of a tradeoff would try to spell out and defend ways to measure the size of an interference. In this case, one underlying consideration (of many) might be the importance of bodily integrity, which being lashed infringes upon while being taxed does not. A second factor in determining the extent to which autonomy is infringed upon is the area of life interfered with. Intuitively, a fine for not wearing a seat belt infringes less on autonomy than the same fine for not attending church. The underlying principle might be the centrality of religion, or its absence, in life compared with driving unbelted. Obviously, what makes some aspect of life more central than another would need thinking about, and we return to centrality in Chapter 8.

Next, remember that we are allowing a person's autonomy to be overridden for the sake of enough improvement to their well-being. How much is enough? Plausibly the gain in well-being would have to be much larger to override a major infringement on autonomy than to override a minor infringement. Perhaps a major infringement would never be justified: after all, competent people are allowed to refuse lifesaving treatment, even for such peculiar reasons as that life has lost its sparkle.[39] By contrast, minor infringements, such as banning brand names on cigarette packets, could in principle be justified. A difficulty arises when an infringement is minor because the intervention affects an area of life that is trivial. The infringement might be minor but so too would be the gain in well-being. Here is another way to see the point. When it comes to blighting my life, marrying the wrong person or picking the wrong career is much more consequential than eating too many pies. The benefit from not making mistakes in marriage or career could be great, but so is the autonomy objection to paternalistically interfering in my choices. The loss of autonomy from being discouraged from eating a pie might be small, but so too would be the offsetting benefit.

The idea of a tradeoff allows us to draw some practical conclusions. By way of example, suppose that smoking is against someone's interests defined, as usual, by their own preferences, and consider these methods to stop that person smoking: a ghastly picture of charred lungs, a high tax, an annually renewable smoking licence, and making smoking a criminal offence. Suppose that these methods would interfere with autonomy to different degrees, and that this list is in ascending order. Suppose initially that any of these methods would succeed in stopping the person smoking. The first practical conclusion from the idea of a tradeoff is that the ghastly picture

[38] The Nuffield Council on Bioethics' Intervention Ladder is an attempt at ranking types of public health interventions by level of intrusiveness, with bans at the top and doing nothing or monitoring the situation at the bottom. See Nuffield Council on Bioethics, *Public Health: Ethical Issues* (London: 2007). Angus Dawson criticizes the ladder in detail. I agree with much of his detailed criticism—to me, the ladder looks like the sort of tool a committee would design—but I am not persuaded by his attack on the coherence of the idea. Angus Dawson, 'Snakes and Ladders: State Interventions and the Place of Liberty in Public Health Policy', *Journal of Medical Ethics* 42 (2016): 510.

[39] King's College NHS Foundation Trust vs. C and V (2015 EWCOP 80) https://www.39essex.com/cop_cases/kings-college-nhs-foundation-trust-v-c-and-v/ (last accessed 4 June 2024).

should be chosen because it achieves the same goal as the others, while being the least interfering.[40] Another practical conclusion is that some public health measures may be unjustified because the cure is worse than the disease. Suppose this time that the ghastly picture would not stop someone smoking but a criminal penalty would. Despite, by stipulation, making the smoker better off, the penalty might be unjustified because it sacrifices too much autonomy.[41] Thus one should not reason like this: 'We aim to stop people smoking and we want to respect autonomy. So first we will try the least restrictive way and, if that does not work, the next least restrictive, and if that does not work, we will ban cigarettes.' If one wants to respect autonomy properly, one might in some cases have to give up better fulfilling people's ends.

The tradeoff idea helps us think through cases in public health where some restrictions would affect not only autonomous adults but also other people, such as children. Assume that banning cigarettes from vending machines so as to discourage adults from smoking would make them better off but still be wrong, because it would violate their personal sovereignty. In this case, their autonomy beats their well-being. But suppose now that the ban would not only discourage the smoking of adults but also help keep cigarettes out of the hands of children, whose wish to smoke is not protected by personal sovereignty. One way to think of the policy choice is as a conflict between the autonomy of adults and the well-being of children. But I think the tradeoff idea suggests a more complex choice. Given what I have assumed in this case, we have, against the ban, the autonomy of adults and, on the side of the ban, both their well-being and the well-being of children. We should not set aside the benefits to adults if we are willing to allow that a person's autonomy may in principle be overridden for the sake of their well-being. The benefits to the adults when added to the benefits of the children could be enough to tip the balance in favour of the ban.[42]

Beyond saying that neither autonomy nor well-being should have absolute priority over each other, I doubt much can be said about their relative weightings in abstraction from reflecting on actual cases. However the weightings turn out though, some tradeoffs will be easy and some will be hard. Easy tradeoffs come in two sorts. The first is where people would be much better off in terms of their preferences for the sake of a minor infringement of their autonomy. Earlier, I floated, as a possible example, laws that require people to wear seatbelts in vehicles. The second sort of easy tradeoff is where the infringement on autonomy is major and

[40] This idea corresponds to the requirement to seek the Least Restrictive Alternative in controlling contagious disease. See e.g. Lawrence O. Gostin, *Public Health Law: Power, Duty, Restraint* (Berkeley and Los Angeles: University of California Press, 2000), p. 69.

[41] This idea corresponds to the requirement of Proportionality. See Gostin, *Public Health Law*, p. 103.

[42] One valuable approach to the question of trading off well-being and autonomy is to think about what it takes to override a right and specifically whether a person's well-being counts for anything in overriding their rights. See Samantha Brennan, 'Paternalism and Rights', *Canadian Journal of Philosophy* 24 (1994): 419; and Hanna, *In Our Best Interest*, ch. 5.

the gain in preference fulfilment is minor. People might be better off eating healthy food but they should not be threatened with gaol for possession of a doughnut. The difficult tradeoffs are ones where interventions would cause a substantial loss of autonomy but also produce substantial gains in fulfilling preferences or, alternatively, a small loss of autonomy but only a small gain in fulfilling preferences. A ban on cigarettes might help a lot of people but it would be a major infringement on autonomy. A ban on adding sugar to cigarettes, which can produce a more attractive smell, seems a minor infringement because it leaves plenty of legal options for the smoker but it also probably does not do much good.[43]

Conclusion

Public health paternalism must at least sometimes yield to respect for autonomy, but a small loss of autonomy could be justified for the sake of a large gain in fulfilling preferences. Thus, contrary to what some paternalistic writers say, paternalism is not justified whenever it would make people better off because it might wrongly infringe on autonomy. And, contrary to what libertarians might think, autonomy is not a show-stopper.[44]

When tradeoffs between well-being and autonomy are hard, people might reasonably disagree about how they should be done. My own view, for instance, is that some anti-smoking policies, such as quite high taxes, do enough good despite infringing on autonomy, whereas others, such as banning the sale of cigarettes to people born after 2008, are too great an infringement on autonomy for any extra benefit they bring.[45] But I can see that this view is a matter of judgement rather than demonstrably correct.

While we might reasonably object to even beneficial public health interventions if they infringe on autonomy, public health advocates have said that what they want does not infringe on autonomy. On their view, we need not decide how to trade off well-being against autonomy. The advocates have offered many arguments for why autonomy and public health do not conflict, and here are the ones we shall consider over the next few chapters:

1. Public health interventions do not amount to interferences so they do not infringe on autonomy.

[43] Italy, among other countries, has such a ban. See Campaign for Tobacco-Free Kids, 'Legislation by Country: Italy', https://www.tobaccocontrollaws.org/legislation/italy/cigarette-contents/regulated-contents (last accessed 4 June 2024).

[44] 'Show-stopper' is Sunstein's term, in *Why Nudge?*, p. 133, although of course Sunstein is not one of these libertarians.

[45] New Zealand would have been world-leading in being the first country to implement such a ban had it not chosen instead to be world-leading in being the first to repeal the ban before it took effect.

2. Autonomy applies only in important areas of life such as religion, career, and romantic partnership. Public health interventions typically do not interfere in the important areas of life.
3. Public health interventions make people more autonomous.
4. People want the interventions because they want to prevent themselves making unhealthy choices. The interventions are an exercise of their autonomy.
5. Public health interventions do not interfere with our autonomy because we are not autonomous creatures anyway.
6. Unhealthy choices specifically are not autonomous because they are irrational or manipulated or due to addiction, so public health interventions do not interfere with autonomy.

The last two objections are about our capacities and I will consider them in Chapter 9. The others will be discussed in the next.

8
Do Public Health Interventions Infringe on Autonomy?

Introduction

If people choose to behave in unhealthy ways, what could be done, apart from leaving them alone? Public health workers could advise, encourage, or warn. The government could push up the price of unhealthy products or make them harder to access, or ban them to try to prevent them from being consumed. The interventions within these types vary a great deal. Some warnings are relatively neutral, others try to scare people stiff. Their messages can be more truthful or less. Some taxes and regulations would make unhealthy options a little more expensive or difficult, others would make them financially out of reach or close to impossible to access. Bans can be enforced with feeble sanctions or rigorous ones.

Not all public health interventions infringe on autonomy, but it would be surprising if none of them did. However, advocates for public health often try to downplay the conflict between the interventions they favour and the autonomy of the people they target. They have several reasons and we work through these ones in this chapter:

1. Taxes and other cost-raising measures do not infringe on autonomy.
2. Unhealthy options are often trivial and removing trivial options does not interfere with autonomy.
3. Public health interventions can make people more autonomous, not less, for instance by getting them to think harder before they act.
4. People want to have their own choices restricted to avoid temptation. Public health interventions are an exercise of their autonomy, not an infringement.

For various reasons, some philosophical and some empirical, I do not find these arguments persuasive.

Interfering with Autonomy

The opening claim we consider is that public health interventions are not the sort of measures that would infringe on autonomy. This claim is certainly true of some interventions; it seems unreasonable to regard as interference everything public

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health does to try to get people to lead healthier lives. Offering screening, for instance for cholesterol levels or bowel cancer, does not interfere because it provides an extra option that does not have to be taken. If the offers are accompanied by scare stories, then they might become interferences, but the offers and the screening do not on their own interfere. Nor does providing information neutrally.[1] Even some warnings do not interfere. The British government used to require this message to be written on cigarette packets: 'Warning by HM Government: Smoking Can Damage Your Health.' This warning gives true, authoritative information that any reasonable potential smoker would regard as important, so it does not seem to me to interfere with autonomy.[2] If that advice is accompanied by ghastly pictures of diseased organs, then perhaps it shades over into manipulation and therefore potentially infringes on autonomy, as some writers claim.[3] But giving information to people so they can decide how to act does not manipulate them.

On the other hand, coercion and manipulation do infringe on autonomy. Threatening people with gaol for taking drugs is a clear example of coercion. Dishonest health campaigns (such as many about recreational drugs when I was growing up) are examples of manipulation, at least if people believe and act on the messages. So some public health interventions clearly could interfere with autonomy.

Public health advocates recommend measures to make unhealthy behaviour more expensive in time or money. These measures include taxes, licensing restrictions, government monopolies on sale, banning sales outside certain days or hours, and preventing sales in certain areas. It is less clear how cost-raising measures affect autonomy compared with being gaoled, which does infringe on autonomy, or neutrally informed, which does not.

Let us take sin taxes to stand for all cost-raising measures. In my view, whether taxes would infringe on autonomy would depend partly on their purpose. Remember that to interfere with autonomy, they must fall within the personal sphere. If they aim to raise revenue rather than discourage consumption, then they need not infringe on personal sovereignty.[4] People can be personally sovereign even if they have a duty to contribute to the cost of the state, and perhaps paying sin taxes is a way of fulfilling their duty. If, however, the goal is the paternalistic one of reducing people's consumption for their own good, then it falls within the personal sphere.[5] In that case, taxes might infringe on autonomy. But would they? I can see

[1] At least not in the usual public health context. A reader pointed out that telling people things they have asked not to be told might infringe on their autonomy.

[2] You can see the government health warning here: https://www.istockphoto.com/photo/government-health-warning-on-old-cigarette-packets-gm639893422-115600875 (last accessed 6 June 2024).

[3] Mark D. White, *The Manipulation of Choice: Ethics and Libertarian Paternalism* (New York: Palgrave Macmillan, 2013), pp. 139–41.

[4] Could measures have two goals, to raise revenue and to reduce consumption? These goals are in tension because the revenue is only obtained from people who continue to consume.

[5] Mill opposed taxes designed to reduce consumption but was willing to allow them to raise revenue. He was also willing to allow taxes to be especially heavy on commodities of which the state

three answers: that taxes cannot infringe on autonomy no matter how high they are, that they can if they are high but not otherwise, and that even small taxes are a small interference with autonomy. I am inclined to support this last answer.

I know of two arguments that taxes do not infringe on autonomy. The first says that taxes still leave the choice to consume, and the second says that taxes on sellers do not infringe on the autonomy of consumers. As an example of the first, Jonathan Cummings writes: 'Rather than banning a product or activity outright, sin-tax policies merely provide economic and health-related incentives not to consume an unhealthy product; the final choice whether to consume or not still remains unabridged.'[6] If the argument here is that the tax would not infringe on autonomy because it only changes prices but does not remove the option, it ought in principle to apply to any level of taxation. Thus if the tax on a packet of cigarettes went up to $1,000 in 2024 US dollars, a person should still be said to have the choice to smoke, so long as they sold their house. That conclusion is implausible enough but, even worse, it implies that coercive threats would not infringe on autonomy. Banning cigarettes and backing up the ban with threats of imprisonment, like taxing, also is likely to leave the final choice to smoke because cigarettes would probably still be available, just as heroin is in countries where use or possession is a crime. Even if a coercive ban caused supply to dry up, and therefore in a sense did not leave the final choice to the consumer, so too could a tax at any level, but particularly a high level, that makes it uneconomic to supply the good.

A second argument says that excise taxes do not infringe on the autonomy of the consumer because excise taxes fall on the seller. The seller may pass on the cost in full to the consumer, but that is up to the seller. And if the seller does raise the price, they do not thereby infringe upon the autonomy of consumers. After all, consumers do not generally choose the prices they must pay.[7]

To see that something is wrong with this argument, consider a parallel in which a state allows uninvolved private citizens to sue abortion providers with the upshot that abortion providers will only perform abortions on women who can pay a large fee to offset the risk. Suppose the aim of the policy is to deter abortions by raising their price beyond what many women can afford.[8] Would we say here that the state

'deems the use, beyond a very moderate quantity, to be positively injurious.' J. S. Mill, *On Liberty* (Harmondsworth: Penguin, 1982), p. 171 (ch. V, par. 9). Whether his position is consistent with his wider argument is questionable. See Anne Barnhill and Matteo Bonotti, *Healthy Eating Policy and Political Philosophy: A Public Reason Approach* (New York: Oxford University Press, 2022), p. 99 and ch. 3 generally.

[6] Jonathan Cummings, 'Obesity and Unhealthy Consumption: The Public-Policy Case for Placing a Federal Sin Tax on Sugary Beverages', *Seattle University Law Review* 34 (2010): 293–4.

[7] Carissa Véliz, Hannah Maslen, Michael Essman, Lindsey Smith Taillie, and Julian Savulescu, 'Sugar, Taxes, and Choice', *Hastings Center Report* 49 (2019): 26–7 have a variant of this argument. They claim that the negative liberty of buyers is unaffected by the tax on sellers.

[8] This example adapts the legal situation in Texas after the Texas Heartbeat Act Senate Bill 8 took effect in 2021. The aim was to reduce the number of abortions, as is clear from this press release from the Texas Attorney General, Ken Paxton: https://www.texasattorneygeneral.gov/news/releases/pax

does not infringe on the autonomy of the women just because it has abortion providers as an intermediate target and the abortion providers do not themselves infringe on women's autonomy by raising their prices?[9]

It seems much more plausible to say that a low tax does not infringe on autonomy than to say that no tax could infringe on autonomy. Douglas Husak writes: 'Unless rates of taxation become prohibitive, they should be thought to influence rather than to interfere with choice.'[10] However, as Mill points out in the context of taxing alcohol: 'Every increase of cost is a prohibition to those whose means do not come up to the augmented price.'[11] Taxes do not make smoking impossible, but they do reduce options for anyone on a budget since if someone smoked and paid taxes, they would have less money, and therefore fewer options, than if they smoked and paid less tax. Moreover, according to the thesis of personal sovereignty discussed in Chapter 7, decisions within a personal sphere should be up to us. As Joel Feinberg pointed out, even small incursions into political sovereignty are incursions.[12] In politics, an unauthorized overflight by foreign aircraft is an incursion into sovereign airspace although, obviously, it infringes less on sovereignty than a military invasion. As for personal sovereignty, consider the English Act of Uniformity 1558, which imposed fines of a shilling for refusing to attend services in the Church of England.[13] These fines were not large for rich Catholics, but they nonetheless infringed on religious liberty, generally taken to be a central aspect of personal autonomy. The fines might be small infringements, but infringements they were. By extension, a tax or other imposed increase in cost could infringe on autonomy even if it is a small increase.

We have been thinking about measures, such as taxes, that reduce consumers' options. What about public health interventions that try to influence people to behave in healthier ways? Earlier, I contrasted truthful warnings, which would not

ton-defends-sb8-saving-thousands-lives-process (last accessed 18 June 2024). The Act was widely criticized as an interference with women's rights (including by dissenting judges in the US Supreme Court case *Whole Woman's Health et al. v. Austin Reeve Jackson, Judge, et al.* 594 US (2021), https://www.supremecourt.gov/opinions/20pdf/21a24_8759.pdf (last accessed 6 June 2024). As readers probably know, the Texas policy was superseded after the Supreme Court decided in 2022 that Americans did not have a constitutional right to abortion after all. See 'The Supreme Court Erases the Constitutional Right to Abortion', *The Economist*, 24 June 2022.

[9] Drinking sugar is less important than having access to an abortion, but that is a different point. See the next section.

[10] Douglas Husak, 'Paternalism and Consent', in *The Ethics of Consent: Theory and Practice*, edited by Franklin Miller and Alan Wertheimer (Oxford: Oxford University Press, 2010), n. 10. Angus Dawson thinks taxes on unhealthy products infringe on liberty only when they stop the 'average person' affording them. See Dawson, 'Snakes and Ladders: State Interventions and the Place of Liberty in Public Health Policy', *Journal of Medical Ethics* 42 (2016): 512, n. 7. What, one might ask, about the liberty of those with below-average amounts of money?

[11] Mill, *On Liberty*, p. 171 (ch. V, par. 9).

[12] Joel Feinberg, *Harm to Self* (New York: Oxford University Press, 1986), p. 55.

[13] Peter Ackroyd, *The History of England*, Vol. 2: *Tudors* (London: Pan Macmillan, 2012), p. 292. Being fined for non-attendance was comparatively liberal for its day.

infringe on autonomy, with a dishonest health campaign, which could. These cases seemed easy enough to assess, but others are harder, such as making subtle changes to the environment, as recommended by enthusiasts for nudges, or anti-smoking campaigns that play on maternal guilt. Would these infringe on autonomy? It is a fascinating but difficult question which I shall postpone answering. We will be better able to evaluate influences after Chapter 9, once we have gone a bit further into the capacities needed to be autonomous.

Important and Trivial Interferences

People should be free to worship the god or gods or no gods of their choice; they should be free to form personal relations with other willing people; they should be free to choose their careers. These are important areas of life. But being made to wear helmets on motor bicycles or seatbelts in cars would not interfere in important areas of life, and nor would banning brand names on cigarette packets or requiring sugary drinks to be sold in less-than-huge containers. On the basis of these plausible-sounding claims, several writers have concluded that public health restrictions on choice need not infringe on autonomy. For instance, Carter, Entwistle, and Little favour a conception of autonomy they call 'relational'. They write, 'the relational conception will give weight only to those infringements that undermine self-determination, self-governance and/or self-authorization. The relational conception is unlikely to support preoccupations with infringements that are less important, or even trivial (e.g. constraints on access to giant-size portions of soda).'[14] The argument we shall consider makes two claims: (1) trivial choices are not protected by autonomy and (2) some, or many, public health interventions are with trivial choices. I want to cast doubt on both these claims.

The first claim is that autonomy, understood correctly, does not protect trivial choices. Carter, Entwistle, and Little want to say that such restrictions as banning the sale of sugary drinks in large containers do not infringe on (relational) autonomy.[15] They seem to think that the ban would not undermine self-determination, which they describe as follows: 'A person who is self-determining is able to make important choices in her life and act on them'; and 'To be self-determining, people require political and/or personal freedoms and at least a threshold level of opportunities'.[16] I can see that buying drinks in large containers

[14] S. M. Carter, V. A. Entwistle, and M. Little, 'Relational Conceptions of Paternalism: A Way to Rebut Nanny-State Accusations and Evaluate Public Health Interventions', *Public Health* 129 (2015): 1027. The authors go on to use their relational conception to criticize an anti-obesity campaign that they regard as stigmatizing, so they are by no means doctrinaire public health advocates. See pp. 1026–7.

[15] Carter, Entwistle, and Little, 'Relational Conceptions of Paternalism', p. 1026.

[16] Both quotations are from Carter, Entwistle, and Little, 'Relational Conceptions of Paternalism', p. 1024.

might not be important and that being prevented from doing so could leave plenty of opportunities, although a ban would entail losing some personal freedom. Even so, why not say that self-determination requires being able to make both important choices and not-so-important choices? Some restrictions infringe more on autonomy than others, but why not conclude that relatively minor restrictions are a relatively minor infringement rather than no infringement at all? In other words, even if we agree with Carter, Entwistle, and Little's conception of self-determination, we need not accept their claim that it does not apply to trivial choices.

Furthermore, other views of autonomy would protect some or all trivial choices, so we should not accept without question the assertion that autonomy is concerned only with the important. For example, Joseph Raz believes that to be autonomous we must have an adequate range of options, as do Carter, Entwistle, and Little, but unlike them, he thinks an adequate range would include some trivial choices. Raz writes:

> It is intolerable that we should have no influence over the choice of our occupation or of our friends. But it is equally unacceptable that we should not be able to decide on trivia such as when to wash or when to comb our hair. This aspect of the requirement of adequate choice is necessary to make sure that our control extends to all aspects of our lives. This is clearly required by the basic idea of being the author of one's life.[17]

On Raz's view, interventions could infringe on autonomy even when they affect trivial options. However, one could accept Raz's point and still argue that public health interventions can respect autonomy. One might say: 'autonomy protects a range of trivial choices, but it does not protect every unhealthy trivial choice.' But even this claim ought to be controversial. The view of autonomy I have put forward, personal sovereignty, counts any choice within a person's sovereign sphere as a matter for their autonomy.[18]

The second claim we must assess is that some or many public health policies involve intervening only in trivial choices. Who determines whether a choice is trivial? We are thinking of individual autonomy so the most likely answer is, the person who would make the choice.[19] It seems rash to say that any of the unhealthy behaviour targeted by public health interventions is of no importance in anyone's lives. Some unhealthy food is culturally significant. Some cultures value getting drunk. Smokers, as we saw in Chapter 3, have built up a culture based on shared smoking. Most people might not much mind wearing a helmet on a motorbike,

[17] Joseph Raz, *The Morality of Freedom* (Oxford: Clarendon Press, 1986), p. 374.
[18] Feinberg, *Harm to Self*, p. 94.
[19] Douglas Husak, *Drugs and Rights* (Cambridge: Cambridge University Press, 1992), p. 98.

but some riders have cared so much they have gone to court to fight the laws.[20] I do not say that the autonomy of a tiny, or even a large minority, of people must be reason enough to block public health interventions that do a lot of good.[21] But I am saying that their autonomy would be overridden even though other people regard the same choice for themselves as trivial.

I want to float another argument against the claim that public health interventions affect trivial choices. There cannot be very many such interventions, if we take seriously what their advocates say. They say that choosing to smoke, drink too much, eat lots of junk food, or not move one's body, all pose substantial risks to health and life. But then, in being matters of health and life, they are not trivial. However one tries to distinguish between the important and the trivial in personal matters, what substantially affects one's life or health is important. Now I can imagine some replies to this argument, but I can also imagine some replies to the replies, and I will leave this argument as a challenge to claims that public health interventions amount only to trivial interferences.

To sum up the chapter so far, we should agree that some public health interventions (such as those that expand options) do not interfere with autonomy at all. However, interventions that reduce choice, including by raising the time or money costs of options, typically do interfere. While the interventions may not always greatly interfere with autonomy, and while small interferences may be justifiable if they do a lot of good, an interference is an interference.[22]

Interventions That Increase Autonomy

Public health interventions that expand people's options, such as the offer of screening mentioned earlier, would plausibly make people more autonomous. What about restricting or influencing choices? Some argue that these could make people more autonomous too. Two arguments for this conclusion are more conveniently discussed elsewhere in this book. One we came across in Chapter 7. In stripped-down form, it went like this: people ultimately prefer to be healthier; the interventions make people healthier; therefore, the interventions give people what they ultimately prefer; autonomy is increased when people get what they ultimately prefer; therefore, the interventions make people more autonomous. This argument is wrong about autonomy because, as I said, autonomy does not reduce to fulfilling ultimate preferences. Another argument points to all sorts of factors that might make unhealthy choices non-autonomous, such as addiction, or

[20] e.g. John L. Spears in the US case, *City of Bremerton vs Spears* 134 Wn 2d. 141 (1998) https://www.casemine.com/judgement/us/5914bbf1add7b049347998f9 (last accessed 6 June 2024).

[21] See Chapter 7 on when autonomy may be overridden.

[22] Could small intrusions do a lot of good? Possibly only rarely. See Chapter 7 on tradeoffs, and the contrast between marrying the wrong person and eating too many pies.

manipulative marketing. Interventions that remove or counter these factors might make decisions more autonomous. This argument is important and partially persuasive, but it is also too complex to deal with briefly, so I have postponed it until Chapters 9 and 10.

One argument I will discuss here says that intervening in people's decisions can make them more autonomous if it prompts or forces them to think harder about their decision making. A sugar tax, for instance, might make consumers think harder about how and why they value sugary drinks.[23] According to this view, autonomy is complex. Restricting choice generally reduces autonomy, but autonomy has more to it than the absence of restrictions, and the loss from restricting choice can be more than counter-balanced by a gain in the quality of decision-making.

I agree that autonomy is complex and is more than the absence of interference. Nonetheless, I am not persuaded by this argument. It is disingenuous to claim that public health interventions aim to get people to think harder. Taxing soft drinks or turning off escalators are not designed to get people to stop and think. They are designed to get people to drink fewer sugary drinks and take the stairs; in other words to act in a healthier way, not a more autonomous way. Of course, what also counts for autonomous decision-making is how people react, not just what the designers of schemes intend. Possibly people whose choices are made harder do give more thought to their options than they otherwise would; but without evidence, we are merely speculating, and it is equally possible that they would give less thought. Suppose a smoker plans to buy cigarettes, forgets to ask for them, and gets no visual reminder because the law says cigarettes must be hidden; the smoker would fail to act on their plan, which sounds as if the law has made them less autonomous. If we want to know the actual effects of laws on thoughts, we need some evidence but, as far as I am aware, the writers who say that public health interventions get people to think harder do not cite any.

In any case, even getting people to think harder need not make them more autonomous. Remember from Chapter 7 that a decision can be autonomous when someone's capacities reach a threshold. The ordinary adult has the same right to decide whether to accept heart surgery as a patient who happens to be a cardiac surgeon. Once someone's capacities are at the threshold, they would not be more self-ruling even if they exercised or developed their capacities to a higher degree. An intervention that made them develop those capacities but otherwise restricted their autonomy would therefore be, other things equal, a net loss in autonomy. The exception, in principle, would be if the intervention got them from below the threshold to above it. To take the sugar tax example, perhaps before the tax someone gave so little thought to what they were doing that that they were not acting autonomously (despite intentionally locating, buying, and drinking sugary

[23] Véliz et al., 'Sugar, Taxes, and Choice', p. 29.

drinks). After the tax, they come to think about sugary drinks enough to move from below a threshold of autonomy to above it. I have not seen an argument for this exception made out but, if anyone wants to try it, they should be careful. As I shall argue at more length in Chapter 9, decisions need not be carefully thought through to count as autonomous.

A quite different argument points to the relation between being alive and autonomy.[24] One cannot be autonomous and dead. Suppose that heavy smoking shortens lives by about eight years on average and that a public health intervention would stop people smoking. Suppose that the intervention counts as an autonomy-reducing interference. Then we must set the autonomy-loss of the interference against the autonomy-gain of having an extra eight years to be autonomous in. The interference would have to be really very bad to come out as reducing autonomy overall rather than enhancing it.[25] This argument resembles Mill's criticism of slavery contracts. Mill wrote, 'by selling himself for a slave, he abdicates his liberty. . . . The principle of liberty cannot require that he should be free not to be free'.[26] One might say that autonomy cannot require letting people give up their autonomy by shortening their lives through their unhealthy behaviour.

Voluntary slavery is a problem for anyone who would give absolute priority to respecting autonomous decisions, although it is more of a theoretical problem than a practical one. But I am not arguing for giving absolute priority to autonomy. I think autonomy can be overridden by well-being, and voluntary slaves are likely to lose so much well-being that voluntary slavery should not be allowed. If we want to reject voluntary slavery, we need not and should not resort to asserting that people should be prevented from giving up their autonomy. Nor should we stop autonomous people behaving in unhealthy ways just because they will not be autonomous after they die. In the first place, contracts generally involve giving up future liberty, and we do not object to contracts. In the second, ordinary medical ethics does not treat people as having an overriding enforceable duty to stay alive for as long as they would be autonomous. A competent person may turn down lifesaving surgery that would give them years more autonomous life. If we want to explain these conclusions philosophically, we might distinguish between respecting autonomy and promoting it. Respecting autonomy requires following the decision of an autonomous person about themselves whereas promoting autonomy means maximizing that person's autonomy, even if that means overriding their decisions. We might say that autonomy ought to be promoted only subject

[24] Véliz et al. think non-fatal ill health reduces freedom in 'Sugar, Taxes, and Choice', p. 28.

[25] Andrew Sneddon has a version of this argument. He thinks stop signs on roads, which appear to restrict choice, enhance both 'shallow autonomy', by preserving options, and 'deep autonomy', by preventing head injuries that prevent autonomous thought. See Sneddon, 'Equality, Justice, and Paternalism: Recentreing Debate about Physician-Assisted Suicide', *Journal of Applied Philosophy* 23 (2006): 396. But Sneddon does not think suicide is contrary to deep autonomy even though death prevents autonomous thought (p. 399).

[26] Mill, *On Liberty*, p. 173 (ch. V, par. 11).

to the constraint of respecting people's decisions about themselves.[27] In brief, we should not think of autonomy as a value to be maximized. Public health advocates might be more inclined to agree after they see the argument for their interventions in the next section, which is that people often want to constrain their own choices to remove options they worry they will foolishly take.

Autonomy and Self-Binding

In this section, we shall consider the idea that a public health intervention would not conflict with people's autonomy when the intervention was itself an exercise of their autonomy. Many of us are aware of how our weaknesses can prevent us from achieving our goals. Quite often, we try to get round those weaknesses by shaping or constraining our options. Let us call this idea 'self-binding'. As a basis for concluding that public health restrictions do not infringe on autonomy, it is much the most promising of the arguments we have considered so far. I shall argue that self-binding would be a good reason for public health restrictions, and enough to show that they would not infringe on autonomy, so long as people want to bind themselves. The trouble is that the evidence does not suggest they do. The problem for self-binding is not primarily one of principle but of application.

Let me say first what self-binding involves and why it is promising. The fictional Ulysses, in what is close to literal self-binding, had himself tied to a mast. As his ship sailed close to the Sirens, he begged and demanded to be released. The real Samuel Taylor Coleridge is supposed to have hired guards to stop him buying laudanum, an opiate to which he was addicted.[28] Like Ulysses, he vigorously told his guards to ignore his previous instructions. These stories are dramatic in two respects: the self-binding was supposed to constrain high passion and the constraints involved force. Not all cases where temptation might be constrained have such passion. The philosopher J. L. Austin described it as a grotesque confusion to 'collapse succumbing to temptation into losing control of ourselves':[29]

> I am very partial to ice cream, and a bombe is served divided into segments corresponding one to one with the persons at High Table: I am tempted to help myself to two segments and do so, thus succumbing to temptation and even conceivably (but why necessarily?) going against my principles. But do I lose control of myself? Do I raven, do I snatch the morsels from the dish and wolf them down,

[27] T. M. Scanlon, *What We Owe to Each Other* (Cambridge MA: Belknap Press, 1998), p. 384, n. 20.

[28] The story was told by Thomas de Quincey, *Confessions of an Opium Eater*, cited in K. Bell, 'Thwarting the Diseased Will: Ulysses Contracts, the Self and Addiction', *Culture, Medicine, and Psychiatry* 39 (2015): 382.

[29] J. L. Austin, 'A Plea for Excuses', in *The Philosophy of Action*, edited by Alan R. White (Oxford: Oxford University Press, 1968), p. 37.

> impervious to the consternation of my colleagues? Not a bit of it. We often succumb to temptation with calm and even with finesse.[30]

Self-binding can not only constrain temptation of lower heat than experienced by Ulysses or Coleridge, it need not always be so dramatic as to involve physical force. We might throw out our cigarettes, avoid our usual drinking haunts or our drug-taking cronies, use small plates to reduce our portion sizes, or shop on a full stomach so as not to buy peanuts. All of these are methods to shape and constrain our future choices so that they conform better to what we now want.

Self-binding sometimes has ethically controversial aspects. Throwing away our cigarettes or getting rid of our large plates is a private act in the sense that it does not, or need not, involve others. By contrast, when Ulysses had himself tied up and Coleridge hired guards, they did involve other people. Cases like theirs raise an ethical question of whether people who want to bind themselves ought to put other people in the awkward position of trying to decide what to do.[31] Put that to one side. Another ethical question is whether these other people are permitted or obliged to carry out the prior instruction. The problem is most difficult when someone says, in a version of what Ulysses and Coleridge said, 'do not do X even when I order "do X"', and then later gives the order 'do X'. We cannot assume that the prior instruction is the one to be followed because people can change their minds for good reasons and they generally have the right to have their changes of mind acted upon. Things become even more difficult when writers invoke changes in personal identity.[32] If we think that an earlier self binding a later self is like one person binding another, then we might think the obligation to do what the earlier self says could not be cancelled by the different later self. But we might also wonder how an earlier self could be entitled to bind a later self that is a different person. As it happens, thinking of earlier and later selves as different persons seems excessive to me. Still, we can see that self-binding is not always ethically straightforward. Then again, though, sometimes it is straightforward. Not every case of self-binding involves imposing bonds on a later self that struggles to break them. If I ask you not to give me pudding later and you do not, I might be pleased even at the time. If I ask you to hide my cigarettes, I might not even notice that I have not had one. If you have tipped my gin down the sink at my request, you are unable give it to me when I later ask you for it. In these cases, the hard problem does not arise of which side to go with, the earlier or the later self.

[30] Austin, 'A Plea for Excuses', pp. 37–8, n. 2.

[31] Husak, 'Paternalism and Consent', pp. 116–17.

[32] In two essays on self-command in his book, *Choice and Consequence*, Thomas Schelling adopts an 'official position' that it can be most useful to model humans metaphorically, as if they were two different selves, but at one point he writes 'the more I reflect on it the more I wonder whether there is any reason for excluding the literal possibility [that the later self is a different person from the earlier self]'. See his *Choice and Consequence* (Cambridge, MA: Harvard University Press, 1984), p. 96.

Self-binding makes an ethical difference to the permissibility of interventions by others. You might not be justified in destroying my cigarettes unless I ask you, in which case you would be. My consent makes your destruction on a par with my destroying my own cigarettes, something I am entitled to do because they are mine. With a person's valid consent to an intervention, any objections to it that are rooted in autonomy largely or entirely disappear.

If we accept that a self-sought constraint is usually more defensible than one that is imposed, we are still some way off defending public health policy. People may enlist the help of others to get them to stick to their goals, and so not be private in one sense, but they are still private in another sense, which is that they do not directly involve public policy or the state. In the private cases, people typically consent. In the public cases, they typically do not. They might vote in a referendum, as with referenda on legalizing marijuana, and we might think of voting as a proxy for consent, but most public health policies are not subject to referenda and are usually only one tiny factor that shapes voting for political parties.

I do not think it is reasonable to require individual consent to a public policy for it to count as a self-sought constraint. Perhaps it is enough that individuals want the constraints. My colleague, Tom Gregory, told me he is pleased that he may no longer buy cigarettes individually or in packs of ten. Having to buy cigarettes in larger amounts is enough to put him off buying any at all. Perhaps many people resemble him and want their freedoms reduced to stop themselves indulging their weaknesses.[33] If so, one could argue for public health restrictions on the grounds that they are an autonomously wanted service to citizens. But notice that, to be an autonomously wanted service, people must want the restrictions themselves, not just the benefits of the restrictions. When Robert Goodin writes, 'Banning or restricting smoking in public places (especially the workplace) can contribute crucially to an individual's own efforts at smoking cessation',[34] he is not making a point about self-binding, only the point that restrictions can help us achieve our goals. Wanting to stop does not entail wanting a ban.[35] When Véliz et al. write, 'one way to be more autonomous is through Ulysses-style precommitment contracts, which limit one's future options in order to support one's values in the face of temptation or distraction',[36] their idea can only be applied to the sugar taxes they favour if we can find some element that resembles contractual agreement. Without free agreement to the limit, a limit on freedom is not based on a contract, and so is not a 'Ulysses-style precommitment contract'.

[33] I do not know of a term to describe people who want less freedom so they cannot indulge their weaknesses. Tom suggested 'gimps'.

[34] Robert E. Goodin, *No Smoking: The Ethical Issues* (Chicago: University of Chicago Press, 1989), p. 29.

[35] As Kalle Grill and Kristin Voigt make clear when arguing for a ban on cigarettes. K. Grill and K. Voigt, 'The Case for Banning Cigarettes', *Journal of Medical Ethics* 42 (2016): 295.

[36] Véliz et al., 'Sugar, Taxes, and Choice', p. 25.

It would not be a contract just because it helps people overcome temptation or avoid distraction.

Suppose some people do want restrictive policies because they want to be bound. The idea I am advancing is that these option-shaping, freedom-constraining policies could be justified as a public service akin to other public services that citizens cannot easily organize for themselves.[37] Bans on the public display of cigarettes, for instance, could be like flowers in parks or government grants for community groups. Of course, not everyone is likely to want their options shaped or constrained, just as not everyone likes flowers in parks or grants to community groups, or not enough to want to pay for them. Whether public goods should be provided and in what form depends on such matters as how many want them and how much they would benefit. The important point here is that by construing the public health policies as a service sought by voters, we should evaluate them as public services with no special objection on grounds of infringing on autonomy or being paternalistic.[38] To explain further, think of what one might say to you if you want to buy alcohol on Sundays in a society where the overwhelming majority of adults wants to be prevented from doing so. One could say that the ban is not for your sake but their sake; that it is regrettable that alcohol would not be available to you; that we are 'reluctant deniers' of alcohol to you;[39] that we do not mean that you are incapable of making good decisions. At the very least, you should not feel that you, or your rational faculties, are insulted by the policy. It may well be that your autonomy is not infringed upon either.

Could a policy infringe on autonomy even when devised as a service to self-binders? Some aspects of our lives could be so important for us to determine as to be protected by a right, which should not be infringed upon even if many rightholders wish they did not have the right and want it taken away. Even if a large majority wants marriages to be indissoluble because they fear being tempted to get divorced, perhaps the minority who want the option of divorce should not be denied it. But many cases of public health do not involve such weighty matters. To return to alcohol, people might be unfree to buy alcohol on Sundays, but they could get round the problem at some inconvenience by buying extra on other days of the week. Their autonomy, understood as having discretion within some personal sphere, would be no more under threat from this policy that one mandating folate in bread to prevent foetal spina bifida or fluoride in water to prevent tooth decay. At the least we can say that even if those policies do infringe on autonomy (as I do not believe), they would not do so as paternalistic policies.

[37] See also Chapter 11 on why private self-binding is an imperfect substitute for public restrictions on choice.

[38] Feinberg, *Harm to Self*, pp. 18–20; Gerald Dworkin, *The Theory and Practice of Autonomy* (Cambridge: Cambridge University Press, 1988), p. 128.

[39] Jim Leitzel, *Regulating Vice: Misguided Prohibitions and Realistic Controls* (Cambridge: Cambridge University Press, 2007), pp. 22, 23.

I suggest that public health policies that can be justified as self-binding have a big advantage over ones that cannot. They respect autonomy. But it is time to consider whether in fact people do want to bind themselves. Perhaps hardly anyone does. Jon Elster reported the Norwegian historian, Jens Arup Seip, as saying: 'In politics, people never try to bind themselves, only to bind others.'[40] And here, since I mentioned divorce, is a striking example outside politics: Lousiana, Arizona, and Arkansas offer the option of 'covenant marriage', which makes divorce especially difficult, and yet only 3 per cent of marriages have taken this form.[41]

Some writers do provide evidence that people want bans on smoking. Edwards et al. surveyed smokers in New Zealand and found that 46 per cent of them wanted a ban on cigarettes within ten years, conditional on some alternative effective nicotine delivery system becoming available.[42] Since the survey was in 2007–9 and e-cigarettes are now widely available, that condition may well be met. In England, Shahab et al. found that a third of smokers wanted a ban.[43] So too did a third of smokers in the United States.[44] Much higher figures supporting a ban came from non-smokers.

When it comes to establishing self-binding, this evidence is insufficient. We need to know not just that people support a ban but why they do.[45] To make the point, consider how unimpressed we should be if someone who has never smoked supports a ban. To paraphrase Jens Arup Seip, they do not want to bind themselves, they want to bind other people. Nor is it impressive to be told that ex-smokers want to ban smoking. They, with the convert's zeal, could also want to bind others. And perhaps the New Zealand smokers who wanted a ban in ten years saw themselves as ex-smokers by then, so it would not be their weaknesses they were constraining. It is not even an example of self-binding if someone is willing to be banned for the sake of stopping a future generation from smoking. That would be altruism rather than self-binding. None of the surveys shows that smokers want to bind themselves. Equally, however, the survey results are consistent with more smokers wanting to bind themselves than would support a ban. Such smokers might oppose

[40] Jon Elster, *Ulysses Unbound* (Cambridge: Cambridge University Press, 2000), p. ix.

[41] Ellen Rosner Feig, 'Is Covenant Marriage the Answer to a Rising Divorce Rate?', 31 March 2023, https://www.legalzoom.com/articles/is-covenant-marriage-the-answer-to-a-rising-divorce-rate (last accessed 18 June 2024). Among the many drawbacks of covenant marriage, the two-year 'cooling off' period between separating and divorce makes a marriage last longer and so increases the size of alimony payments.

[42] R. Edwards, N. Wilson, J. Peace et al., 'Support for a Tobacco Endgame and Increased Regulation of the Tobacco Industry among New Zealand Smokers: Results from a National Survey', *Tobacco Control* 22 (2013): 86.

[43] L. Shahab and R. West, 'Public Support in England for a Total Ban on the Sale of Tobacco Products', *Tobacco Control* 19 (2010): 143.

[44] G. N. Connolly, I. Behm, C. G. Healton et al., 'Public Attitudes Regarding Banning of Cigarettes and Regulation of Nicotine', *American Journal of Public Health* 102 (2012): 1.

[45] Grill and Voigt miss this point in 'The Case for Banning Cigarettes', p. 296.

a ban because they think it is impractical or infringes on free choice even though they themselves would like to be prevented. We do not know.

We have a further absence of evidence from referenda on legalizing marijuana. American data correlates voting against legalization with being Republican, older, and religious.[46] But we do not know whether the voters against legalization wanted to prevent themselves from consuming dope. However, according to Karen Jochelson, analysis of studies of 'public opinion on specific policies, such as alcohol, smoking and road safety, shows that people do not favour policies that limit their personal choices and view their own behaviour as benign, but they strongly favour stricter legislation controlling the potentially dangerous behaviour of others'.[47] She, or we, might doubt the accuracy of the self-assessments; it seems unlikely that all their behaviour is so benign. But that is not the point here, which is that if she is right, people do not want to bind themselves. When they want constraints on freedom, it is to bind others.

We might go a bit further and be sceptical about the demand for self-constraint. As Robert Sugden, who is such a sceptic, points out, some of the private sector self-binding techniques can be described as 'niche'.[48] William Hill, the bookmakers, offer a 'panic button' so that online gamblers can prevent themselves from gambling for a while. Only 0.1 per cent of gamblers use it at any time.[49] StickK.com, a firm offering online self-commitment, reports 374,000 commitment cases from 2008–17. These are not nothing, but they are not much.[50] Sugden also criticizes some interpretations of the evidence cited in writings on behavioural economics. In his view, they have been over-interpreted as evidence of demand for self-constraint when other explanations are more plausible. Take, for instance, the default of making employer pensions opt-out rather than opt-in. People seems to accept being defaulted into opt-out schemes and they do then save more. But Sugden warns us against interpreting this evidence as showing that people knew they were prone to splurge their money and wanted to prevent themselves from doing so. People could instead accept any default rather than having to think about something as complicated, boring, and difficult as retirement savings.[51]

[46] J. Frendreis and R. Tatalovich, 'Postmaterialism and Referenda Voting to Legalize Marijuana', *International Journal of Drug Policy* 75 (2020).

[47] Karen Jochelson, *Nanny or Steward: The Role of Government in Public Health* (London: King's Fund, 2005), p. 6.

[48] Robert Sugden, *The Community of Advantage: A Behavioural Economist's Defence of the Market* (Oxford: Oxford University Press, 2018), p. 154.

[49] Sugden, *Community of Advantage*, p. 154. Annie Kang, who helped me with the research for this chapter, told me that this 'button' is easy to find, so its low usage seems unlikely to be due to gamblers' ignorance.

[50] Sugden, *Community of Advantage*, p. 154.

[51] Sugden, *Community of Advantage*, p. 155.

Here is an example from public health, if public health has gambling in its scope, which suggests that the demand for self-constraint is low. New Zealand allows people to exclude themselves from gambling venues. The Gambling Act (2003) allows New Zealanders to, in effect, take out a trespass order against themselves. If they try to enter the venue they have excluded themselves from, the police may be called, and they may be fined $500 (and the venue may be fined $5,000 if it lets them in). It turns out that no one knows how many people do exclude themselves from all gambling venues, but 1,290 people have excluded themselves from the subset of venues with gaming machines.[52] An earlier report estimated that about 13 per cent of New Zealand adults gambled on machines in a given year, which in a population at the time of about 3.6 million adults would have been roughly 468,000 and would be slightly more now.[53] 1,290 is only about 0.27 per cent of 468,000; thus very few of the people who would gamble on machines exclude themselves.

In short, one could reasonably think of public health restrictions on choice as exercises of autonomy through self-binding so long as one had some evidence that people do want to bind themselves. We appear not have the evidence and some grounds to think we are not likely to get it. At this stage, we must conclude that as a defence of public health restrictions, self-binding may work in principle but not in practice.

Conclusion

The critics of the nanny state see public health interventions as violating autonomy. Public health advocates have tried to avoid the criticism by denying that their interventions interfere with autonomy. The advocates argue that taxes, and similar cost-raising measures, do not infringe on autonomy; that typically public health interventions are in relatively trivial matters outside the protection of autonomy; that interventions, despite restricting choice, enhance autonomy; and that people want to limit their unhealthy options so as to avoid indulging their weaknesses. These arguments are not, I have said, persuasive.

We have implicitly assumed in this chapter that when public health measures try to change people's behaviour, it is autonomous behaviour that they would affect. But what if people are not autonomous generally, or if their unhealthy behaviour

[52] I am very grateful to Ganesh Vijayanath, the National MVE (Multi-Venue Exclusion) Administrator at The Salvation Army for supplying the figures and helping me understand them. The figures were the ones on record in 2021. The Salvation Army is the agency responsible for administering exclusions from gambling venues. I was referred to them by the Ministry of Health, having been referred to the Ministry of Health by the Department of Internal Affairs.

[53] Health Promotion Agency, *New Zealanders Participation in Gambling: Report from the 2018 Health and Lifestyles Survey*, results available at https://kupe.hpa.org.nz/#!/gambling/gambling-participation (last accessed 6 June 2024).

specifically is not autonomous? Either way, public health interventions may not conflict with autonomy because it would not be autonomous behaviour that they affect. This is a line of argument for public health interventions that we shall consider in the next chapter. Once we have, we shall then be in a better position to assess public health interventions that try to influence our choices through nudges, education, or marketing.

9
Rationality, Addiction, and Manipulation

Introduction

For some writers, the idea that a nanny state would interfere with autonomy rests on an illusion. We think we are autonomous, but we are not. Our illusion might have to be indulged by politicians and policymakers, but public health measures to discourage unhealthy behaviour could not genuinely infringe on our autonomy. This claim about our lack of autonomy might apply to whatever we do, or it might be specific to unhealthy behaviour. The arguments for the claim can be summarized as saying that we are not rational enough to be autonomous, or that unhealthy behaviour is not autonomous when it is addictive, or that manipulation makes us behave in unhealthy ways and prevents our behaviour being autonomous. Although these arguments are separate, the phenomena they describe need not be distinct. Addictive behaviour might be irrational behaviour, for instance, and the tendency of behaviour to be affected by non-rational influences can be exploited by manipulators.

The main points I want to get across in this chapter are as follows. The argument that we are not rational enough to be autonomous demands too much of autonomy and exaggerates the effects of non-rational influences. The argument about addiction fails because not enough consumers are addicted and even those who are behave much the same as autonomous people. The argument that unhealthy consumption is substantially due to manipulative 'illness promotion' has not been proved, for a mixture of conceptual and empirical reasons. In sum, as in the previous chapter, we should not accept the claims of public health advocates that their measures would leave our autonomy untouched.

Let me immediately qualify that conclusion. When advocates argue that adults' unhealthy behaviour is not genuinely autonomous, they may well be right about some adults some of the time. Some targeted restrictions, such as banning particularly manipulative advertising, may not then infringe on autonomy. Nonetheless, the wide range of taxes and regulations advocates often favour will tend to infringe on autonomy. From the point of view of public health advocates, this conclusion is a cloud, but it has a silver lining: if commercial marketing generally does not manipulate people, neither would public health messaging or nudging, a point I elaborate in the next chapter.

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Rationality and Autonomy

We have come across rationality in Chapter 5, where we saw how people may act irrationally against their interests. In this section, we revisit rationality in the context of autonomy. The arguments I consider here say that we, meaning all of us, are not the kind of creatures capable of being autonomous. In other words, none of our behaviour, not just our unhealthy behaviour specifically, is autonomous. The arguments are both empirical, about what we are like, and normative, in expressing an understanding of what it is to be autonomous. These arguments fail. The evidence is not as decisive as those who advance the argument say it is and the way they conceive of autonomy makes it unreasonably demanding. The arguments therefore do not refute the criticism that public health interventions infringe on autonomy.

One public health advocate who denies that we are autonomous is Robyn Toomath, an endocrinologist and campaigner against obesity. Toomath claims that government regulation of food and drink does not infringe on autonomy because, although we like to think we control ourselves, 'scientific evidence indicates that behaviour is no more than a predictable biological response to a set of environmental stimuli'.[1] Toomath's remark is a very brief one about biological determinism and its relation to free will.[2] This topic is far beyond the scope of this book so, by way of a brief reply only, we might ask why behaviour being predictable would mean it is not autonomous, about how predictable behaviour is anyway, given the unreliability of so much predicting, and how much of a biological response to environmental stimuli are such decisions as solving a chess problem or allocating a particular sum of money to mortgage protection insurance rather than income protection.

A longer and more sophisticated argument is offered by Eldar Shafir.[3] Shafir, drawing on what he calls a 'sea' of findings from social psychology and behavioural economics, says that the ways in which we make decisions and behave show we are not autonomous, if autonomy is taken in a 'naive' way.[4] Moreover, 'our' (i.e. most people's) views of autonomy are naïve. Shafir, like Toomath, thinks our sense of our autonomy is an illusion. He, like Toomath, applies his ideas to public health, in his case by recommending manipulating people into being healthier on the grounds that they are only going to be manipulated anyway and it is better for them to be healthier than unhealthier.[5] That last idea is one we come to when thinking about counter-manipulation in Chapter 10.

[1] Robyn Toomath, *Fat Science: Why Diets and Exercise Don't Work—and What Does* (Auckland: Auckland University Press, 2016), p. 155.

[2] In a blog, Toomath describes herself as 'a nihilistic biologist' who thinks there is no such thing as free will. See 'Who Is Responsible for Stopping NZ's Obesity Epidemic?', https://blogs.otago.ac.nz/pubhealthexpert/perspective-who-is-responsible-for-stopping-nzs-obesity-epidemic/#more-2010 (last accessed 7 June 2024). I am not sure why she thinks of herself as a nihilist since she values health.

[3] Eldar Shafir, 'Manipulated as a Way of Life', *Journal of Marketing Behavior* 1 (2016): 245.

[4] Shafir, 'Manipulated as a Way of Life'; 'sea' is on p. 250, 'naive' on p. 254.

[5] Shafir, 'Manipulated as a Way of Life', pp. 254, 255–9.

Shafir's position is unusually stark in its dismissal of autonomy, but it represents a type. Ideas from social psychology and behavioural economics have travelled widely and many writers say that we have the psychological quirks Shafir describes and conclude that we are irrational.[6] People are often impressed by the doubt the science seems to cast on the idea that we are autonomous, and I hope in this section to make them less impressed.

When we assess Shafir's argument and those like it, we should be trying to answer two questions: what are we like? And how does what we are like connect to a conception of autonomy? In Shafir's case, he cites all sorts of evidence about what we are like, such as studies in which people choose differently when the same options are presented in different ways, or rate job candidates less highly when they are interviewed on rainy days rather than sunny days. He claims that this evidence shows we are not autonomous, in a naïve sense of autonomy. He does not explicitly describe this naïve conception but, piecing his remarks together, it appears to have three elements:

1. He dismisses the idea that 'the decisions we make are just as they ought to be, and should not be touched, and that nobody and nothing can reliably make them better'.[7] Since his target is the naïve conception of autonomy, presumably the naïve conception says that autonomous decisions are as they ought to be, and should not be touched, and that nobody and nothing can reliably make them better.
2. He asserts that '[t]he cues around us have an influence on almost everything we do, and many of those cues function at a level that is not detectible or controllable, nor typically available to introspection, let alone to rational, consensual, dignified deliberation'.[8] Presumably the simple conception of autonomy requires that rational, consensual, dignified deliberation controls our behaviour.[9]

[6] See such titles as Dan Ariely's *Predictably Irrational: The Hidden Forces That Shape Our Decisions* (London: Harper, 2009) and *The Upside of Irrationality: The Unexpected Benefits of Defying Logic at Work and at Home* (London: HarperCollins, 2010). Daniel Kahneman, by contrast, refuses to call people 'irrational' despite his and Amos Tversky influential findings of human deviations from text book models of rationality. See Daniel Kahneman, *Thinking, Fast and Slow* (New York: Farrar, Straus, and Giroux, 2011), p. 412.

[7] Shafir, 'Manipulated as a Way of Life', p. 248, attributes this idea to John Stuart Mill in *On Liberty*, but Mill did not hold it. See e.g. Mill's remarks in Chapter 4 about depraved people and fools who need warnings, and his account of the benefits of free speech in Chapter 2. Shafir also attributes the view to Friedrich Hayek, which is unlikely to be fair since Hayek stresses 'men's necessary ignorance of much that helps him achieve his aims'. Friedrich A. Hayek, *The Constitution of Liberty* (Chicago: University of Chicago Press, 1960), p. 29.

[8] Shafir, 'Manipulated as a Way of Life', p. 250.

[9] I must admit that I do not understand what Shafir means by either 'consensual' or 'dignified' in this context.

3. He asserts that '[o]ur preferences are malleable and shaped constantly, everywhere, and often in ways we are unaware'.[10] Again, the simple conception of autonomy presumably denies that our preferences are so malleable.

I do not think the simple conception is the only or best way to think of autonomy. A decision can be autonomous without being right or even being most likely to be right, as I explained in Chapter 7 when describing personal sovereignty. It is thus not an objection to holding people to be autonomous that they make mistakes. In fact, we are considering whether public health measures would infringe on autonomy even when they would successfully prevent people from making mistakes about their interests. Nor does autonomy always requires rational, consensual, and dignified deliberation, if that means it must be the result of carefully gathering evidence and weighing the options. We can very quickly make sound decisions that properly reflect our preferences. We should not say that only carefully deliberated choices are rational;[11] and nor should we say that only such choices are autonomous. Consider this example. When parents are told their child needs an organ transplant and that they are clinically suitable donors, they often decide immediately to donate. In the past, these rapid decisions were criticized as non-voluntary because they were not the outcome of careful deliberation, but that criticism was misguided. The decisions expressed the genuine will of the parents.[12]

If our decision-making were hopelessly bad and ineffectual anyway, and our preferences entirely malleable, then we could not be autonomous on any plausible sense of autonomy, including autonomy as personal sovereignty. We would not be able to rule ourselves. But Shafir's evidence did not go that far. It is easy to read Shafir and think he has been dazzled by his evidence—dazzled in the sense that he sees the changes the environmental cues cause but not the changes they do not.[13] He cites a lending experiment in South Africa in which adding a picture of a smiling woman increased the uptake of loans by men (but not women) to an extent equivalent to dropping interest rates by 4.5 per cent—but not, I notice, 5 per cent or 25 per cent.[14] He cites no evidence that framing or rainy days have caused

[10] Shafir, 'Manipulated as a Way of Life', p. 253.

[11] See the scepticism about deciding by ordered list in Timothy D. Wilson, *Strangers to Ourselves: Discovering the Adaptive Unconscious* (Cambridge, MA: Belknap Press, 2002), pp. 164–5.

[12] T. M. Wilkinson, *Ethics and the Acquisition of Organs* (Oxford: Clarendon Press, 2011), pp. 129–30.

[13] Compare 'ethnographic dazzle': by being too close to the members of a culture, one sees the superficial differences between them and not the similarities. See the Introduction to Kate Fox, *Watching the English: The Hidden Rules of English Behaviour* (London: Hodder and Stoughton, 2004). Remember too, from Chapter 5, the doubts about the reliability of some studies in social psychology and behavioural economics.

[14] The study appears to be Marianne Bertrand, Dean Karlan, Sendhil Mullainathan, Eldar Shafir, and Jonathan Zinman, 'What's Psychology Worth? A Field Experiment in the Consumer Credit Market', NBER Working Paper Series Working Paper 11892 http://www.nber.org/papers/w11892. According to this study, the annual interest rate was 50–200 per cent (p. 4), so a 25 per cent drop is possible.

people to sell their grandmothers or parents to pick up the wrong children from school. Furthermore, while some writers think that deliberations are ineffectual, in the sense that they just rationalize non-deliberative responses, their view is not straightforwardly supported by a sea of findings: some can be interpreted in other ways and contrary evidence exists.[15] And the idea that preferences are entirely malleable seems inconsistent with the conclusion of many psychotherapists that our desires are deep-seated from an early age and will cause us problems with our mental health if they are not satisfied.[16] Psychotherapists aside, one might think that long-term aims are more stable than any given attempt to satisfy them, and the evidence that such attempts can be swayed by cues outside consciousness does not show that the underlying preferences are unstable.[17] Finally, if we are all supposed to be irrational or non-rational, what of the clever marketers with their tricks to manipulate us, or the clever regulators who try to control their tricks? Are they not acting rationally?[18]

We are not hopeless at running our lives, but we are not perfect. Are we good enough to be autonomous? To start to answer that question, remember that autonomy and reason must be connected in some way. Entities that are incapable of thought and actions at all, such as stones or amoeba, are not autonomous. Young children can think and act, but it is widely accepted that they are not rational enough to be autonomous. Adults who are blind drunk when they try to join the Foreign Legion, or in hypothermic shock when they remove all their clothes on a cold, wet hillside, are also not acting autonomously. While we should not assume that any apparent deviation from some textbook account of rational decision-making is enough to make a choice either irrational or non-autonomous, we obviously do not want to say that all human, or even all adult human, behaviour is autonomous.

What makes someone not autonomous, in the examples of the preceding paragraph, is that they do not understand or appreciate their options, for instance because they are deluded, or that they do not act on a sensible appreciation due to a drastic loss of inhibition. Understanding, appreciating, maintaining control; however one wants to characterize these, they are matters of degree. One can understand more or less, appreciate more or less, be more or less in the grip of hazy or

[15] Wilson, for instance, thinks our conscious selves have some, but not complete, control. See *Strangers to Ourselves*, pp. 47–8.

[16] See e.g. Frank Tallis, *The Act of Living* (London: Little, Brown, 2021), pp. 64–5, on infantile needs. For a further example of powerful underlying preferences, which in this case break through ideological and moral commitments, see p. 197: 'Communal utopias, in which everyone is allowed to have sex with everyone else, have a tendency to fragment . . . or to revert to exclusivity and commitment. The fundamental problem that undermines all sexual utopias is that human beings fall in love, and when this happens they become jealous of rivals and possessive.'

[17] Sarah Conly, *Against Autonomy: Justifying Coercive Paternalism* (Cambridge: Cambridge University Press, 2013), p. 124.

[18] See the rational arms race, in Daniel C. Dennett, *Freedom Evolves* (New York: Viking, 2003), pp. 269–71.

impulsive thinking. As we saw in Chapter 7, the element of 'I rule me' in personal sovereignty calls for a threshold above which a choice is autonomous and below which it is not. We then come to a difficult question to which, I think it is fair to say, few feel they have a really good answer: how much does a choice have to have been understood, appreciated, and under the agent's control in order to be autonomous?

We will not get the answer just by thinking conceptually about autonomy. One option is to consider the close cousin of public health, clinical medicine, which has well-worked out doctrines of informed consent. Within clinical medicine, people are in effect sorted into two groups for the purposes of some decision: those who are competent, whose decisions to accept or refuse treatment are binding, and those who are incompetent, whose decisions are not binding. Embarrassingly for public health paternalists, nearly all adults are judged to be competent, and competent patients in clinical medicine have the power to refuse not only the treatments that would make them a bit healthier but also ones that would save their lives. Compare what is at stake in obesity or smoking. Obesity can cause Type 2 diabetes and it is argued that this fact helps justify food regulations; but patients may refuse bariatric surgery even though it would make their diabetes go away within days. Smoking reduces life expectancy by several years; but competent patients may refuse the dialysis necessary to save their lives now. If we took the analogy seriously between clinical medicine and public health, then paternalistic public health interventions would be hard to justify.

Writers in public health often say, correctly, that the doctrine of informed consent in clinical medicine is in some ways not suited to public health; but those ways are irrelevant to the point I am making. They are right that deciding whether to regulate the safety of food, medicine, or roads should not depend on getting the informed consent of each individual.[19] The reason is, though, that these involve public goods, and are therefore not entirely self-regarding, rather than because people are peculiarly unable to decide for themselves whether they want them. Moreover, in one way the disanalogy goes against public health. In the context of medicine, patients are often sick, confused, and frightened and so not ideally placed to decide for themselves; and yet the doctrine of informed consent says that the decision is theirs. By contrast, preventive public health measures usually try to head off diseases and are designed to affect the choices that people make when they are not sick, confused, and frightened. In that respect, the targets of public health are better placed to decide for themselves than patients are about their medical treatment.

If we are reasonable about what we require for autonomy and we have a nuanced appreciation of the evidence about what we are like, then it is hard to see

[19] Onora O'Neill, 'Informed Consent and Public Health', *Philosophical Transactions of the Royal Society of London. Series B: Biological Sciences* 359.1447 (2004): 1135. See also the discussion of self-binding in Chapter 8.

why we are not, in general, autonomous. Even if we are, though, it might be that unhealthy behaviour specifically is not autonomous. We shall consider two lines of argument: first, unhealthy behaviour is often addictive behaviour and, second, unhealthy behaviour is typically shaped by manipulation.

Addiction

Public health advocates often say, as a reason for regulation, that people can be addicted to tobacco, alcohol, many other legal and illegal drugs, gambling, and, possibly, sugar. How does addiction connect to a case for regulation? While they do not always set out their reasoning, one idea advocates have in mind is that addiction can be in itself harmful, when it includes distress, and another is that it can cause problems, such as cirrhosis of the liver from alcoholism or losing one's money from problem gambling.[20] They hope that regulations would reduce these harms. A yet further idea, which is the subject of this section, is that addictive behaviour is not voluntary or, as I shall interpret it, not autonomous. This idea is advanced explicitly by some writers and is implicit in the advocates' retort, to critics of the nanny state, that corporate interests push addictive products.[21]

As we saw in Chapter 4, consumers of unhealthy products are mostly not addicted, smokers being the exception. Public health regulations could therefore restrict the options of many people who are not addicts. If the regulations restrict the options of non-addicts, it would be a drawback, but not a decisive one because substantial benefits to a minority could outweigh the losses in autonomy and well-being for the majority. Whether any costs to the majority are outweighed would depend in part on whether the regulations infringed on the autonomy of the minority, and this is the point where addiction comes in. If the minority are addicts, and if addicts are not autonomous, then the regulations would not infringe on their autonomy. But if even the minority who were addicted were having their autonomous choices interfered with, the case for public health regulations would be that much weaker. Do addicts, then, make non-autonomous choices? What feature of addiction would mean that an addict is not autonomous?

[20] See e.g. Aaron Warnick, 'Loosening of Gambling Laws Raises Concerns for Addiction: 7% of Youth Develop Gambling Disorders', *The Nation's Health*, January 2022. See also Ashley N. Gearhardt, Carlos M. Grilo, Ralph J. DiLeone, Kelly D. Brownell, and Marc N. Potenza, 'Can Food Be Addictive? Public Health and Policy Implications', *Addiction* 106 (2011): 1208.

[21] One explicit example may be found in Robert E. Goodin, *No Smoking: The Ethical Issues* (Chicago: University of Chicago Press, 1990), pp. 29–30, whose argument that smoking was often involuntary was discussed in Chapter 6. For another example, James O'Brien writes, of gambling on fixed-odds betting terminals, 'the choice being exercised here is actually anything but free'. 'James O'Brien on Why the "Nanny State" is Nonsense', https://www.penguin.co.uk/articles/2019/05/james-o-brien-how-to-be-right-nanny-state (last accessed 7 June 2024).

The vital question is whether addicts have some compulsion to consume.[22] If they are, then plausibly they are not autonomous; if they are not compelled, they are autonomous. Why would addicts be compelled? One might take addiction to be a chronic, relapsing brain disease that entails uncontrollable consumption. One might see an addict as in the grip of a compulsion and akin to a castaway on a boat who drinks seawater, oblivious to its dangers.[23] One might see addicts as forced to consume to avoid the pains of withdrawal. These explanations need not be rivals. Perhaps the compulsion to consume or the symptoms of withdrawal together force consumption, and perhaps they are both aspects of a brain disease.[24] Before assessing the accuracy of these explanations, we might pause to wonder how the case for public health regulations is supposed to be helped by supposing that addicts are compelled to consume. Tax rises or restrictions on availability or portion control ought to have virtually no effect on the demand of consumers whose diseases or compulsions are entirely insensitive to costs and benefits. While the argument could be made that price-raising regulations would prevent people falling into the trap of addiction in the first place, many advocates in fact argue that they would reduce demand from existing consumers. They are right that demand falls with a rise in price, but it does not seem as if demand falls just because consumers, even addicted consumers, run out of money completely.[25] Those who consume less when prices rise are not addicts in the sense that they must consume.

Many writers have argued that addiction is neither a disease nor an irresistible compulsion. They cite the following about people who meet diagnostic criteria for addiction to drugs:[26]

[22] What about unwilling addicts whose first order desire is wanting to have drugs but whose second order desire is wishing they did not want to have drugs? Is this mismatch between their first and second order desires enough to make them not-autonomous? In brief, no. Our desires generally are not under our control. Think of trying and failing to acquire a taste for intellectual films or anchovies. What matters for autonomy is whether we can control how we act on our desires. See Roy F. Baumeister, 'Addiction, Cigarette Smoking, and Voluntary Control of Action: Do Cigarette Smokers Lose Their Free Will?', *Addictive Behaviors Reports* 5 (2017): 79. Note that Harry Frankfurt, from whom the idea of the unwilling addict often derives, assumed that addicts could not stop consuming (his answer to what I am saying is the vital question). See Harry Frankfurt, 'Freedom of the Will and the Concept of a Person', in his *The Importance of What We Care About* (Cambridge: Cambridge University Press, 1988), p. 17.

[23] The example is from Jon Elster, who goes on to argue that addicts are not like castaways because they are at least minimally rational, in being sensitive to costs and benefits. See Jon Elster, *Strong Feelings: Emotion, Addiction, and Human Behavior* (Cambridge, MA: MIT Press, 1999), pp. 136, 166–9.

[24] Bennett Foddy and Julian Savulescu describe this synthesis of different explanations in 'A Liberal Account of Addiction', *Philosophy, Psychiatry, & Psychology* 17 (2010): 2. However, Foddy and Savulescu go on to reject it as an accurate account of addiction.

[25] Elster, *Strong Feelings*, p. 168.

[26] See also the summary in Hanna Pickard 'The Puzzle of Addiction', in *The Routledge Handbook of Philosophy and Science of Addiction*, edited by Hanna Pickard and Serge H. Ahmed (Abingdon: Routledge, 2019), p. 11.

1. The majority quit cocaine and marijuana by their early 30s without medical intervention.[27]
2. People give up drugs when they otherwise stand to lose a great deal, such as their jobs as airline pilots or physicians.[28]
3. Lee Robins and colleagues studied over 400 American soldiers who had been addicted to opiates while in Vietnam during the War. After their return to the United States, only 12 per cent resumed their use at or above the level that met criteria for addiction.[29]
4. Higher prices reduce consumption of a drug, lower prices increase it.[30]
5. Drug treatment programs that use incentives for being clean are moderately effective even when the incentive is as small as a cinema ticket.[31]
6. As Roy Baumeister points out, smokers follow rules, such as obeying 'No Smoking' signs or bans on smoking in aircraft, and have quit in very high numbers. These sorts of behaviour are not involuntary.[32]

When people quit, they obviously cannot have been addicted in the sense that they were unable to quit. What about the ones who do not quit? It may be that they cannot quit or it may be that they could but do not want to. In the case of smokers, Baumeister is sceptical about whether anyone is unable to quit. He points out that the smokers who ought to find it hardest to quit are those who have smoked heavily for a long time; but they have amongst the highest quit rates. He rejects the idea that some smokers cannot quit because their willpower is so severely depleted. People with severely depleted willpower struggle to function at all, whereas smokers can park their cars, order from a menu, plan an afternoon's activities, and so on.[33] Moreover, Baumeister says, all smokers show the signs of voluntary behaviour, such as planning their consumption, and obeying social norms and rules.

What about dieting? Dieting for weight loss is not very successful. After an initial period, weight tends to return, often higher than it was before.[34] In a way, this cycle looks like the relapse of an addict. If, however, the reason for weight-cycling is physiological, such as changes to metabolism, rather than psychological, such as having irresistible appetite, then autonomy seems unaffected. People might autonomously consume food and drink at a level where their bodies adapt, making

[27] Gene M. Heyman, 'Deriving Addiction: An Analysis Based on Three Elementary Features of Making Choices', in Pickard and Ahmed (eds.), *Routledge Handbook of Philosophy and Science of Addiction*, pp. 30–2.
[28] Gene M. Heyman, *Addiction: A Disorder of Choice* (Cambridge, MA: Harvard University Press, 2009), p. 86.
[29] Heyman, *Addiction: A Disorder of Choice*, pp. 75–6.
[30] Elster, *Strong Feelings*, p. 168.
[31] Heyman, *Addiction: A Disorder of Choice*, pp. 105–7.
[32] Baumeister, 'Addiction, Cigarette Smoking, and Voluntary Control of Action'.
[33] Baumeister, 'Addiction, Cigarette Smoking, and Voluntary Control of Action', p. 79, and §4.6 generally.
[34] Toomath, *Fat Science*, ch. 1 is particularly illuminating.

it impossible thereafter to lose weight in more than the short term. They might autonomously consume afterwards even though their weight is not what they prefer. In this respect, they might be like an athlete who autonomously trains hard causing irreversible arthritis, and who then must adapt, autonomously, to the limitations on mobility that arthritis creates.

We can be sceptical about whether addiction undermines autonomy without thinking that changing unhealthy behaviour is always easy. Some people say they think about food all the time, are always hungry, and never feel full. Life for those of them who do not want to be heavy is a constant battle against temptations around them.[35] Some smokers describe their struggle in similar terms. I can see how people like these could be helped to fulfil their goals with fewer temptations around them. I can see, therefore, how they could benefit from public health regulations. But I have yet to see a persuasive argument for why they are not autonomous in the sense of personal sovereignty.

While I do not think we have proof that anyone is unable to quit, some such people might exist and they might not be autonomous.[36] At most, though, they would be a small subset of addicts. Since most unhealthy behaviour is not due to addiction, even in a stretched sense of 'addiction', the ones who cannot quit, if any, would be a small subset of a small subset. Addiction is not going to be a sound basis to claim that unhealthy behaviour is typically non-autonomous. Perhaps, though, some other factor undermines autonomy. The argument we now consider is that unhealthy behaviour is not autonomous because it is due to illness-promoting marketing.

Manipulation and Marketing

The Marlboro Man is one of the best-known examples of twentieth-century advertising. Real Men, like the lean, masculine cowboy in the advertisements, smoked Marlboro.[37] Real Men also did not care what a bunch of prissy doctors said about the dangers.[38] Less well known is that Marlboro cigarettes were originally marketed to women under the tagline 'Mild as May'. Filter tips were added to appeal to women, filter tips being thought feminine at the time, and coloured red to hide

[35] David A. Kessler, *The End of Overeating: Taking Control of Our Insatiable Appetite* (New York: Penguin, 2009), Introduction.

[36] Hanna Pickard and Steve Pierce write 'the stereotype of addiction as a chronic disorder, with little hope of recovery, is not an accurate picture for the general population. It is an accurate picture for psychiatric patients.' See their 'Addiction in Context', in *Addiction and Self-Control: Perspectives from Philosophy, Psychology, and Neuroscience*, edited by Neil Levy (Oxford: Oxford University Press, 2013), p. 166. These patients might, but might not, be unable to quit. See also Chapter 5 for discussion of this quotation.

[37] Marlboro cigarettes brought me much pleasure between the ages of 16 and 18 (when I gave up smoking).

[38] Several of the men portraying the cowboys died of lung cancer.

lipstick.[39] But in 1954, Marlboro only had around 1 per cent of the American market and so the firm switched to the Marlboro Man: 'The result would be nothing short of extraordinary, catapulting Marlboros from less than one percent of the cigarette market to the fourth-biggest brand in under a year, eventually becoming the top cigarette brand in the world.'[40] In 1955, the year the campaign was started, sales rose to $5 billion, which was a 3,241 per cent increase from the year before. Within two years, sales reached $20 billion.[41]

Unhealthy products are frequently marketed through sporting sponsorship. An Australian study of the 2013 State of Origin rugby league matches describes the marketing for firms such as KFC, Coca-Cola, XXXX beer, and TAB Sportsbet. Advertisements appeared on the match ball, the logos, the pitch, the electronic banners by the pitch, in the television commentary, on screen-based pop-ups, and, of course, in the commercial breaks.[42] Sports sponsorship not only attracts attention, it also aligns products, including unhealthy ones, with healthy activities. Furthermore, the emotional power of a sporting event, according to some, creates a heart-mind connection between sponsorship and audience.[43]

Tobacco marketing is now illegal or heavily restricted in many rich countries, but huge amounts are spent on promoting unhealthy foods and sugary drinks, alcohol, and gambling.[44] Nor is marketing confined to private sector firms in capitalist societies. The Milk Marketing Board, a British legislatively established producer group, invented the bogus-historical Ploughman's Lunch in the 1960s to shift more cheese.[45] The state tobacco near-monopoly in semi-capitalist China enthusiastically promotes its cigarettes.[46] From the point of view

[39] Aria Bendix, 'Vintage Ads Show the Hidden Legacy of the Marlboro Man. The Brand First Became Popular as a Women's Cigarette', *Business Insider*, 21 February 2020, available at https://www.businessinsider.com/marlboro-man-cigarette-brand-history-vintage-ads-2020-2 (last accessed 17 June 2024).

[40] Brian VanHooker, 'An Unfiltered Oral History of the Marlboro Man', *mel*, 5 November 2019, https://melmagazine.com/en-us/story/an-unfiltered-oral-history-of-the-marlboro-man (last accessed 7 June 2024).

[41] Kurian M. Thakaran 'The Malboro Man Misses His Lung', *Strategy Peak* (no date), https://strategypeak.com/the-marlboro-man-misses-his-lung/ (last accessed 7 June 2024).

[42] S. Lindsay, S. Thomas, S. Lewis, K. Westberg, R. Moodie, and S. Jones, 'Eat, Drink and Gamble: Marketing Messages about "Risky" Products in an Australian Major Sporting Series', *BMC Public Health* 13 (2013): 1.

[43] Jill Sherriff, Denise Griffiths, and Mike Daube, 'Cricket: Notching Up Runs for Food and Alcohol Companies?', *Australian and New Zealand Journal of Public Health* 34 (2010): 19.

[44] But in case we think of all corporate advertising as the work of controlling masterminds, consider Schlitz's disastrous advertising campaign, known in the business as 'Drink Schlitz or I'll Kill you', that helped cause the demise of the brand. See W. J. Rorabaugh, *Prohibition: A Very Short Introduction* (Oxford: Oxford University Press, 2018), p. 116. You can see one of the advertisements here: 'Schlitz, 1977 12 11, Wilderness Man and Cougar', https://www.youtube.com/watch?v=f_baloTGt5M (last accessed 20 June 2024).

[45] 'Food of the Frauds', *The Economist*, 20 December 2022. Amongst other modern bogus-historical inventions, this article cites Swiss fondue, ciabatta, Bailey's Irish Cream, and salmon sushi.

[46] F. Wang, P. Zheng, B. Freeman, and S. Chapman, 'Chinese Tobacco Companies' Social Media Marketing Strategies', *Tobacco Control* 24 (2015): 408–9.

of public health advocates, all this marketing amounts to a massive effort at 'illness promotion'.[47]

Naturally, the advocates object to promoting illness because they think that unhealthy consumption is bad for people, but they also object because they think that the enormous efforts of marketers interfere with people's decision-making. Let me give some examples of what these advocates say. Margaret Whitehead, in a massively cited article on health equity, recommends restricting marketing for unhealthy products to 'enable people to adopt healthier lifestyles'.[48] She thinks that targeting young working-class men with alcohol advertising and young women with tobacco promotion 'puts them under greater pressure than others to consume these products'.[49] While she does not explain what she means by 'pressure', or how the marketing of unhealthy products disables people from adopting a healthier lifestyle, she cannot mean the pressure of a threat.[50] Her answer is probably that marketing manipulates people so that, when they consume unhealthy products, they do not act autonomously. Bruce Laurence writes that 'shaping people's choices should not be seen as state overreach or disrespectful of individual autonomy, when it is used to support those whose choices are . . . driven by powerful cultural and commercial forces'.[51] David Kessler writes: 'With its ability to create superstimuli, coupled with its marketing prowess, the [food and drink] industry has cracked the code of conditioned hypereating and learned exactly how to manipulate our eating behavior.'[52] These writers, amongst many others, criticize marketing for manipulating people. Notice that to criticize marketing for manipulating differs from criticizing marketing for increasing the consumption of unhealthy products.[53] A slogan on the side of a shop that says 'Cigarettes (or

[47] Stephen Holland, *Public Health Ethics*, 2nd ed. (Cambridge: Polity Press, 2014), p. 295. See also M. Steele, M. Mialon, S. Browne, N. Campbell, and F. Finucane, 'Obesity, Public Health Ethics and the Nanny State', *Ethics, Medicine and Public Health* 19 (2021). The authors explicitly claim (pp. 4–5) that food advertising manipulates and infringes on liberty.

[48] Margaret Whitehead, 'The Concepts and Principles of Equity and Health', *Health Promotion International* 6 (1991): 223.

[49] Whitehead, 'The Concepts and Principles of Equity and Health', p. 220.

[50] Some public health advocates do seem to think people are pressured by cheaper prices, for instance through two-for-one deals or happy hours for alcohol. See e.g. Toomath, *Fat Science*, p. 111. However, buying more of something because it becomes cheaper is generally rational and lower prices leave one with more options, assuming a limited budget, so these advocates owe us an explanation of how lower prices are either manipulative or otherwise pressurizing. The recent phenomenon of shrinkflation (e.g. smaller boxes of chocolates for the same price) may alleviate concerns about upsizing and supersizing. See 'The Shrinkflation State', *The Economist*, 19 February 2022.

[51] Bruce Laurence, 'Health, Paternalism, and the "Nanny State": A View from the Frontline', in *Perspectives on Paternalism and Public Health*, edited by Jonathan Parry, Farhang Tahzib, and Jessica Begon (Faculty of Public Health: 2022), p. 21. Laurence seems to count advertising as one of these powerful forces, but not one so powerful that it deprives individuals of all agency. See p. 23.

[52] David Kessler, *The End of Overeating*, p. 244.

[53] Both can be found in public health advocacy, often in the arguments of the same advocate, such as Lawrence O. Gostin in his case for regulating cigarette advertising. Lawrence O. Gostin, *Public Health Law: Power, Duty, Restraint* (Berkeley and Los Angeles: University of California Press, 2000), pp. 167–71. As a parallel, recall, in the section on addiction, the distinction between 'addiction is bad because it causes unhealthy consumption' and 'addiction is bad because it undermines autonomy'.

heroin) sold here' might increase unhealthy consumption but the slogan would not be manipulative if it simply communicates truthful information. It is the idea of manipulation we shall focus on in the rest of this chapter, and in the specific context of marketing.

Marketing to children is a leading target of public health advocates, who say that children are too mentally undeveloped to evaluate critically the marketing that is targeted at them.[54] It is possible that the advocates exaggerate the effects of marketing on children's consumption.[55] They might also not pay enough attention to the considerable differences between 4-year-olds and 14-year-olds when it comes to their gullibility. However, as usual, I shall set aside children and concentrate on marketing as it affects adults.

While many writers confidently believe it to be obvious that even adults' choices cannot be autonomous when so much money is spent on demonstrably effective marketing, other writers disagree and confidently assert that for the most part we are not manipulated by marketing. I am not confident either way, but I do not think that public health advocates have the evidence they need for their claims of manipulation. Establishing whether people are manipulated into acting in unhealthy ways is not easy because manipulation is an elusive concept and because the causal claims are difficult to verify. The confident answers overlook the complexities, as I shall show. We begin with the concept of manipulation and its ethical significance. We then see why it is hard to justify confident answers about whether we are manipulated into unhealthy consumption.

What Is Manipulation and Why Does It Matter?

Manipulation is a pejorative term and implies that manipulating people is generally wrong. Because manipulation is a pejorative term, we cannot be completely free to stipulate a meaning because its definition must maintain contact with its being morally suspect. In my analysis, which I shall keep brief, an influence is manipulative if and only if it meets four conditions: agency, intention, method, and success.[56]

The agency condition says that manipulation must be done by agents. Thus we cannot be manipulated by non-agents such as natural forces. The intention

[54] Mary Story and Simone French, 'Food Advertising and Marketing Directed at Children and Adolescents in the US', *International Journal of Behavioral Nutrition and Physical Activity* 1 (2004): 1.

[55] On exaggeration, see Pauline M. Ippolito 'Regulation of Food Advertising', in *Oxford Handbook of the Social Science of Obesity*, edited by John Cawley (Oxford: Oxford University Press, 2011). Ippolito writes: 'Certainly, the mix of food ads that children see today [i.e. when childhood obesity rates were high] does not represent a well-balanced diet; but this was also true in 1977, when few children were obese.' See p. 747. 1977 was around the time of an ill-fated regulatory attempt in the United States to limit advertising of sugary foods on children's television.

[56] I say a lot more in T. M. Wilkinson, 'Nudging and Manipulation', *Political Studies* 61 (2013): 341.

condition says that the agents must in some sense intend to influence their targets.[57] If you copy my behaviour, my behaviour has influenced you; but if I did not intend you to copy me, I did not manipulate you. However, not every intentional influence is a form of manipulation. You would not manipulate me if you shouted a truthful warning not to cross an unsafe bridge and I, hearing your warning, decided not to cross it. Hence some influences are manipulative, others are not. That leads us to a methods condition: the agent tries to shape the target's decisions, beliefs, emotions, values, or desires using some method that is manipulative. Lying is one method that is generally manipulative, although it is likely to be a limited problem in advertising and marketing given the regulatory constraints on deception.[58] However, a manipulator has many other methods to choose from.[59] A difficulty, when it comes to non-deceptive influences, is deciding whether and why they are manipulative, and this difficulty is, as I shall explain, one reason not to be confident that unhealthy consumption is due to manipulation.

Finally, manipulation has a success condition: for manipulation to occur, the target must have been manipulated. Put another way, A can act manipulatively towards B, and yet B would not be manipulated by A if A's attempt failed. This condition is very important in assessing many of the claims that people are manipulated. All too often, these claims are based only on what the alleged manipulators have said or done. The claims implicitly assume that people have fallen for the manipulator's tricks, but this assumption cannot be accepted without evidence. Moreover, as we shall see, even claims that are backed up by evidence are often inconclusive.

By way of example of these conditions, consider Iago, as he appears in Shakespeare's *Othello*. Iago is (1) an agent who (2) intentionally influences Othello, Cassio, Desdemona, and Roderigo. Iago (3) uses manipulative methods, such as suggestion and outright deception, that generally work through Iago's analyses of the characters' vulnerabilities. Finally, (4) he succeeds: the characters act as he wishes because of his manipulation.[60] Iago even obligingly tells us he is

[57] I realize that, since only agents have intentions, the intention condition entails agency. But I think it is helpful, in thinking through manipulation, to ask 'is an agent doing it? If so, do they have manipulative intentions?'.

[58] See e.g. 'Misleading Advertising', §3 of the United Kingdom's Advertising Standards Authority code, https://www.asa.org.uk/type/non_broadcast/code_section/03.html (last accessed 15 May 2023). Not all lying has the intent to deceive. The United Kingdom's then-Minister of Defence, Ben Wallace, described the promises of his Russian counterpart as 'vran'e.' "Vran'e" I think is sort of a demonstration of bullying or strength: I'm going to lie to you. You know I'm lying. I know you know I'm lying, and I'm still going to lie to you. He knew I knew, and I knew he knew. But I think it was about saying: I'm powerful.' As reported in Karla Adam, 'Putin Threatened to Kill Me, Britain's Boris Johnson Said', *Washington Post*, 30 January 2023, https://www.washingtonpost.com/world/2023/01/30/boris-johnson-putin-missile-strike/ (last accessed 7 June 2024).

[59] A classic presentation is Robert B. Cialdini, *Influence: The Psychology of Persuasion* (New York: Collins Business, 2007).

[60] As we know from what the characters say and do. See, for instance, Othello's appalling opening soliloquy in Act Five, Scene Two.

manipulating them, for instance in Act One, Scene Three, where he says, 'Thus do I ever make my fool my purse'. Iago's soliloquies avoid the problem of determining whether someone has a manipulative intention. In real life, people tend not to admit or agree that they are manipulating. They might, for instance, say they were merely informing, not manipulating.

As I said, manipulation is a pejorative term. Manipulation may be wrongly against the target's interests, betray trust, conflict with authenticity, or express a vicious attitude on the part of the manipulator. But the leading explanation of its wrongness is that manipulation infringes on autonomy.[61] Manipulation infringes on autonomy because autonomy requires self-rule and self-rule requires being free from the control of a manipulator. It is important to see that the problem with manipulation does not lie just in the mistaken thinking manipulation might produce. One can make mistakes for all sorts of reasons and remain autonomous. The point is that manipulation (like coercion) is especially damaging to autonomy because it is a form of intentional control by other agents. In Joseph Raz's terms, manipulation (like coercion) violates independence from the will of others, a dimension of autonomy.[62] As Daniel Hausman and Brynn Welch put it: 'Even when unshaped choices would have been just as strongly influenced by deliberative flaws, calculated shaping of choices still imposes the will of one agent on another.'[63]

Many of us care not only about the outcomes of our decisions but how they are shaped by other people. However, not everyone can see why we should care. Eldar Shafir, whose ideas were discussed in the opening section of this chapter, thinks one's autonomy is no more reduced by being intentionally manipulated than by having one's behaviour influenced non-intentionally, say by the weather. He does not have an argument for why intention does not matter, only the observation that an outcome that is in some way inconsistent or an error in our decisions could be the same whether it is the result of intentional influence or not. Correct though that observation is, it presupposes what is being denied, that it is irrelevant to our autonomy whether any mistakes we make come about through intentional control by other people. To see how deeply we feel that the control of others especially infringes on our autonomy, let me take advantage of Shafir's opening observation in his article. Shafir describes quirks in our linguistic and perceptual processing (such as falling for optical illusions), our sense of navigation, and our memory. He then claims that people who have these quirks pointed out to them do not mind and are indeed amused, and he contrasts this insouciant attitude with the insult that we feel when problems with our decision making are drawn to our attention.[64]

[61] See e.g. Allen W. Wood, 'Coercion, Manipulation, Exploitation', in *Manipulation: Theory and Practice*, edited by Christian Coons and Michael Weber (New York: Oxford University Press, 2014), p. 31.

[62] Joseph Raz, *The Morality of Freedom* (Oxford: Clarendon Press, 1986), pp. 377–8.

[63] Daniel M. Hausman and Brynn Welch, 'Debate: To Nudge or Not to Nudge', *Journal of Political Philosophy* 18 (2010): 133.

[64] Shafir, 'Manipulated as a Way of Life', pp. 246–8.

Suppose, though, we feel tricked into doubting our memories and the evidence of our senses. We would think this is worse, more of an attack on us, than if we formed the same beliefs as result of the quirks alone with no intentional influence. Put another way, a failure of memory is one thing, and gaslighting another.[65]

In summary, to assert that unhealthy behaviour is due to manipulation is to make both a causal and a conceptual claim. The manipulation claim requires that the target decide because (a causal claim) her decision is perverted (a conceptual claim) by the manipulative act, so telling whether someone has been manipulated requires telling whether that person's decision was both caused by the manipulative act and in some perverted way.

Are We Manipulated into Unhealthy Behaviour? Confident Answers Are Unjustified

Some writers are confident that manipulative marketing in capitalist societies greatly affects consumption generally.[66] Others are confident that manipulative marketing is a powerful cause of unhealthy consumption specifically.[67] Some are confident of both. For instance, Gerard Hastings regards consumers generally as engaging in 'voluntary servitude'[68] and believes marketing, which he calls 'corporate power', to be a necessary cause of smoking, alcohol misuse, and obesity, a cause he clearly considers manipulative.[69] I think the confidence is unjustified. A lot of bad, or at least incomplete, reasons have been given to think that people are manipulated. The difficulties in both gathering empirical evidence and attributing manipulation mean that we should be doubtful about manipulation arguments. Notice that I am not arguing that manipulation never occurs, and I am leaving it open that evidence could be found that it is widespread.

We have some general grounds for being sceptical about whether people are manipulated into long-term unhealthy behaviour. To some degree, perhaps a high

[65] 'Gaslight' was a play by Patrick Hamilton, who was mentioned in Chapter 6.

[66] Amongst philosophers, see G. A. Cohen, *Karl Marx's Theory of History: A Defence* (Oxford: Clarendon Press, 1979), ch. 11, esp. §7; and Wood, 'Coercion, Manipulation, Exploitation', esp. p. 38. Wood makes many descriptive claims about market economies and the power and methods of advertising, but the only empirical sources he cites are the first volume of Karl Marx's *Capital* (published in 1867) and the obedience to authority experiments of Stanley Milgram.

[67] Stephen Holland writes, 'We know full well the power of advertising', by which he means we know that it has a lot of power. See his *Public Health Ethics*, p. 273.

[68] Gerard Hastings, 'Public Health and the Value of Disobedience', *Public Health* 129 (2015): 1046. In part, Hastings's objection seems to be that firms find out what consumers want and then supply it to them. While I can see that some ways of finding out what consumers want might infringe on their privacy (although not if they involve volunteers, for instance in a focus group), I do not see how they thereby manipulate consumers nor why we should regard people who get what they want as being in servitude.

[69] Gerard Hastings, 'Why Corporate Power Is a Public Health Priority', *British Medical Journal* 345 (2012): 26.

degree, we are primed to be cautious of advertising or con artists. Fairy tales and folklore are full of the dangers of smooth talkers.[70] We are often cynical about advertising.[71] We learn too. For the most part, overdoses being the exception that comes to mind, our individual acts of consuming unhealthy products do not cause us ill health. Ill health is the cumulative effect of unhealthy behaviour over a long time. Over this time, we can tell that, for example, we are putting on weight and work out what is doing it, or we can receive counter-messages about the danger to our health. We are thus less likely to be manipulated over long periods than over short periods. To paraphrase Lincoln, you cannot fool everyone all of the time. It could be argued that regulating even short-run manipulation would be justified, and perhaps it would. But if the aim is to argue that consumption both causes ill health and is substantially due to manipulation, the causal story must extend from individual acts of consumption to individuals' acts over a long period of time.

Arguing that people are manipulated involves the conceptual problem of determining when an influence is manipulative and so we need to have at least a sense of what methods are manipulative and, ideally, why. Let me begin with some easy cases, starting with deception. I, like many, regard deception as a form of manipulation. I said earlier that regulation limits deception, including advertising that misleads, but some almost certainly gets through. Here is an example, which appears to be genuine, that was used in a study by Dixon et al.[72] The advertisement promoted a children's snack. It had a voiceover that said '40 per cent less sugar than other leading kids' snack products', although it was talking about unhealthy 'ultra-processed, sugary "fruit" snacks'. Parents who saw this misleading advertisement rated the health of the product higher than ones who did not. One can see how this sort of advertisement can manipulate through deception. It is an easy case. Another easy case, that contrasts with deception, is advertising that gives true information, such as where to buy a product and the genuine advantages of doing so. Truthful advertising would generally not be manipulative.

What about methods that appear neither deceptive nor give truthful information? These are harder to decide. Consider another example from Dixon et al.'s study. A group of parents saw an advertisement with a puppet sprinkling jelly sweets over a crowd of happy 'dyads' (such as fathers and young sons). This advertisement does not seem deceptive since lolly scrambles are fun and jelly sweets can

[70] Daniel C. Dennett, *Elbow Room: The Varieties of Free Will Worth Wanting*, new ed. (Cambridge, MA: MIT Press, 2015), pp. 202–3.

[71] Avner Offer, *The Challenge of Affluence: Self-Control and Well-Being in the United States and Britain since 1950* (Oxford: Oxford University Press, 2006), pp. 121–2. *The Economist* reports a survey of Gen Zers (born roughly between 1996 and 2010) in six countries. The survey found that 70 per cent fact check the claim made in advertisements. See 'Buying Time', *The Economist*, 21 January 2023.

[72] Helen Dixon, Maree Scully, Claudia Gascoyne, and Melanie Wakefield, 'Can Counter-Advertising Diminish Persuasive Effects of Conventional and Pseudo-Healthy Unhealthy Food Product Advertising on Parents?: An Experimental Study', *BMC Public Health* 20 (2020): 5. I am grateful to Helen Dixon and Maree Scully for helping me understand their work.

make parents and children happy.[73] But perhaps associating the sweets with happy families is in some way manipulative. Tim Lobstein, in discussing food marketing, says that it has two purposes. The first is to provide information, which is presumably non-manipulative, but the second is to induce positive feelings. Quite likely, the point of the sweet-sprinkling puppet was to induce positive feelings towards the sweets. Lobstein writes that, compared with providing information, inducing positive feelings 'is more contentious as it works largely at an unconscious, subliminal level, and operates outside the classical market assumption of a purchaser making a purely rational choice'.[74] Cass Sunstein writes: 'A statement or action can be said to be manipulative if it does not sufficiently engage or appeal to people's capacity for reflective and deliberative choice.'[75] Putting Lobstein and Sunstein's ideas together, the implication is that intentional influences would be manipulative unless they operated through conscious, rational, reflective deliberation.[76] I am doubtful about this account of manipulation.

Some writers assume that if an influence shapes behaviour in a non-deliberative way, then the behaviour is not autonomous.[77] But we saw earlier that deliberating and reflecting are not necessary for decisions to be autonomous. Underlying this idea are theories and evidence about how our attention is necessarily limited given our capacities and the vast number of stimuli in our environment. We use heuristics, unconscious processing, and emotions to direct our focus and make quick decisions in ways that are frequently highly effective, although they can lend themselves to being manipulated.[78] However, we certainly do not want to say that it is always manipulative to work through people's heuristics, unconscious processing, or emotions. By way of example, you need to know something about how people think if you have ideas you want to get across. For instance, the headings and paragraphs in this book are designed to make it easier to read and more attractive for readers than a single wall of unbroken text, and what is wrong with that? Or take

[73] As it happens, the misleading advertisement for the healthiness of the processed fruit snack appeared to have less effect than the jelly sweet advertisement.

[74] Tim Lobstein, 'Foreword', in *The Psychology of Food Marketing and (Over)eating*, edited by Frans Folkvord (Abingdon: Routledge, 2019), p. 1.

[75] Cass R. Sunstein, 'Fifty Shades of Manipulation', *Journal of Marketing Behavior* 1 (2015): 1. Deception often does engage our deliberative and reflective capacities because we weigh up whether we think the speaker was telling the truth, so if deception is a form of manipulation, it is a counterexample to Sunstein's definition.

[76] Sunstein would qualify 'operated through … deliberation' with 'sufficiently', which means he could avoid the objection that influences that do not work entirely through conscious, rational deliberation need not manipulate us. But the (understandable) vagueness of 'sufficiency' leads straight to my claim that we do not have a general account of manipulation that gives us the right answers in difficult cases. How much rational deliberation is 'sufficient'?

[77] Steele et al., 'Obesity, Public Health Ethics and the Nanny State', pp. 4, 5.

[78] As an example of manipulation, Robert Cialdini tells us of a salesman of fire alarms who would visit potential customers in their homes, deliberately leave a folder in his car, get their permission to retrieve it and let himself back in, and thereby create a bogus feeling of trust in customers. See Robert Cialdini, *Pre-Suasion: A Revolutionary Way to Influence and Persuade* (London: Random House Books, 2016), pp. 6–7.

framing information, which is sometimes treated as if it were obviously manipulative. Framing can be a way to enhance as well as reduce understanding. If you want people to understand a risk, for example, it is better to explain it in absolute terms (e.g. 'Your risk is 1\1000') rather than relative terms (e.g. 'Your risk will increase by 15 per cent').[79]

I am inclined to think we have no adequate generally applicable account of what manipulation is.[80] I do think, though, that we can engage in case-by-case evaluation and, in some of these, the answers will be clear. A sign in a shop selling alcohol that says 'Beer Chiller' tells you where beer is to be found; it does not manipulate you into buying it. A bait and switch, by contrast, is clearly manipulative. It tries to lure someone with a cheap price for a product or service that turns out to be 'unavailable' when the customer tries to buy it. The aim is to prime the customer to buy something else. Perhaps less clear is product placement. Think of a pile of books on a table in a bookshop with a notice saying 'staff picks'. One can tell a story in which the pile is manipulative (the consumer blindly buys) and a story in which it is not (it helps consumers choose from a giant selection).[81]

At least some marketing for unhealthy products will use manipulative methods. It is another question, though, whether it manipulates people or even affects them at all. The assertions that consumers are manipulated are often based on little more than describing some marketing tricks or the writer's interpretation of an advertisement.[82] Take the anti-consumerists described by Dixon et al.: 'Anti-consumerists criticise advertising for its use of unrealistic, escapist messages that exploit people's insecurities by implying that owning advertised products will enhance a person's image, popularity and happiness.'[83] In this description, the anti-consumerists focus on the message but do not give us evidence of its effects. Here are two examples from writings on public health. Robyn Toomath, in her criticism of the marketing of food and drink, cites such tricks as product placement in supermarkets, celebrity endorsements, and labelling a sugar-stuffed fruit smoothie as having 'no added sugar'.[84] But she only tells us what the marketers do, not the effects of what they do on the consumer. Lawrence Gostin writes: 'Imagery in tobacco advertisements is not merely devoid of useful information, but also misleads

[79] John Paling, 'Strategies to Help Patients Understand Risks', *British Medical Journal* 327 (2003). See also my 'Nudging and Manipulation', pp. 348–9.

[80] See my 'Nudging and Manipulation', pp. 349–51. For more on the difficulties in generalizing about manipulation, see Christian Coons and Michael Weber, 'Introduction', in their edited collection, *Manipulation*.

[81] Product placement could be described as a nudge, on which more in Chapter 10.

[82] This weakness appears to be quite widespread in the field of communications studies more generally. See Sonia Livingstone, 'Active Audiences? The Debate Progresses but Is Far from Resolved', *Communication Theory* 25 (2015): 439.

[83] Dixon et al., 'Can Counter-Advertising Diminish Persuasive Effects?', p. 3. The authors, however, do not quite endorse this view and, since they did run an experiment, did not forget the need for evidence of effects.

[84] Toomath, *Fat Science*, pp. 111, 117.

the public. It can deceive consumers into believing that cigarette health warnings are exaggerated and that smoking is consistent with a robust and active existence.'[85] Gostin's assertion that the public are misled (a success claim) is based only on looking at the advertisements and interpreting them a particular way; notice too how he switches from the actual ('misleads') in the first sentence to the merely possible ('can deceive') in the second.

It is sometimes thought that advertising simply must manipulate because people are so exposed to it. In this context, consider the claim that by the age of 66 most of us will have seen about two million advertisements on television. But exposure might dull the effect: a 2007 ACNielsen phone poll of a thousand people found that the number of television advertisements the average person could recall was only 2.21.[86] Another argument is that industries spend enormous sums of money promoting products and they would not unless it increased demand. For example, Alcohol Action Ireland wrote: 'Alcohol sponsorship of sports works in terms of increasing sales and, as a result, alcohol consumption. If it didn't the alcohol industry simply would not spend so much money on it.'[87] As against this argument, Christopher Snowdon points out that that it is largely firms that spend money on advertising, rather than entire industries, and these firms compete with each other. He argues that, while advertising affects market share, it does not increase overall consumption except, perhaps, when products are new.[88] He bases his view on some evidence from mature markets, including for cigarettes and alcohol, that advertising does not increase consumption.[89] Snowdon's point is important. If we want to see whether marketing unhealthy products makes people less healthy than they would otherwise be, we need evidence that the marketing does not simply redistribute demand from one unhealthy product to another. Nonetheless, I think Snowdon may be, like Alcohol Action Ireland, too confident. An unchanging market demand could be held up by advertising that counteracts what would otherwise be a decline. Perhaps tobacco and alcohol sales would have fallen without the marketing.

Snowdon is sceptical about manipulation and he seems to think that people largely do what they really want and are relatively impervious to influence.[90] When

[85] Gostin, *Public Health Law*, p. 168.

[86] Both pieces of information are from the United States and reported in Martin Lindstrom, *Buyology: How Everything We Believe about Why We Buy Is Wrong* (New York: Random House, 2008), pp. 37–8. If we assume sixty years of viewing, two million advertisements works out at around eighteen per hour at five hours per day of watching. The reader may want to check whether this figure is accurate for their own country.

[87] Alcohol Action Ireland, quoted in Christopher Snowdon, *Killjoys: A Critique of Paternalism* (London: Institute of Economic Affairs, 2017), p. 91.

[88] Snowdon does not mention the possibility that by advertising a brand, firms also promote the product generally. Furthermore, Toomath, following Janet Hoek, asserts that one effect of food marketing is to normalize a diet high in fat, sugar, and salt. Toomath, *Fat Science*, p. 111.

[89] Snowdon, *Killjoys*, pp. 90–1.

[90] Snowdon, *Killjoys*, p. 111.

they smoke, drink, or overeat, that is what they really want to do. One of his arguments is that, if marketing were so powerful, then health promotion marketing would be effective, but it is not effective, so marketing is not so powerful.[91] This argument is not persuasive, and health promoters might retort that their health promotion does not stand much chance in the face of the vastly larger budgets of the illness promoters.

Plenty of empirical studies do address the question of how far marketing unhealthy products affects their consumption. It is, of course hard to establish causality. Some studies find that young people who were more exposed to alcohol marketing remembered brands better or had more intentions to drink, but the studies could not control for other factors, such as that the people who were more exposed to marketing came from backgrounds that independently made them more likely to be focused on drinking.[92] Even those that try to control for confounding factors tend to show lesser effects of marketing on adults than on the children and young adolescents who are out of scope in this chapter.[93] Controlled experiments, on the other hand, may not carry over to the real world. As an example, let us return to the study by Dixon et al. This study was partly about how advertising unhealthy products might get parents to buy them. Parents were shown advertisements, including the misleading one mentioned earlier for processed fruit snacks. The parents were to imagine buying a snack for their children and researchers then checked whether the parents were more likely to imagine buying unhealthy products than a control group who had not seen relevant advertising. The answer is that they were. Does the study show that advertising affects people? Yes, but only in an imaginary task. We do not know how the advertising would affect real buying behaviour, a limitation the authors are aware of.[94]

Suppose some marketing for unhealthy products would use what could reasonably be considered manipulative methods and suppose it does increase demand. It still does not follow that consumers were manipulated. Let me explain. Critics of marketing say that it associates products with fun, or celebrities.[95] Or that marketing sells people on brands. Or that advertisements merely grab attention and, in Gostin's words quoted earlier, are 'devoid of useful information'. We might be

[91] Snowdon, *Killjoys*, p. 90.
[92] Snowdon, *Killjoys*, p. 93.
[93] e.g. Peter Anderson, Avalon de Bruijn, Kathryn Angus, Ross Gordon, and Gerard Hastings, 'Impact of Alcohol Advertising and Media Exposure on Adolescent Alcohol Use: A Systematic Review of Longitudinal Studies', *Alcohol & Alcoholism* 44 (2009): 229. Emma Boyland et al. found no effects on adults of acute exposure to advertising, but did find a moderate effect for children. See Emma J. Boyland et al., 'Advertising as a Cue to Consume: A Systematic Review and Meta-Analysis of the Effects of Acute Exposure to Unhealthy Food and Nonalcoholic Beverage Advertising on Intake in Children and Adults', *American Journal of Clinical Nutrition* 103 (2016): 519.
[94] Dixon et al., 'Can Counter-Advertising Diminish Persuasive Effects?', p. 10.
[95] Christian Coons and Michael Weber cite celebrity endorsements as an example of manipulation without deception. See Coons and Weber (eds.), *Manipulation*, p. 11.

tempted to conclude, as the critics often do, that when such advertising works, it works at a subliminal level rather than by giving information. However, consumers could be getting information even from these sorts of marketing. Think about the consumer's point of view when deciding whether to buy a product. How can the consumer trust that it is any good? The producer's say-so is hardly disinterested. But bear in mind that, in a competitive market, consumers can switch from one supplier to another, which means they do not have to put up persistently with bad products. Consequently, firms will not want to spend money advertising products that, after consumers have tried them, they will not buy again. Thus even advertisements that appear to give no information tell consumers that the product exists, and that the firm advertising it must be confident of repeat sales, or else it would not put money into a marketing budget that would be wasted if consumers did not like the product. As for brands, they can acquire a value because they have a reputation, and consumers can see that the producer has an incentive to maintain its reputation and not rip them off.[96] Even celebrity endorsements give information. Celebrities have a reason to associate themselves only with products that are reasonably reliable, otherwise their reputation will suffer. When a celebrity endorses a product, that makes it more reasonable to think that the product does what it says. Of course, all this information may be unreliable, but it is nonetheless information to be gleaned and weighed. In sum, even advertisements that appear to use manipulative methods may bypass people's deliberation a lot less than a superficial reading of them would suggest.

We have been considering the idea, common amongst public health advocates, that steering people away from unhealthy consumption does not disrespect their autonomy because unhealthy choices are caused by commercial manipulation. If unhealthy choices were indeed the result of manipulation, then they would not be autonomous. But people might consume unhealthy products even in the absence of marketing, or they might consume more because of marketing, but not in a manipulated way, or they might be manipulated, but only into consuming in ways that are too isolated or short-run to cause ill health. Public health advocates who want to assert manipulation as a major factor in ill health need evidence that meets the following conditions: a substantial quantity of unhealthy consumption, over a long enough time to lead to ill health, is caused by marketing, and this cause operates in a manipulative way. The task of establishing that a cause operates in a manipulative way requires a conceptual justification that the method indeed is manipulative, and the concept of manipulation is not always easy to apply; and it requires evidence that consumers' choices were changed by the manipulative method, which cannot be assumed. We seem to have no body of evidence that

[96] Joseph Heath and Andrew Potter, *The Rebel Sell: How the Counterculture Became Consumer Culture* (Chichester: Capstone, 2005), pp. 215–16. They explain how branding offers protection. They also say that branding speaks to people's sense of identity (to which they do not object).

meets the conditions required to show that long-term unhealthy consumption is substantially due to manipulation.

Conclusion

Here is a summary of the last three chapters. In Chapter 7, we saw that autonomy is a value separate from well-being. Chapter 8 and this chapter have been about whether public health interventions would infringe on autonomy. Chapter 8 discussed arguments by public health advocates that interventions, such as taxes, bans, and restrictions on availability, would not infringe on autonomy because they are too minor, or increase autonomy, or are a form of autonomous self-binding. We saw that these arguments are not persuasive. This chapter has discussed arguments that public health interventions could not infringe on our autonomy because unhealthy consumption is not autonomous. According to the first of the arguments we considered, our actions generally are not autonomous. This conclusion rested on an implausibly demanding account of autonomy and an exaggerated view of the evidence. We then considered the argument that unhealthy products are often addictive. I pointed out that most consumers of these products are not addicted, and I argued that even the addicts tend to be autonomous. The final argument, which we have just concluded, is that unhealthy consumption is powerfully driven by manipulation. Once we understand the evidence needed to support this claim, we can see we do not have it. In sum, many of the measures that public health advocates want would infringe on autonomy. Since autonomy is of value, infringing on it poses a difficulty for the advocates' position. In principle, the difficulty could be overcome if what was lost in autonomy were more than compensated for by what was gained in well-being. In practice, though, paternalistic public health interventions would often make people worse off as well as infringe on their autonomy.

What we have not yet discussed, and postponed from Chapter 8, is health promotion, including pro-health manipulative marketing and the use of nudges. If these methods would manipulate people, then they would infringe on autonomy. However, we have seen that we should be sceptical about whether people are substantially manipulated, and I will carry the scepticism over into the next chapter. I give some grounds to doubt that nudges are generally manipulative. I also explain that, even when health promotion takes manipulative forms, it could be justified as counter-manipulation.

10
Nudges and Counter-Manipulation

Introduction

Taxing unhealthy products, banning them, or limiting their sales would, as we have seen in the last two chapters, tend to infringe on autonomy, at least when their aim is to make people be healthier. What we have postponed until now is discussing public health attempts to alter perceptions of options rather than restricting them. By 'attempts to alter perceptions', I mean to include such examples as a government minister informing people that smoking causes cancer,[1] a drugs and alcohol centre advising people to have no more than two drinks each week,[2] a dental council running social media advertisements in which a glamorous athlete recommends drinking water rather than sugary drinks,[3] a law requiring cigarette packets to display large pictures of gangrenous feet and blind, staring eyes,[4] and a government campaign advertising the healthy choices of talking balloons.[5]

Our question in this chapter is about whether and when public health attempts to alter perceptions would infringe on autonomy. Certainly not all would. When the governments of sixty years ago or so told people that smoking caused lung cancer, they altered perceptions. Many smokers rapidly changed how they thought of smoking and they gave up in droves.[6] But the British government, at least, was not trying to manipulate smokers or even discourage them; it aimed only to inform smokers so they could decide for themselves.[7] When information is both true and not misleading, no one can sensibly object on grounds of autonomy. However, some ways of altering perceptions are manipulative, and if people are manipulated then, as we saw in the previous chapter, their autonomy is infringed upon.

[1] See the description of Iain Macleod's smoke-filled press conference in Chapter 2.

[2] Holly Honderich, 'What's behind Canada's Drastic New Alcohol Guidance', *BBC News*, 18 January 2023, https://www.bbc.com/news/world-us-canada-64311705 (last accessed 7 June 2024).

[3] 'Eliza McCartney wants Kiwis to Switch from Soft Drinks to Water', *RNZ*, 2 November 2018, https://www.rnz.co.nz/national/programmes/afternoons/audio/2018669514/eliza-mccartney-wants-kiwis-to-switch-from-soft-drinks-to-water (last accessed 7 June 2024).

[4] Neelima Choahan, 'Update Graphic Images on Cigarette Packages to Remind of Health Risks, Experts Say', *News GP*, 9 July 2018, https://www1.racgp.org.au/newsgp/clinical/update-graphic-images-on-cigarette-packages-to-rem (last accessed 7 June 2024).

[5] Or possibly condoms, in an attempt to promote sexual health subliminally. It is hard to tell what they are. See the Australian Government's 'Swap it, Don't Stop It' campaign in *Adnews*, 16 March 2011, https://www.adnews.com.au/campaigns/swap-it-don-t-stop-it (last accessed 7 June 2024).

[6] See Chapter 5.

[7] V. Berridge, 'The Policy Response to the Smoking and Lung Cancer Connection in the 1950s and 1960s', *Historical Journal* 49 (2006): 1185.

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We begin with nudges for public health. A nudge is an attempt to change people's behaviour by making minor changes in their environments rather than by changing the costs and benefits of their options. Supporters and critics of nudges disagree about their effectiveness in public health and we shall touch on their disagreement before turning to our main question, whether nudges are manipulative. We shall assess nudges against the criteria for manipulation set out in Chapter 9 and see why nudges need not be as manipulative as the critics think. We next see examples in health promotion that really do seem manipulative. We ask what ethical difference it would make if, or when, health promotion is up against the widespread marketing of unhealthy products. The answer is that health promotion can sometimes be counter-manipulation. As counter-manipulation, even manipulative health promotion can be justifiable if it cancels out manipulation by illness promoters or if it replaces their manipulation into illness with its own manipulation into health.

Nudging

Richard Thaler and Cass Sunstein, the leading theorists and popularizers of nudges, define them this way: 'A nudge . . . is any aspect of the choice architecture that alters people's behavior in a predictable way without forbidding any options or significantly changing their economic incentives.'[8] This definition is a broad one.[9] While it would not be a nudge to try to change behaviour by making options illegal, or 'significantly' taxing or subsidizing them, it could be a nudge to give information, to censor, or to use any of a wide variety of the clever tricks of marketing. Other writers use nudging in the even broader sense of using psychological insights to make policy more effective.[10] Let us avoid getting bogged down in trying to define nudges precisely and instead have some of the nudge enthusiasts' examples. We will then consider a psychological account of how nudges might work or fail, a disagreement about whether nudges would make much difference in public health, and whether and when nudging might manipulate the nudged.

People have been nudged to save more for their old age by making the default for pensions opt out rather than opt in.[11] Hotel guests have been nudged to reuse their

[8] Richard Thaler and Cass R. Sunstein, *Nudge: Improving Decisions about Health, Wealth, and Happiness* (New Haven: Yale University Press, 2008), p. 6.

[9] Despite the breadth of Thaler and Sunstein's definition, many examples they think of as nudges, such as banning oneself from a casino, are not nudges as they define the term. See my 'Nudging', in *International Encyclopedia of Ethics*, edited by Hugh LaFollette (John Wiley & Sons Ltd., 2018).

[10] David Halpern, *Inside the Nudge Unit: How Small Changes Can Make a Big Difference* (London: W. H. Allen, 2015), pp. 318–19.

[11] Becky Morrison, 'How a Small Nudge Is Helping People Save for Their Retirement', *Civil Service Quarterly*, 22 October 2013, available at https://quarterly.blog.gov.uk/2013/10/22/how-a-small-nudge-is-helping-people-save-for-their-retirement/ (last accessed 7 June 2024).

towels by being told that most people like them do not use them just once before dropping them on the floor.[12] If we think about nudges to promote health, possibly the best known is the fictional Carolyn who, as a city's director of food services, could nudge schoolchildren into eating healthier foods by changing how they are placed in school cafeterias.[13] The real Auckland City Hospital has tried to nudge people to leave its carpark via the stairs and not the lift by painting footprints in the stairwell with inspiring messages on them (although the stairwell is dingy, which is an anti-nudge, and I have never crossed anyone on those stairs). Other examples of nudges for health include using smaller plates or containers to reduce the consumption of food and drinks, whether alcoholic or sugary; warning labels on cigarettes and alcohol bottles; plain packaging for cigarettes; and markings on roads and rails that subconsciously make people behave more carefully when driving or crossing the tracks.

Nudging, as set out by Thaler and Sunstein, forms part of a broader philosophy they call 'libertarian paternalism'. Libertarian paternalism has two features I want to mention here. The first is that it takes the good for people to be given by their preferences.[14] Libertarian paternalism holds that nudges should be used to correct people only when they choose the wrong means to their ends. The ends themselves are out of scope. The second feature is that nudging leaves people free to opt out. Thaler and Sunstein want opt-outs to be genuinely available because they want people to opt out of nudges that do not work for them. For Thaler and Sunstein, nudging has advantages over traditional command-and-control paternalism because it is more sensitive than are regulations and bans to the differences in people's interests.[15] For example (although it is not their example), mandatory saving schemes that pay out at 65 are no good for people expected to die by 40. With a nudge, by contrast, they might be auto-enrolled into a savings scheme that they can then opt out of. Furthermore, governments, like anyone, can make mistakes. If a government's nudges are misguided, whether paternalistic or aimed at the social good, people can opt out. The freedom to opt out is thus not one that Thaler and Sunstein regard as merely formal, something to be tossed at libertarian critics to assure them that the nudged still have some freedom. As we shall see, opt outs, and Thaler and Sunstein's attitude to them, are important to deciding whether nudges are manipulative.

Do nudges work? In part, the answer depends on why humans do what they do. In a rational choice economics model, people maximize the net benefits of

[12] Noah J. Goldstein, Robert B. Cialdini, and Vladas Griskevicius, 'A Room with a Viewpoint: Using Social Norms to Motivate Environmental Conservation in Hotels', *Journal of Consumer Research* 35 (2008): 472.

[13] Thaler and Sunstein, *Nudge*, pp. 1–2. Ironically, considering we are talking about health promotion, the Carolyn of their story may have had the nudge brainwave while drunk.

[14] Thaler and Sunstein, *Nudge*, p. 5.

[15] See e.g. Thaler and Sunstein, *Nudge*, pp. 186–7.

their choices. In some models of weak-willed behaviour or addiction, weak-willed people care too much about immediate costs and benefits, but their behaviour still responds to costs and benefits. On either account of behaviour, nudging would be largely ineffectual.[16] If policymakers want to change people's behaviour, they would have to add options, remove them, or change their costs and benefits. That is the idea presupposed by taxing cigarettes heavily and restricting the availability of alcohol and junk food. These are ways of making it harder, in the sense of more costly, for people to behave in unhealthy ways.

Thaler and Sunstein, by contrast, draw on modern social psychology and behavioural economics to conclude that behaviour is often governed by processes that are automatic rather than reflective or deliberative. They think these automatic processes can be exploited by policymakers to change behaviour without altering costs and benefits, in other words by nudging. Exploiting automatic processes sounds sinister, but a more favourable way to put the underlying idea is that we are humans, not desiccated calculating machines, and policies should be designed for us as we are, just as doors and toasters should be.

Costs and benefits must play at least some role in behaviour, so nudges could not completely determine what we do. Would they make people healthier at all? A few years ago, Richard Ashcroft described the evidence base for the effectiveness of nudges as 'pitiful'.[17] Have things moved on since then? Judging by a recent summary, they have, but not by as much as one would hope.[18] One can find plenty of studies, but a solid evidence base requires putting them together via a systematic review. A problem is that, as Marteau et al. write, 'the consequence of having no agreed definition and consistently applied terminology is particularly problematic for evidence synthesis'.[19] These authors do, though, cite a systematic review of how changing the size of portions, packages, or tableware affects people's choices of food, alcohol, and tobacco, and this review, they say, implies that nudges could reduce energy intake in the United Kingdom for adults by 12–16 per cent.[20] However, they enter the caveat that most of the studies in the systematic review were laboratory-based or field-based, and they may not generalize to the real world.

Some public health critics of nudges talk down their effectiveness. For instance, some writers in public health doubt that nudging would do much to reduce obesity.

[16] Although these models would allow that information, which does not change options, can change behaviour; and giving information probably fits in Thaler and Sunstein's definition of a nudge.

[17] R. E. Ashcroft, 'Doing Good by Stealth: Comments on "Salvaging the Concept of Nudge"', *Journal of Medical Ethics* 39 (2013): 494.

[18] Theresa M. Marteau, Paul C. Fletcher, Gareth J. Hollands, and Marcus R. Munafò, 'Changing Behavior by Changing Environments', in *The Handbook of Behavior Change*, edited by Martin S. Hagger, Linda D. Cameron, Nelli Hankonen, and Taru Lintunen (Cambridge: Cambridge University Press, 2020).

[19] Marteau et al., 'Changing Behavior by Changing Environments', p. 195.

[20] Marteau et al., 'Changing Behavior by Changing Environments', p. 202.

They believe that non-nudge changes, such as sugar taxes or ending agricultural subsidies, would work better. They think that politicians prefer nudges only because they are less politically controversial.[21] These critics of nudges object that they are a diversion.

As against this view I will make three points. First, the effectiveness of nudges depends on how they are defined. Nudges are more open to being criticized as ineffective when they are defined narrowly and less open to it when defined in the broader sense as using psychological insights to make policy more effective.[22] Second, nudges can lead to benefits that are worth having even if they are not huge. This response would be inadequate if nudges did displace other policies as opposed to supplement them, but the critics of nudges have not offered serious evidence of displacement, merely voiced their fears. Perhaps they should take what they can get. Third, we should remind ourselves of Thaler and Sunstein's point that command-and-control paternalism can itself make mistakes. People can opt out of nudges, so when nudges turn out not to change behaviour very much, the reason might be that people are in fact better off if they do not do as the nudges suggests. They may genuinely prefer unhealthy food, for instance. When a nudge does not change behaviour, we cannot assume that a sterner method is required. Perhaps the unchanged behaviour is for the best.

On the other hand, perhaps nudging would be an ineffective way to deal with unhealthy behaviour that turns out to be against people's interests. Nudging relies on people acting via their automatic mental processes rather than via deliberation. But problems such as smoking, excessive drinking, inactivity, and overeating may fall primarily in categories of temptation, weakness of will, and addiction, and these problems differ from taking the default option or using inaccurate probabilistic heuristics. Automatic processes can interact with temptation— think of looking with horror at an empty bag of absent-mindedly-eaten peanuts. But the question remains of how effective nudges will be in overcoming problems of the will.[23]

Let us suppose that nudges would change behaviour effectively and turn to our main question, whether nudging is manipulative.[24] If we do not like being

[21] Geoff Rayner and Tim Lang, 'Is Nudge an Effective Public Health Strategy to Tackle Obesity? No', *British Medical Journal* 342 (2011): 899.

[22] Halpern, *Inside the Nudge Unit*, pp. 315–24.

[23] Thaler himself says he has been unable to devise a nudge that would get people to lose much weight. See Richard H. Thaler, *Misbehaving: The Making of Behavioural Economics* (London: Penguin, 2015), p. 342.

[24] I should also mention these two criticisms of nudging when done by government agencies. The first criticism is that to nudge is to exercise power, that those who exercise power should be accountable, but that successful nudging would not be transparent enough to hold nudgers to account. See Riccardo Rebonato, *Taking Liberties: A Critical Examination of Libertarian Paternalism* (Basingstoke: Palgrave Macmillan, 2012), p. 147. The second criticism is that nudging is manipulative, and manipulation by governments is especially objectionable because, unlike private sector firms, they are supposed to serve us as citizens. See Mark D. White, *The Manipulation of Choice: Ethics and Libertarian Paternalism* (New York: Palgrave Macmillan, 2013), ch. 6. Both criticisms should be taken seriously, although

manipulated to buy things, why should we like it any better when our governments or public health agencies do it to us? Even public health advocates raise this question. Robyn Toomath, for instance, objects to nudging's 'unconscious nature' and writes, 'While these may be commonly used techniques in the world of marketing, should governments be engaging in the same unethical behaviour?'[25] In Toomath's view, if marketing techniques are unethical, they are unethical not just when private firms use them but also when governments use them.[26] Notice, though, that Toomath believes that commercial marketing techniques work, and work in manipulative ways. If she is wrong about the commercial techniques, as Chapter 9 gave grounds to believe, then the corollary of saying that the marketers' tactics are not manipulative is that the same tactics to promote health would not be manipulative.[27]

Are Nudges Manipulative?

We discussed manipulation at length in Chapter 9. As we saw, an influence must meet four conditions to manipulate: agency, intention, method, and success. That is, only agents manipulate, not non-agents such as the weather; the agent must intend to influence; the influence must involve a method that is manipulative; and the influence must succeed. Lying might be one example of manipulation, withholding information might be another, and so too might be setting defaults and relying on people's inertia not to change their behaviour from the default. As for what is wrong with manipulation, manipulators treat their targets as puppets. If their methods work, manipulators infringe on the autonomy of their targets because they impose their will upon them.

Some nudges seem (to me at least) clearly not manipulative. Consider using psychological insights to make complicated information accessible, as in Thaler and Sunstein's proposal to make mobile phone or credit card charges more understandable for consumers.[28] Their proposal aims to have information provided in a way that makes sense given how, psychologically, people absorb and

I think one can defend nudges against them. See my 'Libertarian Paternalism: A Review Essay', *Political Science* 67 (2015): 73.

[25] Robyn Toomath, *Fat Science: Why Diets and Exercise Don't Work—and What Does* (Auckland: Auckland University Press, 2016), p. 151.

[26] It is another question whether Toomath's objection to marketing on ethical grounds can be reconciled with her disbelief in freedom, which I reported in Chapter 9.

[27] In his *Killjoys: A Critique of Paternalism* (London: Institute of Economic Affairs, 2017), Christopher Snowdon resembles Toomath in treating commercial and pro-health marketing consistently. He differs from her in thinking that people are generally not manipulated by commercial marketing (p. 142) and he does not say that nudging is manipulative either. He does, however, think nudging is not very effective (p. 46).

[28] Thaler and Sunstein, *Nudge*, pp. 93–4.

process it. Recall also an example from the previous chapter. If you want people to understand a risk, it is better to explain it in absolute terms (e.g. 'Your risk is 1\1000') rather than relative terms (e.g. 'Your risk will increase by 15 per cent').[29] Presenting complicated information so people can understand it does not seem manipulative.

Some nudges seem as if they could be manipulative. Lying tends to be manipulative, and lying could be a nudge on Thaler and Sunstein's definition (not that they would recommend lying). How are we to differentiate manipulative from non-manipulative nudges? It would be convenient to have a clear conception of manipulation that we could apply to candidate nudges to determine when their method is manipulative. But we do not. The best I can offer is the approach I mentioned in Chapter 9, separating out nudges that look clearly manipulative, clearly not manipulative, and then not clearly either.

Nudges would not infringe on autonomy when they do not use a manipulative method, but even nudges that do use manipulative methods might not infringe for three further reasons. One is that they might not affect behaviour at all, so they would not meet the success condition for manipulation; but obviously such a nudge would be pointless. The second reason is that people may want to be nudged and the third is that the nudger may not have manipulative intentions.

People are often well aware of the limitations of their decision-making and want to get round them. In Chapter 8, we saw that people may want to bind themselves and, if they do, restricting their choices need not infringe on their autonomy. Equally, it makes an ethically relevant difference to assessing a nudge whether the targets agree with it, regardless of whether a nudge is manipulative. One might say that, if people agree to or with the nudges, their autonomy would remain unviolated even if they were manipulated. What of the people who did not agree? Some of them might not have noticed the nudge but would agree if asked. Plausibly their autonomy is not infringed upon. Others might oppose the nudge or would have had they noticed it. If the nudge was manipulative, then plausibly those who did or would oppose the nudge would have their autonomy infringed upon. Where some people want to be nudged in some way and others oppose being nudged in that way, one ethical consideration would be how many people wanted it and how many opposed it. I do not think we know how many people want to be nudged. When it came to self-binding, we saw in Chapter 8 that people tend not to want to have their options limited, but they might feel differently about nudging.[30]

[29] John Paling, 'Strategies to Help Patients Understand Risks', *British Medical Journal* 327 (2003): 745.

[30] Sunstein provided some very limited empirical evidence that they might want nudges in his article, '"Better Off, as Judged by Themselves": A Comment on Evaluating Nudges', *International Review of Economics* 65 (2018): 1.

I turn now to the intentions of the nudgers. Manipulation has an intention condition. I do not manipulate you if I do not intend to influence you, even if, as it happens, you are influenced by me. Nudgers who follow Thaler and Sunstein's approach obviously do intend to influence people. They intend to get them to act in line with their values. However, I want to argue that nudgers with the right intentions should not count as manipulating even the people they successfully nudge. Remember that nudges, by definition, leave people free to opt out, and remember that, for Thaler and Sunstein, this freedom is not merely formal. As they say, command-and-control paternalism can make mistakes, and they want opt-outs to be genuinely available. Their nudges thus take the form of 'A intends B to do X unless B wants not to' rather than the form of 'A intends B to do X'. I think nudgers who sincerely want people to opt out of unsuitable nudges are not imposing their will, so not manipulating.

Suppose that, while people have the formal freedom to opt out, in fact the nudging methods are so powerful that people go in the direction they are nudged and do not opt out even when the nudges are poorly designed or do not suit them. The argument could then be made, against the nudger, that while the nudger did not intend the result, the nudger is being reckless or negligent. If we go back to autonomy, which underlies our concern about manipulation, the anti-nudge argument could go like this: people are being steered a certain way as the result of the intentional actions of someone else. They do not see the options they have. True, the nudger did not intend them to fail to see their options, but if a nudger does not care (recklessness) or ought to have known better (negligence), the nudger has come close enough to manipulation to count as infringing on autonomy. So much can be conceded to the anti-nudge argument. However, we are considering nudgers who sincerely want people to opt out, so they cannot be reckless, by definition. Sincerely wanting an opt-out implies wanting people to have a genuine choice, which in turn implies avoiding methods that bypass choice. Nor need nudgers be negligent, if they make genuine efforts to find out what their nudges do to and for people. So I believe we can conclude the following: nudging is not manipulative when a nudger sincerely intends people to opt out of nudges that do not suit them and takes steps to find out whether people could opt out.

However, we should also bear in mind the following conclusion. If nudgers see opt-outs as merely formal and hope people will not think hard enough to opt out, then they could have an intention to manipulate. If their nudges were also manipulative and if they worked, then such nudgers would manipulate their targets. Suppose public health agencies use nudges with the sole aim of getting people to make healthier choices. Suppose their criterion for the success of a nudge is only how much more it gets people to make healthy choices and not at all whether it gets them to do what they really want. Then the public health agencies would have intentions that qualify as manipulative. And health promoters may indeed not be careful enough to avoid manipulating people. Geoffrey Rose wrote, years

ago, about his unease about attempts to persuade people, by which he meant manipulate them, into being healthier. He said: 'Such a misgiving is shared by few health educators, most of whom measure their success simply by the extent of behavioural change achieved, just as advertisers assess their success by an increase in sales of the product.'[31] If modern health educators use nudges, and they are as Rose describes them, then they could not say they sincerely intend people to opt out of being nudged.

Manipulative Health Promotion

Consider anti-smoking advertisements such as this one, paid for by the California Department of Health Services: a smooth youngish man at a black-tie event lights up a cigarette as a beautiful woman walks towards him; alas, his cigarette wilts; her face shows a flash of horror, then resignation, and she walks away. Then the same thing happens again, to three men in a row! The voiceover says: 'Now that medical researchers believe that cigarettes are a leading cause of [pause for effect] impotence, you're going to be looking at smoking a little differently. Cigarettes. Still think they're sexy?'[32] The advertisement is funny, to a non-smoker anyway, but a purist might think that using humour can be manipulative,[33] and even a non-purist might find the advertisement manipulative in playing on widespread male fears, in glossing over the distinction between being a 'leading cause of impotence' and impotence being likely to happen, and in showing remarkably young men being victims.[34]

Women have also been targeted in anti-smoking advertisements. In a British National Health Service advertisement, a man approaches a woman in a pub. The mutual attraction is obvious. He gets closer. He smells the cigarette smoke on her body, recoils, makes a helpless gesture at his not-especially-empty pint glass, and bolts off to the bar. The advertisement shows the slogan 'If you smoke, you stink'.[35]

[31] G. A. Rose, K.-T. Khaw, and M. Marmot, *Rose's Strategy of Preventive Medicine: The Complete Original Text* (Oxford: Oxford University Press, 2008), pp. 151–2. In the next section, we shall come back to this quotation, and Rose's qualification of what he says.

[32] The advertisement can be seen here: 'PSA Commercial Smoking Causes Impotence', https://www.youtube.com/watch?v=fYu8crlRe9g (last accessed 20 June 2024).

[33] H. Shabbir and D. Thwaites, 'The Use of Humor to Mask Deceptive Advertising: It's No Laughing Matter', *Journal of Advertising* 36 (2007).

[34] T. O. Tengs and N. D. Osgood, 'The Link between Smoking and Impotence: Two Decades of Evidence', *Preventive Medicine* 32 (2001): 447–52 show that the state of evidence at the time did not support the categorical claims made in the advertisement, although the authors concluded that the risk of impotence was a reason to avoid smoking. P.-A. Tengland mentions impotence and smoking as a potential example of manipulation in P.-A. Tengland, 'Behavior Change or Empowerment: On the Ethics of Health-Promotion Strategies', *Public Health Ethics* 5 (2012): 145.

[35] The advertisement can be seen here: 'If You Smoke, You Stink / Anti-Smoking PSA Video'. https://www.youtube.com/watch?v=I0RLuJO4YdE (last accessed 7 June 2024).

The advertisement is a lot less funny than the one about impotence but funnier than this Australian one.[36] A little boy walks into a train station hand-in-hand with his mother, who then disappears leaving him on his own. He looks around as commuters walk past and realizes he cannot see his mother, whereupon his face crumples and he burst into tears. The voice-over says: 'if this is how your child feels after losing you for a minute, just imagine if they lost you for life' and the camera pans to a poster saying 'Quit13: quit.org.au'. This advertisement is manipulative in triggering maternal guilt, euphemistically described as 'a strong emotional response' by a New York City health official.[37] It is also manipulative in implying, falsely, that mothers who smoke and have 3-year-old children are likely to die soon.[38]

If one wants to defend some instance of health promotion against the objection that it manipulates people, I see three options.[39] One could argue that it is not manipulative at all because it does not meet the conditions, set out earlier, for manipulation. This argument seems to me likely to succeed for the most part. Just as I gave reasons to doubt that people are manipulated by marketing for unhealthy products, so I am doubtful whether people are extensively manipulated by health promotion. One could also argue that in the cases where health promotion does manipulate people and thereby infringe on their autonomy, it makes them or other people so much better off that the loss in autonomy is outweighed. I am more doubtful about this line of argument given the value of autonomy. And finally, if these arguments fail, as they sometimes will, one could argue that the health promotion is counter-manipulative. It is counter-manipulation we now consider.

[36] Which can be found here: https://www.youtube.com/watch?v=SfAxUpeVhCg (last accessed 20 June 2024). New York health officials copied the advertisement and ran it in New York City too. See NBC, 'Anti-Smoking Ad Features Children, Targets Parents', 30 March 2009, available at https://www.nbcnewyork.com/news/local/new-anti-smoking-ad-features-children-targets-parents/1912866/ (last accessed 7 June 2024).

[37] Rich Schapiro and Bill Hutchinson, 'Australian Anti-Smoking Commercial Draws Howls as Boy Sobs for Mommy', *New York Daily News*, 5 April 2009.

[38] In a response to a complaint, the advertisers said: 'This advertisement was made after data from the Cancer Council Victoria identified almost one in three smokers in Victoria (approximately 211,000 people) have children under the age of 12, and every week 4 Victorians lose a parent under the age of 50 to a smoking-caused disease.' See the Advertising Standards Bureau decision, 12 November 2008, https://adstandards.com.au/sites/default/files/reports/459-08.pdf (last accessed 7 June 2024). The complaint was not upheld, perhaps for good reasons, but taking the Cancer Council's data at face value, and assuming one child per parent, around 200 smoking parents under 50 will die from smoking each year, which is only 0.1 per cent of the cohort, and many of those will not have pre-school children. As for complaints about being cruel to the child, who really did think he had been abandoned, a spokeswoman reportedly said that the end justified the means. See Schapiro and Hutchinson, 'Australian Anti-Smoking Commercial Draws Howls as Boy Sobs for Mommy'.

[39] One might also have to defend health promotion against the complaint that it stigmatizes people. The two advertisements involving women who smoke both seem stigmatizing to me, and one can find many other examples in health promotion. See e.g. D. S. Goldberg and R. M. Puhl, 'Obesity Stigma: A Failed and Ethically Dubious Strategy', *Hasting Center Report* 43 (2013): 5–6.

Counter-Manipulation

Health promoters frequently point out that people are subject to all sorts of manipulative 'illness promoting' influences by tobacco, alcohol, or food firms.[40] Geoffrey Rose, as we saw, had misgivings about health 'persuasion', but he also wrote: 'The difficulty is the massive amount of persuasion that comes from the other side. ("Drink more vodka!" "Drive bigger and faster cars!") Maybe freedom suffers less if it is attacked from both sides, not from only one. On that ground alone, I grudgingly allow that persuasion has some place in health education.'[41] One can see the appeal of using the tactics of the 'illness promoters' to counter their manipulative messages and thereby make people healthier. Take an influential description (but not quite endorsement) of counter-manipulation:

> [P]eople are already being manipulated in a plethora of ways. . . . This helps justify health promotion because the alternative is not complete freedom to choose one's health behaviours . . . health promotion is counter-manipulation, as opposed to manipulation proper; it is one of the myriad forces motivating our health behaviours, but one intended to counteract those forces that motivate unhealthy choices. . . . The social marketer [for health promotion] is merely levelling the playing field by combating 'illness promotion' with health promotion.[42]

I see two importantly distinct interpretations of counter-manipulation in this quotation. The first, which is suggested by such phrases as 'levelling the playing field'[43] and 'as opposed to manipulation proper', is that manipulative health promotion cancels out the manipulative promotion of unhealthy products and leaves people unmanipulated. To quote Rose's words again, 'maybe freedom suffers less if it is attacked from both sides, not from only one'. The second is that manipulative health promotion does manipulate people, but it is justified because they would be manipulated anyway, and it is better that they are healthy and manipulated than unhealthy and manipulated. Before we explore these two ways to understand counter-manipulation, I shall make a few remarks by way of background.

I want to compare counter-manipulation with what has been called 'counter-marketing'. Counter-marketing has been defined as involving 'campaigns that use health communications strategies to reduce the demand for unhealthy products

[40] See e.g. Stephen Holland, *Public Health Ethics* (2nd ed.) (Cambridge: Polity Press, 2014), pp. 294–5; Michael Marmot, *The Health Gap: The Challenge of an Unequal World* (London: Bloomsbury Publishing, 2015), p. 75.

[41] Rose, Khaw, and Marmot, *Rose's Strategy*, p. 151.

[42] Holland, *Public Health Ethics*, pp. 293–5.

[43] C. A. Womack also uses the phrase 'level the consumer playing field', in the context of counteracting food industry influences. C. A. Womack, 'Public Health and Obesity: When a Pound of Prevention Really is Worth an Ounce of Cure', *Public Health Ethics* 5 (2012): 224. Perhaps counter-manipulating equates to changing halves at half-time, the usual way in sport to deal with non-level playing fields.

by exposing the motives of their producers and portraying their marketing activities as outside the boundaries of civilised corporate behavior'.[44] One example of counter-marketing has been to expose the tobacco industry's manipulative tactics, such as glamorizing smoking and concealing and lying about the dangers of addiction and harm. Another has been to disparage by parody the marketing of brands, for instance in advertisements showing a Marlboro Man complaining about his missing lung.[45] Counter-marketing relates to counter-manipulation as follows: if it does not itself use manipulative tactics, then it is not the sort of counter-manipulation described in this chapter. In some cases, however, counter-marketing does use potentially manipulative tactics, for instance trying to redirect youthful rebelliousness away from smoking and against tobacco firms.[46] If so, it can fall under the sort of counter-manipulation described in this section, which aims to directly counteract marketing techniques on the other side. But counter-marketing is in one way narrower than the counter-manipulation described in this chapter. Counter-marketing directly attacks unhealthy marketing and so does not include every manipulative way to promote healthy behaviour. Trying to guilt trip parents into not smoking for the sake of their children is arguably manipulative, but it would not directly counteract a pro-smoking message if cigarette manufacturers have never tried to associate smoking with being a good parent. The guilt-tripping might be counter-manipulation but not counter-marketing.

Even in a world in which people are exposed to all sorts of manipulative influences that encourage unhealthy consumption, one might well feel uneasy about using similar tactics to promote health. Why not ban or otherwise regulate the marketing? Tobacco marketing is substantially banned in many rich countries and some countries ban television junk food advertisements before a certain time try to prevent or limit children's exposure. Would it not be better to prevent people being manipulated rather than try to manipulate them some other way? Or why not use taxes, bans, or subsidies to get people to make healthier choices? These measures, like bans on marketing, are at least transparent and open to political debate. By contrast, counter-manipulation might seem suspiciously unethical and risky. Why do it when other options are available?

First, manipulation might have a place when the government does not ban or regulate unhealthy behaviour. NGOs and government health bodies might be unable to persuade the government to act in these ways yet be independent enough to use their own manipulative tactics. Second, firms might find ways around such bans, as for years cigarette firms did with sports sponsorship. Third, bans

[44] P. C. Palmedo, L. Dorfman, S. Garza, E. Murphy, and N. Freudenberg, 'Countermarketing Alcohol and Unhealthy Food: An Effective Strategy for Preventing Noncommunicable Diseases? Lessons from Tobacco', *Annual Review of Public Health* 38 (2017): 119.

[45] Which can be seen in Kurian M. Tharakan, 'The Marlboro Man Misses His Lung', *Strategy Peak*, (no date) https://strategypeak.com/the-marlboro-man-misses-his-lung/ (last accessed 7 June 2024).

[46] Palmedo et al., 'Countermarketing Alcohol and Unhealthy Food'.

on unhealthy products are not a complete alternative to manipulation because they often lead to black markets rather than no markets. Education programmes in American schools may not have done a very good job of keeping children off drugs, but they were hardly made redundant by the fact that the drugs were illegal.[47]

A further reason for counter-manipulation, which I now explain, is that using manipulative tactics may, in some cases, prevent manipulation rather than add to it.

Preventing Manipulation

How might counter-manipulation prevent manipulation? Here are some ways, partly adapted from writings on free speech and commercial advertising:

1. Competing messages might jolt people into realizing there is a second side to the story. As a result, they no longer mindlessly accept the initial manipulation but nor do they mindlessly endorse the counter-manipulation message. Instead, they deliberate for themselves. On an optimistic Millian story, the one-sidedness of advocacy joined to competition is a good way to make people think for themselves.[48] Less optimistically, people might dismiss as lies or distortion what everyone said on a topic and move to a state of disbelief. Either way, they are no longer manipulated.
2. Competition may put people on their guard. The idea here is that their general attitude changes whereas the preceding point was about attitudes to specific messages. People might become sceptical voters or cynical consumers. It is harder to manipulate the wary.

   (1) and (2) prevent manipulation by putting people in a position where they deliberate for themselves. They do not take messages at face value. They evaluate with critical distance what they are told. They may in the end do what one side wants but they have not been manipulated into it because they have not been under the control of that side.
3. Messages may cancel each other out.[49] Perhaps so many messages are given that they become white noise.[50] (3) prevents manipulation in a different way from (1) and (2). Whereas (1) and (2) involved receiving the message and then evaluating it, (3) involves not receiving the message. No matter how

[47] Mark A. Kleiman, Jonathan P. Caulkins, and Angela Hawken, *Drugs and Drug Policy: What Everyone Needs to Know* (New York: Oxford University Press, 2011), pp. 76–7.
[48] J. S. Mill, *On Liberty* (Harmondsworth: Penguin, 1982), ch. 2.
[49] Daniel M. Hausman and Brynn Welch, 'Debate: To Nudge or not to Nudge', *Journal of Political Philosophy* 18 (2010): 131.
[50] See the evidence from Martin Lindstrom, *Buyology: How Everything We Believe about Why We Buy Is Wrong* (New York: Random House, 2008), pp. 37–8, discussed in Chapter 9.

clever your manipulatory telephone manner, I would not be manipulated if you try it on me when the line is dead.

4. Cancelling could also occur because competing messages give opposing reasons, as when competing firms denigrate each other's products. Counter-manipulation may then cause people to do what they would have done if no one was trying to manipulate them. Consider a possible health example. Suppose I would drink fourteen units of alcohol per week if I were exposed to no marketing at all. However, the alcohol industry convinces me that drinking will bring good cheer which, in the absence of further influence, would cause me to drink twenty-one units per week. Enter anti-alcohol marketing, which tells me that drinking more than two units per week risks my health. Suppose both sides exaggerate. I then weigh the promised good cheer against the promised health benefits and drink fourteen units per week. The anti-alcohol manipulation cancels out the pro-alcohol manipulation.

This final cancelling-out case differs from the others in being less clearly one where manipulation is removed. When I drink fourteen units as a compromise between two manipulative influences, I still act as the result of a manipulated process even though I do what neither the pro-alcohol or pro-health promoters would like and even though I do what I would have done if I were not manipulated at all. Arguably, the counter-manipulation still manipulates me. However, one might also say that the counter-manipulation enhances my autonomy in one respect, by preventing my actions being controlled by either pro- or anti-alcohol marketers, even as it damages my autonomy in another respect, by adding manipulated beliefs about the dangers of alcohol to manipulated beliefs about its benefits.

We have seen that counter-manipulation could block manipulation by stopping manipulative attempts from succeeding. Thus we have focused on what happens to the potential targets, not on what the manipulative agents are doing. If instead we evaluate the behaviour of those doing the counter-manipulating, it would be a mistake to think they are off the hook whenever their attempts do not cause people to be manipulated. One can be blameworthy for failed attempts to do wrong. But it matters what counter-manipulators think they are doing. On the one hand, some would realize that they are in a competition which would result in no manipulation; some indeed could welcome that result. It does not seem generally wrong or even manipulative to use manipulative methods when one has both the intention of preventing the target being manipulated and a reasonable belief that the method would prevent manipulation. On the other hand, health promoters who do try to manipulate would be doing something prima facie wrong even if, as it happened, their efforts did prevent manipulation.

The main aim in this section was to show how counter-manipulative health promotion may respect autonomy by preventing manipulation. Whether health

promotion in fact does prevent manipulation is in part an empirical question that turns on such matters as whether advertisements stick in our minds. What, though, if counter-manipulation does manipulate? Even then, we cannot assume that it would infringe upon the targets' autonomy because they might be manipulated already, and therefore not autonomous. This observation leads us to a new argument for counter-manipulation.

Manipulation for a Better Result

Consider this argument: counter-manipulation that manipulates people would leave them no more manipulated than they would otherwise be.[51] However bad manipulation is, manipulation is a constant across the two cases of initial manipulation and counter-manipulation. Thus, in determining the badness of counter-manipulation, we have to go to the next consideration, which we can suppose is the quality of the results. If the result of the counter-manipulation would be better than the result of the manipulation, then the counter-manipulation is justified. By way of example, remember the Californian advertisement about smoking and impotence. Suppose people would be manipulated by tobacco firms unless they were manipulated by the anti-smoking advertisement. Either way, they would be manipulated. But it is better if people do not smoke, let us suppose. So the anti-smoking advertisement is justified counter-manipulation. California's Department of Health Services could say to tobacco firms: 'our manipulation is better than yours.' What needs to be the case for this argument to work? Here are some conditions:

1. The manipulation really must have a better result. The 'better result' could be that the counter-manipulated people are all-things-considered better off for being healthier or that society is all-things-considered better off for their being healthier. However, being healthier need not be all-things-considered better because health is not the only good. Nonetheless, being healthier is plausibly all-things-considered better in many cases.
2. There is no alternative. The tacit assumption is that the only two options are manipulation by one side or another. In other words, there is no third way where targets are de-manipulated, for instance by counter-marketing. When it comes to applying the argument in practice, one would have to check no third way exists.
3. The argument implies that manipulation is a constant across the two cases in the sense that either the degree of manipulation is the same and\or the

[51] As we saw in the previous chapter, this was Eldar Shafir's claim in his 'Manipulated as a Way of Life', *Journal of Marketing Behavior* 1 (2016): 254, 255–9.

> manipulation is equally bad. However, not all manipulation is on a par. If A smokes because a wordless cowboy appeared in an advertisement and B smokes because a tobacco firm lied about the health effects, we should likely say that B is more manipulated, or manipulated in a worse way, than A. Thus for the better result to go through, the manipulative method used in health promotion must either be similar to the manipulation it counters, as when both manipulator and counter-manipulator are lying, or less bad than the manipulation it counters, as when health promoters exaggerate to counter a lie.

One might disagree with counter-manipulation by saying that while it is bad when someone is manipulated by A, it is worse when that person is counter-manipulated by B. Now the target is manipulated twice, not once. So counter-manipulation does not really hold manipulation constant. As against this argument, it is unclear why the frequency of manipulation matters. Duration plausibly matters; it is worse other things equal to manipulate for a longer time than a shorter. But duration is distinct from frequency. Suppose either that someone is manipulated by A for a year or that the person is manipulated by A for six months and then manipulated by B for six months. The duration of manipulation is the same. Leaving aside contingencies, such as one form of manipulation being worse than another, why would it be any worse to be manipulated twice rather than once?

Could then counter-manipulation be objectionable because of its longer-run effects? Jennifer Blumenthal-Barby considers the case of a doctor whose patient has been manipulated into smoking; the doctor decides to manipulate the patient into not smoking instead. Blumenthal-Barby considers the argument that the patient's autonomy, being already at zero, cannot be further impaired by the counter-manipulation, and writes: 'my intuition is that one way in which it could is that this further manipulation . . . makes it harder for [the patient] to recover and govern himself, and in that sense does pose a *further* threat to autonomy.'[52] Blumenthal-Barby does not explain her intuition in more detail than this, so let me speculate about what she meant. She sees autonomy as being recoverable via some process that would be interfered with by counter-manipulation. What could such a process be? The most plausible process I can think of involves feedback, such as learning from one's mistakes or finding out the truth. However, it is an open question whether counter-manipulation delays recovery.[53] It could have no effect,

[52] J. Blumenthal-Barby, 'Assessing the Moral Status of Manipulation', in *Manipulation: Theory and Practice*, edited by C. Coons and M. Webber (New York: Oxford University Press, 2014), p. 127.

[53] The open question point also applies to Tengland's criticism, in 'Behavior Change or Empowerment', p. 145, that manipulative health promotion reduces the ability for self-determination. Maybe, maybe not.

for instance if the target never would learn from mistakes. Counter-manipulation could even speed up recovery, for instance by starting the target on the process of critical enquiry. These are complicated empirical matters and I am not aware of any reason to think that counter-manipulation generally impairs autonomy more than the manipulation it counters.

When it meets all the conditions set out in this section, the argument that counter-manipulation would have better results seems to have great power. How many cases would meet these conditions is another matter. But one could have effective versions of the argument even when some of the conditions are not met. Suppose that the effect of counter-manipulation was that the target was slightly more manipulated overall in a way that prevented emphysema or lung cancer from smoking. Or suppose the counter-manipulation only delayed the recovery of autonomy for a short while. As we saw in Chapter 7, big enough gains in well-being can outweigh small enough losses in autonomy. Counter-manipulation could be justified if it did not reduce autonomy by much.

Counter-Manipulation: Its Scope and Further Problems

Health promotion that uses manipulative methods is ethically questionable. If, however, it is counter-manipulative, then it could make people healthier without sacrificing their autonomy. However, it is essential that the counter-manipulation counters manipulation. Not all influences that cause people to act unhealthily, even irrationally, are manipulative and not all health promotion is up against the promotion of ill health. For instance, campaigns to encourage exercise do not have to compete with a consistently loud message from private sector firms about the merits of not exercising. After all, plenty of firms advertise exercise gear, gym memberships, or the outdoor rugged lifestyle. Even anti-smoking campaigns now seem unlikely to be counter-manipulative in many countries. Tobacco firms did for years use advertisements, sponsorship, and product placement to insinuate that smoking is sexy and either manly or womanly, depending on the brand. But in many jurisdictions, they have not been allowed to market themselves for a long time. Anti-smoking advertisements, like those we considered earlier, should no longer be considered counter-manipulation, unless the manipulation of yesteryear is still somehow being culturally transmitted.

Furthermore, some writers bundle up too many ideas under the heading of manipulation and so give counter-manipulation too wide a scope. For instance, Holland appears to assume that peer pressure is a form of manipulation that health promoters might counter.[54] But peer pressure need not be manipulative in all its

[54] Holland, *Public Health Ethics*, p. 293.

forms. If teenagers smoke so as to fit in with their peer group, we cannot infer that they are being manipulated. They may simply see smoking as the price of entry and one is not manipulated simply by having a price to pay.

As these remarks about scope imply, the would-be counter-manipulator could be wrong about whether their targets were manipulated. They could be wrong about what constitutes manipulation, as in the above example of peer pressure, or wrong about the facts, for instance about whether the targets really were fooled. The counter-manipulator could also be over-broad in their targeting, hitting some people who are manipulated but also some who are not. The risk of error is compounded by the dangers of wishful thinking. It is tempting, if one disagrees with how people act, to see manipulation as the cause.[55] Finally, the counter-manipulator risks moving from manipulation to manipulativeness. While some manipulation is probably justifiable, 'manipulativeness' is a vice—an unconditionally bad vice, according to Marcia Baron.[56] As a vice it involves an arrogance that leads to taking decisions out of the hands of the people to whom they belong and being too quick to resort to manipulative methods, whether because the manipulative person sees reasoning with the targets as tiresome or, wrongly, as futile. The risk is that after acting manipulatively, the moral barriers are lower and, if the manipulation works, it would be tempting to manipulate again and again.

Our focus has been on the relation between counter-manipulation and autonomy. Even when counter-manipulation does not infringe on autonomy, one might have further ethical objections to manipulation by health promoters. Let me mention some briefly. Counter-manipulation could conflict with the value of trust: as a general practitioner put it to me, if he attempted to manipulate his patients even in a good cause, it would destroy their relationship. While I think the general practitioner exaggerated, I agree that in some cases the risk to trust probably should rule out counter-manipulation.[57] Next, some writers object more strongly to manipulative attempts by the government than by private firms because the role of government is to serve its citizens. Roles may matter in health care too. We might feel entitled to expect more from doctors than private firms given that doctors have more power than patients, and given the codes of medical ethics supposed to govern medical behaviour.[58] Finally, counter-manipulation may support a regrettable social practice, for instance by sustaining a culture of exaggerating

[55] In Chapter 4, we saw that cultural critics were too quick to dismiss people's preferences as 'adaptive'.

[56] Marcia Baron, 'Manipulativeness', *Proceedings and Addresses of the American Philosophical Association* 77 (2003): 49.

[57] See also the discussion in J. Blumenthal-Barby, 'Between Reason and Coercion: Ethically Permissible Influence in Health Care and Health Policy Contexts', *Kennedy Institute of Ethics Journal* 22 (2012): 358–9.

[58] Blumenthal-Barby, 'Between Reason and Coercion', p. 357.

and distorting or by undermining simple clear reliable communication.[59] Think how tiresome it would be to live in a society where every communication had to be decoded. If someone died, we would have to ask, as Metternich supposedly did of Talleyrand's death, 'What did he mean by that?'.

While I think counter manipulation can erode trust, can breach role obligations, and can support a regrettable social practice, I also think that not all counter-manipulation in all cases will have these drawbacks.[60] And, despite the value I attach to autonomy, and despite thinking that manipulation infringes upon it, I think the use of manipulative tactics by health promoters may in many cases be permissible as counter-manipulation.

Conclusion

In this chapter, we have considered when and whether it would infringe upon people's autonomy if their perceptions are altered so that they behave in healthier ways. We first asked about nudges and whether they are manipulative. Just as the previous chapter criticized some of the more dramatic claims that people are manipulated into unhealthy behaviour, so this chapter was doubtful about whether nudges must be as manipulative as some critics would have us believe. Whether and when they are depends partly on whether the methods the nudger uses are manipulative, which is not always easy to determine. It also depends on people's attitudes to being nudged and on the intention of the nudgers. We then considered health promotion that is manipulative, which often occurs in a context of manipulative 'illness promotion'. The context matters because manipulative health promotion may then be counter-manipulation. It may enhance, or at least not damage further, its targets' autonomy. When counter-manipulative health promotion cannot be criticized on grounds of autonomy, the leading objection to it is removed.

The conclusion in this chapter has been relatively favourable to public health when compared with previous chapters, where I argued that many public health restrictions on people's options would make them worse off and infringe on their autonomy. That on-the-whole unfavourable conclusion was where we got to by thinking of public health from the point of view of a criticism, the nanny state objection. But perhaps by starting with a criticism, we have been misled about public health. So what I propose, for the next two chapters, is to think of trying

[59] This might be Allen W. Wood's view, in his 'Coercion, Manipulation, Exploitation', in *Manipulation: Theory and Practice*, edited by C. Coons and M. Webber (New York: Oxford University Press, 2014).

[60] See my 'Counter-Manipulation and Health Promotion', *Public Health Ethics* 10 (2017): 257.

to make people healthier from the point of view of public health advocates. Many in public health think of what they do as providing collective goods in response to various failures of the unregulated market. This thought will be the subject of the next chapter. And many in public health emphasize health equity and social justice. That emphasis will be the subject of the subsequent chapter. Do arguments about market failures or equity provide convincing alternatives to the largely unsuccessful paternalistic arguments? I am afraid not.

11
The Nanny State and Market Failure

Introduction

The 'nanny state', in the context of public health, is the derogatory term for paternalistic interventions that supposedly overvalue health and infringe on autonomy. But many advocates for public health do not see themselves as behaving like nannies and they think it misguided to see their interventions as paternalistic.[1] Public health, they say, does not aim to protect adults from making mistakes in their lives. It is a collective effort to achieve more benefits, distributed more equitably, than unregulated markets would provide. Markets, according to many advocates, lead to income inequality, inadequate housing, pollution, poor transport, cheap and unhealthy food and drink, dangerous products such as cigarettes, and a built environment that discourages exercise.[2] Who, then, could sincerely object to public health efforts besides extreme free marketers or libertarians? As against this description of their project, I want to show in this chapter that if much of what public health advocates favour is to be justified, the nanny state criticism cannot be sidestepped.

Certainly, some truth is to be found in the claim that markets are not collectively controlled. The question is, though, what this claim has to do with such measures as taxes on sugar, or manipulative advertisements against smoking, or limiting the number of alcohol outlets. As I explain in the next section, valuing collective control, whether for good reasons or bad, seems irrelevant to the question of whether these measures are justified. A more promising line of argument focuses on collective action problems. As we saw in Chapter 2, part of public health is devoted to solving collective action problems, such as achieving herd immunity or reducing pollution. Perhaps reducing the consumption of unhealthy products would solve a collective action problem, the problem of overconsumption due to negative externalities. Perhaps regulating markets can make healthier products available to people who otherwise cannot afford them.

[1] Dan Buchanan argues that the focus on paternalism in public health is excessive and that public health should be based on autonomy-enhancing social justice. See D. R. Buchanan, 'Autonomy, Paternalism, and Justice: Ethical Priorities in Public Health', *American Journal of Public Health* 98 (2008): 15. See also James Wilson, 'Why It's Time to Stop Worrying about Paternalism in Health Policy', *Public Health Ethics* 4 (2011): 269.

[2] Ruth Faden, Justin Bernstein, and Sirine Shebaya, 'Public Health Ethics', *The Stanford Encyclopedia of Philosophy* (Fall 2020 Edition), Edward N. Zalta (ed.), https://plato.stanford.edu/archives/fall2020/entries/publichealth-ethics/; N. Krieger and A. E. Birn, 'A Vision of Social Justice as the Foundation of Public Health: Commemorating 150 Years of the Spirit of 1848', *American Journal of Public Health* 88 (1998): 1603.

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We shall consider these arguments for public health interventions that do not, on the face of it, raise the frightful hobgoblin of the nanny state:

1. Our unhealthy behaviour does not affect only ourselves. It might be fine to do what we want to our own health but, if we want to be treated in a state health system, or if we damage other people's health, or if we become less productive, then we impose costs on others in ways that public health interventions can legitimately prevent. Trying to stop some people imposing costs on others does not treat them like children or overvalue their health, and need not infringe on their autonomy. In the language of market failure, unhealthy behaviour has negative externalities.
2. Markets produce too many unhealthy options and not enough accessible healthy options. Public health interventions aim to provide us, especially those of us who have least, with better options.

We shall work through those two arguments in this chapter and postpone, until Chapter 12, this last one:

3. Markets, left to themselves, cause inequality and poverty, and they are unjust. Public health interventions can correct some of these injustices. Restrictions of unhealthy options may be against some people's interests, but they are in other people's interests, and justice gives them priority.

These arguments are not paternalistic but they also do not successfully justify many of the bans, taxes, regulations, and sometimes subsidies that public health advocates want. What the advocates want could only be justified if people would be better off by being steered towards being healthier. In other words, the only justification that might work is paternalistic. However, I am not saying that the non-paternalistic arguments have no merit and we can learn from them. Most positively, we can see how public health advocates are right to emphasize the collective in one respect, not as an alternative to paternalism but in showing that public health paternalism is not made redundant by the possibility of privately constraining one's own unhealthy choices.

The Irrelevance of Collective Control

Without in any way suggesting that all public health advocates agree on matters of political economy, a common strain of their thought criticizes the location of power in capitalist markets. We have seen something of this criticism in the preceding chapters, where we considered the advocates' objection to the power of producers of unhealthy products. Since the criticism is likely to be raised by readers

familiar with public health, I want to make a few remarks about it. My main point is that it is irrelevant to justifying public health measures.

The first remark is that we should not run together a criticism of free market thinking with a criticism of corporate power. We should instead distinguish between public health problems due to failures of markets and public health problems due to the capture of government power by sectional interests. To be pro-market is different from being pro-business. To see this distinction in action, let us turn again to two public health writers we have come across before, Geoffrey Rose and Robyn Toomath. Rose criticized enormous subsidies for the over-production of food, and he had in mind the Common Agricultural Policy (CAP) of what was then the European Economic Community; Toomath criticized American subsidies to grow corn, which led to high-fructose corn syrup infiltrating the food supply.[3] These policies are not libertarian or free market policies; indeed Rose and Toomath point out that subsidies are contrary to, what Toomath calls, the 'staunch free market approach' of scrapping agricultural subsidies, which New Zealand did in 1984.

The distinction between criticizing powerful businesses and criticizing markets arises again when we turn to the public health emphasis on the collective, which sometimes takes the form of valuing collective control. The problem with markets might be that they are controlled by corporations or that markets are anarchic and no one is in control.[4] Either way, one might want the people to control the environment they live in for the sake of democracy, or collective freedom. It is for a reason such as this that some criticize free trade agreements which take away the power of governments to regulate markets in food and drink and thereby infringe on food sovereignty.[5] I think much in the idea of collective control is questionable. Are majorities supposed to be able to control the whole environment?[6] What about fair shares of social space? If a majority wants pubs to be smoke-free, why make all pubs be smoke-free rather than only a proportionate majority? However, the main problem, for public health writers who recommend collective choice, is that they have no guarantee that collective choice will coincide with what they want. To take one example, the European Union and the United States have more food sovereignty than New Zealand, as we just saw, but they have used their powers to

[3] G. A. Rose, K.-T. Khaw, and M. Marmot, *Rose's Strategy of Preventive Medicine: The Complete Original Text* (Oxford: Oxford University Press, 2008), p. 152; Robyn Toomath, *Fat Science: Why Diets and Exercise Don't Work—and What Does* (Auckland: Auckland University Press, 2016), pp. 98–9. For a free-market criticism of the CAP, see Richard W. Howarth, *Farming for Farmers?* (London: Institute of Economic Affairs, 1985).

[4] An anti-market-anarchy statement can be found in Theresa Marteau, Adam Oliver, and Richard E. Ashcroft, 'Changing Behaviour through State Intervention', *British Medical Journal* 337 (2008): 122. These writers would like the state to structure environments so that we do not 'remain slaves to the environments we often have little part in shaping'.

[5] Toomath, *Fat Science*, ch. 6.

[6] If not, then how are decisions to be made? See Allen Buchanan, *Ethics, Efficiency, and the Market* (Oxford: Clarendon Press, 1985), pp. 98–9.

encourage overproduction of unhealthy food. More food sovereignty thus might mean more obesity, not less. To take another example, public health advocates often criticize politicians in democracies for not showing leadership (that is, for not doing what the advocates recommend).[7] Maybe politicians should show leadership, but if they do not implement public health regulations because they fear losing votes, that makes the point that the public does not side with public health.[8]

What the arguments about corporate control, anarchic markets, and collective decision-making have in common is that they are about power, but not any specific exercise of power. Put another way, the arguments are about who should decide and not about what the decision should be. That is why the conclusion of these arguments will not be either for or against public health policies.

Harms and Costs to Others

Critics of the nanny state say that public health measures overvalue health and stop adults running their own lives. But someone's unhealthy behaviour usually does not affect them alone. If I smoke near others, I risk their health as well as mine. If I drink and then drive or become violent, I expose other people to danger. Even when it is only my own health that directly suffers, my treatment may well use up scarce healthcare resources, and my sick days reduce my production. Public health measures might then be argued for on the grounds that either they would lower social costs or that they would stop people unfairly harming others or imposing costs on them. Neither of these arguments seems open to the nanny state criticism.

I aim in this section to show some difficulties with these arguments. First, they might support only a few specific public health measures, leaving the rest needing other foundations. Second, broad public health measures, such as taxes on unhealthy products, run into their own problems of unfairness. And, third, sometimes the arguments crumble because the unhealthy behaviour turns out not to have social costs on balance. In sum, if one wants to make a case for a wide range of public health measures, one will need to argue that people are better off for being healthy than unhealthy, which of course then invites the 'healthism' criticism.

We need some detailed examples and I will mainly focus on smoking and obesity. Let me begin with smoking near other people. Suppose smoking near other people is bad for their health and imposes a harm on them that, in all fairness, ought to be prevented. Bans on smoking in enclosed public places are a direct and

[7] Boyd A. Swinburn, Gary Sacks, Kevin D. Hall, Klim McPherson, Diane T. Finegood, Marjory L. Moodie, and Steven L. Gortmaker, 'The Global Obesity Pandemic: Shaped by Global Drivers and Local Environments', *The Lancet* 378 (2011): 811.

[8] Swinburn describes civil society as a 'sleeping giant' that could change the food system. But he gives no reason to think that, if the giant awoke, it would do what he wants. Boyd Swinburn, 'Power Dynamics in 21st-Century Food Systems', *Nutrients* 11 (2019): 2544, §3.3 and §5.3.

effective response to second-hand smoke. But many other policies affect smokers, such as restrictions on marketing or high tax rates. These policies might help reduce smoking, but what do they have to do with the aim of preventing second-hand smoke? I suppose one might argue that even with a ban on smoking in public places, some public smoking might still go on and extra policies to reduce smoking would help prevent it. Equivalently, one might argue—more convincingly—that bans on drink driving or violence have not prevented either entirely, and price rises for alcohol would help further reduce them.[9] These policies might be said to go after the causes of the causes: the cigarettes necessary for second-hand smoke, the alcohol necessary for drink driving. However, as Mill argued, the 'preventive functions of government', although legitimate, are wide open to abuse because almost anything can be dressed up as increasing risk.[10] The causal connection between many public health policies, such as banning marketing, and the end to be achieved, such as reducing drunken violence or second-hand smoke, might well be thought too tenuous for the policy to be justified as preventing harm to others. Moreover, these policies have their own problems of fairness. People who do not smoke over others or drive drunk or punch anyone end up paying the costs of higher taxes, reduced availability, and so on, and that looks unfair to them.

Let us move on from physical harms. Arguments for public health restrictions frequently cite social costs with 'scary numbers'.[11] New Zealand's Ministry of Health says: 'The economic cost of smoking calculations were last updated in 2005 when it was estimated that tangible costs of smoking to the health and welfare system were in the order of $1.7 billion representing 1.1 percent of GDP.'[12] Wang et al. estimated a $46 billion to $48 billion per year increase in medical costs by 2030 in the United States from the effect of rising obesity on diabetes, heart disease, stroke, and cancer, and they claim that 'the monetary value of lost productivity is several times larger than medical costs'.[13] Scary numbers are often exaggerated if not outright wrong. For instance, the New Zealand Ministry 'garbled' its statistic.

[9] Peter Anderson and Ben Baumberg, whose work was discussed in Chapter 6, think a main benefit of a price rise in alcohol would be fewer accidents and less crime. See their *Cost Benefit Analyses of Alcohol Policy—a Primer*, Report for the European Commission Health & Consumer Protection Directorate—General Directorate C—Public Health and Risk Assessment, 2010. However, smoking and obesity, unlike getting intoxicated, do not tend to cause crime or accidents. Admittedly, smokers can burn down forests and houses, and philosophers have discussed a 'fat man' who gets stuck in a cave, trapping everyone else. For a tactful presentation of the example, see Philippa Foot, 'Abortion and the Doctrine of Double Effect', in her *Virtues and Vices: And Other Essays in Moral Philosophy* online ed. (Oxford: Oxford University Press), https://doi-org.ezproxy.auckland.ac.nz/10.1093/0199252866.003.0002.

[10] John Stuart Mill, *On Liberty* (Harmondsworth: Penguin, 1982), p. 165 (ch. V, par. 5).

[11] A term from Joel Best in his book, *More Damned Lies and Statistics: How Numbers Confuse Public Issues* (Berkeley and Los Angeles: University of California Press, 2004), ch. 3.

[12] Ministry of Health, 'Background Information: New Zealand's Tobacco Control Programme', April 2016, https://www.health.govt.nz/system/files/2024-05/appendix-8-april-background-info-tobacco-control-programme_1.pdf, p. 3 (last accessed 10 June 2024).

[13] Y. C. Wang, K. McPherson, T. Marsh, S. L. Gortmaker, and M. Brown, 'Health and Economic Burden of the Projected Obesity Trends in the USA and the UK', *The Lancet* 378 (2011): 817.

The original source included estimates of lost productivity, absenteeism, and some of the resources used to make tobacco products, all of which are questionable but in any case substantially beyond costs to state-provided health and welfare.[14] Leaving aside whether these scary numbers are even approximately correct, they often lump together costs that fall on the people who are unhealthy, such as an economic valuation of their loss of Quality Adjusted Life Years due to dying early, and those that fall on others, such as healthcare expenditure.[15] But if we want to argue for a public health measure as a way to prevent people imposing costs on others, we cannot cite the costs they impose on themselves.[16]

We must also avoid inflating social costs. Suppose that if I smoke, I will die early and as a result not help raise my grandchildren. The cost here might be not just to my family but to an economy that would benefit from having the parents of my grandchildren go to work. Even so, I would not, in normal circumstances, unfairly impose a cost on anyone by dying early. I would at most fail to benefit the parents, or society, just as I would if I chose to live a distance away from my grandchildren.[17] An analysis that simply aggregates costs and benefits across society might count my early death as a social cost but it is not one that should be picked up by an unfairness argument.

If, for some reason, policy should aim to reduce overall costs, that is, costs to the people who become unhealthy as well as the costs to others, then policymakers should be careful of the 'count the costs, ignore the benefits' fallacy.[18] Smoking, drinking, and other unhealthy activities have benefits. If people make sensible decisions when they behave in unhealthy ways, the benefits to them would tend to outweigh the costs to them, otherwise they would not have engaged in the activity. So why think that unhealthy activities must have a net social cost? If a public health advocate were to reply that people do not make sensible decisions and the costs of

[14] The source was a 2007 report for two lobby groups, Smokefree Coalition and Action on Smoking and Health by D. O'Dea and G. Thompson, *Report on Tobacco Taxation in New Zealand*. This report can be found (as at 10 June 2024) by using a search engine that goes direct to a University of Otago pdf, www.otago.ac.nz. For a discussion of 'garbling' and mutant statistics see Joel Best, *Damned Lies and Statistics: Untangling Numbers from the Media, Politicians, and Activists* (Berkeley and Los Angeles: University of California Press, 2001), ch. 3.

[15] As pointed out by J. Bhattacharya and N. Sood, 'Who Pays for Obesity?', *Journal of Economic Perspectives* 25 (2011): 139. An example of swerving from the 'external costs' of smoking to the costs to smokers themselves is Robert E. Goodin, *No Smoking: The Ethical Issues* (Chicago: Chicago University Press, 1989), pp. 40–1.

[16] Occasionally, writers argue that earlier selves can treat their later selves unfairly. I shall say no more about this unlikely idea other than that it could equally be unfair to deny the earlier self the benefits of unhealthy behaviour; that is if (as I do not believe) it makes any sense to think of being fair to selves at different times.

[17] Mill thought that behaviour that harmed others was in principle open to interference, but he limited what counted as a harm to others to the breach of a distinct and assignable duty to others or society. See *On Liberty*, pp. 148–9 (ch. IV, par. 10). If we count as a harm any behaviour making someone less well off than they might have been, then we would leave no protected space for liberty, except perhaps private thoughts unuttered. See *On Liberty*, p. 158 (ch. IV, par. 19).

[18] Joseph Heath, *Filthy Lucre: Economics for People Who Hate Capitalism* (Toronto: HarperCollins Publishers, 2009), p. 8 and passim. See Chapter 3 for discussion.

ill health outweigh the benefits to them, then they must face the criticisms of the nanny state: the advocate is overvaluing health and interfering with how adults live their lives.

What, then, of the costs to the healthcare system? To the extent that healthcare is provided privately, unhealthy behaviour might not impose costs on others if those who use healthcare more also pay more, if only in insurance premiums.[19] But even in a state-funded system, unhealthy behaviour need not cause net costs to others. Smoking, perhaps surprisingly, does not.

One argument is that the revenue from taxes on smoking more than covers its costs. This argument has a long history. Iain Macleod, then the British Minister of Health, wrote in 1954 to a colleague at the Treasury: 'we all know that the Welfare State and much else is based on tobacco smoking', and Harold Macmillan, Chancellor of the Exchequer in 1956, wrote in his diary: 'If people really think they will get cancer of the lung from smoking it's the end of the Budget!'[20] Another argument, based on the high risks of smoking, points to savings elsewhere in the welfare state. Consider the infamous briefing, 'Public Finance Balance of Smoking in the Czech Republic,' commissioned by the tobacco firm Philip Morris for the Czech government. This briefing, by the consulting firm Arthur D. Little, tried to make a fiscal case against tobacco restrictions on the grounds that smoking raised revenue and, importantly, that smokers did not cost so much in pensions because they died early.[21] Its publication caused a furore and the firm apologized and disassociated itself from it.[22]

Nonetheless, the apparently cynical observation that money can be saved if people smoke does not have to be an argument for encouraging early death. It can instead be used against a fairness argument which, after all, has to show that unhealthy behaviour—in this case, smoking—really does have costs to others.[23] Since smokers tend not to collect pensions for as long as non-smokers, they do in one way save money for others rather than impose costs. If fairness is our concern and if pensions are paid for, even in part, out of taxation, I cannot see any reason why the pension-saving should not offset other costs that smokers might impose in a welfare system. So does smoking impose an overall cost on the welfare system? One relatively recent twenty-seven-year cohort study of male

[19] Bhattacharya and Sood, 'Who Pays for Obesity?'.

[20] Both cited by V. Berridge, 'The Policy Response to the Smoking and Lung Cancer Connection in the 1950s and 1960s', *Historical Journal* 49 (2006): 1196–7. According to Berridge, tobacco tax was 16 per cent of central government revenue in 1950.

[21] The original report can be found here (not, as it happens, on the Philip Morris International website): 'Morris Study Blasted', *CNN*, 16 July 2001, https://edition.cnn.com/2001/BUSINESS/07/16/czech.morris/index.html (last accessed 10 June 2024). Its methods and conclusions were criticized by H. Ross, 'Critique of the Philip Morris Study of the Cost of Smoking in the Czech Republic', *Nicotine & Tobacco Research* 6 (2004): 181.

[22] 'Philip Morris Issues Apology for Czech Study on Smoking', *New York Times*, 27 July 2001.

[23] This point is missed, in the case of obesity, by Wang et al., 'Health and Economic Burden of the Projected Obesity Trends', p. 822.

smokers and non-smokers in Finland concluded that: 'Smoking was associated with a greater mean annual healthcare cost of €1600 per living individual during follow-up. However, due to a shorter lifespan of 8.6 years, smokers' mean total healthcare costs during the entire study period were actually €4700 lower than for non-smokers. For the same reason, each smoker missed 7.3 years (€126 850) of pension.'[24] Thus, according to this study, smokers not only cost less in pensions but they even cost less in healthcare. Of course, cost calculations are sensitive to all sorts of assumptions, such as discount rates over time, and anyway this is only one study of one place. The extent of pension savings, for instance, would depend on how generous pensions are, although equally any costs to a state-funded health system from smoking would depend on how generous healthcare funding was. But it does seem widely accepted that, in the words of the New Zealand Treasury, 'at least from an external costs perspective, no further increases in tobacco excise are justified'.[25]

What about the costs of obesity? While pretty much everyone agrees that smoking damages health, they do not agree about whether being obese is anything like as harmful or even if it is directly harmful at all, at least for obesity below a high level.[26] Obviously if obesity did not cause ill health, then obesity would not directly cause increased health expenditure. Alternatively, obesity might be like smoking: so bad for people's health that it causes their early deaths, in which case, the state would get a substantial saving by not paying out their pensions.[27] A different supposed cost of obesity is to production because obese people take more time off sick; but any such costs might well be paid by the absent workers themselves, if they are paid or promoted less than they if they had not gone off sick.[28] Moreover, lost production traceable to obesity might not be due primarily to absenteeism but to discrimination.[29] Obese people might be kept out of certain jobs

[24] J. Tiihonen, K. Ronkainen, A. Kangasharju et al., 'The Net Effect of Smoking on Healthcare and Welfare Costs. A Cohort Study', *BMJ Open* (2012): 2. The authors make the usual move (pp. 3–4), in response to their finding, of saying that the costs to the smokers themselves are massively larger than the (genuine) gain to others from their smoking.

[25] New Zealand Treasury, *Regulatory Impact Statement: Increases in Tobacco Excise*, 26 May 2016, p. 8, available at https://www.treasury.govt.nz/sites/default/files/2016-05/ris-tsy-tbe-may16.pdf (last accessed 10 June 2024). See also Philip DeCicca, Donald Kenkel, and Michael F. Lovenheim, 'The Economics of Tobacco Regulation: A Comprehensive Review', *Journal of Economic Literature* 60 (2022): 883, §3.2.

[26] Neil K. Mehta and Virginia W. Chang, 'Obesity and Mortality', in *Oxford Handbook of the Social Science of Obesity*, edited by John Cawley (Oxford: Oxford University Press, 2011).

[27] A possibility conceded by Swinburn et al., 'The Global Obesity Pandemic', p. 806. See also J. Anomaly, 'Is Obesity a Public Health Problem?' *Public Health Ethics* 5 (2012): 218.

[28] S. L. Averett, 'Labor Market Consequences: Employment, Wages, Disability, and Absenteeism', in Cawley (ed.), *Oxford Handbook of the Social Science of Obesity*.

[29] Discrimination is likely to be an important explanation. Obese people tend to be paid less than others. According to some, this 'wage penalty' seems to be almost entirely paid by women. See 'The Economics of Thinness', *The Economist*, 22 December 2022. A more recent sort through the data finds that obese men are also penalized when they are more educated or in higher-skilled jobs. See 'The Obesity Pay Gap Is Worse Than Previously Thought', *The Economist*, 23 November 2023.

or assumed to be incompetent.[30] Such discrimination would cause a cost to them, of course, and also a social cost in the inefficient use of workers. But while obesity in some sense would cause the discrimination, one could not in fairness expect the people discriminated against to pay the social costs.

Discrimination aside and other things equal, some tax might make matters more fair by either preventing a public health problem, and thereby its costs, or by raising revenue to offset the costs. But other things might not be equal. In richer countries, the poorer tend to be more obese and smoke more than the richer, although they drink less alcohol.[31] If, as public health advocates hope, an offsetting tax would be passed on to consumers in higher prices, the tax would disproportionately affect people without much money, and that would be in one way unfair.[32] Put another way, fairness may not justify a tax even if a public health problem does have costs to others, which it might well not anyway.

I do not want to say that public health policies could never be justified on grounds of fairness, but many cannot and I wonder how far their advocates are really motivated by a desire to stop people imposing net costs on others. Suppose you aim to get people to pay the costs to others of an activity such as smoking, and suppose a tobacco tax achieves your aim. Then it should not matter to you whether people either give up the cigarettes or else carry on smoking but pay the tax. If people carry on smoking and you react by saying the tax is not high enough, then it sounds as if your aim is to reduce or prevent smoking rather than to get people to pay the costs of their activities. And that is how many in public health react.

Geoffrey Rose, a clear-sighted advocate of public health, was sceptical of what he called the 'Economic Argument'. Sometimes, he said, making people healthier would reduce economic costs but sometimes it would increase them. Rose favoured instead the 'Humanitarian Argument': 'It is better to be healthy than ill or dead. That is the beginning and the end of the only real argument for preventive medicine. It is sufficient.'[33] One sign that many public health advocates agree with him is that, when the limits of the economic argument are pointed out to them, they still want public health measures.[34] But then they need another argument.

[30] John Cawley, 'The Economics of Obesity', in Cawley (ed.), *The Oxford Handbook of the Social Science of Obesity*, p. 128.

[31] See Chapter 4 for details and evidence.

[32] What if the tax disproportionately improved their health? It would be unfair, unless they were making a mistake about the value of health in their lives and would perhaps still be unfair even then. See Chapter 12.

[33] Rose, Khaw, and Marmot, *Rose's Strategy*, p. 38. Even so, Rose did not think that health had overwhelming priority over other values in life, as we saw in Chapter 3, and he also disapproved of compulsion, as when he wrote on p. 76 of 'taxation as a means of discouraging smoking and drinking: the end may be worthy, but the means are ethically unacceptable. Virtue should not be compelled.'

[34] Janet Radcliffe Richards has a parallel in the field of transplantation ethics: people who oppose a market in organs come up with practical problems in lieu of the principled reasons that really motivate them. The practical problems, like the social cost arguments against smoking, are often implausible or overblown but they are just rationalizations. See Janet Radcliffe Richards, *The Ethics of Transplants: Why Careless Thought Costs Lives* (Oxford: Oxford University Press, 2012), ch. 3.

The Market and Healthy Options

For many writers in public health, uncontrolled markets fail. The market has produced a vast quantity of aggressively promoted cheap unhealthy products. The products are then over-consumed, causing disease, injury, and premature death. One way to read this criticism of markets is as saying that people need to be protected from 'illness promotion' and from the temptations of cheap, unhealthy products. Put like that, the criticism assumes that people would otherwise make mistakes in their choices, to which an opponent of the nanny state would ask: why think people make mistakes and why treat them like children? But we can read the criticism of markets in another way, as observing how markets lead to limited options, especially for those on the lowest incomes who can afford only what is cheap, but unhealthy. Understood this way, the call seems to be for more and better options or, put another way, for more choice. That hardly sounds like the nanny state.

Some policies could improve choice, such as transferring money to people on low incomes, without being the target of nanny state criticisms. But these are not really 'public health' policies. Rather closer to public health are policies such as subsidies for healthy food or gym memberships. These could also improve choice, although they might be criticized as 'nanny state' if it were feasible to transfer money instead of subsidizing, since people can spend money on whatever they want, healthy or not. What it is hard to see, though, is how choice could be improved by the taxes and regulations favoured by public health advocates. Could, for instance, taxes on tobacco or sugar, or regulations to limit alcohol or fast-food outlets improve choice? In short, it is unlikely.

Tax and regulations generally reduce options.[35] I could still afford a sugary drink, even if it costs more due to a tax, but I can buy less overall if the price of the drink increases and my budget does not. The point is sometimes obscured in public health arguments. Many writers do not seem to see the ethical difference between choice-restricting measures, such as taxes, and choice-enhancing ones, such as subsidies.[36] Public health advocates often tendentiously use the slogan 'Make the Healthy Choice the Easy Choice' to include making unhealthy options harder to take.[37] If sugary drinks or junk food were banned, taxed, or compulsorily moved into the next suburb, then water and healthy food would in one sense have become relatively easier to consume. But the method would be by worsening options. The more honest slogan would be 'Make the Unhealthy Choice the Hard Choice'.[38]

[35] Competition regulation might increase consumer choice, say by breaking up supermarket duopolies, but the result might be even cheaper food and drink and so not be what public health advocates want.

[36] Such as C. Hawkes, T. G. Smith, J. Jewell, J. Wardle, R. A. Hammond, S. Friel, A. M. Thow, and J. Kain, 'Smart Food Policies for Obesity Prevention', *The Lancet* 385 (2015): 2410.

[37] Such as Swinburn et al., 'The Global Obesity Pandemic', who think (p. 806) that 'make the healthy choice the easy choice' is a good response to the 'charge of so-called nannyism . . . in relation to regulatory interventions'.

[38] Thanks to Mike King for this suggestion.

However, it is not impossible that taxes and regulations would create new options that give consumers more of what they want. If so, one could argue that taxes and regulations make consumers better off without having to criticize the way in which they choose. One mechanism for this fortunate result might be reformulation. Firms could change their ingredients or their manufacturing methods to make food and drink that tastes no different, and costs no more, but is healthier. They could have an incentive to make these changes if, for instance, an unhealthy ingredient is banned or taxed. New York City's ban on trans fats has been cited as an example on the grounds that it caused reformulation, consumers did not think the food tasted different, and price was unaffected.[39] Apart from reformulation, perhaps taxes and regulations would allow firms selling healthy products to enter the market. Mary Cheh, a Washington, DC, councillor, once argued for a soda tax by saying: 'The soda tax would help low-income residents by encouraging them to choose healthier beverages and by creating more grocery stores and jobs in low-income neighborhoods.'[40] The first part of this statement, about choosing healthier beverages, looks as if it says that residents with low-income need encouraging because they have problems with how they choose, and, as the critic of the nanny state would ask, why think that? But the second part, about stores and jobs, suggests the tax would increase options and so not be subject to nanny state criticisms. Another example might be planning regulations to limit the density of fast-food outlets, thereby making it economically feasible to open healthy food outlets. Again, this result could be framed as enhancing rather than limiting choice.

I agree that tax and regulations could increase choice in principle, but probably not in practice. Reformulation, to take our first mechanism, seems likely to have limited success. One reason is that it can be technically impossible to turn an unhealthy product into a reasonably healthy one. Tobacco firms tried for years to devise a filter that would remove the harmful elements in cigarette smoke while leaving enough of the taste and effect. Kent cigarettes even used a filter made out of blue asbestos.[41] The filters did not work, although they lived on as a misleading indicator of safety.[42] To take other examples where reformulated products may not be healthier, critics of previous reformulation efforts have cited margarine as

[39] Sarah Conly, *Against Autonomy: Justifying Coercive Paternalism* (Cambridge: Cambridge University Press, 2013), pp. 152–5.

[40] Quoted in Anne Barnhill and Katherine F. King, 'Ethical Agreement and Disagreement about Obesity Prevention Policy in the United States', *International Journal of Health Policy and Management* 1 (2013): 118.

[41] It was the Kent micronite filter, used from 1952–6. See Michelle Wittmer, 'Asbestos Cigarette Filters: History of Kent Micronite & Lawsuits', 3 January 2023, available at https://www.asbestos.com/products/cigarette-filters/ (last accessed 10 June 2024).

[42] New Zealand has considered banning filters on the grounds that they are misleading and cause pollution. See Janet Hoek, Phil Gendall, Tom Novotny, Nick Wilson, Lindsay Robertson, Richard Edwards, James F Thrasher, 'The Case for Banning Cigarette Filters', https://blogs.otago.ac.nz/pubhealthexpert/the-case-for-banning-cigarette-filters-addressing-a-consumer-fraud-smoking-decoy-and-environmental-hazard/, 17 May 2021 (last accessed 20 June 2024).

a less healthy replacement for butter and sugar as a less healthy replacement for fat.[43] Reformulated products might taste worse too, as many of us thought with margarine and sugar-laden fat-free ice cream. Even where reformulation might be more promising, it will often have economic costs in research and in the substitution of more expensive ingredients for cheap ones such as sugar, and these costs may well be passed on to consumers.

In fact, reformulation raises an economic puzzle. If firms could make healthier products that better satisfy existing preferences, including by costing no more, why would they not make them anyway without the push of a regulation? One would think that in a competitive market they would jump at the chance. Possibly firms are too nervous to try the new product on their own but would be willing to venture it if other firms also had to reformulate. But if their reformulated product really tasted no different, what would they be frightened of? It is true they might have to solve a marketing problem. Rory Sutherland describes a case where a biscuit firm used a new, lower fat recipe. In blind tasting, the new biscuits were indistinguishable from the old and yet sales dived. According to Sutherland, the problem lay in their advertising: writing 'Now with lower fat' on packaging not only gets consumers to expect a product to taste worse, but it also makes the product actually taste worse.[44] However, this marketing problem hardly seems insuperable. Sugarless cola sells in vast quantities. In sum, if firms would not reformulate without the push of a preventive regulation, that suggests they have limited scope for doing so with no change in taste, price, size, or other desirable features.[45]

What if people could get used to a product that tasted a bit different but was healthier? We discussed adaptation in Chapter 4 and saw that people could be better off for adapting. However, adaptation is not an alternative to paternalism as a justification for regulating. If people would be better off for adapting and knew it and were motivated to do what was best for them, firms in a competitive market would reformulate and sell them what they want without regulation. If, though, people would not buy the reformulated products despite their being better overall, firms would probably not make them unless pressured by regulation. But then the justification for the regulation is that consumers underestimate their gains or are not motivated to do what is best for them or, in other words, that consumers make mistakes about their interests.

[43] Michael Pollan, *In Defense of Food: An Eater's Manifesto* (New York: Penguin, 2008); Gary Taubes, *The Case against Sugar* (London: Portobello Books, 2017).

[44] Rory Sutherland, *Alchemy: The Surprising Power of Ideas That Don't Make Sense* (London: W. H. Allen, 2019), p. 296.

[45] According to one source, reformulation might be a promising way to remove trans fats or reduce salt, but it will not do much to prevent obesity. See Mathilde Gressier, Boyd Swinburn, Gary Frost, Alexa B. Segal, and Franco Sassi, 'What Is the Impact of Food Reformulation on Individuals' Behaviour, Nutrient Intakes and Health Status? A Systematic Review of Empirical Evidence', *Obesity Reviews* 22 (2021): §4.6.

Could taxes and regulations enhance choice in some way other than reformulation? Suppose that the market offers a choice of cheap unhealthy food or expensive healthy food, and suppose, as a way to improve choice, a planning regulation is proposed that would ban some fast-food outlets.[46] What seems to be envisaged is that by preventing cheap unhealthy food, cheap healthy food would somehow become available. But why? What cause of the high price of healthy food, such as short shelf-life, would disappear because of a planning regulation?

It seems unlikely in market economies that the market for unhealthy products has widespread failures of competition that could be remedied by public health taxes or regulations. In short, those who argue that taxes or regulations would increase choice have an implicit or explicit model of the economy that on the whole seems implausible, although improvements may be possible in some cases. If advocates want these measures, they need another reason. And so we return to the one most have in mind: people who make unhealthy choices are making a mistake about their interests.

Collective Choice and the Limits of What We Can Do Privately

We began this chapter with the conception of public health as a collective effort to solve the collective problems of ill health. This conception is not, I have argued, an alternative to paternalism when it comes to justifying a broad range of public health measures that steer people away from unhealthy choices. However, although the collectivism of public health is not an alternative to paternalism, it is a valuable adjunct. It is because of its collective nature that public health paternalism is not made redundant by the possibility of private measures. Let me explain.

Paternalism to adults is most justifiable when they find it difficult or impossible to act on their own preferences because, for instance, they are prone to give in to temptation. Public policy certainly could help people avoid acting on their weaknesses. If casinos were successfully banned as a matter of law, then that would help people who want to resist the temptation to gamble. But why ban casinos for everyone when self-banning is possible? Why not let them take care of themselves? If they cannot take care of themselves directly, they can ask their family, friends,

[46] Planning regulations to limit fast-food outlets for the sake of health have been implemented in Barking and Dagenham, in England, and South Los Angeles, in the United States. For Barking and Dagenham, see Patrick Butler, 'Fast Food England: Does Putting a Cap on Takeaways Improve People's Health?', *Guardian*, 25 July 2017 https://www.theguardian.com/inequality/2017/jul/25/fast-food-engl and-does-putting-a-cap-on-takeaways-improve-peoples-health (last accessed 10 June 2024). Butler reports that the regulation has had little apparent impact on obesity. For Los Angeles, see Roland Sturm and Aiko Hattori, 'Diet and Obesity in Los Angeles County 2007–2012: Is There a Measurable Effect of the 2008 "Fast-Food Ban"?', *Social Science & Medicine* 133 (2015). They answer their title question by writing 'we find no evidence that it resulted in improving the diet of residents or reduce (*sic*) obesity rates'. See p. 210.

churches, and self-help groups to keep them on the strait and narrow. They can even turn to the private market, which provides all sorts of ways to limit one's unhealthy choices. Here is one example. William Hill, a British bookmaker, used to take bets on weight loss. If you wanted to lose weight, you could specify a goal and William Hill would offer odds. Britons therefore had the free market option of incentivizing their weight loss by gaining money if they lose weight and losing money if they gain weight. For a while, William Hill did nicely and won 80 per cent of the bets, which was thought to show the limits of this self-binding and how hard it is to lose weight;[47] in fact, though, William Hill scrapped this option in 2017 because they started losing too much money.[48] Another example of private self-binding is Stikk.com, which takes money from people who specify goals that they want to achieve. They get the money back only if they achieve their goals.[49]

Since private self-binding is practically possible, what do we need public policy for? This question needs an answer because public binding has its drawbacks. In the first place, some good grounds can be given for thinking that the state should do only what cannot be done well privately.[50] Second, private self-binding has the big advantage of being specific to the people who want to be bound and leaving alone the people who do not. Those who want to raise the costs to themselves of not losing weight or of continuing to smoke can place bets or sign up on websites. Those who do not need not. By contrast, legal bans, high taxes, restrictions on availability, mandatory hiding of products in shops, nasty pictures, and awful warnings are not specific to those who want to constrain their behaviour. That does not mean these measures would directly affect everyone. People who have no interest in smoking or taking other drugs would not be directly affected by them. But within a large class of actual or potential consumers, these policies would affect some for the worse. A cigarette tax is not the equivalent of signing up to Stikk.com.

Some public health interventions could still closely approximate or achieve the ideal of making healthier only those who would benefit. Giving or mandating information is an example. If people are told that consuming trans fats threatens their health, and producers must disclose trans fats in their food, people can decide for themselves whether to avoid food with trans fats. Other policies can replicate the element of choice in private measures. A possible public health example is smoking licences, favoured by some writers: buying cigarettes would only be allowed for those who were licensed and the licence would available only annually.[51] The idea

[47] Roy F. Baumeister and John Tierney, *Willpower* (New York: Penguin, 2011), p. 219.

[48] Todd Davey, 'William Hill Scrap Weight Loss Incentive after Losing Out', *The Betting Site*, 1 February 2017, available at https://bettingsite.com.au/william-hill-scrap-weight-loss-incentive-after-losing-out/ (last accessed 10 June 2024).

[49] Robert Sugden, *Community of Advantage: A Behavioural Economist's Defence of the Market* (Oxford: Oxford University Press, 2018), pp. 149–50.

[50] John Stuart Mill, *Principles of Political Economy: Part II*, in *The Collected Works of John Stuart Mill*, vol. 3, ed. John M. Robson (Toronto: University of Toronto Press, 1970), ch. XI.

[51] Julian Le Grand and Bill New, *Government Paternalism: Nanny State or Helpful Friend* (Princeton: Princeton University Press, 2015), pp. 156–9.

is that smokers who want to quit could summon their will-power and not acquire a licence, thus binding themselves into not smoking for a year at a time. Again, this would be a publicly enforced measure with the advantage of being available to all and only those who want to use it. Some real policies do attempt to discriminate between people, such as age restrictions on buying alcohol which attempt to exclude children without stopping adults. However, even the best-crafted policies would typically be good for some of those directly affected and bad for others.[52] If a minimum drinking age is 18, it will exclude some sensible 17-year-olds and include some foolish 18-year-olds. Even the smoking licence proposal would be a burden on those who did not get round to applying for their licence. Moreover, attempting to tailor policies to only those who would benefit can have administration costs, for instance in setting up competence tests, and be stigmatizing for those who fail the tests.[53] Even narrowly crafted public paternalism would not be as specific as private measures. Why, then, have public health paternalism at all? One reason, likely to occur to readers from public health, is that only public measures would lead to large shifts in population behaviour, and only such large shifts would achieve the largest total of health benefits. This reason is not good enough if, as I have argued it ought to be, our interest is not in the largest total of health benefits but in fulfilling people's ultimate preferences. Nonetheless, other reasons can be given for thinking that broad public health interventions would genuinely benefit some people more than the private market or more tailored measures.

One reason is that the private market does not just provide options for self-binding. It also provides the options to undo the self-binding. You can destroy your cigarettes and then go out late at night to a convenience store and buy some more. As Robert Sugden puts it, 'in a competitive market, self-constraint technologies tend to be made available to those people who are willing to pay for them, but so too are the counter-technologies that allow people to escape from constraints they no longer wish to be bound by'.[54]

Another reason is that broad public health interventions can do things that the private sector or tailored policies cannot. Let me give three examples, involving tax, the removal of cues, and changing social norms. Taxes have been effective in reducing smoking (although some countries, such as New Zealand, might have

[52] See the discussions of 'heterogeneous' smokers in G. M. Lucas, Jr, 'Saving Smokers from Themselves: The Paternalistic Use of Cigarette Taxes', *University of Cincinnati Law Review* 80 (2011): 693.

[53] Richard Arneson makes this point in 'Egalitarian Perspectives on Paternalism'. He thinks that a test to decide who would be competent to take recreational drugs could be so stigmatizing for those who fail that a blanket ban on drug-taking would be more just according to an egalitarian theory, although for some reason he does not consider the stigmatizing effects of a drug conviction. See Richard Arneson, 'Egalitarian Perspectives on Paternalism', in *The Routledge Handbook of the Philosophy of Paternalism*, edited by K. Grill and J. Hanna (Abingdon: Routledge, 2018), p. 198.

[54] Sugden, *Community of Advantage*, p. 149. Richard H. Thaler and Cass R. Sunstein make the same point in *Nudge: Improving Decisions about Health, Wealth, and Happiness* (New Haven: Yale University Press, 2008), pp. 48–9.

reached the limit of what tax can achieve) because higher cost is a motivating factor. Probably, then, if taxes were not used, some people would not be motivated to give up smoking even though they would benefit. However, it is hard to see any realistic way of taxing cigarettes only for those likely to benefit. An attempt at price discrimination would be foiled by a secondary market in which smokers who were supposed to be charged a high price would buy cigarettes from the people who were charged a low price. A tax that affects all potential smokers might be the best way to help the large subset who would be better off not smoking.

As for the removal, or at least minimization, of 'cues', people who have taken drugs, such as nicotine or alcohol, can prefer not to take them and then find they are triggered by cues into buying and consuming them. It is not just drugs either. Thaler and Sunstein report the triggering effect of smelling (730-calorie) cinnamon buns in O'Hare Airport in Chicago.[55] We can try to avoid cues; some people, for instance, will not keep chocolate in their house because, if they see it, they will want to eat it. But, unless we hide at home, we will be unable to avoid all sorts of incitements to consume. A public policy, such as the one requiring cigarettes to be sold in plain packaging and hidden from sight in shops, can remove cues that we cannot remove privately.

Finally, consider changing social norms in the context of an example we have come across before. Geoffrey Rose favoured an alcohol strategy to reduce population-mean levels of drinking. His reason was not because of the dangers of moderate drinking. He was careful not to assert that moderate drinking was harmful because he thought that (at the time he was writing) it was unknown whether it was or not.[56] His reason was because he thought that the mean level of drinking predicted the level of heavy drinking and reducing the mean level would reduce alcoholism.[57] Why should reducing the mean level reduce alcoholism? One mechanism could be a change in social norms. Societies that license or encourage drinking alcohol tend to frown upon alcoholism, but nonetheless their norms make it easier for people to drink and harder for people not to drink because alcohol is available and because people want to fit in.[58] It is likely, then, that some of the alcoholics in those societies would not have become alcoholics in a society less friendly to drinking. For similar reasons, denormalizing smoking has been a major aim of public health. While it is fair to ask whether denormalizing has wrongly stigmatized smokers, the point here is that social norms influence consumption. Social norms are not directly available to people to change privately, but they can be changed by collective efforts, such as the collective effort of public health. Again, public health paternalism can do things that cannot be done privately.

[55] Thaler and Sunstein, *Nudge*, p. 49.
[56] Rose, Khaw, and Marmot, *Rose's Strategy*, p. 120.
[57] Rose, Khaw, and Marmot, *Rose's Strategy*, p. 102.
[58] See Owen Flanagan, 'Identity and Addiction', in *The Routledge Handbook of Philosophy and Science of Addiction*, edited by Hanna Pickard and Serge H. Ahmed (Abingdon: Routledge, 2019).

Conclusion

To object to the nanny state is to object to paternalism. If one wants to defend public health measures against the nanny state objection, one option is to defend paternalism, and another is to deny that the measures are paternalistic. In this chapter, we have been considering arguments that public health is not paternalistic. Public health, it is said, redresses market failures by its collective efforts. It reduces social cost, or stops people unfairly harming others, or it makes healthy options available. The difficulty is that, while these arguments may support some taxes, bans, and regulations, they do not support the wide range that public health advocates want. We have yet to consider equity arguments, but so far public health advocates have a choice of reactions to the nanny state criticism: stop advocating such a wide range of taxes, bans, and regulations or come up with a good paternalistic argument for them.

In the final section of this chapter, we saw that public health measures might have to range broadly to be effective; and then they would inevitably produce losers as well as winners. That they would have losers is regrettable, but then having only private self-binding or tailored paternalistic policies would also produce losers as well as winners. Paternalism, like the absence of paternalism, raises a problem of distributive ethics. In the next chapter, we consider this problem in the terms familiar in public health, health equity and social justice.

12
Health Equity and Distributive Ethics

Introduction

Up to this point in the book, I have argued that public health interventions are often against the interests of those they affect and infringe on their autonomy. I have also argued that they often cannot be defended as providing collective benefits. That leaves another possible basis to justify them, equity or social justice. Public health advocates see societies as unjust and inequitable because some social groups have worse health or worse health prospects than others, and these inequalities are avoidable, or at least reducible. The advocates think some of these inequalities are caused by poor housing, poor sanitation, the stress of low incomes, poor working conditions, and unemployment, all of which seem open to at least some mitigation by social and economic policy.[1] As we shall see, they also think that health inequalities come about because some disadvantaged groups are especially likely to behave in unhealthy ways, often because of their poor living conditions.[2] Public health interventions that steer people into healthier behaviour might be criticized as 'nanny state' paternalism but, from the point of view of public health advocates, they could reduce health inequity. It may then appear that these interventions are not paternalistic after all.

In this chapter I mainly focus on preventive regulations. Preventive regulations include taxes, such as on alcohol; bans, such as making it illegal to supply cigarettes to anyone born after 2008;[3] limits on ingredients, such as on salt and sugar in food; and regulations, such as those preventing too many fast food or liquor outlets from opening up or being sited near schools. The important feature of these measures is that they reduce choice because they increase the money or time costs of unhealthy consumption without decreasing the costs of healthy consumption.[4]

[1] Michael Marmot, *The Health Gap: The Challenge of an Unequal World* (London: Bloomsbury Publishing, 2015).

[2] Marmot, *The Health Gap*, ch. 3. John Kemm writes: 'No one disputes that both environment and lifestyle are important though the relative importance to be attached to each has been a source of much non-productive dispute.' John Kemm, *Health Promotion: Ideology, Discipline, and Specialism* (Oxford: Oxford University Press, 2014), p. 4.

[3] New Zealand would have had this ban from 2027 had a new government not repealed it. The ban has been defended as saving young people from addiction, which seems an odd reason to ban 80-year-olds from buying cigarettes in 2089.

[4] See 'The Market and Healthy Options' in Chapter 11.

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I agree with what I take to be the main thrust of the concern for social justice, that many inequalities in health are unfair and that social and economic policy both could and should reduce them. However, I do not see that social justice is an alternative to paternalism as a foundation for preventive regulations. Let us take the term 'equity' to stand for social justice. My argument, in brief, is as follows: no defensible interpretation of equity would say that reducing the well-being of the worst off is more equitable; public health taxes, regulations, and restrictions would tend to reduce choice, particularly the choice of the worst off; and having less choice tends to make the worst off worse off, not better off, except on one condition. This condition is that choosing unhealthy options is a mistake. Thus if, but only if, the unhealthy choices of the worst off were mistaken could it be more equitable to reduce their choice. Since reducing choice to stop people making mistakes is paternalistic, the equity case for preventive regulations is not an alternative to paternalism but presupposes it.

If equity is not an alternative to paternalism, would it give some support to it? Some political philosophers say that equity supports paternalism when it benefits the worst off, even if it comes at the expense of the better off. Perhaps so, but the obvious and fundamental empirical question is whether public health paternalism would benefit the worst off. We can speculate about the answer but in the end we need evidence. I think the evidence, when interpreted correctly, does not give us a good reason to believe that the worst off are mistaken in their unhealthy behaviour, except when the behaviour is smoking.

Is there anything in the idea of equity that might support public health paternalism? In the final section, I return to an example from previous chapters, of alcohol and alcoholics. Policies to reduce alcohol consumption generally, such as a tax rise, may well come at a cost to the majority of drinkers but could help save a relatively small number of people from falling into alcoholism. I do not know of a developed case for giving priority to this small minority, but I do not rule it out. Given how awful it is to be an alcoholic, I can imagine a utilitarian argument and I can imagine something that resembles an equity argument. All I can do here is sketch the arguments and some of the challenges they face.

Let me make two more initial comments. First, although we focus on preventive regulations, many of the arguments made here can also be applied, with some changes, to providing healthy options, and I will later indicate briefly how. Second, I shall assume that the actions of the state would succeed in their aims so that, for example, a tax rise on cigarettes would reduce smoking rather than being evaded by smuggling or leaving poorer people to smoke at the same rate but pay more. It may well be a fair objection in practice to further tax rises they would be regressive and that is a problem referred to briefly below.

Health Equity

Ill health follows a socially patterned distribution. For instance, some ethnic groups have worse health than others and, even in rich countries with publicly funded health care, poorer and less-educated people have worse health than richer and better-educated people. These health inequalities seem wrong. However, not all inequalities of health are wrong; the inequality between a 75-year-old and a 5-year-old in years left to live is not wrong. Perhaps this inequality is not wrong because it natural, or because it is unavoidable, or because inequalities are wrong only when taken over whole lives, and a 75-year-old is better off than the 5-year-old for having lived longer.[5] The point is that, for whatever reason, even those who value health equity would not say that this inequality is wrong. Nor would they say that it is wrong that BASE jumpers have a lower life expectancy than the rest of us.[6] The reason here is that the BASE jumpers choose to take the risks.

In the field of public health, the usual way to mark the difference between morally suspect inequalities and morally innocuous ones is to describe the suspect ones as 'inequities'.[7] Inequalities in health are often thought to be inequitable when they are unfair or unjust, linked to some social indicator, and are to some degree avoidable.[8] The social indicator need not be money because health inequities are differences in health in which 'disadvantaged social groups' have worse health than advantaged groups, and advantage is not just a matter of money.[9] But to keep things simple, I take the badly off to be people who do not have access to much money. As for avoidability, it is a rule of thumb, one writer says, that: 'If a difference is unchosen and preventable then it is probably inequitable.'[10] Now, accounts of health equity raise many questions that we cannot answer.[11] Let me mention briefly the problem of levelling down and then ask about the relation between health equity and equity more broadly.

To aim for health equity is to aim to remove certain inequalities. An inequality in health means that some people have more health than others. Thus it might be

[5] See the discussion in Dennis McKerlie, *Justice Between the Young and the Old* (New York: Oxford University Press, 2013).

[6] As might be recalled from Chapter 3, BASE is an acronym for 'Bridge, Antenna, Span, Earth'.

[7] People who work in the field of public health in the United States may be more familiar with the term 'health disparities' than 'health inequities'. See Paula Braveman, 'Health Disparities and Health Equity: Concepts and Measurement', *Annual Review Public Health* 27 (2006): 167.

[8] Margaret Whitehead, 'The Concepts and Principles of Equity and Health', *Health Promotion International* 6 (1991): 219.

[9] See Braveman, 'Health Disparities and Health Equity', p. 167. Inequities, she says, can apply to 'racial\ethnic minorities and women'.

[10] Kemm, *Health Promotion*, p. 114. See also Whitehead, 'Concepts and Principles of Equity and Health', p. 219.

[11] The conceptions of health equity to be found in public health writings make many questionable ethical assumptions. James Wilson brings some of these out in his *Philosophy for Public Health: Beyond the Neglectful State* (Oxford: Oxford University Press, 2021), §9.2.

possible to reduce an inequality by making some people less healthy while making no one else more healthy. It might even be possible to achieve equality by making everyone, including the worst off, less healthy than they would otherwise be. Political philosophers will know this as the problem of levelling down.[12] Writers on health equity do not tend to consider levelling down, in the sense of reducing an inequality by making some worse off and no one better off. However, their supporting arguments make it clear that they would not favour levelling down.[13] Thus, if a policy did level down, as preventive regulations may, we can take it that that would be a decisive objection to it.

Another question is about the relation between health equity and equity more broadly. If inequity in health were reduced by improving the health of the worst off, but at a price in some of the non-health goods of the worst off, under what conditions would this reduction be unjust? Writers in public health may be tempted to avoid this question. They may say that health, education, housing, and job opportunities tend to go up together. But what if they do not or, more accurately, what about when they do not? Here is a way to think about the importance of health equity: it depends on the importance of health. To see why, consider that not all inequalities matter. As Joseph Raz says: 'There is no reason to care about inequalities in the distribution of grains of sand, unless there is some other reason to wish to have or avoid sand.'[14] To explain Raz's thought, if you and I walk on the beach, and I get more sand in my shoes than you, the inequality in sand between us does not matter because the sand is not valuable. The distribution of something 'matters only because what is to be distributed is valuable for independent reasons'.[15] Thus the reason an inequality in health would matter is because health is valuable. Now let us add to this claim the one in Chapter 3 that I said was undeniable: health is not the only value and it is not overwhelmingly more important than the other values. And, to add the claim from Chapter 4, the value of health is in its contribution to well-being. The plausible conclusion is that the importance of health equity depends on the value of health, which depends on its contribution to well-being. And the plausible conclusion of that chain of reasoning is that reducing health inequity is unjust when it increases inequity of well-being.

[12] The classic discussion is Derek Parfit, 'Equality or Priority?', in *The Ideal of Equality*, edited by Matthew Clayton and Andrew Williams (Basingstoke: Palgrave Macmillan, 2002), pp. 98–9.

[13] One example is M. Powers and R. Faden, *Social Justice: The Moral Foundations of Public Health and Health Policy* (New York: Oxford University Press, 2006), ch. 3. Another example is Paula Braveman, who says that John Rawls's difference principle, Amartya Sen's capabilities approach, and international human rights all support her view of equity. None of these would permit levelling down. See Braveman, 'Health Disparities and Health Equity', pp. 182–4.

[14] Joseph Raz, *The Morality of Freedom* (Oxford: Clarendon Press, 1986), p. 235.

[15] Raz, *The Morality of Freedom*, p. 240.

Health Equity and Preventive Regulations

Here is a public health equity argument for preventive regulations: preventive regulations would reduce unhealthy behaviour; unhealthy behaviour is disproportionately high among the badly off; therefore, preventive regulations would reduce health inequity. Furthermore, regulations would be more equitable than health promotion, which tends to benefit the middle class.[16] Here are some examples of the equity argument. On behalf of a tax on sugary drinks, Kelly Brownell and Thomas Frieden write: 'But the poor are disproportionately affected by diet-related diseases and would derive the greatest benefit from reduced consumption.'[17] Franck et al. make a similar point in arguing for taxes on junk food: 'However, low-income populations consume more junk food than do high-income ones, and they are generally at higher risk of obesity and chronic diseases. It follows that low-income individuals might be more likely to change their consumption behaviors and experience long-term health benefits.'[18] Another example is the proposed ban on menthol cigarettes in the United States, which has been argued for as promoting social justice on the grounds that African-Americans are the main users of them and their health tends to be worse than the health of other groups.[19]

Preventive regulations might improve the health of the worst off, and therefore appear a gain in health equity, but they are often characterized as nannyish restrictions on choice. To this objection, many public health advocates retort that people at the bottom do not really have a choice. Kass et al. write, 'disparities in access to healthy food and in rates of obesity . . . challenge the meaning of "individual choice" '.[20] And Michael Marmot writes, 'Poverty and inequality are deeply disempowering. People with little control over their lives do not feel able to make healthy choices.'[21]

As against the public health case, one might make the counterargument that the problem for poor people is a lack of money and the solution is to give them some.[22] The poor do not need their choices being supervised or policed, they need more options, which secure and accessible incomes provide.[23] Preventive regulations,

[16] Fran Baum and Matthew Fisher, 'Why Behavioural Health Promotion Endures Despite Its Failure to Reduce Health Inequities', *Sociology of Health & Illness* 36 (2014): 215.

[17] Kelly D. Brownell and Thomas R. Frieden, 'Ounces of Prevention—The Public Policy Case for Taxes on Sugared Beverages', *New England Journal of Medicine* 360 (2009): 1806.

[18] C. Franck, S. M. Grandi, and M. J. Eisenberg, 'Taxing Junk Food to Counter Obesity', *American Journal of Public Health* 103 (2013): 1951.

[19] 'Why the Proposed US Ban for Menthol Cigarettes Is Controversial', *BBC*, 29 April 2021 https://www.bbc.com/news/world-us-canada-56934957 (last accessed 10 June 2024).

[20] Nancy Kass, Kenneth Hecht, Amy Paul, and Kerry Birnbach, 'Ethics and Obesity Prevention: Ethical Considerations in 3 Approaches to Reducing Consumption of Sugar-Sweetened Beverages', *American Journal of Public Health* 104 (2014): 792.

[21] Marmot, *The Health Gap*, p. 62.

[22] Brian Barry, 'Real Freedom and Basic Income', *Journal of Political Philosophy* 4 (1996): 275.

[23] Hence some of the appeal of basic income schemes. See e.g. 'What the Spread of Universal Basic-Income Schemes Says about America's Safety Net', *The Economist*, 31 January 2023.

especially those raising the monetary price, would remove options from the worst off, the very people who have the fewest options. Moreover, people without much money might have good reasons to pick unhealthy options and one cannot assume that if a policy makes them behave in a healthier way, then it must be good for them. Preventive regulations are therefore likely to be inequitable.

One crucial distinction will help us sort through the arguments over poverty, choice, and well-being. This is the distinction between:

1. badly off people have poor options
   and
2. badly off people have problems in how they choose between their options.

To forestall some criticism, let me acknowledge that this distinction will not always be sharp. One reason is that having few options might affect one's capacity to choose well. Another is that the badly off, like members of any group, are unlikely to be identical, and some will choose well and others will choose badly. Nonetheless, we shall now see that the distinction between options and choosing abilities gives us a heuristic with which to think through the many factual, explanatory, and value claims about public health preventive regulations. In brief, if badly off people have poor options but do not have problems in how they choose between them, then the equity case for preventive regulations is lost. As we shall see, preventive regulations would make matters more equitable only if the badly off had problems with their choosing or, to make my familiar point, if the regulations are paternalistic.

Poor Options

Suppose someone wants their appendix removed because they want to adopt the sick role; or suppose someone wants it removed because of a delusion of illness. They have a problem with their choosing. But suppose someone wants their appendix removed because they have appendicitis and they want to avoid peritonitis. This person has poor options (appendectomy or grave danger), not a defect in their ability to choose. Moreover, it would be crazy to deny them an appendectomy on the grounds that it was a choice from poor options. The general points are that having poor options can make it more reasonable, not less, to choose an option that should otherwise be avoided; and removing options, in this case an appendectomy, makes things worse for the person with appendicitis, not better. I now want to make the same points in the context of public health. Unhealthy choices due to poverty may be reasonable and show no problem with the choosing abilities of the badly off; and taking unhealthy options away could make things worse for them, not better. I will use food and obesity as an example.

The leading cause of the rise in obesity is often held by economists and obesity researchers to be the much greater availability of cheap and convenient processed food and drink.[24] If so, the badly off could be more obese because they choose well from poor options. Healthy food is often more expensive in time and money than unhealthy food. A carton of chips might cost only $2 when avocadoes cost $10.[25] Fresh fruit and vegetables take longer to prepare and, because they perish, more time to shop for than processed foods.[26] The money and time cost of healthy food may be too high for badly off people, especially single parents, trying to hold down jobs, feed their families, and spend time with their children.[27]

Suppose poor options were the whole explanation for disparities in obesity. Then the impulse behind equity, which is concern for the badly off, would oppose, not support, preventive regulations. The badly off do have a problem with the options from which they can choose; that is what it means to be badly off. But if they have no problem in how they choose between their options, it must be at least in one way wrong simply to reduce options they might want to take. I say 'in one way wrong' because other considerations might justify the regulations, such as reducing healthcare costs. But if we want to help the badly off, it would be obviously perverse to reduce their poor set of options even further, and it would be perverse even if restricting them reduced inequalities in health.

The point just made can be explained in terms of equity. Suppose equity is particularly concerned with the well-being of the badly off and suppose preventive regulations would steer them away from unhealthy choices, as their proponents intend. Continue to assume that the badly off have no problems with how they choose, only with the options they can choose from. Preventive regulations would then cause them to consume what they prefer less, which would reduce their well-being and therefore be inequitable.[28] Suppose, instead of well-being, a conception of equity focuses on opportunities for well-being. Reducing the options of the worse off would again be inequitable because it would reduce opportunities they might value.

[24] David M. Cutler, Edward L. Glaeser, and Jesse M. Shapiro, 'Why Have Americans Become More Obese?', *Journal of Economic Perspectives* 17 (2003): 93; Avner Offer, *The Challenge of Affluence: Self-Control and Well-Being in the United States and Britain since 1950* (New York: Oxford University Press, 2006), ch. 7.

[25] 'High Avocado Prices Cause Spike in Thefts', *RNZ News*, 22 June 2019, https://www.rnz.co.nz/news/national/392680/high-avocado-prices-cause-spike-in-thefts (last accessed 17 June 2024).

[26] Lucy C. Farrell, Megan J. Warin, Vivienne M. Moore, and Jackie M. Street, 'Socio-Economic Divergence in Public Opinions about Preventive Obesity Regulations: Is the Purpose to "Make Some Things Cheaper, More Affordable" or to "Help Them Get Over Their Own Ignorance"?', *Social Science & Medicine* 154 (2016).

[27] Kostas Mavromaras, 'Economics and Obesity', *Australian Economic Review* 41 (2008): 78; Anne Barnhill, and Matteo Bonotti, *Healthy Eating Policy and Political Philosophy: A Public Reason Approach* (New York: Oxford University Press, 2022), pp. 27–9.

[28] This claim leaves aside non-self-interested preferences. See Chapter 4. Self-interested mistaken preferences are excluded by the stipulation that people do not choose badly.

I was just talking about equity in relation to well-being. What might a conception of equity in relation to health say about a health inequality that is reduced because the worst off have some options removed? The answer would depend on details of how a conception of health equity is developed. Writers on health promotion favour 'empowerment' as well as health.[29] Empowerment might be a component of health equity and one might say, given we are assuming for now that the badly off have no problem with choosing, that it would be inequitable to disempower them further by removing some of their options. If nonetheless some conception of health equity favours reducing options overall, then I say, so much the worse for that conception. By hypothesis, the badly off have become healthier but at an overall cost in their well-being. One might ask, could a gain in health outweigh an overall loss in well-being? Could a gain in health equity outweigh a loss in equity of well-being? The answer to both questions is the same: of course not. Remember, from the section on health equity, that the value of health is its contribution to well-being and the value of health equity depends on the value of health. Health and health equity are parts of a whole, well-being and equity of well-being, and to give up the whole for a part would be like giving up a pound to save sixpence.[30]

To make my claim again: 'When someone's problem is a poverty of options, and not poor choosing, do not restrict their options further if you want to help them.'[31] This claim may be misunderstood, and I would like to forestall some misunderstandings by connecting it to what some public health writers say about whether the badly off are free or responsible. Remember, throughout the rest of this section, that the claim is a hypothetical: when the problem is poor options, and not poor choosing, do not restrict options further. I have not said that unhealthy choices are due to poor options, although I think what I have said shows it to be not merely a possible but a plausible explanation.

If we go back to a strand of argument we saw earlier, many writers say that people in poverty do not have real choice or freedom. One reason why public health advocates say so is to rebut the argument that badly off people have poor health because of their choices. I take them to be arguing against the view that the badly off are to blame for their poor health and so the state or society should not spend money trying to improve their health. Another reason for the advocates to say that

[29] Kemm, *Health Promotion*, p. 8.

[30] Here I am arguing against Elizabeth Fenton, 'Equity and Preventive Regulations', *Journal of Medical Ethics* 45 (2019): 330.

[31] This claim may not always be true. A minimum wage removes the option to work below a set pay rate, and it can benefit low wage workers. Notice though the disanalogy between the minimum wage and typical arguments for public health preventive regulations. The case for the minimum wage does not rest on workers being misinformed about low wage jobs, or addicted to them, or tempted to take them against their better judgement. The case rests on strengthening workers' bargaining advantage, and bargaining seems irrelevant to public health.

the poor are not free is to argue against critics of the nanny state, who wheel out 'freedom and responsibility' to oppose public health interventions.

Writers on public health often bundle together 'choice', 'responsibility', 'freedom', and opposition to preventive regulations.[32] They then think that, because the badly off cannot fairly be held responsible for their health and because they do not have real freedom, one should not object to preventive regulations as interfering with choice. This section shows how the ideas come apart. One can consistently (and reasonably) believe (1) poor options cause ill health, and so the badly off are not to blame and should not be held responsible; and (2) the badly off act responsibly (they do not behave like children) and they should not have their choices further restricted by preventive regulations. Furthermore, one can favour all sorts of policies to improve people's living conditions while opposing restrictions on their choice.

What about freedom? Michael Marmot, for instance, cites the higher consumption of alcohol following a fall in price to counter the critics of the nanny state. Marmot's idea seems to be that the choice to drink is not free anyway because price is a social determinant, a circumstance beyond individual control.[33] Of course he is right, but he leaves it a mystery how that observation is a counter to the critics. A lower price for goods increases options compared with a higher price so it seems less of a constraint on freedom than the higher price. The general point is that, even if we should think of people without much money as being unfree, they would become even less free if those products are made harder to get, with no improvements in other options.

To restate my claim, when the problem is a poverty of options and not a problem with choosing, do not restrict options further. One might wonder whether it matters that the examples we had were an appendectomy and food, neither of which was really optional in the circumstances. People without much money must eat, as must people generally, but pretty much no one has to smoke, or drink alcohol or sugar.[34] However, I do not think this observation affects the argument. We saw at length in Chapter 3 how people can reasonably choose in ways that make them unhealthy. If people have no problem with their choosing, they will not benefit from worse access to tobacco, alcohol, or sugar. People like pleasures and treats, and people without much money might have to take what they can get. Smoking,

[32] Baum and Fisher are two of many who do this in 'Why Behavioural Health Promotion Endures', p. 217. Like many other writers, they label the package 'neoliberalism', which is for them a term of disapproval. James Wilson, a supporter of public health, unbundles the package and distinguishes various types of responsibility in *Philosophy for Public Health: Beyond the Neglectful State* (Oxford: Oxford University Press, 2021), ch. 8.

[33] Marmot, *Health Gap*, pp. 69, 75.

[34] An exception is for people with Type 1 diabetes who must respond to an episode of hypoglycaemia (low blood sugar). See National Health Service, 'Hypoglycaemia (Hypos)', https://www.nhs.uk/conditions/type-1-diabetes/managing-blood-glucose-levels/hypoglycaemia-hypos/ (last accessed 20 June 2024).

for instance, might be the one pleasure they get, or the one source of stress-relief. Smoking might not provide benefits to richer people, but then they can afford other things.

The argument I am making goes beyond the question of whether preventive regulations are regressive. A regulation is regressive if it causes poorer people to spend disproportionately more of their incomes than richer people. Consider a flat tax on sugary drinks that did not change anyone's consumption. This tax would be regressive and looks inequitable. But if the tax does reduce consumption, it might not seem inequitable. Jason Hanna writes, 'while "sin taxes" are often claimed to be regressive, this concern may be tempered if lower income groups are more likely to reduce or eliminate consumption in response to price increases'.[35] Hanna may mean that people on lower incomes would gain more in health than they would lose by a higher price. Andrea McDonald makes that point explicitly:

> Some may claim that an SSB [sugar-sweetened beverage] tax is unfair on the poor because the cost of the tax corresponds to a greater proportion of incomes for a low-income household. The health benefits are, however, greater for low-income people, high consumers of SSBs and children, because these groups are more sensitive to price changes. . . . Financial regressivity is largely outweighed by progressive health benefits.[36]

In fact, at the limit, a sugar tax would not be regressive at all if poorer people ceased to buy sugary drinks because none of their income would then be spent on the drinks or the tax. However, a tax might not be regressive and yet make outcomes more inequitable. Consider now a tax on junk food. Suppose the badly off rank these options from best to worst:

A. Cheap healthy food;
B. Cheap junk food;
C. Expensive healthy food;
D. Expensive junk food.

Before the tax, Option A is not available so the badly off take Option B, buying cheap junk food. After the tax, Option B is removed but the tax does not make Option A available, so the badly off switch to Option C, buying expensive healthy

[35] Jason Hanna, *In Our Best Interest: A Defense of Paternalism* (New York: Oxford University Press, 2018), p. 239. See also Robyn Toomath, *Fat Science: Why Diets and Exercise Don't Work—and What Does* (Auckland: Auckland University Press, 2016), pp. 160–1, where she also implies that objecting to regressive taxes is the preserve of 'neoliberals'.

[36] Andrea McDonald, *Sugar-Sweetened Beverage Tax in Pacific Island Countries and Territories: A Discussion Paper* (Noumea, New Caledonia: Public Health Division, Secretariat of the Pacific Community, 2015), p. 3.

food. The tax would not be regressive in the sense that the badly off would be disproportionately paying the tax because, by hypothesis, they would not be paying the tax. It would, however, put them into a position that they preferred less than before the tax or, put another way, make them worse off as judged by their preferences. Suppose now that richer people always preferred Option C, expensive healthy food, to Option B, cheap junk food. The tax, in removing Option B, has no effect on them. Then the tax would not be regressive, but it would raise no revenue and it would leave the richer unaffected and the poorer worse off, which is both a loss of well-being and an increase in inequity.

Our discussion has focused on preventive regulations that reduce choice. This focus might be criticized. It might be said that preventive regulation should not be considered in isolation. Preventive regulations are just one aspect of public health. The fight for public health requires many policies, including making healthy options more available, educating people, altering the design of the built environment, changing the nature of transport, and even revising agricultural policy. In my view, this argument makes the sensible point that it is no objection to preventive regulations that, alone, they would not prevent ill health. But it is also no defence of preventive regulations that they are an element in a package that is on-balance good. Why not have the package without the regulations? For instance, we could have more public transport or water fountains without also restricting fast food outlets. We should ask, of given preventive regulations, what they would separately add or take away from some overall package of measures.

My argument has been that removing unhealthy options would harm the people who want to take them so long as they are not making mistakes about their interests. Let me make some brief remarks about how this argument might apply to making healthy options cheaper or more available, and let us continue to assume that people do not make mistakes. In this context, one main question asks who would pay for making healthy options cheaper and another asks what else the resources could have been used for, such as giving people money to spend as they wish, which might be on healthier options, or not.[37]

Bearing these questions in mind, take a claim made by Toni Ashton about preventive regulations, such as a sugar tax, that raise revenue: 'Any regressive nature of a tax could be further offset by using the revenue gained . . . to provide

[37] All sorts of practical problems can arise with trying to promote healthier options. Perhaps, for instance, a tax cut on fruit and vegetables would be pocketed by retailers rather than passed on to consumers in lower prices. Perhaps lower prices on fruit and vegetables would cause people to eat even more food, healthy and unhealthy. Perhaps, too, a subsidy for fruit and vegetables could primarily benefit the middle class. In New Zealand, which has a Goods and Services Tax (GST) on almost everything, the Child Poverty Action Group has opposed dropping the tax on fruit and vegetables because they think it would be better to get the tax revenue from everyone and spend it on the badly off. See Child Poverty Action Group, 'Will Removing GST on Fresh Fruit and Vegetables Achieve Its Stated Aim?', December 2010, https://static1.squarespace.com/static/60189fe639b6d67b861cf5c4/t/62d7b58675c2e131693fe2cf/1658303879260/Backgrounder_GSTExemptions+on+Food+final.pdf (last accessed 10 June 2024).

health-promotion programmes targeted to low-income groups.'[38] The first point to make is that a regulation would raise revenue only if people carried on consuming, since people have to buy the regulated product in order for revenue to be raised. Next, we need to know who is paying this tax. If the low-income groups drink sugar, they pay the tax, in exchange for which they would get health promotion, if we follow Ashton's recommendation, or cookery classes, or children's playgrounds, to take other examples I have come across. If they would rather have untaxed food and drink and no health promotion, the tax would make them worse off. If instead it is the higher-income groups who consume and pay the tax, while the low-income groups switch to untaxed food and drink, then the low-income groups would get health promotion paid for by the revenue raised from the higher-income groups. But the low-income groups might benefit more from having the money instead of the health promotion, and they lose from the tax by having to consume what they would otherwise rather not, such as expensive healthy food and drink. Leaving aside political feasibility, why would it not be better, if we want to help low-income groups, to tax only the richer people on the sugar they drink, or tax them in some other way, and transfer the revenue as money?

To conclude this section, if the reason for unhealthy behaviour lies in choosing well from a set of poor options, it would be inequitable to reduce options. Preventive regulations would indeed reduce options, a few cases aside. Preventive regulations would usually then be inequitable. The equity case for preventive regulations therefore hinges on poor health being the result of problems in choosing. Restricting options because people would otherwise choose ones that are bad for them is paternalism, which is the first point I wanted to demonstrate. Granted, then, that the case for preventive regulations must be paternalistic, is the case a good one?

Paternalism and Priority to the Worse Off

Let me restate some ideas from previous chapters. First, unhealthy choices might be due to all sorts of factors that one could label problems with choosing, such as cognitive biases, motivational weaknesses, or being manipulated. Second, a case for constraining options requires more than establishing that people have problems with their choosing; it requires that the problems cause people to pick options that are against their interests. Third, to choose unhealthy options need not be against their interests. And, fourth, the criterion for a choice being against

[38] Toni Ashton, in Alan Johnson and Susan St John, Submission to the Tax Working Group, 'Taking a Child-Focused Lens to Tax' (Child Poverty Action Group), 30 April 2018, p. 12, https://taxworkinggroup.govt.nz/sites/default/files/2018-09/twg-subm-3983200-child-poverty-action-group-cpag.pdf (last accessed 10 June 2024).

someone's interests is that it does not fulfil their ends as well as some alternative. Tested against these criteria, only smoking, of leading types of unhealthy behaviour, was found to be against the interests of most who did it. Public health restrictions on choosing junk food and alcohol (and no doubt gambling) seem likely to be against the interests of most consumers. Moreover, even those who might benefit from having their choices restricted would generally have their autonomy infringed upon. But would the worst off especially benefit from paternalistic policies? If so, given its importance, would the gain in equity outweigh the losses in well-being for some and the loss of autonomy for nearly everyone? Since I think the answer to the first question is 'no', I shall leave the second question unanswered.

Some people, it seems, unthinkingly assume the socially disadvantaged must be poor choosers. For instance, the Nuffield Council on Bioethics issued a report that mentions children and the socially disadvantaged together as cases of vulnerability.[39] Perhaps they did not mean to, but it certainly looks as if they are treating adults like children just because they do not have much money. At any rate, if we are to justify paternalism as being more equitable, we have to have some reasons to think the worst off, who are the focus of equity, are especially likely to choose against their own interests.[40]

The philosopher Richard Arneson thinks the worst off are especially likely to choose badly, and we can learn from the strengths and weaknesses of an argument he has been making for many years.[41] Arneson emphasizes the connection between paternalism and distributive justice. Here is his argument. Whether someone would gain or lose from free choice depends partly on how good they are at choosing. Abilities to choose vary in that some people are better than others at deciding how to fulfil their ends and at having the will power and perseverance to implement their decisions. If people had free choice, some would choose in line with their interests; they would not benefit and may suffer from options being removed. Others would mistakenly act against their interests; they could benefit from the paternalistic removal of bad options.[42] Paternalism would thus be good for some people but bad for others. Arneson then connects a normative claim to an empirical claim. The normative claim (which he does not quite endorse) is that

[39] Nuffield Council on Bioethics, *Public Health: Ethical Issues* (London, 2007), e.g. 6.37 (p. 117); 8.7–8.8 (p. 144).

[40] As we saw earlier, health inequities are differences in health in which 'disadvantaged social groups', including 'racial\ethnic minorities and women', have worse health than advantaged groups. However, I am not aware of any arguments by public health advocates that either women or members of racial\ethnic minorities are especially likely to choose badly, except perhaps insofar as they overlap with the group 'people in poverty'.

[41] See R. Arneson, 'Paternalism, Utility, and Fairness', *Revue Internationale de Philosophie* 43 (1989); 'Joel Feinberg and the Justification of Hard Paternalism', *Legal Theory* 11 (2005), and 'Egalitarian Perspectives on Paternalism', in *The Routledge Handbook of the Philosophy of Paternalism*, edited by K. Grill and J. Hanna (Abingdon: Routledge, 2018).

[42] Arneson sets aside the practical problems of paternalism, such as regulatory capture and administrative incompetence. See, 'Egalitarian Perspectives on Paternalism', p. 197.

distributive justice gives priority to the worst off when people's interests conflict. The empirical claim, which I think he does endorse, is that the worst off tend to be the poorer choosers and are therefore more likely to choose against their own interests. Arneson's conclusion is that giving priority to the worst off supports paternalism.

I agree with what Arneson nearly says, that distributive justice gives priority to the worst off, and I also agree that a loss of autonomy can be outweighed by gains in well-being, especially gains to the worst off. But why think the worst off are the poorer choosers and why think they would choose against their interests if they had free choice? Arneson's way to answer these questions is *a priori* rather than empirical. He makes a tendency claim: worse decision-making abilities tend to lead people to make decisions against their interests, which in turn tends to make them worse off than average.[43] He does not observe that this tendency could be very weak and more than counteracted by other factors. People may have low incomes or status because of discrimination, or being born into a hierarchy in a society with low social mobility, and they could be badly off and yet no worse at choosing than anyone else. Arneson only hints at this possibility.[44]

Indeed, if we stay at Arneson's *a priori* level, it is possible that paternalism could be especially bad for the worst off. Consider a ban on short-term loans with high costs in interest and establishment fees. Those loans might benefit people who are desperate for money to pay the rent and cannot get it anywhere else, but be bad for middle class students in a bar who want to use their mobile phones to take out a loan to buy another round of drinks. And, from the previous section, consider restrictions to make junk food harder to get or more expensive. The restrictions might be good for middle class people who want to control their weight but bad for people who need a cheap hot meal.

In any case Arneson's argument has another weakness. Let us grant that some people are worse choosers than others. To say that B is a worse chooser than A is not to say that B is a bad chooser. The point is obvious outside health. A might be better than B at map reading, investment, or interior decoration, and yet B could be good at all of these. What is needed for distributive justice to support paternalism, which does after all require trying to make people better off, is not that some are worse choosers than others. It is that some are bad choosers, who tend to make mistakes about their interests, while others are good ones.[45] A further difficulty for Arneson is that, even for bad choosers, it does not follow that they would

[43] Arneson 'Egalitarian Perspectives on Paternalism', p. 197.

[44] 'Some bad choosers will have high initial bank account wealth as they enter adult life' is all he says, but he would presumably agree that some good choosers will have low initial bank account wealth and possibly other disadvantages. See Arneson, 'Egalitarian Perspectives on Paternalism', p. 197.

[45] Arneson may or may not see that 'worse chooser' does not entail 'bad chooser'. He only writes: 'For simplicity, we can divide individuals into good choosers and bad choosers.' 'Egalitarian Perspectives on Paternalism', p. 196. Of course some people are not only worse choosers but bad ones, such as the young children who are largely out of the scope of this book.

benefit from paternalism. Person A might be good at choosing for A, while B is bad at choosing for B. And yet person A might be even worse at choosing for B than B is. In short, paternalism, even paternalism supported by equity, does not follow from the truism that choosing abilities vary.

Some writers have applied Arneson's argument to public health and in the process have tried to fill in the empirical gaps. One such writer is Johannes Kniess who, in the context of obesity, points to the social gradient in unhealthy choices as a reason to think the worst off have a problem in their choosing.[46] But the social gradient is not a sufficient reason for this conclusion because an alternative explanation for the social gradient is, as we saw, that the worst off have fewer options rather than that they have a problem with their choosing. Another gap-filling writer is Kalle Grill, who gives a list of reasons why the worst off might not be 'able choosers'.[47] These reasons include a lack of healthy food and exercise facilities; limited access to childcare and transport, so that it would be hard to go to the gym or medical appointments; low purchasing power and a lack of flexibility that means they cannot take advantage of discounts; and 'unhealthy behaviours may be coping mechanisms in the face of deprivation'.[48] Grill continues: 'To this list, we should add the fact that people who are poor tend to spend much time and effort managing their everyday finances, in a way that leaves them with less effective ability for other cognitively demanding tasks.'[49] The conclusion from this list is supposed to be that 'people vary in their ability to make rational choices, and so to make choices that promote their own interests. High ability to choose tends to be correlated with a generally advantaged position in society.'[50]

Grill's approach is a good example of confusing the distinction between poor choosing and poor circumstances. Contrary to his own interpretation, the first items on Grill's list in no way impugn people's abilities to make rational choices or choices in line with their interests. People who do not go to the gym because it is too expensive, even with a public health discount, or do not attend medical appointments because they cannot get transport may be choosing wisely. It is less obvious what we should make of coping mechanisms and having less ability for cognitively demanding tasks. These items on Grill's list could explain how people make mistakes, but they do not establish that they make mistakes. If people smoke, eat junk food, or drink alcohol to cope with difficult lives, then in one sense they are getting something out of what they are doing. Coping mechanisms can be good as well as bad. Nor can we conclude that unhealthy choices are mistakes even if

[46] Johannes Kniess, 'Obesity, Paternalism and Fairness', *Journal of Medical Ethics* 41 (2015): 889.
[47] Kalle Grill, 'Incentives, Equity and the Able Chooser Problem', *Journal of Medical Ethics* 43 (2017): 158. Grill takes this list from Kristin Voigt, 'Incentives, Health Promotion and Equality', *Health Economics, Policy, and Law* 7 (2012): 263.
[48] Grill, 'Incentives, Equity and the Able Chooser Problem', p. 158.
[49] Grill, 'Incentives, Equity and the Able Chooser Problem', p. 158.
[50] Grill, 'Incentives, Equity and the Able Chooser Problem', p. 158.

having little money makes it harder to perform cognitively demanding tasks. In the first place, the choice between unhealthy and healthy options is often not cognitively demanding, so the point may not apply at all. The choice of whether to have a cigarette is not like trying to make sense of an overcomplicated offer of tax credits.[51] In the second, the poor can be better at spending their limited resources than people with plenty of money (such as professional economists).[52] The unhealthy choices could be the right ones.

What about the motivational mistakes, described in Chapter 5, such as weakness of the will? Theresa Marteau and Peter Hall describe a 'double hit faced by those born into poverty: living in environments that contain more cues for unhealthy behaviours, coupled with a reduced capacity to inhibit responses to those cues'.[53] What they mean here is that unhealthy products are more marketed and more widely available in poorer areas, hence 'more cues', and that the badly off are less able to resist the temptation to consume them. I think the most plausible reason why the products are more marketed and available in poorer areas is because that is where the demand is, so any problem must lie in the demand. But even granted that the badly off are less able to resist temptation than the better off, why think that these unhealthy products lead them into temptation? Marteau and Hall do not say. Perhaps, taking everything into account, the unhealthy choices are the ones they really want to make. It cannot be said too often that 'poor people choose unhealthy options' does not entail 'poor people behave poorly'.

The public health paternalist needs to show that unhealthy choices are against people's interests, which in this book we are taking to be derived from the fulfilment of their preferences. If paternalism is to be supported by equity, we need evidence that the unhealthy choices of the badly off specifically are contrary to their ultimate preferences. I do not think an overall body of evidence exists. This conclusion may be surprising. Surely we have a mountain of evidence about what smoking, alcohol, unhealthy foods and drinks, a lack of exercise, and so forth do to our health? And we do have evidence about how preventive regulations and other interventions affect the choices of people when broken down by education, income, gender, ethnicity, locality, age, and so on, and this evidence allows conclusions to be drawn about the health equity effects of interventions. But this evidence

[51] Anthony King and Ivor Crewe tell the story of the well-meaning but disastrous British attempt at tax credits for the working poor in the early 2000s in *The Blunders of Our Governments* (London: Oneworld, 2013), ch. 10. The policy failed for many reasons and being 'inordinately complicated' (p. 147) was one of them. I mention this example because Grill has a point when he emphasizes that policy should take account of whether people are 'able choosers'.

[52] See the study reported in S. Mullainathan and E. Shafir, *Scarcity: Why Having Too Little Means So Much* (New York: Times Books, 2013), ch. 4. The study found that economists were much more likely to commit a specific economic mistake in reasoning when compared with research subjects without much money.

[53] Theresa M. Marteau and Peter A. Hall, 'Breadlines, Brains, and Behaviour', *British Medical Journal* 347 (2013): 2.

is not enough. 'Health equity', as we saw, could go up while the well-being of the badly off goes down, and interventions that reduce health inequity can be inequitable and harmful. We also have evidence about the determinants of consumption choices, but that also does not show whether the people who make these choices act against goals that they regard as more important.

In Chapter 6, I presented such evidence as I could find that connected smoking, alcohol, and fattening food and drink to people's behaviour and attitudes in a way that might help us decide whether consumers act mistakenly, that is, contrary to their own ultimate preferences. Smoking was the only case that it seemed reasonable to think of as usually a mistake. So many smokers regretted starting and have tried to quit. We also saw that badly off smokers seemed just as likely to regret smoking as better off smokers.[54] Successful anti-smoking measures might not reduce the inequity between better off and worse off smokers, but, since smoking is disproportionately high among the worse off, the measures would plausibly reduce the inequity between better and worse off people. But when we considered alcohol, it appeared that drinkers in general valued their drinking; and when we considered fattening food and drink, people with less money were both unlikely and the least likely to be dieting. Now, I hedged the conclusion in Chapter 6 by saying more evidence may exist, or new evidence may be discovered. Nonetheless, we seem to have no special equity reason to limit options in the case of alcohol and we may have a special equity reason against limiting the choice of other unhealthy food and drink.[55]

As far as the evidence goes, paternalistic interventions towards adults outside the area of smoking would be against the interests of most of them, including, perhaps especially, those with the least money. They would also infringe on autonomy. Damning though that conclusion might look, we still cannot say definitively that public health paternalism is wrong. What if the few who benefit would each gain a lot whereas the majority would each lose little? Then, I think, public health advocates might have a point. Whether it can be turned into a developed and persuasive argument is another matter, as we shall now see.

[54] T. F. Pechacek, P. Nayak, P. Slovic, S. R. Weaver, J. Huang, and M. P. Eriksen, 'Reassessing the Importance of "Lost Pleasure" Associated with Smoking Cessation: Implications for Social Welfare and Policy', *Tobacco Control* 27(e2) (2018): 148.

[55] Another hedge before concluding against paternalism is that smoking, drinking, and obesity are not the only areas of public health concern. For instance, in 2022, the United States had 81,806 deaths from overdoses of synthetic opioids, primarily fentanyl. See National Institute on Drug Abuse, 'Drug Overdose Death Rates', https://nida.nih.gov/research-topics/trends-statistics/overdose-death-rates#:~:text=Deaths%20involving%20synthetic%20opioids%20other,overdose%20deaths%20reported%20in%202021 (last accessed 10 June 2024). Using fentanyl may be against the interests of many who take it, especially if they do not know it is fentanyl. On the other hand, plenty of users do know so, if taking fentanyl was against their interests, it would not be because of their sheer ignorance. For some data, see Ralph Foglia III, Nina Cooperman, Dina Mattern, Suzanne Borys, and Anna Kline, 'Predictors of Intentional Fentanyl Use: Market Availability vs Consumer Demand', *International Journal of Drug Policy* 95 (2021): 1.

Helping the Few at the Expense of the Many

As an example of when policy might have to choose between the minority and the majority, let us return to an example we have come across before, involving alcoholism and Geoffrey Rose's population strategy of intervening on a large scale. Rose wrote:

> there seems to be no way of reducing the dire problems of alcoholism that does not involve a general reduction of intake in the population as a whole. This is hard on Mr and Mrs Average, who presumably enjoy their moderate drinking, but it is the necessary price of being members of a society rather than solitary individuals (a price that is far outweighed by the benefits of social interactions and support).[56]

Why should reducing mean alcohol consumption lead to fewer alcoholics? Perhaps the method would involve changing social norms, making drinking less socially encouraged; perhaps the method would involve raising prices, putting large amounts of alcohol beyond the budgets of some potential alcoholics. Whatever the mechanism, assume that Rose is right on the facts about the options. Why would reducing the number of alcoholics justify the costs to the many Mr and Mrs Averages? Rose does not seem to see a problem but there is one, and it is not to be waved away by Rose's vague reference to society. He is no doubt right that being a member of a society is better than being a member of none, but that gets us nowhere. Alcoholics are members of society too so one could equally say that the necessary price for them of being members is that they are the unfortunate casualties of benefiting the majority. We need, then, a better reason to help alcoholics at the expense of the majority of drinkers.

To focus on Rose's case, leave aside, as he does, any indirect benefits from less drinking, such as a drop in violence or accidents. The measures that reduce drinking are to be justified by the benefits to the drinkers themselves. One could first try to defend paternalistic alcohol restrictions on utilitarian grounds. Utilitarians would tot up the gains and the losses to different people from a regulation and select the regulation (or have none at all) that maximizes the net sum of benefits. Policies such as taxes that affect all consumers would be more defensible the greater the proportion who would benefit and less defensible the greater the proportion who would lose. Other things equal, a policy that is bad for a majority of people is a bad policy. But other things may not be equal for utilitarians. A pill that would cure the colds of 90 per cent of sufferers, but kill the remaining 10 per

[56] G. A. Rose, K.-T. Khaw, and M. Marmot, *Rose's Strategy of Preventive Medicine: The Complete Original Text* (Oxford: Oxford University Press, 2008), p. 144.

cent, would not maximize the sum of benefits even though it benefited a large majority.[57] Perhaps raising taxes on alcohol would lead to a net gain in utility because the few people who did not become alcoholics gained more than the majority of drinkers lost. If this argument is to be developed, we would need to know how the interpersonal comparisons of welfare were done and why they came out that way. If these aspects of the utilitarian case can be made out, we would also need a reply to non-utilitarian considerations. We would need to know why the gains in aggregate welfare outweigh the loss in autonomy discussed in Chapters 7 and 8, and the unfairness to be discussed shortly.

Suppose, as is quite possible, that utilitarianism does not support helping the minority of alcoholics at the expense of the majority of drinkers. Utilitarianism aggregates and lots of small gains could outweigh a few big losses. In a phrase, utilitarians would trade lives for headaches, so long as enough headaches were prevented. Some writers object to this tradeoff.[58] Consider paternalist policies that impose more costs than benefits in aggregate. A policy requiring childproof caps on medicine and poison bottles might be an example. Childproof caps mainly benefit young children, and they are a minor nuisance to many adults and a more substantial nuisance to those with arthritis in their hands or wrists.[59] Although adults greatly outnumber young children, it seems reasonable to require caps to prevent children being poisoned even if utilitarianism is against it. We might say that distribution, ethically speaking, ought to take more account of the severity of a loss than utilitarianism would.

It is easy to see how an argument by analogy could then be made on behalf of public health policies. A policy, such as imposing higher prices on alcohol, might come at the expense of a majority but benefit the few who would avoid the miseries and premature death due to alcoholism. Even if the majority's losses from higher prices added up to a bigger total than the minority's gain, the magnitude of what the alcoholics would each lose is morally more important. Refusing to impose the taxes on utilitarian grounds would be like trading lives for headaches. The trouble with arguing by analogy is that we have many other apparently analogous cases pointing in the opposite direction. Speed limits are higher than the level that would minimize road deaths because the small gains to so many people from being able to drive faster, though individually much smaller than the loss from being killed, are so great that we think they justify higher limits.[60] Analogies alone would not make the case for or against public health.

[57] I heard John Broome give this example at a conference in 2011.

[58] F. M. Kamm, *Intricate Ethics: Rights, Responsibilities, and Permissible Harm* (New York: Oxford University Press, 2007), p. 408.

[59] Or those who are clumsy, such as Richard Nixon. See the story of the teeth marks on the pill bottle in Bob Woodward and Carl Bernstein, *The Final Days* (New York: Simon and Schuster, 1976), p. 44.

[60] Alistair Norcross, 'Comparing Harms: Headaches and Human Lives', *Philosophy & Public Affairs* 26 (1997): 159–60. As Norcross says, you might miss the point if you think that, as it happens, the speed

To summarize so far, one could try to make a utilitarian argument for paternalistically helping the minority at the expense of the majority, or one could try to argue that the minority would otherwise suffer so much that their interests should prevail. Even assuming either argument could be made out, a further difficulty involves fairness. Remember that we are considering preventive regulations that reduce options, benefiting some and harming others. The regulations do not provide new options, they just make unhealthy options harder or impossible to take so that people choose the healthy options instead. But the healthy options were available all along. People who do not smoke because a tax is raised had the option of not smoking when the tax was lower. People who drink tap water when sugary drinks are taxed would have the option of drinking tap water even without the tax. A preventive regulation does not redistribute options from those with more to those with fewer. How is it fair, then, to reduce the options of people who choose well to help people who voluntarily choose badly?[61]

Let us now apply the factor of voluntary choice to childproof caps and a higher alcohol tax. Suppose someone complains about childproof caps being required on medicine bottles: 'Why should I have to suffer the pain in my wrist of opening these bottles when children can keep their hands out?' The obvious answer is that children do not know any better. Their claims to be helped are not reduced by the factor of voluntary choice since they did not choose voluntarily. Now consider someone who complains about the difficulty of buying alcohol because the government has made it so expensive: 'Why should I have to pay so much just because other competent adults cannot or will not moderate their drinking?' This complaint seems to make a more persuasive point.

A likely reply is that alcoholics are addicts and therefore unable to control their drinking. Notice, though, that this reply does not deny that voluntary choice is a moral factor; it instead denies that the alcoholics who would be helped would be choosing voluntarily and implies that alcoholics are, in respect of voluntary choice, like young children. This claim is more plausible for alcoholism than for other unhealthy choices (such as unprotected sex or eating junk food) and even then it draws on a controversial interpretation of addiction, as we saw in Chapter 9. In any case, a supposed benefit of higher prices is preventing people becoming alcoholics in the first place, in other words while they are still, by definition, able to avoid drinking. One cannot defend raising the price of alcohol to Mr and Mrs Average by saying it would help the alcoholics who cannot voluntarily choose if they are not yet alcoholics at the time they are helped.

limit in your jurisdiction is too high. Most of us (including cyclists and e-scooter users) would not accept a speed limit of 10 kph even if it minimized deaths.

[61] Richard Arneson, 'Luck Egalitarianism and Prioritarianism', *Ethics* 110 (2000): 348.

The fairness argument is often made in political disputes about regulating public health, often by business groups that do not want to be regulated.[62] Obviously, that an ethical argument is used, or appropriated, to protect corporate self-interest is not a good objection to the argument. However, some better objections can be made.[63] I do not want to say that the fairness argument is a basis for a decisive objection to public health regulations. I do want to say, though, that if public health advocates propose policies that restrict unhealthy options at the expense of the majority, then they have to either explain why those policies are not unfair, or why their benefits outweigh any unfairness.

Conclusion

We are almost at the end of this book. We have seen reasons to be critical of public health paternalism. Steering adults into making healthier choices will make many of them worse off, not better off, and it will infringe on their autonomy. In the last two chapters, we have considered a couple of attempts to change the subject. The interventions that public health advocates want are not paternalistic, some say, because they achieve a collective good that is out of reach of individuals and markets, and because they aim at social justice by reducing health inequities. In Chapter 11, we saw the limits to the arguments about collective goods. In this chapter, we saw that public health interventions that make it harder to make unhealthy choices could be justified only by presupposing that people would make mistakes about their interests. Social justice and equity are therefore not alternatives to paternalism when it comes to arguing for these interventions. And then we were back to the same problems. We had no more reason, if anything less, to think that paternalistic policies would help disadvantaged groups than they would help people in general.

I then sketched an argument for public health interventions that would help a minority at the expense of the majority. I used Rose's example of alcoholism to explain how interventions might be justified by saving a small minority from a great loss even at the expense of the majority. But the argument was only a sketch, and it faces difficulties. Perhaps these difficulties could be overcome, perhaps not.

It is no accident that the last sentence was inconclusive. This book does not aim to be (and of course is not) the Last Word. There is always more to say, and the

[62] Pamela Mejia, Lori Dorfman, Andrew Cheyne, Laura Nixon, Lissy Friedman, Mark Gottlieb, and Richard Daynard, 'The Origins of Personal Responsibility Rhetoric in News Coverage of the Tobacco Industry', *American Journal of Public Health* 104 (2014): 1048.

[63] Tom Walker is keener on taking account of fairness, in his 'Why We Should Not Set a Minimum Price per Unit of Alcohol', *Public Health Ethics* 3 (2010): 107, than Stephen John, in his 'Should We Punish Responsible Drinkers? Prevention, Paternalism and Categorization in Public Health', *Public Health Ethics* 11 (2018): 35.

argument can always continue. On the other hand, we have to stop somewhere and decisions cannot wait forever. In the next, and final, chapter, I will summarize the reasons why the task of evaluating public health interventions is not complete, and how one can use the ideas in this book as a heuristic to ask some of the necessary questions of a proposed intervention.

13
What Is Left for Public Health?

The Conclusion to This Book

We have been thinking about public health interventions that try to benefit adults by getting them to choose healthier options. I have recommended being sceptical about the merits of these interventions, particularly when their method consists of making the unhealthy options more expensive or harder to access. Insofar as we have evidence, it appears likely that the people whose choices are steered in the direction of health would often be made worse off, not better off, and they would usually have their autonomy infringed upon. One might wonder if this scepticism leaves any room for public health.

Quarantine, isolation, disease surveillance, directly observed therapy, vaccination, environmental health, school health checks, health education, screening programmes, making health information genuinely accessible, banning the sale of cigarettes, alcohol, and vapes to children: this is a partial list of activities in public health that my arguments in this book leave untouched. Now, it would be surprising if the arguments, such as about the limited and variable value of health or the importance of respecting autonomy, had no implications for the activities in this list. But what they imply would have to be worked out separately from what I have done here. My focus has been on attempts to make adults healthier by reducing or otherwise interfering with their choices. Compare this focus with the items on the list. The methods to control contagious disease are substantially about protecting people besides the contagious; offering screening or making health information accessible improves people's options or their capacity to choose between them; banning sales to children aims to protect them from themselves, but then children usually are legitimate targets for paternalism. My aim in this book was not to dispose of public health, but, as I said, to make us sceptical about its attempts to steer the choices of adults. I do not deny that public health is an essential responsibility of the state; I only try to limit what falls under that responsibility.

Many who work in public health see health inequalities as unjust and think that the state should try to reduce them. I agree, but I think that much of what the state should do falls outside public health, for instance by having policies for state welfare and the labour market that ideally secure reasonable health care, avoid involuntary unemployment and the stress of precarious work, and provide incomes for people that they can use to pay for reasonable food, drink, and housing, if they want to. What exactly these policies ought to be is a hard question, of course, and answering it is beyond this book.

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I mention reducing inequality for two reasons. First, criticizing public health policies as 'nanny state' is usually associated with the political right, but the criticisms I have offered here do not depend on a right-wing political philosophy or theory of the state. Second, I want to remind the reader that some 'solutions' can make things worse for the people they are supposed to help. At an abstract level, that point is obvious enough, but I think it should be borne in mind when thinking of health inequalities. Reforms to state welfare and the labour market might be the best way to respond to inequality, but it does not follow, if we do not get those reforms, that public health policies are better than nothing. Public health policies, such as sugar taxes or bans on discounts for junk food, might be worse than nothing. They reduce the options of the worst off and may well be against their interests.

While we ought to be sceptical about public health policies that try to make people be healthier, scepticism need not end in opposition. Any proposed public health intervention, whether a ban, a tax, an advertising campaign, or a gift of condoms, can have all sorts of reasons in its favour or against. Some people might benefit, others lose; some might benefit but have their autonomy infringed upon, others not; some might be adults, others children. Weighing up these competing interests is often going to be difficult quite apart from the further problems of predicting how interventions would affect people, or would backfire, or be abused. While we might be sceptical about the interventions, they may turn out to be justified at least in some times and some places.

Let me conclude by turning the arguments from this book into a brief checklist of ethical questions to use to evaluate public health interventions. Imagine we are speaking to someone who proposes a tax on sugary drinks, or a scary health campaign to discourage smoking. First, we should ask, Who do you think would benefit? Is it the people who become healthier, or other people? Suppose that the reason for the intervention is, at least in part, the benefit to the people who become healthier. Then we can ask: why think they would be better off for being healthier? Do you think that they are wrong about how their behaviour would affect their health? Or that they underestimate the importance of health in their lives? Or that, while they know they ought to be healthier, they give in to the temptations of unhealthy behaviour? Do you have any evidence that they make these factual or motivational mistakes and that unhealthy behaviour is against their interests? How good is your evidence? Are you sure you are not (wrongly) assuming that it just must be better to be more healthy rather than less?

We can also ask: does your intervention reduce choice, for instance by making some things (such as sugary drinks) more expensive without making anything else cheaper? If so, are your targets adults? If they are, your intervention looks as if it would infringe on their autonomy. Do you have any reasons to the contrary? If not, do you have any reasons to think that what your targets lose in autonomy is outweighed by what they gain in well-being?

If your intervention does not reduce choice, does it try to influence choice (as with the scary anti-smoking campaign)? If so, is it manipulative? If it is, does it counteract manipulation on the other side, such as the smoking marketing of yesteryear? If it is manipulative and does not counter other manipulation, why think that what your targets would lose in autonomy would be outweighed by what they gain in well-being?

I have provided some of my own answers to these questions for at least some interventions here, but you do not have to accept them to think that these are sensible ethical questions to ask of public health interventions. Let me conclude with two meta-comments. First, the checklist involves the questions, raised by the critic of the nanny state, of whether public health policy overvalues health and interferes with people's autonomy. The checklist is, though, not complete, even as an ethical checklist. I have not asked, for instance, about public acceptability, considered as a separate value, and nor have I mentioned the possibility of stigmatizing people.[1] Second, if I had to pick one question from the checklist, it is the one asking what reason we have to think people would benefit from being healthier. I think the most important advice from this book is this: do not assume (in fact, for many writers and advocates, stop assuming) that people must be better off for being healthier, and that unhealthy choices must be mistaken. If we do not make this assumption, we might be more likely to see that we must have evidence that people make mistakes before we interfere with their choices, and then we might start looking properly for some.

[1] These two factors are both considered, in the context of eating, in Anne Barnhill and Matteo Bonotti, *Healthy Eating Policy and Political Philosophy: A Public Reason Approach* (New York: Oxford University Press, 2022). They provide a helpful checklist of their own to evaluate proposals to exclude sugary drinks from government welfare assistance; see ch. 7.

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