Can Republicanism Tame Public Health?

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Liberalism and Public Health have always had a difficult relationship, because of the former's emphasis on the illegitimacy in all cases of unconsented-to interferences. Republicanism, with its emphasis on freedom as non-domination, has the potential to give rise to a more nuanced view of the relationship between public health interventions and a robust defence of liberty. This article argues that public health interventions not justified by the Millian harm principle can be justified on republican grounds if, though paternalistic, they aim to promote the autonomous decision-making of agents on matters to do with their health, and with the place of health within their overall conceptions of the good life.

The practice of public health has always been difficult for political philosophers of broadly liberal sympathies to justify (Holland, 2015: 48–62). After all, most liberals are moral individualists, in that they believe that only individuals are legitimate sources of moral claims. They are wary of communitarian claims, according to which groups might be taken to be possessed of irreducible moral worth. But public health takes populations rather than individuals as the targets of their policies. They are concerned with population-level patterns of disease. This leads to a second source of apparent incompatibility between liberalism and public health: public health policies nudge, and sometimes coerce individuals, to achieve community-level goals of health promotion and disease reduction. They engage in health surveillance, which is difficult to square with the liberal value of individual privacy (Fairchild *et al.*, 2008). They sometimes recommend mandatory vaccination and banning super-sized sodas, thus on the face of it violating the liberal belief in the supremacy of the value of individual liberty.¹

The *prima facie* incompatibility between public health practice and liberalism has meant that many contributions to the nascent discussion of public health ethics have failed the test of reflective equilibrium. Defenders of liberal values have ended up lapsing into a libertarianism that (in my view counter-intuitively) ends up questioning the value of pretty much all public health interventions, and of public policy as a whole (Flanagan, 2013). Theorists concerned with accounting for the

value of public health policy have correspondingly made short work of many liberal concerns—to do with consent, coercion and the like—which we would ideally want to integrate into the practice of public health (Wilson, 2011).

Republican theory, exemplified most clearly in the work of Philip Pettit (1997, 2012) and of Frank Lovett (2010), holds out promise for such a reconciliation, because it maintains the traditional liberal worry with individual freedom with a more nuanced take on the different *kinds* of interferences into the sphere of the individual's negative liberty. According to republicans, such interferences are only problematic if they evince the power that some may have to dominate others, where domination means (at a first approximation) the power to bend someone to one's will arbitrarily. They are not problematic, and may even be desirable, when they are controlled in the right way.

In this article, I investigate the potential of republican theory to strike a middle course between the libertarian rejection of many² forms of public health practice, and the insouciance displayed by some theorists towards the degree to which such practice can be problematic from the point of view of a duly qualified concern with individual freedom and autonomy. I will proceed as follows. First, I will show why one simple avenue by which to reconcile this concern with the practice of public health does not work. This path simply points to the fact that, at least for most advanced societies, public health practice takes place in the context of competitive electoral democracy. Secondly, I will examine problems that emerge when the attempt is made to curb the potential for public health policy and practice to give rise to domination through a set of substantive principles of professional ethics. Thirdly, I will propose a solution to the problem of potential domination that avoids the difficulties that I will have identified with both the institutional and ethical solutions that I will have considered. I will end by comparing my proposal with the currently fashionable approach pioneered by Sunstein and Thaler, and that privileges manipulating the choice environment in which agents choose through policy 'nudges'.

A simple response to the worry that some theorists have expressed to the fact that much public health practice seeks to achieve collective outcomes sometimes at the cost of individual freedom is simply to point out that in a democratic political system, there is a lot of policy that, though it coerces individuals, is rendered legitimate by the fact that the policies on the basis of which such coercion takes place have passed through the crucible of electoral competition. Parties that win free and fair elections form governments, and these governments enact legislation based on an electoral platform that has been presented to the electorate and that has been the subject of debate with other political parties putting forward different political platforms. Thus, for example, Thomas R. V. Nys writes that ‘public health care regulations did not just fall out of thin air; they are the result of—let’s hope—fair and democratic mechanisms, and as such they reflect the will of the people’ (Nys, 2008: 69). That democracy is key to removing the potential for domination from the operation of government is also a key theme in the recent work of Philip Pettit. He writes that ‘democracy has to promote popular control and it has to put in place the institutions that such control requires, if it is to serve the cause of freedom as non-domination’ (Pettit, 2012: 23).

But democratic institutions by themselves cannot ensure that the practice of state officials will not be dominating. I do not want here to rehearse the usual complaints against democracies such as we find them in the world today, with their many imperfections. My claim is that even if electoral democracies are functioning tolerably well, they are in and of themselves insufficient to guard against domination. This is so for a number of reasons. The most obvious being democratic processes can sometimes give rise to results that would violate the rights of individuals were they permitted to proceed unchecked. Democracy, if it is to be rights-respecting, must be *liberal* democracy, that is, a democracy that places certain possible democratic outcome out of bounds of democratic decision-making.

One can imagine certain public health practices that might be justified on the basis of purely population-level, consequentialist considerations violating people’s rights in ways that would be ruled out by constitutional courts enforcing entrenched rights charters. One could, for example, imagine health surveillance practices that were so invasive and so incautious in collection and sharing of data that they would amount to an assault on people’s constitutional right to reasonable levels of privacy.

But domination can occur even in the absence of overt rights infringement. This is so for two reasons. First, the actions that are undertaken by public health officials in the pursuit of population-level health goals can fall short of rights infringement while still posing a problem from the point of view of a normative framework concerned not just with protecting people’s rights, but also with ensuring that they are not dominated. Secondly, and relatedly, public health institutions may pose problems from the point of view of the republican concern with non-domination not in virtue of what they do, but of the powers that they possess, powers that, though they may not ever get used to deny people their rights, are nonetheless ones that place people in the position of the kind of vulnerability to domination that republican theorists are concerned with.

If this is the case, then our focus should not exclusively bear on what public health bodies do. Rather, we should look at the way in which their power is institutionalized. Do public health authorities possess powers that would allow them to dominate?

The main focus of republican vigilance is the laws that are passed by elected legislators. If people have effective control on the way in which their elected officials act as lawmakers, then these lawmakers do not exercise domination over them, because they cannot act in a purely discretionary or arbitrary way. If citizens have the right kind of control over the ways in which laws are made, then domination is kept at bay.

The problem from the point of view of republican theory is that many state officials who possess the authority to enact coercive policies possess that power in virtue not of laws that stipulate precisely the ends that they are to serve nor the constraints that they are to observe in the use of the authority vested in them by the state, but of enabling legislation that sets up offices and official bodies with broad discretion.³ If republican control by citizens aiming at taming the potential of government to dominate is exercised through the pressures that they are able to exercise through elections, then the actions of public bodies instituted through such enabling legislation may very well lie beyond their reach.

In other work (Weinstock, 2015), I have argued that electoral platforms are important elements of an overall theory of legitimacy of government action. Platforms, I argued, are ‘organized proposals as to how different kinds of goods are to coexist within an overall scheme of public provision’. Democratic systems should be organized in such a way as to maximize the degree to which the debate and deliberation that takes place during elections focus on rival platforms, rather than,

say, on the personalities of candidates and party leaders. Focusing elections on platforms means that citizens can, when voting, cast their ballot on the basis of their real policy preferences. What is more, platforms serve the purposes of grounding legitimate state action. When laws passed by the government can reasonably be inferred from the commitments made through platforms during election campaigns, those laws can be seen as democratically legitimate. When laws passed through parliament derogate from platforms, then the question of the democratic legitimacy of laws is at least posed. And so, I would argue, is that of the extent to which governments violate the norm of freedom as non-domination. For it is when they act in ways that were not sanctioned by citizens in elections that they can most readily be seen as acting arbitrarily. Let me refer to this as the problem of ‘democratic opacity’, to refer to the fact that there are practices of government, and in particular of the civil service that staff public administrations, that escape the scrutiny of organized democratic deliberation and decision-making.

Now, one way in which to deal with this problem is to reduce the discretion that public officials who occupy roles in public administration bodies such as Public Health Agencies occupy. Thus, the requirement might be that political parties make explicit in their platforms the manner in which the authority invested in bodies such as Public Health Agencies will be used. But this is not likely to reduce the problem of discretion, and thus, of potential domination. Platforms inform the public as to the laws and policies that governments intend to pass during their time in office. But even platforms that are articulated in good faith are subject to two important limitations. First, laws and policies are inevitably articulated in fairly general terms, and leave much of the practicalities of implementation to public administrations. It is difficult to see how things could be otherwise, given the plethora of domains in which governments must act. Secondly, platforms are formulated on the basis of a set of empirical assumptions that may end up proving false. The phenomenon of new governments coming into power and finding that the financial situation bequeathed to them by previous administrations was worse than they had thought, forcing budgetary adjustments, is widespread. And most importantly, empirical assumptions about the future are always necessarily based on extrapolations and projections from the present, which can only be expressed probabilistically. There are thus general features of the task of fulfilling the very general policy guidelines included in the legislation that enables public administrations that put paid to the possibility of democratic control. This set of facts about

public administration, often neglected by normative political philosophers, gives rise to what Joseph Heath has identified as the need for a ‘general framework for the ethics of public administration’ (Heath, 2014).

The problem of democratic opacity is arguably heightened in the case of public administrations tasked with monitoring and with acting to improve population health. While public policy in general looks into the future and attempts to achieve policy goals that can form the basis of at least tolerably reliable predictions and probabilistic assessments (‘if we do *x* in the present set of empirical circumstances, it is likely that *y* will eventuate’) that make democratic deliberation in the form of the comparison of various policy scenarios possible at least in principle, much (though by no means all) of the work of public health agencies is reactive. It is to respond to difficult-to-predict health emergencies, such as arise in the wake of natural disasters, or of infectious disease outbreaks, or to emerging health issues identified through health surveillance measures. Thus, it is possible that the problem of democratic opacity is greater in the case of public health than it is in the case of other areas of policy.

Given how tenuous the connection is, even the best set of circumstances can tie the operation of public health agencies to the public’s will, as that will is expressed upstream in elections; perhaps another way in which to proceed to reduce the potential for domination is to organize downstream consultations. Public Health Agencies could take it upon themselves, or could be required by their enabling legislation, to organize downstream public consultations on important issues that they face. But as Heath has shown, effective and normatively attractive democratic control of public administrations faces difficulties. Consultation risks give rise to a skewed picture of the range of interests and values that are present in society with respect to any given policy decision. Organized groups risk ‘capturing’ the consultative process through their greater ability to mobilize and to make the needs of their constituencies known. Most importantly, unless it is tied to the kind of decision-making process that democratic elections represent, consultation lacks two features that are essential to effectively ‘bind’ the actions of public administrations to a democratically formed collective will. First, consultation is not designed to deal effectively with disagreement. As Jeremy Waldron (1999) has shown, elections are procedures whereby decisions are taken despite ongoing disagreement. Consultations typically allow public officials to become aware of the range of opinions that are present among the population with respect to an issue (problems of ‘capture’ notwithstanding), but they

do not allow for decision-making in the face of that range. Referenda are decision-making mechanisms that allow a democratic public to bind public officials to its will in an issue-specific way. But there are many reasons to doubt the desirability of using referenda as tools to determine the direction of public policy (Parkinson, 2015).

Thus, to the extent that public health measures are put in place by public administrations whose authority is constituted through fairly vague enabling legislation establishing the general function of public health officials, and in particular of a Chief Public Health Officer (rather than through legislation laying out fairly clear policy guidelines), public health policy is plagued by the problem of democratic opacity, and is thus potentially dominating. The problem is made worse by the fact that public health measures are in significant measure reactive to changing circumstances, some of them difficult to predict. It may therefore be more difficult to bind public health measures to the policy guidelines defined in platforms.

II

If the work of public health officials is difficult to bind through the operation of democratic mechanisms, in virtue of the problem of democratic opacity defined above, then perhaps other mechanisms can be identified through which the risk of domination might be avoided. Following a cue from Heath, we might explore the possibility that the potential for domination might be avoided if the professional ethics enforced among public health officials is one that is geared towards the avoidance of domination.

What might this ethics look like? Before beginning to spell out what some of its main ingredients might be, it is important to bring to the fore a difference between liberalism and republicanism that flows directly from the different ways in which they conceive of liberty. That difference has to do with the greater tolerance that republicans have for certain forms of *paternalism*. A paternalist action is one in which someone interferes with me for my own good, but in the absence of my consent. For liberals, the absence of consent is usually sufficient to rule paternalist actions out of court. This priority to consent is a direct consequence of the importance that liberals ascribe to negative liberty.

For republicans, what matters most is not that the negative liberty of citizens be protected, but rather that they not be subjected to the *arbitrary* interferences of others. Now, one way in which to avoid

arbitrariness—defined as action taken on the basis of the interferer's own conception of what a situation requires—is to constrain the putative interferer through democratic checks. But we have seen that democratic opacity makes that difficult in the case of public health interventions, at least given the manner in which public health authorities have been institutionalized in many liberal democracies. Another road to non-arbitrariness involves the interferences of others tracking the interests of those who are being interfered with. Were public health officials bound by a professional ethics that required of them that their actions always track the interests of those they serve, then the republican concern with arbitrariness would be at the very least mitigated. As a matter of empirical fact, it is probably the case that most paternalists also dominate. That is, they act at best on their conception of what the interests of those they are interfering with are, and so their actions fail to reliably track the interests of those on whose behalf they claim to act (Pettit, 2012: 59). But it is possible in principle to imagine paternalistic interference that is not dominating because, through it is not consented to, it is governed by people's interests. Thus, *a fortiori*, it is possible to conceive of the action of public health officials steering clear of the risk of domination by tracking the interests of those they serve.

It might however be more difficult to cleave to this ethic in the case of public health than in other policy domains. Many who have questioned the troubled relationship between public health and liberalism have noted that the practice of public health officials sometimes offends against the fact that people's conceptions of the good tend to be pluralistic in character, recognizing the importance, but not the supremacy, of health among the various goods that are fitting objects of human aspiration (Radoilska, 2009). The claim is that public health practice often seems to be premised on the view that health is the most important of all goods. A related, but distinct, objection is that public health practice is grounded in a *conception* of health that is often controversial, but that is taken as objective. The health of humans encompasses a broad range of variables, including mental and physical health, each one of these being in and of itself complex and multiform. But, the argument goes, public health practice often rules out plausible conceptions of health and organizes interventions around a single conception the claim to objectivity of which goes unvindicated.

If this is at all plausible, then public health officials can unwittingly come to dominate in the manner in which they paternalistically interfere by acting on the basis of conceptions of people's interests that are false,

either because they elevate health to a supreme status that some people do not give it, or because they act on the basis of conceptions of health that some reasonable people do not share.

How can public health officials provide themselves with an ethics that avoids this kind of domination? The line of inquiry that I wish to pursue in the rest of this article is that they can do so by privileging modes of intervention that are designed to increase people's capacity for autonomous agency. I pursue this line of inquiry in the final section of this article.

III

Citizens of modern societies have an interest not just in having their interest in their own health catered to by third parties, but in being the agents of their own health. This is so for at least two reasons. First, the claim seems plausible for the general reason that human beings have a general interest in being agents rather than passive subjects, but secondly, and connected with the point I have just been making about the potential for domination inherent in public health officials setting out to serve the interests of agents as they conceive of them, under the right sets of circumstances, individual agents can be taken to have epistemic privilege concerning the way in which health fits into their overall conception of the good, and concerning the way in which they conceive of their own health. Reasonable agents can have differing views on both the issue of the place of health within well-being, and about the way in which health itself should be construed. Given this complexity, it seems as if individuals themselves are better situated than third parties are to determine how to understand health, and how to integrate it into an overall conception of the good life.

If this is the case, what should the ethical code of public health officials be?

Let me begin by describing in very broad strokes a wide area of public health interventions that are unproblematic from the point of view of both liberal and republican normative frameworks. This is the area of intervention that can be justified on the basis of the Millian harm principle.⁴ In its most general formulation, that principle asserts that state officials are justified in interfering with an agent's actions when those actions would otherwise harm others. Now, it is no easy task to define exactly how harm should be defined so as to justify state action in a manner that is neither too permissive nor too restrictive, but let us assume for the sake of argument that there are some forms of interventions

that are justified not on the basis of the claim that these interventions are, unbeknownst to those agents whose behaviour is being interfered with, in those agents' best interests, but rather on the basis of the fact that agents are capable through their actions and inactions of harming each other and, in particular, of harming each other's health. Mandatory vaccination campaigns might fall into this category, as would smoking bans. Liberals and republicans join hands in approving of much of the work of public health officials. Liberals do not disapprove of interferences with people's negative liberty when such interferences are required to protect others from significant harm. Republicans will be reconciled to such unconsented action on the part of public health officials in virtue of its being non-arbitrary. Indeed, though those interfered with may not view the intervention as being in their interests, officials can plausibly claim that the interests of others are served by restrictions on certain kinds of health-inhibiting behaviour.

The concern with domination only has to do with a sub-set of the complete set of actions and interventions that public health officials engage in, those that purport to be in the best interests of agents, and in the absence of any kind of 'harm to others' justification. Interventions aimed at changing people's self-regarding behaviour (their dietary habits, their levels of physical activity and the like) are the most likely sources of domination. And the problem in this domain, to repeat, is that though people have interests in these areas that *might* be well served by public health interventions, such interests are potentially dominating in being premised on conceptions of health, and of the priority of health relative to other goods.

The central claim I want to make in this final section is that domination can be avoided when public health interventions target obstacles to people's agency, rather than acting on a conception of the good that many might find unacceptable. In other words, public health interventions must serve autonomous decision-making and action if they are to minimize the risk of domination.

For illustrative purposes, let me sketch three kinds of interventions that would serve this general goal. First, public health interventions can act on factors that tend to distort people's judgments about what is in their interest. Secondly, they can provide people with information with which to make fully informed decisions about what is in their best interests. Thirdly, they can take steps to ensure that people are to the greatest degree possible able to act on the basis of the judgments they formulate as to what is in their best interests. Let me

briefly gloss each of these directions that non-dominating public health might take.

To begin with, people often form health-affecting preferences as a result of the operation of causal factors that might lead us to want to reject those preferences as authoritative (Sunstein, 1991). To acknowledge this is not to buy into a particularly ambitious false consciousness claim, according to which there are 'authentic' preferences that must be unearthed and protected from exogenous causal forces. Rather, one can argue more modestly that *some* causal pressures on preference formation are ones that we have reasons to reject, or at least to try to counteract. For example, we may think there are reasons of justice to attempt to counteract them. Thus, for example, when we say of a 1950s housewife that her preferences for child-rearing and house-cleaning should be taken as defeasible, we neither refer to some underlying set of authentic preferences on the basis of which we think she ought to act, nor do we condemn the choice that a woman might make to take on traditional gender roles. We are merely saying that we may want for reasons of justice to take steps that will make it the case that this decision is not the result of an individual adapting her preferences to unjust gender hierarchies.

Do such mechanisms operate in areas that fall within the purview of public health authorities? Consider the well-documented fact that certain kinds of unhealthy behaviour, such as smoking, are far more prevalent as one goes down the socio-economic scale. To be blunt, poorer people smoke more than rich people do (Voigt, 2010).

Now, it is possible that people lower down the socio-economic scale have made a clear-headed decision that they will prioritize short-term pleasure above long-term health. That is possible, but unlikely. In other words, it is likely that people smoke more because they are lower down the socio-economic scale, rather than the people who make the trade-off between short-term reward and long-term pleasure just happening to be clustered among the worse-off as a result of the operation of purely adventitious causes.

The precise mechanisms that make it the case that smoking is distributed within the population in the manner I have described are complicated to unearth. What is more, they may be multiple. Class identities may form around practices such as smoking. It may become a way in which to mark one's identification with a specific class. It may simply be the case public health campaigns are designed in a manner that is less geared towards working-class people. Or it may simply be the case that the greater availability of tobacco

products in the homes of people at the lower end of the socio-economic spectrum leads to a greater level of adoption among the young.

If we accept the modest claim that there are certain mechanisms in preference formation that we want to counteract, because they bear witness to and reinforce inequities, then it follows that public health interventions, rather than interdicting unhealthy behaviour (except in contexts in which they exact third-party costs), should inquire into the precise causal pathways that lead to already underprivileged people engaging in behaviour that is likely to detract from their health, and to put measures in place that will be designed to counteract those mechanisms. Thus, to revert to the causal hypotheses mooted above, public health campaigns could take care to ensure that their messaging is targeted at social groups that are more at risk. In particular, they could study ways in which to uncouple class identities from harmful behaviours such as smoking.

My intention here of course is not to claim that the mechanisms that I have just sketched are actually the ones that lead to greater prevalence of smoking among the least well-off. It is rather to provide a sense of the direction that non-dominating public health research and intervention might take. The intention should be less to prohibit or moralistically to condemn self-regarding behaviour, but rather to investigate ways in which to try to make it as likely as possible that such behaviour will result from people's decisions about what to prioritize in their lives, rather than through the operation of causal factors that we have independent reason to want to minimize.

To promote the decision-making capacity of individuals, it is not enough that one removes the causal factors that reflect inequities. We must also provide people with appropriate information on the basis of which they can make up their minds. The area of nutrition provides us with a good example of an area in which autonomy-enhancing public health measures can be enacted. In many jurisdictions, labelling requirements have been put into effect. Food producers are required to inform their customers of the contents of their products. Information however is likely to be insufficient to provide people with appropriate information in a wide range of cases. In its barest form, the listing of ingredients can be provided without providing information about the health benefits and harms of listed ingredients.

But even information about the health benefits of food ingredients will not allow people to make choices if they do not possess a range of further skills. These skills have to do, for example, with how to make healthy

choices within the temporal and financial skills that many people will have to work within as they make nutritional choices for themselves and their families. They will also have to have some knowledge about how to prepare healthy meals, especially when the meals they prepare have to compete for the attention and appetite of children and adolescents who are regularly subjected to barrages of advertising from fast food producers.

The point I am making here parallels one that has been made by Onora O'Neill and Neil Manson (2007) about informed consent in the medical setting. They argue that the mere unilateral proffering of information by physicians to patients does not in and of itself increase the latter's decision-making capacity. Communication aimed at making the information usable is necessary for the practice of informed consent to be more than just a hollow, formalistic requirement.

Similarly, public health interventions aimed at increasing the capacity of people to actually act on healthy food choices, rather than simply providing information, may be one way in which public health authorities might act in non-dominating ways to increase the autonomous decision-making capacity of individuals.

Finally, individuals are not only prevented from acting on their choices by lack of skill or of the right kind of information. They can also be prevented from acting on their choices due to lack of available options. People can have a good understanding of nutrition, and of how to make healthy food choices, but be constrained by circumstances into living in food deserts. They can form the preference to engage in more physical activity, but be prevented from doing so due to bad city planning depriving them of easily accessible recreational space in which to exercise during their leisure time, and of the opportunity to avail themselves of active commuting choices. Public health interventions need not force individuals to cycle or walk to work, or to eat healthy meals, but they can take steps to ensure that if individuals make those choices, then they will be able to act on them at reasonable cost.

Thus, it is possible, in the domain of public health activity that cannot be justified by appeal to the harm principle, to engage in non-dominating interventions aimed at securing the conditions for people being able to engage in autonomous decision-making with respect to their health, and with respect to the manner in which they weigh health against other goods that also conduce to their overall well-being. It is a strength of the republican conception of freedom as non-domination that it allows us to identify mildly paternalist interventions

which, because they are geared at the interest we all have in being agents of our lives rather than having others' determinations of what has value in life becoming normative for us, are acceptable because non-arbitrary. Classical liberalism's emphasis on negative liberty, and its undifferentiated concern for all manner of unconsented-to interferences, is comparatively a blunter instrument with which to distinguish public health policies that are and that are not compatible with a concern for freedom.⁵

IV

It will be noted that at no point in this account do I appeal to the fashionable notion of 'nudging' as a potential instrument of public health policy (Sunstein and Thaler, 2008; Ménard, 2010). Nudging, as is now widely known, consists in shaping choice environments so as to make it more likely that people will make the 'right' choices, not by leading them to deliberate differently, but rather by leveraging 'System 1' heuristics that bypass deliberation. The standard illustration is that of the high-school cafeteria queue reorganized so as to place healthy food choices at a strategic point at which adolescents are most likely to pick them. Sunstein and Thaler, whose work has propelled 'nudging' into the centre of debates about the proper role of the state, employ the term 'libertarian paternalism' to refer to the strategy. It is paternalistic because it engineers the choice situation so as to make the 'correct' choice seem more likely. But it is libertarian in that it allows people to make up their own minds within that choice situation.

The argument put forward in this article suggests strongly that 'nudging' would, in my view, be looked upon askance by the republican for at least two reasons. First, the values on the basis of which the engineering of choice situations takes place aims at making the choices determined by others as the superior ones more likely, rather than increasing the capacity of individuals to make and act on their own choices. While not fully arbitrary ('nudging' is after all governed by a concern with acting in the interests of those being nudged), it nonetheless risks laying the groundwork for domination by being grounded in a simplified conception of the value landscape, one that gives short shrift to the fact that people can have reasonable conceptions of the good that differ from those that govern the construction of choice environments. Republicans in the area of public health can countenance mild paternalism, aimed at empowering people to make their own choices. Despite the use of the term 'libertarian' to characterize at least part

of the ‘nudging’ agenda, a republican would worry that nudging short-circuits individual decision-making rather than propping it up.

Secondly, and relatedly, ‘nudging’ does lead to certain choices being more likely than others in virtue of having been chosen rather than coerced by policy. But the kind of choosing that the ‘nudger’ is willing to countenance is one that liberals and republicans have reason to reject. The point, remember, is to make these choices more probable by working on the ‘architecture’ of choice situations, rather than leading people to reflect on the greater value of the choice that they are being nudged towards. It is a shared commitment of both republicans and liberals that institutions be set up so as to promote autonomous choosing. Clearly, neither family of theorists denies that autonomous choosers are subject to myriad influences in making up their minds about what to do. But there is a fine line between influencing and manipulating, one that theorists concerned with individual freedom may view the partisans of ‘libertarianism paternalism’ as having stepped over.

Notes

1. For a good survey of the ethical issues surrounding vaccination see Dawson (2011). For a survey of issues surrounding the banning of soft-drinks, see Wikler and Eyal (2013).
2. As we shall see, even libertarians can countenance public health interventions justified on the grounds of some version of the liberal harm principle.
3. See, for example, the enabling legislation that sets up the Public Health Agency of Canada. It establishes the role of the Chief Public Health Officer of Canada in the broadest possible terms as providing the Minister of Health with advice concerning public health, and as having the right (though not the obligation) to consult with key stakeholders, including provincial governments, ‘the public’ and voluntary organizations in the field of health. At <http://lois-laws.justice.gc.ca/eng/acts/P-29.5/page-2.html#docCont> [accessed 23 April 2016]
4. The place of the harm principle within a general ethics of public health is of course a vexed question, which could itself form the basis of a long inquiry. See Dawson (2011), Jennings (2009), Powers, Faden and Saghai (2012). I hasten to add as well that in talking of a Millian harm principle, I am of course not claiming that this principle was actually defended by Mill himself. Mill’s position on the appropriate role of the state was too complex to be

simply reduced to the single principle of ‘anti-paternalism’.

5. That many who consider themselves to be ‘classical liberals’ may find the kinds of proposals that have been briefly described and defended here congenial shows that the distance between liberalism and republicanism may at the end of the day be one of emphasis rather than of fundamental ethical difference.

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