The right to public health

James Wilson, james.wilson@ucl.ac.uk

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Abstract. Much work in public health ethics is shaped by an "autonomy first" view, which takes it to be axiomatic that it is difficult to justify state interference in the lives of competent adults unless the behaviours interfered with are compromised in terms of their autonomy, or would wrongfully infringe the autonomy of others. However, such an approach is difficult to square with much of traditional public heath practice. Recent years have seen running battles between those who assume that an "autonomy first" approach is basically sound (and so much the worse for public health practice), and those who assume that public health practice is basically sound (and so much the worse for the "autonomy first" approach). This paper aims to reconcile in a normatively satisfying way what is best about the "autonomy first" with what is best about a standard public health approach. It develops a positive case for state action to promote health as a duty that is owed to each individual. On this view, the state violates individuals' rights if it fails to take cost-effective and proportionate measures to remove health threats from the environment. It is thus mistaken to approach public health in the way that "autonomy first" accounts do, as primarily a matter of individual entitlements *versus* the common good. Too little state intervention in the cause of improving population health can violate individuals' rights, just as too much can.

Introduction: autonomy versus public health

Few dispute that government interventions such as speed limits on roads, regulation of toxic chemicals, and bans on smoking in public places improve population health. Nonetheless, concerted government action to improve population health—I shall refer to such activity as public health—is often treated with suspicion.[i] Public health sceptics challenge both the assumption that promoting population health is an effective way of promoting the common good, and the moral legitimacy of government interventions that interfere with individual liberties in the course of promoting the common good.

When such concerns rise to a philosophical level, they are most usually articulated through an interpretation of the proper role of governments, which places respect for individual autonomy at its core. This approach—call it the "autonomy first" view—takes it to be axiomatic that it is difficult to justify state interference in the lives of

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i In ordinary language, 'public health' tends to be used both to denote the health states of a particular population (so that we might say that, for instance, a high incidence of smoking in a population is bad for public health), and to refer to those activities that are collectively undertaken to ensure that the health of the population is protected and promoted.[1] I shall refer to the first as population health, and the second as public health.

competent adults unless the behaviours interfered with are compromised in terms of their autonomy, or would wrongfully infringe the autonomy of others. State interference in other circumstances is argued to be either counterproductive or wrongful, or both.[ii]

Autonomy first approaches are united in thinking that public health activity is legitimate only where something that has gone wrong, autonomywise, with the behaviours or choices interfered with. The focus of justification for state public health activity must either be on showing that certain choices are not adequately autonomous and are thus fair game for interference (for example those made by addicts about their drug of choice), or that the behaviours involve wrongful infringement of others' sovereign domain (for example, smoking in an office environment). Either way, it is assumed that individuals have an entitlement that their adequately informed and adequately voluntary decisions not be interfered with unless the interference is necessary to prevent violation of rights or rectify existing rights violations (call this the non-interference principle).

Autonomy-first approaches to public health face a fundamental challenge: much if not most socially controllable health harm is caused in circumstances in which there is neither an obvious failure of choices to be autonomous, nor an obvious wrongful infringement of autonomy. Obesity provides a good example. The rise of obesity has a large number to contributory causes, many of which are distal rather than proximal. For example, a rise of processed foods; a decline in cooking skills; a shift towards designing spaces around car ownership and a corresponding decline in active transport; and a shift to more sedentary forms of work, as well as potential reinforcement effects from the rise of obesity itself.[4]

Obesity is harmful in the sense of setting back people's interests in being healthy. But this harm has causes that are structural, diffuse and multilayered. There are few if any individuals or institutions that act with the aim of increasing obesity, and the contribution of any given individual or corporation to obesity rates will usually be small or negligible. So while the harms are significant, there need be no sense of *wrongful agency* and no agent who can be singled out as "the" cause of obesity. Rather, we are more likely to find that at each node of the network, agents (whether individual or corporate) act in ways that make sense given the constraints upon them. If no one can be shown to have acted wrongly, it is initially difficult to see how there could have been a wrongful infringement of autonomy. It is also far from clear if individual food choices are sufficiently non-autonomous to allow state action either.

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ii Within bioethics, such a view is widely attributed to Mill on the basis of a few passages from *On Liberty.* However Mill's actual position is rather more complex. [2,3]

This raises a fundamental question about the usefulness of the "autonomy first" approach as a basis for public health policy, particularly when we step back and notice that complex and multilayered systems of causation are the rule rather than the exception in public health.[iii] Significant health harms result from structural processes that are contributed to by many people, and which are not intended to cause harm. If we put autonomy first, then it is unclear how the state could ensure that citizens are protected from diffuse and systemic harms.[3,7][iv]

Rethinking autonomy

Much work within public health ethics has stayed broadly within the confines of the "autonomy first" approach, but has sought to expand what is allowed by it, through reinterpreting both the nature of autonomy, and the extent to which activities such as food choices meet a minimum threshold of autonomy. The underlying project has been to show that public health activity may not be so much in tension with a properly worked out "autonomy first" approach.

Such contributions have struggled to establish a consensus on the correct interpretation of autonomy, because the idea of autonomy functions in at least two different ways in "autonomy first" accounts. First, autonomy is used to qualify *choices*, the key claim being that autonomous choices are worthy of a respect that nonautonomous choices are not. Second, autonomy is used in the sense of "infringing someone's autonomy", where autonomy refers to a sphere in which the individual is sovereign. While these two views are often combined (both in the popular imagination and in the philosophical literature), it is important to notice that they are distinct, and there is a degree of tension between them.[8] Autonomy as sovereignty assumes that, so long as a self-regarding choice is genuinely attributable to an individual, there is a duty on the part of the state not to interfere with it, regardless of whether that choice has been well-deliberated or is in line with the chooser's deepest values. Autonomy as autonomous choice sets a rather more

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iii Such problems are also common outside of the realm of public health. Climate change, and global supply chains provide good examples. Sinnott-Armstrong[5] examines how difficult it is to make the case that an individual action such as going for an unnecessary Sunday drive merely for pleasure, which contributes to climate change, could constitute a wrongful harm on conventional moral theories. In the face of similar examples, Iris Marion Young[6] argues that adequately understanding the wrongs involved in structural and systemic harms requires significant rethinking of conventional normative frameworks.

iv It is of course possible for individuals or groups of citizens to organise non-state means of protecting themselves against some such threats (for example by setting up a slimming club). But in cases such as obesity where there are a number of systemic drivers, it is likely that such individual measures will prove ineffective.

demanding standard: on its view, only choices that meet the appropriate standard of autonomy in deliberation are to be immune from state interference.

Many individuals make use of autonomy as sovereignty in some contexts and autonomy as autonomous choices in others. Health professionals frequently hold that patients with mental capacity should have the right to refuse treatments for any reason or for none (autonomy as sovereignty), while also holding that food choices are not very autonomous and so the state should play a much greater role in shaping diets by preventing the sale of oversize sodas (autonomy as autonomous choice).

This looks potentially inconsistent. One way for the "autonomy first" theorist to respond would be to impose the same standard everywhere for what is required by respect for autonomy, settling on an autonomy as sovereignty model or on an autonomy as autonomous choices model. Given the scale of the differences between approaches adopted in clinical medicine (where the usual assumption is that patients should have the right to refuse any intervention), and government tax policy (where it is assumed that governments have a right to enforce payment regardless of objections individuals may have) a "one-size fits all" an approach would have radical and counterintuitive implications.[v]

An alternative is to adopt a contextual approach to autonomy: on such a view, respect for autonomy may still come first, but what respect for autonomy requires will differ according to normatively relevant features of the situation.[vi] Following this line of reasoning, it would be open to the "autonomy first" theorist to develop a normatively rich account of context that allowed differentiated and satisfying discriminations to be made about what respect for autonomy requires in different circumstances.[vii] It might be that a properly specified conception of respect for autonomy would allow public health measures that might initially seem to be ruled out by an "autonomy first" approach, such as where measures undertaken are necessary to restore and ensure 'deep autonomy', or have a strong democratic

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v See for example Flanigan, who argues that the doctrine of informed consent (and its corollary power to decline interventions for any reason or for none), which governs clinical interactions, should also apply to public health policy.[9]

vi Elizabeth Anderson suggests such a view when she argues that "to respect a customer is to respect her privacy by not probing more deeply into her reasons for wanting a commodity than is required to satisfy her want. The seller does not question her tastes. But to respect a fellow citizen is to take her reasons for advocating a position seriously. It is to consult her judgment about political matters, to respond to it in a public forum, and to accept it if one finds her judgment superior to others."[10]

vii Two accounts that show how such a contextualist approach to autonomy might be constructed (though neither supports an "autonomy first" approach to public health) would be Manson and O'Neill[11] and Nissenbaum[12].

mandate from the population to whom they apply, or are necessary to supply health-related public goods, or to overcome asymmetric information.[13–15]

However, it is argued that even such more nuanced "autonomy first" approaches are still significantly out of step with much of actual public health practice, which frequently involves interferences to improve population health without any attempt to show that the choices interfered with are compromised in terms or their autonomy, or infringe the sovereign domains of others.[16] Health and safety inspections of restaurants, compulsory seatbelts in cars, product safety standards, and water fluoridation provide good examples. Recent years have seen running battles between those who assume that the "autonomy first" approach is basically sound (and so much the worse for public health practice) and those who assume that public health practice is basically sound (and so much the worse for the "autonomy first" approach).

The strategy

This paper aims to reconcile in a normatively satisfying way what is best about the "autonomy first" with what is best about a standard public health approach. It develops a positive case for state action to protect and promote health as a duty that is owed to each individual. On this view, the state violates individuals' rights if it fails to take cost-effective and proportionate measures to remove health threats from the environment. On this view, it is mistaken to approach public health in the way that "autonomy first" accounts do, as primarily a matter of individual entitlements *versus* the common good. Too little state intervention in the cause of improving population health can violate individuals' rights, just as too much can.

I argue that even if we accept the basic premisses of the "autonomy first" account, and in particular the noninterference principle, this would be a threat to the ethical justifiability of public health only on the assumption that there is no right to public health. If there is a right to public health, and this right entails that governments have a duty to take significant action to promote and protect health, then government action taken to avoid violating this right would by definition not count as interference in the relevant sense. The noninterference principle is thus compatible with quite extensive government action, if this is necessary for the purpose of rights protection. So it is question-begging to use the argument from noninterference as an argument against the possibility of the legitimacy of extensive state action to promote health.

The rights based approach shares with traditional public health a concern for protection and promotion of health as a core concern of the good society. But it differs from it in that it explicitly frames protection and promotion of health as a right of individuals, and to be undertaken for the sake of individuals, rather than as something that should be done for population benefit. On a traditional public health

approach, there will be duties on the part of governments to tackle air pollution or obesity, but no corresponding entitlement on the part of citizens to insist that such measures are taken. The rights based account places an individual entitlement to such public health measures centre stage. The shift to an indidualistic model also makes a significant difference to the content of public health obligations: as is well known, risk reductions at a population level may create expected health benefits for each individual that are so small that most individuals would prefer not to have the benefit if it came with any additional inconvenience at all. (This is often known as the prevention paradox.[17])[viii] My account takes it as axiomatic that it is not sufficient to justify interferences solely on the grounds that they will improve population health, or even that they will increase overall wellbeing, but that it is necessary to do so via an account of what is justifiable to particular individuals.

The account presented here transforms but does not fundamentally contradict the Millian paradigm[3,7] that is so prevalent within bioethics writing on public health. The Millian approach to public health begins from a suspicion about the overweening power of the state, and introduces the harm principle as a way of protecting individuals from this power. Most modern commentators have followed Feinberg [19] in thinking that the conception of harm invoked in the harm principle needs to be clarified by distinguishing between mere harms and wrongful harms, given that nearly all liberals assume that the mandate of state to intervene to prevent wrongful harms such as unconsented to violence is much stronger than its mandate to preventing nonwrongful harms such as those arising from fair competition.

Once we follow Feinberg and rethink the harm principle via a moralised conception of harm, the idea of rights violation becomes paramount. My account shares with Feinberg's harm principle the fundamental thought that protecting individuals against violation of their rights is a central justification for state activity. But it differs from it in arguing that Millians have been too narrow in their account of individuals' rights. Once the right to public health is introduced, and once it is clarified that this right can be violated by failures to reduce risk as well as by actual harms, and once the mechanism for determining when this right is violated by the state is clarified, then we have a robust account of public health that is in the spirit of liberalism.

This article makes an ethical rather than a legal argument, but it is worth noting that the existence of a human right to public health is well established within international law. The International Covenant on Economic, Social and Cultural Rights (which has been ratified by 164 states) recognises a "right of everyone to the enjoyment of the highest attainable standard of physical and mental health" (ICESCR

viii For a penetrating discussion of what the prevention paradox means from the perspective of a moral position that takes justifiability to individuals seriously (such as the right to public health), see John [18].

Art 12.1), and explicitly requires states to undertake public health and health promotion activity (ICESCR Art 12.2). States party to the covenant agree that they will progressively realise the highest attainable standard of health for their own citizens and take measures to better allow other signatories to do the same for their citizens (ICESCR 2.1). It follows that states can violate the human rights of their citizens (and potentially citizens of other states) if they fail to take appropriate means to promote and protect health. Of course, the fact that a human right to public health is legally recognised does not by itself show that there is sufficient ethical reason to do so, though it might give some indication about how a moral right to public health might best be interpreted, and certainly helps us to ward off any scepticism that it would be impracticable to implement such a right.

I begin by clarifying what it is to justify a rights claim. As will become apparent, even what would count as an adequate justification of a rights claim is contested, so it would be wildly optimistic to presume that my argument will be acceptable to all. I then set out an argument for why it is plausible to think that there is a right to health, and why a right to public health follows from the right to health. I then argue that, just as in the case of the right to security, the right to public health justifies significant (though proportional) interferences with liberty.

I should clarify that the paper aims to defend public health activity at a general level: as an activity that aims to remove significant health threats from the environment and empower individuals and communities to improve their own health.[ix] Even if I am correct, adequately specifying the content of the right to public health will require a considerable amount of additional work.

Justifying rights claims

It is a commonplace that the philosophy of rights is rife with disagreement both about what the function of a right is, and the role that rights in general should play in moral discourse, so I shall make a few remarks by way of clarification. My aim here is not to say anything new, but to map out the contours of agreement and disagreement within the literature.[20]

Rights, as I use the term in this article, are high priority claims that are correlative to directed duties. To describe a duty as directed is to say that it is owed *to* an individual in such a way that if the duty is not performed appropriately, the person

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ix Thinking about public health in rights terms disrupts the traditional assumption that a different normative justification is required for health promotion (which attempts to promote population health by educating and empowering individuals) than for health protection (which aims to remove health threats from the environment). On my view, both are grounded in the right to public health. I thank an anonymous referee for pushing me to be clearer here.

to whom the duty is owed has a privileged basis for complaint. In such circumstances, unless there are adequate excusing factors, the duty bearer wrongs the holder of the directed duty.

Directed duties are to be distinguished from non-directed duties, such as a general duty to maximise the good: if someone fails to perform a non-directed duty, this does not give any third party grounds for claiming that he or she has been wronged as an individual, even though there will be grounds for saying that the dutybearer has acted wrongly (or at least suboptimally). So an initial test for whether you think there is a right to public health is if you think it possible that someone could be wronged as an individual by government failure to take measures to protect health. I shall assume that the duties correlative to rights must be of high priority, but apart from that shall not take a stance on what the strength of such duties must be.[x]

Directed duties correlative to rights can take various forms. There is no reason to think that each right will give rise to only one duty, or only one undifferentiated class of dutyholders. Indeed, the human rights literature (following an influential interpretation of Shue[21] by the UN Special Rapporteur on the right to food, Asbjørn Eide[22]) assumes that a human right is divided up into three separate sets of obligations: obligations to respect, obligations to protect, and obligations to fulfil. On this view, uncontroversial rights such as the right not to be tortured are commonly taken on closer analysis to involve not just duties on the part of individuals and states not to torture, but duties at a state level to prevent torture from occurring, and to bring to justice those who are suspected of torturing, as well as a duty to create systems in which torture is less likely to occur.

It is possible to conceive of a world without rights, albeit one that most of us would not find attractive.[23] But it is not the role of this article to make the case for rights based thinking in general. Rather, I mainly address myself to those who agree that there are some rights (perhaps to liberty, or not to be tortured), but are sceptical that these rights include a right to public health.

Will and interest theorists have waged a long and sometimes fractious dispute about the function of rights. Will theorists argue that the function of rights is to allow the rightholder to control the duties of others.[xi] On this view, all rights (even rights not

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x The idea of a directed duty does not by itself entail that such a duty must be of high priority. It is possible to conceive of a directed duty that would easily be outweighed by other duties. However, it is commonly assumed that the claims correlative to such duties would not be rights. Suppose I make a commitment to you that I will come to your birthday party so long as I can swap my shift at work to be free that night. This generates a directed duty because, in the case where I do get the night off work, and then do not come to your party, you might legitimately mildly reproach me. But the strength of my duty to attend your party would fall far short of what would usually be thought to be required for a rights claim.

to be enslaved) can be waived, and only those who have the wherewithal to waive rights can be rightholders, ruling out young children and non-human animals as potential rightsholders. For the interest theorist, the function of rights is to protect or promote interests. Interest theorists argue that there is nothing incoherent about the idea of rights that the right holder does not have the moral power to waive or annul, and so there is no bar to young children or non-human animals being rightholders.[xii]

Cross-cutting the debate about the function of rights is another debate between intrinsic and instrumentalist conceptions of rights. Intrinsic conceptions of rights hold that rights are an intrinsic part of the furniture of the moral universe: human beings have rights because of the moral status that they already have prior to anything we do.[xiii] Rights instrumentalists think that rights are constructed by us with a purpose of protecting, promoting or making possible morally valuable states of affairs.[xiv]

What counts as a legitimate move in justifying a particular right depends on prior claims about the nature of moral justification. Styles of justifications of moral duties can either be foundationalist or holistic. In foundationalist justifications, moral duties are derived from moral principles that are more basic in the order of moral justification and explanation. These more basic principles must be supported by more basic principles, until we reach a small number of basic principles (perhaps

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xi In H. L. A. Hart's words, it views the right holder as 'a small-scale sovereign' in the area in which the duty is owed, 'able to waive or extinguish the duty or leave it in existence'.[24].

xii This dispute partially explains the two conceptions of autonomy that are combined within the common discourse of respect for autonomy in health. In some contexts, autonomy is seen (in accordance with the interest theory of rights) as an interest in being able to take deliberated decisions about the shape of one's life. In other contexts, autonomy is seen as a feature that makes the individual a small-scale sovereign, able to refuse interventions for any reason or for none.

xiii As Warren Quinn put it, "It is not that we think it fitting to ascribe rights because we think it is a good thing that rights be respected. Rather we think respect for rights a good thing precisely because we think people actually have them—and… that they have them because it is fitting that they should."[25]

xiv Instrumentalist justification can involve simple means-end reasoning (where a right is introduced solely as a means of reducing instances of a particular bad state of affairs), or constructions of a more complex and open-ended kind (such as where a right to privacy is entrenched because it is believed that giving individuals the guarantee that certain aspects of their lives will be undisturbed will allow them to pursue forms of life that are valuable in themselves and would not otherwise be possible).

just one) that are not themselves supported by any other principles.[xv] Holistic approaches acknowledge that some duties can be justified by reference to others that are more basic in the order of justification, but they deny that this is always the case. On a holistic approach, justifications can also legitimately be a matter of mutual support of a variety of different concerns (as in reflective equilibrium).

The upshot of all these disagreements about the function, fundamentalness, and justification of rights is that it is far from clear what would count as giving a satisfactory justification of the right to public health (or indeed any other right). We can distinguish two levels of controversy: first, there are high level abstract questions about whether a right should be recognised at all. Second, there are a host of specificatory questions about what a given right should mean in practice: what its extension should be, who the dutyholders are, and how stringent the duties relative to the right should be.[xvi] My aim in this article is to defend the idea of a right to public health at a high level. I recognise that there will be a significant number of questions about duties and entitlements that remain controversial and unresolved even if the broad idea of such a right is accepted.[xvii]

Arguing for the right to public health

Is there sufficient moral reason to impose on governments those high priority directed duties that would be correlative to a right to public health? In what follows, I aim to establish a case for this right. My case relies in part on the positive effects that protection and promotion of health have for individuals' wellbeing, and in part negatively, on the wrong of those who have a duty to prevent others from being subjected to risks failing to do so.

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xv Will theorists tend to be keener to attempt to derive all rights from one single foundational right to freedom, whereas interest theorists are more relaxed about the possibility of the interests that are sufficient to ground rights being disparate, and thus there being multiple (and potentially conflicting) rights.

xvi For example, the right to life is widely accepted at an abstract level. Much more controversial is whether the best specification of the right to life includes an entitlement to the means necessary to sustain life, or if the right provides only protection against being unjustly killed. See for example Thomson[26] on this question.

xvii Of course, defending the right to public health even at a high level cannot be entirely separated from the problem of specification: whether it is correct to claim that there is a right to public health depends ultimately on whether there is a plausible set of duties and entitlements that is adequately defensible. Hence I attempt in an indicative way to put some more flesh on the bones in the final sections of the article.

It is difficult—even for those who are unsympathetic to the idea of a right to public health—to deny that health is of very great significance for wellbeing. Health is arguably a constituent part of wellbeing, but even leaving this on one side, health is an all purpose enabler for any number of other ends we might value for their own sake. Even if an individual places no particular value on their health per se, it will very often be the case that health enables them to pursue the goals they do value. Individuals thus have a universal (or near universal) interest in their health. What is controversial is not the claim that health is of significant and near-universal importance for wellbeing, but the relationship between this claim, and the further claim that governments have duties to protect and promote health, and that these duties are sufficiently stringent that individuals can sometimes legitimately claim that their right to public health has been violated.[xviii]

For the interest theorist, there is a relatively quick route to the claim that there is a right to health. Interest theorists such as Raz hold that a human interest which is (a) universal or near universal, and (b) of sufficient moral importance to wellbeing that it is legitimate to hold others to be under a duty to at least not frustrate this interest, and possibly help to promote it, is a sufficient ground for a right.[28] Given this account of when an interest is sufficient to ground a rights claim, and the relatively uncontroversial status of the claim that individuals do have a significant interest in preserving their health, the outline case for the right to health is simple: health is not only a near-universal interest, but is also an interest of sufficient moral importance (given the relationship between health and flourishing) to hold some others to be under a duty not to frustrate this interest.

The main reason for thinking that the type of interest we have in our health generates a right to *public* health is that socially controllable factors make a very significant difference to rates of morbidity and mortality.[29] Take road traffic accidents as an example. Government policies such as adequate speed restrictions, mandatory motorcycle helmets and car seatbelts, enforcement of proper seating restraints for children, and reduction of drink driving make a very significant difference to the risks citizens are exposed to.[30][xix] Individuals cannot adequately control these risk factors for themselves: I may be able to reduce some risks by wearing a seatbelt and not myself speeding, but I cannot prevent drivers from speeding or drink-driving. These risks from others' driving behaviours are potentially catastrophic for my health, and can practicably be reduced by

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xviii Thus Sreenivasan, in arguing *against* a moral human right to health does not dispute that "each human being has a morally very important interest in preserving (or restoring) his or her own health, in so far as this can be achieved through social action.[27]

xix Rates of death from road traffic accidents differ very significantly from less than 5 per 100,000 vehicles per year (Norway, Switzerland) to over 5000 per 100,000 vehicles (Guinea, Burundi, Benin, Central African Republic).[30]

government action. Thus, through my morally important interest in my own health, I also have a morally important interest in risk factors being removed from the social environment.

Assigning duty-bearers can sometimes be complex, but in this case it is relatively straightforward: in order for an agent to be a duty bearer under a right, it is sufficient that the agent has (1) the power and liberty to act and (2) a responsibility or duty of care in respect of the good in question (and so could sometimes do wrong in virtue of not acting). It should be uncontroversial that governments in functioning states do have the power to affect the social determinants of health; given the breadth and complexity of the types of causal relationships in play, governments are perhaps uniquely well suited to affect the distribution of social determinants of health. Whether governments have a responsibility to protect citizens' health should also be uncontroversial. Governments have a duty to act in the public interest. Acting in the public interest requires reducing significant and avoidable risks of harm to citizens where it is cost-effective and practicable to do so.[xx] Many risks to population health are significant and avoidable and can be practicably and cost-effectively reduced. Therefore there is a right to public health that citizens hold against their governments.[xxi]

Someone could object to this argument in a more or a less radical way. In a more radical way, they could argue that governments simply do not have a directed duty to reduce significant and avoidable risks of harm to citizens even where it is cost-effective and practicable to do so. I do not have a knockdown objection against such a view, but it is worth noticing that whilst it entails that there is no right to public health, it would also entail that there are no rights to safety or security either.

Less radically, someone could agree that governments have *some* duties to reduce risks of harm, but these justify at most a subset of traditional public health policies. First, someone could argue that even though governments do have a directed duty to reduce harm to citizens, health is the wrong type of interest to create such duties on the part of governments. For example, it might be objected that citizens usually care about their overall wellbeing, rather than their health per se, and that individuals

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xx This way of framing the right to public health suggests that it could also potentially be grounded in the right to security, as the next section explores.

xxi This argument is supposed to establish that duties relative to the right to public health are held by governments, but it is not my intention to suggest that these duties fall exclusively on governments. While I do not argue for these duties or attempt to specify them in this article, I also think that there are duties on corporations, institutions and individuals in respect of this right. I acknowledge that there are some cases—for example failed states—where there is legitimate doubt about the power that a government has to affect the social determinants of health. I leave such cases of state incapacity on one side for the purposes of this article.

often and reasonably make choices that involve trading off their health against other goods—as when someone chooses to be a soldier, or to climb a dangerous mountain. Second, it could be argued that while governments have a duty to reduce behaviour that imposes *uncompensated* risks on other people, there is no duty for governments to reduce behaviour that either does not impose risks on others at all, or where these risks are fully compensated.

Both objections raise valid concerns. There can be risks to health and wellbeing that are adequately consented to and which do not impose uncompensated risks on others; and it can sometimes be perfectly rational for individuals to endanger their health in order to pursue other goods that matter more to them. Where either of these conditions hold, it looks problematic for a government to *enforce* reduction of risks to health. But what results from these concessions is a requirement to better specify the appropriate targets of public health, and better specify what counts as a proportionate measure in reducing health risks, rather than a fundamental challenge to the right to public health.[xxii]

My claim is not that public health must win out against claims such as those of autonomy, but the weaker one that there is *a* morally important interest in such health threats being removed from the environment, which is sufficient to ground a right on the part of individuals that the state take steps to do so. As in the case of all other rights, it will need to be interpreted in the light of other justified rights claims, and also broader social goals. The right to public health will not be infringed if there are countervailing normative commitments of even greater weight that prevent a state from taking steps to reduce a particular health threat. But the right might be violated if the government either directly increases health threats to individuals, or does nothing to reduce a health threat when it is practicable to do so.

Specifying the right to public health

What would a right to public health look like in practice? The first thing to clarify is that no one will stay healthy forever, and so it is untenable to interpret the right to health as implying that there is a right to be healthy (even before we consider how to balance protection of health against competing interests). The right to health is thus best interpreted in terms of a right to the control and reduction of risk factors to health, and the availability of care for those who do become ill, rather than through any kind of unattainable goal of elimination of ill-health. The right to public health, similarly is to be understood in terms of a right to risk reduction, rather than risk elimination. However, it would be a mistake to think that the right to public health

xxii I argue elsewhere[14] that the proportionality of liberty-limiting public health measures depends on the normative significance of the choices interfered with, the extent to which the policy is coercive, and well as the degree of public support for such measures.

could, or should, lead to something like a uniform reduction of all risks by, say, 30%. Some risks to health — such as polio or asbestos in building materials — can practicably be completely eliminated, but others will be much more difficult to reduce.

It is sometimes assumed that public health aims only at (or ought to aim only at) the provision of public goods—health benefits that are nonrival and nonexcludable.[15] This seems to me to be mistaken both empirically and normatively. It is true that some goals of public health policy (such as the eradication of polio) are paradigmatic cases of public goods. But eradication is at the very far end of a continuum, and most vaccination campaigns have a significantly different profile. As a global eradication campaign moves closer to success, less and less of the expected benefits of a vaccination will accrue to the person vaccinated, and more and more to the world at large through the elimination of the health threat from the environment. As the number of cases of the disease approaches zero, the expected benefit to individuals who are vaccinated may become less than the expected costs, if the vaccine itself poses at least a minimal risk. In an ordinary vaccination campaign such as that for measles, it is usually in the ex ante interests of those vaccinated to be vaccinated. Unlike in the eradication endgame scenario, the goals of seeking to benefit individuals and seeking to establish a public good of herd protection are congruent. Other vaccination campaigns (such as seasonal influenza in England) have as their main aim giving protection to the most vulnerable, and do not aim to establish sufficient coverage to ensure herd protection. Lastly, there are vaccination campaigns for tetanus, which is not communicable from person to person and so the vaccination cannot create a public good.

It strikes me as implausible to think that seasonal influenza or tetanus vaccination is not a public health activity. I am thus inclined to think that the normative core of public health lies in systematic attempts to reduce health risks, rather than in the provision of public goods. Given this, I am fairly unmoved by sceptical arguments such as those of Sreenivasan[27], which aim to refute the idea of a right to public health on the basis of difficulties in justifying rights to public goods. Public health often involves public goods, but even more often it involves risk reductions for individuals, and it is these risk reductions for individuals that are the key justifying factor on a rights based approach to public health.

The key specificatory question is thus: which risks need to be reduced and by how much if the right to public health is not to be violated? My answer in outline is the right to public health is best interpreted as requiring *accountability for risk reduction.*[xxiii] The idea that I shall explore is that if there are public health risk reduction measures that would be practicable and cost-effective to implement, then

xxiii This suggestion draws on Daniels's[31] account of accountability for reasonableness, and particularly the account of the human right to health that Daniels gives in chapter 12.

the state should take itself to be under a prima facie duty to implement these measures.

There are some internationally recognised "best buys" in public health, such as raising taxes on alcohol and tobacco, restricting access to retailed alcohol, enforcing bans on alcohol and tobacco advertising, and replacement of transfats with polyunsaturated fats across the supply chain. (On the WHO's account, a best buy is "an intervention with compelling evidence for cost-effectiveness that is also feasible, low-cost and appropriate to implement within the constraints of the local health system"[32].) The presumption should be strong that the right to public health will be violated unless such best buys are enacted.

Other cases will be less clear-cut. Suppose an interested group of citizens wants the government to introduce a ban on the sale of sugary beverages in fast food restaurants above a certain size (say half a litre). They come up with something like the following argument:

1. Psychological research shows plausibly that portion size has a significant impact on the amount of food and drink that people consume. The larger the 'standard' portion, the more food and drink people will consume.

2. A culture of large portions (particularly of foods that are high in calories) is a significant driver of obesity.

3. Obesity is a very significant health threat.

4. A culture of large portions therefore presents an ongoing health threat.

5. If the government does nothing to counteract this health threat where proportionate and cost effective means are available, it violates its citizens' rights.

6. Preventing the sale of excessively large sugary beverages is a cost effective and proportionate means of reducing the health threat of large portion sizes.

7. Therefore the government has a duty to reduce the sale of excessively large sugary beverages.[xxiv]

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xxiv It is worth noting that an argument of this kind is implicit in the UN Committee on Economic, Social and Cultural Rights' General Comment 14: "Violations of the obligation to protect follow from the failure of a State to take all necessary measures to safeguard persons within their jurisdiction from infringements of the right to health by third parties. This category includes such omissions as the failure to regulate the activities of individuals, groups or corporations so as to prevent them from violating the right to health of others; the failure to protect consumers and workers from practices detrimental to health, e.g. by employers and manufacturers of medicines or food; the failure to discourage production, marketing and

Given the existence of the right to public health, arguments of this kind set up a prima facie duty for governments to act to reduce health threats. The onus is then on the government to explain why it does not want to act.

There are various things that the government officials could say in defending the lack of action. First, there needs to be adequate evidence that the intervention would work. There is no duty to impose policies that are either proved not to work, or for which there is an inadequate evidence base. Second, even if the policy would plausibly work, it might not be suitable for implementation due to competing public health priorities.

At any one time, there are a very large number of potential policies that could reduce risks to health, and only a subset of these will be able to be implemented. So it is vital that states have a transparent and reasonable system for setting priorities for public health risk reduction.[34] This prioritisation process need not, and probably should not, be a matter solely of multiplying the size of the risk reduction by the number of people affected. To the extent that an approach to public health is rights based, it needs to be justified with reference to reducing individual, and not merely population, risks. Moreover, factors such as the distribution of reductions in health risks also matter.

It is impossible to eliminate all health risks, and the resources required to reduce even those health risks that can practicably be reduced are limited, and must be balanced against other projects within public health and outside. If the system of prioritisation for public health policies is fair, then there is no violation of the right to public health in virtue of a government funding one public health policy rather than another.[xxv]

If there is both a sufficient evidence base for a policy, and the policy is one that meets the criteria for prioritisation within public health, but the government decides not to go forward with the policy, then a reasonable justification for not so doing is required. The most obvious such argument would be that the policy would have a disproportionately adverse impact on some good other than health the community has reason to care about. There are a variety of interests that could be invoked by a government in this regard, including on occasion commercial interests. It is beyond the scope of this article to consider all such interests; I shall instead return to where we started the article, namely with the idea of autonomy as a fundamental stumbling

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consumption of tobacco, narcotics and other harmful substances; the failure to protect women against violence or to prosecute perpetrators; the failure to discourage the continued observance of harmful traditional medical or cultural practices; and the failure to enact or enforce laws to prevent the pollution of water, air and soil by extractive and manufacturing industries."[33]

xxv Fairness here would have to include the total budget envelope for public health, as well as allocating resources within this budget.

block for legitimate public health activity. If, as I shall argue below, the right to public health can justify significant infringements of liberty and autonomy, then it should be relatively easy to see how the same kinds of argument apply a fortiori to interests such as commercial interests, which do not invoke fundamental rights.

Public health, security and liberty

Many experience an initial stumbling block with the very idea of a rights based approach to public health, which would allow government interventions to protect health that interfere not only with individuals' liberty, but also their autonomously deliberated decisions. How could interfering in a person's life without their consent (and even in the face of their informed and autonomous dissent) be justifiable in the name of protecting that individual's rights?

I aim to disarm this line of objection by showing that in other circumstances the protection of rights frequently involves the state restricting the liberty of the holders of the right, and sometimes coercing them, all in the cause of protecting the right. So if public health activity involves governments in restricting liberty or coercing individuals (and even if some individuals violently oppose some of the public health measures that the government adopts), that does not by itself show that these interventions could not be justified by a right to public health.

The right to security is usually interpreted in such a way that it allows (or even requires) extensive interferences in the name of protecting the right. Take mandatory airport security measures, which involve systematic interference with the liberty of those who have not committed a crime or other wrong, and are not even suspected of so doing. Under current regulations, if I am going to fly on a plane, I must submit to the scanning of my luggage and to bodily examinations. Many of the activities that are interfered with for the purposes of the right to security look to be self-regarding if anything is (e.g. carrying a small bottle of water).

If it were correct to think that the importance of autonomy precludes protecting rights by interfering in self-regarding actions, then it would be impossible for such interferences to be justified on the grounds of the right to security. But most people in fact believe that proportional government interferences in self-regarding acts are rendered not just rendered permissible, but even mandatory via the right to security. The usual rationale for this policy would be that while there is no specific reason to suspect the vast majority of those who are stopped and only a miniscule percentage of those who are stopped would have been going to commit a crime, these measures are justifiable in the round because they are the only practicable way of detecting and deterring terrorists who otherwise would be able to violate rights with impunity. Most believe also that such security measures are not just rendered permissible, but actually mandated by the right to security.

The nature of security as a public good entails that it is difficult to protect the security of all without infringing the liberty of some. Even if *I* wish to waive *my* right to security, this does nothing to waive others' rights to security. Hence, if the state is entitled to interfere (in a proportional manner) with the liberty of anyone in order to protect individuals' rights to security, it can interfere in this way with my liberty even if I wish to waive my own right to security. I may not want to have my security protected by being forced to take off my shoes and belt in order to get on an airplane, but it does not follow from this that the government is not entitled to do so in the course of protecting others' rights to security.[xxvi] Indeed, if there are cost-effective and proportionate measures available that could have foreseeably prevented a threat eventuating and these are not taken, then there will be a case that the government has violated the right to security.

Of course, not just any interference can be justified in the name of the right to security. Many measures are disproportional, and moreover the drive to securitisation of the state can have a number of very severely problematic side effects.[xxvii] For our purposes, I wish to take two things away from this brief consideration of security: (1) the claim that a right could not support interference with self-regarding actions is a non-sequitur; (2) even if a given individual would prefer not to have their right to protected in a way that they personally find burdensome or annoying, this would not by itself defeat the claim that such measures were required by rights.

If it is true that preventing the sale of sugary beverages in large containers is required, and that citizens rights will be violated if the government *does not* do this, where does this leave the individual who prefers to have a "Big Gulp", consuming a massive cup of Coke or Sprite at one sitting? Has her right to non-interference been violated? We can distinguish two kinds of worries here. First, someone might place a particular value on the ability to buy soft drinks in large containers – it may be that for them then, having two half litre cups if Coke is problematically different from

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xxvi Sreenivasan[27] seems to assume on this basis that apparent rights such as the right to security cannot be waived, and so could not be rights on the will theory of rights. This seems to mistake what needs to be waivable for there to be a will theory right. Compare a case where all the residents in a shared house have a right (that they can individually waive) that loud music not be played after 11pm. If I waive my right, then I extinguish the duty that my housemates would otherwise have had in respect of me not to play loud music after 11pm. But the other housemates each separately maintain their rights not to be disturbed by loud music. The fact that my waiving of my right does not give a permission for loud music to be played does not show that I did not have a will theory right.

xxvii For a helpful discussion of the foundations of security policy, see Loader and Walker[35].

having a single one litre cup. I have to say that I find this preference difficult to take seriously as the grounds for a potential rights violation.

A second interpretation would be as a more general worry about the state overstepping its proper role. But if that is supposed to be the argument, then it seems to amount to little more than the denial (without argument) of the claim that there could be a right to public health. Clearly *if* there is a right to public health, then protecting health forms a legitimate part of the state's role, as by definition, acting in a way that is proportionate and necessary to protect rights is not wrongful. As we saw in the case of the right to security, activity that infringes liberty and/or overrules individuals settled wills about their own life is justifiable if necessary and proportionate to prevent violation of rights. Therefore, curtailing individuals' liberty, and even acting against individuals' settled wills can be morally legitimate (where it is necessary to prevent rights violations).

A third potential objection would be that the policy is paternalistic. It's not entirely clear to me whether it counts as a case of paternalism if we restrict the liberty of X (along with all other citizens) in a way that is a proportionate response to a right that all have. But it seems to me that this is not the most important question from a normative perspective. If we start from the assumption that the interference is morally legitimate, then complaining that the interference is paternalistic is beside the point. Anything that is morally legitimate is either not paternalistic at all, or paternalistic but not morally wrong. Therefore paternalism cannot be a valid objection to proportionate action in the name of the right to health.

Overall, I suggest that we see the right to public health as analogous to the right to security. It might be as well to set out the argument stepwise, to see where there is disagreement. I am proposing the following argument:

1. There is a right to public health.

2. Infringing personal liberty for the sake of public health is relevantly similar to infringing liberty for the sake of security.

3. Significant infringements of personal liberty are justifiable for the sake of security.

4. Therefore, significant infringements of personal liberty are justifiable for the sake of public health. Interventions to promote or protect *health* that infringe liberty and/or over-rule individuals' settled wills are justifiable in the same kind of way as in the case of the right to security.

5. Therefore, significant infringements of personal liberty are justifiable for public health.

There seem to be two options for the defender of the noninterference assumption (beyond, as we have already considered, simply denying that there is a right to public health).

1. The interference with liberty in cases like airport security are not in fact permissible (despite their ubiquity). Therefore we should not infer that other equally significant infractions of liberty are permissible in the cause of promoting public health.

2. There is a relevant dissimilarity between the right to security and the right to public health. Even if it is legitimate to interfere with liberty for the sake of security in the airport is case, it does not follow that interferences with liberty are justifiable for the sake of public health.

If someone wishes to make objection (1), then the problem goes much wider than health promotion activities. Rights will be systematically violated by all kinds of security policy and surveillance activities. Whilst much public health activity would be difficult to justify, so would much existing government activity that is widely accepted by those who are in general sympathetic to the noninterference assumption. (What is puzzling and interesting is that the case of interference for the purposes of improving health, and interfering for the purposes of security are usually treated very differently; and that some of those who are most vociferous in their denunciation of state interference to promote health are strong supporters of state interference for the sake of security.)

If someone wishes to make objection (2), this would require them to say what the relevant dissimilarity is. One apparent difference might be that the actions stopped by checks such as the right to security would involve moral wrongs, whilst those prevented by the right to public health would not. However, if this were the argument, then it would beg the question against the existence of the right to public health: if there is a right to public health, then individuals can be wronged by governments failing to fulfil their to reduce risks to health.

Conclusion

I have argued that there is a right to public health, which includes entails that individuals have an entitlement that their governments systematically remove threats to human health by undertaking health protection and health promotion measures. Just like the right to security, this should have teeth. Whilst any government action under the right to public health needs to be justifiable as proportional, significant infringements of personal liberty can be justified where this is necessary.

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