

## MODULE 6

### Ethics of Health Promotion and Disease Prevention

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*There is now widespread agreement among both the general population and health professionals that a good deal of disease is self-inflicted, the product of our own imprudent behavior. The premise that individuals contribute significantly to their own ill health or premature death appears unassailable in view of the mounting evidence relating various personal habits and lifestyle choices, such as poor nutrition, smoking, alcohol and drug abuse, failure to wear seat belts, and unsafe sexual practices, to major causes of morbidity and mortality.*

*While it is generally accepted that each of us is, to a certain extent, "dangerous to our own health," there is far less agreement on what can or should be done about making people less foolish. In particular, there is the question of how far government should go in fashioning lifestyles to minimize the physical and mental harm we inflict upon ourselves and others in society through risky personal choices. Where does personal choice and collective responsibility begin? How we reconcile two of our most prized social values, personal freedom and good health?*

—Howard M. Leichter, **Free to be Foolish.**

#### Introduction

The above-cited quotation sets the stage for the issues with which we will be concerned in this module. The issues posed can be reframed in the following way. What are the appropriate limits of the state in a liberal society in regulating, restricting or prohibiting behaviors that lead to premature morbidity and mortality; in shaping, molding or influencing the preferences and desires of its citizens; in protecting citizens from commercial influences that may encourage or sustain patterns of behavior that are antithetical to the goals of public health?

The contemporary discussion of these issues can be traced to a number of public reports that underscored the extent to which medicine can only play a limited role in affecting the patterns of morbidity and mortality in what was viewed as a post infectious disease society. In 1975 Marc LaLonde, Minister of Health for Canada, issued a landmark report, *A New Perspective on the Health of Canadians*, which boldly stated that unless the environment changed self-imposed risks reduced death rates could not be significantly improved. LaLonde was acutely aware of the ethical challenges posed by this orientation: "Whether and to what extent government can get into the business of modifying human behavior, even if it does so to improve health." These views and concerns were echoed in United States in the introduction to the 1979 Surgeon General's report *Healthy People*. Secretary Joseph Califano declared, "You the individual can do more for your own health and well-being than any doctor or hospital or exotic medical device." Like LaLonde, the Secretary underscored the ethical challenges signaling as well the treacherous political terrain. "There will be controversy—and there should be—

about what role government should play, if any, in urging citizens to give up their pleasurable but damaging habits. But there can be no denying the public consequences of those private habits. "

The scope and significance of the challenge posed by these public documents can most forcefully captured by the clash that emerged between those who saw in this new perspective a call for vigorous and legitimate governmental intervention and those who believed that represented the public health version of victim blaming.

No one more forcefully took up the banner for behavior change than John Knowles, a physician and Rockefeller Foundation president. In a widely read essay entitled "The Responsibility of the Individual" he took the opportunity to challenge a culture that fostered behaviors that caused illness and premature death:

*The idea of individual responsibility has been submerged in individual rights or demands to be guaranteed by government and delivered by public and private institutions. The cost of sloth, gluttony, alcoholic intemperance, reckless driving, sexual frenzy and smoking is now a national and not an individual responsibility. This is justified as individual freedom—[but] freedom in health is another man's shackle in taxes and insurance premiums. I believe the idea of a "right" to health [ought to be replaced by an] obligation to preserve one's health—a public duty if you will.*

These claims, which despite some recognition of the way in which broad social and institutional forces affected behavior, laid much of the responsibility for such actions on the individual. As a consequence they were viewed by many as an ideological strategy for relieving government of the obligation to assure the conditions of health or provide health care services to those were ill. It was a perspective, the critics noted, that despite the apparent attention to social conditions, tended to conceptualize behavior as the outcome of individual choices. Thus those who behaved foolishly had only themselves to blame for their condition. Finally, critics noted that the assertion that individuals had an obligation to be healthy had profoundly troubling implications. Just what was the source of this duty? Did each of us have an obligation to behave in every way possible to foster society's economic and social well-being? If there was a duty to be healthy was there also a duty to be productive?

However one framed the general issue, whether one saw the behaviors as a consequence of choice or as socially embedded, it was critical, as noted at the outset of this module, to confront the question of the role of the state. Because of the profound influence of individualism in American culture and politics it would be useful to begin this discussion with an oft quoted passage from John Stuart Mill's essay *On Liberty* where we encounter a robust defense of the individual against intrusions by the state.

*The only purpose for which power can be rightfully exercised over any member of the civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not sufficient warrant. He cannot rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because in the opinion of others to do so would be wise or even right. These are good reasons for remonstrating with him or reasoning with him or persuading him or entreating him [but not for] compelling or visiting him with any evil in case he do otherwise. To justified that, the conduct from which it is desired to deter him must be calculated to produce evil to someone else. The only part of the conduct of anyone, for which he is amenable to society, is that which concerns others. In the part which*

*merely concerns himself, his independence is, of right, absolute. Over himself, over its own body and mind, the individual is sovereign.*

Before proceeding, it is crucial to understand the conceptual distinction being made by Mill. The target of his animus is paternalism—the attempt to impose limitations upon someone or to require actions by someone for his or her own good. Such impositions can be justified in two circumstances: (1) with children because it is assumed that they are incapable of deciding on their own behalf; and (2) with those who because of cognitive limitations cannot choose on their own behalf. The one exception that Mill makes only serves to underscore his position: one cannot sell oneself into slavery. One cannot do something that would forever preclude the exercise of one's freedom. (It is worth noting here that some have used this exception as providing a justification for paternalistic intrusions designed to prevent individuals from using addictive drugs or even smoking cigarettes. How far such an exception would go in eviscerating Mill's strong position on liberty is worth bearing in mind throughout this module.)

By contrast intervention is justified for Mill when one acts in a way that may pose a harm to others. Other-regarding harms are the appropriate target of government regulation. The shorthand for this justification has come to be known as the "harm principle." Conventionally put the principle asserts "your freedom to swing your arm ends where my nose begins." This apparently straightforward formulation opens the way to a series of questions involving the nature of harms that may be prevented. While the bodily injury entailed in a blow to the nose is clearly a harm for Mill, what about an injury that is threatened, one that is possible, or only remotely so, one that is merely statistical, smoking in an open-air café, for example? What if the potential harm involves an annoyance, for example the smell of smoke in an open-air stadium? What if an act that is self-regarding in terms of injury is other-regarding in terms of economic costs, for example smoking alone? The point here is to underscore the extent to which Mill's formulation can either serve to impose radical limits on what government can do in the name of public health, or if very broadly interpreted open the way to kind of interventions that would for all practical purposes eliminate the distinction between the realm of the private and social, between the self regarding and other regarding? After all, in a highly integrated society what action does anyone take that does not *ultimately* have an impact on "society"?

If Mill's antagonism to paternalism is understood as imposing severe limits on governmental intervention can it serve as a basis for an ethics of public health? If Mill's doctrine is very broadly construed does it compel justifications for public health that ultimately involve gross contortions, finding harms to others when they can only remotely be understood as such? In this module we will note how on several occasions the need to avoid the appearance of paternalism shaped and distorted justifications for state intervention in the name of public health. The alternative would be to embrace paternalism explicitly as a core value of public health. While such a strategy might be politically untenable it would open the way to a more candid discussion of the extent to which communal well being justifies limits on behaviors that impose harms to individuals themselves and only secondarily on others. That is the strategy adopted by philosopher Robert Goodin.

*We do not leave it to the discretion of consumers, however well informed, whether or not to drink grossly polluted water, ingest grossly contaminated foods, or inject grossly dangerous drugs. We simply prohibit such things on grounds of public health ... to a very large extent ... the justification of public health measures, in general, must be baldly paternalistic. Their fundamental point is to promote the well-being of people who might otherwise be inclined cavalierly to court certain sorts of diseases.*

Goodin's posture represents a bracing corrective and while he is acute in pointing out that instances of public health paternalism abound it is remarkable how often efforts are made to mask such interventions as ultimately involving the protection of third parties. This was the case as we will see below in the discussion of mandatory seat belt laws.

It is worth noting here that despite Goodin's embrace of public health paternalism he is quick to underscore that it is a "weak" form of paternalism that he advocates. He argues that in a fundamental sense his paternalism takes the most basic preference of individuals to live long and well as its starting point. It simply seeks to impose on the reluctant or the foolish interventions designed to secure those ends. "It is one thing to stop people who want to commit suicide from doing so," he writes, "but quite another to stop people who want to live acting away that they falsely believed to be safe." Provocative though this distinction may be, we should note that it provides a justification for paternalism that is breathtaking in its scope. Since we all want to be happy, fulfilled, healthy, what government intrusion could not be termed a "weak" form of paternalism? Is there something here that is akin to the paradoxical question asked in political philosophy "Can someone be forced to be free?"

With these preliminary observations in place, it is now possible to confront the ethical issues posed by government effort to affect behavior in name of public health. In this module we will examine efforts involving health communication campaigns (and censorship), taxation designed to discourage consumption, and prohibitions or mandates on certain behaviors. In each case we will be concerned with the impact on individual liberty as well as fairness of burdens.

### **Health communication campaigns and the censorship of advertising**

Health communication campaigns that discourage certain activities or encourage the adoption of others are the most common form of intervention designed to promote healthy behavior. They would at first appear to pose no ethical challenges. They provide needed information and thus enhance personal autonomy in the face of health risks. They may affect behavior that produces health related burdens for society. Thus such campaigns may limit the extent to which community may be compelled to tolerate negative externalities generated by those who engage in activities linked epidemiologically to morbidity and mortality. Finally, at an expressive level such efforts represent a public demonstration of the community's concern for the health and well-being of its members.

Yet even such interventions may raise troubling issues. Messages targeted at those most at risk may open the way to stigmatization and hence to the imposition of inequitable burdens. Two examples illustrate this point. In the context of the AIDS epidemic efforts to counter the tendency toward marginalization of those most at risk led to the creation of campaigns that suggested that everyone was at risk for HIV infection. While technically and biologically correct the campaign represented an epidemiological misstatement. In this instance a decision had been made to sacrifice veracity and perhaps effectiveness to protecting those most at risk for stigmatization. Was this determination to protect ethically warranted? The second case involved decision made by the New York State Health Department to require the posting of warnings at bars about the potential hazards of alcohol consumption during pregnancy. That rather straightforward effort to inform was greeted with dismay and hostility by advocates of women's rights who saw this health information message as stigmatizing, as reflective of a paternalistic assumption that women did not know what was in their best interest and the interest of their fetuses, as an invitation to meddling by bartenders and patrons. Were such

concerns of sufficient merit to warrant the scuttling of an effort that was viewed as pertinent to the public health?

In large measure critiques of health communication campaigns have centered primarily on the extent to which they have been understood to be a substitute for more effective public health interventions. But health communication campaigns can be successful. We know that the cumulative impact of many efforts over time is enhanced when novel messages, conveyed in a variety of media, have been supplemented by more personal interventions. Can such campaigns be too successful? Can they undermine autonomy by their efforts to reform the way in which we think about our health-related preferences? It is a striking feature of American fear regarding governmental intrusions that concern has been generated for some by the mere prospect of successful state sponsored programs to influence health-related behaviors. For commercial advertisers to advance exaggerated claims is almost expected. But were government to engage in similar levels of exaggeration, even in the name of public health, fears of unwarranted and dangerous manipulation would abound. Such reactions, if taken seriously, could place public health education campaigns at a disadvantage.

In light of these considerations is worth thinking about the ethics of social marketing. Is not surprising that public health officials have come to recognize that they had much to learn from the advertising industry. After all, years of efforts had created a vast industry designed to understand the wellsprings of motivation that could be tapped to encourage the purchase of products through the creation or manipulation of desire. If, for example, advertising could convince adolescents around the world that they wanted and needed Nike running shoes could they not be convinced that cigarette smoking was bad? Could not the manipulative capacity of advertising be mobilized for public health goals?

Whatever the answer to those questions will be--and the challenges of using advertising for public health goals may be substantial--social marketing raises critical ethical issues. Is the subversion of autonomy implicit in the manipulation of desire and preference ever justifiable? Can the protection of individuals from the manipulative activity of commercial advertisers justify counter-manipulation in the name of public health? Does such manipulation simply attempt to level the playing field? And does such an effort at balancing provided the ethical warrant for what otherwise might be considered morally troubling?

But if efforts at public health education raise important ethical challenges proposals to restrict advertising in the name of public health pose direct questions about the relationship between the community's well-being and freedom of expression. Here a discussion of the ethics of public health must inevitably engage American constitutional law. We will approach this issue through the case of proposed bans on cigarette advertising.

Efforts to impose radical restrictions--and even total bans--on cigarette advertising emerged in the mid-1980s. These initiatives had to confront an evolving constitutional debate over the extent to which commercial speech should be accorded protections under the First Amendment. In 1986 the American Medical Association called for a total ban on cigarette advertising and promotion and in so doing joined the American Heart Association and American Lung Association. In testimony before Congress the American Public Health Association stated, "Advertisements should be to promote good health products and not products that kill."

While proponents of the ban on all cigarette advertising and promotion sought to ground their arguments in a uniquely dreadful consequences of the sale and consumption of tobacco products many who opposed such efforts centered their claims on the uniquely important role of the First Amendment in American political culture. While the former believed it possible to prohibit advertising of cigarettes without unraveling the fabric of freedom of expression, even for commercial speech, the latter saw freedom as indivisible.

While support for an outright ban on advertising gained strength in the 1980's there was little evidence that such a move had anything like the necessary political support. It would require a reframing of the issue to make the call for restrictions more politically potent. That reframing gradually took place in the 1990's as the argument for restricting advertising and promotion increasingly focused on protection of children. At the heart of this reorientation was a pair of linked claims, one moral the other empirical. Children and young adolescents were incapable of making determinations on their own behalf and needed protection from manipulation by those who sought to stimulate their desires for harmful goods. Whatever the limits of paternalism in a liberal society, the exercise of the state's protective authority was certainly appropriate with those below the age of consent. Since cigarette smoking once commenced, was driven by the addictive power of nicotine, the exercise of restrictive and protective authority to prevent smoking was morally justified. That such measures would indirectly impose limits on advertising and promotion viewed by adults was a price worth paying.

The struggle between proponents of restrictions on tobacco advertising and advocates of First Amendment protection of such "speech" was played out against an ongoing controversy over the potential efficacy of advertising bans. The debate had both practical and constitutional implications. Certainly restrictions on advertising directed at youths could only be justified if, in fact, they affected patterns smoking. From a constitutional perspective the issue was crucial. The Supreme Court's jurisprudence on commercial speech restrictions stipulated that no matter how narrowly tailored, limitations could not pass muster if there was no evidence that they could achieve their goal. And here it is remarkable to note that despite decades of agitation for restrictions on advertising by public health advocates the evidence of efficacy had been very limited. This is the backdrop to the Supreme Court case *Lorillard vs. Massachusetts* decided in 2001. In that critically important case the Supreme Court stated that Massachusetts had failed to bear the burden of demonstrating that its restrictions on outdoor advertising designed to protect children would in fact achieve their goal. Hence there emerges a paradox: narrowly tailored restrictions on advertising designed to protect children are unlikely to be effective; those that might be effective are unlikely to pass constitutional muster.

It is here that we need to confront a critical set of ethical questions. Is it true that a vibrant democratic culture requires unfettered commercial speech? Is the protection of children through measures that burden the rights of adults morally acceptable? And perhaps most pertinent do adults have a right to be protected from the seductions offered by advertising? In short, questions of advertising restrictions force us to confront the limits of paternalism.

### **The wages of sin: taxes, consumption and the public health**

Given the focus of public discussion on the economic consequences of the relationship of personal behavior to morbidity and mortality it is not surprising that considerable theoretical attention has been devoted to the role of taxes as a critical element in health promotion efforts. Much of the concern has centered upon the issue of negative externalities, including the cost of health care and lost productivity.

Thus it was only natural that proposals were made to recapture those costs through excise taxes applied to products directly implicated in disease and early death.

From the point of view of economics such taxes would correct for market imperfections. They would pass on to consumers the true cost of their behaviors by having the price of a dangerous product reflect the costs imposed on society by the consumption of such a product. From an ethical point of view efforts were made to justify such taxes as central to a more equitable distribution of the burdens associated with certain behaviors. On the other hand, since excise taxes are always regressive, burdening the consumption options of the poor more than the well-off, it was argued that such levies rather than enhancing fairness would generate inequity.

The imposition of taxes in excess of those justified by calculable negative externalities, those downstream burdens that others are compelled to bear as a result of one's behavior, would require arguments that went beyond the claims of society in the face of such costs. Such efforts would entail paternalistic imposts designed to reduce consumption patterns deemed undesirable from the perspective of public health. Indeed such taxes drew the ire of J.S. Mill. In writing about proposals to tax alcohol in the 19th century he stated, "To tax stimulants for the sole purpose of making them more difficult to be obtained is a measure differing only in degree from their entire prohibition." We will discuss the issues posed here by the example of cigarette excise taxes.

It was not until the mid-1980s that the idea of using the power to tax emerged as a central feature of the anti tobacco campaign in United States. Faced with a challenge of affecting mass behavior public health advocates concluded that a substantial increase in tobacco excise taxes might be the most effective measure that state and local governments could take to advance public health. As the issue was joined it became necessary to address a host of both technical and moral issues: How would price increases affect the consumption of an addictive product? What was the elasticity of demand for cigarettes among those who might be poised to begin smoking, young smokers, those who had smoked for years? Would such excise taxes be inherently regressive and therefore inequitable? Did smokers impose collective burdens on nonsmokers because of the medical costs they incurred and did equity justify or require the internalization of such negative externalities? Was the imposition of excise taxes on cigarettes, at least in some part, an act of paternalism designed to place economic burdens on smokers in order to enhance the prospect of quitting? And if so was such paternalism morally justified?

Despite the recognition that increases in cigarette taxes could have a direct impact on tobacco consumption the public justification for such levies very quickly began to center on the social costs of smoking. Thus, for example, when California voters were asked to consider a ballot proposition that would have increased the cost of cigarettes by 25¢ a pack a coalition supporting the new tax declared: "The tobacco companies have said that a tax is unfair that taxes only smokers .... We say that for many years it was unfair that nonsmokers to have had to subsidize the smokers relative to their increased costs of medical care." The advocates of the proposed tax increase provided a second justification, one that focused on the need to protect those who were the appropriate targets of paternalistic intervention. The new resources generated by the levy would provide funds to educate children about the dangers of smoking. Furthermore increased prices for cigarettes would raise the barrier to consumption by children and adolescents. Taxes might be more effective than the already existent legal prohibitions on such sales.

A powerful indication of the extent to which tobacco activists wanted to avoid the taint of paternalism was the following observation made by Kenneth Warner, an economist and longtime proponent of aggressive anti-tobacco efforts on the part of government. Were taxes, he said, a way of asserting that "we know better than you" and that "we don't want people doing things the bad for themselves" he would oppose them. But taxes were not about protecting adults from their own choices but were rather a matter "discouraging children, the next generation from initiating its tobacco addiction."

Central to the moral arguments of the social costs of tobacco addiction were a set of assumptions about how smoking increased the cost health care. The evidence would, however, ultimately suggest that given the premature mortality associated with smoking the social cost argument far from definitive. Early death reduced social security payments, expenditures on nursing home care, and medical care late in life. Indeed by the year 2000 Kenneth Warner declared that claims that smoking clearly imposed costs on society in terms of expenditures was a "myth." In the end then a central justification for increasing taxes was brought into question. What remained was the claim that higher prices protected children. And once again the question posed for the ethics and public health would be on the extent to which the invocation of child protection could serve as the engine force for broad public health policies.

By the turn of the 21st century in a climate suffused with neo-prohibitionist trends regarding tobacco, it was, of course, possible to press for steeply increased cigarette taxes for purely fiscal reasons--increasingly burdening through a sin tax a product subject to wide scale marginalization.

It was a trend toward higher taxes and prices and the changing demography of smoking in America that provided the context for a question regarding equity and public health. Cigarette smoking by the end of a 20th-century was increasingly a behavior of the less educated and the less affluent. There was, in fact, a steep social gradient inversely relating smoking and class. Excise taxes that were, by definition, regressive were being borne by those least able to pay. Was such a burden inequitable or did it, precisely because of its potential impact on consumption, ultimately serve the interests of the least advantaged. If it did so, was the imposition of such burdens an expression of paternalism. Was such paternalism justified? Did the right to take risks, or enjoy dangers, and pleasures, without the intrusive concern of the state make such intrusions unacceptable?

Increased prices, unlike direct prohibitions ultimately leave to the consumer the choice of whether or not to purchase a product. Because they permit such choices while imposing burdens expressed through the market some have viewed them as a less troubling paternalism. But, at the end of the day, for those who must pay is such paternalism in fact less troubling? And while the case of tobacco may seem an especially appropriate target for health-inspired taxes would the extension of levies to high-fat foods sold by McDonald's, for example, be morally acceptable? To the extent that current policy does not cover all products linked morbidity and mortality can we conclude that the decisions are reflective of the pattern of an invidious discrimination, even moralism, masquerading as public health?

### **Restrictions, prohibitions, and mandatory behavior**

Whatever the ethical challenges posed by health education campaigns or by the use of the excise taxes they do preserve a realm of choice and hence avoid some of the obloquy that attends policies that unambiguously impose penalties for failing to behave in prescribed ways or for behaving in ways that have been proscribed. Prohibitions evoke the specter of Big Brother and of America's "noble experiment" with alcohol. Yet on a broad range paternalistic public health regulations are an accepted

part of contemporary life. Prohibitions on the sale or prescription of many intoxicating substances are challenged only by libertarians opposed, in principle, to any but the most limited restrictions on individual liberty. Pure food and drug laws, as well as legislation governing the use of potentially carcinogenic food additives are not only rarely opposed but often demanded by those committed to public health despite the clear impingement on liberty and autonomy of potential consumers.

It is only when government seeks to restrict the availability of a product well integrated into the social fabric, or when it plans to mandate behavior that is not already required that the ensuing controversy brings to the fore the ethical issues that undergird even the most widely accepted practices.

The debate surrounding mandatory motorcycle helmet laws, which occurred more than three decades ago, provides a unique window on the extent to which explicitly paternalistic measures can encounter opposition and as a consequence require justifications compatible with the individualistic trends in American culture. Hence the case remains of enduring significance. Stephen Teret has provided an analysis of the saga. In the nine years following the decision of the federal government to link highway funds to the enactment of mandatory motorcycle helmet laws, 49 states adopted the mandated requirements. Only California refused to do so. Utah limited the statutory requirements to highways on which travel exceeded 35 miles per hour.

Despite the vehement opposition to the statutes by representatives of cycling groups compliance with helmet requirements was nearly universal. As a consequence, deaths from motorcycle accidents declined dramatically. But because motorcyclists viewed mandatory helmet laws as unacceptable, a violation of their civil liberties, an intrusion upon their autonomy, and an example of unjustifiable paternalism, they brought suit in state after state challenging the constitutionality of the statutes. Only in Illinois did the court hold mandatory helmet laws unconstitutional. In one case that was pursued to the U.S. Supreme Court, the nation's highest tribunal refused to overturn a U.S. District Court holding that government could legitimately compel the use of helmets.

In their decisions, courts tended to avoid justifications that suggested a warrant for paternalistic intervention. Rather, they sought to demonstrate that the social impact of private behavior provided ample justification. Characteristic was the language used by a U.S. District Court in Massachusetts

From the moment of injury [society] picks the person up of the highway; delivers him to a municipal hospital and municipal doctors; provides him with unemployment compensation if, after recovery, he cannot replace his lost job; and if the injury causes permanent disability, may assume the responsibility for his and his family's continued assistance. We do not understand the state of mind that permits the plaintiff to think that only he himself is concerned.

Here in unvarnished words was a justification that relied on the harm principle conceptualized in terms of social costs. Strikingly absent was the will to assert that it was a legitimate social interest to protect motorcyclists from their own imprudent choices, a justification that might have articulated society's interest in preventing death and suffering regardless of its social costs.

What opponents of motorcycle laws had failed to do in the courts they succeeded in accomplishing in the Congress. The Secretary of Transportation was forbidden from using the power of the purse to force the states to impose protective requirements on motorcycles. Within three years of the 1976 congressional action 27 states had repealed their laws. As a consequence motorcycle helmet use

declined by 40 percent in the repeal states. The mortality toll began to rise in terms of medical expenses and lost productivity. So too did the toll in human suffering.

Here again we must address a set of critical ethical challenges: When can the state do just what Mill decried? Is an ethics of public health, focused on the well-being of populations, compatible with a Millian liberalism? How should we think about strained claims about third party costs and harms? When such claims are made despite the fact that they mask the true purpose of policy do they corrupt the discourse on public health? Would a public health that explicitly acknowledged the paternalism inherent in policy be more desirable or does such reluctance in fact serve important social functions?

## Conclusions

A theme that runs through virtually every policy debate involving health promotion and disease prevention is the fear of the slippery slope. If the state is justified in imposing limits on smoking or requiring motorcyclists to wear helmets will that inevitably open the way to a cascade of intrusions--some petty, some truly burdensome. Does the logic of public policy dictate that once the first step is taken down the road to paternalism there is no stopping point? Does consistency demand of a state that imposes restrictions on smoking that it impose restrictions on French fried potatoes because their fatty nature threatens health as well? On the number of hours each of us devotes to exercise? Alternately, is it possible that the invocation of the slippery slope rather than revealing an important truth represents a barrier to reflective consideration of the ethics of public health?

## Cases in Health Promotion and Disease Prevention

*1. Health Communication Campaigns and the Censorship of Advertising* – Using the case of tobacco highlights the tension between robust conceptions of freedom of expression and the claims that the protection of the public health requires bans or restrictions on advertising that may stimulate the consumption of tobacco products.

*2. Taxes, Consumption and the Public Health* – Increasing taxes on cigarettes to limit consumption highlights the tension between the claim that individuals have a right to purchase products that give them pleasure even if they produce illness and the public health claim that there is an obligation to inhibit behaviors that can predictably be the cause of morbidity and mortality. In this instance, the tax-induced increase in prices does not represent a prohibition but the creation of an economic burden that leaves individuals formally free to choose.

*3. Mandatory Motorcycle Helmet Laws* – This case places into bold relief the assertion that the protection of the public health, as represented in decreases in morbidity and mortality, may justify the imposition of outright prohibitions designed to protect individuals from their foolish choices, choices that incidentally may also produce burdens on society.

## For Further Reading

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H. Leichter, "Saving Lives and Protecting Liberty: A Comparative Study of Seat Belt Debates," *Journal of Health Politics, Policy and Law* (Summer 1986) 323-344.

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