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Smoke Free? Public Health Policy, 'Coercive Paternalism', and the Ethics of Long-Game Regulation

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ABSTRACT

Contemporary public health advocacy promotes a 'fifth wave of public health': a 'cultural' shift wherein the public's health becomes recognised as a common good, to be realised through concerted developments in the institutional, social, and physical environments. With reference to examples from anti-tobacco policy, in this paper I critically examine the fifth-wave agenda in England. I explore it as an approach that, in the face of liberal individualism, works through a long-game *method of progressive social change. Given the political context, and a predominant concern with narrow understandings of legal coercion, I explain how efforts are made to apply what are presented as less ethically contentious framings of regulatory methods, such as are provided by 'libertarian paternalism' ('nudge'). I argue that these fail as measures of legitimacy for long-game regulation: the philosophical foundations of public health laws require a greater—and more obviously contestable, but also more ambitious—critical depth.*

INTRODUCTION

Public health law has emerged as a field that is practically and conceptually distinct from medical law.[1] It looks at but also far beyond the healthcare system to 'those aspects of law, policy, and regulation that advance or place constraints upon the protection and promotion of health

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[1] A-M. Farrell et al., *Health Law: Frameworks and Context* (2017) ch. 1.

(howsoever understood) within, between, and across populations.'[2] Public health law spans government sectors, incorporating more obvious legal measures such as those providing minsters' and local authorities' public health powers and duties,[3] as well as wider health-affecting areas of policy, such as environmental, road traffic, and education laws. Equally, public health law scholarship looks to policies that are not enshrined legally, but nevertheless constitute 'governance for health',[4] such as NHS smokefree.[5] The field is founded in part on social epidemiology, which explains the social determinants of health.[6] Social determinants theses demonstrate how our health outcomes and opportunities are not reducible to individual responsibility; rather, causal factors from across the socio-economic environment are of fundamental significance. These scientific observations have come to be combined with questions of normative ethical theory, and form the basis of challenges to existing legal and political orders to reduce health inequalities and achieve greater social justice.[7]

Robust legal reforms that could accommodate and respond to social-determinants theses have, however, met resistance in the legal academic literature.[8] This is true too in the prevailing political climate of contemporary English public health policy, which is well represented by the (albeit, since relatively recently, defunct) 'public health responsibility deal'.[9] That political climate overwhelmingly places responsibility for 'unhealthy behaviours' such as smoking, drinking, and poor diet in the hands of individuals and non-governmental (for example, commercial) institutions.[10] As explained below, the political ideologies that constrain public health policy are underpinned by jurisprudential received wisdoms concerning liberal individualism and the distinct nature of coercive ('hard') 'paternalistic' interventions. The context tends against policy agendas that would rely on such measures to improve the public's health; rather, insofar as they

[2] J. Coggon et al., *Public Health Law—Ethics, Governance, and Regulation* (2017) 72.
[3] Health and Social Care Act 2012, ss. 11 and 12.
[4] *Cf* L.O. Gostin, *Global Health Law* (2014) ch. 3.
[5] <http://www.nhs.uk/smokefree>.
[6] See M. Marmot, *Status Syndrome: How your place on the social gradient directly affects your health* (2004).
[7] Eg: N. Daniels et al., 'Why justice is good for our health: The social determinants of health inequalities' (1999) 128 *Daedalus* 215; L.O. Gostin and G. Bloche, 'The politics of public health: a response to Epstein' (2003) 46 *Perspectives in Biology and Medicine* S160; L.O. Gostin and M. Powers, 'What does social justice require for the public's health? Public health ethics and policy imperatives' (2006) 25 *Health Affairs* 1053; S. Venkatapuram and M. Marmot, 'Epidemiology and Social Justice in Light of the Social Determinants of Health Research' (2009) 23 *Bioethics* 79; S. Venkatpuram, 'Global Justice and the Social Determinants of Health' (2010) 24 *Ethics and International Affairs* 119; L. Wiley, 'Rethinking the New Public Health' (2012) 69 *Washington and Lee Law Rev.* 207.
[8] R. Epstein, 'In defense of the "old" public health' (2004) 69 *Brooklyn Law Rev.* 1421; R. Epstein, 'Let the shoemaker stick to his last: a defense of the "old" public health' (2003) 46 *Perspectives in Biology and Medicine* S138.
[9] <http://webarchive.nationalarchives.gov.uk/20180201175643/https://responsibilitydeal.dh.gov.uk/>. See also J. Gornall, 'Big tobacco, the new politics, and the threat to public health,' (2019) *BMJ* 365:I2164.
[10] G. Scally, 'Whose behaviour needs to change? Key factors in an effective response to the burden of non-communicable disease' (2017) 3-4 *Social Business* 279.

might be accommodated, there is a reliance on what are considered to be 'soft' interventions. This phenomenon is accepted and encapsulated in the idea of a 'fifth wave of public health', which aims progressively to create a 'culture of health', as it has been advocated for by Sally Davies, the Chief Medical Officer for England and Chief Medical Advisor to the United Kingdom government from 2011-2019.[11] Davies and colleagues frame an agenda of what I call in this paper *long-game regulation*. As a regulatory approach, within this framing, fifth-wave public health accepts the constraints of the dominant political climate and, accordingly, its underpinning rationales and received wisdoms concerning coercive paternalism.

In what follows, I respond to the coherence of the political and jurisprudential rationales within which debates on public health policy are framed, and consider their practical implications.[12] My aim is to critique the normative coherence of long-game public health policy. My argument is that dominant but mistaken wisdoms from legal and political theory give rise to problematic reasoning on how public health policy should be developed and implemented. This is not just a problem at the level of theory: it brings us to a point wherein policy proposals that seem favourable to public health agendas in reality give too much to concerns for individual responsibility over wider social (including political, commercial, and so on) determinants of health. My focus is thus on the quality of the reasoning that we find in ethico-legal and jurisprudential debates in this area. It bears noting that in parallel with this manner of philosophical critique, public health literatures are increasingly drawing from methods in political science.[13] These works raise direct questions about the credibility of protagonists who deny, for example, the validity of interference with health-harming commercial freedoms: questions such as the abuse of brute political and economic power, and matters such as conflicts of interest that might better explain the rationales that people have for articulating apparently principled claims about what may or may not justify particular policies.[14] The discussion in this paper focuses on the quality of the arguments themselves, without regard to these sorts of critiques. A sound

[11] S. Davies et al., 'For debate: a new wave in public health improvement' (2014) 384 *The Lancet* 1889.
[12] This paper looks to the aggregate aims and effect of multiple, concertedly-implemented 'soft' paternalistic methods of regulation. For relevant but distinct arguments about 'hard paternalism' and the incoherence of rationales for permitting some such individual coercive measures but not others see S. Conly, *Against Autonomy* (2012); L.O. Gostin and K,G. Gostin, 'A broader liberty: J.S. Mill, paternalism and the public's health' (2009) 123 *Public Health* 214; R.E. Goodin, *No smoking: the ethical issues* (1989).
[13] For example, C. Bambra et al., 'Towards a politics of health' (2005) 20 *Health Promotion International* 187; I. Kickbusch, 'Foreword: we need to build a health political science' in C. Clavier and E. De Leeuw (eds), *Health Promotion and the Policy Process* (2013); M. Bekker et al., 'Public health and politics: how political science can help us move forward' (2018) 28 *European Journal of Public Health* 1.
[14] For example, D. Raphael, 'Beyond policy analysis: the raw politics behind opposition to healthy public policy' (2014) 30 *Health Promotion International* 380; S. Greer et al., 'Policy, politics and public health' (2017) 27 *European Journal of Public Health* 40; M. McKee and D. Stuckler, 'Revisiting the corporate and commercial determinants of health' (2018) 108 *American Journal of Public Health* 1167.

public health agenda must be philosophically coherent, requiring attention to overall critical consistency of arguments taken on their own terms, as well as such wider, real-political analyses. We need conceptual and analytical understanding, as well as the capacity to question the rationales and conflicting interests of different actors. Here I focus on the first of these tasks.[15]

In Part I, I introduce and contextualise the fifth-wave public health agenda, emphasising its approach of effecting radical social change through 'soft' regulatory methods. In Part II, I present the theoretical assumptions that underpin influential debates in legal philosophy and public health ethics, arguing that the former have problematically encouraged the unquestioning treatment of formally 'hard' measures of paternalistic regulation as exceptional, and thus distinctly difficult to justify. In the remainder of the paper, I explain how theorising and responding to concerns about coercive paternalism becomes more complex still in long-game regulation. Here, the 'hard/soft' distinction, applied to individual measures, encourages analysis that begs the question of justification: an abstract commitment to the relatively benign nature of individual instances of non-coercion does not allow evaluation of the aggregate effect of concerted policy agendas, either in their method or their aim. To demonstrate why this is so, in Part III I explain the idea of long-game regulatory approaches, exemplified with reference to aspects of law and policy on smoking as a point of practical reference: at the core of smoking regulation we see the normative complexities of a progressive public health policy that ostensibly aims at once to create a 'smoke free' society and leave people free to smoke. I then explain the contestability of such a position in part IV, critiquing a policy climate that frames politically legitimate interventions through the justificatory rationales of 'libertarian paternalism' (or 'nudge theory').[16] In response to the problems identified, I argue that we require a fundamental re-evaluation of public health agendas and a more robust—albeit therefore more challenging—approach to ethical justification.

I. TOWARDS A 'FIFTH WAVE' OF PUBLIC HEALTH

Writing with colleagues, Phil Hanlon has characterised four accumulatively-coexistent historical 'waves' of public health within the UK, and advocated for a fifth.[17] This work built on a report by one of Hanlon's co-authors, Andrew Lyon, which focused on the NHS in Scotland and was

[15] For an analysis that focuses on both things, see J. Coggon, *The Nanny State Debate: A Place Where Words Don't Do Justice* (2018).
[16] C. Sunstein and R. Thaler, 'Libertarian Paternalism is not an Oxymoron' (2003) 70 *The University of Chicago Law Rev.* 1159; R. Thaler and C. Sunstein, *Nudge: Improving decisions about health, wealth, and happiness* (2009).
[17] P. Hanlon et al., 'Making the Case for a 'Fifth Wave' in Public Health' (2011) 125 *Public Health* 30.

entitled *The Fifth Wave*.[18] Their framing and ideas have taken grip in relation to English health policy, notably in the advocacy of Sally Davies, who, as noted above, served as England's Chief Medical Officer from 2011-2019. In an influential co-authored paper published in *The Lancet*, Davies has represented Hanlon et al.'s ideas and given an account of how the fifth wave should be shaped for developing public health policy in England following the health reforms instituted by David Cameron's first government.[19] There is inevitably an element of simplification in the identification of the different waves, which is allowed for by Davies et al., as it was in the earlier analysis of Lyon, Hanlon, and colleagues. Nevertheless, their overall representation is clear, and soundly reflective of marked changes in public health agendas and activities from the nineteenth century to the present day. In their summary form, the different waves are particularly instructive as they are identified by reference to the socio-political and legal approach that each reflects in public health activity.

The first, covering the period of approximately 1830-1900, is labelled 'structural'. Davies and colleagues describe this as 'top down'. It is characterised by developments in understanding in the Victorian era of disease transmission and the impact of environment on health. Public health activity then:

> [W]as concerned with enhancing environmental conditions, such as through the provision of clean drinking water, safe sewage disposal, and improved food safety, alongside legislation aimed at improvement of working conditions and protection of children[.][20]

The second wave is described as 'biomedical'. Falling roughly from 1890-1950, this wave overlaps with the first (for example, Davies et al., reflect on the Vaccination Act 1853, requiring mandatory vaccination against smallpox for children by three months of age). At the centre of the second wave is an increased focus on medical and other sciences, with an aim to prevent and treat disease. This leads to the 'clinical', third wave of public health, from approximately 1940-1980. The third wave emerged with the welfare state, and grew from 'our enhanced understanding of the causes of many of the leading chronic diseases such as cardiovascular disease, diabetes, or cancer.'[21] Preventive measures that developed in the third wave would target groups at high risk of morbidity and early mortality.

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[18] A. Lyon, *The Fifth Wave* (2003).
[19] S. Davies et al., op. cit. n. 11. For analysis of the development of public health *law*, see Coggon et al., op. cit., n. 2, ch. 3.
[20] Davies et al., id., p. 1890.
[21] id..

Following this clinical wave is the fourth, which is characterised as 'social'. Beginning around 1960, this wave emerged from 'increasing understanding of the social distribution and social determinants of states of health'.[22] Within the fourth wave, epidemiological studies, such as those led by Michael Marmot,[23] have established scientifically that the social and economic environments are primary causes of (ill) health, with the concomitant recognition that health interventions should also be effected through socio-economic changes.[24] This scientific understanding of cross-sector impacts on health has not, however, led to the levels of success in protecting and improving the public's health for which many had hoped.

Davies and colleagues therefore build on Hanlon et al.'s arguments for the stimulation of a fifth wave, which would be 'cultural'. It is, they write, "needed, and needed now".[25] This works from acknowledgments of the social determinants of (ill) health and health inequalities, and of how evolving political ideology has contributed to an individualism that forestalls collectivist efforts to promote health.[26] The fifth wave embodies an agenda that operates by:

> [W]orking towards achieving a cultural shift that emphasises a society characterised by individual dependence and social interdependence, and which embeds engagement so that personal and social goals can be achieved justly. The term culture is commonly defined as a shared system of learned norms, beliefs, values, and behaviours, and … we use it in this paper as an overarching term to describe the context within which the proposed fifth wave is set.[27]

The fifth wave thus entails a directed process of 'normalisation' of healthy behaviours, which is to be supported by an appropriately developed 'institutional, social, and physical environment'.[28] The agenda embraces empirical ('dependence' and 'interdependence' as established through

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[22] id..
[23] M. Marmot et al., 'Employment grade and coronary heart disease in British Civil servants' (1978) 32 *J. of Epidemiology and Community Health* 244; M. Marmot et al., 'Health inequalities among British civil servants: the Whitehall II study' (1991) 337 *The Lancet* 1387. M. Marmot, 'Social determinants of health inequalities' (2005) 365 *The Lancet*, 1099. See also Marmot, *Status Syndrome*, op. cit., n. 6.
[24] See also G. Rose, 'Sick Individuals and Sick Populations' (2001) 30 *International J. of Epidemiology* 427.
[25] Davies et al., op cit., n. 11, 1891
[26] id..
[27] id. (reference omitted).
[28] id..

social epidemiological research) and normative/ethical ('achieved justly' as established by reference to political morality) commitments.[29]

To be realised, Davies and colleagues explain how the overall process of (de/re)normalisation, and the changes to the environments and institutions, require law and regulation. These would come, first, from mechanisms aimed at maximising the value of health, for example by fiscal incentives to encourage healthier choices and behaviours. Second, defaults would be changed to increase the ease of making healthy choices, for example by limiting the availability of unhealthy products and improving public understanding of the health impacts of different products. And third, measures that push people towards unhealthy choices would be minimised, for example through restrictions on advertising.[30] In other words, nudge-type law and regulation (explained below) are encouraged, rather than 'harder' regulatory approaches that may conduce to a 'culture of health' but in a way that might be viewed as coercively paternalistic.

The English fifth-wave approach offers a timely and influential framing of public health policy rationales. Its *aims* are necessarily of interest, but we should critically examine too the regulatory *methods* suggested. Exclusive resort to nudge-type interventions perpetuates the overstated individualism that such public health agendas seek to challenge. More fundamentally, where this is based on acceptance of an absolutist opposition to coercive paternalism, the paper will show that the logic of the agenda anyway presents problems: a coercive aggregate of 'mere' nudges cannot be seen as coherently providing straightforwardly justified methods of achieving the policy aims without offending liberal principles. A sound public health ethic is therefore required to explain and defend harder forms of paternalistic intervention, whether achieved over shorter or longer timeframes. To explain this, it is necessary first to situate our understanding with reference to jurisprudential debates on paternalism and coercion.

II. COERCIVE PATERNALISM, LEGITIMACY, AND LAW AND POLICY

The legitimacy of measures to promote the socio-cultural shift of the fifth-wave agenda are set against a predominant political morality of liberal individualism.[31] Such a position brings with it assumptions about both the *goals* and the *methods* of legitimate governmental activity.[32] Regarding

[29] On the rationales for mixing social epidemiology and social justice research, see the works cited above, n. 7.
[30] Davies et al., op. cit., n. 11, 1891-1893.
[31] See also A.M. Viens, 'Public Health and Political Theory: The Importance of Taming Individualism' (2016) 9 *Public Health Ethics* 136.
[32] See also C. Sunstein, *Why Nudge?* (2014), ch. 2, especially 61-72.

the former, they suggest a wariness of governmental mandates to implement various sorts of policy end, with particular concerns about paternalism (or 'nannying'). Regarding the latter, there are apprehensions about such ends being achieved through *coercion*. Such concerns, if taken uncritically, place sharp contours on our understandings of the appropriate mandate for state interventions regarding health-affecting phenomena: that is, on the possibilities for achieving legitimate moves from individually-achieved to collectively-coordinated responsibility for health. If, as social determinants theses indicate, collective measures are required, we need a clear account of how this works in the context of justifiable government policy: how might law and policy properly serve the public's health? The political context of English fifth-wave public health provides a source of tension: it is designed through its goals and methods at once to honour and dissemble an individualistic political morality. Analytically, we can explore this with reference to two relevant and (roughly) contemporaneously-developed sources of ethico-philosophical inquiry into state interventions. The first comes from jurisprudential theory concerning legal paternalism. The second comes from (what is now labelled[33]) public health ethics. Both build upon age-old questions in political philosophy and examine the basis of the ethical legitimacy of law and policy. They advance parallel concerns that are reflected in practical debates today about legitimate governance for the public's health,[34] and provide the normative context within which the fifth wave debate takes place. The three sections in this part therefore present foundational perspectives on paternalistic law and policy, before we move to the more complex arena of long-game regulation in parts III and IV.

1. Legal paternalism and public health

As part of his seminal analysis of legal coercion, Joel Feinberg provides conceptual and normative analysis of the legitimacy of state interventions to protect and promote individuals' welfare: to implement 'paternalistic' policy agendas.[35] Whilst arguing that it is relatively straightforward to justify 'soft paternalism' (that is, non-coercive paternalistic measures, or coercive paternalistic measures that would protect people who lack decision-making capacity), 'hard paternalism' (coercive paternalism applied to adults with decision-making capacity) is regarded as raising acutely challenging justificatory standards. Feinberg characterises paternalism in its 'hard' forms as follows:

[33] B. Jennings, 'Frameworks for Ethics in Public Health' (2003) 9 *Acta Bioethica* 165; N. Kass, 'Public Health Ethics: From Foundations and Frameworks to Justice and Global Public Health' (2004) 32 *J. of Law, Medicine, and Ethics* 232.
[34] J. Coggon, *What Makes Health Public?* (2012) part II.
[35] See especially J. Feinberg, *Moral Limits to the Criminal Law, Volume 3: Harm to Self* (1989).

> The principle of legal paternalism justifies state coercion to protect individuals from self-inflicted harm, or in its extreme version, to guide them, whether they like it or not, toward their own good.[36]

Jurisprudential and political-philosophical wisdoms concerning paternalism are at the heart of some of the most contested debates regarding legitimate public health policy aims and methods. The stated missions of public health agencies and actors are explicitly directed to improving aggregate levels of population health and reducing health inequalities.[37] These ends are achieved through (accordingly rare) 'hard' paternalistic means, such as laws compelling everyone to wear seatbelts when travelling in cars. And they are achieved through (accordingly more numerous) 'soft' paternalistic means, such as laws aimed at vulnerable persons who are deemed unable to make decisions, for instance prohibitions on children buying cigarettes, or 'soft' regulatory measures that apply to persons generally, such as tax breaks engineered to encourage people to cycle to work. And, of course, beyond paternalistically-rationalised policies, many measures—'hard' and 'soft'—are instituted, for example, to protect *others* from harm (for example, bans on smoking in enclosed public spaces) or through 'indirect' protections (such as through product safety regulations).

Significantly, in light of how Feinberg frames his concerns about paternalism in the quotation above, the focus of public health interventions is not just about protections from or prevention of harm; they also relate to promotion of positive concepts of *well-being*, distinguishable from narrower understandings of health.[38] The World Health Organization (WHO)'s definition of health incorporates both a biomedical component, referring to 'the absence of disease', and a more philosophically-abstract component, referring to a state of 'complete physical, mental, and social well-being.'[39] A health remit that includes well-being is claimed too by Public Health England, an executive agency of the Department of Health and Social Care.[40] This focus on well-being should be understood in conjunction with the prominence that is given to 'lifestyle

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[36] This definition is taken from J. Feinberg, 'Legal Paternalism' (1971) 1 *Canadian J. of Philosophy* 105, 105. As the passage quoted here may suggest an alternative reading, it should be stressed that Feinberg's concern is with what I am labelling 'formally coercive' measures rather than 'nudges', but consider his fine-grained analyses of coercion, compulsion, and related concepts, in particular in id. chapters 23 and 24. See also chapters 17 and 20.
[37] J. Coggon and A.M. Viens, *Public Health Ethics in Practice: An overview of public health ethics for the UK Public Health Skills and Knowledge Framework* (2017), available at <http://www.gov.uk/government/publications/public-health-ethics-in-practice>.
[38] Coggon, op. cit., n. 34, ch 1.
[39] WHO, *Constitution of the World Health Organization*, (1946).
[40] Website available at <http://www.gov.uk/government/organisations/public-health-england/about>.

diseases' and 'unhealthy' products and behaviours: rather than just consider existing disease, or disease that is likely or certain to arise in any individual case, concern is directed to risk factors understood across a population and across lifespans (for example obesity as a risk factor for cardiac disease, meaning obesogenic behaviours and products are themselves deemed 'unhealthy'). Overall, public health activities thus have extraordinary reach and breadth. For sound practical as well as principled reasons, it is unremarkable that many policy aims would be best achieved through 'soft' means (given, for instance, considerations of proportionality and effectiveness), or with reference to non-paternalistic rationales. Nevertheless, dominant principled wisdoms regarding coercive paternalism are highly influential: the normative distinctions between 'hard' and 'soft' identified by Feinberg lend enormous explanatory power in English public health law.

2. 'Coercive healthism': coercion pervading 'hard' and 'soft' measures?

The distinctions between 'hard' and 'soft' paternalism as a measure of relative (ease of establishing) legitimacy are fundamental within political philosophy, jurisprudence, and indeed practice. However, these introductory reflections bring us to a basis for drawing together the ideas stimulated by work such as Feinberg's with those found in Petr Skrabanek's contemporaneous anti-public health arguments. Feinberg identifies particular problems of justifying 'hard' legal interventions for people's own good. This includes arguments about the instability or uncertainty in the very idea of what is meant by our basic interests or welfare, claims that people are best positioned to decide for themselves, and the position that people's moral and rational development require the freedom to make 'bad' choices. Similarly, Skrabanek's critical works on public health promotion are based on the epistemic and normative challenges that are familiar in relation to legal paternalism.[41] However, Skrabanek's works suggest a weakness in treating compulsion through criminal, as opposed to other, 'softer' modes of regulation, as exceptional: they challenge the wisdom in the received formal construction of contrasts between 'hard' and 'soft'.

Central to Skrabanek's analysis is a critique of, in his term, 'coercive healthism'. He applies this to all publicly- or professionally-coordinated methods of health promotion. His main influence from within health and philosophy is Ivan Illich, a critic of mid-late twentieth-century medicine

[41] See especially P. Skrabanek, *The Death of Humane Medicine and the Rise of Coercive Healthism* (1994).

and medical paternalism.[42] Skrabanek's broader philosophical influences are varied, but his commitment to protection of *modus vivendi* as a cardinal political principle is mirrored by his avowed cynicism of interfering governments of the right or the left. Skrabanek advances arguments against, in his characterisation, the moralistic, ideological use of health in support of policies that push people into particular ways of life, or in modifying the choices that they might make. For Skrabanek, health is undefinable; a 'metaphysical concept like love'.[43] And thus, he argues, such a concept is dangerous in the hands of government. Referring to a central WHO slogan, Skrabanek writes: 'The roads to unfreedom are many. Signposts on one of them bears the inscription HEALTH FOR ALL.'[44] He considers health to be a term that is used nefariously to legitimise unjustifiable political interventions; unjustifiable because of their interference with individual freedom.

Skrabanek's framing of 'healthism' as political ideology draws on the same breed of concerns raised in debates on legal paternalism. However, theorists such as Feinberg focus on the machinery of the State being used to support coercive measures through criminal regulation. Such a focus creates distinct justificatory burdens for criminal interventions, whilst providing that other forms of legal and policy measures are, in terms of political morality, by analysis more benign.[45] The fifth-wave agenda outlined in part I of this paper reacts precisely to a political climate in which such a position holds. Yet in contrast with Feinberg's position, Skrabanek's arguments also apply against measures that are *not* in formal terms coercive. Skrabanek would be starkly opposed to the fifth-wave agenda in England (and elsewhere); concerned about the use of fiscal disincentives (for example taxation on tobacco to deter its uptake or use), health promotion messages (such as health warnings on cigarette packets), and 'denormalisation' campaigns (for example the stigmatisation of smoking). For Skrabanek, coercion is conceptually a much more pervasive and insidious phenomenon than it is for Feinberg. Yet the formal 'hard/soft' distinction has become a received wisdom, and accordingly pivotal in evaluations of what constitute legitimate paternalistic interventions. Before moving to analysis of this in relation to long-game regulatory agendas, it is worth briefly considering existing challenges to how we conceptualise coercion.

3. Moving beyond formal conceptions of the 'hard/soft' distinction

[42] I. Illich, *Limits to Medicine – Medical Nemesis: The Expropriation of Health* (1976). See also I. Illich, "Disabling Professions," in *Disabling Professions*, ed. I. Illich et al. (1977).
[43] Skrabanek, op. cit., n. 41, 11.
[44] id..
[45] See text below to n. 50.

Skrabanek's work provides an ostensibly distinctive concept of coercion that moves beyond the idea of a rule supported by a threat of (criminal) sanction, instead critiquing a range of legal and policy mechanisms and instruments, and professional practices. These are judged according to their actual impact on persons' freedom to define their own lives without the structure of 'the good' having been imposed through political institutions. Within such framing, it is arguable that Skrabanek's concept of coercion is more sustainable than Feinberg's. This becomes clear if we consider their respective contributions in light of more recent jurisprudential analyses. Grant Lamond's work, for example, examines the concept of coercion by reference to understanding first *how* law is coercive.[46] Lamond argues that we should consider the different sorts of pressure exerted by the law itself, as against the pressure exerted by legally-empowered officials, when understanding how the law coerces.[47] The relevant sense of coercion in legal analysis, Lamond argues, is law's functions in its 'action-inducing role'. He argues that law may be physically coercive (meaning people may be physically forced to follow it, for example through arrest by a police officer), or rationally coercive (meaning it may compel people through reason). In regard to the latter, disadvantages may be conferred on citizens should they not follow a particular course of action (or by analysis, advantages conferred if they do), amounting to a form of *rational coercion* that requires no sanction or threat of penalty.[48] Indeed, in illustrating his point, Lamond uses an example familiar both to legal theorists and to members of the public health community: the coercive use of taxation as a means of pricing an activity or substance out of the market.[49]

It is instructive to contrast Lamond's treatment of coercion with Feinberg's. Feinberg supposes that, for example, raising taxes on cigarettes with a view to limiting their consumption does not require special justification in the way that criminalising smoking would do. He rests his ideas on a qualitative distinction that fails to account for the subtleties exposed in Lamond's conceptual separation of criminal prohibition in the law and its enforcement. Similarly, the focus on what are formally 'hard' interventions does not allow for means of rational persuasion that may come to serve as rational coercion regardless of whether they happen to be criminal justice measures. For Feinberg:

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[46] G. Lamond, 'The Coerciveness of Law' (2000) 20 *Oxford J. Legal Studies* 39.See also C. Sunstein, *The Ethics of Influence: Government in the Age of Behavioral Science* (2016), 18-21.
[47] Lamond, id., 41.
[48] id., especially 56-7. Note that Lamond explains too that on this understanding criminal law measures will sometimes also not be coercive.
[49] id., 57.

> Constant reminders of the hazards [of smoking tobacco] should be at every hand and with no softening of the gory details. The state might even be justified in using its taxing, regulatory, and persuasive powers to make smoking (and similar drug usage) more difficult or less attractive; but to prohibit it outright for everyone would be to tell the voluntary risk-taker that even his informed judgments of what is worthwhile are less reasonable than those of the state, and that therefore, he may not act on them. This is paternalism of the strong kind, unmediated by the voluntariness standard. As a principle of public policy, it has an acrid moral flavour, and creates serious risks of governmental tyranny.[50]

Lamond's claims about coercion, by focusing on the effect of laws on the individual, are essentially empirical. We see parallels here with Cass Sunstein's analysis of 'soft' *versus* 'hard', which presents a continuum rather than a binary, and invites consideration not of a measure's legal form, but the weight of its "costs, material or non-material",[51] to the person. Such analyses falsify ideas about what does or does not count as a coercive measure where the base reference point is simply the word of the law and an abstract philosophical understanding of coercion: we move from a falsifiable formal understanding to a demonstrable practical understanding. This more refined perspective lends support to the position that apparently 'softer' methods of regulation can properly be considered within an analysis of coercive policy: this is all the more true, as explained in the second half of this paper, in the context of long-game regulatory approaches. We may accordingly compare Feinberg's quotation just above with the following from Skrabanek:

> The ways of implementing healthist politics include the substitution of health *education* by health-promotion *propaganda*; the introduction of regular 'health' screening for all citizens; the coercion of general practitioners, through financial incentives, to act as agents of the state; the presentation of the politically corrupt science of healthism as objective knowledge; the taxation of goods deemed to be 'unhealthy'; interference with the advertising of legal products; and introducing legislation which is 'nothing better than the hurried botching of short-sighted interests and blind passions'.[52]

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[50] Feinberg, op. cit., n. 36, 116.
[51] Sunstein, op. cit., n. 32, 57. For parallel conceptual and critical analysis, see also Feinberg's more detailed considerations in *Harm to Self*, above n. 35, especially chapters 23 and 24.
[52] Skrabanek, op. cit., n. 41, 138-9, emphases in original; quoted text from B. de Jouvenel, *Du pouvoir: Histoire naturelle de sa croissance* (1945), English translation by J.F. Huntington, *On power: its nature and the history of its growth* (1948) 403.

In considering whose perspective is to be preferred, I would emphasise that the discussion here is conceptual: I do not invite (or hold) agreement with Skrabanek's substantive political conclusions. Rather, in light of his and others' analyses, I agree that we should not, when assessing the legitimacy of paternalistic interventions, assume that formally coercive ('hard') measures are of necessity less easily justified than formally non-coercive ('soft') measures. We need to focus on the impact rather than form of measures to effect policy aims. Indeed, we can use Feinberg's own words, cited above, to frame the point in relation to tobacco regulation: a wide range of non-criminal, *even non-legal*, regulatory interventions rationally coerce smokers, and serve clearly and intentionally to tell them that their informed judgments '*are less reasonable than those of the state*.'[53]

Skrabanek's normative claims combined with Lamond's and Sunstein's conceptual refinement bring a persuasive challenge to regulatory approaches whose legitimacy is considered to be (more easily) established by the formal 'softness' of the regulatory methods used. However, in what follows, I will explain the additionally-complicating factors that arise in a context of *long-game regulation*. I will show how and why these create heavier burdens of justification for the *aims* of public health agendas, but in so doing also indicate more forcefully the viability and legitimacy of the possible methods that may be available to effect the sorts of cultural change that are advocated for within (for example) fifth-wave public health.

III. LONG-GAME REGULATION: COLLECTIVE AND CONNECTIVE MEANS OF GOVERNANCE

The idea of long-game regulation is widely familiar, and features prominently within and beyond public health advocacy.[54] As indicated above, it is notably core to the fifth-wave agenda. I use the term to denote a government-driven, gradualist, goal- or goals-directed approach to policy design and implementation. Policy-makers may—and do—play the long game when practical or political reasons mean an end cannot be achieved immediately. In essence, long-game approaches form a paradigmatic slippery slope: regulators contrive to alter the regulatory environment so that people will 'slide' in a particular direction.[55] From the perspective of political legitimacy, this raises the question: *if it is not, in principle, legitimate to legislate a particular end*

[53] Feinberg, op. cit., n. 36, 116, emphasis added.
[54] See Gostin, op. cit., n. 4, 239-242.
[55] For conceptual and critical analysis of slippery slope arguments, see D. Walton, *Slippery Slope Arguments* (1992). See also Part IV, section 2, below.

(say eradication of tobacco use) overnight, why would it be acceptable to advance the same agenda over (say) a 30-year timeframe? To explore why this question is our proper focus, and cannot be side-stepped simply by using 'soft' individual regulatory measures, let us consider first how long-game regulation works.

In practice there are many instances—big and small—of gradualist, long-term, goal-based legal and regulatory approaches. Perhaps the most high-profile but succinct example of long-game regulation within the context of health law is the 'progressively realisable' human right to health.[56] Recognising that 'a complete state of physical, mental, and social well-being' cannot realistically be met, and that even the optimal conditions in which people can be healthy will have to develop over time, the WHO advances the more modest goal of moving progressively towards that target. The right to health thereby imposes both 'core obligations' that states must meet immediately, and further obligations to enhance population health that may be realised on an ongoing, ever-increasing basis.[57] Such gradualism is designed to allow the right to health to remain simultaneously robust *and* realisable, accounting, for example, for economic limitations on its implementation.

In whatever context, rather than provide a full (by reference to the ultimate aim) suite of immediately enforceable obligations on the back of an immediately present legal and regulatory super-structure, long-game regulation provides a wide array of complexly networked and concertedly implemented measures. These move towards a given goal whose achievement rests on their *combined* effect, because immediate achievement is not an option. Long-game health agendas by their nature require overall a sufficiency of general political, legal, and social momentum. This is something that will, if successful, accumulate over time. And, depending on the nature and scope of the specific matter being regulated, it may entail progressive changes in ostensibly quite diffuse areas, and through a coordination of a great diversity of public and private regulatory actors.

Progressions in tobacco policy provide a useful reference point to see how 'hard/soft' paternalist rationales operate within long-game public health agendas.[58] Tobacco regulation has developed

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[56] See WHO and Office of the UN High Commission for Human Rights, *Fact Sheet 31 on the Right to Health* (2008), available at <http://www.ohchr.org/Documents/ Publications/Factsheet31.pdf>.
[57] For further detail, see <http://www.who.int/en/news-room/fact-sheets/detail/human-rights-and-health>.
[58] Alberto Alemanno suggests that tobacco regulation is distinctive, and does not raise concerns about legitimacy in a way that would apply in relation (say) to diet: A. Alemanno, 'Nudging Smokers-The Behavioural Turn of Tobacco Risk Regulation' (2012) 3 *European J. of Risk Regulation* 1. Given how regulatory measures are advanced in other areas

in a quintessentially long-game fashion, to the point where we have now reached what is described as the tobacco *endgame*.[59] To have arrived at the point of aiming to conclude the 'game', the long game has involved myriad legal, political, and social methods of reform, from public awareness campaigns through to legal regulation and litigation strategies.[60] For a more comprehensive representation than can be provided in this paper, the collective and connective nature of this enterprise is captured in the Tobacco Atlas. This demonstrates the methods of industry and governmental actors, the evidence bases and different forms of reasoning required to respond to them, and modes of political engagement and legal strategy, both in bringing and responding to challenges by commercial and state organisations.[61]

Within the context of English public health law and policy, long-game approaches are attractive to health improvement advocates because their measures generally avoid being brought by laws that prescribe modes of 'healthy living' using coercion in the formal sense presented above:[62] 'denormalisation' and 'renormalisation' are key aspects of changing attitudes and behaviours, and are achieved in the main through individually non-coercive measures.[63] Anti-tobacco policy provides a clear public health goal—reduce, and eventually eradicate smoking—that could not be satisfactorily and effectively legislated overnight. Evolving tobacco regulation from successive Westminster governments (as elsewhere) is directing this general, goal-based agenda, but through incremental developments, with continued resistance to 'hard paternalism'.[64] Political and legal moves to control tobacco use were slow to develop in the last century.[65] The past two decades, however, have seen a sharp acceleration in anti-tobacco regulation. Globally, the great symbol of this is the Framework Convention on Tobacco Control; an international treaty negotiated

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of public health concern, with the development of long-game strategies and the explicit call to learn from tobacco control, my view is that tobacco regulation does provide a salient example to use in the context of the current paper's analysis: see especially Davies et al., op. cit., n. 11.

[59] R. Malone et al., 'It is time to plan the tobacco endgame' (2014) 348 *BMJ* 1453.

[60] Regarding litigation, contrast, for example, the legal impacts of: *R (G)* v. *Nottinghamshire Healthcare NHS Trust* [2009] EWCA Civ 795 (smoking ban upheld in a secure psychiatric unit); *R (Black)* v. *Secretary of State for Justice* [2017] UKSC 81 (policy permitting smoking in prison upheld); *R (British American Tobacco UK Ltd)* v. *Secretary of State for Health* [2016] EWCA Civ 1182 (failed IP law challenge against the Standardised Packaging of Tobacco Products Regulations 2015). Relevant statutory measures are outlined below. For discussion of international litigation strategies, see Gostin, op. cit., n. 4, ch. 7; E. Nanopoulos and R. Yotova, '"Repackaging" Plain Packaging in Europe: Strategic Litigation and Public Interest Considerations' (2016) 19 *J. of International Economic Law* 175.

[61] <http://www.tobaccoatlas.org>; J. Drope et al. (eds.), *The Tobacco Atlas* (2018, 6th edn.).

[62] Consider for example Nuffield Council on Bioethics, *Public Health—Ethical Issues* (2007), 26: this report holds as a guiding principle that public health programmes should 'not attempt to coerce adults to lead healthy lives'.

[63] S. Chapman and B. Freeman, 'Markers of the denormalisation of smoking and the tobacco industry' (2008) 17 *Tobacco Control* 25.

[64] See, for example, Department of Health, *Towards a Smokefree Generation: A Tobacco Control Plan for England*, (2017), ch. 3, available at <http://www.gov.uk/government/publications/towards-a-smoke-free-generation-tobacco-control-plan-for-england>.

[65] C. Keating, *Smoking Kills: The Revolutionary Life of Richard Doll* (2009); Alemanno, op. cit., n. 58; Gostin, op. cit., n. 4, ch 7.

through the WHO, which provides for wide-ranging (many of them long-game) measures to be adopted to reduce demand for tobacco products.[66] Domestically, there have been several significant regulatory steps. Crediting reduced rates of smoking as "the result of decades of concerted effort and government action", the Government's recent Green Paper on public health policy announces a "smoke-free 2030 ambition".[67] It does this whilst saying: "This green paper is not about nannying, but empowering people to make the decisions that are right for them."[68]

Notable regulatory changes in England, all of which would likely be castigated by Skrabanek but which (of necessity) have proven in practice to be politically justifiable, have been implemented directly through statute or delegated powers. They include:

- A ban on advertising of smoking tobacco[69] (not coercive in Feinberg's sense);
- A rise in the age at which a person can buy tobacco, from 16 to 18[70] and a prohibition on the purchase of tobacco for persons under 18[71] (not hard paternalism in Feinberg's sense);
- A ban on smoking in places of work, and enclosed and substantially enclosed public places[72] (coercive in Feinberg's sense but justified by reference to harm to others (albeit even if they would consent));
- A prohibition on smoking in vehicles where a minor is present[73] (coercive in Feinberg's sense but justified by reference to harm to others);
- Ongoing increases in taxes on tobacco products[74] (not coercive in Feinberg's sense);
- The introduction of standardised 'plain packaging'[75] (not coercive in Feinberg's sense).

[66] See further Gostin, op cit. n. 4, ch. 7.
[67] Cabinet Office and Department of Health and Social Care, *Advancing our health: prevention in the 2020s—consultation document* (CP110, 2019), chapter 2.
[68] id.
[69] Tobacco Advertising and Promotion Act 2002.
[70] Children and Young Persons Act 1933, s. 7.
[71] Children and Families Act 2014, s. 91.
[72] Health Act 2006, s. 2.
[73] Health Act 2006, s. 5(1A), and see Smoke-free (Exemptions and Vehicles) Regulations 2007/765, r. 11.
[74] Finance Act 2018, s. 45.
[75] Children and Families Act 2014, s. 94, and see Standardised Packaging of Tobacco Products Regulations 2015/829.

This ongoing regulatory agenda represents a long-game approach to reducing tobacco use across the population.[76] Furthermore, these 'headline' regulatory developments exist as progressively-implemented measures alongside wide-ranging smoking-cessation programmes and services implemented by local authorities through their public health responsibilities under the Health and Social Care Act 2012, and through schemes such as the NHS smokefree initiative.[77]

Further changes are to come,[78] and whilst in their detail these will be contingent on political priorities and social context, they are moving in the same direction. As indicated by discussions of an 'endgame', strategy has moved to the final stages in a long-game policy agenda that does not aim simply to prevent harm to children and third parties; the classical point of concern, reflected in the above bullet points, of rationales for justifying coercive regulatory interventions in this area.[79] Proposed measures to expedite the closing stages of the 'game' include, for example:

- The medicalisation and licensing of smoking tobacco: permit tobacco use, but as a licensed and regulated activity rather than a 'life choice'[80] (at least approaching hard paternalism on Feinberg's terms);
- The extension of smoking bans to places where people are resident (such as prisons) and to further, 'open' public places[81] (hard paternalism on Feinberg's terms, albeit with some potential justifications in harm-to-others reasoning);
- A reformulation of the age restriction on buying tobacco, set by reference to a particular date (for example, no-one born after the year 2000)[82] (hard paternalism on Feinberg's terms).

Such 'hard' measures, according to the jurisprudential wisdoms outlined in part II, are relatively more challenging to justify, and thus are more challenging to implement. The agenda therefore

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[76] Department of Health, op. cit., n. 64; Department of Health and Social Care, *Tobacco Control Plan: Delivery Plan 2017-2022* (2018), available at <http://www.gov.uk/government/publications/tobacco-control-plan-delivery-plan-2017-to-2022>.
[77] D. Selbie, 'A tobacco-free NHS: letter to NHS trust and FT chief executives,' (2016), available at <http://www.gov.uk/government/publications/tobacco-free-nhs-achieving-a-step-change>; Department of Health and Social Care, id., 15-17; Cabinet Office and Department of Health and Social Care, op. cit n. 67.
[78] Department of Health, op. cit., n. 64; Cabinet Office and Department of Health and Social Care, op. cit n. 67.
[79] See R. Ashcroft, 'Smoking, health and ethics,' in *Public Health Ethics—Key concepts and issues in policy and practice*, ed. A. Dawson (2011).
[80] K. Danishevskiy and M. McKee, 'Tobacco: a product like any other?' (2011) 6 *Health Economics, Policy and Law* 265.
[81] Department of Health, *Towards a Smokefree Generation*, above n. 64, 25.
[82] D. Khoo et al., 'Phasing-out tobacco: proposal to deny access to tobacco for those born from 2000' (2010) 19 *Tobacco Control* 355.

continues as one wherein legal and policy developments primarily emerge that push people away from smoking through 'softer' and non-paternalistically-rationalised means, whilst leaving them 'free to choose'. In Part IV I challenge this position, which at once re-enforces liberal individualism's outright rejection of individual instances of hard paternalism, whilst aiming at producing what *in effect* is a ban, even if formally it is otherwise.

IV. TEMPORALITY, MEANS AND ENDS, AND PUBLIC HEALTH ETHICS AND LAW: DEFICIENCIES AND OPPORTUNITIES

In this part of the paper, I argue that the ethico-legal approach in English public health policy gives too much to the distinction between 'hard' and 'soft' regulatory methods.[83] First, I explain the idea of libertarian paternalism ('nudging'), whose 'third way' framing is seen as providing the means to traverse the normative challenges discussed in Parts I-III. Second, I demonstrate why libertarian paternalism fails as a measure of assessing, less still establishing, the justification of policy agendas such as fifth-wave public health. Finally, I reflect on the challenge of identifying a robust justificatory rationale, and what it means to address this head on. Significantly, whilst for practical reasons there may be a difference in implementing a ban over 30 years rather than overnight, and allowing that for many reasons nudge-type measures will often be the most appropriate form for regulation to take, I will argue that the principle that permits the institution of a progressively-implemented ban by apparently 'soft' and incremental means can also support justifications for 'harder' methods of political and legal governance for the public's health.

1. Coercion avoided? Libertarian Paternalism

We have seen above how advocacy for a 'cultural' change for the public's health is constrained by a deference to a predominant individualism that treats formally coercive regulatory measures as distinctly difficult to justify, meaning it would be considered illegitimate in principle (say) to ban smoking overnight. Nevertheless, the wisdom of not smoking is considered sufficient to warrant paternalistic (and other) rationales that support a policy that will eventually lead to its eradication. Accordingly, English public health policy in this area is framed as properly being effected, in instances of paternalism, through the incremental institution of non-coercive ('soft') measures. The basic idea that supports this (and other) areas of regulation, at times more and at

[83] See also Conly, op. cit., n. 12, and Luc Bovens' analysis of the long-term effects of nudges, and considerations of the impacts on preferences, autonomy, and population-level harms and benefits: L. Bovens, 'The Ethics of *Nudge*' in T. Grüne-Yanoff and S.O. Hansson (eds), *Preference Change: Approaches from Philosophy, Economics and Psychology* (2008).

times less explicitly, is found in 'libertarian paternalism'; a position into which successive Westminster governments have invested both politically and economically.[84] Libertarian paternalism may be introduced through reference to the regulatory method that its authors, Richard Thaler and Cass Sunstein, say it recommends; the 'nudge':

> A nudge, as we will use the term, is any aspect of the choice architecture that alters people's behaviour in a predictable way without forbidding any options or significantly changing their economic incentives. To count as a mere nudge, the intervention must be easy and cheap to avoid. Nudges are not mandates. Putting the fruit at eye level counts as a nudge. Banning junk food does not.[85]

Nudge is advanced as a philosophically-friendly (in the sense of being theoretically rigorous *and* friendly to liberal philosophy) response to twentieth century left/right politics:

> With respect to government, we hope that the general approach might serve as a viable middle ground in our unnecessarily polarized society. The twentieth century was pervaded by a great deal of artificial talk about the possibility of a 'Third Way.' We are hopeful that libertarian paternalism offers a *real Third Way* – one that can break through some of the least tractable debates in contemporary democracies.
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> […T]here is all the difference in the world between senseless opposition to all 'government intervention' as such and the sensible claim that when governments intervene, they should usually do so in a way that promotes freedom of choice.[86]

Thaler and Sunstein's approach is framed to allow the realisation of paternalistic ends without offending against those who hold concerns about coercive methods:

> Libertarian paternalism is a relatively weak and nonintrusive type of paternalism, because choices are not blocked or fenced off. In its most cautious forms, libertarian paternalism imposes trivial costs on those who seek to depart from the planner's [that is, the regulator's] preferred option. But the approach we recommend nonetheless counts as paternalistic, because private and public planners are not trying to track people's

[84] See <www.behaviouralinsights.co.uk>.
[85] Thaler and Sunstein, op. cit., n. 16, 6.
[86] id., 253-254 (emphasis added).

> anticipated choices, but are self-consciously attempting to move people in welfare-promoting directions.[87]

Nudge has given rise to an extraordinarily large literature.[88] There are works that favour the insights in Thaler and Sunstein's analysis, and which advocate for a better and more coherent coordination of nudges in health law and policy.[89] Equally, however, there are works that have highlighted ranging concerns about nudge.[90] Whilst the current paper does not (could not) aim to offer a comprehensive presentation of the critiques, two points bear noting.

First, the idea of the nudge has, essentially, developed beyond the conceptual boundaries of Thaler and Sunstein's definition. This applies within their own explication of the theory, most notably in their acceptance of nudges to advance non-paternalistic ends. And importantly, given that nudge is now an idea that has a wide public and political traction, what are considered nudges in practice are often not 'true' nudges (that is, in pedantic accordance with Thaler and Sunstein's characterisation). Within the context of public health policy, minimum pricing schemes and taxation are both seen as 'nudge-type interventions' to discourage unhealthy behaviours.[91] In this paper, I thus use this broader-sweep term, whose key indication is the (perceived) relative regulatory 'softness' of individual measures.

Second, there are strong arguments against the idea that nudge theory is as respectful of libertarian agendas as Thaler and Sunstein suggest. Despite their disavowal of attempts to defend the outright denial of choice, Thaler and Sunstein do not, within the terms of their own analysis, actually advocate for libertarianism at all.[92] Rather, their work more modestly points out that, at times, measures that are not coercive can be effective to encourage particular behaviours. Members of the public health community have argued that this is hardly a new insight.[93] Perhaps more concerning for libertarians who are hoping to buy into this 'third way', Thaler and Sunstein explicitly accept the principle that hard paternalistic legal measures are anyway justifiable, saying:

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[87] Sunstein and Thaler, op. cit., n. 16, 1162.
[88] For some indication of the scope, Google Scholar suggests, at 18th June, 2019, 12,905 citations for *Nudge*.
[89] See M. Quigley, 'Nudging for Health: On Public Policy and Designing Choice Architecture' (2013) 21 *Medical Law Rev.* 588; K. MacKay and M. Quigley, 'Exacerbating Inequalities? Health Policy and the Behavioural Sciences,' (2018) 26 *Health Care Analysis* 380.
[90] See P. Hansen and A. Jespersen, 'Nudge and the Manipulation of Choice: A Framework for the Responsible Use of the Nudge Approach to Behaviour Change in Public Policy' (2013) 4 *European Journal of Risk Regulation* 3; K. Yeung, 'Nudge as Fudge' (2012) 75 *Modern Law Rev.* 122.
[91] See also Coggon et al., op. cit., n. 2, ch. 9. Note too Sunstein's conceptualisation of a spectrum of how 'hard' or 'soft' regulation may be: see text to n. 51, above.
[92] See also Sunstein, op. cit., nn. 32 and 46.
[93] C. Bonell et al., 'One Nudge Forward, Two Steps Back' (2011) 342 *BMJ* 241.

"nothing we have said denies the possibility that in some circumstances it can be advisable to impose significant costs on those who reject the proposed course of action, or even to deny freedom of choice altogether."[94] They do not in their work advocate for moves towards greater libertarianism. Rather they advocate, through their acceptance of it, for the freedom/coercion conditions of the *status quo*: from here, regulation is a tool for achieving greater paternalism, not greater libertarianism.[95]

These practical and theoretical limitations underpin my critique of regulatory agendas for the public's health: not for such agendas' reliance on the of use nudge-type measures of regulation *per se*, but for their treatment of these as more straightforwardly justified/mandated. Nudge's political presentation and public reception suggest that there is an attractiveness to, and acceptance of, the idea of libertarian paternalism within public and political imaginations: it is a touchstone of politically-legitimate health promotion measures. Yet its apparently exclusive adoption within fifth-wave public health reinforces individualistic assumptions that social determinants theses so forcefully undermine. Furthermore, its justificatory quality is question-begging in the context of public health approaches that are based on a systematic, long-game agenda that aims to effect radical social change through the implementation of an *aggregation* of 'mere' nudges; 'soft' interventions. The following section explains why this is so.

2. Objections to 'Libertarian Paternalism' as a measure of the means and ends of long-game regulation

Even if we extend our understanding of 'hard' regulation to include non-criminal law methods of coercion, and instead understand interventions' intrusiveness by reference to the magnitude of their costs to the person rather than their (non-)legal form,[96] particular legitimacy problems arise for 'soft' measures as a tool in the *additionally complicating* context of long-game strategies. In essence, the problem is that we are invited to assess any given 'nudge' individually and at a particular point in time: libertarian paternalism reaffirms condemnation of individual 'hard' measures but fails to offer a satisfactory means of evaluating the legitimacy of a *networked* scheme of multiple regulatory interventions. This is so notwithstanding that by design these combine *eventually* to ban or promote outright a tranche of 'lifestyle choices'. This leads to the conclusion that libertarian paternalism (and related nudge-type reasoning) is deficient, on its own terms, as a

[94] Sunstein and Thaler, op. cit., n. 13, 1200-1201. See also Sunstein, op. cit., n. 46, especially ch. 8.
[95] See A. Schmidt, 'Withdrawing versus withholding freedoms: Nudging and the case of tobacco control' (2016) 16 *American J. of Bioethics* 3. For a broader critique of the libertarian credentials of libertarian paternalism, see G. Mitchell, 'Libertarian Paternalism Is an Oxymoron' (2005) 99 *Northwestern University Law Rev.* 1245.
[96] See Sunstein, op. cit., n. 32, 55-61.

mechanism for understanding legitimacy within long-game approaches. It is useful here to repeat a short line from Thaler and Sunstein's outline of the idea of libertarian paternalism:

> To borrow a phrase, libertarian paternalists urge that people should be 'free to choose.' Hence we do not aim to defend any approach that blocks individual choices.[97]

These sentences are, of course, only a summary. But the way things are framed through the use of the present tense in 'blocks' is indicative of two practical problems with nudge as a reference point for legitimacy. First, there is the *status quo* bias noted above.[98] But beyond this, nudge can too easily be taken just to apply in any instance to an *individual* measure rather than a more widely-networked series of regulatory interventions that might be instituted concertedly over a long timeframe to block choice(s). Writing alone, Sunstein states: "if welfare is our concern, paternalism should be evaluated on a case-by-case basis—unless there is some systematic reason to support a principle or presumption against paternalism."[99] This exception for background systematic concerns about paternalism, which Sunstein rightly says is "a description, not an epithet",[100] permits for the in-principle justifiability of coercive paternalism. But it nevertheless relies on the acontextual analytical claim that nudges are more benign than coercion for being a 'soft' form of regulation. And allowing that values other than welfare—autonomy, dignity, self-government—may be foundational, Sunstein argues that "at least when the interest of the choosers is all that is involved" we should refer to the slogan: "influence yes, coercion no, at least as a presumption."[101]

This does not adequately address how the systematicity of cross-temporal networks of nudges, characterised as long-game public health regulation, give their own cause for scepticism about the non-coercive nature of measures evaluated case-by-case. When defending nudges as preferable to mandates, Sunstein's focus is on the immediate measure's effect.[102] Yet of necessity this cannot account for itself where the individual, non-coercive, measure is in design and effect part of an overall coercive agenda. Or to put this on its head, Sunstein's arguments against individual mandates also speak to overall methods of achieving a mandate through a multiplicity of nudges. Paradoxically, his attention to avoiding the "trap of abstraction" in order to

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[97] Sunstein and Thaler, op. cit., n. 16, 1161.
[98] See Schmidt, op. cit., n. 95.
[99] Sunstein, op. cit., n. 46, 58, and see. 54-59.
[100] id., 56.
[101] id., 189.
[102] id., ch. 8.

demonstrate an absence of "serious ethical issues", looking instead at individual "concrete practices", leads to its own ethically contentious abstraction: that we may presume that nudges are benign.[103]

It bears stressing that Sunstein does engage directly with the place of regulation ('hard' and 'soft') in changing "social meanings".[104] This may be seen as capturing precisely ideas such as a transition to a 'culture of health' through long-game regulation. But again, the defence that Sunstein provides fails to allow for the coercive effect of the policy in its aggregate. He suggests that we should prefer social change to be implemented through nudges rather than hard legal requirements because softer measures mean that "the risk of government overreaching is significantly reduced."[105] Although he is somewhat circumspect in defending this position,[106] he emphasises the analytical truth "that insofar as it maintains freedom of choice, soft paternalism is less intrusive and less dangerous [in terms of libertarian concerns] than mandates and bans."[107] However, such general analytical claims do not address the point that should invite consideration: as seen with long-game regulatory agendas, the effect of policy (in terms of leading to bans or mandates) is not to be understood by reference to the form of individual measures, but by the overall magnitude of and political impetus behind the agenda itself, and its overall (likely) impact across time. No abstract claim can help here: we require an aggregated consideration of the means and ends of the project as a whole, and do not gain assistance from analytically true claims about presumptions concerning the more benign nature of nudges taken individually and at a particular moment.

As stressed above, we do of course need to appreciate that many of the interventions that will be appropriate within a large regulatory scheme will be nudge-like. But given its nature, we cannot coherently advance an agenda such as fifth-wave public health without considering the viability of 'hard' as well as 'soft' measures of paternalistic regulation. And once it is justified as a sound regulatory agenda, there is no principled reasons to suppose, even at a useful level of generality, that of necessity particular 'hard' measures within this agenda will be more challenging to justify than particular 'soft' measures. Accordingly, this implies a deficiency in the libertarian paternalism framework as a sound means to assess political justification in (public health) law understood as a dynamic field of practice: defences of nudge overplay understandings of the

[103] id., 26.
[104] Sunstein, above n. 32, 60-61.
[105] id., 61.
[106] id., 151-154.
[107] id., 153.

relatively easier standard of legitimacy when we look to means rather than ends in regulation; the framework it provides is not apt to assess *the policy agenda itself* whose intended aim is a radical amendment to the socio-legal and political landscape, the ultimate eradication of a particular commodity, or commodities, from the market, and the establishment of a new culture.

This point can be illustrated by reference to a potential policy that might feature as part of the tobacco endgame. Imagine a proposal modestly to extend the existing smoking ban, to ensure that people can only smoke if they are further than five metres from the entrance to a public building. According to the way that nudge theory is understood and applied, this proposal seems quite benign: it represents a modest change that does not stop people smoking (so not obviously offensive to Feinberg's analysis) but makes the option less attractive (because it denies the chance to shelter in the doorway of the building). Yet there is a qualitative distinction where this measure is considered on its own (it is just a small nudge) compared with its manifestation as part of a wider, goal-based scheme (it is a big, choice-limiting agenda). The policy is not just a block to an option now; a 'micro instance' of (say) rational dissuasion. Rather, it is properly conceived as a component of a wider scheme that will, over time, eradicate what are currently available choices: *outright, purposeful coercion is the very idea of such progressive policy*. An exclusive focus on individuals, individual choices, and a *status quo* bias comes at the cost of examining the legitimacy of concerted political measures driven in a particular direction, and ignores how temporality can feature more subtly in radical policy agendas.

All of this invites a reconsideration of the idea of the slippery slope. Generally, I would endorse sceptical reflections on slippery slope arguments.[108] However, for long-game policy-making the standard objections to slippery slopes cannot be overcome because a 'slope' is concertedly being created. This is problematic absent a coherent account of the legitimacy of the overall regulatory regime and the rationale that supports it; and once we have that, we find a position that, consistently with the above analysis, need not treat formally coercive measures as exceptional in terms of (non-)justifiability; it means that 'harder' methods, such as those outlined at the end of Part III, may be more easily justified—even required[109]—than the received wisdom would have us believe.

[108] D. Enoch, 'Once You Start Using Slippery Slope Arguments, You're on a Very Slippery Slope' (2001) 21 *Oxford J. of Legal Studies* 629.
[109] *Cf* Conly; Gostin and Gostin; Goodin, op. cit, n. 12.

This point can be underscored with reference to Thaler and Sunstein's own response to slippery slope objections, which cites tobacco regulation as an example that might be used against libertarian paternalism.[110] Long-game regulation strategies, whether for public health or other areas of policy, are not protected by Thaler and Sunstein's threefold defence. First, they suggest that we should not resort to critiques based on a 'hypothetical slippery slope'.[111] But in long-game regulation the 'slope' is designed and created rather than hypothetical. Second, they re-emphasise their commitment to the 'libertarian condition' that measures should not interfere with choice; paternalistic interventions should be easy to avoid. The above analysis shows how easy avoidance may be apparent when we consider policies individually, but the measure provided by nudge-type evaluation does not account for the combined prohibitive effect of a progressive aggregation of measures. Finally, Thaler and Sunstein note that any which way there will be a default policy position, so we should make the default good (in terms of its promoting welfare): 'Choice architects, whether private or public, must do *something*.'[112] Rules, they argue, must be established even if they are permissive. This position is not straightforwardly sustainable. The absence of rules is sufficient for a behaviour to be permitted (and the default, of course, of a libertarian is that policy-makers should do *nothing*); express governmental permission of any given conduct is not required. And the making or amending of rules is subject to precisely the sorts of normative concerns that this paper has shown nudge-type reasoning cannot address. In short, it is clear, given the resonance with received wisdoms on formal coercion, why public health policy strategies might aim to develop through a long game of nudge-type 'renormalisation'. But if the long-game campaign of renormalisation is acceptable, it is not clear—and cannot be made clear through nudge-type theory and methods—why 'harder' interventions may not also be justified. The *aims* of the fifth-wave agenda may be solidly argued, and should root themselves clearly in explicit concepts of social justice that explain why health opportunities and outcomes, measured at a population level in England, demonstrate rank inequity. And following that manner of ethical engagement, it would be mistaken to constrain the implementation of interventions for the public's health by deferential reference to nudge-type measures that are built on flawed jurisprudential orthodoxies. This problematically perpetuates the very paradigms and commitments that social-epidemiological research challenges. And as indicated, such an approach anyway fails conceptually to account for legitimacy on the terms that it sets for itself. As outlined in the next section, what is rather

[110] See Sunstein and Thaler, op. cit., n. 16, 235-237.
[111] id., 236.
[112] id..

required is a more robust, rigorous, and clear underpinning for public health ethics and law that explains not just the ends, but also the means, of regulating for the public's health.

3. Opportunities for a more radical public health ethics and law

The dominant perspective in early works in health and law (especially medical law) gave great primacy to individual autonomy ,[113] albeit that more recent studies challenge the rigour and consequent supremacy of that principle.[114] The field of public health ethics and law, whilst containing libertarian voices,[115] carries many 'anti-autonomy' arguments: for example, through critiques about the inflated value given to liberty as just one amongst several values of political importance.[116] The field may even be characterised as a corrective movement within bioethics, aiming to displace the presumed value of autonomy with that of (population) health. The important point to emphasise is that, *pace* nudge theorists, there is no middle way that avoids the inherent political controversies at play here.[117] If public health policy might claim legitimacy in practice, it cannot use nudge-type methods as a means of escaping a burden of justification against individualistic arguments. Collective responsibilities and paternalistic rationales require to be defended, in terms, for the policy's normative success. As Adam Burgess argues:

> [I]t is not only nudging in its various forms that requires examination and debate, but the wisdom and consequences of the fixation on lifestyle health issues and where the limits to *all* forms of direct external interference lie.[118]

A positive rationale is needed in support of public health policy; one that explains what political mandates there are for public health activity, and what economic, legal, social, and political constraints limit potential activity. The indications of the above analysis, and of public health critiques of 'upstream' causation and social equity,[119] suggest that the theories that we use to evaluate law and policy must be able to account for a longer-term, regulatorily-networked

[113] K. Veitch, *The Jurisdiction of Medical Law* (2007); I. Kennedy, *Treat Me Right: Essays in Medical Law and Ethics*, (1991).
[114] For example, M. Brazier, 'Do no harm—do patients have responsibilities too?' (2006) 65 *Cambridge Law J.* 397.
[115] For example, Epstein, op. cit., n. 8; Skrabanek, op. cit., n. 41.
[116] A. Dawson, 'Snakes and ladders: state interventions and the place of liberty in public health policy,' (2016) 42 *J. of Medical Ethics* 510.
[117] Coggon op. cit., n. 34.
[118] A. Burgess, '"Nudging" Healthy Lifestyles: The UK Experiments with the Behavioural Alternative Regulation and the Market' (2012) 3 *European J. of Risk Regulation* 3, 16 (emphasis added).
[119] See above, nn. 6 and 7.

agenda.[120] This is because the effects of contemporary policy cannot be measured with reference only to its current, local, sectoral, or near-term impacts. Long-game approaches may be justified in any given instance, but their justification is not—and cannot be—rooted in their apparent adoption of individual measures that taken one-by-one fall short of being 'hard' regulation.

A crucial point that follows is that where a sound, albeit paternalistic, health policy end is established, there is *ex ante* no reason to suppose that it needs to be reached exclusively through measures that do not offend the received wisdoms regarding coercion and paternalism. Where a justified governmental goal is defended, a comprehensive scheme of political acceptability will be able to explain where and how 'harder' methods of regulation are rightfully available. If, for example, it is accepted that a currently-existing choice should be eradicated, or a potential new choice barred, parity of reasoning will suggest in given cases that a more interventionist approach to health promotion may well be permissible; even mandated.[121] The fifth-wave agenda as advocated for in English public health policy serves well in its articulation and defence of the policy goals. However, in relation to *means* of regulation it reinforces political assumptions about individual responsibility that it would be better to challenge. We may assume that 'nudges' will feature rightly and prominently within regulatory measures. But it would be radically mistaken to assume that they should exhaust our approach to achieving governance for health. Equally, their individually-measured status as a 'mere' nudge cannot indicate their straightforward, easier justification, or that they are even presumptively more benign from the perspective of political morality. We need to consider the 'game' as a whole: its methods and its goals, in their aggregate.

CONCLUSIONS

Long-game regulatory agendas are grounded, for clear reasons, in a need to account for the *status quo* and aim to reload the dice through gradual reformulations of that *status quo*. In regard to public health strategies such as the fifth-wave agenda, that means changing the legal, political, and social environments to renormalise towards a 'culture of health'. This paper has considered the means of 'playing the long game' as they are advocated for in England, and questioned the deferential commitment to a limited concept of coercion as a predominant concern, and to 'nudge-type' governance approaches as a satisfactory means of circumventing that concern. It has shown why 'nanny state' critiques are not avoided simply by evading formal methods of

[120] This complexity is why political science approaches to public health treat it as a 'wicked problem': see I. Kicksbusch, *Implementing Health in All Policies* (2010), introduction and ch. 1.
[121] Consider the evaluative approaches applied respectively in Goodin; Gostin and Gostin; Conly, op. cit. n. 12.

coercion in paternalistic policy; and in a long-game agenda nor are they circumvented by the range of individual measures' each being consistent with 'libertarian paternalism'.

On its face, this may seem damning for fifth-wave public health. However, it is far from that. What it reveals is the need, and the opportunity, for more rigorous rationales, necessarily rooted in a comprehensive public health ethics and law. Theorising and advocacy must be prior components of work here. Middle ways are illusory. Apparent commitments to liberty fail to account for the whole of political morality, and for the design of a longer-term regulatory agenda. Lawrence Gostin and Gregg Bloche are right to suspect that consensus will not be achieved.[122] But where sufficient political will exists to recognise and respond to public health problems and injustices, a more ethically robust public health law and policy agenda will be built on a more honest account of the state's commitment (or otherwise) to available means of optimising the conditions in which people can be healthy. Public health law and policy require foundations in a fully-theorised understanding of social justice and political morality. Efforts to side-step this, such as we find in a resort to nudging, fail. A more nuanced account of shared responsibilities for health and the role of government opens up broader and better justified social, political, and regulatory possibilities. It is to these that we should aim.

[122] Gostin and Bloche, op. cit., n. 7.