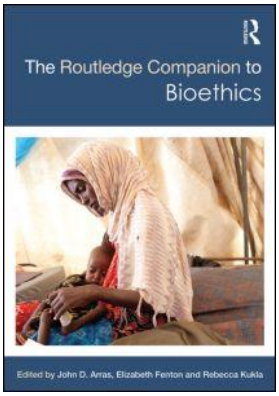

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PUBLIC HEALTH AND CIVIL LIBERTIES
Resolving Conflicts

James F. Childress

Introduction

This chapter considers public health ethics in a particular context—a liberal, pluralistic, democratic society that maintains explicit commitments to several basic civil liberties: Bodily integrity, privacy, freedom of movement, freedom of association, and freedom of religion and conscience (Gostin 2008). In addition to functioning as sociocultural norms, these liberties are embedded in legal and, in some cases, constitutional rights. They are also incorporated into international human rights documents and discourse. Beyond these civil liberties, there are several basic economic liberties, including freedom of contract and uses of property, which this chapter does not address. Nor is this the place to offer a theoretical defense of a liberal, pluralistic, democratic society; I assume this as the context for these reflections about public health ethics.

Examinations of the relations between public health and civil liberties are often framed by one of two major perspectives: conflict or concord. These differ according to whether they hold that conflict between public health and civil liberties is more fundamental and prevalent than their harmony. Of course, both perspectives acknowledge that conflicts do arise between public health and civil liberties, but their starting assumptions differ greatly. One views conflicts as common and inevitable, and trade-offs as unavoidable (Gostin 2002, 2003), while the other views conflicts as occasional, even rare, and trade-offs as generally avoidable (Annas 2002a, 2002b, 2007). The conflict perspective is also captured in the language of "inherent tensions" between public health and civil liberties "across the spectrum of threats to public health" (Bayer 2007). The concord perspective stresses that respect for civil liberties and rights constitutes an important part of public health policy and practice and is essential for voluntary public cooperation with public health authorities. The dominance of conflict or concord perspectives varies in different sociocultural contexts and over time.

The perspective of this chapter, which its overall argument supports, is that concord is more basic than conflict. However, difficult conflicts do sometimes erupt, and public health officials, invoking the "police power" of the state, sometimes rightly believe they must restrict civil liberties in order to protect or promote public health. In this chapter, I argue that:

- When conflicts do emerge, a presumptivist framework is more defensible and helpful than an absolutist or a contextualist one for determining appropriate public health interventions, some of which may infringe civil liberties.
- The presumptivist framework involves specifying public health ends and goals and viewing civil liberties, also specified, as presumptive directions for and constraints on measures to accomplish those ends and goals.
- The presumptivist framework operates with several conditions for rebutting the presumption, in some circumstances, against interventions that infringe civil liberties.
- Often, rebutting the presumption against infringing civil liberties is not necessary because it is possible to obtain voluntary cooperation and compliance. The metaphor of the intervention ladder from the Nuffield Council on Bioethics allows us to explore different ways to secure individuals' cooperation and compliance with public health measures without infringing their civil liberties.

I focus my discussion on a few civil liberties—freedom of movement and association and freedom from intrusions on bodily integrity—and I mainly draw examples from vaccinations, directly observed therapy (DOT) for tuberculosis (TB), and quarantine following probable infectious disease exposure.

Frameworks of Ethical Analysis of Conflicts between Civil Liberties and Public Health

If conflicts emerge between public health and civil liberties, how should they be adjudicated? Among three possible frameworks for adjudication, I argue that a presumptivist framework is preferable to either an absolutist or a contextualist framework (for a fuller discussion, see Childress and Bernheim 2003, 2008; Bernheim et al. 2014).

An absolutist framework holds that a certain value has absolute priority over some or all conflicting values. It is not plausible in public health ethics to take an absolutist approach, whether the absolute value is liberty or public health. Only an extreme libertarian position—verging on anarchism—could assign absolute priority to liberty in the face of, say, a major pandemic that threatens a country's survival. Most libertarians recognize warrants for overriding liberty in such cases—for instance, David Boaz, an influential libertarian, concedes that forcible quarantine, exercised with "great caution, and with appropriate safeguards for due process" appeared to be a "necessary" step in response to the outbreak of SARS (Severe Acquired Respiratory Syndrome) which is known to have infected over 8,000 persons worldwide and killed 775 of them in 2002–3 (Boaz 2003). Similarly, only an extreme communitarian position—verging on totalitarianism—could assign absolute priority to public health. Most communitarians recognize some liberties as communal values, along with public health and other values.

At the other end of the spectrum is a contextualist approach that refrains from assigning advance weights to either public health goals or civil liberties. Instead, it considers all of them equally in particular contexts. The dominant metaphors are "weighing" and "balancing." For instance, Amitai Etzioni (2002: 102) holds "that individual rights and social responsibilities, liberty and the common good, have equal standing; that neither should be assumed *a priori* to trump the other; and that we need to seek a carefully crafted balance between these core values."

It is common for governmental officials to describe their reasoning as *balancing* public health and civil liberties. Often, this focuses on public health and liberty as abstract concepts, as though all public health goals are equally significant and all civil liberties are equally important. Attending to particular contexts offers at least a partial corrective, but this approach still fails to provide an adequate structure for moral reasoning and relies too much on bare intuition. Furthermore, it fails to capture a key commitment of liberal societies to assign presumptive priority to means in public health and elsewhere that respect civil liberties and voluntary choices. It tends to reduce all judgments to proportionality, failing to see that even policies that pass an overall balancing test still need to be necessary, the least restrictive, the least intrusive, and so forth.

A presumptivist approach, by contrast, requires specification of the public health ends or goals that are sought and then assesses the range of potentially useful and available means. In pursuing public health goals, it starts from a presumption in favor of interventions that respect, and against measures that violate, basic civil liberties. To be sure, this presumption can sometimes be rebutted, but this rebuttal process requires a more precise and nuanced analysis than is available to the contextualist.

The presumptivist framework avoids pitfalls that trouble both absolutist and contextualist approaches. It avoids the extreme and implausible absolutist positions—that public health always trumps liberty/ies or that liberty/ies always trump public health. It is closer in spirit to the contextualist approach but provides a needed and helpful structure for moral reasoning about public health interventions. The presumptivist framework assigns presumptions, starting points, and burdens of proof in deliberation about interventions that could be used to realize the goals of public health. The presumption favors those that do not infringe civil liberties.

Goals of Public Health

The first task in justifying interventions is to identify, specify, and justify the assignment of weights to the goals of public health. Too often "public health" is presented as a univocal and sufficient goal even though it is too broad without further specification. Here I focus on five general types of goals offered as justification for public health interventions.

Public health has historically encompassed actions that individuals cannot perform entirely for themselves, for instance, when collective action is required in public sanitation and in preventing the spread of communicable diseases. The major justification for liberty-limiting interventions is the "harm-to-others principle," presented in John Stuart Mill's *On Liberty* (Mill 1975). This principle authorizes the society's intervention into individuals' other-regarding actions, that is, actions that harm others or put them at risk of harm. A version of what Mill calls societal "self-protection" appears in the early twentieth century U.S. Supreme Court decision, *Jacobson v. Massachusetts* (1905), which upheld a mandatory vaccination law: "Upon the principle of self-defense, of paramount necessity, a community has the right to protect itself against an epidemic of disease which threatens the safety of its members."

A second goal is protecting people who lack the capacity to protect themselves, even from effects of their own actions (Gostin 2008). In *On Liberty* Mill gives an example of a person about to cross a dangerous bridge and there is "no time to warn him of his danger." In such a case, Mill said, it would be ethically acceptable to "seize him and turn him back, without any real infringement of his liberty" on the assumption that he does

not want to fall into the river (Mill 1975: 89). In such a case, a person's lack of information or, as we might broaden this, lack of capacity, combined with the risk to him or her, warrants the intervention. This is a form of weak or soft paternalism that is unobjectionable from the standpoint of civil liberties if it is exercised in good faith (Childress 2007; Beauchamp and Childress 2013).

A third possible goal is protecting an individual's health interests even if she is competent, has adequate information, and voluntarily rejects the intervention on her behalf. This is strong or hard paternalism. Mill (1975) argued for an absolute prohibition of coercive interventions in an individual's self-regarding actions, i.e., actions with adverse effects that fall only on the autonomous individual herself or also on others with their consent. Such strong or hard paternalism is very difficult to defend as a warrant for breaches of civil liberties.

A fourth possible goal employs an expanded notion of "harm to others." It rejects Mill's sharp distinction between self-regarding and other-regarding conduct and contends that some apparently paternalistic interventions may be primarily, or at least significantly, aimed at protecting others. Such expansionist views of *public* health hold that in the modern welfare state, so different from Mill's context in the mid-nineteenth century, some apparently self-regarding conduct is now other-regarding in its effects if not in its intention.

Consider the following example: Arguments for mandatory motorcycle helmet laws appear paternalistic in nature, having only the goal of protecting motorcyclists themselves from severe head injuries or death. However, some other arguments focus on the increased risks, burdens, and costs to other individuals and to the society. Such an extension of the harm-to-others principle appears in a Massachusetts court decision:

> From the moment of the injury, society picks the person up off 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 many assure the responsibility for his and his family's continued sustenance . . . We do not understand a state of mind that permits a plaintiff to think that only he himself is concerned.
>
> (quoted in Bayer 2007: 1102)

A fifth possible goal under the rubric of public health is *population health*. A healthy population is a worthy societal goal in and of itself. It also provides human capital for a more productive society, more capable of competing in the global arena and defending itself from external enemies. Even if individuals' health-damaging actions appear to affect only themselves, they are at the same time depriving society of fully capable and productive citizens. This goal also allows the society to target chronic conditions such as diabetes and/or obesity in its public health programs. Its logic is similar, on a larger scale, to the logic of the expanded "harm-to-others" principle. For instance, after arguing for paternalistic regulation of individuals' conduct in order to protect the individuals themselves, Ronald Bayer adds "because such [paternalistic] efforts can have a broad and enormous impact at a population level" (Bayer 2007: 1102). This joins a paternalistic rationale with the societal benefit of population health.

A sixth possible goal also attends to population health but from a distributive rather than an aggregative perspective. This goal, resting on egalitarian conceptions of social justice, involves efforts to close the health gaps between the better off and the worse off

in the society. Over the last several decades, for example, this goal has been clearly evident in mandatory vaccination laws, tied to school attendance, that seek to "foster the equitable distribution of the benefits of vaccines, especially among children whose life circumstances make them less likely to be fully immunized" (Colgrove 2010).

Of course, it is possible—and common—to combine several of these goals as warrants for policies and practices that limit or override civil liberties. Strong (but not necessarily overriding) unmixed goals, when the proposed interventions conflict with civil liberties, are the first, second, and sixth; the third is the most controversial in a liberal society but has its defenders (Bayer 2007); the fourth and fifth are commonly invoked but require close attention to the actual effects of individuals' actions on others and on the society before they can override civil liberties. Under these six broad goals, under the rubric of public health, we need to formulate and deliberate about specific, concrete goals.

Justificatory Conditions for Liberty-Limiting Public Health Measures

A presumption in favor of interventions that respect civil liberties in the pursuit of public health goals can be rebutted under some conditions, and it is important to delineate these rebuttal conditions. We can call them *rebuttal conditions* because they specify conditions for rebutting the presumption in favor of respecting specific civil liberties, or we can call them *justificatory conditions* because they specify conditions for justifying infringements of specific civil liberties. (For other versions of these conditions, see Childress et al. 2002; Childress and Bernheim 2003, 2008.)

The presumption-rebuttal or justification process occurs in particular contexts when measures that limit, infringe, or violate civil liberties are being considered as possible ways to achieve specific public health goals. The process should be directed at all stakeholders.

The first task of this process, as we noted above, is to specify and weight the public health goals, and so the first rebuttal condition focuses on the following question: Is there a legitimate and important public health end or goal? The other justificatory conditions kick in once there is a specific, legitimate, and important public health goal and some of the possible interventions involve limiting liberties. It is not sufficient merely to assert that public health is at stake. As we have seen, some of the general types of goals are weaker than others in justifying infringements of civil liberties.

Second, would the proposed liberty-limiting measure probably be effective in achieving an important public health goal? If there is no reasonable chance that the liberty-limiting measure—such as forcible quarantine—would achieve its goal, then it is both unwise and unethical. A reasonable prospect of success is a condition for rebutting the presumption in favor of civil liberties of movement and association.

Third, is the proposed liberty-limiting measure necessary? We can imagine circumstances in which liberty-limiting measures, such as forcible quarantine or mandatory vaccination, would be effective but nonetheless ethically unjustifiable because they are not necessary to realize the public health goal being sought. It is often, though not always, possible to secure individuals' voluntary adherence to public health measures without coercion or threat of coercion. Moreover, the logic of presumptive principles or values compels us to seek alternatives before we can justifiably override them. A liberty-limiting measure is necessary only if other measures have failed or have been determined to have no reasonable chance. Only then is it a last resort.

Some frameworks do not include necessity as a justificatory condition, holding instead that it is incorporated into the fifth condition of proportionality. However, it serves as a valuable reminder that consequentialist considerations, such as effectiveness and proportionality, which would also include cost-effectiveness and a wide range of consequences, do not exhaust our moral concerns in public health.

Fourth, is the proposed infringement of liberty the least restrictive or least intrusive means available? In some interpretations, this justificatory condition is simply a corollary of the previous one, necessity. If liberty-limiting measures are necessary, the degree of infringement, as well as the kind of infringement, should be necessary. Nevertheless, it is also useful to consider this condition as a specific requirement of the logic of presumptive principles or values—to minimize the restrictiveness, intrusiveness, and invasiveness of justified infringements, such as infringements of freedom of movement and association and protections of bodily integrity, and to narrow their scope as much as possible. If, for example, public health officials have determined that forcible quarantine is necessary to control a SARS outbreak, they should employ the least restrictive, intrusive, and invasive measures and aim at the narrowest range of possible targets of quarantine consistent with achieving the public health goal being pursued. They might, for instance, select quarantine in home rather than in a hospital or in jail; of course, other factors such as cost will enter into these deliberations too.

Fifth, is the proposed liberty-infringing measure proportionate? From one standpoint, if a proposed limiting-infringing measure is effective, necessary, the least intrusive, etc., then it is proportionate in the sense of being appropriate and fitting (see Working Group 2003). In this chapter, proportionality involves the kind and range of balancing featured in contextualist analyses. It considers not only the probable benefits of the proposed measure, weighed against the relevant liberty interests, but also attends to the probable overall balance of good and harmful short- and long-term effects of the proposed liberty-limiting interventions.

Sixth, is the proposed liberty-limiting measure impartially applied? In a seminar on "Confronting Epidemics: Historical and Contemporary Perspectives," which I co-taught several times with a colleague in law and public health, we were initially surprised to see how often liberty-limiting measures were imposed unfairly, based on race, ethnicity, and social class, among other characteristics. Discrimination based on such characteristics is common in epidemics, particularly in singling out some victims for blame. In the 2003 SARS outbreak in Canada, Asian persons in Toronto experienced stigmatization and discrimination (Schram 2003).

There are concerns that presumptions and rebuttal or justificatory conditions, such as those just delineated, too often stand in the way of effective measures for reaching public health goals. Some advocates for public health worry that these presumptions and rebuttal conditions erect barriers to public health by requiring that liberty-limiting measures pass excessively stringent tests (Gostin 2002; Etzioni 2002). And yet if the commitment to civil liberties in a liberal, pluralistic, democratic society is meaningful, it at least sets a (rebuttable) presumption against infringements of civil liberties. Moreover, such criticisms fail to note that safeguarding civil liberties regularly goes hand in hand with protecting and promoting public health, in part because of the need for public trust and cooperation. Finally, as I have suggested and elaborate in the next section, respect for civil liberties can often be maintained by persuading or nudging individuals voluntarily to accept and act on public health measures, such as vaccination or quarantine or directly observed therapy (DOT) for TB. Hence, the justificatory conditions compel public

health officials to seek measures that may elicit voluntary cooperation before resorting to infringements of civil liberties.

The Intervention Ladder

The metaphor of an "intervention ladder," introduced by the Nuffield Council on Bioethics (2007), helps us think about a range of interventions that may secure the public's cooperation with public health measures without infringing civil liberties. The interventions higher on this ladder are considered to be more intrusive and thus to require a stronger justification (Nuffield Council 2007). In line with a presumptivist approach, the justificatory burden increases as higher rungs of the ladder, involving infringements of liberty, are reached. Not every rung is available for every public health measure. My primary examples, as earlier, are vaccinations, DOT for TB, and quarantine for infectious diseases (Figure 25.1).

This ladder is not complete, there is overlap among the rungs, and each covers several possible kinds of policies and practices. In some contexts, some of the lower rungs may be unjustifiable for reasons other than infringement of civil liberties—indeed, for the most part, the lower rungs do not infringe civil liberties. Doing nothing—or monitoring the situation (1)—may seem unproblematic, but if, for example, serious illnesses or deaths are occurring while vaccination rates are being monitored, without any interventions, then it too requires solid ethical justification in view of the risks involved.

Providing accurate and truthful information (2) also appears ethically unproblematic, whether the goal is to ensure informed choices or to convince citizens and residents to act in certain ways, for instance, to accept certain vaccinations. Ethical issues do arise in efforts to motivate individuals through presenting graphic images, appealing to emotions, stigmatizing conduct, shaming failures to comply with social norms, and the like. Most governments have relied mainly on persuasion and motivation through a variety of educational and advertising campaigns to promote needed vaccinations, but they have employed other interventions as well.

Intervention Ladder
8. Eliminate choice
7. Restrict choice
6. Guide choice by disincentives
5. Guide choice by incentives
4. Guide choice by changing the default policy
3. Enable choice
2. Provide information
1. Do nothing

Figure 25.1 Intervention ladder

Source: This figure was prepared by the author from the Nuffield Council on Bioethics report (2007)

A policy or practice of enabling choices (3) seeks to secure compliance with public health measures by providing resources or otherwise increasing individuals' capacities to act in certain ways. It does not violate civil liberties to enable people to exercise those liberties in particular ways or to choose to waive their liberties. Enabling choices may involve removing financial, logistical, and other disincentives, obstacles, or barriers. These could be as straightforward as providing free fresh fruit for students or constructing lanes for bicyclists.

Consider the following scenario: Public health officials may believe that a particular individual who has TB should be in a DOT program until non-contagious or even cured in order to protect others and to reduce the chances of multidrug-resistant TB with its serious risks and huge costs to the individual and the society. It may be possible to secure that individual's compliance by providing vouchers for transportation to a center for DOT along with free care. In this case, the individual's failure to comply may not reflect a lack of will but rather a lack of resources for easy and non-burdensome compliance. Similarly, programs to increase access to vaccinations and to reduce or eliminate parents' out-of-pocket costs for getting their children vaccinated, according to the recommended schedule, have also been effective (Community Preventive Services Task Force 2008). Such programs do not infringe civil liberties and hence are unobjectionable from that standpoint.

For some public health measures, it may be possible and ethically justifiable to take another step and to guide individuals' choices by altering defaults (step 4 on the intervention ladder) or using other nudges. This is attractive because it maintains individuals' liberties while gently pushing their choices in certain directions. As Richard Thaler and Cass Sunstein argue in *Nudge: Improving Decisions about Health, Wealth, and Happiness* (2008), a "nudge" is an aspect of a society's "choice architecture" that seeks to change what people do without prohibiting any of their options and without significantly modifying their economic incentives. A mere nudge must not be difficult or costly to avoid. Changing the default in an organ donation system from opt in, as is current in the U.S., England, and Australia, to opt out, as is common in a number of European countries, selects one nudge over another in an effort to increase the rates of organ donation. Placing fruit, rather than less healthy foods such as potato chips, at students' eye level in a school cafeteria counts as a nudge, in contrast to banning junk food altogether from the choices in the cafeteria (Thaler and Sunstein 2008).

I briefly consider the role of nudges in one part of mass mandatory immunization programs. It is worth noting that immunization programs in about half of the countries in the European Union do not have any mandatory vaccinations, only recommended ones, while the other countries include at least one mandatory vaccination (Haverkate et al. 2012). Many of the countries only recommending vaccinations have high coverage nonetheless (Haverkate et al. 2012; specifically for the U.K., see Salmon et al. 2006). Immunization programs generally aim at herd or population immunity, which does not require universal immunization. Governments that mandate vaccinations generally exempt some individuals from the requirements. On the one hand, some children and adults have medical conditions that put them at risk from particular vaccinations; all states in the U.S. recognize medical exemptions. On the other hand, mandatory vaccination programs threaten another civil liberty, freedom of religion or, more broadly, freedom of conscience. Freedom of religious/conscientious action is generally more limited than freedom of belief. However, only two states in the U.S. do not allow exemptions from immunizations to religious objectors, and nineteen states also allow exemptions to

persons (or to parents or guardians of minors) with philosophical, personal, moral, or other objections (National Conference of State Legislatures 2012). In the U.S., such non-medical exemptions are not deemed to be constitutionally required, and they may legitimately be overturned in a declared public health emergency or epidemic.

Not only is there a question about whether non-medical exemptions should be allowed, but there are also questions about how to exempt particular objecting individuals. States have had to consider whether to grant these non-medical exemptions upon request or also to require further steps and formal review. This has become an important question because outbreaks of communicable diseases, particularly pertussis (whooping cough) in some states, have resulted in part from the increased numbers of exemptions (Omer et al. 2006). Some states have responded by introducing such formal requirements as an annual written request for exemption followed by a review. The available evidence suggests that such nudges can effectively reduce the number of requests for exemptions (Salmon and Siegal 2001; Salmon et al. 2006). The explanation is simple: Parents or guardians whose children have fallen behind on their immunization schedules may find it much easier to request an exemption, in the absence of nudges and slight hurdles, than to complete the immunizations. These nudges and slight hurdles may also serve as a limited test of objectors' sincerity. In any event, they represent only minor and justifiable encumbrances of freedom of religion and freedom of conscience without violating those fundamental civil liberties.

Nudges work for several reasons (Thaler and Sunstein 2008; Johnson and Goldstein 2003). One factor is the cost of acting against the nudges, for instance, by taking the non-default option, especially when the default option is recommended by public health officials and is considered socially normative. However, to count as a mere nudge, an option's cognitive, psychological, or other costs must be insignificant. If they are significant, then (4) is indistinguishable from (5) and (6), guiding individuals' choices by incentives or by disincentives. To return to our example of ensuring adherence to DOT by a person with TB, providing vouchers for transportation (an instance of (3)) may not be sufficient to secure his or her compliance. It may also be possible and desirable to provide incentives, such as additional money, to motivate compliance. A small incentive, such as money for an inexpensive lunch, could count as a nudge whereas a more substantial amount would fall under (5).

What evidence do we have for the effectiveness of incentives? The Community Preventive Services Task Force (2011a), a body of independent, non-federal, unpaid experts in prevention and public health, established by the U.S. Department of Health and Human Services, looked at studies from Australia and the U.S. of the use of several types of positive incentives, which it labels "incentive rewards," for vaccinations: One time payments; child care assistance; lottery prizes (grocery vouchers and monetary prizes); gift cards (for baby products); food vouchers; and baby products. It concludes that, based on the solid evidence of effectiveness of such incentive rewards in increasing the vaccination rates of both adults and children, there is warrant to recommend their use either alone or conjoined with other interventions (Community Preventive Services Task 2011a; for more on the positive effects of incentives on vaccination rates in Australia, see Salmon et al. 2006).

According to some critics, incentives, especially larger and more significant incentives, are potentially coercive. For instance, one such critic objects to paying people to take care of their health: "Cash might coerce some people into changing behavior . . ." (Popay 2008). By contrast, I take the view that providing incentives is not coercive

because it expands rather than restricts personal options (Hawkins and Emanuel 2005). However, providing incentives still needs ethical scrutiny in order to avoid either exploitation or undue inducement and in order not to stigmatize disadvantaged persons through cash transfers conditional on their behavioral changes.

Some critics point to incentives' deeper potential harms to individuals (and ultimately to public health). Incentives target individuals' conduct, usually in the short run, but may damage their overall motivational structure and character in the long run. Hence, these critics sound a strong cautionary note (Grant 2012). Sometimes, however, it is important to achieve short-term public health goals through altering conduct—for instance, using incentives to get individuals to undergo DOT or to receive vaccinations—even if their motivational structure or character is not improved and perhaps even slightly damaged. Claims of character damage through such incentives are difficult if not impossible to substantiate. As a result, we can make judgments about effectiveness and cost-effectiveness, in light of an important public health goal, but judgments of proportionality will be incomplete because of missing information and evidence about possible threats to character.

The final three rungs on the intervention ladder introduce more liberty-limiting and coercive policies than the ones below them; they thus stand in greater tension with civil liberties. Policies at rung 6 on the intervention ladder significantly shape individuals' choices through the imposition of disincentives, including but not limited to financial disincentives. Substantially increasing taxes on harmful products, such as cigarettes, is one example. Another is fining people who seek to avoid mandatory vaccinations. In *Jacobson v. Massachusetts* (1905), the U.S. Supreme Court upheld Massachusetts' imposition of a fine for failing to accept a vaccination in a smallpox outbreak and imposition of a jail term for failing to pay the fine (Willrich 2011).

Despite *Jacobson*, vaccination policy in the U.S. has historically relied mainly on persuasion rather than coercion. However, in the late 1960s, efforts to eradicate—and not merely to control—infectious disease, in the context of a campaign against measles, more states adopted laws requiring children to be immunized in order to attend school (Colgrove 2006, 2010). These laws, which had already been upheld by the U.S. Supreme Court in 1922, represent a significant non-monetary disincentive or sanction to ensure the vaccination of school-age children; they may also have monetary effects if parents have to resort to home schooling. Even so, the assumption was that parents are basically willing to have their children vaccinated but may need this "special stimulus" (Colgrove 2010). Moreover, the use of school attendance laws to ensure vaccinations was based in part on the egalitarian value of increasing children's access to conditions for healthy lives. Some supporters viewed these laws "as a kind of societal safety net to catch the children of the 'hard to reach'" (Colgrove 2010: 12). The laws also had the benefit of protecting other children in interactions at school.

More problematic is applying certain monetary disincentives or sanctions when parents or guardians do not adhere to the official public health schedule for children's vaccinations. Particularly troubling is withholding or reducing food vouchers (e.g., providing food vouchers for one month rather than for three months) or other welfare benefits to families, thus potentially damaging children's health by reducing their available nutrition. Even though a few studies indicate that such financial disincentives or sanctions may be somewhat effective in the short term (Hoekstra et al. 1998; Kerpleman et al. 2000), critics have rightly challenged them as unfair and potentially harmful to children (Wood and Haflon 1998; Minkovitz and Guyer 2000; Davis and Lantos 2000).

Even their effectiveness is not clear cut. Based on its review of a range of recent studies, the Community Preventive Services Task Force (2011b) found "insufficient evidence to determine the effectiveness of monetary sanction policies to increase vaccination rates in children of families on government assistance." The finding of "insufficient evidence" reflects the limited number of studies testing different sanctions and reaching inconsistent results. The Community Preventive Services Task Force (2011a) also noted the "limited information on potential harms of these policies."

Starting from a baseline of eligibility for food vouchers or other welfare benefits for preschool-aged children and then threatening to stop those benefits in an effort to motivate parental or guardian behavior is arguably unfair and harmful to the children as well as coercive to the parents or guardians. It may be unreasonable to reject such sanctions altogether, but they should be used, in line with our justificatory conditions, only as a last resort when persuasion, removal of disincentives, provision of positive incentives, and nudges fail to work, and only when children's nutritional status and other health indices can be maintained.

The final two rungs (7 and 8) of the intervention ladder involve restricting choice or eliminating choice. Examples of restricting choice include legal requirements that food producers remove certain unhealthy ingredients from their food products and former New York City Mayor Michael Bloomberg's proposed ban on the sale of sugared drinks over sixteen ounces in certain settings. Both would make it more difficult, to different degrees, for consumers to partake of unhealthy foods. Some of what we discussed under step 6 related to disincentives and sanctions for vaccinations would also fall here, for instance, not allowing children to attend school if they have not been vaccinated.

Step 8 goes farther to eliminate choice, sometimes even by forcible confinement. An obvious example is forcibly quarantining individuals who have been exposed to certain communicable diseases, such as SARS, and who do not voluntarily comply with a quarantine order. Another example is forcibly detaining a person with TB who, after efforts to secure his or her cooperation with DOT, still refuses to adhere to the protocol. Among infringements of civil liberties, forcible detention, as a restriction of free movement and association, is easier to justify than forcible administration of the required medication through an invasion of the uncooperative person's body. Indeed, the Nuffield Council on Bioethics (2007) indicates that it is "not aware of any countries that go so far as to force individuals to be vaccinated."

Some public health measures on the final three rungs of the intervention ladder are or may be coercive. In general, they need to pass a higher bar of justification because of their threats to civil liberties. But they can sometimes meet our several justificatory conditions and thus rebut the presumption against their use. Often, however, interventions that stop short of coercion can secure individuals' cooperation without violating their liberties. In such cases individuals voluntarily comply with the recommended public health measures, such as quarantine, vaccinations, or DOT, whatever their motivations for doing so as a result of other interventions. These interventions, as we have seen, may not be objectionable from the standpoint of civil liberties themselves, but they may raise other ethical issues that need attention and resolution in particular circumstances.

Conclusion

In conclusion, we should not overlook, but also should not overemphasize, liberty-limiting interventions in the pursuit of effective public health measures. In public health,

concord with civil liberties is more basic than conflict. However, conflicts do emerge, and several rebuttal conditions, or justificatory conditions, need to be met to justify liberty-limiting interventions. The presumptive limits set by civil liberties can often direct public health officials to find ethically preferable interventions that do not sacrifice effectiveness in the pursuit of important public health goals. Focusing mainly on examples from vaccination, DOT for TB, and quarantine, this chapter has considered a variety of interventions, stressing possible ways to secure individuals' compliance with important public health measures without breaches of civil liberties. In many contexts, individuals voluntarily choose to exercise their civil liberties, such as freedom of movement and association, or waive their rights to civil liberties, such as freedom from intrusion on bodily integrity. In those cases, it is not necessary for public health officials to infringe those liberties.

A distinction between *imposing* community and *expressing* community is useful (Childress 1997). Certainly, in some cases, it is ethically justifiable to impose community, in the sense of enforcing communal responsibilities and obligations, in order to protect or promote public health. However, public health officials can generally avoid imposing community by using the various non-coercive interventions discussed in this chapter. This outcome is more likely if the society has also expressed community by displaying solidarity with and respect for all its citizens and residents. This expression of community, which includes respecting civil liberties and rights and providing adequate resources, can usually generate trust and voluntary cooperation through such measures, coupled with truthful public communication and active public engagement.

Related Topics

Chapter 23, "Incentives in Health: Ethical Considerations," Richard Ashcroft
Chapter 24, "Privacy, Surveillance, and Autonomy," Alan Rubel

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