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# Liberty, Public Health Ethics, and Policy Responses to Covid-19

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ABSTRACT

This paper presents, defends and applies a conception of public health ethics as focused on liberty-limiting public health action. This approach has been persistently criticised, but the criticism is ambiguous between two challenges: that the focus on liberty makes an objectionable presumption in favour of liberal values and that the focus on liberty fails to address institutionalised social injustice. Part One of the paper addresses both challenges to show they can be met by a nuanced account of a liberty-oriented public health ethics. Part Two establishes that debates about policy responses to the current Covid-19 pandemic illustrate and vindicate this conception of public health ethics as focused on liberty-limiting public health action. The discussion then turns to the methodological question as to how public health policies are to be evaluated, focusing particular on the role of normative theory in such evaluations. The methodology of 'wide reflective equilibrium' is described and endorsed; the paper ends with a case study to illustrate this evaluative methodology, focused on the ethics of Covid-19 immunity passports.

## Introduction

This paper is in two parts. Part One presents a conception of public health ethics as focused on liberty-limiting public health action. This has been persistently criticised, but the criticism is ambiguous between two challenges: that to focus on liberty is to make an objectionable presumption in favour of liberal values; and that this approach to public health ethics fails to address institutionalised social injustice. It is argued that there is something in both challenges, but they can be met by a more nuanced account of a liberty-oriented public health ethics. Part Two establishes that this conception of public health ethics as focused on

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liberty-limiting public health action is illustrated and vindicated by debates about policy responses to the current Covid-19 pandemic. Given this, the discussion turns to methodology: how are liberty-limiting public health actions to be evaluated? In particular, what is the role for normative theory in such evaluations? The methodology of 'wide reflective equilibrium' is described and endorsed. The paper ends with a case study – the ethics of Covid-19 immunity passports – to illustrate this evaluative methodology.

## Part One

### 1. Public health ethics and liberty-limiting interventions

Public health actions are state-backed interventions to achieve the principal public health goals of monitoring, protecting and improving the health of populations. Public health actions include a wide range of policies and programmes, such as gathering health information to monitor population health, providing health education to encourage healthy behaviour, and introducing preventive legislation in response to public health emergencies. The current Covid-19 pandemic has necessitated an unusual amount, and unusual sorts, of public health action, including lockdowns, social distancing measures, quarantine, and vaccination programmes.

Public health ethics involves evaluating public health actions to establish their justification. Individual liberty or personal freedom is a major feature of this justificatory exercise. Specifically, there is a focus in public health ethics on public health actions which limit individual liberties or curtail personal freedoms. Crudely, this is because of liberal assumptions about the value of individual liberty and concerns about state overreach. Of course, public health ethicists are not only interested in public health actions which limit liberty nor is the impact on individual liberty the only salient ethical feature of public health actions. Nonetheless, a major concern in public health ethics is to evaluate liberty-limiting public health actions to determine whether such state interference is justified.

This distinctive feature of public health ethics tends to be characterised in terms of 'individual versus community'. In particular, there is said to be a tension between individual rights to self-determination and non-interference, on the one hand, versus the communal benefits of protecting and promoting the health of populations, on the other. This tension is by no means universal,

necessary or essential – liberal values and public health goals are often compatible – but it exists and can create dilemmas. Given the role of the state in adjudicating the trade-offs between these claimants, it has been described as a 'problematic triad' involving individuals, communities and the state (Holland 2010). The aim of the first part of this paper is to provide a highly qualified defence of this way of characterising public health ethics, which has been strongly criticised (Dawson 2010).

Before getting onto the main discussion, it is worth quickly dealing with one way in which describing public health ethics as addressing 'individual versus community' is criticised. The criticism is that a society is made up of more than discrete individuals and the entire population. In between, as it were, are sub-groups of a multi-cultural society which 'cluster around a plurality of shared values, beliefs, doctrines, commitments and ideologies' (Hafez Ismaili M'hamdi 2021: 1). The criticism is that these seem to be left out when addressing problems of 'individual versus community'. But this is easily dealt with by replacing individuals with sub-groups in the original characterisation. In other words, public health ethics sometimes focuses on the tension between the rights of individuals *or sub-groups* to self-determination, and the health of the entire population (Holland 2010: 34).

This is perfectly illustrated by a controversy in the UK at the time of writing. According to the UK government's 'road map' out of lockdown, all Covid-19 restrictions are due to be lifted in England on June 21st 2021. But there is increasing concern about the 'Delta variant' of the virus. This variant is particularly associated with areas in which there are high concentrations of ethnic minority groups known to be vaccine hesitant. This has prompted calls on the government to increase pressure on members of those sub-groups to get vaccinated. But so far the government has refused, relying instead on measures such as 'surge testing', and increasing publicity and vaccination capacity, and stopping short of mandatory or coercive measures. In other words, the government is trading-off the rights of ethnic minority sub-groups to self-determination and non-interference against the public health goals of reducing the effects of the Delta variant of Covid-19.

### 1.1 Criticism of the focus on liberty

So, the conception or characterisation of public health ethics under discussion centres on evaluating liberty-limiting public health actions. And as mentioned, this has been strongly criticised. The basic complaint is that this is a narrow,

conservative conception of public health ethics, one that tends to hinder the advancement of key public health goals. Conversely, there are more radical and ambitious conceptions of public health ethics better suited to a public health agenda. The heart of the complaint is that the focus on liberty-limiting public health actions prioritises individual liberties and the right to non-interference over values closely associated with public health, such as solidarity and social justice, a 'healthy society' in the broader sense. This criticism of a liberty-oriented way of characterising or construing public health ethics began at the origins of the sub-discipline (Beauchamp 1985), continued throughout its short history (Dawson 2010), survived attempts to meet it (Holland 2015), underpins methodological discussions (Rajczi 2016) and, as we shall see, informs the evaluation of responses to Covid-19. So it is important.

The aim in Part One is to analyse this dispute in order to provide a qualified defence of the focus on liberty-limiting public health action in public health ethics. In particular, the criticism of a conception of public health ethics as focused on liberty is ambiguous between two challenges. The first challenge is that a liberty-oriented construal of public health ethics makes a presumption in favour of liberty. The second challenge is that focusing public health ethics on liberty fails to address a social status quo at odds with promoting public health values and achieving public health goals. In response, it is argued here that there is something in both challenges, but a focus on liberty-limiting measures in public health can and should be retained. The upshot is a modified defence of liberty-oriented public health ethics. The next two sections take each challenge in turn.

## 2. The presumption in favour of liberty

The core thought in the 'presumption in favour of liberty' challenge is that a focus in public health ethics on liberty-limiting measures prioritizes liberty over other values. The conception of liberty in play here is the negative conception of liberty as non-interference, as opposed to positive conceptions of liberty as, for example, autonomy or effective freedom (Swift 2019). So, the charge is that focusing on liberty-limiting public health action makes a presumption in favour of mere non-interference. Specifically, the presumption is in favour of non-interference over values central to public health. The practical impact of this presumption is that it biases evaluations of public health actions towards

avoiding non-interference which, in turn, hinders the pursuit of public health goals.

In response, it is crucial to distinguish two sorts of presumptions in favour of liberty. The first is that interference requires justification. The second is that negative liberty trumps all other values. There is a tendency for critics to interpret a focus on liberty in public health ethics as making a presumption of the latter sort. And such a presumption would be objectionable and bad for public health. But the only presumption behind a focus on liberty-limiting public health action is of the former sort, i.e., liberty-limiting public health action stands in need of justification. And this presumption is defensible, unobjectionable, and only appropriately unaccommodating of public health. Trading on this distinction allows us to maintain the focus in public health ethics on liberty – in particular, on liberty-limiting public health action – without thereby hindering the pursuit of public health goals.

### 2.1 The presumption that interference requires justification

Why think that interference requires justification? The simple answer is that all interference requires justification, because unjustifiable interference is objectionable. To take a quotidian example of interference, nothing to do with public health action, suppose someone stops you moving towards, or reaching for, an object. This requires justification. Of course, in a vast range of cases, it is easily and obviously justified (a point to which we return below). The interference might be obviously in one's interests, socially sanctioned, previously consented-to, and so on. All these are justifying reasons or explanations for the interference. But the fact that interference is so often so easily and obviously justified should not obscure the fact that interference requires justification. Put conversely, interference that is not justified – it lacks a justifying reason or explanation (it is not in one's interests, social sanctioned, consented-to, and so on) – is objectionable.

Furthermore, interference in one's life by an authority stands in particular need of justification, simply because a person or institution's claim to authority ought to be justified, as should any interfering action of theirs. Again, this truism can be obscured by the fact that appropriating and exercising authority is so often and readily justified. Familiar authority figures such as parents do not need to continually explain the grounds of their authority over their children, or provide justifying reasons and explanations for their every action, for example. But the fact remains that claims to and exercises of authority stand in need of

justification, for the simple reason that unjustified authority is objectionable arrogation.

And further still, interference in the lives of citizens in a liberal democracy by the state stands in particular need of justification. This is because a defining characteristic of such societies is that non-interference is valued and the individual right to non-interference is respected. Without labouring the political-philosophical point, this emphasis on non-interference is well grounded in both positive and negative ways. The positive grounding is that non-interference is required to allow individuals to devise and pursue their own conception of the good; for example, because they are best placed to judge what is in their interest, and to allow what Mill described as 'experiments in living' (Muldoon 2015). The negative grounding is in perennial liberal worries about state perfectionism and a slide into totalitarianism – worries which are understated by critics of liberty-focused public health ethics – which are in turn based on the tendency for states towards arrogating power and increased authoritarianism. Hence, in the liberal tradition, there is an insistence on preserving negative freedom and resistance to endorsing positive accounts of freedom (see Berlin 1958, bearing mind that, as is now well documented, Berlin's view was not a straightforward endorsement of negative freedom or dismissal of all forms of positive freedom).

The point is that the focus in public health ethics on liberty-limiting state action does make a presumption in favour of liberty of the first sort distinguished above – i.e., state interference in our lives for public health purposes requires justification – but this is entirely appropriate. All interference requires justification; in particular, interference by authorities stands in need of justification, especially when that authority is the state which interferes in the lives of citizens in a liberal democracy. Public health action is just a case in point.

### 2.1.1 A complication: the liberal context of the discussion

This defence of the first sort of presumption in favour of liberty has been explicitly situated within a particular sort of polity, namely, Western liberal democracies such as the UK. This invites at least the following responses. First, this defence of a presumption in favour of liberty is circular: a presumption in favour of liberty is justified by a liberal political culture which is in favour of liberty. A second, similar response is that the defence is question-begging: to appeal to our liberal political culture to support a presumption in favour of liberty is to assume the relative importance of liberal values, which is in question.

Underlying both these is a third response: the defence of a presumption in favour of liberty is ethnocentric; in particular, this discussion would have unfolded very differently in political cultures dissimilar to ours, ones that prioritise negative liberty to a lesser extent, or prioritise values other than non-interference to a greater extent.

The fundamental problem here is that a focus in public health ethics on liberty-limiting public health action is local to a liberal polity whereas public health is a global endeavour. The latter point – the global nature of public health – is perfectly illustrated by the Covid-19 pandemic. This coronavirus has no respect for international borders, and responses to the pandemic have to be international because, for example, there is no point in one country rolling out a successful vaccination programme unless there is access to vaccines in other countries. The pandemic also perfectly illustrates the significance of differences between local political cultures to public health action. In particular, there is an increasing body of work on how both the content and success of responses to Covid-19 vary between polities (Etzioni 2021).

There is an underlying dilemma here. On the one hand, we can pursue public health ethics by focusing on liberty-limiting action: this will centre on justification for state interference for public health, but resultant judgements will only hold within the liberal polity in which the evaluation takes place. Or we can attempt to undertake universally applicable evaluations of public health actions: this conception of public health ethics does justice to the global nature of public health, but it founders on the fact that there is a plurality of political cultures and little prospect of their converging. To put the dilemma extremely crudely: we can do public health ethics in the UK; in which case non-interference will be central, and our judgements will hold here but not in, say, South Korea. Or, we can try to do public health ethics in a way that results in evaluations and judgements that hold in both the UK and South Korea; but this is hopeless, because negative liberty is valued so differently in these two political traditions.

This is an important and complicated issue, but it is not fatal to a liberty-oriented public health ethics. The first thing to say is that the problem is unavoidable. We have to do public health ethics somewhere and, given the plurality of seemingly incommensurable political cultures, the problem will arise wherever we do it. That 'we' are undertaking this discussion 'here' – i.e., in a liberal-democratic polity – influences evaluations and judgements of public health action, but no more so than would be the case if public health ethics was

undertaken in a non-Western or non-liberal-democratic polity: the influences would be different, but equally inescapable.

The other thing to say is that the background to this issue is moral relativism, i.e., the metaethical debate about whether moral judgements are absolute and universal, or are in some way dependent on local moral codes and standards. This helps ameliorate the problem here, because relativism versus absolutism is hardly a debate restricted to public health; on the contrary, it is in the background of evaluations of any sorts of action which, like public health action, takes place both within and between countries. Any such actions – involving trade, counterterrorism, movement of people, and so on – create the tension between a local evaluate perspective (which is not globally shared) and a global evaluate perspective (which does not exist). So, the charge that focusing on liberty-limiting public health action in public health ethics is objectionably ethnocentric is deflected by pointing out that the issue is both unavoidable and hardly unique to public health.

### 2.1.2 The 'intervention ladder'

This sort of presumption in favour of liberty – interference for the sake of public health requires justification – is expressed in the metaphor of the 'intervention ladder', presented first by the Nuffield Council on Bioethics (2007: xix) and now very well known in public health ethics. The idea is that each rung of the ladder represents a public health policy option characterised by how intrusive it is. The bottom rung of the ladder represents entirely non-intrusive responses ('do nothing or simply monitor the current situation'); the top rung represents full-on coercive public health action ('entirely eliminate choice'). Each successive move up the ladder represents increasingly intrusive public health policies: from providing information, to enabling choice, to guiding choice – by changing default options, offering incentives, putting disincentives in place – to 'restricting the options available'.

The ladder perfectly captures the presumption that liberty-limiting public health action requires justification, because we are supposed to start at the bottom. In other words, the presumption is that non-intrusive public heath action is the default, any move above the bottom rung requires justification, and the higher the rung, the stronger the justifying reasons and explanations that are required. All of which is underpinned by the value of non-interference, i.e., negative liberty. Since this section is defending a conception of public health ethics as presuming that interference for the sake of public health requires

justification, and the intervention ladder expresses this presumption, presumably, the metaphor will be endorsed here. It is; but it is also important to remember that it is only a metaphor, should not be taken too seriously, and can be critiqued and embellished.

Griffiths and West's (2015) analysis is a good illustration. They 'replace the one-sided ladder, which has any intervention coming at a cost to autonomy, with a two-sided 'Balanced Intervention Ladder' where intervention can either enhance or diminish autonomy' (p.1092). Their main argument is that the ladder assumes and promotes a negative conception of freedom and autonomy as non-interference, but ignores or devalues positive conceptions of freedom and alternative theories of autonomy. They argue for building these into evaluations of public health interventions, which necessitates modifying the intervention ladder.

The way Griffiths and West advertise different conceptions of freedom and autonomy to public health ethicists is important (Holland 2015: 55-62), and these different conceptions might require some embellishment of the metaphor of an intervention ladder. But there is no fundamental objection to the point of the original metaphor, which is that non-intervention does not require justification, interference for public health does require justification, and greater interference requires stronger justification. For one thing, most interventions which promote positive freedom or enhance autonomy are not particularly contentious. This is demonstrated by Griffiths and West's illustrative policies – health education and information, counter-manipulation, nudges, and so on – all of which fall well short of coercion. And where such a policy actually does infringe on negative freedom – Griffiths and West discuss a communal decision to ban the sale of alcohol – they rightly recognise that it is contentious and requires stronger justification, which is the point of the original 'ladder' metaphor.

The best way to think of promoting positive freedom or enhancing autonomy is as ways of justifying intrusive public health action, not as a deep objection to the conception of public health ethics expressed by the intervention ladder. In fact, promoting positive freedom or enhancing autonomy were built into the original metaphor as 'educate the public', the ladder's second rung, indicating that it requires very little by way of justification since it does not come at a high cost to individual liberty. The important point is that the more intrusive the intervention, the more it needs to be justified by, in the example under discussion, promoting positive freedom or enhancing autonomy. So, for

example, health education is not restrictive so requires little by way of promoting positive freedom or enhancing autonomy to be justified. But for the state to force restaurants to provide certain items for the sake of positive freedom or autonomy – one of Griffiths and West's illustrations – it had better be true and proven that this policy works well enough to justify such intrusion. In sum, promoting positive freedom or enhancing autonomy are putative justifications for interventions, not fundamental objections to the conception of public health ethics expressed by the intervention ladder.

### 2.2 The presumption that liberal values trump public health values

Subsection 2.1 clarified and defended a presumption in favour of liberty that amounts to seeing public health action as standing in need of justification. This subsection rejects the other sort of presumption in favour of liberty distinguished above, namely, that liberal values trump other values, in particular, values associated with public health. The issue here is the relative weight to be attached to values when evaluating public health actions; in particular, the weight to be attached to the value of non-interference relative to other values. It is argued here that non-interference does not automatically trump other values relevant to public health action, but we need a nuanced account of the way negative freedom relates to values other than non-interference.

#### 2.2.1 Refinements: liberties of different sorts

Powers et al. (2012) provide an excellent template for this. They start by exposing a naïve application of Mill's political philosophy to public health, one which grounds 'a general presumption in favor of liberty such that a burden of proof lies with the proponent of any state intervention that interferes with its exercise' (p.6). This sounds very much like the presumption in favour of liberty defended in the previous subsection – and no one wants to be called naïve – so it will be instructive to look at what Powers et al. say about this way of framing public health ethics.

They say that Mill rejects any general presumption in favour of liberty; rather, he distinguished three sorts of liberty interests that enjoy an unequal presumption in their favour. First, 'interests that are immune from state interference' include liberties of conscience and (increasingly contentiously) expression and (some forms of) conduct, over which the individual is sovereign. Second, 'interests that enjoy a presumption in favor of liberty' are not immune from state interference but are 'still weighty enough to warrant a moral

presumption in their favor, but unlike cases involving matters over which the individual is sovereign, they properly may be subject to some balancing'. Third, 'interests that enjoy no such presumption [in favor of liberty]', because, unlike the first two sorts of liberty interests, which are covered by Mill's Principle of Liberty, the third is covered by Mill's doctrine of Free Trade.

Powers et al. have provided a taxonomy of interests distinguished by Mill according to whether, and in what sense, they enjoy a presumption in their favour. This is an interesting exegesis, but the important point is that it is not at odds with the liberty-oriented approach to public health ethics defended in this paper. On the contrary, Powers et al.'s taxonomy is an important template for how to make the approach defended here more sophisticated, not a deep objection to the approach. To reiterate, the conception defended here is that of public health ethics as a justificatory exercise: state action for public health requires justification, and the more intrusive it is, the greater the justification required. This is entirely compatible with the sort of refinement of public health ethics illustrated by Powers et al.'s argument.

For example, the fact that some liberty interests are immune from state interference – Powers et al.'s first category of interests – is simply to say that some intrusive public health actions would be unjustifiable. Enormous public health gains could be achieved by managing people's sex lives, reproductive decisions, and so on, but we disallow the state access to and authority over such personal matters. Powers et al.'s second sort of liberty interests are entirely in keeping with the conception of public health ethics advocated here; in fact, weighing liberty interests of this sort – weighty enough for a presumption in their favour, but appropriately balanced against other considerations which can override them – just is public health ethics as construed here.

The third sort of interests Powers et al. identify is a little more complicated, because these are grounded in Mill's doctrine of Free Trade, not his Principle of Liberty, so it looks as though negative liberty as the right to non-interference is irrelevant. But this third sort of interest is not at odds with the conception of public health ethics presented here. Powers et al. illustrate this third category of interests:

> various forms of consumer product regulation and mandatory hazard labeling, state registries for the purchase of dangerous substances, laws regulating product adulteration, worker safety and wage laws and a whole host of contract and other marketplace regulations ... Such regulatory targets are precisely the sorts of matters that many traditional public health interventions are designed to

address (p.8)

Even if the individual liberties of the citizenry are not directly affected by such 'regulation' – and they often will be, for example, when aggressive consumer product regulation determines that a product is made unavailable to a consumer – Powers et al. make perfectly clear that these 'traditional public health interventions' stand in need of justification. The justificatory exercise will involve 'the balancing of societal interests in overall economic efficiency and societal interests in public welfare protection', as opposed to directly trading off individual liberty rights to non-interference and public health values, but the focus is still on justifying public health action, as advocated for here.

Not only is the conception of public health ethics defended above compatible with Powers et al.'s refinement, in fact, they do an excellent job of grounding it. Part of their argument involves asking why Mill wanted to protect liberty, because answering that will help establish which interests enjoy which sort of presumption in their favour. Their answer is that Mill saw 'the essential role that the value of self-determination plays in human well-being'; later, they describe this as 'the distinctly moral interests that individuals have in directing and shaping their own lives' (pp.7-8). And this is precisely why public health actions which intervene in people's lives stand in need of justification: self-determination, and directing and shaping one's life, are highly valuable, so state interference for public health purposes requires justification.

So, the conception of public health ethics advocated in this paper is liberty-oriented only in the sense that public health action that limits negative liberty requires justification, but not to the extent that liberal values – non-interference, basically – trump other, public health oriented values. Powers et al. (2012) illustrate the sort of refinements that can be made to this conception by distinguishing liberty interests of various sorts and weights.

### 2.2.2 Resources to justify public heath action

We can go further in appeasing critics of the approach to public health ethics taken here who are worried about liberal values trumping others. As suggested above, concerns about focussing on liberty-limiting public health action are fuelled by the worry that this hinders public health. But such worries are largely ungrounded for the simple reason that it is very easy to justify a great deal of public health action. Here is a non-exhaustive list of ways (see Rajczi 2016. Cf. Weinstock's (2016: 125) comment that the 'practice of public health has always been difficult for political philosophers of broadly liberal sympathies to justify

(Holland, 2015: 48–62)': as will be evident from the ensuing discussion, this is not my view, and is based on a very partial reading of Holland (2015)).

For one thing, the presumption in favour of liberty defended here is that interference for the sake of public health requires justification; but lots of public health escapes this stricture simply because it does not interfere in the lives of the citizenry. People do not even notice a good deal of standard public health practice, such as routine surveillance and health monitoring. Since such standard practices do not infringe on negative liberty, they are unobjectionable, do not require justification, and are unhindered by the focus in public health ethics on liberty-limiting public health action.

Furthermore, lots of public health action expressly preserves negative liberty. Public health nudges are a perfect illustration. Nudging is the practical application of the 'libertarian paternalism' advocated by Thaler and Sunstein (2008). The basic idea is well known. Behavioural sciences reveal that people's decision making is influenced by unconscious cognitive biases. Planners can use those cognitive biases to 'nudge' people towards certain options. This is paternalistic when planners nudge people towards options that are in their best interests. But it is libertarian in that no options are removed and the cost of resisting nudges is very low, so people remain free to choose however they like. Public health has enthusiastically adopted nudging (Holland 2014), but the point here is that nudging illustrates public health actions that are explicitly designed to preserve individual freedom of choice, so clearly not at odds with a focus on liberty-limiting public health action in public health ethics. Nudge is only an example: there is a great deal of soft paternalism in public health – autonomy-enhancing health education and information, and so on – which explicitly respects individual freedom of choice, so is unhindered by focusing on liberty-limiting public health action.

Further still, lots of public health action that does interfere in people's lives is not contrary to their will and therefore unobjectionable. There are two things to discuss here. First, a strong theme in public health ethics is that seemingly objectionable infringements on people's freedoms do not contravene their will on subtler or more sophisticated accounts of freedom of the will and individual autonomy. There are a number of versions of this idea: we encountered one in the previous discussion of Griffiths and West's (2015) appeal to positive conceptions of freedom and autonomy; others include Frankfurt's (1971) famous distinction between first-order and second-order desires, Nys' (2008) notion of 'deep autonomy', and so on. A simple illustration of the general

approach is the smoker whose first-order desire is for a cigarette, but whose second-order desire is not to be a smoker. Suppose a public health policy limits the smoker's freedom to smoke: is this objectionably illiberal? This depends on whether it contravenes their will and, focusing on their first-order desire, it might seem to do so; but the policy aligns with their second-order desires or accords with their 'deep' autonomy (or whatever version of the idea is in play) so, in that sense, does not contravene their will and is therefore unobjectionable.

The second thing to discuss is whether public health action which intervenes in the lives of citizens in a democracy is justified by the democratic mandate. One might think as follows. Public health action is state action. In a democracy the electorate have chosen the government. So, state action for public health is in accordance with the will of the people. Given this, all public health action – even that which restricts negative liberty – is unobjectionable. But this line of thought is surely too quick. Objection to liberty-limiting public health action not only persists in, but is particularly associated with, liberal democracies, despite the democratic mandate. And it is easy to see why the democratic mandate does not justify all intrusive public health action: in complex democratic societies lots of people did not vote for the successful political party, lots of those who did are disappointed by the policy options their party takes when in office, and no one feels that they consent directly and individually to a particular government action (Holland 2009: 288-289).

But although it is clearly not the case that all liberty-limiting public health action is justified by the democratic mandate, some might be. We can distinguish public health interventions according to how plausible it is to appeal to the democratic mandate for their justification. For the sake of brevity, consider two paradigms. Suppose a well-publicised, well-understood and much discussed restrictive public health policy goes to a referendum and there is a big turnout and a clear majority in favour. Of course, some individuals will be disappointed, but in some sense 'the people' have consented to the restriction, which is an expression of the will of 'the people' and, as such, this restrictive policy is democratically justified. By contrast, a restrictive public health action which was not in a governing party's manifesto, not endorsed by a referendum or any other form of participatory democratic procedure, and which is clearly unpopular amongst the electorate, would not be justified by a democratic mandate.

So, lots of standard public health action does not interfere in people's lives, and some that does is not against their will. We can go even further. One of the

best established ways of justifying intrusive public health action is very familiar from both the liberal tradition and public health ethics. This applies Mill's harm principle that 'the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others' (Mill 1975). Mill called this a 'very simple principle' and the basic point is simple: state coercion – i.e., forcing free citizens to do or desist from something against their will – is justified to avoid third party harms; conversely, for the state to coerce individuals to benefit themselves or others, or to avoid harming themselves, is not justified. But the principle is far more vexed than this suggests. To mention just a few controversies: is avoidance of third party harm a necessary or sufficient condition for coercive state action? What precisely is meant by 'harm', and how can this be defined other than by reference to the sorts of things it would be legitimate for a government to force people to avoid perpetrating on others, which would be blatantly circular? How does the principle cohere with Mill's suggestion that people can be compelled to perform 'positive acts for the benefit of others ... such as ... joint work necessary to the interest of [one's] society'?

Notwithstanding such controversies, lots of liberty-limiting public health action is fully and easily justified by appeal to the harm principle. Population health is often informed by the way individuals interact with one another, which creates lots of potential third party harms and, in turn, lots of liberty-limiting state action justified by the harm principle. This is readily illustrated by the current Covid-19 pandemic. The Covid measures imposed in, for example, the UK are unusually restrictive of personal freedoms, but coercion is justified to ensure that individuals avoid harming others by transmitting the disease. In addition to such straightforward applications, lots of intrusive public health action has mixed aims, including avoiding third party harms, so is justified by the harm principle. A classic example is the UK ban on smoking in certain public places. The ban is partly to avoid the third party harm to bar staff and others of passive smoking, and partly to motivate smoking cessation by, for example, making smoking less convenient. But the ban is justified by the former consideration, i.e., to avoid third party harms, because this brings it under the harm principle.

Lots of public health action is easily justified by the harm principle, but we can go even further, because liberty-limiting public health policies that are not obviously legitimate are justified on further reflection. Evaluating intrusive public health policies and restrictive interventions to enquire into their

legitimacy is informed by lots of considerations, including identifying and weighing relevant values – liberal and, of course, others, where liberal values are not trump cards, as discussed above – and applying principles (such as the harm principle), and attending to particularities of the case, such as, which freedoms the policy restricts and the likelihood and importance of potential public health gains. Part Two, below, discusses this justificatory exercise as a process of 'wide reflective equilibrium'; the point here is that the upshot of such reflection is often to endorse liberty-limiting public health actions which were not obviously or easily justified at the outset.

None of this is to deny that the outcome of the evaluative exercise might be that the policy in question is not justified. In other words, some public health action will be objectionably illiberal and therefore illegitimate. In particular, there will be a residue of hard cases, i.e. public health actions that create dilemmas between individual liberty and public health goals, because their legitimacy remains contestable even after well-informed reflection. An obvious example is hard paternalism, i.e., to what extent and in what ways is it legitimate for the state to force people to act in their own interests, against their will and without their consent? But that is exactly how it should be: the legitimacy of liberty-limiting public health policies is always in question, resulting in principled but contestable limits on public health action.

## 3. Failure to address background injustice

In Section 1. criticism of a conception of public health ethics as focused on liberty was said to be ambiguous between two challenges. The first challenge is that a liberty-oriented construal of public health ethics makes a presumption in favour of liberty; this was discussed in Section 2. The second challenge – that a focus in public health ethics on liberty-limiting public heath action fails to address a social status quo at odds with promoting public health values and achieving public health goals – is discussed in this section.

We can clarify this second challenge by focusing on social determinants of health. Health status is not simply a consequence of people's autonomous decisions. On the contrary, social determinants are 'conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life' (WHO 2021; cf. Solar and Irwin 2010). Although there is no agreed list, WHO examples of social determinants are typical and include income and social protection, education, working life

conditions, food insecurity, housing, early childhood development, social inclusion, and structural conflict. These are not directly medical factors, but they influence health outcomes, often to a greater extent than health care or individual health behaviour. Crucially, social determinants are unequally distributed, resulting in marked health inequalities between social groups.

The challenge under discussion is that research on social determinants of health reveals low and unequal health status to be a matter of social injustice, and orientating public health ethics around liberal concerns about state interference will fail to address this. For one thing, it is the wrong focus: fussing over whether a liberty-limiting public health action is justified seems trivial compared to tackling the morally outrageous differences in people's 'conditions of daily life' resulting in such unfair health outcomes, and hardly seems like a proper ethics of public health. For another thing, this way of approaching public heath action is bound to leave social conditions unaltered, because of the emphasis on negative liberty as non-interference: how are we to address matters of social injustice by not interfering? Conversely, tackling low and inequitable health outcomes caused by unequal distribution of social determinants will surely require a good deal of interference.

The fundamental issue here is that there are two evaluative perspectives to take in public health ethics. The first perspective focuses on discrete public health actions to ask whether each is justified. The second perspective is wider and has within its purview the conditions or context in which public health actions take place. Broadly speaking, the former perspective invites a particular concern with individual liberty, but the latter perspective seems altogether more significant and far-reaching. The tension between these perspectives is important but, arguably, does not obviate a focus on liberty in public health ethics.

For one thing, evaluating liberty-limiting public health actions – which is required unless they are to go unscrutinised – is compatible with full recognition of the outrageousness of health inequalities, the importance of addressing social determinants of health, and the need for a radical agenda of social reform. Not only are they compatible, the two perspectives – on individual state action for public health and on wider social conditions and factors – are interrelated, because whether a particular public health intervention addresses social determinants or reduces health inequalities must be built into its evaluation. For example, a public health intervention that curtails individual freedoms might well be justified precisely because it addresses unequally distributed social

determinants and reduces health inequalities. Hence, attempts to systematise evaluations of discrete public health actions include social determinants and health inequalities: for example, Ferrinho et al.'s (2020) 'seven principles to guide public health best-practices' includes 'the equity principle'.

In addition, the awkward interplay between these two evaluative perspectives is hardly unique to public health ethics; on the contrary, it arises in any public policy debate. To illustrate, consider the long-standing debate in Developing World Bioethics about the legitimacy of clinical trials by Western pharmaceutical companies in low-income countries (Angell 1997). The same two evaluative perspectives are available. To take the first is to focus on and evaluate individual trials, commentators arguing plausibly that some trials are exploitative but nonetheless permissible, because they are consensual and mutually beneficial (Wertheimer 2010). To take the second perspective is to put the trials in the context of the systematic and institutionalised global injustice – what Malmqvist (2017) calls 'background injustice' – that makes the trials possible in the first place. And the same response seems warranted: individual ongoing trials require evaluation unless they are to go unscrutinised; this is compatible with outrage at, and attempts to tackle, global injustice; and the two projects interrelate because, for example, systematic evaluation of trials must include whether they worsen or improve 'background injustice'. This is only an illustration and, as suggested above, these two evaluative perspectives are available on any public policy issue, so there is no strong objection particular to a liberty-oriented approach to public health ethics here.

## Summary of Part One

Part One presents a qualified defence of a conception of public health ethics as focused on the justification for liberty-limiting public health actions. This is persistently criticised as narrow and conservative, and at odds with public health. It has been argued that this criticism is ambiguous between two challenges: first, this conception makes a presumption in favour of liberty; second, it fails to address social justice concerns in public health. Regarding the former, the conception of public health ethics defended here does assume that state interference for the sake of public health requires justification, but not that negative liberty as non-interference trumps other values in a way that unwarrantedly hinders public health. Regarding the latter, evaluating liberty-limiting public health policies is compatible and interrelated with another

evaluative perspective, one that addresses social injustice and health inequalities, as is the case in other controversial public policy debates.

## Part Two

### 4. Public health ethics and Covid-19

Covid measures are public health actions as defined at the outset: state-backed interventions to achieve principal public health goals, in this case, the overall goal of protecting the population from a public health emergency. And as also stated at the outset, the Covid-19 pandemic has required unusual amounts and sorts of public health action. These measures are all too familiar so a quick overview of some of the main ones will suffice.

Lockdowns have imposed massive restrictions on the movement people. International travel is banned or strict requirements such as quarantining measures are imposed on permitted travel. Workplaces are closed which, at best, requires people to work from home and, at worst, causes unemployment and the collapse of viable businesses. School closures necessitate home education. Requirements are imposed on individual behaviour, including social distancing, wearing masks in public places, and hand sanitizing. There is a host of measures around testing and tracing: testing is compulsory in some workplaces and for school children returning to reopened schools; a positive test for Covid-19 triggers a series of interventions, such as the UK government's 'track and trace' system which communicates the legal requirement to self-isolate for ten days. And various Covid vaccination policies are under discussion, including mandatory vaccination for some workers, such as healthcare staff, and some form of 'vaccine passport' to demonstrate vaccine status.

One of the reasons for labouring a conception of public health ethics as oriented around liberty concerns in Part One of this papers is that this conception is perfectly illustrated and vindicated by debates about responses to the Covid-19 pandemic. Covid measures of the sort just sketched – from lockdowns to hand sanitizing – are taken to be discrete public health actions. The central question about each is whether it is justified. This necessitates an evaluation of the measure in question. Central to this evaluative exercise is liberty – negative liberty as non-interference – the central question being whether the infringements on individual liberties and restrictions on personal

freedom are justified. In sum, debates about Covid measures just is public health ethics as construed in the first part of this paper.

There are two caveats to this. First, the claim that the debate about Covid measures illustrates and vindicates a conception of public health ethics as oriented around liberty is restricted to liberal democracies such as the UK. But this was fully discussed in 2.1.1, where it was argued that, whilst a liberal conception of public health ethics does not universally apply, this is not fatal to that conception. To reiterate, we have to do public health ethics somewhere and we are doing it in a liberal political context; and the tension between locally and globally applicable judgements on public policy is not particular to, so not particularly problematic for, evaluations of public health measures.

The second caveat is that curtailing individual freedoms is not the only focus of ethical discussions around Covid-19. Questions such as which patients should have access to ventilators, or about the obligations on wealthy nations to make vaccines available in low-income countries, are not centred on individual liberty. Arguably, these are not obviously topics in public health ethics, the former being part of the long-standing discussion about the just allocation of scarce resources in Bioethics, the second being part of the wider issue of global development. But nomenclature is not important: 'public health ethics' could be stipulated to include these topics, and the point would still stand that liberty is central to the public health ethics of Covid measures.

More specifically, detailed aspects of the liberty-oriented conception of public health ethics defended in Part One is illustrated by debates about Covid measures, including their instigation, modification, and withdrawal. For example, regarding whether to instigate an intervention, the single biggest criticism of the UK response to Covid-19 is that the government did not impose a lockdown quickly enough. Why not? Because the UK Prime Minister is avowedly 'libertarian' and was reluctant to impose such restrictions on civil liberties and personal freedoms. Having instigated a measure in response to the pandemic, the ensuing debate results in to-ing and fro-ing over specific versions of the policy. Variants of lockdowns (such as 'tiers systems'), testing, quarantining, vaccine rollout, and so on, are policy modifications perfectly depicted as rungs on the intervention ladder discussed in 2.1.2: the higher the policy rung (such as moving an area into a higher tier), the greater the justification required (in terms of transmission, hospitalizations and deaths). Regarding withdrawing interventions, the UK Government's main aim is to

'return to normal' as soon as possible in order to restore the civil liberties and personal freedoms restricted by Covid measures.

More specifically still, the nuanced liberty-oriented approach to public health ethics defended in Part One maps onto the public health ethics of Covid measures. To recall, the upshot of the discussion of a presumption in favour of liberty was that any state interference for public health requires justification (2.1), but liberal values do not trump other values (2.2). This is mirrored in debates about Covid measures. The assumption from the start of the pandemic has been that liberty-limiting policies require justification; the greater the interference, the greater the justification required; but where interference is warranted, it is permissible and even obligatory. And, as discussed in 2.2.2, justification is neither hard to come by – Mill's harm principle alone justifies lots of intervention, given the third-party harm of infecting others – nor difficult to concur with (compliance with liberty-limiting Covid policies has been remarkably high). So, liberty is central to the debate but hardly a trump card, given the amount of justifiable state interference with which people have complied. In fact, weighing negative liberty too highly has been widely castigated, an obvious example being the UK's failure to lock down earlier, as just mentioned.

The other main point of discussion from Part One also applies to the Covid measures. To recall, Section 3 identified a criticism of liberty-oriented public health ethics, namely, that it fails to address issues of social injustice, such as social determinants of health. In response, it was argued in Section 3 that this is not fatal, because a focus on liberty is not inimical to addressing social injustice, the two projects are interrelated, and these two evaluative perspectives – on discrete liberty-limiting public health actions and on 'background injustice' – are available on any public policy issue. All this is illustrated by debates about policy responses to the pandemic. Focussing evaluations on the liberty-limiting aspect of the measures is entirely compatible with addressing aspects of 'background injustice'. Intra-nationally, for example, the disparate impact of Covid-19 has done more than anything in recent years to highlight disparities and inequities between social groups in, for example, the UK. And internationally, the unfairness of global injustice has been forcibly revealed by vaccine nationalism, because wealthy nations cannot protect their populations unless everyone, including people in low-income countries, is protected.

## 5. Methodology: reflective equilibrium and the role of normative theory

The previous section described how debates about Covid measures illustrate and vindicate the focus on liberty in public health ethics defended in Part One. The rest of this paper focuses on methodological issues arising from this. How, precisely, are liberty-limiting public health actions to be evaluated? This section outlines the preferred methodology, namely, wide reflective equilibrium; the next section contains a case study to illustrate this approach. To work into this, consider a puzzle about the role of normative theory in evaluating public health actions.

A descriptive judgment is about what is the case – for example, smoking increases the risk of lung cancer – whereas a normative judgement is about what ought to be the case (such as, you ought to stop smoking). So, normative theories are intended to inform us about right action, or what ought to be done. Two sorts of normative theories are relevant: moral theory focuses on right action by individual agents; political theory addresses how governments and other state agents ought to act. Traditional moral theories include consequentialism (principally, utilitarianism); deontological theories (notably, Kantianism); virtue ethics; and Principlism. Political theories include liberalism, alternatives such as communitarianism, and theoretical perspectives within such traditions, for example, Mill's Harm Principle, as discussed in 2.2.2. There are alternatives to and variants of all such normative theories – act versus rule utilitarianism, Aristotelian versus other sorts of virtue ethics, libertarianism as opposed liberalism, etc. – and important non-traditional normative theoretical approaches, such as ethics-of-care, feminism, and personalism.

A precise taxonomy is not important here. What is important is that normative theories have been consistently applied in evaluating public health interventions throughout the brief history of public health ethics as a sub-discipline. Some commentators apply moral and political theory to public health ethics in general (Holland 2015); more frequently, specific moral or political theories are applied to discrete public health interventions or policy issues (Christie, Groarke, and Sweet 2008; Rajczi 2008). At the time of writing, the flow of papers applying normative theories to Covid measures is predictably and steadily increasing, as one commentator drily observes: 'All standard ethical theories made cameo appearances in the discussion' (Häyry 2021). Illustrative examples include applying utilitarianism (Savulescu, Persson, and Wilkinson

2020), virtue ethics (Bellazzi and Boyneburgk 2020), and political philosophy (Fusiek 2020).

But on reflection such appeals to normative theory in public health ethics are puzzling. There is a dilemma between normative theories having too big and too small a role in evaluating public health policies. To illustrate the former, an algorithmic approach consists of identifying a correct moral or political theory and applying it to an intervention to churn out an evaluative result. A crude example would be to subscribe to a very basic form of act utilitarianism, apply it by asking whether the policy in question would maximise utility, and conclude that the policy is ethically sound because it would. This is obviously too big a role for normative theory. No one thinks evaluations should proceed in this way. For one thing, there is no consensus on normative theories, so this kind of algorithmic approach either shifts the discussion back to whether the applied moral or political theory is correct, or commentators seem dogmatic and in the grip of their preferred theory.

The latter part of the dilemma is too small a role for normative theory. One version of this has been dubbed the 'redescription problem' (Holland 2015: 238-241): public health interventions are controversial when they create tensions between different values and competing goals, and normative theorising only succeeds in redescribing these tensions in academic jargon. For example, familiar talk of 'the nanny state' gets rendered in terms of autonomy, paternalism, negative liberty, and so on. Clearly, to redescribe a controversy is not to resolve it. In the background here is the worry that most people – including those making policy decisions – are simply unaware of normative theories, and for those familiar with them (academics, mainly), their main role is to provide post hoc justification for what commentators already think about a public health policy. For example, a more community-minded academic will (unsurprisingly) vindicate their view by appealing to communitarianism, whereas a more individual-freedoms oriented academic will rely on resources within the liberal tradition. Evidently, this is not a substantive role for normative theory in evaluations.

The question is how to avoid these pitfalls and retain a role for normative moral theory in public health ethics. The most promising response is 'wide reflective equilibrium'. This methodology goes back to mid-20th Century pursuit of inferential rules (Goodman 1955), was formulated by Rawls (1971), and Daniels (1979) clarified its application; for an overview see Daniels (2020). The basic idea is to undertake a justificatory process comprised of reflecting on

our background theories, mid-level principles, and considered judgements about specific cases, in order to bring them into equilibrium. This gives normative theories – including the moral and political theories most relevant to public health ethics – the right role in the justificatory process: indispensable, but neither privileged nor foundational. Further, reflective equilibrium is 'narrow' when theories and principles we are inclined to hold cohere with judgements we are inclined to make. Although this can offer insights, it seems limited to revealing and clarifying a person's moral belief system. By contrast, 'wide reflective equilibrium' involves testing our preferred theories, principles, and considered judgements against plausible, well-developed alternatives in order to ensure they are justified.

Reflective equilibrium features in public health ethics literature, but often briefly and perfunctorily (Allen 2011). And more detailed discussions are questionable on various grounds. For example, Latham's (2016: 140-142) objections to reflective equilibrium in public health ethics – such as, political theories are only partially right – apply better to narrow as opposed to wide reflective equilibrium, a distinction he does not make. Walker's (2018) three-tiered schema for reflective equilibrium in public health ethics is promising, but seems overly focused on mid-level principles, whereas none of the tiers is more important than the others in the reflective process; it also seems to confuse principles with goods, such as housing and physical security. Rajczi (2016) argues that liberalism is the right theory for public health ethics, because it is the one we arrive at in reflective equilibrium. This is sophisticated, but it privileges liberalism, whereas the aim and upshot of a process of reflective equilibrium should not be a defence of a particular theory, because a fundamental tenet of the approach is that no component – theory, principle or considered judgement – is immune from revision.

In sum, wide reflective equilibrium is a promising methodology for ethical evaluation of public health interventions, not least because it gives normative theories the right role (indispensable but neither privileged nor foundational), but the frequent appeals to reflective equilibrium in the public health ethics literature are not compelling. So the next section is a case study intended to illustrate this methodology in public health ethics.

## 6. A case study: immunity passports

Immunity passports are a proposed policy response to the pandemic, the basic idea being to lift restrictions from individuals who can prove they are immune to Covid-19. There are lots of specific versions of such a policy depending, for example, on what is being certified (immunity or vaccination status) and how it is certified (paper versus digital certification; bespoke certificate or medical records, and so on). The ethics of immunity passports has been much debated, but this section focuses on a recent dialogue between Brown et al. (2021a, 2021b) and Baylis and Kofler (2021), the broad contours of which are as follows. Brown et al. (2021a) cautiously support immunity passports. Baylis and Kofler (2021) say this is undergirded by the political philosophy of liberal individualism, which they reject, arguing that problems with immunity passports only come into view from the perspective of a different political philosophy, namely, communitarianism. Brown et al. (2021b) respond by denying an overemphasise on individual liberties or unwarranted commitment to liberal individualism, pointing out the interconnectedness of individual interests and the common good, and that restoring liberties is compatible with communitarian thinking.

The main reason for focusing on this debate is that it elucidates the methodology of wide reflective equilibrium in public health ethics. But, in passing, the debate also nicely captures the theme in Part One, namely, how to orientate public health ethics innocuously around liberty. The debate starts with, and is oriented around, negative liberty. For example, Brown et al.'s (2021a) positive argument for immunity passports starts, 'a strong presumption should be in favour of preserving people's free movement', and the whole thrust of their argument is that individual liberties should be restored as soon as is feasible. But it is clear from the dialogue that this 'presumption' is the one defended in Part One, Section 2, above – i.e., restrictions require commensurable justification – and not the more extreme presumption that liberal values (such as freedom of movement) exclude or trump other values (including public health values, such as solidarity). Furthermore, that orientating evaluations around liberty is compatible with a full recognition of background or structural injustice – as argued in Part One, Section 3, above – is clear from Brown et al.'s appreciation of objections to immunity passports based on impacts on marginalised groups and existing inequalities.

But the main reason for focusing on this debate is that it elucidates the methodology of wide reflective equilibrium in public health ethics. Specifically, the debate can be read as either a bad way of going about public health ethics, or as an exemplar of wide reflective equilibrium. The bad way is to argue for or against a public health intervention on the basis of a prior commitment to a theory. In this case, Brown et al. apply liberal individualism, whilst Baylis and Kofler apply communitarianism, to the evaluation of immunity passports. Clearly, this is a specific version of the general problem of allowing too big a role for normative theory in public health ethics, as described in the previous section. It is bound to result in theoretical to- and fro-ing, each side of the debate trying to convince the other of the merits of their theory. And it will produce inaccurate analyses: in this case, applying liberal individualism will understate negative effects of using immunity passports; applying communitarianism will understate the feasibility of using immunity passports to restore liberties.

Impugning their dialogue with this sort of algorithmic approach is highly uncharitable to these experienced public health ethicists. Much better to appreciate that both the style and the substance of their debate exemplifies wide reflective equilibrium. All three components of wide reflective equilibrium are involved here. First, background theory: as we have just seen, these interlocutors explicitly appeal to normative political theories, namely, liberal individualism and communitarianism. There is also implicit appeal to normative moral theories, for example, utilitarianism is implied in discussions of the benefits to society of lifting restrictions on immune individuals. And there is explicit appeal to non-normative scientific evidence and theories, including behavioural sciences. Second, mid-level principles also figure in the dialogue. For example, Brown et al. (2021a) discuss privacy, the 'right to privacy' being one of Walker's (2021: 15) mid-level principles in his schematic representation of reflective equilibrium. And the requirement to reduce inequalities is also a mid-level principle; for example, the 'equity principle' is one of Ferrinho et al.'s (2020) seven principles for public health ethics. Third, the discussion includes numerous considered judgements about, for example, the likelihood that immunity passports will create perverse incentives or worsen discrimination.

The way these components interact in the dialogue exemplifies the methodology of wide reflective equilibrium. For one thing, the dialogue gives background theories the right role: indispensable, but neither privileged nor foundational. Take, for example, Brown et al.'s (2021b) insistence that a concern to restore liberties is 'compatible with communitarian thinking'. This

is best interpreted as acknowledging that we need both background theories – liberal individualism and communitarianism – to inform reflection to achieve equilibrium. Another example is that the hallmark of wide (as opposed to narrow) reflective equilibrium is that we test our theories, principles and judgements against well-developed and plausible alternatives. The dialogue exemplifies this: Brown et al.'s (2021a) support for immunity passports was exposed to Baylis and Kofler's (2021) communitarian thinking, resulting in refinement and readjustment of their position (Brown et al. 2021b). Further contributions by these interlocutors, or by other public health ethicists entering the debate, as necessitated by changes to the context in which immunity passports are proposed, iterate this process of bringing theories, principles, and judgements into wide reflective equilibrium.

### Summary of Part Two

Part One clarified and defended a conception public health ethics as oriented around liberty. The basic premise of the discussion in Part Two is that this conception is perfectly illustrated and vindicated by debates about Covid measures. This introduced the methodological question as to how to evaluate liberty-limiting public health policies, including responses to the pandemic. In particular, what is the role of normative theory in this? The basic problem is a dilemma between too big and too small a role for normative theories. In response, the method of wide reflective equilibrium was advocated: the way to evaluate public health action is to bring background theories, mid-level principles, and considered judgements into wide reflective equilibrium. This give normative theories – moral and political – the right role, i.e., indispensable, but neither privileged nor foundational. This preferred methodology was illustrated and clarified by reference to a recent dialogue about the ethics of immunity passports.

## 7. Concluding remarks

The overarching theme of this paper is a conception of public health ethics as focused on liberty-limiting public health action. This conception was clarified and defended in Part One, and illustrated by reference to Covid measures in Part Two. The main motivation for the paper is to reduce the tension around this focus on liberty, so it will be worth reiterating some of the main claims. First, that a public health action limits liberty is a sufficient, but not a necessary,

condition for the attention of public health ethicists. In other words, if a policy limits liberty then it is of interest, but there are lots of public health ethics concerns other than liberty, such as triaging intensive care beds and vaccine nationalism – to reiterate a couple of examples from the current pandemic – and, as argued in Section 3, background or structural injustice. Second, to be concerned with liberty in public health is not to stymie public health unnecessarily: vast amounts of public health practice need no justification, because it does not limit liberties, or is easily and readily justified, or is justified on wider reflection. Third, this position is illustrated and vindicated by debates about policy responses to Covid-19, because the fact that these policies limit liberties or restrict freedoms has been one (though not the only) major focus in these debates. So, the overall aim of this article has been to present a nuanced account of the focus on liberty in public health in order to show that, in Allen's (2011: 260) words, 'the tension between liberty and health is often overstated and much can be done to relieve this tension'.

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