

# THE DANGERS OF 'PUBLIC HEALTH'

*What was once a concern about public goods has transformed into a social crusade with a political agenda.*

◆ BY PIERRE LEMIEUX

Until late in the 19th century, public health was by and large concerned with what economists call “public goods.” A public good is something whose consumption is nonrival (the consumption by one individual does not reduce the consumption of another) and nonexcludable (no consumer, including free riders, can be excluded). National defense is the most common example: it’s hard for an army to protect only certain homes that pay a private “defense fee.” Similarly, basic sanitation and controlling epidemics of infectious diseases or antibiotic resistance may be examples of public goods because they benefit everyone’s health once they are available.

Public health, however, has always been tempted by authoritarian drifts. In the 19th and early 20th century, “public hygiene” became “racial hygiene” and “social hygiene.” A parallel development was the eugenics movement, which aimed at preventing people who were deemed “unfit” from passing on their genetic defects—and sometimes simply eliminating those people altogether.

In America, both public health and eugenics flourished during the Progressive Era. Although the two movements were not identical, they had many similarities and shared promoters. The founder of the U.S. Food and Drug Administration, Harvey Wiley, figured among the supporters of a Chicago surgeon who, in the late 1910s, “permitted or hastened the deaths of at least six infants he diagnosed as eugenically defective,” according to University of Michigan historian Martin Pernick. The 1927 U.S. Supreme Court decision upholding involuntary eugenic sterilization invoked a 1905 compulsory vaccination case. As Justice Oliver Wendell Holmes explained, “the principle that sustains compulsory vaccination is broad enough to cover cutting the Fallopian.”

PIERRE LEMIEUX is an economist affiliated with the Department of Management Sciences of the Université du Québec en Outaouais. His latest book is *Who Needs Jobs? Spreading Poverty or Increasing Welfare* (Palgrave Macmillan, 2014).

In 1920, Charles-Edward Amory Winslow, professor of public health at Yale University, defined public health as including “the development of the social machinery to insure everyone a standard of living adequate for the maintenance of health.” In its 1946 constitution, the World Health Organization (WHO) declared, “Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.”

University of Illinois at Chicago clinical professor Bernard Turnock, author of a current textbook on public health, recognizes the field’s “broad and ever-increasing scope.” “Traditional domains of public health interest include biology, environment, lifestyle, and health service organization,” he writes. The latest version of the *Stanford Encyclopedia of Philosophy* opens its article on public health by identifying federal public health agencies, including the Center for Disease Control and the FDA as well as the Environmental Protection Agency and the “Consumer Protection Agency” (the authors probably mean the Consumer Product Safety Commission or the Federal Trade Commission’s Bureau of Consumer Protection).

Public health now encompasses noncommunicable diseases and “lifestyle epidemics,” such as the use of tobacco and alcohol, as well as obesity—matters that are very far removed from public goods concerns. Also included are many conditions or forms of behavior, such as riding a motorcycle, driving a car, owning firearms, engaging in “substance abuse,” having imperfect access to medical care, being poor, and so forth. Public health means health care and everything that is related to health writ large.

Moreover, “social justice” has become an essential feature of public health: “Social justice,” writes Turnock, “is the foundation of public health.”

## “SOCIETAL” VS. INDIVIDUAL PREFERENCES

Methodologically, the current view of the world according to public health clashes directly with the standard economic

approach. Public health experts, who typically come from the medical field, view the individual as unable to make the “right” tradeoffs to maximize his own well-being. Tradeoffs, of course, must be made: virtually anything that an individual does entails some risk to health. But the public health experts have decided those tradeoffs are best determined by experts like themselves, who supposedly better appreciate what benefits should be forgone in exchange for health risk reduction.

A good example of this is the justifications for the public health campaign against tobacco use. Scott Ballin, a public health expert and activist, expressed the opinion of many of his colleagues when he declared that “there is no positive aspect to [smoking]. The product has no potential benefits.” To an economist, this reasoning makes no sense. Tobacco consumers cannot want something that carries only costs (the purchase price of tobacco products plus the health risks), so tobacco use must have *some* benefit as judged by the consumers themselves. It won’t do for public health advocates to respond simply that smoker demand arises from addiction, not desire for pleasure; many smokers stop smoking and half of non-smokers are former smokers—so “tobacco addiction” isn’t destiny. Moreover, *everything* one likes is difficult to abandon, but that doesn’t mean people are addicted to everything they like.

Another argument, at one time overexploited by the anti-smoking movement, is that the consumer is incompetent at maximizing his utility because he lacks information about the risks of tobacco use. This line of argument was abandoned when

researchers discovered that consumers generally *overestimate* the health risk of smoking. Moreover, nobody would seem more motivated than the individual himself in obtaining optimal information (considering the cost of information) about the choices that affect his own life.

**Paternalism** / Over the past couple of decades, behavioral economics has argued that consumer rationality is diminished by cognitive limitations. Individuals tend to attach more significance to information that confirms their preconceptions (the so-called confirmation bias), give too much credence to immediately available information (availability bias), and so forth. Some public health advocates seize on these ideas to argue for public health officials’ involvement in people’s health choices. Yet an individual probably remains in the best position to make choices regarding his own life, if only because anybody else—including politicians and bureaucrats—is subject to the same cognitive limitations. As University of Richmond political philosopher Jessica Flanigan puts it, “Public health experts are people too.”

A related line of attack on individual preferences and choices is that some people have better health knowledge than others. If consumers do not know what is good for them, somebody who “knows better” should decide in their stead. This approach is called paternalism and it serves to justify coercive interventions.

But who are these wise paternalists who know better than the individual how to maximize his welfare? Nineteenth-century



British historian Thomas Macaulay nailed down the problem:

And to say that society ought to be governed by the opinion of the wisest and best, though true, is useless. Whose opinion is to decide who are the wisest and best?

In practice, public health experts and activists resemble Plato's philosopher kings. They reign, subsidized, in universities and government health institutions, ostensibly knowing what is good for society and willing to impose it by force.

Public health experts deny this and claim they are merely implementing what society wants. Turnock talks of the value of public health activities "in the eyes of society." The Institute of Medicine defines public health as "what we, as a society, do collectively to assure the conditions in which people can be healthy." Abhay Indrayan, a now-retired professor of biostatistics at Delhi University College of Medical Sciences, invoked such societal preferences:

If you have resources to save only one life, would you choose the one with age 25 or the one with age 70 years? It has been observed that most societies value life between 15 to 40 years more than at younger or older age. Note that we are talking of societal preferences and not of individual choices.

This preference talk is scientific nonsense, beyond its troubling political implications. A well-known result of social choice theory and welfare economics is that "societal preferences" simply do not exist if, by this, we mean a democratic, coherent, and stable aggregation of all individual preferences. The term "societal" itself, which has no ascertainable scientific meaning, may be just a term to avoid the scientific methodology used by welfare economists in discussing social preferences and social welfare. Previously in these pages ("Merkel, Thatcher, and the Stony Minded Stone," Summer 2003), I explained that so-called "social preferences" are either inconsistent (as we often see in electoral outcomes) or dictatorial in the sense that some people impose their preferences on others.

The contradictory notion that stupid consumers are also wise voters who elect enlightened politicians who hire paternalist philosopher kings to rule the public health system may explain why social justice must come to the rescue. Social justice will determine what goes into public health, how tradeoffs must be made, whose "physical, mental, and social well-being" is to be favored, and who is going to pay for it. But note that we have just come back full circle to the philosopher kings, for social justice is a complex philosophical (and economic) concept that can only be given content by philosophers, who have been debating it for centuries.

Social justice is a mirage that can never be attained because some individuals will always find they don't get enough of it, and the solution will be more and conflicting social justice. (See Friedrich Hayek and Anthony de Jasay on this topic.) In the field of public health, the values or preferences used will be those of

the reigning experts or their political masters. (In this context, values are simply preferences regarding preferred states of society.)

## THE SUPPLY AND DEMAND OF PUBLIC HEALTH

If public health laws and regulations exist, there must be a demand for them. On the demand side, we find organized interests, which are (as usual) overrepresented in the political process. The public health practitioners themselves constitute a large part of these organized interests. They get subsidies and jobs from the government, which they partly use to lobby for more public health intervention. Corporate interests include nonprofit organizations, such as universities and the so-called "poverty industry," as well as for-profit corporations. Since the 1990s, biomedical sciences and the National Institutes of Health have been the main recipients of science and technology funding from the federal government.

Organized interests only explain part of the demand for public health. By themselves, they might not have beaten the corporate lobbies on the other side—tobacco manufacturers, fast-food chains, alcohol producers, etc.—but they have found allies in those members of the public who want to impose their preferred lifestyle on others. The median-voter theorem probably comes into play here.

Consider again the example of smoking. The habit is now found mainly among the poor segments of the population. Once the median voter does not smoke anymore and obsesses about his "complete physical, mental, and social well-being," he will be tempted to ask government to impede the competing lifestyles that annoy him—for example, to forbid private venues from catering to smokers. Smoking prohibitions combine with zoning regulations to exclude the poor from places where the median voter hangs out. And they may be the same places that the public health experts sometimes patronize too.

These lifestyle demands are the contemporary version of the temperance movement that gathered speed after the Civil War. Despised lifestyles are now identified as noncontagious epidemics.

In a society lacking a strong concern for individual liberty, a generalized demand for security will also be addressed to the state. A large proportion of the people will want their health—in the general WHO sense—to be taken care of. They want to be guaranteed "a state of complete physical, mental, and social well-being." James Buchanan, the 1986 Nobel economics laureate, calls "parentalism" this desire of the people to be taken care of like children by the state. Paternalism then finds consenting victims.

**Supply /** In order to understand how government will respond to these demands, one needs to have at least an implicit model of the state. The implicit model of the government action privileged by public health is rather simple—some would say naive. The state is conceived as an accounting machine that aggregates individual preferences into collective choices, and then moves efficiently to implement them. Public choice theory proposes a more realistic model in which public health measures

are supplied by the interaction of politicians and bureaucrats, in response mainly to the demands of organized interests and important electoral clientele. The interests of politicians and bureaucrats play a big role.

This second model explains why the state uses public health as a fundraiser. The paradigmatic case of tobacco is interesting. In a 1998 out-of-court settlement following a suit launched by state governments, the states obtained some \$243 billion in future payments from tobacco manufacturers for costs that the states claimed smokers foisted on the taxpayers. In fact, those costs didn't exist on net. That smokers do not receive a net subsidy from the government (for the simple reason that they die earlier) is a fact that has been established by an important literature (and is acknowledged in the *Encyclopedia of Philosophy* entry).

The ink was barely dry on the 1998 Master Settlement Agreement before many state governments rushed to securitize their future tobacco money in order to spend it immediately on their pet projects. According to Vanderbilt law and economics professor Kip Viscusi, 90 percent of the money collected was allocated to projects such as roads, bridges, parks, and jails—not tobacco-related programs or public health.

## SCIENCE AND CHOICE

The less anti-market public health supporters argue that public health policy choices will not be arbitrary but instead reflect cost-benefit analysis. The main problem with this argument, long recognized by welfare economists, is that the benefits usually go to different people than those who are forced to support the costs. And there is no scientific way to compare subjective costs and benefits, ultimately defined in terms of utility, among different individuals. De Jasay summarizes the problem:

The long and short of it is that objective and procedurally defined interpersonal comparisons of utility ... are merely a roundabout route all the way back to the irreducible arbitrariness to be exercised by authority.

... The two statements "the state found that increasing group *P*'s utility and decreasing that of group *R* would result in a net increase of utility" and "the state chose to favor group *P* over group *R*" are descriptions of the same reality. [Emphasis in original]

The fundamental reason for the arbitrariness of public health goes back to the fact that only a small part of its mission is concerned with public goods. Most public health intervention amounts to a redistribution of private goods and privileges.

Yet, even cost-benefit analysis is too restrictive for most public health experts because it does, however imperfectly, determine whether policies have the potential to improve welfare. To avoid this mild constraint, they prefer other methods, like cost-effec-

tiveness analysis or cost-utility analysis, that have fuzzier methodologies and more arbitrary foundations. Ultimately, they invoke "social justice," which is essentially a way to justify the tradeoffs they favor.

The activist fringe of the movement is even less scientific. A rule of thumb often proposed for public health interventions, notably in the case of gun control, is the mantra, "If it saves only one life..." Even Barack Obama and Joe Biden have used that incantation. This rule will not do because saving one life here may condemn another one there—for example, the life of the person who is prevented from defending himself. The killing of

*The fundamental reason for the arbitrariness of public health is that only a small part of its mission is concerned with public goods. Most public health interventions amount to redistribution of private goods and privileges.*

Eric Garner while he was being arrested for selling illegal cigarettes reminds us that even the war on smoking takes lives. And only the crudest and least scientific utilitarianism would find the political solution in counting the corpses on each side.

Public health experts and activists are prone to invoke "science" as an *ex cathedra* criterion for forcing choices on others. Paradoxically, they generally ignore public choice analysis, welfare economics, and social choice theory, three fields of social science that would be most scientifically helpful to them. More fundamentally perhaps, they confuse science and preferences, apparently believing that scientific (provisional) conclusions justify overruling individual preferences that they think conflict with science. In other words, they confuse the positive with the normative.

Instead, much can be said for an enlightened libertarian approach that combines the recognition of positive science with a moral presumption for the primacy of individual preferences. Even if science establishes that something carries some elevated level of risk for you, you should still be the one making the necessary tradeoffs in your own life. For example, one can admit the statistical evidence that smoking has negative health effects (as shown in Frank Sloan et al.'s *The Price of Smoking*) and still believe that the decision to smoke or not is each individual's choice. Similarly, one can admit the medical efficacy of vaccines and oppose overriding the preferences of those who refuse them. One can admit that, other things equal, it is better not to be fat, but believe that lifestyle choices leading to obesity should be left to each individual, with whatever advice that he may want to receive or that his friends and family may volunteer.



**SLIPPERY SLOPES**

Today's wide concept of public health carries huge implications for regulation. One is that much regulation, if not outright prohibition, of "unhealthy" behaviors and products is required. As public health extends its reach, more foods, drugs, plants, and activities must be controlled.

Regulation and control have consequences, not all of which are good. Just consider the fact that many products, such as wine, that carry health risks apparently also bring health benefits along with their subjective benefits. Whether to release drugs sooner or wait until they are deemed "safe enough" trades off some lives for others. And this is not counting the fact that some uncertainty always attends these tradeoffs; even scientists change their minds on the health effects of food, as the recent reversal on consumption of fat illustrates.

Slippery slopes are another implication. Some people don't believe in slippery slopes, often because they don't understand the logic of institutions. Government intervention calls for more intervention. Consumers become more and more dependent on coercive organizations like the FDA. The whole process creates and feeds a constituency of subsidized public health experts who will make sure that more bans and regulations are requested and enacted. A good example is the current push for banning electronic cigarettes. Even from the point of view of medical science, such a ban appears about as scientific as smoking bans for parks and beaches.

Interestingly, public health itself can be seen as the product of a slippery political slope. It is barely enumerated powers that have allowed the federal government to enter this field. Since "health" is not mentioned a single time in the U.S. Constitution, the federal government's intervention in public health has been justified by citing the general welfare and commerce clauses.

The public health slope remains very slippery. For example, some public health advocates have argued for a parenting license scheme. Sir Roy Calne, a famous British surgeon, writes:

It would not be unreasonable, by analogy with a motor vehicle license, that a permit to reproduce should also be needed with a minimum age of, for example, twenty-five, and a proof required that the parents are of sufficient maturity and financial resource to take proper care of the child.

Jack Westman, a professor at the University of Wisconsin School of Medicine and Public Health, explains:

The denial or revocation of a parenting license would be expected to be a painful experience, particularly for mothers. ... The overall importance of protecting innocent children from incompetent parenting justifies the inconvenience to a few parents and the inevitable imperfections of a licensing system.

**Duty to be healthy?** / Depending on the political system, the rulers, their preferences, and the constraints they face, the results of the public health regulatory agenda can be very troubling from both an economic and a moral viewpoint.

In his remarkable book *The Nazi War on Cancer*, Robert Proctor shows how Nazi Germany was as close to a public health utopia as could be imagined—except of course for the persecuted Jews and other victims who were on the cost side of the cost-benefit balance. Nazi slogans expressed in stark terms the collectivist and statist drift of public health: "Your body belongs to the nation." "Food is not a private matter." "You have the duty to be healthy." The Nazis were the first to mount a government campaign against smoking. They were the first to ban smoking on a university campus, at the University of Jena, presided by Karl Astel, a Nazi official who committed suicide before the Allies entered Berlin.

Those who govern today's western countries are not wicked like the Nazis, but nice and paternalistic. They still impose, albeit much less cruelly, their preferences—or the preferences of their electoral clienteles—on nonconformists. The results are not blissful for those who do not share those preferences.

How ideology interfaces with public health is an interesting question. Peter Jacobson recognizes that "most health law/policy scholars would identify as being on the political left." Most of the rest are probably also statist. At least in America, public health experts may be carrying over some the coercive values of the nation's Puritan ancestors. To paraphrase H. L. Mencken's characterization of Puritanism, public health experts are subject to the haunting fear that someone, somewhere, is having fun.

Whether the motivations presiding over public health policies are nice or nasty, public health regulations will not necessarily be consistent with scientific requirements. It is not only that scientific evidence is often uncertain and always evolving, but also that public health regulation responds to the preferences and values of the ruling public health experts and their political masters, as mediated by political and bureaucratic processes. And like ordinary people, all the involved officials have cognitive limitations and biases.

This may explain why, for example, the public health establishment campaigns more against guns than against swimming (and swimming pools), although accidental drowning and submersion accidents kill four times more people than gun accidents. They also campaign more against guns than against motor vehicles, which kill 13 percent more people than guns (homicides and suicides combined). Similarly, alcohol, which is known to impose a "social cost" much higher than tobacco, is probably better accepted because the ruling classes like it. Perhaps the same reasoning applies to recreational drugs, which public health currently seems to tolerate better than tobacco. Today's push toward decriminalization of some recreational drugs is an encouraging break in public health's disturbing long-run trend.

**A SANITARY UTOPIA**

The public health movement naturally wants to undermine institutions that favor resistance to its regulatory agenda. Private property is one such institution, for it can solve many externality problems without resorting to public health experts and government coercion.

The standard example is smoking in so-called “public” places. Assume (even if it strains credulity) that minimal exposure to secondhand tobacco smoke carries real health risks. In a free society, one would expect private entrepreneurs to open private venues (restaurants, bars, etc.) on private property in order to welcome smokers and other patrons who are unconcerned about secondhand smoke or believe the benefits of patronizing a given smoking-allowed establishment outweighs the risk. (See “The Case Against Smoking Bans,” Winter 2006–2007.) Or a non-smoker may just want to be nice to a smoking friend he will have lunch with. Similarly, workers would make their own choices between working in a smoking or non-smoking environment. To prevent this diversity, the public health movement has contributed to the redefinition of “public place” as any private place where the public is admitted, a redefinition that amounts to a nationalization of the air in private businesses.

Illustrating further the logic of regulatory institutions, one new trend is to ban smoking in private cars where children are present, bulldozing the rather straightforward idea that private cars are private spaces like the family living room. The state should, no doubt, protect children against criminal aggressions and egregious neglect, but what we have here is another step in the usurpation of the parent’s role. The exploitation of children by the public health movement is troubling, as if it were not in most children’s interest to inherit a world where individual liberty and private property are respected.

Some public health experts and activists openly oppose capitalism and the free market. In a 2006 *American Journal of Public Health* article, “Public Health and the Anticorporate Movement: Rationale and Recommendations,” William Hist argues that “the field of public health needs to address the corporate entity as a distal, structural, societal factor that causes disease and injury.” A 2012 *BMJ* (formerly *British Medical Journal*) article titled “Why Corporate Power Is a Public Health Priority” by Gerard Hastings argues that “lethal though tobacco is, the harm done to public health by our economic system is far greater.” Marketing, he claimed, “undermines our mental as well as our physical well-being,” and marketing by multinationals presents “a major threat to public health.”

The prohibition of fracking in the state of New York recently provided another interesting example of public health’s regulatory imperialism. The state’s acting health commissioner declared that fracking raises “red flags” and should be forbidden. “I consider the people of New York as my patients,” he explained (quoted in *The Telegraph*, December 24, 2014).

Public health theorists, even enlightened ones, argue for creating a “public health culture.” The idea is to lead people, by propaganda and habit-creating laws, to espouse the public health priorities decided by the experts. It amounts to social engineering society so that individuals voluntarily pursue what the state wants them to pursue.

## CONCLUSION

Public health today is not a field of science but a political move-

ment with a regulatory agenda. “In many respects,” writes Turnock, “it is more reasonable to view public health as a movement than as a profession.” “Public health,” the *Encyclopedia of Philosophy* tells us, “is focused on regulation and public policy.” Public health experts claim a jurisdiction that covers anything related to welfare, little of which consists of genuine public goods.

The basic thrust of public health is to remove decisions from the domain of individual choice. For example, public health experts believe that driving is a privilege, not a right, and probably extend this characterization to any activity that they don’t like or for which they think they would easily qualify (like parenting rights).

Slippery slopes mar the whole history of public health, from the eugenics movement’s forced sterilization to the Nazi drift or, if one wishes softer examples, from the treatment of the insane to Prohibition, to the current harassment of smokers, and to the partial nationalization of “public” places. Despite some reversals, the slope is as slippery as it ever was.

Twentieth-century literature presents us with two main models of dystopias, depending on the wickedness or niceness of those who control the state. George Orwell’s *1984* is dominated by an egoistic, totalitarian, and cruel tyrant. Aldous Huxley’s *Brave New World* labors under a more impersonal and paternalistic, but still totalitarian, tyrant: people can be happy provided they stay within the official definition of happiness and take their pills. One variant of the Huxley model is George Lucas’s movie *THX-1138*: “Work hard, increase production, prevent accidents and be happy. ... Blessings of the state, blessings of the masses.... We are here to help you.... You’re in violation. I’m gonna have to report you to the authorities.” The sanitary utopia of today’s public health looks like the Huxley–Lucas dystopia. R

## READINGS

- “Afraid to Be Free: Dependency and Desideratum,” by James M. Buchanan. *Public Choice*, Vol. 124 (2005).
- “Eugenics and Public Health in American History,” by Martin S. Pernick. *American Journal of Public Health*, Vol. 87, No. 11 (November 1997).
- *Health, Civilization and the State: A History of Public Health from Ancient to Modern Times*, by Dorothy Porter. Routledge, 1999.
- *Lau, Legislation, and Liberty: The Mirage of Social Justice*, Vol. 2, by Friedrich A. Hayek. University of Chicago Press, 1976.
- “Public Health Ethics,” by Ruth Faden and Sirine Shebaya. *Stanford Encyclopedia of Philosophy*, 2015.
- *Public Health: What It Is and How It Works*, 5th edition, by Bernard J. Turnock. Jones & Bartlett, 2012.
- “Puritanism, Paternalism, and Power,” by Robert Higgs. *Independent Review*, Vol. 2, No. 3 (Winter 1998).
- *Smoked-Filled Room: A Postmortem on the Tobacco Deal*, by Kip W. Viscusi. University of Chicago Press, 2002.
- “Symposium: The Scope and Reach of the Regulatory State,” miscellaneous authors. *Social Science and Modern Society*, Vol. 51, No. 3 (May/June 2014).
- *The Nazi War on Cancer*, by Robert N. Proctor. Princeton University Press, 1999.
- *The State*, by Anthony de Jasay. Liberty Fund, 1998.
- “The Vacuity of the Political ‘We,’” by Pierre Lemieux. *Library of Economics and Liberty*, October 6, 2014.
- “The World Bank’s Tobacco Economics,” by Pierre Lemieux. *Regulation*, Vol. 24, No. 3 (Fall 2001).