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HEALTH PROMOTION: ETHICAL AND SOCIAL DILEMMAS OF GOVERNMENT POLICY

by Ronald Bayer and Jonathan D. Moreno

Prologue: Does government have the right to require its citizens to use seatbelts and to place limits on alcohol and cigarette use? This question has been raised by those fearful of losing their personal autonomy as an increasing number of states pass seatbelt laws and tighter controls on smoking and alcohol use. In this article, authors Ronald Bayer and Jonathan Moreno assert that beyond economic incentives to encourage health promotion and discourage risky behavior, there are ethical reasons as well for government to take an active role in the health of the public. In addition, Bayer and Moreno offer a set of ethical guidelines for public policymakers in fashioning personal behavior and health regulations. This article is the result of a Hastings Center study funded by the National Center for Health Services Research which brought together scholars from the fields of law, economics, philosophy, and public health to examine the ethical issues in government health promotion. Bayer, who received his doctorate in political science from the University of Chicago, is an associate for policy studies at the Hastings Center in New York. He has been affiliated for the past eight years with Hastings, a think tank which focuses on a variety of ethical issues. Bayer is involved in issues of health policy such as access to healthcare and the ethical issues surrounding public health responses to AIDS (acquired immunodeficiency syndrome). Moreno is an associate professor of philosophy and health care sciences at George Washington University in Washington, D.C. He was involved with the Hastings Center report as an associate for social and behavioral studies during 1984-85, while on leave from George Washington University. He received his doctorate in philosophy from Washington University in St. Louis.
That health is endangered, lives are lost, and illness increased as a result of poor or destructive personal habits are by now well-established facts.¹ In the United States, as well as in other societies with advanced systems of medical care, repeated calls are made for efforts to alter or modify behavioral patterns with negative consequences for health.² Interest in such policies stems partly from growing doubts about the ability of therapeutic medicine to solve the problems posed by the current pattern of morbidity and mortality.³ The interest also stems from the realization that an upper limit may have been reached in the willingness of the citizenry to shoulder the burden of an expanding health care sector that now consumes close to 11 percent of the gross national product. But whatever the sources of the interest in the modification of personal habits and behaviors that affect the health of men and women, it is clear that many now believe that something must be done.

Despite the popularity of this perspective, there is considerable doubt and confusion as to the appropriate course of action. Who has the right to modify whose behavior and under what circumstances? What should the role of government be in promoting or mandating those behaviors that presumably produce good health, and in discouraging or forbidding those behaviors that presumably produce illness and lead to early death? Issues in this arena raise difficult questions about the appropriate relationship between the individual and the state. We are compelled to deal in a concrete fashion with the conflict between liberty and paternalism, between personal preference and social welfare. We must address complex issues regarding the relationships between coercion and incentives, between education and manipulation.

How may the state justify the control of personal behavior that appears, at first, to affect only the individual? To what extent do individuals have the right to behave foolishly and self-destructively? Can state action only be justified by arguing that self-destructive behavior is not truly voluntary (the product of coercive factors—either psychological or social), and that state intervention thus represents a restoration of “true” autonomy? When an individual argues that he or she has freely chosen to engage in certain behaviors despite the possibility of disease and premature death, can the state legitimately attempt to behave paternalistically?⁴ It is of course possible to argue that though the individuals who engage in hazardous behaviors suffer the primary consequences themselves, society must bear the cost of such “self-regarding” acts. Because of the tendency to place greater and greater obligations on society for the provision of health care through third-party mechanisms, the burden has increasingly become communal and not just individual. Additionally, because morbidity and mortality affect the general well-being of society in terms of its productive capacity, such behavior produces a social impact.⁵ To the extent that these arguments are accepted, the realm of individual
action will become harder to distinguish from that of social action. Self-regarding behavior will cease to exist, and the claims of liberty will increasingly be subordinated to those of community. To what degree should the imperatives of health be permitted to provide the justification for so fundamental a change in our deepest ethical and political commitments? Should the ideal of health provide the warrant for such a transformation when other social goods do not?

This paper sets out the ethical principles that ought to guide policymakers as they attempt to fashion government policy regarding personal behavior and health. Secondly, the paper examines the ethical issues that must be confronted as alternative strategies to affect personal behavior are considered and applies this set of ethical considerations to three critical cases.

Though it is clear that virtually every dimension of personal behavior can contribute to the onset of disease or to its prevention, we have chosen to limit our discussion to cigarette smoking, alcohol consumption, and vehicular behavior. Though limiting discussion of policy interventions to these activities that occur in public or which can be controlled through the regulation of commerce may appear to be a timid gesture, to include changes in the patterns of exercise, diet, and sleep along with these more public forms of behavior conjures up images of profound invasions of privacy, scarcely tolerable in a liberal society. In fact, it is the precondition for a serious discussion of whether government should seek to modify personal behaviors linked to disease and untimely death.

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**Personal Behavior And Health**

If a single event could be pinpointed as representing the commencement of the public and official discussion of the role of government in health promotion, it would be the publication in 1975 of “A New Perspective on the Health of Canadians.” In that report Marc Lalonde, the Minister of National Health and Welfare, bluntly stated: “Self-imposed risks and the environment are the principal or important underlying factors in each of the five major causes of death between ages one and seventy, and one can only conclude that unless the environment is changed and the self-imposed risks are reduced, the death rates will not be significantly reduced.”

But even the pursuit of health had to be bounded by other considerations especially when matters of liberty and privacy were at stake. Lalonde not only recognized the risks involved, but was alert to the nature of the opposition his challenge could well provoke: “The ultimate philosophical issue . . . is whether and to what extent government can get into the business of modifying human behavior, even if it does so to improve health.”
Involved were not only issues that would arise in the course of direct efforts at restriction and prohibition, but those that would surface if the government took on the function of “marketing ideas.” These themes found expression two years later in the United States in the widely read and cited essay by John Knowles, “The Responsibility of the Individual,” that appeared as part of the Daedalus symposium, “Doing Better and Feeling Worse: Health in the United States.” Though he noted the extent to which environmental and socioeconomic factors contributed to behavior with disastrous consequences for health, it was his striking comments on personal responsibility for morbidity that were to provoke a lively and important debate. For Knowles, the social consequences of individual behavior in terms of the cost of medical intervention could no longer be tolerated: “The costs of individual irresponsibility in health have now become prohibitive. The choice is individual responsibility or social failure. Responsibility and duty must gain some degree of parity with right and freedom.”

The untoward social consequences of individual behavior were to become the leitmotiv of the American debate over health, life-styles, and government responsibility. It clearly was central for Department of Health and Human Services Secretary Joseph Califano in his introduction to Healthy People. “Indulgence in private excess,” wrote Califano, “has results that are far from private. Public expenditures for health care are only one of the results.” While acknowledging that there might well be controversy and debate about the appropriate role of government in urging citizens to give up their “pleasurable but harmful habits,” Califano argued that “there could be no denying the public consequences of these private acts.”

From an ethical perspective, the determination of whether government should regulate the behavior of individuals in the name of health requires that policymakers go beyond the questions of efficiency and political acceptability. What moral warrant is there for such intervention? Does such a warrant also impose an obligation on the part of government to intercede? The demands of autonomy, equity, and community are central to any attempt to fashion an ethically sensitive public policy in this domain.

**Autonomy.** No issue has received more attention in the public and professional discussions of the appropriateness of government policy designed to affect personal behavior in the name of health than that of autonomy. Reflecting the profound influence of liberalism in American social thought, any attempt by the state to affect behavior that is conceived of as self-regarding is viewed with great suspicion.
The realm of privacy is held to be inviolate, except for those occasions when it can be demonstrated that what initially appears to be self-regarding is in fact behavior with demonstrable and marked consequences for others, or when it can be demonstrated that what appears to be the decision of a competent adult acting under his or her own volition is in fact the consequence of some powerful, dominating, or coercive force. Given this commitment to individual autonomy, state actions directed at individuals in the name of their own health—paternalistic actions—are difficult to justify. Though there is, in fact, a broad range of extant regulatory provisions that are demonstrably paternalistic, each contemporary effort to overcome the predilection for autonomy must show that apparently voluntary behavior is the product of misinformation or the result of an irresistible compulsion. The goal of justifiable paternalism is to protect the individual from the consequences of actions that he or she would not choose to engage in were the capacity for free choice truly present.

Though it would be theoretically possible to argue that many forms of personal behavior that produce ill health are undertaken only because the individual does not fully appreciate the ultimate consequences of such behavior, this would be a difficult proposition to defend today. Given the widespread dissemination of public health information regarding smoking, alcohol consumption, and reckless vehicular behavior, it would be necessary to argue that individuals cannot appreciate the consequences of behaviors that produce their effects in the (personally) remote future, or that the statistical risk to any individual is so small that it is not possible to make personal decisions incorporating such information.

The difficulty that attends efforts to provide the justifications of paternalism has made such arguments largely unattractive to those seeking a moral foundation for regulatory policies put forth in the name of health. As an alternative, advocates of government intervention have sought to demonstrate that the consequences of personal behavior are social burdens that warrant public action. Thus shifting the grounds of discussion obviates the necessity of putting forth arguments to demonstrate that the individual must be protected from his own ill-conceived actions. Instead, since the burden generated by personal behavior causing ill health must be assumed by others, it has been argued that an issue of equity is involved.

**Equity.** The discovery of the social impact of personal behavior on morbidity and mortality has provided the foundation for public discussions of the appropriate scope of governmental activity. Both the Lalonde Report and Healthy People provide ample evidence of this fact.

Invariably such discussions are based upon economic analyses of the externalities associated with personal behavior. The cost of health care
and of health insurance, the burden of social security payments to those who are disabled, the necessity of providing social supports to families deprived of primary wage earners, the toll of reduced productivity, these are typically the costs traced back to the “private” acts of those who engage in behavior that produces disease and untimely death.

What from the point of view of economics is a negative externality requiring efforts at internalization of costs, from the vantage point of ethics becomes a matter of distributive justice. What does equity demand in terms of the burdens generated by the costs of behaviorally induced ill health? Why should nonsmokers be forced to bear the burden of smokers’ behavior? Why should nondrivers or drivers who do wear seat belts be required to bear the burdens of those who refuse to do so? Equity, some have argued, demands that those who choose to smoke, or to drive without seat belts be forced to bear the economic consequences of their own behavior. In those instances where no mechanism exists to internalize the costs of behavior, equity might necessitate the application of disincentives, and even prohibitions of the behavior itself.

The focus on the social costs of personal behavior seems to suggest that if it were possible to avoid the problem of negative externalities by internalizing such costs, there would be little justification for social intervention, for tolerating government intrusion. But does the characterization of the problem of morbidity and mortality associated with personal behavior in terms of economic costs alone adequately capture the extent of our moral intuitions? Limiting the costs of smoking (including death from lung cancer) to smokers themselves, or limiting the cost of neurosurgery to the unbelted victims of automobile accidents, cannot be viewed as a satisfactory moral solution.

The contemporary stress upon quantifiable economic social costs of personal behavior presses upon us a conception of public concern for health that begins and ends with an accountant’s ledger and which is in fact at variance with the desire to prevent untimely death, suffering, and illness as ends in themselves. A reading of court cases in this area—especially those associated with motorcycle helmet laws—reveals a strained quality in the argumentation. While data on social costs are mobilized in defense of state regulation, another set of motivations is clearly involved. The acceptable public rationale appears to be at odds with the unspoken, perhaps unspeakable, commitment to health and well-being of individuals and the community.

Community and the public health. Most contemporary court decisions involving cases testing the constitutionality of government efforts to regulate behavior in the name of health have focused on the state’s interest in reducing the cost of negative externalities. But Dan E. Beuchamp has noted that there is an older, “radical republican” constitutional tradition in which a more robust definition of the community’s interest in
the well-being of its members finds expression. Thus, one late nineteenth century Supreme Court decision involving the state’s effort to prevent the sale of alcohol held: “We cannot shut out of view the fact, within knowledge of all, that the public health, the public morals, and the public safety may be endangered by the general use of intoxicating drinks.”

Unlike those who have argued that the central issue raised by government intervention is that of autonomy and paternalism, Beauchamp asserts that “the individual’s liberty is not being restricted to produce benefits to himself as an isolated individual, but rather to maximally protect an entire class of individuals of which he is only a small part.”

Nor is the central issue the protection of the interests of third parties from the undue imposition of those who insist on behaving in ways that produce ill health: “Such a perspective seeks to reduce the idea of the common good to little more than the protection of the interest of others, confusing the protection of the body politic with the protection of the rights of the private citizen.”

What is for Beauchamp the signal advantage of his perspective, the stress on the community’s interest in health as an irreducible good, is for those fearful of an overbearing government a threatening call for the dissolution of the essential tension between the public and private realms. Nevertheless, a consideration of the community’s interest in the health and well-being of its members warrants careful attention. While privacy and autonomy provide essential standards against which to judge proposed government actions, they are not the sole standards, nor ought they be permitted to overwhelm all other values. The National Research Council, in its report on public policy and alcohol, sought to strike a balance when it said: “Individual freedom is not the only premise defining the proper role of government. There are other (equally venerable) notions of politics in which the government is called on to enhance the general welfare, promote the spread of knowledge and encourage civil behavior among its citizens as well as guarantee various liberties.”

**Ethics And Policy Choice**

As policymakers confront the prospect of fashioning governmental action in the name of health, they ought to be sensitive to the ethical tensions posed by such efforts. Sensitivity to such issues will help to determine whether or not government should take steps to affect behavior that is linked to illness and early death; it will also guide decisions about how to intervene.

**Education and health promotion campaigns.** Health communication campaigns that warn against certain activities or encourage the adoption of certain forms of behavior would at first appear to pose no ethical
problems. But Ruth Faden has provided an analysis that reveals how complex the issues can be. Her critical review informs the following discussion. Health communication campaigns provide needed information and thus enhance personal autonomy in the face of health risks. They seek to reduce behavior that produces health-related burdens for society. Thus, such campaigns limit the extent to which the community as a whole may be compelled to tolerate the negative externalities generated by those who engage in activities linked to morbidity and mortality. Finally, on an expressive level, they represent a public demonstration of the community’s concern for the health and well-being of its members.

The challenge to health communication campaigns derives primarily from empirical studies that question their efficacy. Kenneth Warner has thus noted that the failure of the American campaign to encourage seat belt use “is echoed by experience in Canada, Great Britain, and France: in each case, major publicity campaigns either did not increase belt use at all, or at best increased use only slightly and temporarily.” Since such campaigns often accomplish little, their existence may, in fact, betray an unwillingness to undertake more effective interventions.

However, health education campaigns can be successful. The cumulative impact of many efforts over time is enhanced when novel messages, conveyed in a variety of media, are supplemented by more personal interventions. It is generally believed that years of antismoking campaigns have had a marked impact on cigarette consumption. But can such campaigns be too successful? Can they undermine autonomy by their efforts to reform the way in which we think about our health-related preferences?

It is a striking feature of American distrust for governmental intrusions that fear is generated by the mere prospect of a successful state-sponsored program to influence health-related behavior. For commercial advertisers to advance exaggerated claims is almost expected. Were government to engage in similar levels of exaggeration—even in the name of health—fears of manipulation would abound. This quite understandable reaction places public health education campaigns at a disadvantage. Concern about balance in governmental education efforts should not, however, provide a subterfuge for permitting gross imbalances in the marketplace. Such an outcome would produce the very results Marc Lalonde expressed concern about ten years ago.

Public health campaigns not only seek to influence members of the community as consumers of products, but as citizens as well. They may, in fact, Faden has noted, have as their most important consequence the creation of constituencies willing to support more aggressive health promotion strategies. Antismoking campaigns, for example, were certainly instrumental in preparing the public for legislation restricting cigarette smoking in enclosed public spaces. Some have expressed concern about
whether such governmental influence is appropriate in a liberal society. Though it is possible to conceive of instances in which government efforts to “educate” the people would be troubling, it would be a mistake to exaggerate such threats. Government never merely mirrors public opinion. In the case of health, to do so would represent an abdication of the responsibility to enhance the general welfare.

**Taxation.** Given the focus of public discussion on the economic consequences of the relationship of personal behavior to morbidity and mortality, it is not surprising that considerable theoretical attention has been devoted to the role taxes might play in government health promotion efforts. Much of the concern of the past decade has centered upon negative externalities, including the cost of health care and lost productivity. Thus, it is only natural that proposals would be made to recapture those costs through excise taxes applied against products directly implicated in disease and early death.

From the point of view of economics, such taxes would correct for market imperfections that failed to pass on to consumers the true cost of their behaviors. From an ethical point of view, it would be possible to justify such efforts as critical for the more equitable distribution of the burdens associated with certain behaviors. On the other hand, since sales taxes are always regressive, it could be argued that such levies would generate inequity. The evaluation of such competing ethical claims cannot be restricted to an analysis of the incidence of taxation. As important would be a full appreciation for the ways in which such taxes would affect the social class distribution of morbidity and mortality.

The imposition of excise taxes in the name of equity would inevitably result in price increases that would create disincentives to consumption. One analysis of the elasticity of demand for cigarettes found that a 10 percent rise in the price of cigarettes would result in an equivalent reduction in teenage smoking. A study of the elasticity of demand for alcohol found that an increase in federal excise taxes and hence in the price of alcohol would “reduce total consumption and in particular . . . those portions of total consumption associated with auto fatalities and liver cirrhosis.” How such disincentives would affect the social class pattern of consumption is an empirical matter with important implications for ethical analysis. But in any case, it is clear that without adopting either paternalistic justifications or more far-reaching arguments regarding the community’s interest in the health and well-being of its members, imposing higher taxes on tobacco and alcohol would make it possible to reduce society’s burden of illness and early death.

The imposition of taxes in excess of those justified by calculable negative externalities would require arguments that go beyond the claims of society in the face of such costs. Such arguments would have to demonstrate why the community’s interest in health as an end in itself, or why
a concern for autonomy in the face of addictive consumption, required such interventions.

What is remarkable about the theoretical discussion of the role of taxes in health promotion and disease reduction is how limited its impact has been on actual public policy. Commercial interests have succeeded in thwarting the robust application of excise taxes. In the case of alcohol, federal taxes adjusted for inflation have actually declined. Increases in federal taxes on cigarettes have been imposed primarily for purposes of revenue enhancement rather than for purposes of recapturing the costs associated with smoking.

In the presence of enormous social costs—calculated in terms of medical care, reduced productivity, suffering, and early death—an ethical analysis would find the failure to use fiscal interventions more aggressively at least as troubling as the putative risks that might attend their overly severe application.

In arguing the regressive nature of excise taxes, some have said that the poor have at least as much right to indulge in relatively minor vices as their more comfortable neighbors, especially since these activities constitute a small measure of relief from lives largely devoid of luxuries. However, the demands of equity do not require equal opportunity for access to all forms of morbidity and mortality. The demands of community may well counsel particular concern for those especially vulnerable to the damaging effects of certain life-styles and products. Preservation of the community’s commitment to the well-being of its members might dictate the use of excise taxes to discourage behavior that would create additional burdens for those already at economic disadvantage.

**Restrictions, Prohibitions, And Mandatory Behavior**

The creation of disincentives through the application of taxes to certain commercial products like cigarettes and alcohol would impinge upon the autonomy of those who found the added costs burdensome, perhaps prohibitively so. Nevertheless, at some price individuals would remain free to purchase cigarettes and alcohol.

There is no such ambiguity attached to public policies that would seek to bar the purchase of certain products, prohibit certain behaviors, or mandate the performance of others. Because such prohibitions or requirements would so clearly impose the government’s preference on competent adults, discussion of such options tends to arouse ardent opposition.

Prohibitions evoke the specter of Big Brother and of America’s “noble experiment” with alcohol. Yet on a broad range—for both paternalistic and public health reasons—governmental regulations are an accepted part of contemporary social life. Prohibitions on the sale and prescription of many intoxicating substances are challenged only by libertarians who
are opposed, in principle, to any but the most limited restrictions on individual liberty. Pure food and drug laws, as well as legislation governing the use of potentially carcinogenic food additives, are not only rarely opposed but often demanded by those committed to the public health, despite their clear impingement on the liberty and autonomy of potential consumers.

It is only when government seeks to restrict the availability of a product well-integrated into the social fabric, or when it attempts to mandate a form of behavior that has not been required in the past, that the ensuing controversy brings to the fore the ethical issues that undergird even the most widely accepted practices. As Stephen Teret has pointed out, the debate surrounding mandatory motorcycle helmet laws provided a unique opportunity to examine the ethical issues raised by efforts on the part of government to mandate behavior in the name of health.\textsuperscript{19}

In June 1967, pursuant to the Highway Safety Act, the Secretary of Commerce declared that any state that did not require motorcyclists to wear helmets would lose all federal highway safety funds and 10 percent of federal highway construction funds. Teret notes in his analysis of this effort that in the next nine years, forty-nine states adopted the mandated helmet requirement. Only California refused to do so. Utah limited the statutory requirement to highways on which travel exceeded thirty-five miles per hour.

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

In their decisions, the courts tended to avoid justifications that suggested a warrant for paternalistic interventions. Rather, they sought to demonstrate that the social impact of private behavior provided ample justification for state legislative action. Typical was the language used by a U.S. District Court in Massachusetts: “From the moment of injury, [society] picks the person up off the highway; delivers him to a municipal hospital and municipal doctors; provides him with unemployment compensation if, after recovery, he cannot replace his lost job, and if the injury causes permanent disability, may assume the responsibility for his and his family’s continued subsistence. We do not understand the state
of mind that permits the plaintiff to think that only he himself is concerned.”

What the opponents of motorcycle helmet laws had failed to do in the courts they succeeded, Teret notes, at accomplishing in the Congress when the Secretary of Transportation was forbidden from using the power of the purse to force the states to impose protective requirements on motorcyclists.

Within three years of the 1976 congressional action, twenty-seven states had repealed their laws. Helmet wearing in the repeal states declined by 40 percent. The toll in mortality began to rise as did the cost in terms of medical expenses, lost productivity, as well as human suffering.

The dispute surrounding mandatory helmet laws raised issues of autonomy, paternalism, and general welfare, but in a sphere of behavior engaged in by a relatively small number of individuals. These same moral concerns have emerged in the course of the debate on mandatory seat belt laws that would affect tens of millions of drivers.

After years of controversy, states have just now begun to enact such requirements. Public education campaigns that sought to encourage such behavior on a voluntary basis were by all measures a failure. One 1983 study reported that less than 10 percent of Americans regularly wore seat belts. Public opinion polls revealed deep opposition to such requirements from more than three-quarters of those surveyed. Nevertheless, those pressing for seat belt enforcement legislation noted repeatedly the social burden generated by each individual’s choice to drive unbelted and demanded government action.

Ironically, the turn toward mandatory seat belt laws, under strong federal encouragement, is the result of a concerted effort on the part of automobile manufacturers to resist imposition of a requirement that all cars be equipped with automatically inflatable air bags. Detroit opposed the enactment of an air bag requirement because it would have forced added costs upon consumers and industry. And so, ultimately, the Secretary of Transportation was willing to consider the substitution of a more intrusive form of government regulation—mandated seat belts—for one that would have operated through product redesign.

Though prohibitions and restrictions such as seat belt and motorcycle helmet laws are ethically defensible, this does not suggest that such intrusions ought to be a first line of defense against all behavioral causes of disease and untimely death. The political, economic, and moral costs of such intrusions dictate that they be considered with prudence as a guide. What should be underscored, however, is that an excessive focus on autonomy entails a disregard of competing moral concerns. Indeed, in some circumstances a refusal to consider prohibitions and restrictions on personal behavior would be ethically problematic.
In the past, discussions of the significance of personal behavior for patterns of morbidity and mortality and about the appropriate role of government in responding to such behaviors have occurred under the shadow of the charge of “victim blaming.” For those concerned about the intensifying focus on individual behavior, nothing short of an ideological effort to divert attention from the social and environmental causes of disease and death seemed involved. Though some of the public discussion and literature on health promotion provided justification for such fears, many public pronouncements have stressed both environmental and personal factors.

Instead of viewing health promotion through behavioral restrictions as antagonistic to concerns about access to health care and the environmental and occupational causes of disease, they should be viewed as mutually reinforcing. A sterile debate should not be permitted to deflect attention from a course which the public health requires. The community ought to assume greater responsibility for regulating both the environmental and behavioral causes of disease.

Cigarette smoking, excessive alcohol consumption, and the failure to make use of devices that could reduce automobile fatalities, ought to be the central foci of any governmental effort to reduce the pattern of behaviorally related morbidity and mortality in America. More than exhortations about such desirable goals are necessary, however. For two decades advocates of aggressive government intervention in this arena have had to bear the burden of proof. Politics, economics, and ethics have all been relied upon to provide arguments against anything but the most modest of efforts. The sheer toll in morbidity and mortality associated with such behavior provides ample justification for shifting the burden of proof. Those who oppose government health promotion efforts, including the use of fiscal measures and even carefully designed restrictions and prohibitions, ought to be compelled to provide arguments against proceeding more aggressively.

This paper was prepared as the staff report on a Hastings Center project sponsored by the National Center for Health Services Research, “Ethical and Social Dilemmas of Government Policy.” The members of the Research Group whose work is drawn upon in this paper—but whose views are not necessarily reflected in it—were Dan E. Beauchamp (University of North Carolina at Chapel Hill), Ruth Faden (The Johns Hopkins University), Stephen Teret (The Johns Hopkins University), Daniel Wikler (University of Wisconsin), and Peter C. Williams (State University of New York at Stony Brook).
NOTES

7. Ibid., 36.
10. Ibid.
12. All quotations from Beauchamp’s paper cited in footnote 11.
19. This narrative is based on Stephen Teret, “Motor Cycle Helmet Laws: Can the State Mandate Prudence?” commissioned by The Hastings Center for its project, “Health Promotion: Ethical and Social Dilemmas of Government Policy,” funded by the National Center for Health Services Research, No. SO4522.
21. Ibid., 66.