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RESEARCH ARTICLE

Political Ideology and Public Health

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Abstract

The ideological nature of public health is a problem for the profession. Ideological uniformity in the field of public health undermines scholars' and officials' legitimacy and compromises their ability effectively to prevent death and disease. I first provide some evidence that public health is ideological and then I argue that the ideology of public health is counterproductive. Additionally, public officials are also likely to violate people's rights in trying to advance their ideology through public health policy. In light of these moral considerations against the ideological nature of public health, there are compelling reasons for people to resist the expanding scope of public health insofar as it consists in the further imposition of this counterproductive and harmful ideology. I therefore conclude that the profession would be more effective and just if public health officials and scholars focused more narrowly on improving health outcomes instead of promoting their broader ideological agenda through public health policy.

Keywords: public health; political ideology; polarization; paternalism

Political ideology and public health

In this essay, I argue that the ideological nature of public health is a problem for the profession. When scholars and officials explicitly adopt and advance a political ideology in their role as public health professionals, they undermine their institutional legitimacy. Public health professionals who aim to advance their political ideology through their institutional role also compromise their ability effectively to promote citizens' health and overall well-being.

As an alternative to the current ideological nature of public health, I will argue in favor of a less politicized approach to public health. The history of public health shows that there is a better way forward. Public health officials historically advocated and implemented sanitation programs and regulations to limit air pollution, lead pollution, and water pollution. Mass vaccination programs effectively eradicated Measles, Mumps, Rubella, Polio, Smallpox, and Chickenpox. Vaccination initiatives also reduced the prevalence and severity of Pertussis, Flu, Pneumonia, and HPV. Public information campaigns increased the number of people who wear sunscreen and seek out preventative cancer

screenings. Public awareness efforts changed people's attitudes toward condom use, too, which was instrumental in reducing the sexual transmission of some illnesses, including HIV.

Each of these examples shows how public health officials can play a vital role in helping people live longer, healthier, happier lives. In each case, public health officials exercised message discipline. When it was possible to achieve a desirable public health outcome without coercion, public health officials in these cases did not resort to coercive or punitive policies. When coercion was necessary to protect the commons and to provide the public good of a healthy environment, public health officials did not rely solely on the administrative state, but defended their proposed reforms in the courts, legislatures, and media and made an effort to persuade people instead of mandating compliance.

I am concerned that public health has lost its way, making these kinds of public health victories more difficult to achieve going forward. To improve public health, scholars and public officials must first acknowledge the problem. Insofar as the profession is an ideological field that lacks viewpoint diversity and punishes dissent, this dynamic creates significant problems for public health officials.[1] Even when there is consensus among public health officials about how to make trade-offs between health and other values in public policy, officials cannot be confident that these judgments are not clouded by psychosocial pressures to conform to the dominant ideology of the profession. Officials' ideological commitments can impede officials' ability effectively to protect people's health by blinding officials to epistemically valuable information about people's preferences and cultures.

I am sharply critical of the field of public health throughout this essay. However, it is only because I have such a deep appreciation for what well-crafted health policy can accomplish that I am adamantly opposed to the ideological expansion of public health. I first make the case that there is a coherent and influential political ideology in the public health profession. I then argue that this ideology is often counterproductive in the long run. Next, I argue that even if public officials can successfully advance their ideology, they should not because this ideology violates people's rights, enables officials to police and prohibit deviance, and generally promotes social conformity through the use of legal threats.

Considering the harmful effects of public health ideology, the ever-expanding scope of public health is especially concerning. Whereas this damaging ideology was once limited to public policy related to food, sanitation, pollution, and medicine, public health officials are now claiming that education, gun rights, housing, immigration policy, transportation access, and criminal justice also fall within the purview of public health. I conclude that officials should resist involving public health workers in these areas of public policy in light of the

[1] For further discussion of these ideological dynamics in public health professions, see Harold Pollack, "Why Public Health Experts Aren't Reaching Conservatives on Covid," *POLITICO*, August 12, 2021, https://www.politico.com/news/magazine/2021/08/12/conservative-public-health-covid-conservative-affirmative-action-503448; Robert Graboyes, "Conservatives and Public Health: A Warm Welcome into a Cold Climate," *Discourse*, September 17, 2021, https://www.discoursemagazine.com/politics/2021/09/17/conservatives-and-public-health-a-warm-welcome-into-a-cold-climate/.

harms of public health ideology. Additionally, officials should minimize the influence of public health ideology even in areas of policy that more straightforwardly relate to health and health care. To close, I consider some objections to my case against public health ideology and I describe a potential alternative to public health ideology.

I advance these arguments because the first step toward improving public health is to identify the problems with public health. There is reason to be optimistic that the field can change. As science and public attitudes progress, public health officials reversed course on a number of issues. For example, alcohol prohibition was initially justified partly as a way of promoting public health, but voters and officials changed course when they saw that the policy did more harm than good. Similarly, many public health officials now favor decriminalization and a harm-reduction approach to sex work and recreational drug use. Today, people in the field of public health are increasingly conscientious about crafting policies that do not stigmatize unhealthy behaviors or people. These are welcome reforms not only because they involve improvements to public health, but also because they show that public health officials can respond to arguments and change course, enabling them to serve the public more effectively.

Public health ideology

Public health is a highly politicized field. To see what I mean by this claim, consider the stated missions of a few of the most prominent nongovernmental public health organizations. The American Public Health Association (APHA) states that their mission is to "[i]mprove the health of the public and achieve equity in health status" and that their vision is to "[c]reate the healthiest nation in one generation."[2] The Public Health Foundation (PHF) states that their mission is to "improve public health and population health practice to support healthier communities" and their vision is "equitable and optimal health and wellbeing for all."[3] The PHF website goes on to state that the organization aims to achieve this mission and vision by "advancing health equity and social justice, working to end racism, fostering a sense of belonging among diverse individuals and organizations [and] eliminating health disparities." The Society for Public Health Education (SOPHE) states that their mission is "[s]upporting leaders in health education and promotion to advance healthy and equitable communities across the globe."[4]

Prominent definitions of public health describe the field similarly. The Institute of Medicine's influential definition of public health describes it as "what society does collectively to assure the conditions for people to be healthy."[5]

[2] "About APHA," *American Public Health Association*, https://www.apha.org/About-APHA.

[3] "Vision, Mission, Values," *Public Health Foundation*, https://www.phf.org/AboutUs/Pages/VisionMissionValues.aspx.

[4] "SOPHE Premieres a New Brand Logo and Tagline," *Society for Public Health Education*, October 7, 2021, https://www.sophe.org/news/sophe-premieres-a-new-brand-logo-and-tagline/.

[5] Institute of Medicine (US) Committee on Assuring the Health of the Public in the 21st Century, *The Future of the Public's Health in the 21st Century* (Washington, DC: National Academies Press, 2002), https://www.ncbi.nlm.nih.gov/books/NBK221233/.

Other definitions characterize the field similarly as a social initiative dedicated to promoting health at a population level, with a focus on large-scale environmental and political reforms, equity, and justice.[6] More generally, the field of public health is broadly aligned with a statist ideology and a progressive ideology.[7] Additionally, the ideology of public health causes public health officials to emphasize the value of achieving better population-level health outcomes.[8] Support for public health may also be associated with a tendency to under-weigh other morally important values, such as autonomy.[9]

Of course, not all public health organizations emphasize population health and health equity while giving less weight to the value of autonomy.[10] However, there is enough of a consensus within the field of public health that the field has a clear ideological disposition and this disposition does not always align with the

[6] See, e.g., how the prominent journal *Public Health Ethics* defines the field: "About the Journal," Oxford Academic, https://academic.oup.com/phe/pages/About.

[7] Another way of understanding what I mean by a "statist ideology" is what psychologists describe as authoritarianism. In the wake of the pandemic, Joseph Manson finds that both left- and right-wing authoritarians supported authoritarian pandemic policies, but support for public health authorities was only correlated with left-wing authoritarianism. Joseph H. Manson, "Right-Wing Authoritarianism, Left-Wing Authoritarianism, and Pandemic-Mitigation Authoritarianism," *Personality and Individual Differences* 167 (2020), https://www.sciencedirect.com/science/article/pii/S0191886920304402.

[8] As Ruth Faden et al. write: "At its core, public health is concerned with promoting and protecting the health of populations." Ruth Faden, Justin Bernstein, and Sirine Shebaya, "Public Health Ethics," *Stanford Encyclopedia of Philosophy*, ed. Edward N. Zalta (July 8, 2020), https://plato.stanford.edu/archives/spr2022/entries/publichealth-ethics/.

[9] This tendency is consistent with research that finds that a strong sense of national identity (as well as political ideology) is correlated with support for public health interventions. Other research finds that libertarianism and anti-egalitarianism are two distinct elements of political ideology that were associated with dismissal of public health guidance during the COVID-19 pandemic. Becky L. Choma et al., "Ideological and Psychological Predictors of COVID-19-Related Collective Action, Opinions, and Health Compliance Across Three Nations," *Journal of Social and Political Psychology* 9, no. 1 (2021): 123–43; Edward J. R. Clarke, Anna Klas, and Emily Dyos, "The Role of Ideological Attitudes in Responses to COVID-19 Threat and Government Restrictions in Australia," *Personality and Individual Differences* 175 (2021): 110734, https://www.sciencedirect.com/science/article/pii/S0191886921001094; Yilang Peng, "Give Me Liberty or Give Me COVID-19: How Social Dominance Orientation, Right-Wing Authoritarianism, and Libertarianism Explain Americans' Reactions to COVID-19," *Risk Analysis* 42, no. 12 (2022): 2691–2703; Jay J. Van Bavel et al., "National Identity Predicts Public Health Support during a Global Pandemic," *Nature Communications* 13, no. 1 (January 26, 2022), https://doi.org/10.1038/s41467-021-27668-9.

[10] This is not to say, though, that all public health agencies advance a broadly progressive agenda. There are some major exceptions to this trend when officials can appeal to public health ideology in order to justify the criminalization of drugs or sex work. For example, in the United States, the National Institute on Drug Abuse (NIDA) advocates carceral policies that are likely more favored by Republicans than Democrats. So, too, for policies that criminalize sex work, which receive bipartisan support. Additionally, conservative and libertarian think tanks employ public health scholars. But these exceptions prove the rule. Ideological outliers in public health exist, but they are not integrated into the mainstream profession.

ideologies of the people who public health officials aim to serve.[11] In saying this, I acknowledge that I am making many generalizations and that the political dynamics I identify may be present to varying degrees in different contexts. To sharpen the argument, I focus mainly on public officials and scholars in the American context. The arguments I develop here may apply to a lesser extent to clinicians and front-line providers and officials in other contexts. That said, my sociological characterization of public health is intentionally broad. I prioritize explanatory power and parsimony over nuance because, while there are obviously exceptions to the claims I make about the profession, the sociological model of the profession that I advance has greater explanatory power than a more nuanced presentation of the field does.[12]

In the rest of this section, I will focus on four distinctive aspects of public health ideology. First, the most obvious aspect of public health ideology is that it is focused on health. At first glance, it may be unclear why a focus on health would be ideological. Health is a value like any other, though. An ideology is a system of values that informs how people approach public policy. By focusing on population health, public health officials and scholars value health over other values, such as happiness, fun, religious compliance, cultural traditions, or freedom. This is understandable because public health workers' jobs require them to promote health at a population level. I point this out here only to highlight that even a fairly sparse institutional mandate to "promote the health of everyone" is not ideologically neutral in a world where promoting health could undermine the promotion of other values.

Second, public health ideologues are also generally very focused on opportunities to promote health through public policy.[13] Some of them engage in political advocacy and some public health agencies are government agencies with a legal mandate coercively to enforce policies that aim to improve people's health. Here again, it is worth emphasizing that public health workers' implicit assumption that public policy should promote health at the population level is not ideologically neutral. For example, people who assume that coercive governmental intervention for the sake of promoting health is presumptively legitimate are more likely to downplay the moral importance of individual freedom from state action. This tendency within the field of public health is

[11] For survey research in support of this claim, see Robin Ringstad, "Political Diversity Among Social Work Students," *Journal of Social Work Values and Ethics* 11, no. 2 (2014): 13–23; Alex Woodruff, "Are Public Health Schools Politically Diverse?" *Public Health Post*, January 24, 2019, https://www.publichealthpost.org/viewpoints/are-public-health-schools-politically-diverse/; Elizabeth A. DeVilbiss et al., "Assessing Representation and Perceived Inclusion among Members in the Society for Epidemiologic Research," *American Journal of Epidemiology* 189, no. 10 (2020): 998–1010.

[12] For further discussion of the reasons for discounting nuance in sociological work, see Kieran Healy, "Fuck Nuance," *Sociological Theory* 35, no. 2 (2017): 118–27.

[13] As one scholar observes: "That the government has a role to play in improving the health of the public is in some ways baked into a public health mindset, and that is going to clash with those who don't believe the government has a role to play in the health space." Sarah Frostenson, "Health Shouldn't Be Contentious, But It's Incredibly Polarizing," *Vox*, February 6, 2017 (updated March 23, 2017), https://www.vox.com/policy-and-politics/2017/2/6/14229276/public-health-contentious-polarizing-opioids-aca-obesity.

consistent with the widespread endorsement of coercive paternalism as a tool for public health promotion in policy contexts, even though health workers generally reject coercive paternalism in clinical contexts. In contrast, conservative ideologues may be more tolerant of unhealthy conduct insofar as they view individuals as responsible for their own health and are therefore more skeptical of governmental intervention.

Third, as the above mission and value statements show, many organizations in the field of public health ideology are also purportedly egalitarian, at least when it comes to promoting equality between politically salient socioeconomic groups.[14] Public health agencies often proclaim that their goal is to reduce health disparities between groups, to provide equal access to health or health care for all, or to advance the cause of social justice. In Europe and Canada, the concept of solidarity is very prominent in discussions of health policy. People appeal to this value to justify systems that subject patients to long wait times and limited access to care, on the grounds that everyone at least has equal access to the same quality of public health care. In contrast, with few exceptions, public health agencies and organizations do not proclaim that they hope to foster flourishing markets in health care even if they result in disparate health outcomes.

The fourth distinguishing feature of public health ideology might be called epistemic elitism. Public health officials advocate their preferred policies by citing scientific researchers and health workers as authorities on public policy and by encouraging policymakers and citizens to "follow the science" or to trust the experts. They then present these calls as politically neutral or apolitical. In some contexts, epistemic elitism can be warranted. After all, medical experts often have access to more information than others, they are more skilled at knowing how to interpret complex data, or they know how to craft an effective intervention to promote health better. Yet as I will argue below, people should discount experts' credibility when the experts are likely motivated by ideological considerations. Also, as should be clear by now, public health officials cannot claim that their research is ideologically neutral. Moreover, even if it were possible to separate the science of public health from the political values of people in the profession, the claim that public officials should enforce policies that are based on science is itself a nonscientific claim that is orthogonal to public health workers' expertise.

Public health is thus ideological. In some respects, this orientation may be intrinsic to the field. Public health is distinctive from other areas of public policymaking because it focuses on health, for example. But public health is also ideological in a way that aligns with broadly left-wing political ideologies more than conservative political ideologies. Public health, as a discipline, need not focus on promoting health outcomes through government regulation and

[14] Here, I contrast a concern for establishing egalitarian relations between citizens and a concern for establishing more egalitarian relations between public officials and citizens. As I argue elsewhere, purported egalitarians often overlook inequalities between officials and citizens. Jessica Flanigan, "Social Equality and the Stateless Society," *Ethics, Politics & Society* 5, no. 2 (2022): 1–26.

taxation while intervening for the sake of reducing socioeconomic disparities. These aspects of the profession are not intrinsic to the enterprise of public health.

There are structural reasons why public health ideology aligns with a broadly progressive ideology. Progressives tend to live in more densely populated areas, while conservatives live in more rural areas. People who live in rural areas are less likely to be able to access and experience the benefits of public health, such as access to emergency care, hospitals, and community health programs.[15] People in rural areas are also less likely to suffer from the environmental health hazards associated with population density, such as air and noise pollution. Progressives also tend to be more educated, whereas conservatives are less educated.[16] Since public health is a field dominated by credentialed professionals, they are likely to hold the ideological commitments of their class. There are also likely selection and treatment effects that contribute to ideological homogeneity in public health. People who agree with the dominant ideology of the public health profession are more likely to choose to work in the field, while people who disagree may be discouraged from continuing in the profession or disadvantaged insofar as they experience ideological discrimination from other public health professionals.[17]

For all these reasons, conservatives may understandably be suspicious when educated progressives appeal to their credentials or self-proclaimed expertise as a justification for imposing progressive values on others. This is especially true in contexts where people perceive these policies as unethical or as directly harmful to them.

Despite the clear connection between public health ideology and progressive ideology, public health officials nevertheless present themselves and their work as if they are not partisan. This is related to their tendencies (1) to present controversial policy proposals as if they are value-free and politically neutral and (2) to accuse people who disagree with their policy proposal as if they are denying the science rather than to engage in an open debate about values. Yet at the same time, public health organizations are also eager to release mission statements, position papers, and press releases that tout the value of promoting population health through governmental programs for the sake of advancing equity between different social groups. Rather than gaslighting people about public health ideology, public health officials and scholars should be open to a frank and open discussion about the merits and hazards of advancing the values that are implicit in the field.

[15] Abby Vesoulis, "Democrats Need Rural Voters: Can They Win Them Over by Fixing Rural Healthcare?" *Time*, November 1, 2019, https://time.com/5715649/democrats-rural-healthcare-2020/.

[16] Nate Cohn, "How Educational Differences Are Widening America's Political Rift," *The New York Times*, September 8, 2021, https://www.nytimes.com/2021/09/08/us/politics/how-college-graduates-vote.html.

[17] For discussion of ideological selection and discrimination in public health, see Pollack, "Why Public Health Experts Aren't Reaching Conservatives on Covid."

The pragmatic case against public health ideology

Having defined public health ideology, we can now evaluate whether public health organizations effectively advance their ideology and whether this ideology is good. In this section, I argue that *even if* public health officials are justified in thinking that they should advocate evidence-based policies that promote population health and health equity, they often fail to advance these values.[18] This suggests either that public health workers are not equipped to advance their institutional values or that people who purportedly hold the ideology of public health are insincere.

Public health officials do not effectively advance their purported ideology, because the policies they support and endorse often fail in their stated aims. Consider, for example, public health officials who advocate paternalistic taxes on trans fats, soda, or cigarettes for the sake of reducing health disparities. These policies may be effective in reducing health disparities by deterring unhealthy behavior in disadvantaged populations, but they are also economically regressive because these kinds of taxes are more burdensome for people who have less income and wealth.

Even if we conceive of public health more narrowly—say, only as promoting health at a population level without paying attention to health disparities—public health officials still support and enforce policies that backfire. For example, consider bans and regulations on electronic nicotine delivery systems (ENDS) intended to reduce youth nicotine use, but which are also likely to prevent many smokers from switching to a safer and healthier nicotine product. As another example, consider the regulation of sex work. Brothel regulations, restrictions on street sex work, internet regulations on sex markets, and arduous licensing requirements for sex workers discourage sex workers from reporting violence and make it more difficult for public health officials to track outbreaks of sexually transmitted diseases. Consider, too, the harmful health effects of America's failed war on drugs.[19]

More generally, public health policies are not reliably backed by social science. Often, public health policy is promoted based on unsupported assumptions about human behavior. By this I mean that many health policies are defended only on the grounds that people would be healthier if they were to

[18] Pollack and Caroline Kelly make a similar point: "The public health community sometimes displays poor cultural competence in crossing this divide, in part because of the community's own limited viewpoint diversity." Harold A. Pollack and Caroline Kelly, "COVID-19 and Health Disparities: Insights From Key Informant Interviews," *Health Affairs Forefront*, October 27, 2020, https://www.healthaffairs.org/content/forefront/covid-19-and-health-disparities-insights-key-informant-interviews.

[19] For the example of ENDS, see, e.g., Colin Paul Mendelsohn and Wayne Hall, "Vaping Nicotine Is Far Less Harmful than Smoking Tobacco," *Chest* 158, no. 2 (2020): 835–36. For the example of sex work, see, e.g., Carrie E. Lyons et al., "The Role of Sex Work Laws and Stigmas in Increasing HIV Risks among Sex Workers," *Nature Communications* 11, no. 1 (2020): 773; Lynzi Armstrong, "'I Can Lead the Life that I Want to Lead': Social Harm, Human Needs and the Decriminalisation of Sex Work in Aotearoa/New Zealand," *Sexuality Research and Social Policy* 18, no. 4 (2021): 941–51. For the example of the drug war, see, e.g., Alana Klein, "Harm Reduction Works: Evidence and Inclusion in Drug Policy and Advocacy," *Health Care Analysis* 28, no. 4 (2020): 404–14.

comply with the policy, ignoring how the policy would affect people who refuse to comply and the anticipated rates of compliance. Health policies are sometimes justified on the grounds that they would be effective if they were perfectly enforced rather than considering how they would actually be enforced in practice. Public health officials also often focus on ways that a policy can promote one health-related value while ignoring other ways that a policy puts people at risk. Even if officials were justified in using public health policy to advance their ideologies, these dynamics suggest that they are often poorly equipped to do so insofar as policymakers fail to account for the costs of enforcement and rates of noncompliance.

Consider a few more examples of public health regulations that backfire for these reasons. By prohibiting access to investigational drugs, the U.S. Food and Drug Administration (FDA) prevents people from purchasing and using dangerous and untested drugs. But proponents of this policy overlook the dangers of this policy, namely, that people suffer and die waiting for drugs to gain approval and the high cost of the approval process disincentivizes drug development and innovation. By mandating that all health workers be vaccinated, hospital administrators and public health officials may prevent hospital staff from becoming vectors of contagious transmission, but they can also reduce the supply of health workers in an emergency.

Public health officials' responses to the COVID-19 pandemic reinforce this point and demonstrate how the politicization of public health hampers efforts to promote public health. Many social scientists have pointed out that public officials tasked with enforcing pandemic-mitigation policies should be mindful of retaining perceived legitimacy among all citizens and that this may require them to favor more universalist policies over policies perceived as ideological.[20] Yet public health messaging during the pandemic took the opposite form. As a result, people's willingness to defer to officials' recommendations about masking, social distancing, and vaccination were determined more by their partisan identities than by their individual interests or by their independent assessments of the evidence.[21]

Public health officials also undermined their claim to scientific authority when they communicated misleading and contradictory information about public health interventions, especially when people viewed this information as partisan. Consider, for example, messaging about the effectiveness of masking.[22] At the start of the pandemic, there was mixed but fairly poor evidence about the efficacy of masking. Masks likely do something, but how much they do is *very*

[20] Jay J. Van Bavel et al., "Using Social and Behavioural Science to Support COVID-19 Pandemic Response," *Nature Human Behaviour* 4, no. 5 (May 2020): 460–71.

[21] Don Albrecht, "Vaccination, Politics, and COVID-19 Impacts," *BMC Public Health* 22, no. 1 (2022), https://doi.org/10.1186/s12889-021-12432-x; Dhaval Adjodah et al., "Association between COVID-19 Outcomes and Mask Mandates, Adherence, and Attitudes," *PLoS One* 16, no. 6 (June 23, 2021), https://doi.org/10.1371/journal.pone.0252315; Robert N. Collins, David R. Mandel, and Sarah S. Schywiola, "Political Identity Over Personal Impact: Early U.S. Reactions to the COVID-19 Pandemic," *Frontiers in Psychology* 12 (2021), https://doi.org/10.3389/fpsyg.2021.607639.

[22] Kerrington Powell and Vinay Prasad, "The Noble Lies of COVID-19," *Slate*, July 28, 2021, https://slate.com/technology/2021/07/noble-lies-covid-fauci-cdc-masks.html.

unclear. There was also insufficient evidence in favor of the claim that mask mandates would prevent population-level mortality and transmission—nor does the evidence support mask mandates today. At first, public health officials reported that masks were not effective at all. They said this not because that was the state of the science, but because they were worried that health workers would run out of personal protective equipment (PPE) if private citizens started buying PPE as well. Then public health officials reversed course on mask messaging by not only claiming that they would effectively prevent transmission and reduce mortality, but also arguing in favor of mask mandates.

None of these messaging strategies regarding masks communicated the state of the scientific literature on masking. Nor were these messaging strategies calibrated to reflect social-scientific research about how to get people to adopt new sanitation and disease-prevention habits. For example, the literature on handwashing provides an instructive guide for mask policy. There, researchers find that public health guidance is more effective when messages are tailored to specific demographic groups and when it is fun and easy to comply with the guidance.[23] Researchers also find that people are much more likely to comply with public health guidelines when compliance aligns with their social identities.[24] People are much less likely to comply with guidelines when doing so is threatening to their identities. Based on this research, public officials who believed that masking was effective still had reasons to refrain from mandating masking, given that a governmental mandate would have politicized masks, thereby associating masking with people's partisan identities. Similar considerations apply to lockdowns and social distancing policies.

In each of these cases, public officials traded their long-term institutional legitimacy for short-term political victories. And it is not even clear that public health policy was necessary to achieve these victories. After all, it may look like public health officials effectively changed people's behavior with respect to masking, for example, but it can be difficult to tell whether public health authorities' recommendations changed behavior or reflected preexisting preferences for masking. At the same time, when public health recommendations differ from people's preexisting preferences, they can have ironic consequences. As many scholars argue, the politicization of scientific topics is inversely correlated with the public's willingness to trust scientific experts.[25] Conservatives are especially mistrustful of scientific experts who make claims about

[23] Nadja Contzen, Iara Helena Meili, and Hans-Joachim Mosler, "Changing Handwashing Behaviour in Southern Ethiopia: A Longitudinal Study on Infrastructural and Commitment Interventions," *Social Science & Medicine* 124 (2015): 103–14; Wai Khuan Ng, Ramon Z. Shaban, and Thea van de Mortel, "The Effect of a Hand Hygiene Program Featuring Tailored Religion-Relevant Interventions on Healthcare Workers' Hand Rubbing Compliance and Beliefs in the United Arab Emirates: A Cohort Study," *Infection, Disease & Health* 24, no. 3 (2019): 115–23; Gaby Judah et al., "Experimental Pretesting of Hand-Washing Interventions in a Natural Setting," *American Journal of Public Health* 99, no. S2 (2009): S405–11.

[24] Bavel et al., "Using Social and Behavioural Science to Support COVID-19 Pandemic Response."

[25] See, e.g., Aaron M. McCright and Riley E. Dunlap, "The Politicization of Climate Change and Polarization in the American Public's Views of Global Warming, 2001–2010," *The Sociological Quarterly* 52, no. 2 (2011): 155–94.

environmental or public health issues in the United States.[26] In contrast, liberals are mistrustful of scientific experts who advocate new inventions or innovations.[27]

These dynamics can also be excessively burdensome for public health officials who must navigate a highly politicized medical landscape. Consider, for example, Dr. Leana Wen's experiences with the APHA. In the early days of the COVID-19 pandemic, Wen supported mask mandates and lockdowns. She then changed course when vaccines became available, advocating a return to normal life and becoming a vocal proponent of mass vaccination. In response, more than 600 public health professionals signed a letter to the APHA condemning Wen and urging the association to disinvite her from their annual meeting.[28] At the same time, two people who were critical of vaccination faced criminal charges for threatening Wen's safety.[29]

It is ironic that so many public health policies backfire in predictable ways because so many public health officials and their political supporters claim that they are "following the science." Here, they tout the legitimacy of the biomedical research when justifying coercive health policies, while ignoring social-scientific evidence about the effects of law enforcement and likely rates of compliance with health incentives.[30] These missteps can also confirm people's more general mistrust of government interventions, thereby exacerbating the problems of noncompliance that public health officials so often overlook, making it more likely that public health initiatives will backfire.

To this argument, a proponent of public health as it is currently practiced may defensively point fingers at conservative critics of public health, arguing that they should bear more of the blame for the politicization of public health and a lack of trust in science. Yes, conservative lawmakers and media personalities also undermined trust in science and they are also partly to blame for ordinary citizens' refusal to comply with public health guidelines. Yet this observation does not negate the fact that progressive politicians, media personalities, and public health officials also failed to justify their claims that people should trust them in virtue of their scientific expertise.

Moreover, if public health officials knew that people are less likely to comply with public health guidance if they experience compliance as a social identity threat, as well as the fact that conservatives tied public health compliance to people's social identities, then they should have known that their efforts would

[26] Gordon Gauchat, "Politicization of Science in the Public Sphere: A Study of Public Trust in the United States, 1974 to 2010," *American Sociological Review* 77, no. 2 (2012): 167–87.

[27] Aaron M. McCright et al., "The Influence of Political Ideology on Trust in Science," *Environmental Research* 8, no. 4 (2013), https://iopscience.iop.org/article/10.1088/1748-9326/8/4/044029.

[28] Kay Lazar, "Prominent Doctor Faces Backlash amid 'Fight over the Heart of Public Health,'" BostonGlobe.Com, September 1, 2022, https://www.bostonglobe.com/2022/09/01/metro/prominent-doctor-faces-backlash-amid-fight-over-heart-public-health/.

[29] Justin Fenton, "Another Man Charged with Making Threats against Former Baltimore Health Commissioner Dr. Leana Wen," *The Baltimore Banner*, https://www.thebaltimorebanner.com/community/criminal-justice/another-man-charged-with-making-threats-against-former-baltimore-health-commissioner-dr-leana-wen-VIVS2HXP2BFINC2IX3KBAUOI6U/.

[30] Bavel et al., "Using Social and Behavioural Science to Support COVID-19 Pandemic Response."

likely backfire. If public health officials sincerely cared about following the science and maintaining people's trust in scientific expertise, they should have consulted the relevant social science and concluded that governmental mandates are likely to backfire or fail to secure sufficient compliance, especially in a highly polarized political environment. Instead, scientists and public health officials leaned into their political identities, for example, by engaging in highly partisan social media campaigns and protests.

To these examples, public health officials may reply that I am being uncharitable to their field. After all, public health officials in some countries embraced ENDS. Some public health regulators tried to speed the approval process for new drugs. And many public officials have walked back their support of mask mandates as more people learned about the limits of the research in favor of them. Yet in each of these cases, public health officials did not change course because the science changed; they changed course because the politics changed. For this reason, these counterexamples do not undermine my claim that public health initiatives often fail to promote their stated goals, because they are not supported by the evidence.

The ethical case against public health ideology

I am not concerned only about the fact that public health ideology often backfires and fails to promote its stated aims. Even if public health ideologues who have power in governments, hospital systems, and nonprofit organizations were entirely effective at promoting the life expectancy of a population through coercive policies, they would not be entitled to do so, because public health ideology is a flawed moral system. My main objection to the ideology of public health is that it is disrespectful to those who are subject to it. Public health ideology is disrespectful because it often violates people's rights and because it fails to treat people as moral equals to public health experts and political authorities.

Coercive policies that are justified by an appeal to public health ideology are the clearest examples of how it is disrespectful to promote this ideology. The argument against these policies goes like this:

> P1: Public officials presumptively lack the authority to enforce coercive policies that criminalize or penalize morally permissible behavior.
>
> P2: Unhealthy behavior is often morally permissible.
>
> C: Public officials lack the authority to enforce policies that criminalize or penalize unhealthy behavior.

This argument applies to all public health policies that involve legal penalties for facilitating or engaging in morally permissible unhealthy behavior, including policies that punish third parties for reselling unhealthy products or services and policies that tax risky or unhealthy conduct. We can interpret the first premise's

emphasis on a presumption against enforcement as a weak presumption; it still retains its force for the argument in the context of public health. At a minimum, public officials should refrain from coercively enforcing policies that criminalize or penalize morally permissible behavior, unless doing so is *necessary* to advance a substantial governmental interest. As Douglas Husak argues, when public officials overuse criminal sanctions to achieve their goals, even though non-coercive alternatives are available, they make citizens especially vulnerable to arbitrary interference by public officials.[31] Overcriminalization is especially morally risky in contexts where law enforcement is militarized or excessively violent and in contexts where there is reason to believe that the law will be enforced in a discriminatory way.

Many U.S. public health officials acknowledged the harms of overcriminalization in their responses to the killing of George Floyd in 2020. For example, some argue that police violence can have negative effects on public health at a population level.[32] Others argue that police violence can exacerbate preexisting inequalities of health and create new barriers to public health promotion.[33] Yet at the same time, insofar as public health officials also advocate policies that empower state actors to interfere with individual conduct, they effectively support policies that heighten the discretionary power of police. Consider, for example, the police killing of Eric Garner in 2014. In general, public health officials support high taxes on cigarettes as a way of discouraging smoking. Garner was initially approached by police officers for selling single untaxed cigarettes, which violated New York State's cigarette tax laws.[34] In this case, a coercive policy that aimed to promote public health also put some community members at a heightened risk of police violence.

To this example, a proponent of public health taxes may reply that Garner's case was an extreme outlier. On this view, fines, taxes, and administrative guidelines are generally not very burdensome and should not be equated with criminal penalties that involve incarceration and arrest. Yet fines, taxes, and administrative guidelines are only effective because people face criminal penalties if they fail to comply with them. Citizens who persistently ignore public health regulations and evade taxation can eventually go to jail, be forced into treatment, or have their property seized. Thus, even public health policies that

[31] Douglas Husak, *Overcriminalization: The Limits of the Criminal Law* (New York: Oxford University Press, 2008).

[32] American Public Health Association, "Addressing Law Enforcement Violence as a Public Health Issue," *American Public Health Association* (Policy Number 201811), November 13, 2018; Benard P. Dreyer, "The Toll of Racism on African American Mothers and Their Infants," *JAMA Network Open* 4, no. 12 (2021), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2786943.

[33] Jordan E. DeVylder et al., "Police Violence and Public Health," *Annual Review of Clinical Psychology* 18 (2022): 527–52; Hannah Cooper et al., "Characterizing Perceived Police Violence: Implications for Public Health," *American Journal of Public Health* 94, no. 7 (2004): 1109–18; Osagie K. Obasogie and Zachary Newman, "Police Violence, Use of Force Policies, and Public Health," *American Journal of Law & Medicine* 43, nos. 2–3 (2017): 279–95.

[34] Karen Matthews and Cedar Attanasio, "'I Can't Breathe': Eric Garner Remembered on the 10th Anniversary of His Chokehold Death," *AP News*, July 17, 2024, https://apnews.com/article/eric-garner-death-anniversary-chokehold-dca9708c2dee062f95f35483e1e2cfed.

do not directly invoke criminal sanctions still indirectly rely on the threat of criminal penalties.

The second premise is that it is not wrong to eat food, smoke, use drugs, pay for sex, or do any of the other unhealthy or risky things that officials try to ban in the name of public health. Some proponents of public health policies may argue that these behaviors are unethical because they impose risks on others. But even when these activities do impose some small risks or costs on others, the risks and costs are comparable to other costly and risky activities that public officials tolerate in other contexts, such as noise pollution or driving through a residential area.[35] Another reason these behaviors may be unethical is that citizens collectively bear the cost of their neighbors' unhealthy behavior through state-mandated insurance policies or because taxpayers finance health care directly through social welfare programs. However, the fact that some members of the public subsidize health care does not justify the prohibition or regulation of unhealthy behavior. If the public provision of health care is a mere act of beneficence toward people in need, then taxpayers and insurance providers are under no moral obligation to bear the cost of people's risky behavior. On this view, the provision of health care to people who make risky choices is optional, so those who do it have no complaint against the risk-takers whose care they voluntarily subsidize.

Alternatively, if the public provision of health care through insurance and the welfare state is morally required, then it is because even people who make risky decisions have a right to health care. If people can waive their right to health care, then those who provide health care to those in need cannot claim that restrictive public health policies are justified considering the social costs of risky behavior, because risk-takers could instead waive their entitlement to impose these costs on others. In some other cases, people may forfeit their right to health care, if they knowingly take risks that could impose serious costs on others. But if people cannot alienate, waive, or forfeit their right to health care, then those who provide health care to those in need still cannot claim that restrictive public health policies are justified in light of the social costs of risky behavior, because risk-takers do not forfeit their entitlement to take risk just in virtue of the fact that risk-taking makes it more likely that they will access benefits that they were independently entitled to.[36]

For these reasons, public health officials lack the authority to enforce policies that criminalize or penalize unhealthy behavior. Officials lack the authority to interfere with people's personal, self-regarding medical choices just as physicians lack the authority coercively to require that their patients make healthier choices in clinical contexts.

[35] For further discussion of how public health officials hold tobacco use to higher standards of risk reduction than other activities, see Jessica Flanigan, "Double Standards and Arguments for Tobacco Regulation," *Journal of Medical Ethics* 42, no. 5 (2016): 305–11.

[36] I defend this claim in more detail elsewhere. See Jessica Flanigan, "Can Social Costs Justify Public Health Paternalism?" in *New Perspectives on Paternalism and Health Care*, ed. Thomas Schramme (Cham: Springer International Publishing, 2015), 233–45.

These same considerations against coercive public health policies also apply to deceptive public health campaigns. Just as public officials lack the authority to threaten people into making healthier choices, they also lack the authority to trick people into better health. In addition to the more deontological harms associated with deception, "noble lies" for the sake of public health are rarely justified, because they are generally unnecessary and likely to backfire.[37] For these reasons, it is wrong when public health officials lie or mislead people in order to promote population health on balance. For example, public health officials misrepresented the evidence about which vaccination rates would be necessary to achieve herd immunity from COVID-19.[38] Also during the COVID-19 pandemic, the Centers for Disease Control (CDC) misleadingly claimed that more teens were hospitalized with COVID-19-related illnesses when increases in teen hospitalizations were more likely due to mental health problems that were worsened by lockdowns and online schooling.[39]

Together, these arguments against coercive and deceptive public health policies also weigh against policies that enable public health officials coercively to interfere with commercial speech in ways that censor the dissemination of truthful information. For example, public health officials currently impose marketing restrictions on tobacco and alcohol advertising that prohibit vendors from portraying their products as cool, pleasurable, and fun, even though they clearly are.[40] To take another example, the FDA prohibits drug companies from publicizing truthful information about potential off-label uses of their products.

These coercive and deceptive public health policies are disrespectful to those who are subject to them not only because they violate people's rights against deception and interference, but also because paternalism is expressively disrespectful. There are two reasons to think that paternalism is expressively disrespectful. First, paternalistic public health policies disrespect citizens' judgment. Second, paternalistic public health policies disrespect citizens' authority to make their own decisions. Consider paternalistic seatbelt laws as an illustration of these two points. Grant for the sake of argument that seatbelt laws save lives on balance. Even still, seatbelt mandates treat citizens as if they are not qualified to decide whether to wear a seatbelt and mandates treat citizens as if their lives are not theirs to risk when they get behind the wheel. Moreover, it is important not just to consider the expressive drawbacks of enforcing any given public health policy that limits people's options, but also to consider the

[37] Samuel Director, "Public Health Officials Should Almost Always Tell the Truth," *Journal of Applied Philosophy* 40, no. 5 (2023): 951–66.

[38] Mike Allen, "NYT: Fauci Acknowledges Moving Goalposts on Herd Immunity from COVID-19," *Axios*, December 25, 2020, https://www.axios.com/2020/12/25/fauci-goalposts-herd-immunity.

[39] Emma Goldberg and Emily Anthes, "Hospitalizations for Children Sharply Increase as Delta Surges, CDC Studies Find," *The New York Times*, September 3, 2021, https://www.nytimes.com/2021/09/03/health/delta-children-hospitalization-rates.html; CDC, "New CDC Data Illuminate Youth Mental Health Threats during the COVID-19 Pandemic," *Centers for Disease Control and Prevention*, March 31, 2022, https://www.cdc.gov/media/releases/2022/p0331-youth-mental-health-covid-19.html.

[40] Flanigan, "Double Standards and Arguments for Tobacco Regulation."

expressive harm of being subject to government enforcement even if people would have otherwise behaved in ways that did not violate the policy.

In addition to the expressive harms of public health policies and the moral risk of unjust enforcement, these policies can also backfire. Return to the examples of ENDS, pharmaceutical regulations, mask mandates, lockdowns, and social distancing policies. Many of these policies can be costly, even if they never require enforcement because everyone complies. By refraining from switching to an e-cigarette, a smoker puts herself at greater risk of lung disease. By waiting for FDA approval, a sick person may suffer and die due to a lack of treatment. Voluntary masking and social distancing can inflict social and economic costs on those who do it.

In contrast to coercive public health policies, voluntary public health restrictions are less morally risky because they are not coercive. Private schools, clubs, and business owners' voluntary adoption of policies that comply with what I am calling public health ideology are far easier to justify than public health policies that are compulsory. For example, if a business owner decides to ban e-cigarettes and to require social distancing and mask wearing, she may be enforcing policies that are counterproductive or ineffective. However, her fellow citizens could simply choose to shop or dine elsewhere and she would not violate anyone's rights to vape or to stand near unmasked strangers.

Another reason to reject public health ideology, even in voluntary contexts, is that public health guidelines often contribute to the medicalization of deviance. As many sociologists have long noted, people are quick to pathologize or medicalize behavior that they view as subversive, disagreeable, or inappropriate. When nonmedical aspects of life are reconceived in medical terms, it gives people who have power and authority over health to regulate and deter behavior that they find socially undesirable. As P. J. McGann and Peter Conrad argue, "constructing deviance as illness confers a moral status different from crime or sin," but nevertheless provides a pretext for interference or control.[41] Joseph Schneider cites many cases where people with social power medicalized behavior in ways that enabled them to reframe behavior that people previously viewed as bad to then view it as a form of sickness.[42] These cases include the medicalization of promiscuity, homosexuality, drinking, gambling, birth, shortness, shyness, unattractiveness, criminality, and the dying process. In each case, professionals used the medical system to change people's behavior, even though that behavior was a normal behavior or phase of life.

Public health is now a part of the medicalization of deviance as well, building on earlier patterns of medicalization in clinical contexts, including psychiatry. Consider, for example, the ways that poor diet and obesity are addressed by public health campaigns to address food deserts. There is no clear evidence that food deserts are a primary cause of obesity, nor is there evidence that they are

[41] P. J. McGann and Peter Conrad, "Medicalization of Deviance," in *The Blackwell Encyclopedia of Sociology*, ed. George Ritzer et al. (Malden, MA: John Wiley & Sons, Ltd, 2007), https://doi.org/10.1002/9781405165518.wbeosd049.

[42] Joseph Schneider, "The Medicalization of Deviance: From Badness to Sickness," in *The Handbook of Deviance*, ed. Erich Goode (Malden, MA: John Wiley & Sons, 2015), 137–53.

the primary cause of socioeconomic disparities in weight. As Hunt Allcott, Rebecca Diamond, and Jean-Pierre Dubé find, "neighborhood environments do not have economically meaningful effects on healthy eating."[43] This finding has been confirmed elsewhere, including by the CDC, which finds that adding a supermarket within one mile of a person's home *at best* decreases the average body mass index (BMI) in that area by .115, or about 1 pound.[44]

And yet despite the lack of evidence connecting food deserts to obesity or to socioeconomic disparities in obesity, the Annie E. Casey Foundation announced an initiative to address food deserts and the alleged negative health effects associated with them.[45] The Foundation has since changed its terminology to refer to "communities with limited food access," but the substantive point remains. Like the aforementioned coercive public health initiatives, even non-coercive public health initiatives can effectively give authority figures the power to address or "cure" deviant behavior under the pretext of addressing a medical problem.

When the medicalization of deviance provides a justification for political intervention, the moral objections to this dynamic are even more forceful. Consider, for example, how the medicalization of recreational drug use happened by way of the administrative state and professional agencies that rely on the administrative state. In these cases, public officials made decisions about drug policy, including decisions about addiction treatment and punishment for drug-related crimes, through government agencies that were often unaccountable to courts or legislatures.[46] These public officials therefore operated with little democratic oversight and few requirements for transparency. Historically, people do not question undemocratic expansions of medicalization as much as they question the imposition of other values. But when voters do have an opportunity to challenge the medicalization of deviance, they often reject these policies. For example, in 2018 voters in Washington State decided to tie local public health officials' hands by banning soda taxes statewide.[47]

An especially pernicious aspect of public health and the medicalization of deviance is that it ostensibly avoids accusations of elitism or legal moralism. If wealthy and educated officials outright were to say that they disapprove of the ways that low-income people feed themselves and their children, on the grounds that those food cultures were correlated with a body type that they also did not approve of, then wealthy and educated officials would rightly be condemned for

[43] Hunt Allcott, Rebecca Diamond, and Jean-Pierre Dubé, "The Geography of Poverty and Nutrition: Food Deserts and Food Choices across the United States" (Working Paper No. 3631, Graduate School of Business, Stanford University, Stanford, CA, January 14, 2018).

[44] Aiko Hattori, Ruopeng An, and Roland Sturm, "Neighborhood Food Outlets, Diet, and Obesity Among California Adults, 2007 and 2009," *Preventing Chronic Disease* 10 (2013), https://www.cdc.gov/pcd/issues/2013/12_0123.htm.

[45] The Annie E. Casey Foundation, "Exploring America's Food Deserts," *The Annie E. Casey Foundation*, February 14, 2021, https://www.aecf.org/blog/exploring-americas-food-deserts.

[46] Carl Hart, *High Price* (New York: HarperCollins, 2013).

[47] Bill Lucia, "Washington Voters Approve Ban on Local Soda and Grocery Taxes," *Route Fifty*, November 8, 2018, https://www.route-fifty.com/finance/2018/11/voters-approve-washington-grocery-tax-soda-tax-oregon-ballot-measure/152696/.

their intolerance and fatphobia. If wealthy and educated officials were to state that they view obesity and poor diet as moral failings that the government should intervene to correct, they would then face the difficult task of defending the claim that it is unethical to eat fast food.

Instead, the guise of public health enables wealthy and educated people to impose their cultural values on low-income communities under the guise of paternalistic concern. Yet there is a tension in this strategy. After all, the claim that taxes and subsidies can effectively improve people's health outcomes appeals to the claim that people's health outcomes are at least partly a result of how they voluntarily respond to incentives. But if so, then a proponent of these policies seemingly is committed to the view that people are, at least in part, responsible for their food choices. In this way, although paternalistic justifications may appear to sidestep accusations of legal moralism and elitism, proponents of these policies are implicitly committed to the view that unhealthy food choices are voluntary choices that public officials aim to discourage on the grounds that they disapprove of them.

We all make trade-offs and many of the best things in life involve a substantial degree of medical risk. Even if it is better to be healthy, all else being equal, all else is never equal. People in different circumstances may rationally make different choices.[48] It is a serious problem when public health ideologues narrowly focus on the value of health benefits without attending to the ways that efforts at health promotion implicitly cast judgment on people who have different values or are making trade-offs that are reasonable, given their circumstances.

Expanding the scope of public health

The APHA lists gun violence, high school graduation, housing, transportation, and climate change as public health issues. None of these issues addresses the medical system directly. While each of these areas of public policy concern, in a sense, do affect health outcomes, so does every other kind of public policy, including tax reform, immigration, and military enlistment. Yet the subset of public policy issues that the APHA lists under their purview are distinct from other political issues that they could address in that these issues are policy priorities for the Democratic party.

In this section I argue against expanding public health into other areas of policymaking. Expanding the scope of public health is a mistake in the first place because, given that so many existing public health initiatives backfire and violate people's rights, we have reason to believe that the expansion of public health would do the same. At the same time, to the extent that public health policies are justified and effective, expanding the scope of public health to new domains of policymaking potentially dilutes support for more targeted public health efforts and redirects health experts to intervene in areas where they are unqualified to

[48] Daniel Hausman, "Egalitarian Critiques of Health Inequalities," in *Inequalities in Health: Concepts, Measures, and Ethics*, ed. Nir Eyal et al. (Oxford: Oxford University Press, 2013), 112.

influence policy. Expanding the scope of public health is also a mistake because the guise of public health enables lawmakers and public officials to subvert legislative and judicial mechanisms for lawmaking and to enforce coercive policies through the administrative state. Also, expanding the scope of public health in its current partisan form could undermine the legitimacy of public health officials at a time when it is important for at least some public health officials to retain their perceived legitimacy.

Consider first the claim that expanding the scope of public health is likely to magnify problems with the implementation of public health ideology. Above, I argued that public health policies often put people at risk of excessive interference by public officials. Public health policies can also be used—and historically have been used—as a tool for enforcing compliance or for controlling people. They often backfire because public officials are not qualified to judge which reforms will improve people's health at a population level, much less to judge which reforms would promote overall well-being. Expanding the scope of public health policies involves extending the moral risks of public health ideology to new domains of political decision-making, including criminal justice, property law, and education policy.

Say that I am mistaken and public health policies to date have been successful and morally justified. Even if so, expanding the scope of public health could still be a mistake insofar as it potentially dilutes support for more targeted public health efforts. Public officials may have the power to expand their budgets through borrowing and taxation, but they still have a budget. Historically, public health officials focused their efforts on policies that protected people from the contagious transmission of illness and from environmental hazards such as air pollution.[49] These policies protected people from nonconsensual, otherwise unavoidable threats to their health and well-being. Every dollar that public health officials spend on promoting population-level health outcomes is a dollar diverted from protecting people from air pollution, poor sanitation, and the contagious transmission of illnesses. As public officials expand their understanding of population-level health outcomes and as they expand their policy reach to new domains of policymaking, such as gun control, climate change, and high school graduation rates, they further divert resources from causes like pandemic prevention and wastewater monitoring.

In recent decades, and increasingly, public health officials have also devoted institutional resources to crafting and enforcing policies that promote better population-level health outcomes. These include policies that aim to prevent people from making recreational, medical, and occupational choices that could endanger their health, even if people consent to the risks. Notably, this expanding understanding of the purview of public health policy has coincided with a recent decline in life expectancy in the United States. I mention this not to imply that there is a negative causal relationship between the expansion of public health policy and life expectancy, but to cast doubt on arguments for the expansion of public health that appeal to the value of promoting better

[49] Richard A. Epstein, "In Defense of the 'Old' Public Health: The Legal Framework for the Regulation of Public Health," *Brooklyn Law Review* 69, no. 4 (2004): 1421–70.

population-level health outcomes. At the very least, the expansion of public health has not clearly improved population-level health in practice, though it is difficult to know what would have happened otherwise.

Another problem with expanding the scope of public health is that officials acting in the name of public health are typically less accountable to the ordinary restrictions on policymaking (such as they are) than elected officials or even judges are. Most governmental public health officials work for administrative agencies, but their policy decisions carry the force of the law. So as governmental public health officials expand their institutional mandates into new areas of public policy, they expand citizens' subjection to policies that voters, lawmakers, and judges have comparatively less procedural power to influence.

A possible defense of public health ideology

So far, I have argued that public health ideology is often harmful. When public officials enforce policies based on this ideology, they often violate people's rights and do more harm than good. Expanding the scope of public health in order to advance the political ideology of the profession is a mistake because it not only magnifies the harmfulness of public health ideology, but also undermines public health officials' ability effectively to fulfill their legitimate role.

In closing, it is worth considering a broad objection to the foregoing argument. The objection can be stated like this:

> P1: Public officials should implement whatever policy is just, even if people wrongly think that the policy is unjust and even if people think that the implementation of the policy is illegitimate.
>
> P2: Relative to voters, judges, and elected lawmakers, public health officials are more reliable judges about whether a policy is just, especially a health policy.
>
> C: Public health officials should implement the policies that they think are just, even if people wrongly think that the policy is unjust and even if people think that the implementation of the policy is illegitimate. This is especially true for health policy.

Although many political philosophers dispute the first premise, I agree with it. In any case, I will grant it for the sake of argument. The argument is roughly valid, too. Yet, as I argue in this section, the second premise fails because public health officials are not more reliable judges of public health policy than other policy actors are.

The main reason for skepticism about P2 relates to the foregoing arguments that there is a strong partisan ideological consensus among public health professionals. As Rishi Joshi argues, the fact that public health professionals seem to agree on a range of seemingly orthogonal issues and that their agreement strongly aligns with their partisan beliefs, is itself a reason to discount the

reliability of public health officials' judgment on these issues.[50] There is little reason to think that one political party is reliably a better judge of policy than another one across a wide range of policy domains. American public health professionals likely hold false beliefs about many policy questions because their beliefs about these issues are unduly influenced by their partisan political beliefs.

Experts are not immune to motivated reasoning that confirms their partisan beliefs. During the COVID-19 pandemic, political ideology influenced laypeople's and health workers' beliefs about a range of treatments.[51] Researchers also find that people from both parties will discount credible sources of health evidence when they view the evidence through the lens of partisan animus.[52]While it is possible to reduce people's affective polarization across ideological lines, it is challenging to do so in a context where people disagree about a substantive issue, such as health policy.[53] As further evidence of this phenomenon, the examples of public health failure that I described above illustrate how partisan motivated reasoning causes public health professionals to misrepresent or misinterpret the relevant public health evidence.

These arguments aim to debunk public health officials' claim to expertise, especially given that the field is so polarized. Additionally, as I previously mentioned, it is unclear that the expansion of public health to address a broader range of ideologically salient public policies and to focus on population-level health has effectively promoted population-level health anyhow. These changes in public health diluted public health officials' claim to expertise because it is more difficult for any official to establish expertise across such a broad range of policy areas.

Conclusion

In the 1830s, Londoners experienced a devastating cholera epidemic.[54] As the epidemic persisted and recurred, medical experts in the British Royal Society struggled to identify the source of the problem. Some experts attributed the disease to environmental toxins in the air (miasma). Proponents of this view

[50] Hrishikesh Joshi, "What Are the Chances You're Right about Everything? An Epistemic Challenge for Modern Partisanship," *Politics, Philosophy & Economics* 19, no. 1 (2020): 36–61.

[51] Joel M. Levin et al., "The Political Polarization of COVID-19 Treatments among Physicians and Laypeople in the United States," *Proceedings of the National Academy of Sciences* 120, no. 7 (February 14, 2023), https://doi.org/10.1073/pnas.2216179120.

[52] James N. Druckman et al., "How Affective Polarization Shapes Americans' Political Beliefs: A Study of Response to the COVID-19 Pandemic," *Journal of Experimental Political Science* 8, no. 3 (2021): 223–34.

[53] Erik Santoro and David E. Broockman, "The Promise and Pitfalls of Cross-Partisan Conversations for Reducing Affective Polarization: Evidence from Randomized Experiments," *Science Advances* 8, no. 25 (2022), https://doi.org/10.1126/sciadv.abn5515.

[54] This description of the Cholera epidemic is especially informed by Casey Petroff's unpublished work and by a discussion of the analogies between cholera and COVID-19 by Barbra Pfeffer Billauer. Barbara Pfeffer Billauer, "The Future of Public Health Law Lies in the Past—and Lawyers Need to Learn It," *Bill of Health*, May 2, 2023, https://blog.petrieflom.law.harvard.edu/2023/05/02/the-future-of-public-health-law-lies-in-the-past-and-lawyers-need-to-learn-it/.

advocated improved sanitation measures, such as ventilation and the use of disinfectants. Others speculated that cholera was contagious, so they advocated quarantines to reduce person-to-person transmission. Neither solution worked. After decades of research, Dr. John Snow assembled enough epidemiological data to establish that people seemed to get cholera from drinking contaminated well water. Yet experts were slow to change their minds and some continued to advocate their preferred solutions to the epidemic even after scientists identified the water-borne organism that caused cholera.

I bring up this account of a cholera epidemic in closing to highlight how difficult it can be for people effectively to achieve the core mission of public health. If public health workers' professional decisions were shaped by their shared political ideologies and social identities in a way that also influenced their research or policy recommendations, the epidemic would have been even more difficult to understand and prevent. Ideological homogeneity prevents people from accessing the epistemic benefits of disagreement. Researchers eventually identified the origins of cholera because there were different models and opinions about the epidemic. Because there was a lack of consensus in the field, scholars had to contend with compelling evidence for theories that challenged their own views as they continued to collect data and test new hypotheses.

Snow's discovery of the causes of cholera, in addition to many other historical triumphs of public health, is a testament to the promise of the field. When public health professionals stay focused and avoid partisan ideological side quests, they retain their institutional legitimacy and provide meaningful benefits to their fellow citizens. But for public health effectively to protect people and promote well-being, public health officials must be focused and clear-eyed about their mission. Because public health is so difficult and so important, professional experts must refrain from advancing their partisan and ideological priorities on the job.

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