Responsibility as an Ethical Framework for Public Health Interventions

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Bioethical debate has been characterized from the beginning by the central importance placed on autonomy. This is because bioethics has, until now, been concerned with the relationship between doctor and patient in a clinical context or, alternatively, with the rights of individuals involved in biomedical research. The increased involvement of bioethics in the domain of public health, however, makes it necessary to refer to other principles and values, thus shaping a new responsibility-focused bioethics that extends itself beyond the early boundaries of this discipline. (*Am J Public Health.* 2009;99:1197–1202. doi:10.2105/AJPH.2007.127514)

A serious philosophical reflection on public health ethical issues may widen and enrich the young academic field of bioethics. Bioethics, in fact, suffers from an individual-centered approach because its attention is mainly directed toward medicine and medical research, which are concerned with the individual level. Public health, however, focuses on the population level and is concerned with the lives of the whole population or of large subgroups of the population.

Here, I try to show that the ethos of medicine and medical research cannot be transported as such into the realm of public health measures, because that would make public health measures very difficult to implement. Next, I establish the significance of responsibility rather than autonomy as central to public health ethics. At the same time, I stress the difference between retrospective and prospective responsibility, showing that only the latter is a good candidate for public health ethics.

I then show that there is no opposition between autonomy and responsibility, because responsibility necessarily includes respect for autonomy. This argument could be useful for bioethics itself, because responsibility permits the overcoming of the old conflict between beneficence and autonomy, which has been the main problem of bioethics since it began. Responsibility, in fact, represents a good balance between the 2, as I show when I distinguish the 2 senses of responsibility: to answer *to* someone and to answer *for* someone.

Finally, I propose some examples of possible applications of this responsibility-centered model of public health ethics. Public health interventions should reach the right balance between the 2 principal meanings of responsibility. This model stands between the libertarian perspective, which gives priority to the individual and allows only a minimal state, and the collectivist point of view, which aims to promote the greatest aggregate benefit, by considering individual rights as dependent on the shared will of the community.

PUBLIC HEALTH AND THE LIMITS OF AUTONOMY

The importance placed on autonomy, which has characterized the bioethical debate from the beginning, arose from bioethicists' concern with the problems of the relationship between doctor and patient in a clinical context or with the rights of individuals who participate in biomedical research. As Callahan and Jennings argue, "in early bioethics, the good of the individual, and particularly his or her autonomy, was the dominant theme."[1(p169)]

In the field of clinical practice, bioethics introduced the principle of respect for the autonomy of the patient, counterbalancing ancient medical ethics, which was mainly based on the principle of beneficence and the tendency for paternalism. This development was important because it challenged the idea of medical ethics as the "ethics of physicians," which above all took heed of the point of view of the doctor. Indeed, the physician acts for the good of the patient and his or her ethical point of view is prevalently oriented toward the principle of beneficence. By contrast, autonomy is a value claimed by patients who want to be able to establish what is in their interests and not simply undergo that which the physician considers best. Therefore, we could say that the journey from traditional medical ethics to bioethics has allowed wider participation in the ethical debate compared with clinical practice. This enlargement has been accompanied by a corresponding widening of the framework of values guided by the principle of autonomy.[2]

An analogous phenomenon occurred in the field of experimental medical sciences. First the Nuremberg trial[3] and then the shocking cases in the United States of harmful experiments conducted without the informed consent of the participants led to ever greater recognition of the principles of autonomy and informed consent in this delicate field.[4] Callahan and Jennings suggested, in fact, that "bioethics received its initial stimulus from the abuses of human subjects research, the emergence of the patients' rights movement, and the drama of high-technology medicine."[1(p169)] A similar understanding of bioethics' beginning is expressed by Bayer and Fairchild:

> In the beginning there was bioethics. The 1960s and 1970s witnessed extraordinary challenges to the broadly understood authority of medicine. Perhaps most strikingly, the paternalistic authority of physicians was brought into question by a new medical ethics that gave pride of place to the concept of autonomy. Paralleling the challenges to medical practice were those that involved the research enterprise. Against a backdrop of scandal and abuse, and hunted by the experience of the violations of human dignity that had occurred under the aegis of medical research in Nazi Germany, a new ethics of research took hold. Informing that moral worldview was the basic belief that no individual should be required to participate in research endeavors—no matter how important for the public good—without his or her consent. Thus, the ethics of clinical research and the ethics of medical practice were conjoined by a commitment to autonomy and individual rights[5(pp473–474)]

This "individualistic, autonomy-driven mainstream orientation within bioethics . . . has

held sway" despite resistance and criticism, because, "in keeping with the cultural trends of the 1970s and the 1980s, it has often brought together the political left and the market-oriented right in a celebration of choice and freedom."[1(p170)] Nowadays, however, a shift of direction in the field of bioethics is called for, because the increased involvement of various parties in the domain of public health makes it necessary to rethink the individualistic orientation of bioethics, by means of the population and societal focus of public health.[6,7]

Indeed, public health differs in many ways from clinical medicine. First, in terms of its basic activity, because clinical medicine is much more concerned with treatment, whereas the main goal of public health is prevention. Then in terms of patients, because clinical medicine takes care of individuals, whereas public health is concerned with whole populations. Finally, in terms of predominant orientations. There is, in fact, a "predominant orientation in favor of civil liberties and individual autonomy that one finds in bioethics, as opposed to the utilitarian, paternalistic, and communitarian orientations that have marked the field of public health throughout its history."[1(p170)]

If we were to rigorously apply the principle of autonomy in the field of public health as it is applied in the field of biomedical research or in clinical practice, it would make any kind of public health intervention impossible. Indeed, interventions in public health restrict autonomy more than in clinical medicine because of a duty to protect the public's health. It therefore imposes mandatory and legally regulated interventions. In fact, as some scholars argue, "public health also has the potential to be coercive, backed up by police powers, using interventions that are imposed without the consent procedures that we take for granted in clinical healthcare."[9(p3),10] The reason autonomy has a minor role in public health is that the whole community may clearly be harmed if someone, at the individual level, refuses an intervention or chooses to engage in unhealthy behavior. Furthermore, in public health, the respect of informed consent is more difficult, because convincing a community is more complicated than convincing a single patient.

A different concept of beneficence is also involved. In clinical medicine, a physician takes care of a single patient and acts for his or her own good. In public health, interventions can be applied to individuals who are at extraordinarily low risk and therefore stand to gain very little or no benefit from the intervention and yet are exposed to the risks that such an intervention entails.

The moral foundations of public health are clearly expressed by Herman Biggs, a highly influential American health official who implemented a new set of public health interventions between the 19th and the 20th centuries. As Biggs said,

> The government of the United States is democratic, but the sanitary measures adopted are some time autocratic, and the functions performed by sanitary authorities paternal in character. We are prepared, when necessary, to introduce and enforce, and the people are ready to accept, measures which might seem radical and arbitrary, if they were not plainly designed for the public good, and evidently beneficent in their effects.[11(p28, note 2)]

More recently, Kass wrote that the "codes of medical and research ethics generally give high priority to individual autonomy, a priority that cannot be assumed to be appropriate for public health practice."[12(p1776)]

Similarly, when public health interventions are not coercive but simply aim to inform citizens of the lethal effects of certain practices or lifestyles, for example, smoking, alcohol abuse, or poor diet, it cannot be done in accordance with the traditional requirements of informed consent. Guttman and Salmon observe,

> For centuries, governments and other social institutions have engaged communication strategies in the service of public health using tactics some may consider to be "benevolent public manipulation." These have often aimed to "sell" certain health-promoting practices, such as the early detection of high blood pressure or breast cancer, or to discourage other behavior, such as smoking or high consumption of foods rich in saturated fats.[13(pp532–533)]
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> In a world saturated with mediated messages public health practitioners must vie for people's attention: this may require "shock tactics" or strong emotional appeals. . . . More recently, attempts to capture the attention of the public include the use of statistics to amplify risk.[13(p539)]

Another technique, of dubious usefulness according to some, consists of exaggerating factors such as negative consequences, the magnitude of problems, or the degree of the expertise of the authorities it relies upon, thus presenting a 1-sided argument or selecting only favorable supporting evidence.

To illustrate these ideas, think of the typical warning found printed on cigarette packets: "smoking kills." The relation between smoking and the death of the smoker is presented in an absolute way, whereas in reality the situation is more complex. Actually, the warning should say that, according to statistics, there is a certain probability of developing lung cancer through smoking, above all in people with a genetic predisposition. But, nevertheless, there are cases (not so infrequently) of hardened smokers who have not developed lung cancer. It is obvious that the outcome is not the same. No one, however, protests against this type of information that tends to emphasize the potential harm, because, it is said, the intentions are benevolent.

THE PRINCIPLE OF RESPONSIBILITY

If sole autonomy is insufficient and, maybe, problematic for public health ethics, what is the fundamental practical principle of this particular domain of medicine? I would say responsibility, or, more precisely, a kind of responsibility that differs from that which is involved with penal and civil law. In the field of law, responsibility is meant, essentially, as imputability. A widespread notion in law, to impute means to attribute an action to an agent. In civil law, responsibility or imputation involves the obligation to make up for the damage caused by one's own guilty conduct, as described by the law. In penal law, responsibility involves the obligation to undergo punishment. A key feature of consequent responsibility is that it necessarily concerns someone who finds himself exposed to responsibility and who is able to take it on himself as he considers himself to be legitimately subjugated by it. Imputability, therefore, is a particular type of responsibility, that is, the responsibility as a consequence.

If we want to apply the principle of responsibility in the field of public health, however, then we need to look at its meaning in a completely different way. Indeed, in the field of public health, you are responsible as much for what has already happened as for what could happen if all possible preventive measures are not utilized. In public health, responsibility is

intended as a relation with an act that has not yet occurred, i.e., responsibility in an antecedent (or prospective) way. Whereas consequent responsibility is associated with the idea of obligation to answer for an act that has already been done, antecedent (or prospective) responsibility is associated with the idea of a condition or a state, such as when we say that parents answer for the damage that their children might cause.

Whereas consequent responsibility is strongly tied to the concept of blame, antecedent responsibility is free of such associations. This is because with consequent responsibility all attention is concentrated on the blamed person, whereas with antecedent responsibility the attention is concentrated on potential victims, because there is not yet a guilty party. Responsibility without blame is a notion of responsibility intended as a guarantee against risk or a commitment to repair damage, that is, civil responsibility. In this case, elements of punishment and blame can be taken out of responsibility, a process facilitated by the concepts of solidarity, security, and risk, which tend to replace the idea of blame. In this way, attention is shifted from the presumed agent of damage to the victim who needs to be compensated, even in the absence of guilty behavior. The objective evaluation of harm tends to obliterate the appreciation of the subjective link between the action and its agent, by virtue of the calculation of probability that groups together events of a similar nature. As observed by the philosopher Ricoeur,

> In an age in which the victim, the risk of accident, and the harm suffered, are at the very heart of the problematic rights of responsibility, it is not surprising that the vulnerable and the fragile are considered morally equivalent to objects of responsibility, that is things for which we must feel responsible.[14(pp62–63)]

RESPONSIBILITY INCLUDES RESPECT FOR AUTONOMY

Responsibility, as the etymology of the word suggests, is a response. This response, however, takes different forms. At one level, responsibility is "responding to" someone who asks for something, for example, someone who asks to discontinue a particular medical treatment. In this sense, "responding," that is, to be responsible, means respecting the autonomy of that person. At another level, responsibility is "answering for." In clinical practice, this can take the form of the principle of beneficence, whereas within public health it becomes a response to the future consequences of the failure to intervene. Another example in environmental ethics could be being responsible for (answering for) future generations.

The concept of responsibility is so rich and multifaceted that it may seem paradoxical. In the case of public health, for example, being responsible for a population exposed to a contagious virus might require the implementation of urgent measures, even at the cost of failing to fully respect the principle of informed consent that would instead demand a response to requests for explanations, providing rich and exhaustive information, and then gathering a consensus before finally taking action. So, what is the way forward? What rule can settle the conflicts between the different forms of responsibility? The answer is that there are no general rules and that conflicts are always resolved by looking at the individual case that can provide some context. It cannot be said before the fact whether it is better to compulsorily evacuate a community threatened by a toxic cloud or an epidemic or whether it is better to provide everyone within the community with an explanation and then obtain from each person signed consent, given the risk that everyone dies while trying to reach a consensus. It cannot be said before the fact; it depends on the nature of the intervention, the degree to which it infringes an individual's fundamental values, the magnitude and extent of the risk, and the extent to which personal liberty will be restricted. In summary, everything depends on a correct and timely assessment of all circumstances present in any given context. So, this is another form of responsibility, even if it's true that one could derive responsibility from *res* (*rem*) *ponderare* (to ponder), which means to "weigh things up"—evaluate any given situation.

This side of responsibility is clearly underlined by Childress et al.:

> Since any particular action, practice, or policy for the public's health may also have features that infringe one or more general moral considerations, it will be necessary to determine which of them has priority. Some argue for a lexical or serial ordering, in which one general moral consideration, while not generally absolute, has priority over another. For instance, one theory might hold that individual liberty always has priority over protecting or promoting public health. Neither of these priority rules is plausible, and any priority rule that is plausible will probably involve tight or narrow specifications of the relevant general moral considerations to reduce conflicts. From our standpoint, it is better to recognize the need to balance general moral considerations in particular circumstances when conflicts arise. We cannot determine their weights in advance, only in particular contexts that may affect their weights.[15(p172)]

So, even responsibility belongs to the same family as *phronesis,* of moral judgement reached in a particular situation, of reflective judgement, and so on. Acting in a responsible way is similar to acting in a wise way and as a mature person, which resembles neither a mechanical application of abstract rules nor a trial-and-error application of rules that proceeds blindly without the guiding light of any universal principle whatsoever. Whoever acts in this way knows the rules of ethics and applies them while learning from their own experience, utilizing their own discernment, and letting themselves be guided by their habits of acting well.

FORMS OF PUBLIC HEALTH INTERVENTION

In what ways do public health organizations intervene? What are the measures that are actually implemented in various countries? Above all, which measures better fit the 2-sided criterion of responsibility described earlier?

Noncoercive Interventions

Noncoercive interventions are those interventions that simply monitor the situation, that provide information, that enable individuals to change their behaviors by offering psychological or material support, or that guide choices through changing the default policy.

One intervention, most acceptable to public opinion, consists of helping individuals make informed decisions rather than limiting choices. This is one of the typical interventions adopted to prevent smoking: the effects of smoking tobacco products are listed on cigarette packets. Such a policy could also be implemented successfully in the field of diet and

nutrition. Indeed, some nutritionists have shown that knowledge of the nutritional value of food has a strong impact on dietary choices. Such a policy could also be implemented successfully in the field of diet and nutrition. Indeed, it could be easily demonstrated that knowledge of the nutritional value of food has a strong impact on dietary choices. For example, if the same menu options are presented to the same people on 2 different occasions and the nutritional value of the choices is displayed only on the second occasion, one can imagine that the most probable result would be a complete change in the decisions made: food popular on the first occasion would be overlooked on the second, and vice versa.

This intervention is one of the most appropriate if we follow the criterion of responsibility, because, in this case, we are going to implement and enforce both sides of responsibility: responsibility as in "to answer to" (that is, respect for autonomy) and responsibility as in "to answer for" (that is, "to take care of," or "to be responsible for"). In the example regarding company cafeterias, we could say that people's choices on the first occasion were not really autonomous because they did not really know what they were eating. So, in informing them of the nutritional value of their choices, we are responsible for them, and, at the same time, we are implementing their autonomy. Here the balance between the 2 sides of responsibility is very easy to find.

Another strategy consists of making the producers of harmful substances assume responsibility for the consequences on the population of their products. This strategy is also adopted with regard to industrial producers of tobacco, who in the United States have been subject to legal action by exsmokers who became ill because of smoking. Such legal proceedings have led the producers of cigarettes to inform their customers, with much care, of the harmful effects of smoking (often with greater caution than is required by the law in order to protect themselves against potential litigation). This model could also be applied to the field of food production, above all for products aimed at school-aged children.

This strategy is also acceptable from the point of view of the responsibility criterion because it obliges the producers of harmful substances to inform people of the possible consequences of their products. Here the old legal concept of responsibility as imputability is used to oblige the producers to be responsible for their clients and to oblige commercial companies to take seriously corporate social responsibility. This is an interesting case of prospective responsibility (i.e., antecedent responsibility) born from retrospective responsibility (i.e., consequent responsibility or imputability). At the same time, in this case, the 2 meanings of responsibility described above ("to answer for" and "to answer to") do not clash with each other, because producers of harmful substances are obliged to be "responsible for" by means of informing people.

These kinds of interventions are noncoercive regarding the effects on the population. Obviously, they are coercive regarding the producers of harmful substances, but this doesn't matter here, because we are now investigating public health policies and their effect on the whole population.

Soft Coercive Interventions

"Soft" coercive interventions are those interventions that guide choices through advertisements, incentives, and disincentives or those that restrict the options available to people with the aim of protecting them. At least 3 possible applications exist.

One possible application concerns legislative interventions aimed at promoting healthier lifestyles or products that are considered healthy by means of advertising. Justification for such interventions is based on the fact that certain habits are the result of social conditioning, which is often itself a consequence of advertising rather than the product of a free choice. As Childress et al. note,

> the question is where we draw the boundaries of the self and his actions; that is, whether various influences on agents so determine their actions that they are not voluntary, and whether the adverse effects of those actions extend beyond the agents themselves.[15(p176)]

These kind of interventions seem, at first glance, similar to the previous ones described in the "Noncoercive Interventions" section, but thinking carefully, we can find some difference because the logic of advertisement is sometimes distant from the logic of true, correct information. In fact, as we have observed, communication strategies sometimes imply public manipulation. In a world saturated with mediated messages, advertisements must vie for people's attention; this may require shock tactics or strong emotional appeals, by means, for example, of manipulation of statistics to amplify risk or of exaggerating factors such as negative consequences, the magnitude of problems, or the degree of the expertise of the authorities it relies upon, thus presenting a 1-sided argument or selecting only favorable supporting evidence.

Another possibility is the use of financial incentives and deterrents, such as increasing taxes on unhealthy food and lowering taxes on healthier food. Such a "fat tax" policy is supported by the Word Health Organization. Financial mechanisms are often used to discourage the consumption of tobacco, a product that is subject to heavy taxation in almost all countries worldwide. In Italy, the financial legislation for 2008 includes a reduction in tax on gym expenses incurred by parents on behalf of children between the ages of 5 and 18 years.

This kind of intervention differs from the first 2, in which there is no opposition between the 2 meanings of responsibility and in which the implementation of answering for is, at the same time, an equal implementation of autonomy (answering to). In this kind of intervention, there is a light form of coercion, as in the third one. Here, in fact, the coercion is caused by high prices that push people to buy certain products instead of others, whereas in the previous kind of intervention the coercion was caused by communication strategies that imply public manipulation. This kind of coercion is sometimes also unfair, because high prices are more coercive for poor people and public manipulation is more effective among less-educated people. Nevertheless, we cannot say that these interventions are contrary to our criterion, because in these interventions there is a true commitment to peoples' health (in the sense of answering for) and, at the same time, autonomy, unless limited, is not completely absent. In fact, despite taxes on cigarettes and advertising against smoking, many people still continue to smoke.

A third possible intervention consists of restricting the options available to people with the aim of protecting them, for example, removing unhealthy ingredients from foods or

unhealthy foods from shops and restaurants. To give an actual example, the government could ask schools to adhere to particular nutritional guidelines to regulate the quality of products available for consumption in vending machines or the food served in school cafeterias.

This type of intervention is, in some way, coercive, because students' choices of food in vending machines are limited and not completely free. However, students have the chance to choose whatever kind of food they want outside school. This limitation, in other words, aims only at proposing a healthy model of nutrition, for a limited time, without an absolute imposition.

All the soft coercive interventions described in this section could be justified by their effectiveness (i.e., the chance of realizing the goal that is sought) and proportionality (i.e., whether their probable benefits will outweigh the infringed general moral considerations), because they impose only a partial and weak limitation to individual autonomy. This justification has to be offered to the political public in a transparent way[15] to express community rather than impose it: "imposing community involves mandating or compelling testing through coercive measures. By contrast, expressing community involves taking steps to express solidarity with individuals, to protect their interests, and to gain their trust."[15(p174)]

Public justification, as Daniels[16] and others argue, needs openness to public deliberation, honest information, transparency, publicity, and justification about the reasons for a decision; appeals to rationales and evidence that fair-minded parties would agree are relevant; and procedures for appealing and revising decisions in light of challenges by various stakeholders.[16–19] Public justification "provides a basis for public trust, even when policies infringe or appear to infringe some general moral considerations."[15(p175)] Nevertheless, effectiveness, proportionality, and public justification alone are not sufficient to justify more drastic and coercive measures, as noted in the next section.

Highly Coercive Interventions

Highly coercive interventions are those that eliminate choice (e.g., through compulsory isolation of patients with infectious diseases). Thus, we can turn to the most ancient forms of intervention in the field of public health: checking and monitoring the population or groups particularly vulnerable to infections or viral epidemics to isolate them. These are strong measures that involve a large degree of coercion and limit personal freedom but that are sometimes necessary to protect other people from contagious diseases. The problem in this case is how to evaluate the danger of an infectious disease and its contagious capacity. In our democratic societies, coercive interventions could be ethically justified when they address actions that affect others adversely. Such a kind of coercion is not paternalistic, because paternalism affects self-regarding and voluntary actions.[20] Even John Stuart Mill, who is the standard-bearer of civil liberties, agrees with a limitation of other-regarding actions, because they affect others without "their free, voluntary, and undeceived consent and participation."[21(p71)]

The main problem with monitoring, surveillance, and isolation concerns their possible extension. Indeed, we can comprehend and justify such an intervention in the case of severe acute respiratory syndrome (SARS) or avian influenza, but we might start to have strong reservations if such interventions were adopted to other infective illnesses, such as HIV. To use the example of HIV, such an extension would imply the identification, monitoring, and surveillance of infected pregnant women and newborns[22,23] or of high-risk groups such as men who have sex with men, injecting drug users, or persons who engage in sexually promiscuous behavior.[10]

Here we could say that the limitations imposed on individual privacy, autonomy, and liberties are sometimes necessary. However, when they reach the level of unnecessary discrimination or excessive interference with private life, they cannot be conciliated with the principle of responsibility for vulnerable people in a reasonable weighting up of all implicated moral issues. Public health policies, to respect the double-faceted principle of responsibility, should seek to minimize the infringement of autonomy:

> The fact that a policy will infringe a general moral consideration provides a strong moral reason to seek an alternative strategy that is less morally troubling. This is the logic of prima facie or presumptive general moral consideration. For instance, all other things being equal, a policy that provides incentives for persons with tuberculosis to complete their treatment until cured will have priority over a policy that forcibly detains such persons in order to ensure the completion of treatment. Proponents of the forcible strategy have the burden of moral proof. This means that the proponents must have a good faith belief, for which they can give supportable reasons, that a coercive approach is necessary.[15(p173)]

CONCLUSIONS

The responsibility-centered ethical framework I propose stands between the libertarian perspective, which gives priority to the individual and allows only a minimal state, and the collectivist point of view, which aims to promote the greatest aggregate benefit and considers individual rights dependent on the shared will of the community. According to this perspective, based on the principle of responsibility, a greater, more explicit justification is needed when interventions affect important areas of personal life, against libertarians, who always refuse to interfere with individual liberty, and against collectivists, who authorize measures that reduce some choice of individuals only on the basis of democratic decision-making processes. Therefore, public education and information have a key role in the responsibility-centered ethical framework, because they are noncoercive ways of bringing about important improvements in health. This is the most important principle that the ethics of responsibility shares with libertarianism. At the same time, however, an ethics of responsibility has the duty to propose alternative and more effective interventions when such an approach fails. An example of this step-by-step policy is the information campaign concerning the use of seatbelts. In many countries, people were in the first instance exhorted to wear seatbelts through information campaigns, but the outcome was achieved only by making the use of seatbelts a legal requirement.

One of the most important consequences of the principle of responsibility is a limitation of the state's role in favor of third parties. As a matter of fact, when the state monopolizes most of the social functions there is, as a

consequence, a loss of sense of responsibility in individuals and groups, who tend to delegate their initiative to the state. This happened in almost all communist countries during the past century.

Various third parties, beside the state, have an important role in the delivery of public health, and it would be a great mistake to ignore them. These may be medical institutions, charities, businesses, local authorities, schools, and corporate agents independent of government, such as food, drink, tobacco, water, and pharmaceutical companies and owners of pubs and restaurants. This is why corporate social responsibility constitutes one of the most important applications of the principle of responsibility described above. Recent years have seen a significant rise in social responsibility initiatives, and many large companies publish annually the results of their corporate social activities alongside their financial reports. This emergence of corporate social responsibility is noteworthy, because it arises from a new ethical demand in which consumers are playing an active role.

By emphasizing the importance of corporate social responsibility, we are following once again the middle path between collectivism and libertarianism. In accordance with libertarianism, we refuse a hypertrophic state that takes all public health interventions upon itself and whose aim is to force people to be healthy. At the same time, and always in accordance with libertarianism, we recognize the important role that a responsible society has in the delivery of public health, as made by responsible individuals, families, groups, and commercial companies. Conversely, we believe that the libertarian's emphasis on individual choice does not take into account the fact that the environments in which people make choices are not value free and that people very frequently just accept the default policy or the normal practice. Therefore, the state could, in the first instance, oblige commercial companies to take corporate social responsibility seriously through incentives and disincentives, thus framing in this way the default policy; or, in the second instance, if corporate responsibility is lacking, the state could intervene directly when the health of the population is significantly at risk. ■

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