RELATIONAL CONCEPTIONS OF PATERNALISM: A WAY TO REBUT NANNY-STATE ACCUSATIONS AND EVALUATE PUBLIC HEALTH INTERVENTIONS

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ABSTRACT

Objectives: ‘Nanny-state’ accusations can function as powerful rhetorical weapons against interventions intended to promote public health. Public health advocates often lack effective rebuttals to these criticisms. Nanny-state accusations are largely accusations of paternalism. They conjure up emotive concern about undue governmental interference undermining peoples’ autonomy. But autonomy can be understood in various ways. We outline three main conceptions of autonomy, argue that these that can underpin three different conceptions of paternalism, and consider implications for responses to nanny-state accusations and the assessment of public health interventions.

Study design and methods: Detailed conceptual analysis.

Results: The conceptions of paternalism implicit in nanny-state accusations generally depend on libertarian conceptions of autonomy. These reflect unrealistic views of personal independence and do not discriminate sufficiently between trivial and important freedoms. Decisional conceptions of paternalism, like their underlying decisional conceptions of autonomy, have limited applicability in public health contexts. Relational conceptions of paternalism incorporate relational conceptions of autonomy, so recognise that personal autonomy depends on socially shaped skills, self-identities and self-evaluations as well as externally structured opportunities. They encourage attention to the various ways that social interactions and relationships, including disrespect, stigmatisation and oppression, can undermine potential for autonomy. While nanny-state accusations target any interference with negative freedom, however trivial, relational conceptions direct concerns to those infringements of negative freedom, or absences of positive freedom, serious enough to undermine self-determination, self-governance and/or self-authorisation.

Conclusion: Relational conceptions of autonomy and paternalism offer public health policymakers and practitioners a means for rebutting nanny-state accusations, and can support more nuanced and more appropriately demanding appraisals of public health interventions. (249 words)

Keywords: Paternalism; autonomy; nanny-state; public health; ethics

'Nanny-state' is a negative, even derisive, descriptor. It is levelled against states, agencies or interventions that, with the intention of achieving some kind of good, are alleged to interfere excessively—by some standard—in the lives of citizens.[1] Mayor Bloomberg's 2012 attempt to limit the portion size of soda served in New York has become a paradigm example of 'the nanny-state'. This is in part because the *Center for Consumer Freedom*, a third-party organisation funded by food, beverage and tobacco industries, sought to counter the proposed changes by running a high-exposure mass media campaign featuring a photo-shopped image of Bloomberg dressed as a nanny.[1, 2]

As the Bloomberg example illustrates, nanny-state language is a feature of political and public discourse. Although the precise meaning of 'nanny-state' is often unclear, academic analyses suggest that the term is most often used against identifiable, novel interferences in individual choices, made ostensibly for the good of the recipients.[1, 3, 4] Nanny-state criticisms tend to be immoderate, politically or ideologically motivated and poorly argued, sometimes with an ad hominem quality.[5] 'The nanny-state' can operate as a frame,[6] implying—without detailed argumentation—that the problem at hand is interference, or even tyranny, and that the solution is total individual freedom and/or total personal responsibility.[3-5]

These analyses of nanny-state rhetoric suggest that the meaning of 'nanny-state' is close that of another concept: paternalism, a contentious issue in public health ethics.[7] Some authors have argued that concern about the nanny-state, or paternalism more generally, is a distraction from more important moral considerations in public health, and/or that the project of defining paternalism should be abandoned altogether.[3, 5, 8, 9] We agree that paternalism should not dominate public health ethics. However because nanny-state accusations can function as a powerful rhetorical weapon against public health,[3] and because advocates of public health interventions often seem to lack effective rebuttals to these accusations, we

believe the conceptualisation of paternalism does need attention. In what follows we will analyse the concept of paternalism in detail to help assess nanny-state accusations.

We start by outlining a standard account of paternalism, noting that paternalism is a nested concept that relies on two other concepts: welfare and autonomy. The wrong of paternalism lies in its implications for autonomy, so we focus particularly on this. We use Catriona Mackenzie's recent work on competing conceptions of autonomy[10, 11] to derive competing conceptions of paternalism, including nanny-state paternalism. We argue that the nanny-state conception of paternalism relies on problematic assumptions about people, social life and autonomy, and that a relational conception of paternalism is more descriptively accurate and more normatively useful. The relational conception offers resources to rebut nanny-state accusations when these are levelled against morally justifiable public health interventions. It also allows a more nuanced evaluation of the potential for unjustified paternalism within public health interventions.

We will use 'the paternalist' to indicate the individual or group actor whose actions may be paternalistic, and 'the subject' to indicate the recipient/s of this action.[12]

PATERNALISM: THE BASIC CONCEPT

The literature on paternalism is dominated by efforts to differentiate descriptively between paternalistic and non-paternalistic acts.[13-15] Two conditions feature in most standard accounts of paternalism:[15]

1. The paternalist in some way undermines, constricts or limits the autonomy, freedom or liberty of the subject; and
2. The paternalist justifies this action on the grounds that it promotes what she understands to be the good, welfare or benefit of the subject.

On most accounts, both the first (autonomy-undermining) and second (welfare-justification) conditions must be satisfied for an action to be considered paternalistic.

Paternalism is a somewhat paradoxical concept. The term generally has a negative valence. However an action can be paternalistic only if it is expected to produce a good or benefit (or prevent a decrease in an existing good or benefit). Actions that limit autonomy, freedom or liberty but do not have welfare as their goal are merely autonomy-undermining, coercive or restrictive. An accusation of paternalism, in contrast, implies that the paternalist is seeking to justify a wrong (in relation to autonomy) with reference to the welfare that may ensue. Thus, the particular usefulness of the negatively-valenced concept of paternalism hinges on its somewhat paradoxical enclosure of the positively-valenced concept of welfare or benefit.

There is contention over whether the concept of paternalism also includes a non-consent condition. Some accounts suggest that, to be considered paternalistic, an action must be done against the will of, or without the consent of, the subject.[7, 15] There are various ways of understanding consent, and the relation between consent and autonomy is complex.[16] We will assume that a non-consent condition is unnecessary given that an autonomy-undermining condition is central to the concept of paternalism. There are several reasons for this. First, processes designed to attain consent are usually intended to ensure respect for autonomy, although their implications for autonomy in the more meaningful senses of that term are often very limited.[16, 17] Respecting and/or promoting some of the conceptions of autonomy considered below is more demanding than simply attaining consent, but will also be likely to include something like working with rather than against or absent a person's will or consent, at least on things that matter to most citizens. Second, in a public health context, a requirement for active personal consent would essentially forbid most intervention, as it would be impractical to achieve this from individual citizens. A conception of paternalism that required active personal consent would put a much greater demand on public health

actions than on most actions carried out by governments. Third, its impracticality means a consent condition would not offer any additional ability to discriminate between justifiable and unjustifiable public health actions. We believe that closer attention to the conception of autonomy that matters for paternalism will provide more useful discrimination between justified and unjustified public health interventions.

In the context of interventions at a population rather than an individual level, it is not always clear who "the subject" is. In particular, the subjects of the autonomy-undermining condition and the subjects of the welfare-justification condition may not always be the same population or sub-group of the population. In the case of the soda ban, for example, there are two relevant classes of subject: people who buy large sodas and so may lose this freedom, and people who are overweight and thus ostensibly may benefit from consuming fewer calories. These two groups will overlap, but not completely. Thus "the subject" of the soda ban, for the purposes of determining whether it is paternalistic, is not entirely clear. Although this is an important conceptual issue, it is beyond the scope of this paper: we will assume that a population-level intervention is paternalistic if it undermines the autonomy of some people to promote or protect the welfare of some people.

If the autonomy-undermining and welfare-justification conditions are accepted as central to the concept of paternalism, then particular conceptions of paternalism will depend on the conceptions of autonomy and welfare employed. We turn to these now.

THE WELFARE-JUSTIFICATION CONDITION

The welfare-justification condition will be satisfied when an actor attempts to justify an intervention on the grounds that it will promote some aspect of subjects' welfare, or prevent their welfare from diminishing. Assessment of whether or not the welfare-justification condition has been met is relatively straightforward. There is no requirement that a paternalist

is either genuine or single-minded about the pursuit of subjects' welfare. There is also no requirement that the welfare is promoted or protected as claimed. The condition will be met as long as an attempt is made to justify the action at least in part with reference to the welfare it could bring about.

The justification for most public health interventions is an aim to deliver health benefits to a group of people or population. Whether they are oriented to deliver an aggregated good (the sum of benefits received separately by many individuals) or a corporate good (experienced by whole communities or populations, such as herd immunity, reliable city-wide sanitation, or a safe and effective blood bank),[18] most public health interventions will readily satisfy the welfare-justification condition necessary to an accusation of paternalism.

When faced with accusations of paternalism, public health professionals often respond by asserting that the actions concerned will substantially increase health, and so welfare. Notice, however, that this is not an adequate answer. While the welfare that is planned or achieved is likely to be relevant to a complete moral evaluation of an intervention, insisting that 'our intervention will increase welfare' cannot counter an accusation of paternalism. Rather, it provides evidence that one of the conditions for paternalism is satisfied and so supports, rather than refutes, the accusation. To successfully rebut charges of paternalism, public health professionals need to counter the implication that they are undermining autonomy, freedom or liberty.

THE AUTONOMY-UNDERMINING CONDITION AND PATERNALISTIC ACTIONS

Some notion of autonomy, liberty or freedom is fundamental to any discussion of paternalism, but these terms are often used in interchangeable or unexplained ways. Accusations of paternalism will be more serious the greater the moral significance of the

aspects of autonomy, liberty or freedom that are undermined. A case can be made that richer notions of autonomy, not just narrow conceptions of liberty or choice, are most significant.[19]

We now draw on and extend the work of Catriona Mackenzie, who has distinguished between three main conceptions of autonomy—libertarian, decisional, and relational—and show how these alter the interpretation of the autonomy-undermining condition.[10] We outline three associated conceptions of paternalism which we call, respectively, nanny-state, decisional and relational, and argue that the relational conception is the most useful for nuanced appraisals of public health activity.

LIBERTARIAN AUTONOMY AND NANNY-STATE PATERNALISM

Libertarian autonomy is the conception most commonly employed by strong critics of public health interventions. This conception loosely equates autonomy with negative liberty, that is, freedom from any interference by other persons or the state.[11] The central concern on libertarian conceptions is respecting autonomy in a stand-back sense: minimising interference with any of the liberties and choices of individuals. This overlaps with positions which employ an often-oversimplified Millian harm principle to limit morally permissible action.[9, 20]

Libertarian conceptions of autonomy suggest that any infringement on any negative liberty will be paternalistic if it is justified on the basis that it protects or enhances welfare. We propose that conceptions of paternalism associated with libertarian conceptions of autonomy be designated nanny-state conceptions. This is because, as discussed above, the descriptor nanny-state is used in practice to indicate identifiable, novel interferences in individual choices, and to infer that these frustrate achievement of a supposedly ideal state of total personal freedom and responsibility.[1, 3, 4] Any intervention that can be alleged to restrict individual choice is apparently open to nanny-state accusations.

There are several problems with nanny-state conceptions of paternalism. First, they are so potentially inclusive of any interference with choice as to negate the possibility of government, because any functioning government will by necessity alter the choices available to their citizens in some way.[8] Further, they invoke a version of human life in which people are most autonomous when entirely insulated from one another's actions, and in which almost all freedoms and opportunities are equally important. This is descriptively and normatively inadequate. Human actions are rarely if ever unconstrained, we never have infinite choice, and we always live in environments that have been in some way engineered by someone for some purpose. Liberties are also important to us by degree; while some choices or freedoms are central to human wellbeing, others are trivial or invisible.[21] The choices in which public health policies interfere will often be considered insignificant or justifiably limited by most members of a community, and some such interference must be potentially justifiable if any policy action is ever to proceed.[8] Because nanny-state conceptions of paternalism make almost any interference problematic, they fail to distinguish those interferences that matter to citizens from those which do not.

DECISIONAL AUTONOMY AND DECISIONAL PATERNALISM

Another conception of autonomy focuses on decision-making. This conception features strongly in traditional clinical ethics, where respect for autonomy is generally understood to require the following: 1) the consent of patients should be sought when decisions are made about interventions relating to their health; 2) for this consent to be valid, patients should be: i) adequately competent; ii) adequately informed; and iii) acting voluntarily.[11, 22, 23] This obliges health professionals to determine patients' competence, inform them about options, and avoid unduly influencing their preferences and choice.[11, 24]

The associated conception of paternalism, which we call decisional paternalism, would tend to occur between individuals, for example a patient and either a clinician or a family member. On a decisional conception, a person behaves paternalistically if, with a welfare justification, they:

1. Prevent the subject from choosing or having an opportunity to make a decision about something of importance to them;
2. Fail to provide the subject with (or prevent the subject from accessing) information needed to make a good decision; and/or
3. Unduly influence or control a decision that the subject is entitled to make for herself.

The decisional conception of paternalism is normatively relevant: it points to potentially problematic actions. However the decisional conception of autonomy on which it rests is much-criticised, including for:

1) disregarding the conditions in which autonomy is developed and sustained;
2) ascribing too much significance to personal independence (like the libertarian conception);
3) focusing on discrete decisions and neglecting other situations in which autonomy may be compromised; and
4) neglecting the ways that some influences on decisions that appear to be the person's own, including habit, bias and subconscious motivations, may have been shaped by oppressive social circumstances and relationships.[23, 25]

Because decisional conceptions of paternalism are most relevant to local exchanges between individuals, they are relatively unworkable for evaluating most public health measures, other than those—like screening and vaccination—that are administered in clinic settings.

RELATIONAL AUTONOMY AND RELATIONAL PATERNALISM

Relational conceptions of autonomy retain a normative focus on the autonomy of individuals but eschew the kind of independence-idealising individualism associated with libertarian and frequently decisional conceptions. Theorists concerned to take seriously the sociality of human agency have developed a cluster of relational conceptions of autonomy in recent decades.[25, 26] Recognising that human beings are all dependent on others to some degree, they have stressed the need to attend to the various ways in which interpersonal relationships and broader social arrangements can both foster and impede the development of people's capabilities, values, self-identities, and the opportunities they have to exercise autonomy over the course of their lives.[11, 25] Within these conceptions negative liberties are important for autonomy, so are a broad range of socially shaped opportunities. Relational theorists generally highlight the adverse effects of social oppression and exclusion on the development and exercise of autonomy, and often emphasise the need for states and others to positively value, foster and promote autonomy rather than simply respect it in a stand-back sense.[11, 25, 27]

Three dimensions of relational autonomy

Mackenzie recently produced a new analysis of relational conceptions of autonomy.[10] She suggested that autonomy comprises three interrelated dimensions: self-determination, self-governance and self-authorisation. When relationally conceptualised, each dimension can be seen to depend to some extent on the others as well as on a web of mutually supporting conditions. Each dimension can also be experienced to varying degrees.

Self-determination and its conditions

A person who is self-determining is able to make important choices in her life and act on them. To be self-determining, people require political and/or personal freedoms and at least a

threshold level of opportunities. These freedoms and opportunities are important conditions for self-determination: they create possibilities to act, hold values or pursue different ways of being. These conditions are primarily external and structural, shaped by the state and other societal institutions.[10] Most relational theorists see securing them as a matter of justice. Relational theorists generally hold that some freedoms are more important than others for self-determination, and many consider the most important freedoms to be those vital to ensuring equality of opportunity.[10]

Self-governance and its conditions

The external, structural freedoms and opportunities necessary for self-determination influence the development and exercise of the more internal conditions for self-governance. Self-governance involves having the skills and capacities necessary to take advantage of opportunities where they exist, and to do so in a way that expresses, or is consistent with, one's practical identity.[10] A person's practical identity develops throughout the course of her life. It includes her values, beliefs and sense of self, and evolves with ongoing self-reflection, dialogue and social interaction.[10] The skills a person needs to govern herself in accordance with her practical identity are not just cognitive, but also emotional, imaginative and social. Although these skills are largely internal, they are socially shaped.

Self-authorisation and its conditions

Self-authorisation, the final dimension of relational autonomy, involves regarding oneself as having the normative authority required to be self-governing and self-determining.[10] It means being prepared to take responsibility for one's beliefs, values and practical commitments, being willing to provide reasons for these to others, and being willing to defend or revise these reasons if they are critically questioned.[10] A person who lacks self-authorisation will not consider herself worthy to determine her own values or to make the

kinds of commitments that become identity-defining. While conditions for self-determination inhere primarily in institutions, and the skills required for self-governance inhere in the individual, it seems to us that the conditions for self-authorisation arise from relationships between individuals and within communities. These relationships are underpinned by social recognition of people as moral equals and as self-authorising sources of valid claims.

Mackenzie draws on insights from a range of relational theorists and identifies three main relevant conditions for self-authorisation:[10]

1. Recognising oneself as the kind of person who can be held answerable or accountable to others; [28]
2. Possession of, or ability to hold, certain self-evaluative attitudes: for example respecting oneself; trusting that one's own judgements, feelings and desires are a legitimate basis on which to deliberate; and having self-esteem (being able to see one's life as meaningful);[29] and
3. Being recognised by others, to a sufficient degree, as a person who has the social standing of an autonomous agent (this underpins 1 and 2).

The implications of relational autonomy for paternalism

The details of how self-determination, self-governance and self-authorisation are characterised and constituted are the subject of ongoing scholarship and debate.[26] Mackenzie's helpful synthesis is sufficient, however, to allow us to see the value of using relational conceptions of autonomy to think about paternalism in public health contexts. On a relational account of paternalism, public health actors can be considered paternalistic if they:

1) undermine people's self-determination, self-governance, and/or self-authorisation; and

2) justify this by implicitly or explicitly suggesting that it will increase health or welfare.

A relational conception of paternalism foregrounds the moral significance of respecting and promoting even partial or threatened autonomy, not only the autonomy of competent subjects. It emphasises that, because they are causally interconnected, undermining one dimension of autonomy (self-determination, self-governance or self-authorisation) will often have negative implications for the others as well. It recognises that public health interventions can *increase* as well as decrease citizen's autonomy capabilities, and that this is not necessarily tied to health. It is possible that interventions that aim explicitly to increase people's opportunities (and so capacity for self-determination), skills (and so capacity for self-governance) and self-evaluative attitudes (and so capacity for self-authorisation) also enable people to engage in more autonomous health promoting actions,[30] however the value of fostering of autonomy is not contingent on any associated health improvement.

DISCUSSION

We noted at the outset that paternalism is a paradoxical concept, entailing a wrong (undermining autonomy) ostensibly justified by a good (increasing welfare). A well-founded accusation of paternalism must be based on an appropriate conception of autonomy. We have summarised the key features of libertarian, decisional and relational conceptions of autonomy (as elucidated by Mackenzie), and delineated three associated conceptions of paternalism: nanny-state, decisional and relational paternalism.

In this discussion section, we first analyse three examples of public health intervention against the three conceptions of paternalism. We then compare the merits of the three conceptions, explaining why we think relational conceptions of paternalism are particularly valuable for both the defence and the critical appraisal of public health interventions.

THREE EXAMPLES OF PUBLIC HEALTH INTERVENTION

Consider three examples of public health intervention: the New York soda ban, the Australian social advertising campaign 'LiveLighter', and the World Health Organisation-endorsed Directly Observed Therapy Short-Course (DOTS) for tuberculosis (explained in Table 1). For reasons of scope we can discuss these interventions only with regard to whether or not they are paternalistic: a more comprehensive ethical analysis would attend to many other morally relevant considerations. These interventions all meet the welfare-justification condition, so whether or not they are paternalistic relies on whether they undermine autonomy. As explained in Table 1, they will be assessed very differently depending on what conception of autonomy is employed. We refer to these examples in the following discussion.

(Table 1 about here)

NANNY-STATE, DECISIONAL OR RELATIONAL PATERNALISM FOR PUBLIC HEALTH?

Our analysis suggests that the strengths of a relational conception, and the weaknesses of both nanny-state and decisional conceptions, mean that relational conceptions of paternalism are both the most useful and the most demanding for public health.

Comparing decisional and relational conceptions of paternalism

Decisional conceptions of paternalism are of limited relevance for many public health interventions (including the soda ban and LiveLighter—Table 1) because they are limited to decisions about particular interventions made between individuals.

However decisional conceptions are potentially relevant when public health measures are administered in clinical settings. Even then, however, relational conceptions seem more nuanced. Consider DOT (Table1), which requires a person with TB to swallow medication under supervision.[31-33] Under a decisional conception this unavoidably diminishes people's

choices—they must take and be observed taking the medication—and is thus likely to be paternalistic. A relational conception, in contrast, is more nuanced.

A relational conception suggests different ways of implementing DOT can be more or less paternalistic according to their implications for the development and exercise of autonomy. For example, DOT has been criticised for restricting opportunities for people with TB to seek or continue in employment, and then, because of the consequential loss of income, closing down other opportunities for them and their families.[32, 33] The ability to work and earn income is a freedom basic to self-determination, and thus one of the external, structural conditions for self-determination in a relational account. A relational account also encourages attention to the effects of intervention on self-authorisation, which relies on self-respect, self-trust, self-esteem, believing oneself worthy to give reasons for ones actions, and being recognised as worthy. If DOT health workers act on the assumption that people who resist or do not engage with treatment are ignorant or wilfully bad, they will probably act paternalistically on a relational account. In contrast, if they explore and work with people's reasons for resistance or non-engagement, assuming they are willing to be held accountable, they may support and enhance their autonomy and thus be less paternalistic. Approaches to DOT implementation that aimed to support patients' self-determination, self-governance and self-authorisation would be concordant with what many studies suggest people value in the delivery of care.[34] For reasons mentioned above, a less relationally-paternalistic DOT may thus be both intrinsically and instrumentally preferable.

Comparing nanny-state and relational conceptions of paternalism

Our relational conception of paternalism also seems to have several advantages compared to the nanny-state conception.

First, it seems as able as a nanny-state conception to capture serious infringements of negative freedom. However the relational conception will give weight only to those infringements that undermine self-determination, self-governance and/or self-authorisation. The relational conception is unlikely to support preoccupations with infringements that are less important, or even trivial (e.g. constraints on access to giant-size portions of soda) but encourages concern with infringements of fundamental freedoms (e.g. the freedom to work—Table 1). There are no bright lines between serious and un-serious infringements: these will need to be considered case by case. But relational conceptions provide a far more detailed account of the types of freedoms and opportunities that matter and why, and so provide more support for moral evaluation of public health interventions.

Second, relational conceptions of autonomy and paternalism better reflect the complex psychological and social realities of human life; because of this they are also more demanding of the stance public health takes towards citizens. Take, for example, the LiveLighter campaign, which makes fat bodies disgusting and links this to certain behaviours (Table 1). As a messaging campaign, LiveLighter is unlikely to be considered paternalistic on a nanny-state conception as it does not remove choices or constrain action. A relational conception, however, would be much more critical of the campaign, particularly its implications for self-authorisation and self-governance.

Relational conceptions would take seriously the fact that obesity is already a stigmatised condition[35-37] and that disgust-based campaigns risk amplifying this existing social norm, undermining self-respect, self-esteem and social recognition and thus self-authorisation. Empirical evidence shows that, particularly in already-marginalised people, the threat of being stereotyped creates anxiety, stress and self-consciousness (undermining self-authorisation) as well as diminished cognitive performance (undermining self-governance) and thus decreases performance and motivation.[38] Stereotyping messages risk increasing

these effects, and LiveLighter arguably transmits stereotyping messages: e.g. that people are fat because they stand by an open refrigerator at night eating cold pizza, as the protagonist of one advertisement does. Self-governance relies both on the ability to reflectively accept oneself, and the development of the cognitive skills necessary to act in keeping with this self, such as understanding, critical reflection, and self-control. Messages that employ disgust and fear, or demand that citizens conform with "healthy behaviours" rather than fostering critical thinking and understanding, do not seem likely to promote self-governance. Relational accounts can encourage public health practitioners to value autonomy as well as health, and to work in ways that do not promote one at the expense of the other.

The third advantage of relational conceptions over nanny-state conceptions is this: relational conceptions recognise that states are uniquely positioned to ensure citizens have real freedoms and opportunities that matter, and that a negligent state can be as problematic as an interfering state. A relational conception of paternalism can support a case that states have positive as well as negative duties. This potentially sanctions intervening to address social conditions that limit freedoms and opportunities (including but not limited to those that undermine citizens' health), interventions that a nanny-state conception would reject. Public health, as a social institution, can contribute to the political and personal freedoms and opportunities fundamental to self-determination,[39] to effective autonomy-relevant skill development, and to the creation of social space for the expression of diverse identities and the promotion of values of respect and inclusivity. Only relational conceptions recognise these positive duties, and recognise that autonomy capabilities are inter-linked and depend in large part on formal institutions and socio-cultural norms.

CONCLUSION

If a nanny-state conception of paternalism is allowed to dominate public discourse, many attempts to improve public health will be framed as unjustifiable simply by virtue of their 'interference'. This—perversely, given that accusations of paternalism are intended to help protect autonomy—will preclude the tackling of many socially shaped health problems, including obesity and smoking, that arise at least in part in social environments that impair people's autonomy.

A nanny-state conception of paternalism does currently seem to dominate. We noted earlier that public health advocates have often struggled to rebut nanny-state accusations. The most common responses—either denial, or stressing the welfare produced by the intervention—are unsatisfactory. Our analysis suggests a better response to nanny-state accusations. This involves acknowledging the normative significance of paternalism, critiquing the libertarian conception of autonomy entailed in nanny-state accusations, presenting the relational alternative, and explaining how public health interventions can positively support the self-determination, self-governance and self-authorisation that are necessary for autonomy. As well as supporting a robust defence of autonomy-supporting public health interventions, relational conceptions of paternalism can support a nuanced critique of autonomy-undermining ones. Public health, we conclude, should stop being afraid of nanny-state accusations, and instead promote and apply a more robust, relational, view of autonomy and paternalism.

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