



Perspective

Vaccine Mandates and Public Health Paternalism: A Renewed Debate

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ABSTRACT

Vaccine mandates moved from a settled, largely uncontroversial feature of public health law into the center of sustained political and legal conflict during the COVID-19 pandemic, reviving older philosophical debates about when state or institutional paternalism toward individual medical decisions is justified.

This perspective revisits that debate with the benefit of several years of post-pandemic case law, exemption-process experience, and survey data on trust and hesitancy that were not available when the original mandates were designed.

We examine the legal architecture running from Jacobson v. Massachusetts through COVID-19-era litigation, the philosophical status of the harm principle and libertarian paternalism as applied to vaccination, and the equity implications of how mandate compliance burdens and exemption processes are actually administered.

A growing body of post-pandemic research on institutional trust suggests that coercive mandates carry a second-order cost -- eroded credibility for future public health measures -- that earlier ethical analyses of mandates underweighted.

We argue that a defensible approach to future mandates requires narrower risk-based targeting, procedurally fair exemption administration, and explicit attention to how compliance costs are distributed across an unequal population.

Keywords: vaccine mandates; public health ethics; paternalism; autonomy; harm principle

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INTRODUCTION

Vaccine mandates are not a new invention -- school

entry requirements, occupational immunization rules for healthcare workers, and military vaccination programs have existed in various forms for over a

century, resting on the 1905 Supreme Court decision in *Jacobson v. Massachusetts*, which upheld a state's authority to compel smallpox vaccination against an individual liberty challenge [1]. What COVID-19 did was move mandates from a settled, background feature of public health law into the center of a bitter and highly visible political and legal fight, dragging with it the older philosophical question of when the state may override an individual's medical choices for the sake of others [2]. That fight has not fully resolved, and the arguments made during the pandemic have prompted a genuine reappraisal of when mandates are justified, how they should be designed, and what counts as a legitimate reason to refuse one.

This paper revisits that debate with the benefit of several years' distance from the height of pandemic-era mandates. It is not a historical retrospective so much as an attempt to take stock of where the underlying ethical and legal arguments actually stand now that courts have ruled, exemption processes have been tested, and post-pandemic survey data on trust and hesitancy has accumulated. The central tension running through all of it is the one bioethics has always had to negotiate around infectious disease: individual bodily autonomy against a collective interest in reducing transmission, borne out in policy as a choice between persuasion and coercion [3]. Public health paternalism -- the willingness to substitute a state or institutional judgment for an individual's own health decision, on the grounds that doing so serves the individual's or the public's welfare -- rarely announces itself honestly as paternalism, and mandates are one of the clearest cases where it does.

THE LEGAL ARCHITECTURE: FROM JACOBSON TO COVID-19 LITIGATION

Jacobson has aged into something like scripture for public health law, cited in nearly every subsequent mandate case despite being decided under a legal and scientific context utterly unlike the present one [1]. Its holding was narrow -- states may impose reasonable, non-discriminatory vaccination requirements in the interest of public health and safety -- but its rhetorical framing, that liberty in a organized society necessarily accepts restraints for the common good, has proven durable enough to anchor arguments on both sides of the COVID-19 mandate litigation [2]. Courts reviewing COVID-19 vaccine mandates for federal contractors, healthcare workers, and large employers largely upheld them, though not uniformly, and the resulting body of case law has left open questions about the limits of *Jacobson*'s reach into workplace and occupational contexts it was never written to address [4].

Litigation over religious exemptions occupied an outsized share of this legal activity. Employers implementing federal or institutional mandates were required to build exemption processes that could withstand scrutiny under employment discrimination

law, and the resulting procedures varied enormously in how much documentation, sincerity testing, or individualized review they demanded [5]. A recent analysis of these exemption procedures argues that the more defensible ones combined procedural fairness and transparency with a genuine, individualized accommodation review, rather than either rubber-stamping requests or treating every claim with reflexive suspicion [6]. That paper's central claim -- that fairness in the *process* of claiming an exemption matters independently of whether the underlying religious claim is judged sincere -- has become one of the more influential post-pandemic contributions to mandate design, and Table 1 places it alongside three other design dimensions that recent commentary treats as similarly load-bearing.

Outside the United States, courts applying the European Convention on Human Rights reached broadly compatible conclusions through a different doctrinal path, generally finding that mandatory vaccination requirements can survive proportionality review when narrowly tailored, while nonetheless treating bodily integrity as a serious interest that a mandate must actually justify rather than presume away [7]. The comparative picture, across both legal traditions, is one of near-universal judicial deference to public health mandates in principle, combined with real and continuing disagreement about how tightly a specific mandate must be tailored to survive challenge.

AUTONOMY, PATERNALISM, AND THE HARM PRINCIPLE

The philosophical vocabulary for this debate long predates vaccines. John Stuart Mill's harm principle -- that the only legitimate reason to exercise power over a person against their will is to prevent harm to others, not to make them better off by their own lights -- gets invoked constantly in mandate debates, though usually in service of arguments Mill himself did not make about infectious disease specifically [8]. Applied honestly, the harm principle actually supports rather than undermines many mandates, since an unvaccinated person during an active outbreak imposes real transmission risk on others, which is precisely the kind of externality Mill's framework was built to license intervention against. The harder question is not whether the harm principle permits mandates in principle, but how much transmission risk, at what level of confidence, is enough to justify overriding a specific person's refusal -- a question empirical epidemiology, not moral philosophy alone, has to answer case by case. One influential formulation frames this as a gap-filling problem: individual freedom and a collective public health obligation each have a legitimate claim, and the ethical task of policy is to specify, case by case, how much the obligation side may compress the freedom side before the compression becomes unjustified, rather

than resolving the tension by fiat in either direction [9].

This is where "libertarian paternalism," the idea that policy can steer choices through defaults and incentives while formally preserving the option to refuse, becomes relevant to mandate design specifically. A body of public health ethics scholarship has tried to place mandates, vaccination incentives, and softer nudges like default opt-out enrollment on a single spectrum of coercion, arguing that the ethical burden of justification rises steeply as a policy moves from information provision toward penalties for refusal [10]. Recent legal-philosophical work has pushed this further, arguing that "nudges" embedded in law -- automatic enrollment, loss-framed messaging, administrative friction for opting out -- deserve the same scrutiny under the harm principle that outright mandates receive, since a sufficiently strong nudge can be coercive in substance even when it is voluntary in form [11]. Applied to vaccination, this reframes the mandate-versus-persuasion dichotomy as a false binary: most real-world policies sit somewhere on a continuum between pure information and outright compulsion, and the ethically relevant question is where a given policy actually falls on that continuum, not which side of a mandate/non-mandate line it is officially labeled.

A separate strand of bioethics scholarship has tried to specify when *selective* mandates -- targeting healthcare workers or other high-contact occupations rather than the general population -- are more defensible than universal ones, on the theory that occupational exposure and third-party risk are higher and more predictable in these settings, which strengthens the harm-based justification while narrowing who bears the burden [12]. Critics of this occupational framing have replied that it risks concentrating the coercive weight of public health policy onto already lower-paid, majority-female healthcare and caregiving workforces, raising a distributive justice question that a narrowly harm-based analysis does not resolve on its own [3]. Equity concerns of this kind extend to universal mandates as well: analyses of COVID-19 vaccine mandate design have argued that a policy's formal universality does not guarantee equitable impact if access, exemption processing, and enforcement fall unevenly across populations that already face structural disadvantage [13].

TRUST, HESITANCY, AND THE LIMITS OF COERCION

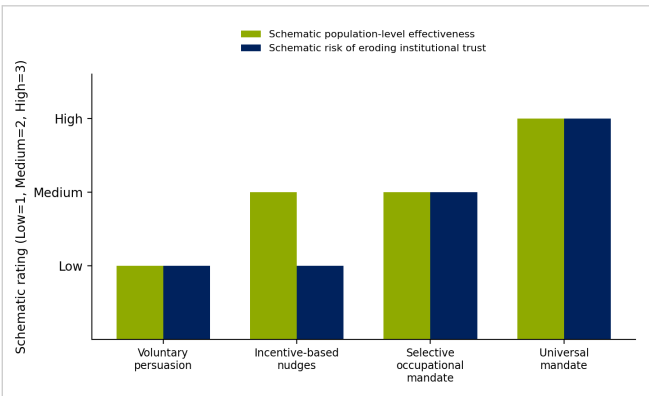
Mandates were always meant to be a backstop for populations that voluntary uptake could not reach, and the post-pandemic literature on trust and hesitancy has become important precisely because it bears on whether that backstop is durable or self-defeating. A large strand of recent survey research finds that trust in the institutions issuing a mandate, not just attitudes toward vaccines themselves, predicts compliance and

downstream hesitancy more strongly than most other variables researchers have measured [14]. Where that institutional trust has been damaged by opaque or inconsistently enforced pandemic-era mandates, some recent work argues the damage generalizes: people who felt coerced into one vaccination decision report broader distrust of public health guidance that persists well after the specific mandate in question has lapsed [15].

Table 1. Design dimensions commonly proposed for defensible vaccine mandate policy, and the ethical rationale each addresses.

Design dimension	What it addresses	Representative source
Narrow, risk-tailored scope	Limits coercion to contexts with genuine, predictable third-party transmission risk rather than applying mandates uniformly	Bayer & Wynia (2022)
Procedurally fair exemptions	Screens for sincerity without functioning as either a rubber stamp or a punitive barrier to genuine objectors	Procedural exemptions analysis (2024)
Transparent, consistent messaging	Preserves institutional trust that future public health measures, including non-vaccine ones, depend on	Addressing hesitancy via consistent policy (2023)
Distributive review of compliance burden	Checks whether a formally neutral mandate concentrates costs on lower-wage or less powerful occupational groups	Jones-Nosacek (2024)

Figure 1. Schematic, illustrative comparison of four vaccine mandate policy approaches on population-level effectiveness and risk of eroding institutional trust. Ratings are qualitative judgments drawn from the literature discussed in the text, not measurements from a single empirical study.



This dynamic complicates any simple utilitarian defense of mandates as a tool that trades a manageable amount of individual liberty for a large public health gain, because the calculation has to account for second-order effects on trust that make future public health interventions, including non-vaccine ones, harder to implement. Recent public

health commentary has argued for policy consistency as an ethical requirement in its own right -- that hesitancy is addressed more durably by health authorities applying consistent, transparent standards over time than by any single persuasive campaign or coercive rule [16]. Complementary survey work on healthcare and public health professionals themselves finds that even within institutions charged with implementing mandates, sentiment about the underlying policies is far from uniform, which undercuts any assumption that mandate design is a matter of expert consensus being resisted only by lay skepticism [17].

A separate line of research situates mandate-era hesitancy within a longer arc, arguing that the specific credibility problems of the COVID-19 pandemic -- shifting guidance, inconsistent messaging across jurisdictions, and visible disagreement among scientific advisory bodies -- did more to seed durable distrust than any single mandate policy did on its own [18]. Newer synthesis work on the sociology of trust argues that public health authorities retain what might be called a home-field advantage in rebuilding credibility, provided they engage the same communication channels and community intermediaries that first-generation hesitancy research identified as effective, rather than relying primarily on regulatory authority [19]. Table 1 summarizes how four commonly discussed policy design choices score against the two outcomes this section has focused on: measured public health effectiveness and the risk of eroding institutional trust, and Figure 1 renders the same schematic comparison graphically.

EXEMPTIONS, EQUITY, AND THE BURDEN OF COMPLIANCE

Every mandate needs an exemption policy, and the design of that policy does much of the actual ethical work, since it determines who bears the mandate's coercive weight and who is permitted to opt out with little friction. Broad, easily obtained exemptions undercut a mandate's public health rationale but preserve individual conscience; narrow, high-friction exemptions protect population-level effectiveness but risk coercing people whose objections, religious or otherwise, are genuine [5]. The procedural-fairness literature discussed above argues that this trade-off is at least partly a false one -- that transparent, individualized, well-documented exemption review processes can screen for sincerity without becoming either rubber stamps or punitive gauntlets, though building such a process well is harder in practice than describing it in principle [6].

Equity concerns run through exemption administration in ways the initial pandemic-era debate rarely engaged with directly. Employees able to work remotely, or in occupations with market power to negotiate individualized accommodations, generally found mandate compliance and exemption processes far less

burdensome than workers in lower-wage, in-person occupations with less bargaining leverage and less access to legal support when an exemption request was denied [20]. A mandate that is formally neutral on its face can therefore still distribute its costs in a way that tracks existing social and economic disadvantage, which is precisely the kind of distributive concern that a purely harm-principle analysis, focused on transmission risk rather than who bears compliance costs, tends to miss [21]. Addressing this requires treating exemption administration, workplace accommodation, and enforcement discretion as first-order ethical questions in mandate design, not as implementation details left for after the underlying policy decision has already been made.

CONCLUSION

The years since the height of COVID-19 vaccine mandates have not produced a tidy resolution to the underlying debate between autonomy and collective health protection, but they have sharpened where the real disagreements lie. Courts have generally upheld reasonably tailored mandates on grounds that trace directly back to *Jacobson*, while leaving considerable room for argument about how tightly tailored a given mandate must be and how exemptions should be administered [1]. Philosophically, the harm principle turns out to support many mandates rather than rule them out, which shifts the live disagreement toward empirical questions about transmission risk and toward a more fine-grained analysis of where a given policy sits on the continuum between information and compulsion [10]. What the post-pandemic trust and hesitancy literature adds is a genuinely new consideration that earlier mandate debates underweighted: coercive policy, even when legally and philosophically defensible in the moment, can degrade the institutional trust that future public health interventions depend on, and that cost needs to enter the ethical calculus rather than being treated as someone else's problem [22]. A defensible approach to future mandates likely requires narrower targeting toward genuine third-party risk, procedurally fair and transparent exemption processes, and honest attention to how compliance burdens fall across an unequal population, rather than either wholesale rejection of mandates or a return to treating them as a self-evidently justified default.

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Conflict of Interest

The authors declare no conflict of interest.

Author Contributions

R. Bakker conceived the paper and drafted the sections on legal architecture and the harm principle; R. Benitez conducted the literature synthesis on trust and hesitancy and drafted that section; N. Toth drafted the sections on exemptions and equity and coordinated revisions. All authors reviewed and approved the final manuscript.

Ethics Statement

This is a literature-based perspective piece; it did not involve new research with human or animal subjects and did not require ethics committee approval.

Data Availability

No new data were generated for this article. All sources discussed are publicly available and cited in the references.

REFERENCES

1. Gostin LO (2005) *Jacobson v Massachusetts*: it's not your great-great-grandfather's public health law. *American Journal of Public Health*, DOI:[10.2105/AJPH.2004.055160](https://doi.org/10.2105/AJPH.2004.055160).
2. Common Good Constitutionalism and Vaccine Mandates: A Review of *Jacobson v. Massachusetts* in Light of COVID-19 (2023) *Appalachian Journal of Law*.
3. Vaccination Mandates, Physically Forced Vaccination, and Rationing in the Intensive Care Unit: Searching for Ethical Coherence in the COVID-19 Pandemic (2022) *The American Journal of Bioethics*, DOI:[10.1080/15265161.2022.2043017](https://doi.org/10.1080/15265161.2022.2043017).
4. Judicial Precedents and Vaccine Mandates (2022) *Ethics & Public Policy Center*.
5. Covid Vaccine Mandates and Religious Accommodation in Employment (2021) PMID:34747499.
6. Procedural Dimensions of Religious Exemptions to Covid-19 Vaccine Mandates: Promoting Clarity, Fairness, and Transparency in Applications (2024) *Journal of Health Care Law and Policy*, DOI:[10.1080/23294515.2024.2336901](https://doi.org/10.1080/23294515.2024.2336901).
7. Mandatory Vaccination vs Bodily Autonomy: ECHR and U.S. Constitutional Principles (2023) *Trinity College Law Review*.
8. A broader liberty: J.S. Mill, paternalism and the public's health (2010) *Public Health*.
9. Boniolo G (2016) Public obligation and individual freedom: how to fill the gap? The case of vaccinations. *Journal of Public Health Research*, DOI:[10.4081/jphr.2016.732](https://doi.org/10.4081/jphr.2016.732).
10. A "Nudge" for Public Health Ethics: Libertarian Paternalism as a Framework for Ethical Analysis of Public Health Interventions?
11. Legal nudges and the harm principle (2025) *Mind & Society*.
12. The Ethics of Selective Mandatory Vaccination for COVID-19 (2022) *Public Health Ethics*, PMC9188377.
13. The Equitability of Universal Vaccine Mandates -- A Bioethical Analysis of COVID-19 Vaccine (2023) *TGHN Collections*.
14. Vaccine hesitancy and respect for public health measures: citizens' trust in politicians and public servants across national, subnational and municipal levels of government (2023) PMC10119790.
15. From Vaccine Skepticism to Institutional Distrust: The Post-Pandemic Shift (2025) PMC13418217.
16. Addressing vaccine hesitancy requires an ethically consistent health policy, Pennsylvania State University research publication.
17. Exploring the complexities of vaccine sentiment among healthcare and public health professionals: essential strategies for encouraging vaccine uptake (2025) PMC12098589.
18. Understanding vaccine hesitancy (2025) *Frontiers in Public Health*, DOI:[10.3389/fpubh.2025.1671457](https://doi.org/10.3389/fpubh.2025.1671457).
19. Trust and science: public health's home field advantage in addressing vaccine hesitancy and improving immunization rates (2023) PMID:37553265.
20. Jones-Nosacek C (2024) Vaccine Mandates: Weighing the Common Good vs Personal Conscience and Autonomy. *The Linacre Quarterly*, DOI:[10.1177/00243639231213515](https://doi.org/10.1177/00243639231213515).
21. An Ethical Analysis of the Arguments Both For and Against COVID-19 Vaccine Mandates for Healthcare Workers (2022) *Journal of Emergency Medicine*.
22. Public trust: the vaccine against vaccine hesitancy (2025) *The Lancet Respiratory Medicine*.