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Does Public Health Have a Personality (and If So, Does It Matter If You Don't Like It)?

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Public health is increasingly a matter of focus in bioethical argument.¹ This is a welcome development. There are many social and moral problems at local, national, and global levels that warrant serious, considered deliberation and, crucially, effective action.² The links between justice and health are well noted,³ and even prior to normative evaluation it is clear that simple, unstructured, individual responsibility does not permit anywhere near to the closest-to-achievable potential for health equity. It would be presumptuous to suggest that everyone sees this as problematic (indeed, given the resilience of many political and institutional structures, it is apparent that many people are in-different to the issue, both nationally and globally). However, it is not difficult to support the moral claim that there is a serious ethical problem presented by the current distribution of health responsibilities and entitlements.

It is, nevertheless, extremely difficult to find agreement on the normative underpinnings to support collective measures to alter responsibilities for health.⁴ From a global viewpoint, to some this will seem unimportant: if millions of people are living miserably and dying horribly, and this is easily avoided, few would need to consult a moral philosopher to establish that this is bad and ought to be remedied. Away from such extremes, though, it is important to grasp the normativity questions in health policy, and the role of the theorist assumes a greater imperative. Liberties and entitlements are not to be played with loosely and should not simply swing on their association with a single, intuitively attractive good. In this paper, I propose to dissect the way that *public health* is used in bioethical argument and consider the way that ethical debates on public health are framed. My starting contention is that within the bioethical literature, public health has assumed—in some cases—an undesirably strong identity, to which a worrying normativity is attached. Provided authors (and their readers) are clear about this, there is no problem.⁵ But there is a problem if public health as a concept comes to obscure meaningful debate. We may compare this with the problem that presents itself with a proliferation of ill-conceived conceptions of autonomy, or the inflated normative force that is often given to autonomy. This comparison is strange (from an argumentation perspective), as much of the worry of which “public health ethics” is born relates to fears that “individual autonomy” has become too strong a concept. Without being too simplistic, one might say that there is an attempt to remedy an excessive focus on the individual’s freedom by switching focus to the (ill) health of groups. This raises its own difficulty: namely, if discourse suffers from one undue prevalent focus (individual autonomy), it will likely suffer if there is another (public health). As analysts, we need a vocabulary that allows all-things-considered analysis, rather than one that obstructs debate by providing prominence to only part of what is important. My primary concern is that an excessive normativity within concepts of public health blocks equal, or more important, goods. This holds true in both good and bad accounts of “public health ethics.”

Following a short consideration of terminology, the paper works through four stages. First, I consider issues raised in the framing of normative debates on public health, spelling out the analytic criticisms made by several commentators. I then consider wariness of autonomy in ethical argument and why it need not present the problems in relation to public health that some suggest. Following that, I look at how public health is advanced in arguments as a

concept with its own normativity. I then make some observations on how public health might usefully feature in ethical argument. Rather than see a concern for public health as a prompt to find a “new ethics,” I contend that we should take the opportunity it presents to reappraise our evaluative framing of health responsibility *and* other social issues. Furthermore, this is what analysts seem to be doing, which means that sometimes their apparent focus on public health is mis-leading.⁶ Health is important, and the defensible reform of health policy is crucial. But theoretical argument on how this is best achieved should be conducted through the clearest means, working from a wholesale social normativity. Governance and evaluation should allow for due weight to be given to all social concerns, not simply health-related ones.

On Terminology

Prior to analysis, I summarize what different categorizations can imply. Readers may find alternative understandings useful. My aim here is not to suggest that this is the only way to conceive things or to claim that the categories offer a perfect, novel, or exhaustive taxonomy. Given what follows, however, the distinctions are useful for identifying the separate matters under issue.

- *Public health* can have various meanings, from the nondirectional to the normatively demanding. For clear ethical analysis, I argue that it is useful to consider public health as relating to objective questions concerning the health of people within a community, such as: What is the prevalence of *X* disease? Is *Y* disease an affliction particularly for a specific social group? Do people who tend to do *Z* disproportionately suffer health problems? This “population perspective” allows for different types of observations than one finds in individual health-care, but it does not suppose, for example, any strong metaphysical convictions about the nature or status of “the public.” Furthermore, there is no presumption about what should be done given knowledge of public health issues.

There are alternative uses of *public health* found in the works considered in this essay, which, I argue, can have a negative impact on discussion in public health ethics. These range across various levels of directivity.

- *Public health* may refer to the work of public health professionals; people who “do” public health. Here, there is (in principle) a clear purpose to public health, which is—to some extent, anyway—worthwhile and thus is to be pursued as a good. The professional ethics of these people is a natural focus of bioethical analysis. However, at times there may be preanalytic acceptance of the ethics underpinning public health professionals’ activities or purposes.
- Public health may be treated as a *social mission*, whose legitimacy is often implicit or considered self-evident. For example, public health as a mission may refer to the overall improvement of health, with a view positively to remedying health inequalities. It may also be presumed that checks on the scope of the mission—for example, the proportionality of measures—is implicit in it. When this is the case, public health becomes in essence a complete social or political theory; that is, public health entails all relevant imperatives. Although conceptually tenable, it is not clear why such a social theory should be labeled *public health*.
- Similarly, public health may be treated as a driving concept, with a directive purpose that is binding. Here, we see the ends of public health as “trumps” over other considerations. For example, if an end of public health is health equality, then factors that impede this become problematic or even indefensible.

- I take *public health policy* to refer to measures instituted with a view to affecting the health of the population or some specifiable subgroup within the population. It is not important to the current paper to distinguish measures designed with health in mind and measures that have an incidental (or unforeseen) bearing on health, though there may be good reason to draw this distinction.
- As academic approaches, I take *public health ethics* and *public health law* to relate to the normative evaluation of (potential and actual) public health policy (and other activity) from ethical and legal perspectives. Someone engaging in public health ethics may be a radical skeptic about the state's authority to institute even minimally coercive public health measures or an advocate of radical social reform to ensure greater health for all. It is crucial, I suggest, that engagement in public health ethics and public health law *not* require any specific prior normative commitments.

On Framing the Debate

Bruce Jennings has argued that

[t]he liberal framing of public health ethics is useful up to a point, but it is ultimately too narrow to provide normative justifications for—or adequate moral insight about—the kinds of social change public health must strive to bring about.⁷

Baylis, Kenny, and Sherwin, working from this premise, state that

[p]ublic health ethics is in need of a theoretical basis that is built on the aims of the enterprise and the moral values inherent in its practices. That requires an ethical framework that will help us to make visible the role of public health in promoting important public goods and help us to understand the importance of attending to relations among humans, rather than focusing on humans as isolated rights holders. Such an ethics must begin in a different place than clinical or research ethics for its target is populations, not individual patients or research participants.⁸

This view is reflected, too, in the introduction to Ronald Bayer and colleagues' collection *Public Health Ethics*:

Because of the individualistic orientation of medical ethics, the concepts of autonomy and negative rights of the person (the right not to be harmed) have tended to predominate in that field. In public health ethics, by the very nature of the problems and policies with which it deals, there will tend to be more emphasis on the interests and health of groups, the social justice of the distribution of social resources, and the positive or social/human rights of individuals. When social interests and the interests of individuals come into conflict, then there will be a conflict between medical ethics and public health ethics.⁹

It is not clear that we can usefully oppose categories of ethics in this way.¹⁰ If ethical arguments are to be sustainable, they must be at least mutually compatible and ideally framed within the same overall system. Nevertheless, there is a perception that analyses of the legitimate institution of public health measures suffer in the constraints of the "received wisdom" that has prevailed in bioethics. This view is widespread and leads to comments such as the following, from Lawrence Gostin's textbook on Public Health Law:

Over the past forty years, emphasis has shifted from social obligation and economic fairness to individual freedom, self-reliance, and personal responsibility, thus relocating health from the public sphere to the private realm.

These are the challenges of public health law: Does it act modestly or boldly? Does it choose scientific neutrality or political engagement? Does it leave people alone

or change them for their own good? Does it aggressively tax and regulate or nurture free enterprise? The field of public health law presents complex trade-offs and poses enticing intellectual challenges that are both theoretical and essential to the body politic.¹¹

The Nuffield Council on Bioethics, a UK body that analyzes bioethical problems and proposes responses to them, is also concerned by the individualistic focus within bioethics. In its report *Public Health: Ethical Issues*, it suggests that there is a problem with arguments focused on “individual autonomy,” which, the Council suggests, is inadequate to accommodate issues outside of a clinical context, such as public health matters.¹² Looking for a suitable frame for public health ethics, the Council claims to cast its eye beyond autonomy as it has grown to be understood (in some quarters) and seeks to ground its normative model in what it feels is a broader, political system.

It is correct that moral evaluation of public health policy requires an overarching political philosophy. The divide between moral and political philosophy is not perfect, but when we need a normative model for a community of people, we will not be satisfactorily helped by simple reference to moral frameworks that tell us about ethereal, moral abstractions cohabiting a strange, moral universe. So, I endorse Baylis, Kenny, and Sherwin’s observation that “individuals are not really independent, purely rational, separate and self interested,” and rather “are all social through and through.”¹³ However, the approaches to discussion within public health ethics outlined above are, in some senses, misguided: the wariness of liberalism and incompatibility of “individual autonomy” as it appears in bioethics need not be such a cause for concern. The normative model that governs doctor and patient may evoke different emphases, but must still be housed in some overarching framework that can soundly govern the whole of society. There is no value, and possible analytic harm, in trying to sustain the idea that we can have different basic justifications for our action-guiding ethics. The subjects of these different models are the same individuals: us. It is no good simultaneously advocating one model that logically pulls us in one direction and a second that pulls us in another. If conceptions of autonomy are bad, this is not a reason to ignore them simply when we consider public health: *it is a reason to ignore them altogether*. Furthermore, as a matter of prudence, if arguments in bioethics have gone wrong because of an excessive focus on, or misconception of, the individual, there is every reason to believe that arguments in public health ethics will go wrong if they suffer an excessive focus on the public and being healthy.

To be clear about this, take two examples of theorists whose broader theories are well argued but who potentially create difficulty with the prominence that they claim is due to public health when they narrow their focus. First, Baylis, Kenny, and Sherwin: these authors provide detailed reasons for the adoption of a relational account of autonomy and demonstrate its importance to public health governance as well as to clinical ethics and to social justice. They are, in fact, articulating an across-the-board normative account. This is in itself fine, but it is analytically troublesome to suggest that the theory is fed by public health or strengthened by its association with a normative conception of public health. My concern is not with the strength of their theory but with the claim that “an appropriate ethic for public health should be grounded first and foremost in the nature of public health.”¹⁴ The *ground* of the ethic should not be public health. The ground should be something like, for example, social justice. Claiming to bind a position to public health and holding that it is therefore good fails truly to establish the basis for evaluation. The authors’ reasons emanate not from public health but from a commitment to an overarching moral or political theory. It is this latter thing that ought to be argued for. “Relational ethics” is the key, not public health’s ethics. The focus on public health gives normative prominence where it is not due. Possibly it is a rhetorical tactic to slip a preferred normativity into the definition of public

health, to stake a claim in the term's proper meaning. There is nothing intrinsically wrong with this, but it does narrow the potential for reasonable debate in public health ethics.

The second example is the work of Bruce Jennings. The scope of Jennings' work is not unduly narrow. His critiques of social normativity do indeed cover the board.¹⁵ In his exploration of civic republicanism, he calls for a reappraisal of our evaluative paradigms and seeks to draw this into bioethical analyses in order to achieve a more defensible social situation. His approach does not entail a denial of the existence of individuals but offers an alternative construction to that of "possessive individualism."¹⁶ Jennings' concern is to develop a theory entrenched in democratic and communitarian values, "a civic community of shared authority and common purpose."¹⁷ My criticism is not aimed at the substance of positions such as this. Rather, my focus is on the meaning and function of *public health* itself within arguments such as Jennings' "Public Health and Civic Republicanism."¹⁸ Even an argument that is in essence defensible, normative suppositions may unduly be implanted in the term public health that can have a negative impact on overall debate. Regardless of the strength of a supporting (or overarching) argument, short-hand that personifies public health or makes it something that with legitimacy strives to do things can be problematic. It lends itself to the out-of-court foreclosing of contrary critiques.

On Autonomy, Individualism, and Public Health

There has been a tedious tendency within much bioethical discourse towards the development of untenable, simplistic, and ill-applicable conceptions of autonomy.¹⁹ This may be because of the formulaic ethical analysis that emanates from the "principles approach"; it may be because of very local analyses being made, for example, of a universe of just two people; it may be an overcompensation following a social situation in which the individual was given insufficient prominence; it may just be because of an excess of bad analysts. Whatever the cause, there is a problem. The answer to this problem is not to cordon off bad autonomy conceptions, leaving them to reign in a medical context while ploughing ahead in a perceived new arena. Rather, we need to reappraise our paradigms.

At times, this point seems to be missed. The Nuffield Council, for example, is guilty of this problematic analytic move in its treatment of "individual autonomy" and Millian liberalism. The Council rightly notes that unsustainable autonomy conceptions have proliferated in the bioethics literature. Its failure, however, comes in not recognizing that outside of this literature—and within it—there *are* many sustainable conceptions of autonomy. Rather than turn to a defensible conception, the Council tries to turn its back on the notion. This is ill treatment of sound concepts of liberalism and excessively deferential to weak analysts.²⁰ Yet the Council's approach is reflected in, and carries weight in, contemporary argumentation.

As I have suggested, whatever a person's moral ideals, it is the political framing that matters. Whatever our commitments in establishing a defensible normative model, we do well to consider it on a spectrum of political philosophies²¹ and to remind ourselves of the sorts of persons that our community is composed of: people of radically varied mental capacities, with radically different commitments, means, preferences, and values. This political spectrum makes visible the levels of internal and external government that might be permissible; in other words, it shows the potential divisions and allocation of sovereignty. At the extremes would be no external regulation—anarchism—and complete external regulation. Beyond anarchism, some external regulation becomes necessary. Any model that places importance on individual autonomy will not do so exclusively. Even strong libertarian frameworks require some external government of individuals, whatever those individuals will. And as we move along the spectrum, we see a greater role for external

government. Therefore, it is important to recognize that, in a political system, autonomy is not a complete theory. In fact, it is useful not to think of autonomy as a theory at all. Rather, it refers in its political sense to freedom within the scope of legitimate liberty. Agents may be able to evidence high levels of mental capacity, but it does not follow, even in a libertarian system, that every self-directed act will be legitimate. An agent's liberty will be constrained by the rights of others and, indeed, by his or her own rights (as established by that system). Autonomy within liberty, then, is best conceived in a description of the domain that remains the individual's once the overarching normativity and its practical effects have been established.

Many of the autonomy conceptions that are advanced in bioethics are commensurate with a political system of libertarianism, sometimes even of anarchism. Critics engaging in public health ethics are right that it is uncommon for collectivist accounts of autonomy to be advanced, though they do influentially come, for example, from neo-Kantian accounts²² and accounts of relational autonomy.²³ What I suggest at this stage is not that we should favor any particular political model. Rather, I simply urge theorists, when considering the proper limits of autonomy, to see where the conception they are articulating is housed and sits on the political spectrum. Some will be unapologetic libertarians. Others will re-appraise the scope of the autonomy they are defending when they recognize that the framework that contains it is conducive to a society with large indifference to shared commitments for the welfare of others.

Once analysts are explicit about the nature of the normative system that holds the autonomy conception they are employing, they cannot be criticized for thoughtlessly being excessively individualistic. The ratio of individualism to collectivism will have been drawn out. An analyst who is an avowed libertarian will not retract a very individualistic account of autonomy. If this radically limits the institution of public health policies, so be it. If, however, the analyst is some way along the spectrum from libertarianism, he or she will (or should) revise the account of autonomy to reflect this. The defensibility of the whole framework is key. Autonomy is just an aspect of the system.

Baylis, Kenny, and Sherwin tell us that public health "ethics must begin in a different place than clinical or research ethics for its target is populations, not individual patients or research participants."²⁴ This gets the approach to analysis the wrong way around. The populations they allude to *are* of individual patients and research participants. It is just that these identities do not exhaust what these people are. We do not need one ethics of sovereignty for populations, another for patients, another for footballers, another for academics, and another for salespersons. We need a complete ethics of sovereignty to account for the whole of society in all its actions.²⁵ And our conception of autonomy will be housed within that. The relevance of the individual's *role* will vary from case to case, but the normativity must come back to the same system. And that is where our ethics must begin.

However, another common theme in public health ethics argumentation is to insist that public health itself is something with authority, which ought to compel us in certain ways. It is to this style of argumentation that I now turn.

On Public Health: An Authoritative Ideal?

Let us review part of the quotation from Baylis, Kenny, and Sherwin:

Public health ethics is in need of a theoretical basis that is built on the aims of the enterprise and the moral values inherent in its practices.²⁶

Need we think of public health as something with inherent aims and moral values and, if so, need we find any authoritative strength in them? Put slightly differently, if we can conceive

of public health as something that has inherent moral values, should these values in any way be binding? I suggest that there are two ways of looking at this matter.²⁷

First, public health, like medicine, may be thought to relate to objective questions concerning health states and status. If this is correct, public health is a factual matter. Just as a physician diagnoses pathology in individuals, a public health expert diagnoses pathologies across and between populations. The expertise lies in knowledge of the causes and implications of, and potential remedies for, disease and illness. On this understanding, public health is an umbrella term for issues relating to population health matters. The practical and normative questions that the information leads to will be informed by factors beyond health-related ones and may best be described as moral, legal, or political matters. For example, if a population has high rates of obesity, should restrictions be placed on the foods its members can access? If people in an area of a country suffer negative health inequalities directly linked to high alcohol consumption, should policy measures be targeted to change this? As a science, public health cannot answer such questions; it simply presents the facts. It does not tell us that populations *should be* healthy; it tells us *if they are* healthy. In individual healthcare, my doctor's view that a treatment is clinically indicated does not demand the conclusion that I receive it; my health is one among various considerations that will bear on my decision. Equally in public decisionmaking, improvement of health will only be one among various considerations for policymakers to account for.

Alternatively, public health, like medicine,²⁸ may also *not* be thought of simply as a science. Science informs rather than directs, but some argue that public health does more than this.²⁹ Many commentators see an agenda implicit in the very name "public health" and on the back of this make value-laden claims whose truth is carried simply by their association with public health. Often cited as a "classic definition" is Charles-Edward A. Winslow's purposive characterization, published in 1920. Winslow described public health as the organized effort to prevent disease, prolong life, and promote health, to "ensure to every individual in the community a standard of living adequate for the maintenance of health."³⁰ The Nuffield Council on Bioethics says "'public health' refers to the efforts of society as a whole to improve the health of the population and prevent illness."³¹ In the United States, the Institute of Medicine (IOM) has suggested an agenda to be contained in the very meaning of public health, describing "a coalition of professions united by their shared mission."³² Indeed, the IOM defines public health in one sentence, and in the following sentence derives a strong imperative from its definition:

Public health is what we, as a society, do collectively to assure the conditions in which people can be healthy. This requires that continuing and emerging threats to the health of the public be successfully countered.³³

As a facetious matter of logic, if a society collectively did nothing to assure the conditions for people to be healthy, that, apparently, would be public health; the purported "requirement" does not follow. But definitions and interpretations such as the IOM's proliferate, and, as they are built upon, public health becomes value heavy.

I wonder if this is to be encouraged. It is praiseworthy to push policy, to serve as pioneers. It is also not a great concern in itself that concepts—for example, public health, the law, and morality—should be personified in argument. However, a stylistic trait that presents itself increasingly in works in public health ethics conveys public health as something that has characteristics such as objectives, self-awareness, and authority. For example, Lawrence Gostin uses phraseology such as the following:

[T]he field of public health is caught in a dilemma. If it conceives itself too narrowly, then public health will be accused of lacking vision ... [I]f it conceives

itself too expansively, then public health will be accused of over-reaching and invading a sphere reserved for politics, not science.³⁴

Another pioneer in global health policy, the late Jonathan Mann, argued that

as public health seeks to “ensure the conditions in which people can be healthy,” and as those conditions are societal, to be engaged in public health necessarily involves a commitment to societal transformation.³⁵

And two other leaders in the field, Daniel Callahan and Bruce Jennings, say:

[P]ublic health is once more a force to be reckoned with, and it is increasingly apparent that public health must contribute to the definition of the ends as well as the means of health policy.³⁶

In some senses this use of language is so trivial that it should not be a problem. Furthermore, the authors cited—and others who argue in a similar manner—cannot be fairly accused of ignoring the bigger picture; their analyses are careful, considered, and clearly made. My focus here, though, is on the concept of public health in ethical argument, and a concern that its normative guise can cause problems. So this is not an entirely trivial matter. Health policy will always have its critics, and the literature is well adorned with works by detractors such as Petr Skrabanek,³⁷ opposed to authoritarian state agendas directed at the totalitarian end of improving the health of all. There is a danger, even without taking a position as extreme as Skrabanek’s, that advancing an alternative view about the limits of the state’s responsibilities for health will be deemed to *contradict* public health, and that this will be considered a necessary cause for concern.

It should not be sufficient in argument, but sometimes seems to be, to knock down a position by virtue of its conflict with the aims, goals, and values of public health. This would be satisfactory only if health were the supreme good or the public health agenda (whatever it may be) were logically entailed by the proper purpose of the state. If these are not demonstrated, the authority of public health is nil. If these are demonstrated, even an ounce of sympathy attracted by the views of Skrabanek and others recommends continued scrutiny of principle, with *all things considered*. Even if it were agreed that we had a sound definition of public health objectives, this should not lead to complacency in the scrutiny of policy and its scope. Nor should health improvement uncritically be accepted as the best good in any situation.

It is not clear to me that public health needs an established identity, despite well-argued claims to the contrary.³⁸ At the very least, if public health must have an identity, we need to know what weight should be given to its views compared with other considerations, as it surely cannot be a lone voice in policymaking. Health is important. So are fun, happiness, freedom, responsibility, self-development, personal values, and countless other things. Advocates of any of health’s companions (or competitors?) as a good must not be excluded from policy debates simply because they “disagree” with some things that public health “says.” Good theories for understanding these matters will mediate such conflicts through models of defensible political philosophy or social justice. The people’s health is one aspect of concern. It should not become too great or small a concern or blind us to other concerns.³⁹ And access to debate—or standing to comment—should not rest on the question of whether a view accords with the perspectives, objectives, or “philosophy” of public health. If works in bioethics have failed because of an overemphasis on one ostensibly good thing—autonomy—there is reason to believe that arguments in public health ethics will fall short if they focus too sharply on another ostensibly good thing—health.

On Ethics, Public Health, and “Public Health Ethics”

Some analysts forcefully argue that a radical change is required in our whole normative conceptions, and that part of the imperative underscoring this obtains in unjust health inequalities.⁴⁰ And that is fine. But if we wish for a grand normative shift, it is best that this happen with our being aware of it. Rather than say “we must institute such and such a measure because public health demands it” we should say “responsibility for such and such a behavior cannot be left within the competence of the individual, and this is legitimate because ...”

And then we need good reasons.

Such reasons may be forthcoming.⁴¹ They need to be explicit, contextualized within a framework that covers the whole of social normativity, and convincing, all things considered. Pointing to the weakness of “individual autonomy” in some of its guises is not sufficient. And just as it is problematic to develop a framework in which the individual is king, so it is problematic to develop a framework in which public health is king. The antitotalitarian objections of commentators such as Skrabanek can be cast as the fears of paranoid libertarianism. But this accusation carries less weight when arguments are leveled that health is the supreme good and that individuals’ interests in their health should trump other interests, including interests that the individuals themselves think are more important.⁴² We do well to remember when we recall articulations such as Lord Donaldson MR’s famous claim that people are free to make healthcare decisions for rational or irrational reasons, or no reason at all,⁴³ that this is not based on a scant regard for people’s interests. Rather, it is the logical outcome of a system of some value agnosticism, in which it is recognized that there are good reasons to allow people to adjudge their own interests and make decisions accordingly.⁴⁴ A prevailing commitment to health chips into such freedom. This might be for the good. In some cases, it certainly will be. But our “subcategories” of ethics⁴⁵ must be commensurate within an overarching framework that applies to individuals within a society. Unless a protagonist argues that public health is itself a sufficient and complete normative theory, the overarching theory must allow itself to protect people’s health (and other things) without being unduly constrained by public health issues.

It is through this line of reason that I would seek to frame ethical analysis of public health matters. Denying its normativity does not devalue it or our existing paradigms. Like Jennings and others, I think a great deal can be drawn from concepts entailed in civic republicanism.⁴⁶ However, I do not see that we need to depart from a properly called liberal model to act on the lessons these writings teach us.⁴⁷ As far as framing the argument goes, though, the key point is that public health should not be asked to do more than it can in establishing legitimacy. Public health as a normative theory or as an authoritative director can interfere with good arguments that advance sound theories of social justice or political philosophy. It can overplay its own benefits—for example, by making it seem better than it is because of the intuitive appeal of good health—or it can underplay alternative goods that also warrant attention.⁴⁸ Comments on the ethics of policy are best kept distinct from claims about something intrinsically normative to the potential practices recommended following public health analysis: these cannot, in themselves, tell us authoritatively what is ethical.

Conclusions

Let us revisit the quotation from Jennings with which we started:

The liberal framing of public health ethics is useful up to a point, but it is ultimately too narrow to provide normative justifications for—or adequate moral insight about—*the kinds of social change public health must strive to bring about.*⁴⁹

I neither want to simplify nor make a caricature of Jennings' persuasive argumentation, from which much very useful analysis can be drawn. However, I think there is a better way to frame this. Public health is not best treated as something that can strive to bring about social change. Rather, social change is something that should be instituted by people and their governments and should be argued for with good reason. At times, improvement of health will provide reason, but it must not cloud an all-things-considered judgment. Public health should not feature as an authoritative persona in argument, but as an objective measure of the health of people. When it comes to justifying social change (or indeed social conservatism), we need to look at whatever normative framework is defensible. Part of assessing the defensibility of a framework will be the effects it has. If we find that a particular setup is more damaging to people's health than is tolerable, we need to alter the framework. In this essay, I have sought to demonstrate that reasoned argument will be hampered by a personification of public health and urged that a "dislike" of public health as an authoritative concept should not debar access to debate. Analysts need to be sure to have a complete model; then concepts such as autonomy, liberty, obligations, and rights will fit within it. So long as the analytic framework is well conceived, none of these things will raise a problem. Whatever a protagonist's political views, eschewing intrinsic normativity in public health is proper in ethical analysis of public health matters. Rather than make public health itself into something that directs our action, we should look to what makes a good society, all things considered, and work with a model that promotes that.

Notes

1. It is false to say (though sometimes implied) that ethical issues in public health have been *overlooked* until recently: for example, see Beauchamp DE. Public health: Alien ethic in a strange land? *American Journal of Public Health*. 1975; 65(12):1338–9. [PubMed: 1200197] However, over the past decade or so, there has been a rapid growth within bioethical literature, with "public health ethics" presenting itself as a field in its own right and an area that demands renewed focus: for example, see Beauchamp, DE.; Steinbock, B., editors. *New Ethics for the Public's Health*. Oxford University Press; New York: 1999. ; Kass N. An ethics framework for public health. *American Journal of Public Health*. 2001; 91(11):1776–82. [PubMed: 11684600] ; Roberts MJ, Reich MR. Ethical analysis in public health. *The Lancet*. 2002; 359:1055–9. ; Gostin, LO. *Public Health Law and Ethics—A reader*. University of California Press; Berkley: 2002. ; Thompson A, Robertson A, Upshur R. Public health ethics: Towards a research agenda. *Acta Bioethica*. 2003; 9(2):157–63. ; Jennings B. Frameworks for ethics in public health. *Acta Bioethica*. 2003; 9(2):165–76. ; Benatar SR, Daar AS, Singer PA. Global health ethics: The rationale for mutual caring. *International Affairs*. 2003; 79(1):107–38. ; Anand, S.; Peter, F.; Sen, A., editors. *Public Health, Ethics, and Equity*. Oxford University Press; Oxford: 2004. ; Boylan, M., editor. *Public Health Policy and Ethics*. Kluwer Academic Publishers; Dordrecht: 2004. ; Bayer, R.; Gostin, LO.; Jennings, B.; Steinbock, B., editors. *Public Health Ethics: Theory, Policy, and Practice*. Oxford University Press; Oxford: 2006. ; Dawson, A.; Verweij, M., editors. *Ethics, Prevention, and Public Health*. Oxford University Press; Oxford: 2007.
2. Commission on Social Determinants of Health. *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health*. World Health Organization Press; Geneva: 2008.
3. Beauchamp DE. Public health as social justice. *Inquiry*. 1976; 13:1–14.; Daniels, N. *Just Health—Meeting Health Needs Fairly*. Cambridge University Press; Cambridge, UK: 2008. ; Gostin LO, Powers M. What does social justice require for the public's health? Public health ethics and policy imperatives. *Health Affairs*. 2006; 25:1053–60. [PubMed: 16835186] ; Powers, M.; Faden, R. *Social Justice: The Moral Foundations of Public Health and Health Policy*. Oxford University Press; Oxford: 2006.
4. Schmidt H. Patients' charters and health responsibilities. *British Medical Journal*. 2007; 335:1187–9. [PubMed: 18003858]
5. Marcel Verweij and Angus Dawson offer a useful and insightful discussion of the descriptive/normative divide in accounts of public health, and the implications of choice of definition, in

- Verweij, M.; Dawson, A. The meaning of “public” in “public health.”. In: Dawson, A.; Verweij, M., editors. *Ethics, Prevention, and Public Health*. Oxford University Press; Oxford: 2007. See especially pp. 14–20
6. This is not always the case: Mark Rothstein, for example, argues on pragmatic grounds that public health ought to have a narrow “jurisdiction,” restricted to that of the public health agencies’ legal authority: Rothstein MA. Rethinking the meaning of public health. *Journal of Law, Medicine and Ethics*. 2002; 30:144–9. Although in the current essay I, too, advocate a narrow role for public health, I do so in a distinct manner to Rothstein. For one thing, I do not consider public health to be something with a jurisdiction. For another, unlike Rothstein, I do think that the bigger picture is usefully considered and dealt with in a normative (legal and ethical) analysis and embrace a role for experts in public health in informing the whole debate. It is my view that this all-things-considered analysis is precisely what is needed in bioethics in order that our conceptions be properly thought through. Beyond this very brief footnote, the current essay does not speak directly to Rothstein’s arguments. For a direct critique of Rothstein’s position and a defense of it, see, respectively, Goldberg DS. In support of a broad model of public health: Disparities, social epidemiology and public health causation. *Public Health Ethics*. 2009; 2(1):70–83. ; Rothstein MA. The limits of public health: A response. *Public Health Ethics*. 2009; 2(1):84–8.
 7. Jennings, B. Public health and civic republicanism: Toward an alternative framework for public health ethics. In: Dawson, A.; Verweij, M., editors. *Ethics, Prevention, and Public Health*. Oxford University Press; Oxford: 2007. p. 31
 8. Baylis F, Kenny N, Sherwin S. A relational account of public health ethics. *Public Health Ethics*. 2008; 1(3):196–209. at p. 206.
 9. Bayer, R.; Gostin, LO.; Jennings, B.; Steinbock, B. Introduction: Ethical theory and public health. In: Bayer, R.; Gostin, LO.; Jennings, B.; Steinbock, B., editors. *Public Health Ethics—Theory, Policy, and Practice*. Oxford University Press; Oxford: 2007. p. 4
 10. To an extent, our perception of the “conflict” alluded to in the quotation will depend on how we interpret “ethics” in this context. If public health ethics and medical ethics are conceived as professional ethics, for example, as the normative underpinnings expressed in professional regulatory codes, there may be superficial, or even substantial, conflict between public health ethics and medical ethics. However, I fail to see that critical ethics can conflict with itself: as public health practices and medical practices ought to be governed according to the same, proper, overarching normative theory (whatever it may be), there cannot be a real conflict between the ethics of each. If there seems to be a conflict, that is simply an indication that ethical conclusions on at least one of them are wrong.
 11. Gostin, LO. *Public Health Law: Power, Duty, Restraint*. 2nd ed.. University of California Press; Berkeley: 2008. p. 41
 12. Nuffield Council on Bioethics. *Public Health—Ethical Issues*. Nuffield; London: 2007. p. 18 It is questionable that the Council’s claim that the “stewardship model” it advances in this report really does add anything substantive to the kind of liberal framework it seeks to move beyond: Coggon J. Harmful rights doing? The perceived problem of liberal paradigms and public health. *Journal of Medical Ethics*. 2008; 34(11):798–801. [PubMed: 18974413] Angus Dawson and Marcel Verweij have also been critical of the report: Dawson A, Verweij M. The steward of the Millian state. *Public Health Ethics*. 2008; 1(3):193–5. Two members of the Council’s Working Party on this report and the secretary to the Working Party have responded to the concerns raised in these pieces: Baldwin T, Brownsword R, Schmidt H. Stewardship, paternalism and public health: Further thoughts. *Public Health Ethics*. 2009; 2(1):113–6.
 13. See note 8, Baylis et al. 2008:200. Reflections such as this, which provide the grounds of many critiques on public health, are welcome and do not (if anyone suggests otherwise) find themselves solely within the feminist literature. For example, this concern is well reflected in the discussion of moral agents in Griffin, J. *On Human Rights*. Oxford University Press; Oxford: 2008. p. 35, where he says: “Our aim must be the more modest one of understanding not the autonomy of a spare, abstract self, but the autonomy of *Homo sapiens*.” See also Jennings, B. Autonomy and difference: The travails of liberalism in bioethics. In: Davies, R.; Subedi, J., editors. *Bioethics and Society*. Prentice Hall; New York: 1998. ; Jennings B. From the urban to the civic: The moral possibilities of the city. *Journal of Urban Health*. 2001; 78(1):88–102. [PubMed: 11368207] ; Gaylin, W.;

- Jennings, B. *The Perversion of Autonomy: Coercion and Constraints in a Liberal Society*. 2nd ed.. Georgetown University Press; Washington, DC: 2003.
14. See note 8, Baylis et al. 2008:199.
 15. See, e.g., note 13, Gaylin, Jennings 2003; Jennings B. The liberalism of life: Bioethics in the face of biopower. *Raritan*. 2003; 22(4):132–46.
 16. See note 13, Jennings 2001:91.
 17. See note 13, Jennings 2001. See also Jennings B. Bioethics and democracy. *The Centennial Review*. 1990; 34(2):207–26. [PubMed: 11659490]
 18. See note 7, Jennings 2007.
 19. See the criticisms in, e.g., O'Neill O. Public health or clinical ethics: Thinking beyond borders. *Ethics and International Affairs*. 2002; 16(2):35–45. [PubMed: 15709277] ; Brazier M. “Do no harm”—Do patients have responsibilities too? *Cambridge Law Journal*. 2006; 65(2):397–422.; see note 17, Jennings 1990.
 20. Given the goals of the Nuffield Council and its stated misgivings concerning autonomy in bioethics, it would have done well to look for an in-principle sustainable theory of liberalism, such as that advanced by Joseph Raz (e.g., in *Ethics in the Public Domain*. Clarendon; Oxford: 1994.), which has all the strengths the Nuffield Council sought, avoids all the weaknesses, and attaches itself to an ideal of objective morality: See note 12, Coggon 2008.
 21. The Nuffield Council report runs from a similar idea, working from libertarianism to collectivism (either in the form of a collective contract or in the form of a model to maximize collective utility): See note 12, Nuffield Council on Bioethics 2007:13–4
 22. For example, see note 19, O'Neill 2002.
 23. For example, see MacKenzie, C.; Stoljar, N., editors. *Relational Autonomy: Feminist Perspectives on Autonomy, Agency, and the Social Self*. Oxford University Press; Oxford: 2000.
 24. See note 8, Baylis et al. 2008:206.
 25. One way in which analysts may dispute this is by claiming that “the public” is its own entity, rather than just the sum of its members. See, e.g., note 7, Jennings 2007, especially pp. 36 and 48–58. I am not able here to offer such arguments the treatment that they deserve, but would note one theoretical problem that might present itself: if the public is a distinct concept, whatever health means, it can hardly mean the same thing for this more-than-its-embodied-parts thing (the public) as it does for embodied agents such as humans. In other words, there is no reason automatically to suppose that a healthy public comprises healthy individuals: the word *healthy* in such a claim would not necessarily have even a similar meaning.
 26. See note 8, Baylis et al. 2008:206 (emphasis added).
 27. In line with Gostin, see text to note 11.
 28. Fox T. Purposes of medicine. *The Lancet*. 1965; 7417:801–5.
 29. Munthe C. The goals of public health: An integrated, multidimensional model. *Public Health Ethics*. 2008; 1(1):39–52.
 30. Winslow C-EA. The untilled fields of public health. *Science*. 1920; 51(1306):22–33. at p. 30.
 31. See note 12, Nuffield Council on Bioethics 2007:v.
 32. Institute of Medicine. *The Future of Public Health*. National Academy Press; Washington, DC: 1988. p. 40
 33. See note 32, Institute of Medicine 1988:1.
 34. See note 1, Gostin 2002:6.
 35. Mann JM. Medicine and public health, ethics and human rights. *Hastings Center Report*. 1997; 27:6–13. at p. 12. [PubMed: 9219018]
 36. Callahan D, Jennings B. Ethics and public health: Forging a strong relationship. *American Journal of Public Health*. 2002; 92(2):169–76. at p. 169. [PubMed: 11818284]
 37. Skrabanek, P. *The Death of Humane Medicine and the Rise of Coercive Healthism*. St. Edmundsbury Press; Bury St. Edmunds, UK: 1994.
 38. See note 5, the analysis in Verweij, Dawson 2007.
 39. Haÿry M. Public health and human values. *Journal of Medical Ethics*. 2006; 32(9):519–21. [PubMed: 16943332]

40. For example, see Beauchamp DE. The neglected tradition of public health. *Hastings Center Report*. 1985; 15(6):28–36. [PubMed: 4066304]
41. As indeed they are in the analysis of Beauchamp (see note 40, Beauchamp 1985) and others mentioned in this essay.
42. See, e.g., Gostin, LO.; Stone, L. Health of the people: The highest law?. In: Dawson, A.; Verweij, M., editors. *Ethics, Prevention, and Public Health*. Oxford University Press; Oxford: 2007. They argue that “[c]ertainly, the power and importance of individual freedom is beyond dispute,” but end the same paragraph with “[e]ach member of society owes a duty—one to another—to promote the common good. And each member benefits from participating in a well-regulated society that reduces risks that all members share. The protection and satisfaction gained from living in a community where public health is recognized as an important value should outweigh the individual self-interest in looking out only for oneself” (p. 62). Gostin and Stone are not arguing that *all* health interests should *always* prevail, but do continue, for example, by saying that “[t]he public health community takes it as an act of faith that health must be society’s overarching value” (p. 66), and go on to argue that “political officials are at least putatively committed to securing health for the population, and members of the community are committed to bear the necessary burdens. The collective efforts of the body politic to protect and promote the population’s health represent a central theoretical tenet of what we call public health ethics” (p. 68).
43. *In Re T (Adult: Refusal of Treatment)* [1993] Fam 95, 102.
44. For a consideration of the interplay between the liberal model that supports this and the resultant position for healthcare decisionmaking, see Coggon J. Best interests, public interest, and the power of the medical profession. *Health Care Analysis*. 2008; 16(3):219–32. [PubMed: 18642085]
45. For example, medical ethics, public health ethics, and so forth.
46. See note 7, Jennings 2007. Bruce Jennings’ analyses provide excellent groundings for normative evaluations in public health ethics. In particular, see also note 36, Callahan, Jennings 2002, and note 1, Jennings 2003.
47. It might be argued that a sufficiently developed account of liberalism will no longer be liberalism; it will be too far removed (see note 13, Jennings 2001:93). Instinctively, I disagree with this, but ultimately I anyway am less concerned with maintaining the term *liberalism*, and more concerned with the substance and import of the theory.
48. See further the arguments in Wilson J. Not so special after all? Daniels and the social determinants of health. *Journal of Medical Ethics*. 2009; 35(1):3–6. [PubMed: 19103934]
49. See note 7, Jennings 2007:31, emphasis added.