2 Justice and Public Health

Many familiar debates between utilitarian and various egalitarian approaches to distributional questions play themselves out in public health. Public health professionals and policymakers are typically committed to bringing about as much health as possible with the resources available. This interpretation of the remit and responsibility of public health is understandable, and in many respects, laudable. There is no context in public health in which resources are unlimited, or even sufficient to bring about all the health that might be secured. Efficiency in the use of constrained resources, especially public resources, is clearly morally important, if not imperative. And from the perspective of some utilitarian accounts, maximizing the amount of net good, in this case, health, that can be secured is also the only just way to deploy resources. (See, for instance, the entry on justice).

Public health professionals and policymakers are well aware, however, of concerns that the health maximizing approach to public health can often perpetuate and even exacerbate existing injustices in health and human well-being. At least since the 1990s, ethics scholars have challenged public health to look beyond efficiency to address other, generally egalitarian concerns of justice. Activists concerned about racial, gender and other social group injustices also frequently call on public health institutions to pursue health equity, particularly by reducing what are viewed as unjust health disparities.

Tensions between efficiency and egalitarian commitments arise in two stage-setting public health functions: the establishing of goals and priorities, for example, when the US Department of Health and Human Services sets goals and objectives to improve the health and well-being of people
in the United States in its Healthy People Initiative, and the allocating of resources that have been budgeted to secure the goals that have been identified, for example, how to distribute the funds that are allocated to the goal of reducing cardiovascular deaths. As important as setting goals and allocating resources are, there are other questions in public health ethics that also engage considerations of justice but that are not centrally structured around tensions between efficiency and equity. These include the moral value of prevention, the moral responsibility of individuals for their health, and stigma in public health programming. Public health also affects other things that matter morally to people, like respectful treatment, personal security or personal relations. Depending on how one understands what social or structural justice entails, these other considerations may be matters of justice, or even in some cases of state legitimacy, but they are not typical of matters taken up in either literatures.

Section 2.1 begins with a review of different reasons that have been put forward for why health matters morally, and thus why health is or might be a matter of justice. Section 2.2 discusses general problems of aggregation, goal setting and resource allocation. Sections 2.3 takes on distinctive moral issues that arise due to public health’s emphasis on prevention, and sections 2.4 and 2.5 take on individual responsibility and stigma, respectively, as well as some other examples where public health’s engagement with justice goes to impacts that are not primarily health. (For instance, stigma can be conceptualized as a concern about social disrespect). Section 2.6 concludes with a brief review of global justice considerations.

2.1 The Value of Health: Why Health Matters Morally

Theories of justice relevant to public health ethics operate with accounts of the value of health that often mark key differences between them.¹ In the case of utilitarian theorists, the value of health is often understood implicitly in terms of the contribution that health makes to utility or
welfare. All health benefits are seen as contributing to welfare and all harms to health as diminishing welfare. How health benefits and harms should be conceptualized and therefore measured is a matter of debate, as is the case with the parent categories of utility and welfare, more generally. We will briefly review some of the health-specific debates in Section 2.2.

Egalitarian theories of justice, including those most relevant to public health ethics, continue to be profoundly influenced by Rawls. (See Rawls 1971; the entry on John Rawls). Health does not figure prominently in Rawls’ celebrated theory and is not included by him as a social primary good. (Rawls 1971, 62) Other theorists have, however, pursued what they understand to be the implications of Rawls’s theory for health policy and public health. The most sustained and notable development of Rawlsian thought comes from Norman Daniels. Daniels argues that the value of health as it matters to justice can be found in its critical connection to Rawls’ principle of “fair equality of opportunity,” which for Rawls centers on social offices and positions. Daniels maintains that health is of special importance to this principle. On this view, enjoying health up to some threshold is integral for each to have a ‘normal opportunity range,’ or the array of life plans reasonable persons are likely to develop for themselves within a particular society (Daniels 2008, p. 43). Thus, Daniels attempts to account for the moral significance of health, including public health, in terms of its connection to opportunities rather than to welfare (Daniels 1985; 2001; 2008). In other words, on this sort of view, health is a matter of justice because of its integral role in allowing us or, in the case of ill health, preventing us from pursuing what we, as a matter of justice, should be able to pursue.

In part in response to Rawls, Amartya Sen pioneered an alternative approach to justice, which has as its central focus the ability and power of individuals—their capabilities—to reach states of valuable functioning or well-being. Capability theory is concerned with the freedom of individuals to pursue these states; the justice of social systems is to be judged by the extent to which this
freedom to be and do is promoted for all, a distinctly egalitarian commitment. (See the entry on the capability approach) The most prominent capability approach to justice, and one with direct relevance to public health, is that of Martha Nussbaum. Nussbaum identifies ten central human capabilities that a just society should make available to its citizens. Bodily health is included within the ten, as is life, which she defines as “being able to live to the end of a human life of normal length; not dying prematurely, or before one’s life is so reduced as to be not worth living” (Nussbaum 2006, 76). Health is understood as necessary or partly constitutive of human dignity or a flourishing human life. For Nussbaum and other capability theorists, the capability for health is thus of direct importance to justice, and not as it is for Daniels, for whom health is of strategic importance to fair opportunity.

Powers and Faden have developed a different theory of structural justice that, like Nussbaum’s capability theory, also sees health as a direct matter of justice. However, while Nussbaum focuses on health capabilities, Powers and Faden focus on health itself. Their theory is anchored in an account of human well-being in which health is one of six core elements. Each element is defended because it is characteristically present in a decent human life and because it requires an appropriate social structure for its secure realization and cannot be experienced by individuals relying solely on their own efforts. Powers’ and Faden’s egalitarian commitments are evidenced in their view that structural justice entails ensuring that all individuals, globally, experience these six well-being elements and the human rights that are grounded in them, commensurate with a decent human life. They are also reflected in the theory’s focal concern with unfair relations of power and advantage as well as with human rights and with the intimate relationship between unfairness, well-being and human rights. (Powers and Faden 2019) Much of their theory is taken up with interconnections between these moving parts of structural injustice. Their view that a deprivation in one core element of well-being like health is likely both a cause and a consequence of
deprivations in other elements of well-being has direct implications for public health policy. So, too, does their view that unfair patterns of disadvantage and unfair power relations are a powerful driver of deprivations and human rights violations, which in turn usher in and exacerbate these forms of structural unfairness.

Each of these different ways of explicating why health is a matter of justice—because health contributes to overall utility or welfare, because of its strategic importance to fair opportunity, because it is a central human capability or because health is a core element of human well-being—provide reasons why national and global policy-setting structures should place a priority on health. Each provides justifications, some overlapping and some distinctive, for extensive collective investment in public health services and practices. They also have different implications for public health policy. For example, arguments from fair opportunity underscore the importance of, and arguably prioritize, interventions that will protect or restore aspects of health that relate to normal opportunity ranges and societal prospects. Theories that focus on capabilities for health and those that focus on securing health may have different implications for how public health institutions should set targets and priorities, and certainly for how health policies should be evaluated. And theories that advocate for the interconnectedness of health with other valued human states suggest a wider range of relevant outcomes for public health and public health ethics than theories that focus only on health. And each is open, in one way or another, to the familiar criticisms of utilitarian, Rawlsian, capability and well-being theories.

Yet another approach to articulating the value of health, and thus of public health, is found in the health and human rights literature. (See Mann et al. 1994; Mann 1996; Beyrer et al. 2007; Beyrer and Pizer 2007; Tasioulas and Vayena 2014; Tasioulas and Vayena 2015; Gostin and Friedman 2013). In the early 1990s, Jonathan Mann pioneered an approach to public health that explicitly framed health as a human rights issue, and human rights violations as public health issues.
Subsequent work in the health and human rights tradition has been dominated by scholars and advocates in health law and public health practice, with strong links to activist and humanitarian organizations. (Gostin 2008, 2010) As a general matter, the health and human rights tradition relies on international declarations of human rights and human rights law as its foundation and does not probe the philosophical underpinnings of human rights or their connection to theories of justice. This is not because philosophical accounts of human rights are not congenial to the inclusion of health as a basic human right, however. Quite the opposite. Multiple rival candidates for the justification of human rights, from interest-based theories (Powers and Faden 2019; Raz 1988; Griffin 2008; Beitz 2015) to control-based theories (Darwall 2006; Hart 1982) to dignity-based theories (Kamm 2007; Tasioulas 2015), can be interpreted to support the inclusion of health as a human right. (See the entry on human rights) Regardless of one’s explanation of the grounds of human rights, by claiming that individuals have a human right to health, health is made a matter of justice, since each individual has an entitlement to health. Moreover, framing health as a human right is appealing in the context of discussions of public health ethics because this framing provides a basis for making states, as the first guarantors of human rights, responsible for promoting and protecting the health of individuals residing within their jurisdictions. However, just as approaching the value of health from the standpoint of different theories of justice is open to the general criticisms associated with each theory, so accounting for health in terms of human rights is open to the broad challenges that apply to accounts of human rights more generally (Buchanan 2012; Sreenivasan 2012)

2.2. Aggregation, Goal Setting and Resource Allocation

As we noted in Section 1.1, a defining characteristic of public health is that it is committed to advancing health at the level of populations. Public health relies on aggregated measures of health to
identify health deficits, set health policy priorities, assess the impact of interventions, and allocate resources. It is this reliance on aggregation that sets the stage for numerous questions of justice in public health, including perhaps most prominently tensions between egalitarian approaches to justice and efficiency-oriented utilitarian approaches.

2.2.1 Justice and natural units measures of population health

Although many challenges in aggregation taken up in the justice and public health literature relate to or are compounded by the way summary measures of health are constructed and deployed, even the simplest of health measures, once aggregated, raise justice concerns. Traditionally in public health, and still today, health outcomes are often measured in what are sometimes called natural units; examples include life expectancy, mortality, five-year survival, and immunization rates. These natural units are typically expressed in terms of averages, as in average life expectancy of American men, although sometimes medians or other ways of presenting the data are used. The problem is that, aggregated over a population, any of these natural measures can obscure differences within the population that are morally relevant. To continue with the example of average life expectancy of American men, focusing only on that measure obscures differences between white men and men of color, rural and urban men, and poorly and well-educated men that many view as mattering morally, and as potential injustices. Reliance on average summary measures of things like income or education can also have implications for public health ethics. To take a classic example, averaged national income data have been used as the basis for determining which countries are eligible for international philanthropic assistance in accessing lifesaving vaccines. Because this approach resulted in the withholding of global vaccine aid from middle-income countries, it was criticized as perpetuating injustices. In middle-income countries with large income inequalities, average income data obscured truly disadvantaged sub-populations who were not likely to receive the vaccine without global assistance. (Shebaya, Sutherland, Levine, and Faden 2010) One job of public health
ethics is to stay attuned to the risk that averaged outcome measures and statistics can mask
differences between subgroups within a population that point to unjust inequalities in need of
redress.

At the same time, whether or how much group differences in aggregated natural measures of
health matter morally is not necessarily obvious and may depend on the account of justice under
consideration. Any sub-group difference in a natural measure of health suggests that it may be
possible to secure more health for more people than is currently the case, a goal underscored by the
public health’s utilitarian commitments. However, whether any group difference is also unjust from
an egalitarian perspective cannot be read off of the existence or even the size of a between-group
disparity. Theories of justice, or more directly accounts of injustice, are needed to fill in the gap
between observing an inequality in health between groups and deciding whether or how egregiously
the inequality constitutes an injustice. (Powers and Faden 2006, pp. 95-99)

2.2.2 Justice and summary measures of population health

From the standpoint of public health policymaking, there are several other problems with
natural measures of population health, like life expectancy or infant survival rates. These measures
cannot provide a summary picture of the overall state of health or burden of ill health of a
population, nor do they allow for comparison of the value or impact of alternative investments in
different health priorities. The latter is a particular problem for allocating health budgets and setting
priorities for funding. Although classic cost-benefit analysis provides a solution that admits of
comparisons across diverse health areas and outcomes, reducing all the benefits and risks at issue in
public health to their monetary value is widely viewed as unsatisfactory. In response, a series of
summary measures of population health have been developed that seek to reduce into one fungible
metric both life expectancy and considerations of impact of disease and of medical interventions on
function and disability. Operating out of the preference-satisfaction tradition, well-known summary
metrics include Quality Adjusted Life Years (QALYs), Disability-Adjusted Life Years (DALYs), Disability-Adjusted Life Expectancy (DALE) and Healthy Life Year (HeaLY). Summary measures have been subject to extensive ethics critique. (See the entry on disability and health care rationing.) Some of these criticisms reflect difficulties with conceptualizing and operationalizing utility accounts of welfare. For example, these measures sometimes rely on assessments of what may be only vague individual preferences for trade-offs between different states of health or different kinds of benefits, or trade-offs made by samples of persons that are viewed as too narrow. These summary measures have also been critiqued to the extent that they rely on average trade-off assessments that may mask wide disagreement about the disvalue of a compromised health state.

Other criticisms focus on different, egalitarian-oriented justice concerns about morally contentious assumptions embedded in the measures, including whether to differentially value years saved in different stages of life and how to disvalue specific disabilities. Depending on how these and other assumptions are determined and specified, summary health measures have been criticized as being ageist or not ageist enough, as discriminating unfairly against people with disabilities, as failing to capture the moral uniqueness of lifesaving, and as treating as commensurable qualitatively different losses and benefits. (Brock 2002, 2006; Daniels 2008; Kappel and Sandoe 1992; Nord 2005; Powers and Faden 2006; Ubel 1999; Williams 2001; Whitehead and Ali 2010; Soares 2012; Pettitt et al. 2016; Schroeder 2017).

A particularly influential deployment of the DALY summary measure of population health is the Burden of Disease Project. Supported by the World Health Organization, national burden of disease studies are conducted in many nations and are widely relied on to help characterize the state of ill health globally as well as within countries. Ethical concerns about DALYs and global disease studies, often discussed in the public health literature under the heading of social issues, include whether DALYs should be age-weighted or time-discounted. Because the results of global burden of
disease studies can be influential in the setting of health priorities, they illustrate well the importance of the ethics of summary measures in public health practice.

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i This description does not apply to libertarian theories that we discuss in Section 3.

ii Some theorists resist conceptualizing health inequalities in terms of groups and instead defend a methodology in which variation in health focuses on health status across individuals rather than across groups. For a discussion of this debate, see Section 4, of the entry on Justice, Inequality and Health.