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› Public Health and the Limits of Justice An Outmoded Reflection

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„Abgesehen von dem bisher Entwickelten war es überhaupt fehlerhaft, von der sog. *Verteilung* Wesens zu machen und den Hauptakzent auf sie zu legen. Die jedesmalige Verteilung der Konsumtionsmittel ist nur Folge der Verteilung der Produktionsbedingungen selbst. Die kapitalistische Produktionsweise z. B. beruht darauf, daß die sachlichen Produktionsbedingungen Nichtarbeitern zugeteilt sind unter der Form von Kapitaleigentum und Grundeigentum, während die Masse nur Eigentümer der persönlichen Produktionsbedingung, der Arbeitskraft, ist.“

Karl Marx

I Introduction

In this article, the subject area of public health will be addressed from a philosophical perspective.¹ I would like to leave open here whether one can or must speak of “a paradigm shift currently taking place” — even “in medicine” — in light of the new orientation or reorientation of the life sciences, as well as of philosophical and biomedical ethics or even questions of public health.² In any case, it is undeniable that questions regarding the equitable distribution of health as a “good” are meanwhile being discussed to an increasing extent in practical philosophy, also in regard to the population on the whole. Considering the empirically indisputable findings of public health research, this is neither astonishing nor criticizable. A difference of up to ten years in average lifetime (for men), caused among other reasons by the overall social

1 According to Rosenthal (2013), this term has also established itself in the German language; in his article, Rosenthal presents the historical reasons for the only gradual return of health care sciences to the life sciences after the humanitarian catastrophe of National Socialism in Germany, without, however, also making a connection between the adoption of the English term “public health” and the possibility that it fulfills a need for avoiding historically encumbered terms; cf. Quante (2010).

2 In any case, this is Rosenthal’s assessment; cf. Rosenthal (2013, p. 323); Daniel Wikler and Dan W. Brock (2007) speak of a new agenda for bioethics in any case.

arrangement in German society, is *prima facie* reason enough for questioning the fairness of the system.³

The time delay in Anglo-American bioethics and political philosophy turning their attention to this issue can perhaps be explained by this area not directly being a matter of individual people, but of the population itself as the primary object of reference. Moreover, this subject area possibly leads our attention away from individual actions and towards institutional designs, i. e. towards the institutional constitution of our societies. Particularly in classical deontological conceptions of ethics and political philosophy, this is not at all an easy exercise.

The delay in classical biomedical ethics addressing this theme is explained simply by the empirically evident circumstance that health inequalities can be explained only to a very small extent by the institutional constitution of the medical sector or the public health system on the whole.⁴ In addition, this also makes the assumption plausible that it is only to a limited extent that changes in this area will be in a position to rectify the identified and potential inequalities. It is evident that biomedical ethics on their own will feel only little motivation to provide proof that some of our most urgent social problems in exactly their core area cannot be solved.⁵ For a philosophical sub-discipline which derives its legitimization partially from the irrefutable urgency and concrete feasibility of its problem definitions and solution proposals, such a delimitation of problem definitions with depotentialization of the effectiveness of its proposals for solution can only have limited appeal.

In Germany, in addition to the somewhat delayed development of philosophically qualified biomedical ethics on the whole, an aggravating factor is that medicine and life sciences withdrew from this subject area for a long while due to the ethically unacceptable conceptions of “*Volksgesundheit*” or “*Rassenhygiene*”, which legitimized massive human rights violations in the context of national socialistic public health policies. Moreover, it is only with great restraint and some considerable unwillingness that biomedical ethics have once again turned to addressing these questions.⁶

In the following, I will discuss in three steps some of the fundamental problems from a philosophical point of view which will have to be tackled by philosophy-based ethics of public health.⁷ Proceeding from methodological considerations (I), I will identify three metaethical problems (II), and finally formulate two fundamental ethical questions (III). Some general remarks, best characterized as ideology-critique, then conclude this article with prospects for the future.

3 Cf., for example, Daniels (2008), Powers & Faden (2008) and Segall (2010).

4 Cf., for example, Marmot (2004).

5 This, of course, does not mean to deny that one part of the problem area within the medical sphere of activity can and must be tackled. It does, however, quickly become evident that a clear perimeter for question formulations regarding medical ethical questions in a narrower sense cannot suffice in this subject area.

6 Philosophy-based biomedical ethics are delayed, on the one hand, in comparison to corresponding developments in the Anglo-American area and, on the other hand, in comparison to theology-based ethics. This is not to deny that we in Germany have been developing philosophy-based biomedical ethics for more than three decades and that this subject area has meanwhile been recognized in the field as an independent sub-discipline.

7 In doing so, I will not be able to discuss in this article the question of how the ethical treatment of this subject area relates to its legal-philosophical and juristic processing. My assumption is that the juristic treatment of questions regarding health equality not only entails far-reaching intra-disciplinary difficulties, but also raises fundamental legal-philosophical questions (such as about the normative willfulness of some sub-divisions in law); cf. Gostin (2000, Part II) and Martin (2009). In the German context, Stefan Huster has developed the best formulated juristic position, as well as the most reflected upon legal-philosophical position; cf. especially Huster (2011).

II Methodological Problems

In this section, I would like to point out three methodological problems in the broadest sense which a philosophy of public health has to confront. The following remarks are simply intended to articulate these points of view clearly; extensive treatment of the problem or the development of approaches for a solution is beyond the intent of this article.

First of all, it should be recalled that we have neither a clear definition of the concept nor a conception for health capable of gaining majority support at the present time.⁸ It should be indisputable that “health” is a thick concept in the sense that it demonstrates descriptive and evaluative aspects of significance which cannot be broken up analytically into two separate components. Moreover, it is more than plausible to assume that the evaluative dimension is involved with social standards and subjective evaluations from the respective subject whose health it concerns, on the one hand, as well as axiological evaluations regarding the good life and deontological evaluations regarding the right thing to do, on the other hand.⁹ In addition to this irreducible evaluative multidimensionality, a similarly indissoluble complexity of descriptive components of meaning is involved which includes biological, medical, and social dimensions, for example. Thus, it is obvious that the issue of public health equity will only be practicable as an interdisciplinary project with a transdisciplinary orientation.¹⁰

The situation is made more difficult since the conception of health cannot be easily differentiated extensionally from perceptions of a good or successful life. Even if the factors only causally beneficial to health can successfully be differentiated from the factors constituting health, the empirical findings in public health research show unambiguously that health cannot be limited to the area of medical activity or of public health. A critical philosophy of public health is thus always in danger of becoming, on the quiet, a sort of comprehensive ethics of the good life or a general critique of society.

Secondly, it must be observed that the area of public health is irreversibly involved with statistical statements. The population as such is only healthy or sick in a figurative sense, and such statements can only be true (or falsified) in terms of the state of health of the individuals composing the population.¹¹ At the same time, such statistical relationships (and general

8 Cf., for the relevance and significance of this issue, Holland (2007, Chapter 5).

9 I make use of the word “evaluative” in this article as a generic term for axiological and deontological aspects which must be assessed in a similar manner in philosophical ethics. The most insightful deliberations in regard to the evaluative dimension of health, in my opinion, are still found in von Wright (1963, pp. 50 ff.).

10 Thus, representative of many others, Rosenthal, too (2013); hence, not only all the difficulties arising in interdisciplinary cooperation, but also the transdisciplinary challenge are found there, so that the questions presented to public health research come from society and the answers generated in this research also have to be conveyed back into society. This presents a double challenge because society cannot directly receive or implement problems formulated the way they are treated in the scientific area, nor can it receive or implement answers directly the way they are formulated from the point of view of the sciences. These interdisciplinary and transdisciplinary challenges are not a unique characteristic of public health research, but they must be mastered anyway. For a practical philosophy in this context, there are, in my opinion, far-reaching consequences which also concern the relationship between philosophical anthropology and ethics, as well as the relationship between ethics and social philosophy.

11 This remark should not preclude the possibility of propositions for public health which — in the sense of methodological individualism — are not reducible to statements about individuals. This can be seen especially when the factors which enable individuals to lead a healthy life are included in the term “health”. Then, at the latest, the institutional design of a society is inevitably included in the scope to be considered; cf. Verweij & Dawson (2009).

formulas) never allow conclusions to be drawn for individual cases, a situation which presents several follow-up problems: on the one hand, the question arises of who the standard-bearers of the ethical claims are and who the addressees are to whom accountability is ascribed. On the other hand, it is difficult to recognize the causal effects of possible interventions in a way that makes them suitable for impact assessment.

Thirdly, it must be borne in mind that most of the measures relevant for a just, enabling public health policy will be found in the area of prevention.¹² This means that the majority of the options for action have to be conceived as prevention (or reduction or even only slowdown) of harm, and consequently as non-occurrence of certain causal effects. There is little doubt that this aspect will have a difficult time in the fields of medicine, public health, or politics in periods where evidence-based medicine predominates. At the same time, the second and third findings of which I will speak in the following also raise metaethical issues.

III Metaethical Problems

The *first* of the three serious metaethical problems to be treated in this section concerns the axiological status of health as a good: Is it an evaluative good in the sense of being able to be interpreted as an instrumental good within the realm of enlightened self-interest? In other words: Does the value of health amount to nothing more than being an enabling precondition for the aspects which a rational participant should pursue in his or her life (or at least take into account)? Or, the weaker variation, is it solely a question of a transcendental 'good' in the sense of a condition for the possibility of evaluatively relevant aspects of human life described individually or qua genus, for example, in philosophical anthropology?

In stronger reading, the status of an intrinsic value would be attributed to health, which could infer the possibility of treating different goals considered by a person to be precious in his or her conception of the good life subordinately in the name of health. The second issue would be whether this subordination were merely expressed in a form of axiologically-based criticism of individual life plans characterized by disregard or even contempt for health, dealt with in paternalistic patronage, or, in the worst cases, even enforced in the form of legal paternalism.¹³ This tendency towards interference would, of course, be intensified if health were proclaimed to be not only an intrinsic, but also a categorical or supreme value.¹⁴ In all three evaluative variations (instrumental, intrinsic, categorical), ethical norms could also be derived from the status of health, so that this fundamental aspect of human existence might be ascertainable in all the classical forms of ethics (deontology, consequentialism, virtue ethics).¹⁵

The characteristics of public health mentioned in the last section as essential in the form of statistical statements and laws regarding the subject area to be recorded and resulting mainly in preventive measures entail two fundamental difficulties for the main variant of consequentialist ethics. As such, (the many versions of) utilitarianism must clearly be considered, and thus I

12 Cf., for example, Huster (2011, pp. 74 ff.).

13 Cf. Gostin (2000).

14 Here, the tendency of the concept of health to include the scope of a conception of the good life involves metaethical questions: the more comprehensive the conception of health is, the more obvious the assumption of declaring health to be the supreme good.

15 Cf. Ruger (2010).

come to the *second* cardinal metaethical problem. On the one hand, in view of the benefits and harms of preventive measures, it is unclear how a quantifying consideration of possible alternative courses of action can be carried out in a methodologically convincing manner.¹⁶ On the other hand, the question must be raised of who should even be counted as the subject of the claims acknowledged as worthy of being respected in regard to the health of the population. Since it is not possible to reduce the population to separate individuals and since the statistical level is unable to account for individual cases due to methodical reasons, any utilitarian conception designating individuals is irrelevant (this problem also arises, as will now be explained, in a deontological framework). Otherwise, one must return to the original versions of utilitarianism oriented at a global public good whose ethical problems were the focus of criticism from the outset (and convinced even supporters of utilitarianism so much that, even today, versions of individual-centered utilitarianism and even so-called equitable utilitarianism are predominate) and which are plainly irreconcilable with any halfway plausible conception of justice.

Anyone who delightedly concludes from this finding that the issue of public health is yet another proof of the theoretical and ethical superiority of deontological conceptions misjudges the power of the *third* cardinal problem: in order to set their ethical argumentation into action, even deontological ethics need a subject for morally acknowledged claims, normally a bearer of rights. If this is not the population as such whose health it should concern, then, in my opinion, a deontologically authored conception of justice is also faced with the insurmountable difficulty of a possible descent from the level of only statistically ascertainable facts and legalities which are not methodically monitored to the level of the separate individual.¹⁷ Moreover, the attempt to make the population as a whole (or even the species itself) into a bearer of rights to be treated equitably in regard to health would have the usually unpleasant side-effect for deontological conceptions of modern morals of limiting individual autonomy in the name of the human species. Furthermore, supporters of the ethics of public health who approach the issue solely on the grounds of a deontological conception of justice stand under the constant threat of a counter-attack which they cannot win, namely that modern deontological morals imply additional crucial fundamental rights which will then, in cases of doubt, dominate claims inferred through health equity. In any case, a limitation of the individual's civil rights within the framework of a conception of just public health in favor of paternalistic health education is hardly imaginable.¹⁸

16 The presupposition in this formulation that such follow-up considerations might be able to be implemented in a methodically controlled manner in different contexts (and might not just represent rhetorical illustrations of independent ethical intuitions) may be conceded here for the sake of argumentation. For, even if this presupposition is accepted, the problem obviously remains in view of the quantified consideration of non-occurring negative consequences.

17 Cf. King (2009); the experiments familiar to us from the debate on human genetic interference in the human genome with the goal of identifying the human species as a bearer of dignity *sui generis* are similarly structured and just as unconvincing.

18 This seems to me to be one of the systematic reasons for why anthropologically and species based conceptions of ethics, such as the capabilities approach by Sen or Nussbaum, have also become increasingly popular now in equity-theoretically oriented political philosophy; cf., for example, Venkatapuram (2011). For my own try at an integrative ethical conception which can overcome the difficulties identified in this article, cf. Maydell (2006, pp. 51–89).

IV Ethical Problems

If I see it correctly, the outline of the problem developed so far results in two ethical issues which must be faced by any kind of ethics of public health. Both of them have such a fundamental form that they cannot simply be discounted as follow-up problems of the choice of a metaethical theory and thus used as an argument in favor of the choice of a different theoretical design.

The *first* problem is clearly enough identified by the keyword “paternalism”. If public health is a good which may not simply be disregarded by an individual in his or her individual interpretation of the good life, the result is at least theory-immanent options which limit individual autonomy in favor of this good (for this part of the paternalism problem, inclusion of the level of the population is irrelevant; this tension results directly from any perfectionist ethics, no matter how weakly worded). This issue becomes all the more serious when it is not just a question of the relationship between the good life and the individually interpreted good life, but rather when THE population comes into play as an additional bearer of ethically justified claims. As long as it is not possible to reduce talk of the population — as a dimension transcending the individual which must be used for representation and elucidation — to talk of separate individuals, models must be developed for evaluation of individual claims opposed to claims made by the population (or even of the species as such) and, if necessary, have them safeguarded. For the philosophy of public health, there is no hope of a reduction of the level transcending the individual because the reduction longed for would, at the same time, lose its genuine subject area. It seems to me to be obvious that we will not be able to dispense with a deontological framework of appropriate ethics of public health at this point since we will probably not be successful in establishing sufficiently strong normative safeguards in the other types of ethics in order to protect the individual’s central fundamental rights from the population’s *prima facie* justified claims.¹⁹

The *second* problem emerges from the assumption that health policies and medicine directed at the population as such will have to be primarily in the area of prevention. The question arises immediately of how far and with what justification redistribution due to financial constraints can be conducted to the disadvantage of medical therapy for individuals and the elimination or at least alleviation of their actual suffering. For, unlike successes in prevention which are due to the non-occurrence of harm and suffering, the case of therapy usually involves an injured party and actual suffering.²⁰ For ethics of public health practiced as classical medical ethics, two follow-up problems arise which probably do not emerge in general philosophical ethics in this form: How would the decision against therapy and healing in favor of prevention be compatible with the ethos of the medical profession? And: Wouldn’t the point be reached quickly where decisive prevention and perhaps also “therapy” would no longer be found within

19 An option which is possibly open for philosophical ethics consists in putting these normative safeguards under the custody of a deontologically conceived legal system. This, however, presents the two follow-up problems of how this law should be justifiable without recourse to philosophical ethics and what about the normative autonomy of social law, for example. In my opinion, this legal-philosophical questioning belongs to the desiderata of a comprehensive philosophy of public health.

20 If I see it correctly, analogous problems to those in the area of transplantation of organs arise here, where the criterion of urgency also constantly threatens to overturn optimization of possible benefit (for example, the survival time of the organ or of the recipient) or also considerations of justice (for example, waiting time).

the context of medical care? Findings in public health research suggest that the most significant origins of and causes for the existing inequities in regard to public health are not to be found in the medical sector and not in the health system as a whole.

V Reflections of ideology-critique – A Tentative Outlook

Raymond Geuss has repeatedly reproached left libertarian practical philosophy in particular and that of Rawls in general for carrying on a discourse on equity which does not include in its analysis the actual social conditions, i. e. the existing social institutions, especially market structures, meaning mainly economic realities, but which remains, instead, on a purely normative level and is thus neither capable of attacking ethical problems at the root, nor in a position to intervene in the existing unjust conditions to bring about change.²¹ This should not only be understood to mean that a normative appeal for equity with no understanding of the inherent dynamics of a capitalistically authored commodity-exchange society is bound to shatter into impotent pieces on the rocks of the material interests of all the participants involved and the economical-political power constellations. The findings of public health research also suggest that the manner in which the working world in modern societies and the economical basis of our material existence have been developed in terms of social institutions has had a serious effect on the observable health inequities. This also obviously includes the direct economical dimension, i. e. the purchasing power in the area of the health market and medical care or also the choice of place of residence, but extends far beyond that point: recognition within the work process or opportunities for empowerment and self-determination within the workflow, as well as contributing to the shaping of one's own working conditions are all relevant factors in being able to lead a healthy life. Any philosophy of public health which does not address the issue of what degree of alienation and (self-) instrumentalization is compatible with a good and successful life has to fall short of the mark.

Furthermore, an insight by Karl Marx pertaining to the nature of the central principles of deontological ethics seems to me to be relevant. In his early essay “Zur Judenfrage” from the year 1843, he not only challenges stopping at a solely normative, i. e. for him moral, political, and legal emancipation, whereby he definitely welcomes the steps towards emancipation which he sees set out in the philosophical articles by Bruno Bauer.²² But Marx then goes one analysis step further in his criticism of human rights in an attempt to show that, accordingly, human rights themselves, i. e. the fundamental deontological norms, must be reviewed to investigate how valuable they are for criticism of the commodity-exchange society and its negative effects. According to Marx, the limitations of such a deontological treatment of the issue, which I believe is inscribed in many of the current approaches to the ethics of public health, are not found in the subjective ideological inconsistency of the respective philosophers, but probably in the theoretical framework they have chosen. As stated by Marx: “so liegt die Halbheit and der Widerspruch nicht nur in euch, sie liegt in dem *Wesen* und der *Kategorie* der politischen Emanzipation. Wenn ihr in diesen Kategorien befangen seid, so teilt ihr eine allgemeine Befangenheit.”²³

21 Cf., for example, Geuss (2008) and, especially for the context of public health, Jennings (2007).

22 Cf. Marx (1843); quoted here as MEW 1.

23 Marx (MEW 1, p. 361).

Marx did not abandon this ideology-critical stance in regard to the central categories of modern morals in his criticism of the political economy. In his late main opus “Das Kapital” twenty years later, Marx writes: “Die Sphäre der Zirkulation or des Warenaustausches, innerhalb deren Schranken Kauf und Verkauf der Arbeitskraft sich bewegt, war in der Tat ein wahres Eden der angeborenen Menschenrechte. Was allein hier herrscht, ist Freiheit, Gleichheit, Eigentum und Bentham.”²⁴ It is well-known that it does not make sense philosophically to continue uncritically and seamlessly with the Marxist criticism of morals, law, or state.²⁵ It is, however, less well-known and recognized that a philosophically convincing philosophy of public health which has been thought through to the end cannot succeed without taking these ideology-critical insights from Marx seriously and examining them critically. Otherwise, it is to be feared that criticism of public health without the inclusion of criticism of the political economy not only remains hollow words, but even risks contributing its ideological contribution to perpetuation of exactly those unsolved grievances which it intends to criticize quite rightly in the name of justice and a good life. This blind spot has to be addressed, even if my diagnosis may seem to some readers to be an outmoded reflection.

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