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## Some Problems of Contemporary Public Health Ethics



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*Der Aufsatz ist die erweiterte Fassung eines ursprünglich als Kommentar zu dem von Bruce Jennings vertretenen Ansatz eines ›relationalen‹ Liberalismus der Public Health-Ethik verfassten Manuskripts. Er verfolgt zwei zentrale Ziele: erstens konstruktive Kritik an dem genannten Ansatz zu üben und zweitens einen Beitrag zur Schaffung des konzeptuellen Rüstzeugs zu leisten, dessen es bedarf, um Klarheit über die von einer kritischen Public Health-Ethik zu leistenden Aufgaben zu gewinnen. Jennings Ansatz kann den Anforderungen, denen eine solche Ethik zu genügen hätte, nicht gerecht werden, weil er gleichsam distanzlos an die Selbstbeschreibung des Systems der öffentlichen Gesundheitspflege andockt. Damit werden problematische Aspekte von Prozessen der ›Vergesundheitlichung‹, die sich analog zu denen der Medikalisierung im Medizinsystem deuten lassen, ausgeblendet. Der von Jennings kritisierte Liberalismus verfügt insoweit über empfindlichere Sensoren. Zugleich ist er durchaus in der Lage, auch ohne Anreicherung mit kommunitaristischem Ideengut jene Blindstellen zu überwinden, die Jennings ihm seinerseits attestiert.*

### I

Public health ethics is a rapidly emerging field of applied ethics that attracts growing interest within the scholarly community. Like any field of academic analysis, it has its strengths and weaknesses. In this paper, I will address what I consider to be some of its weaknesses. In so doing, I will make both a few general points that I believe the advocates of a public health ethics have reason to consider and highlight specific problems that I identify in a particular approach of such an ethics, the approach developed by BRUCE JENNINGS.

The paper is structured as follows. In section II, I suggest a few terminological and conceptual distinctions that set the stage for the subsequent discussion, as well as form the basis for the

1

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consideration of various issues that I think any public health conception has to come to terms with. Section III concerns itself with some of the objections that JENNINGS has made against liberalism, both at a principal level and with regards to its capacity to serve as a foundation of public health ethics.<sup>1</sup> It finds JENNINGS' objections against liberalism to be unpersuasive and argues that liberalism may in fact have several advantages over the communitarian alternative that he himself proposes, not least because it sensitizes us to various difficulties associated with the politics of public health that JENNINGS does not even appear to see. The concluding section IV briefly touches on an issue currently hotly debated in public health circles, namely that of significant and apparently rising health inequalities in much of the OECD-world, and warns against the “dangers” of over-moralization in our responses to these inequalities even where they provide genuine cause for concern.

## II

My point of departure in this section is the by now familiar critique of bioethics as failing to take into account the key determinants of health by focusing almost exclusively on the conditions that regulate access to medical care (see e. g. POWERS and FADEN 2006), which, as epidemiologists have long known, has only a relatively small effect on people's health. So if we are concerned with promoting health, then we had better broaden our perspective and address the social factors that are ultimately responsible for our chances of leading healthier lives, rather than individualizing the problem and relegating its ‘cure’ to the medical profession (alone).

I believe this critique, whose aim is nothing less than to instigate a ‘paradigm shift’ (VENKATAPURAM and MARMOT 2009: 80) in our thinking about, as well as a policy shift in our practical dealings with, questions of (ill) health, is partly mistaken. The reason is not that the epidemiologists are wrong about the largely social determinants of health. Nor it is that they are misleading us in their attempts to direct attention away from medicine if our goal is to promote health in general and to reduce health problems (including health inequalities) in particular, as indeed many public health advocates say it should. Rather, the critique reflects a misunderstanding of the differences between the medical system on the one hand, and the health system on the other, which are often lumped together but should be kept at least analytically distinct because they pursue fundamentally different reference problems. To simplify somewhat, the *medical system* is concerned primarily with the treatment of sick people and the restoration of ill health, if and where disease has struck or disability has afflicted them and the technical means for improving their condition are available. The *health system*, by contrast, is concerned with the shaping or changing of environmental (including social) factors that are conducive or detrimental to health. Logically speaking, the medical system thus comes into play only when and where the health system has reached its limits. And while the former inevitably deals with *individual* bodies, the latter's main target is the body politic of collectivities and its effects on whole *populations*: those of particular nation-states, those of various sub- or supranational units, nowadays increasingly that of the entire globe.

The relationship between the two systems is partly complementary, partly competitive, and partly antagonistic. To the extent that their operations succeed in achieving their respective goals, they can add to, but not substitute one another—except in instances where they offer different, but functionally equivalent solutions to the same type of problems. Access to adequate medical care, while clearly of only limited utility to population health, can make a huge difference to the well-being and/or life prospects of individuals who are suffering from painful, debilitating

disease or threatened by premature death. Bioethics therefore rightly emphasizes its significance. Measures and institutions designed to promote population health are no less, in some sense arguably even more important, but they are also something quite different. They should therefore be addressed in their own terms, in terms suited to understanding their focus on macro-societal structures and policies that go beyond, or are at best only marginally involved in, the delivery of medical care. When these structures and policies raise normative questions, then they, too, should be addressed in separate terms, in terms reflecting their specific nature. Bioethics (at least where it understands itself as a continuation, extension and modernization of medical ethics, as suggested by TOM BEAUCHAMP and JAMERS CHILDRESS' phrase 'biomedical ethics'; see BEAUCHAMP and CHILDRESS 1994), is not going to supply them. This, however, should not be held against it because its frames of reference are tailored to answering questions with a different, micro-level and patient-centered focus. The individualism built into a patient-centered ethics of the medical system is not easily reconciled with the collectivism driving the population-centered ethics of the health system. Moreover, at times the systems' interests conflict with each other, for instance over the allocation of public resources, of which either system would rather have more than less, but which must be limited due to budgetary constraints. In such zero-sum situations, one party's gains are the other's losses. But how can a single ethics, tasked with representing both sides, adjudicate impartially between what *prima facie* seem equally legitimate concerns?

It is of course not always easy to delimit the boundaries between the two systems, and hence also of the rightful spheres of 'jurisdiction' for the pertinent norms and principles, not least because in practice the systems' operations often intersect and overlap. Moreover, their boundaries are not fixed once and for all, but essentially contested by various parties who are affected by, or have a stake in, the conceptualization of problems as falling into one or the other system. This is an area of considerable interest, but cannot be dealt with at sufficient length here.

Instead, I wish to draw attention to a few commonalities between the two systems that are easily overlooked but highly relevant to ethical reasoning about them. The most important of these commonalities is that both systems have the tendency to expand their reach and to absolutize their concerns. An *expansionist* logic is built into their very rationalities which induce both systems to incorporate, and consequently intervene into, ever more aspects of human life, affairs, states of existence. By *absolutizing*, on the other hand, I mean the propensity to prioritize their specific objectives over all others.

The two systems' vehicles of expansionism are the medicalization and the healthicization of reality, respectively. Beginning with the former, *medicalization* involves the translation of sets of problems into medical language, thus rendering them amenable to a medical understanding and treatment (ENGELHARDT 1986, chapter 5). The limits of medicalization are not determined by any biological facts but are ultimately socially constructed—virtually any human difference is susceptible to being considered a form of pathology, hence to being transformed into a medical condition (CONRAD 2007). The same is true of its analogue in the health system, *healthicization* (for this only seemingly odd term, see CONRAD 1992). Healthicization is to the health system what medicalization is to the medical system. Like the former, it is boundless. As one observer revealingly put it, health is ubiquitous ('everywhere'), its attainment is feasible ('do-able'), and it is political insofar as every social choice is at once a choice about health (KICKBUSCH 2006; 2007). But if everything can matter to health, then nothing is exempt from the possibility of being healthicized, from being scrutinized through a health lens, from being brought into the purview of the health system, and from being judged as according with, or deviating from, the demands of health.

Absolutizing is a function of over-identification with one set of values or concerns as against all others. This is not unique to the medical and health systems, but is also found in other sub-

systems of society, such as the economy, science, politics, religion, the law, etc., and it may well be one of the conditions of their very success because it serves as a powerful stimulus to improve system performance. In the medical and health systems, absolutizing expresses itself in the claim that health is special, which is widely used to justify the exceptional salience of health-related concerns in individual and collective decisions and the continuous growth of resources spent on medical/health purposes. This, however, also makes it problematic because it desensitizes both systems to other concerns, which are relatively devalued, but may be no less important from other viewpoints, from perspectives external to these systems.

Medicalization and healthicization are inescapable consequences of establishing medical and health systems—they are quite simply what these systems do, and whatever advantages accrue from their existence depend on their particular modes of reality-construction. They cannot thus be wished away. At the same time, they are far from innocent and unproblematic. In the case of medicalization, this hardly needs mentioning because there is no dearth of literature that sheds a critical light on (what are viewed as) its negative effects; indeed, the term itself is mostly used with pejorative connotations. With regards to healthicization though, a critical awareness of its downsides is only just (re-)emerging.

Amongst the costs that (over-)medicalization and (over-)healthicization incur, two types stand out: (1) what could be called moral costs, and (2) monetary costs. The latter derive from the fiscal inflation of medical and health budgets, and from initiatives that translate specific medical and/or health goals into concrete policies. The former are both more difficult to “capture” and easy targets for scandalization. Examples are the treatment of conditions as pathological at one point in time that are viewed as being perfectly ‘normal’ at another point, such that their medical treatment, even if well-intentioned, becomes a form of abuse in the eyes of later observers, and the over-eager execution of measures deemed good for people’s health even in the face of substantial reservations against them by the envisioned beneficiaries.

The latter point is also one of the normative issues discussed by BRUCE JENNINGS in his pertinent writings, to which I shall now turn.

### III

In order to be effective, population health or, as it is more often (if somewhat misleadingly) called, public health, must sometimes impose measures on collectivities that might, at least initially, not find them agreeable and hence not be inclined to comply voluntarily with the bodily interventions and behavioral expectations that these measures entail. What to do about their recalcitrance? In the last instance, when nothing else works, the administrators in charge may have to resort to coercion, to enforcing compliance against the will of any would-be objectors and to just do what they think right. But how does one justify such coercion in a liberal political system one of whose cornerstones is the ideal of free and equal citizenship?

This problem is widely discussed in the literature, and it also figures prominently in the writings of BRUCE JENNINGS, especially in his article *Public Health and Liberty: Beyond the Millian Paradigm* (2009), on which I focus here. As JENNINGS makes painstakingly clear, the dilemma that the problem of coercion poses is a very real one, and it is a dilemma not just for public health, but for public policy more generally: whenever its regulations go against the stated interests or revealed preferences of some of the constituency in question, they have to be backed up by force. From a liberal viewpoint, this is easy to justify as long as the respective interventions serve to protect the freedom and rights of some from infringement by others. It becomes highly problematic

though when their purpose is to enhance the aggregate welfare of a larger group or the personal welfare of individuals who have not assented to them. The former requires overruling individual freedoms for the sake of collective benefits, i.e. *mandating solidarity*, the latter involves *paternalistic* interference with a person's freedom for his or her own good. Both types of action are widespread and may very well be sensible in many instances. But they are hard to reconcile with classical liberal thought.

Is there a way out of the dilemma? JENNINGS considers the possibility of holding other values embedded in non-liberal traditions up against those espoused by liberalism and then letting them trump the latter in case of a conflict, but dismisses this idea as unsatisfactory. His own suggestion is to reread, reinterpret, reconstruct the concept of liberty itself in such a way as to make it compatible with the requirements of public health. Rather than drawing on something *other than* liberalism, he prefers to fashion himself *another liberalism*, one that can accommodate what lies outside the bounds of liberalism as we know it.

At the heart of this suggestion lies the concept of 'relational liberty'. The aim of working out a theory of relational liberty, by which JENNINGS means a kind of freedom that results from "transactions and relationships with others", is to provide a "justification for limiting or overriding individual liberty by state agencies" tasked with promoting public health (JENNINGS 2009: 130; 126). In other words, JENNINGS' project is to turn liberal thought against itself to render liberalism compatible with the demands of public health. This endeavor, I believe, is doomed to fail. Later, I will discuss a few objections against it and suggest an alternative way out of the dilemma. But before I do that, I would first like to draw attention to two more general difficulties that make his whole project problematic and that are worth pointing out because they seem quite typical for much of the thought guiding the public health literature.

The first difficulty derives from the choice of formulations which indicate a lack of critical distance from the goals of public health. At times these formulations seem to suggest that the respective goals are unambiguously clear and laudable, that we know exactly how to realize them, and that all we need to do is to remove any hurdles standing in the way of their proper implementation. An example of a phrase that appears to reflect this mindset is the following: "How can an open, liberal society", JENNINGS asks there, "also be an objectively healthy and well-off society, one in which each individual follows the best available evidence and scientific advice in matters of lifestyle and risk-taking behavior?" (2009: 128)

At first glance this sounds reasonable enough. After all, leading healthy lives seems better, both individually and collectively, than being stricken with preventable disease, with mental and physical disorders, etc., and to adjust one's behavior accordingly is hardly asking too much, especially when it involves little personal cost. But then, who is to determine the standards of 'objective health'? Are they to be binding on all? If yes, on what grounds? And do we really want to entrust science or public health organizations with the task of determining how we should lead our lives? The problems with this type of reasoning are threefold. First, what counts as healthy or unhealthy, as normal or abnormal, etc., changes over time, and many past standards of normalcy or healthiness are today viewed with apprehension, to put it mildly. That, however, did not prevent the professionals of the past to enforce them with great vigor whenever they possessed the power to do so. We once 'knew' that masturbation is a disease, and strict measures were taken against it (ENGELHARDT 1986, chapter 5). And given that knowledge always carries a cultural and historical index (KUHN 1970), it is quite likely that some of today's 'truths' and 'insights' will be seen as no less quaint in the future than those of our ancestors appear to us. Second, almost all scientific knowledge is provisional knowledge, liable to be rendered obsolete by later knowledge offers. Moreover, in any given science field, much greater uncertainty and contestation usually

exist than tend to meet the public eye. To be sure, some theories are more widely accepted than others, but they are not always the ones that prove to stand the test of time. Third and finally, just like medical rationality puts a premium on medicalization, so does health rationality on healthification, as demonstrated above. But what may make perfect sense from the viewpoints of the medical and health systems, need not be best ‘all things considered’ and can on occasion raise serious normative issues which will not even come into view if we unquestionably identify ourselves with the goals of one or the other system, if we bind ourselves to their internal perspectives and simply echo or amplify them.

Taken together, these observations suggest keeping a healthy distance from the ostensible mandates of (medical) science and the seeming demands of public health, however strong and plausible these may appear on the face of it. Of course, such skepticism should not be taken to extremes. We all benefit from scientific medicine and public health, and where their pursuits require a knowledge basis, they must draw on what is believed to be known today. I just want to caution against taking *too much* of this knowledge for granted and against ever-present temptations to substitute scientific expertise for what ultimately remain *political* choices. The standards we adopt for public health measures inevitably reflect value decisions that we may or may not be comfortable with. Or more precisely, that some of us are likely to endorse while others find them objectionable.

My second point concerns the related impression that the task JENNINGS sets himself follows a rather instrumental logic. Instead of asking which policies might seem justified or warranted in light of valid ethical principles, he posits a quasi-objective need for certain policies and then asks how these policies can best be justified, that is to say: *rationalized* to the affected public. Classical liberalism, he notes, does not provide much aid here, because public health is “not a natural ally” of liberty (2009: 130). True enough. For as mentioned before, public health measures may have to restrain individuals’ freedom, and that goes against the liberal impulse. If liberalism is nonetheless to be used as a source of justification, as JENNINGS suggests it should, then it must first be amended, expanded, reinterpreted accordingly. The concept of ‘relational liberty’ does precisely this. Rather than setting up a bulwark against the encroachment of individual freedom, it presents the curtailing of some freedoms as being in full accord with the tenets of a liberalism that is true to its own spirit. This argumentative strategy turns the logic of ethical reasoning on its head, not unlike what in a different context I have called *adaptive justice* (SCHMIDT 1992). Justice, on such an understanding, is not an independent, critical yardstick used for assessing a policy’s ethical adequacy or for guiding its designation, but first and foremost a justificatory device whose semantics are flexibly adjusted to the need of garnering support or maintaining acceptance for extant policies. But while this seems to be common practice in everyday politics, it falls short of what can reasonably be expected from a philosophical ethics.

I now turn to more specific reservations against the concept of ‘relational liberty’. My main point is that relational liberty is *no liberty at all*. As indicated above, relational liberty is all about subjecting the pursuit of freedom to constraints, and while these constraints may very well be justified in their own right, they cannot be straightforwardly derived from liberal premises. It comes therefore as no surprise that the language Jennings uses to defend the limitations he proposes draws heavily on the vocabulary of an ethical tradition that has long been one of liberalism’s main antagonists, namely communitarianism. The substance of relational liberty is a communitarian morality dressed up as liberal ideals freed from the legacy of false interpretation.

This assessment need not predispose us against the *content* of what JENNINGS calls relational liberty, just as it does not settle any substantive dispute between liberals and communitarians. It only goes against conflating what are, *prima facie*, incommensurable ethical conceptions (for a

similar objection to the confusion of terms, see BERLIN 1969). Equally problematic is JENNINGS' attempt to salvage liberalism from its individualistic underpinnings that he thinks are so harmful. But harmful or not, liberalism is inevitably individualistic. Historically speaking, it is probably the first ethical doctrine that places the individual at the center of social purpose, attributing rights to all people against unwelcome claims laid upon them by some higher authority or overarching group. A non-individualistic liberalism is thus an oxymoron. For a liberalism that gave up its individualistic core would cease to be liberal.

This is not to say liberalism is (always) right. Nor does it downplay values like commitment to the common good, to the well-being of others, to community solidarity. But the roots of such values are not to be found in liberalism.

Where does this leave us with regards to the dilemma pointed out by JENNINGS? A first step toward a solution might be to acknowledge the value pluralism that is so characteristic of modern society. This then leads to the question of mechanisms by which this pluralism can be dealt with in a peaceful manner. The practical answer that has been found in the Western world consists in a mixture of constitutional principles believed to reflect an overlapping consensus between otherwise divergent doctrines and worldviews; democratic procedures; and pragmatic attitudes that sway the contending parties to respect each other, to be open to compromise, and to accept defeat as long as the possibility exists that they may prevail next time around.

But JENNINGS is of course concerned with theoretical problems. Are there also viable theoretical solutions, then?

Since I lean toward a liberal position, it would seem to behoove me to find *liberal* answers to the two main problems that JENNINGS says liberalism presents for public health policies, namely (1) its *lack* of sensitivity to issues of group solidarity and social justice, and (2) its *over*-sensitivity to paternalistic impositions of seemingly reasonable regulations.

As for the first problem, liberalism has arguably long found an answer in the form of *social* liberalism and the associated concept of *positive* freedom. JENNINGS does mention this concept as one of the three interpretations of liberty he distinguishes, but dismisses it—presumably once again mainly due to its individualistic underpinnings. The idea of positive freedom can be traced back at least as far as the work of KARL MARX who maintained that classical liberalism's freedom meant freedom only for the well-off because only they were in a position to reject exploitative contracts, especially in the context of paid work. But if one party to a contract must *de facto* accept whatever the other party offers, then treating that party's agreement to the terms of the contract as a free choice is downright cynical. If liberalism's freedom is meant to be real for all (VAN PARIJS 1995), then something has to be done to level the playing field, to enable each person to lead a life they have reason to value, as AMARTYA SEN put it (see e.g. SEN 1999), rather than being formally freed from the shackles of serfdom but practically forced into quasi-enslavement. To this end, social liberalism pleads for a battery of measures and institutions that commonly go by the name of social policies. Examples include the establishment of public schools, of public health care, of social safety nets, but also the regulation of employment contracts. The financing of social policies combines such measures as compulsory social insurance or savings schemes, progressive taxation, and others, all of which involve substantial legal intervention into the lives of citizens and mandatory solidarity enforced by the political administration.

Once again, such policies and interventions may make sense from some viewpoints, but must they not appear revolting to liberals? They may indeed appear revolting to libertarians such as ROBERT NOZICK (1974), but in the eyes of *social liberals* they are perfectly legitimate. Moreover, to justify them, social liberals need not become communitarians, as attested by the work of JOHN RAWLS (1971; 2001). Like every path-breaking scholarly work, RAWLS' conception of justice is con-

tested, but if nothing else it has clearly shown that it is possible to lay *individualistic* foundations for *social* redistribution and *mandatory* solidarity.

Needless to say, its principles of justice, especially the famous difference principle, are devised for a subject matter—the basic structure of society—that makes them uninformative for more specific policies such as those relating to questions of public health. Tackling such matters therefore requires supplementary principles that, while they must be compatible with those enshrined in the constitution, cannot be directly deduced from them. The theory does, however, provide a strong basis for at least some form of group solidarity—solidarity with those who might be adversely affected by an institutional order that permits social inequalities. And as exemplified by, amongst others, the work of NORMAN DANIELS, it can also serve as a powerful source of inspiration for building similar foundations in lower-level policy fields, public health being one of them.

I now turn to the second problem identified above, that of paternalism, which is arguably a bit ‘thornier’ than the first, but nonetheless amenable to a liberal solution. As indicated, the problem is a very real one, because there is no such thing as a non-paternalistic social policy. Thus, if social liberalism required paternalistic intervention, while paternalism was strictly off limits to liberals, then it would be very hard indeed to reconcile positive and negative liberties within a liberal framework. However, the limits that liberal thought sets to paternalism need not be as absolute as some of its most prominent advocates claim they are. Provided a good, convincing justification is given, even liberals can accept some degree of paternalism (GUTMANN 2014). An argument that might qualify as a good justification and hence be able to legitimize at least some form of paternalism has been put forth by JON ELSTER (1979), who uses the metaphor of *Ulysses and the Sirens* to illustrate its logic. It runs as follows: Under democratic political conditions, paternalistic legal stipulations can be viewed as a form of *auto*-paternalism whereby free and equal citizens, in awareness of their weakness of will, political myopia, proneness to time-discounting and procrastination, give their elected representatives a mandate to impose on them what they themselves, upon due consideration, would have to admit is best for them, but cannot bring themselves to doing in the absence of binding rules that force them into compliance. When such arrangements are combined with opting out schemes, they may even be agreeable to moderate libertarians, as suggested by the phrase libertarian paternalism coined by CASS SUNSTEIN and RICHARD THALER (see THALER and SUNSTEIN 2008).

If ELSTER’s argument holds water, as I believe it does, then it should principally be applicable to public health measures as well. To be sure, liberals will always be wary of paternalism, so they will prefer less rather than more statutory interference. But some alertness to the potential downsides of paternalism would not seem to be a bad thing. Rather, it would encourage and induce us to weigh carefully the competing values at stake.

#### IV

Before closing the paper, I want to briefly address one additional problem that receives much attention in public health circles, namely the problem of health inequalities. As has been shown repeatedly, people’s health status varies systematically with their social status, such that the lower their income, class, and position in work organizations, the lower their chances of leading long and healthy lives—and *vice versa*. This finding has alarmed many observers, including those who criticize bioethics as being too narrowly focused on access to medical care because of its relatively minor impact on health inequalities/chances.

Assuming these inequalities were a problem, how ought we to deal with them? FABIENNE PETER (2001) has distinguished two strategies, one of which she calls the direct approach, and the other, which she herself favors, the indirect approach. Following the self-description of the medical and health systems, the *direct* approach starts from the premise that health is so special that substantial deviations from the ideal of equality are scandalous and hence require remedial action whenever and wherever such action promises to reduce existing inequalities. The *indirect* approach, by contrast, places health inequalities within a broader conception of social justice that, while viewing health as important, refrains from absolutizing it and automatically elevating it above all other concerns that such a conception must consider.

A particularly strong version of the direct approach is represented by SRIDHAR VENKATAPURAM (2011: 24) who accords health justice “priority over all other social values and goals (...) Health injustice (...) is not just a bad, sad or tragic situation; it should not be tolerated and is to be avoided to the greatest extent possible. There is no greater ought for social action”. MADISON POWERS and RUTH FADEN (2006, chapter 1), by contrast, while also ascribing great importance to health, treat health inequalities as only one of several inequalities that public policies have to address in the name of justice. In so doing, they relativize or at least bracket the special urgency of health inequalities. Like VENKATAPURAM and many other public health advocates, they take for granted, without much discussion and substantiation, that existing health inequalities are deeply troubling. At the same time, they point to their embeddedness in a web of other inequalities and of social structures that produce and reproduce them. And given the awareness that reducing inequalities in one field is likely to increase inequalities in another (SEN 1992), they do not want to foreclose prematurely the question of which inequalities matter most. If any attempt to address given inequalities faces the problem of trade-offs between inequalities and/or other policy goals, then prioritizing one over the other raises costs that responsible policy-makers have to take into account and weigh against those of alternative courses of action. But these costs will not even become visible when reality is assessed exclusively or primarily through the prism of health.

The indirect approach is better prepared for taking such costs into account. Treating health care—understood as the sum-total of measures that promote population health and access to medical goods and services—as only one of several pillars of a well-functioning welfare state, it encourages a more ‘holistic’ understanding of public or social policy. It also allows us to step back from the moral outrage that empirical findings of significant disparities in health chances or health outcomes often provoke amongst the observers, thus clearing the ground for sober-minded reflection of both the moral significance of given findings and a careful weighting of feasible policy options. Inequalities, even if seemingly repulsive at first glance, need not *ipso facto* be injustices—facts are, after all, just facts. To be *rendered* problematic, they must first be run through the filter of ethical reflection and deliberation, one of whose results *may* well be that they do not openly violate reasonable demands of justice. But even if upon careful reflection we find existing inequalities to be unjust, we still have to take into account the positive and negative externalities of any policy options that might be available to us for tackling them. Different categories of people are differently affected by different policies, and sometimes the same people who would benefit from a given policy in one dimension of their well-being or welfare would be adversely affected by it in another dimension. There is thus rarely a clear-cut, one-best policy, such that all it would take to follow the mandates of justice would be to do the ‘right thing’.

Finally, the indirect approach permits us to entertain the possibility that some goals are indeed best pursued indirectly rather than directly: “[S]ocial justice (...) is good for population health and its fair distribution”, as DANIELS (2008: 82) has put the underlying premise in his revised theory of just health. Thus, even if our primary goal were to promote health justice,

it might still be advisable to focus on policy measures that fall outside the scope of what would commonly count as health (care) provision/promotion. For instance, it has been suggested that shifting some of the resources devoted to financing medical care into the public education system might yield a higher health dividend than pumping ever more money into the medical and health systems (see e.g. LLERAS-MUNEY 2005). But even to consider such a possibility requires looking *beyond* the realm of health.

What these few remarks and observations suggest is, once again, that a public health ethics aspiring to be more than an extended mouthpiece of the health system needs to keep a certain distance from this system. Conceptions of public health ethics such as those proposed by JENNINGS and VENKATAPURAM, not to mention the declarations of many public health activists, lack such distance. This makes them vulnerable to the pitfalls of (over-)healthicization and the inflationary, potentially limitless demands that the health system places on public and private resources (WEINSTOCK 2011). The determination of health needs is to a large and growing extent supply-driven. As more professionals enter the field of public health, more aspects of people's lives will be healthicized, more 'solutions' to (conditions previously not considered) health problems will be offered, more health monitoring and surveillance of the population will be deemed desirable, and so forth. Without critical distance from the health system, a public health ethics can do little more than sanction and ratify these developments. A second conclusion to be drawn from the foregoing is that sociologist NIKLAS LUHMANN'S (1989) seemingly 'heretical' dictum that one of the core tasks of ethics might well be to keep morality in check, to alert to and reflect upon the dangers of moralization, has quite a bit to say for it. For moral indignation and moral fervor, which pervade much of the recent public health literature, are no good guides for policy-making, for devising policies that are reasonably acceptable to everyone rather than just the lucky few who, absolved of the burden of doubt, know what is right.

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