

Ethical analysis in public health

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Public-health regularly encounters serious ethical dilemmas, such as rationing scarce resources, influencing individuals to change their behaviour, and limiting freedom to diminish disease transmission. Yet unlike medical ethics, there is no agreed-upon framework for analysing these difficulties. We offer such a framework. It distinguishes three philosophical views, often invoked in public-health discourse: positions based on outcomes (utilitarianism), positions focused on rights and opportunities (liberalism), and views that emphasise character and virtue (communitarianism). We explore critical variations within each approach, and identify practical problems that arise in addressing the ethical dimensions of health policy. We conclude by examining challenges posed by the feminist argument of ethics-of-care and by postmodern views about the nature of ethics. Health professionals need enhanced skills in applied philosophy to improve the coherence, transparency, and quality of public deliberations over ethical issues inherent in health policy.

Introduction

Public-health decisions commonly involve conflicting and ambiguous ethical principles. Ideas like efficiency, human rights, cultural respect, equity, and individual choice are commonly invoked but rarely analysed in public-health debates. Yet how these concepts are understood and used can lead to quite different policies. How is cultural respect to be reconciled with human rights when local elders reject equal access to education for females? Is a tax on wages an equitable way to finance health care? What does so-called individual choice mean for an addicted substance user who both wants and does not want to transform her own life experience?

Medical ethics, focused on doctor/patient relationships, is widely discussed and taught to medical students.¹ But a comparable field of public-health ethics is not as well developed to guide public-health practitioners.² We seek to fill that gap by providing a method for describing and analysing the major ethical ideas invoked in discussions of public-health policy.

Our approach sorts ethical arguments into three major categories, each representing a major theme in contemporary public-health discourse: utilitarianism, which asserts that decisions should be judged by their consequences, in particular by their effect on the sum total of individual well being; liberalism, which is focused on rights and opportunities, on where people start, not on where they end up; and communitarianism, which involves visions of an appropriate social order and the virtues that will maintain such an order in a particular community. We also discuss a challenge to this framework raised by recent writings of the ethics-of-care school of feminism.

Consequences

Public-health policymaking is often based on an analysis of consequences. The right choice is viewed as the one that produces the most gain, for example, the largest reduction in the burden of disease. For public-health professionals, this perspective has a strong intuitive appeal.

Philosophically, a leading exponent of this argument was Jeremy Bentham (1748–1832). Bentham proposed a particular way to measure consequences, namely, by the impact of decisions on the wellbeing of all affected individuals, or, as he put it, by “the greatest happiness of the greatest number”.³ He called his measure of wellbeing “utility”, and his doctrine “utilitarianism”. Bentham argued that all individuals’ utility levels should count, and count equally. He proposed that the rightness of an action was not intrinsic, but was determined by the “hedonic calculus” of adding up the pleasure and pain it produced.

If policy is to be judged by its effect on the sum of individual levels of wellbeing, we need to measure and add up these magnitudes. In modern times, utilitarians have divided into two camps.^{4,5} Those who believe that wellbeing is best defined by each individual’s personal experience are called subjective utilitarians. Others doubt the reliability or validity of individual judgments and reactions. These objective utilitarians want to centralise the assessment process and have a group of experts define an index that embodies the “rationally knowable” components of wellbeing. Both approaches focus on consequences and seek to use resources efficiently to produce the most “good” as they define it.

In public health, subjective utilitarians would ask those who benefit from a programme to assess their own health gains. In practice, this approach often uses a technique like cost-benefit analysis, and asks beneficiaries about their willingness to pay for health gains. By contrast, objective utilitarians would rely on an expert-determined index of health status—like Quality-Adjusted Life Years (QALYs) or Disability-Adjusted Life Years (DALYs)—to measure the consequences of alternative decisions. The resulting cost-effectiveness analysis does not translate gains into money, unlike cost-benefit analysis. The differences between subjective and objective utilitarianism can lead to many disagreements over policy. Many subjective utilitarians want to use

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markets to allocate health-care resources, because markets respond to individual preferences. Objective utilitarians, by contrast, tend to favour planning processes, based on data-driven methods of rational resource allocation.

Despite their intuitive appeal, both kinds of utilitarianism face practical and philosophical problems in guiding public-health decisions. As the debate over the DALY index illustrates, there is substantial disagreement over whether health status—which is only one aspect of well being—can be measured in a unique way on a universal scale.⁶ For example, are the relative impairments from dyslexia and from a lost leg the same in a poor agricultural society and a rich industrial nation? Similarly, why should we ignore individual and cultural variations in attitudes toward pain, disability, and death? If we do try to construct a single index, who should make the many critical decisions? Who should decide whether years of life lost at different ages are of the same or different values? Or whether health gains in the future are worth the same as health gains today? How can we ensure that construction of a health index occurs with appropriate transparency and accountability?

However, individuals' subjective judgments produce results that many experts see as irrational. In the environmental arena, for example, citizens worry especially about newly discovered risks, or about cancer risks. They consider these risks more important than other risks of similar objective magnitude.⁷ In health care, individuals who are acutely ill commonly report a higher quality of life than healthy individuals, saying that their illness has given them a new appreciation for life.⁸ Subjective utilitarianism also raises difficult philosophical issues. If we use willingness-to-pay as a measure, then the rich will have more influence because they have more money. Those who are popular or have larger families will be "worth" more, because others will pay more for their survival. If prejudice leads society's members to value the lives of some (by race or gender) less than others, are we really comfortable using such values as a basis for policy decisions?

Philosophically, there are various objections to utilitarian views on grounds that they lead to unfairness.⁹⁻¹⁰ In a lifeboat, is it acceptable to kill a few castaways and eat them so that the rest of the group can survive? And if so, should we choose the least happy, the least popular, or the most nutritious to sacrifice? In health policy, should we compel kidney donation in the service of "the greatest happiness of the greatest number"? If some sick individuals are very expensive to save, are we comfortable in denying them access to high-cost medical care? Can we systematically quarantine people with HIV to restrict the spread of the disease, as was done in Cuba?¹¹

We believe that the utilitarian analysis of consequences has, and will continue to have, a central role in public health practice, despite these objections. It captures a critical concern—namely, improving individual wellbeing. At the same time, many resist use of the utilitarian calculus. For example, in the USA, our concern for people near to death leads us to the irrational practice of "sickest first" in allocating organs for transplantation (which does not maximise total gain).¹² Similarly, we are unwilling to coerce individuals to change their personal habits (for exercise, diet, or sex)—to improve health status. People who oppose these approaches often counter the utilitarian logic with an appeal to individual rights—an appeal that frequently

finds a receptive audience in the public-health community. This claim leads us to the second major category in our ethics framework.

Rights

In recent years, public-health professionals have become increasingly interested in the idea of rights. However, the nature and definition of such rights are often controversial.¹³ From a public-health perspective, are there rights to health itself or to health care? Whose rights take precedence, those of a mother or those of an unborn fetus, and under which conditions? How do health rights relate to human rights more generally? Indeed, some countries have strongly disputed the imposition of what they see as western political values on their governmental systems.¹⁴ Here again, we believe that considering philosophical foundations can provide practical guidance.

The modern philosophical justification for rights is grounded in the doctrine of liberalism. Here, the word liberal does not imply being on the political left, as in the USA, but pertains to the view that individual rights are paramount. Outside the USA, most liberal political parties are centrist or conservative. Like utilitarianism, liberalism is a 19th century doctrine, rooted in the Enlightenment, particularly in the writings of the German philosopher Immanuel Kant.

Kant argued that human beings ought to be treated with respect, as ends in themselves, not as means to another individual's ends.¹⁵ The basis for such respect, Kant argued, was each human being's potential capacity for "moral action", for acting on the basis of impartial rules derived by reason. This view directly opposes utilitarianism's willingness to treat some people as a means to others' ends. Modern Kantians argue that since human beings have the capacity to develop and implement their own decisions about how to live—what philosophers call life plans—they have the right to do so.^{16,17} Because these rights derive from each individual's status as a human being, they are seen as universal—and all political systems are obliged to honour them. Thus, liberals see themselves as creating a set of rules that define how the state should operate and how policies should be determined.¹⁸

Rights implied by the principle of mutual respect are interpreted in two different ways. Libertarians believe that only negative rights deserve protection.¹⁹ These rights guarantee individual freedom, so that people can do what they want, without state infringement on personal choice. Libertarians want only a minimal state to protect individual property rights and personal liberty; they typically oppose restrictions on drug use, limits on abortion, motorcycle helmet requirements, or laws mandating seat belt use in cars—on the grounds that these actions restrict freedom of choice.

By contrast, egalitarian liberals argue that the right to choice is meaningless without adequate resources. Therefore, everyone has a positive right to the minimum level of services and resources needed to assure fair equality of opportunity. The key question for egalitarian liberals is: what does the principle of mutual respect require the state to provide to ensure positive rights? For public-health professionals, the question is how to interpret positive rights to health and health care.

Some commentators argue that there are no special rights to health or health care.¹⁹ If resources were distributed fairly, people could then buy the health care (or health insurance) they want, just as they are free to choose their own food and clothes. This position implies

a moral obligation to redistribute income, but no more. The only role for state action would be in cases where markets fail for technical reasons (such as inadequate information or effects on third parties), as occurs with prescription drugs or vaccination.

By contrast, in the public-health community, health is generally viewed as special or different from most other things produced by the economy. One argument is that a minimum level of health is necessary for people to have a reasonable range of opportunity when they make life choices.²⁰ In this view, health is a component of each citizen's opportunity—like such basic liberties as free speech and political participation. This positive-rights perspective makes government responsible for a minimum quality and quantity of life for all, and to provide the health care needed to guarantee that minimum.

This positive-rights argument implies a redistributive perspective on health, favouring those who are worst off from a lifetime perspective. The health care system should place priority on averting premature death and disability. At the same time, we should spend less on extending the life of the aged, who have already had the chance to develop and implement their life plans. John Rawls called this perspective "justice as fairness".

As a practical matter, asserting a right to health leaves many detailed questions unanswered. Do we meet the standard for every individual, even if doing so is very costly in some cases? How do we decide on the minimum standard, and does it vary as medical technology and a nation's economic position change over time? What public care should people receive if their ill health results from their own behaviour?

An alternative egalitarian liberal perspective has been offered by Amartya Sen. He has argued that health is not a prerequisite for, but rather the result of, individual choice.²¹ In his view, a liberal state should make health care available to its citizens, and leave up to each individual the decisions about personal behaviour and the use of care that determine health status. In Sen's terminology, the aim is to maximise the set of "capabilities" available to individuals. The level of "functioning" each person achieves is then their choice.

The difference between health as a prerequisite for choice and health as the consequence of choice has important implications for public-health professionals. From Sen's perspective, education focused on tobacco's ill effects is appropriate, provided the choice to use or not is left to the individual. A liberal who sees health as a state-guaranteed right, on the other hand, would move beyond education to more aggressive efforts to control smoking, to improve health outcomes.

Despite deep differences, there are some basic similarities in liberalism and utilitarianism. These doctrines are both universal; they seek to develop a single moral standard for all human societies. In addition, they focus on the individual—on individual wellbeing and individual rights. For this reason, both perspectives have been criticised for ignoring the social structure of human life.²² Critics of liberalism argue that important community values are ignored by its individualistic vision. Utilitarianism is faulted for implying that you cannot favour your own family, friends, or fellow citizens over strangers, if helping strangers would yield more utility.^{23,24} Similarly, utilitarian approaches to improve health status can conflict with a society's views about moral conduct. Consider, for example, the controversies over distributing clean needles to drug users or contraceptives to high-school students.²⁵

These examples point to ethical perspectives that are not based on consequences or rights, but focus instead on inculcating virtue and fostering community.

Communities

A focus in ethics on creating a good society, and on producing the right individuals for that society, has a long history. Such communitarian viewpoints are found among Greek philosophers (Plato and Aristotle), among many religious figures, and in many non-western traditions such as Neo-Confucianism.

Communitarianism includes a wider set of substantive philosophical positions than liberalism and utilitarianism, since there are many different views about what constitutes individual and social virtue. For example, the Green Parties of western Europe want to transform the relationship of man to nature, turning from mastery and exploitation to harmony and minimal impact. Similarly, some in the feminist movement want to change the relationship of men to women. Neo-Confucianism begins by analogising the state to the family. Knowing one's place and fulfilling one's duties then become major components of virtuous conduct.²⁶ Similarly, Plato, who lived at about the same time as Confucius explicitly argued in *The Republic* for inequality in political life based on variations in individual talents.²⁷ This position contrasts sharply with that of liberals and utilitarians, who see everyone as equal and who want to leave visions of the good up to each individual.

A basic question in communitarianism is who decides what is virtuous. Communitarians offer two different answers to this question. One view is that every community defines its own norms.^{28,29} This form of relativist communitarianism sees morality as inherently contextual. Lacking a universal place to stand outside any cultural context, relativists argue for respecting each society's particular cultural traditions. Universalist communitarians, by contrast, believe in a single true form of good society and its associated virtues. This approach appears in public health as the belief that certain behaviours (eg, not smoking in public) and cultural patterns (eg, female literacy) should be promoted in all societies, regardless of local cultural norms. Such policies can be justified by their health consequences or as a matter of rights. But they are also defended as good in and of themselves, as part of a superior form of social organisation.

Public-health communitarians face many important questions. If community norms have value, then some attempts to inculcate those norms and limit deviance from them are appropriate. But when do efforts at promoting community values become illegitimate coercion or repression? For example, when can people with certain religious beliefs (such as Christian Scientists) limit their children's access to life-saving medical care for religious reasons? Moreover, what is the boundary of a community? When can a group (or an individual) be allowed to opt out and decide to follow a different vision? And when disagreements occur within a community, who gets to say what its values really are?

Universal communitarians also must confront how to coexist with people who hold a different, universal faith. History has many examples of people who sought to impose their communitarian vision by force—from the Crusades to the Khmer Rouge to the Taliban. Moving from coercion to coexistence, tolerance, and mutual learning requires a degree of openness that many universal communitarians find inconsistent with the certainty of their own vision.³⁰

The debate within public health about female genital surgery for cultural reasons shows how conflict between the two streams of communitarianism can arise (relativist communitarian cultural respect struggling against universal communitarian outrage).³¹ Public-health professionals who want to use communitarian ideas must resolve the definition and justification of their vision of the good community. Ethical analysis can help this process by highlighting what is assumed and implied in various communitarian positions, and their relation to utilitarian and liberal perspectives.

The problem of justification

Confronted with these three basic ethical positions, one might well ask which is correct? What arguments are available to select one ethical view over another? Such questions about justification fall into the realm of meta-ethics, or questions about the nature of ethics itself.

There are various ways of justifying an ethical position. Religious faith is one. Another is the view that human beings have a special faculty for perceiving morality, so that moral truth is revealed to us by our emotions or intuition. A third view holds that logic or reason can dictate the content of morality.³² The most widely accepted modern argument is moral realism.³³ This is the position that the content of morality can be learned from our experience, when that is properly understood and processed. This view takes various forms. Marx believed that morality was revealed by history. Others have argued that we can learn morality by understanding human nature, by analysing human needs, or from the essential components of the human character, or from the requirements of social life.³⁴ But in each case, moral realists take the position that moral truths exist and can be discovered—that there are moral facts just as there are scientific facts.

Other contemporary thinkers reject all these lines of analysis. The postmodern school argues that ethics is not justifiable in any foundational way.³⁵ Instead, postmodernists argue, ethics is created, like art or poetry. Criteria for judging moral arguments are based on rules internal to the enterprise, like the stylistic norms that govern an artistic tradition. But those rules cannot be derived from more fundamental principles. They do not and cannot have a deeper justification. The words that human beings use to describe concepts like justice, well being or tradition are just that—words—symbols to express ideas invented by people, just as Gothic architecture and country music were invented by people.³⁶

A postmodern public-health practitioner must still grapple with the problems of making moral decisions. If there is no fundamental justification, then are all moral views and all courses of action equally compelling? Richard Rorty, a prominent American post-modernist, argues that moral judgments are possible, even though they cannot be justified in a foundational manner.³⁷ We have no choice, he says, but to act on our own view of the good, and to seek to persuade others to accept our perspective. For example, Rorty is prepared to advance the cause of respect for human rights, even though he cannot prove that this moral position is correct by reference to a higher law or basic principle. Instead, Rorty urges a modern version of the doctrine of pragmatism, argued by John Dewey.^{38,39} He proposes the acceptance of moral views that work to make the world a better place, as best we know how. Personally, Rorty is an egalitarian liberal, and he seeks broader acceptance of this moral perspective via poetic or prophetic means, since he recognises that rational argument alone will not suffice.

The postmodern perspective opens up additional arguments for public-health professionals. If moral theory is an artistic creation, then it makes sense that a particular ethical theory might offer only partial insight, and that we might gain useful insights from more than one viewpoint. The risk is that theory could become window-dressing—an after-the-fact justification for unstructured intuitions. The challenge in defending a mixed position is to explain why the line is drawn between various theories in a particular way, and why specific constraints are imposed. For example, if someone believed that health-status considerations justify limits on individual freedom in providing directly observed treatment for tuberculosis, whereas individuals who are mentally ill can legitimately refuse treatment, they would need to explain why.

From this perspective, we can view any particular ethical theory as a contribution to a continuing discussion about how to organise society, and ask, does it move that conversation forward in an interesting way? This returns us to public discussion (what political scientists call deliberation) as a critical process. The task is to create a shared vocabulary that facilitates a serious exchange about the needs, perspectives, and goals of each participant. Developing a capacity to participate in these exchanges, for public-health professionals, can foster both the explicitness and transparency of public discourse.

A feminist challenge

In recent years, a provocative challenge to the arguments presented above has emerged from feminist thinkers, a challenge we believe is of particular relevance to public health. As a social movement, feminism has relied on various ethical ideas, including both utilitarianism and liberal rights-based arguments. However, one newer argument, worthy of particular attention, is called ethics-of-care feminism. A form of consequentialism, ethics-of-care focuses on outcomes, but in a way that challenges basic premises of utilitarianism, especially the values of impartiality, impersonality, and equality.⁴⁰

Ethics-of-care writers argue that real people live in families and that real caring relationships are not impartial, impersonal, or equal. Instead, they embody fundamental inequalities of power, capacity, judgment, information, and responsibility. Moreover, such relationships are based on a particular connection between those involved—which implies that any one person cannot and should not care for all human beings equally. These writers argue that philosophy has ignored family life in particular, and caring in general, because it has been written mainly by men who do not fully understand, or take seriously enough, the centrality of such relationships to human experience.

How can the ethics-of-care perspective inform public-health policy? Making this idea operational could involve a thought experiment like: “How would you want to treat everyone in society if you imagined yourself as everyone’s parent?”⁴¹ This perspective would lead to more supportive policies toward substance abusers or elderly people with Alzheimer’s disease than an efficiency-oriented utilitarianism or a rights-based liberalism. An ethics-of-care perspective also recognises caring roles as an important part of many life plans, and would have society devote serious support to those who provide care. Such caring after all not only improves the lives of those who receive care, but also relieves society of a substantial burden it would otherwise confront.

Conclusion

Public health today grapples with issues rife with ethical dilemmas and political conflict: from toxic wastes and AIDS, to health-care costs and so-called mad cow disease. Yet public-health professionals have minimal training in ethical analysis. If health professionals are to develop coherent positions on these issues, and contribute to democratic deliberation about public policies, then they need enhanced skills in applied philosophy. Understanding alternative ethical arguments has become as important as knowing the advantages and disadvantages of different epidemiological techniques.

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