

Public Health and Public Goods

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It has become increasingly difficult to distinguish public health (and public health ethics) from tangentially related fields like social work. I argue that we should reclaim the more traditional conception of public health as the provision of health-related public goods. The public goods account has the advantage of establishing a relatively clear and distinctive mission for public health. It also allows a consensus of people with different comprehensive moral and political commitments to endorse public health measures, even if they disagree about precisely why they are desirable.

The field of public health is having an identity crisis. From its inception, public health has been concerned with promoting the health of populations rather than individuals, which explains its special emphasis on communicable disease. But many have begun to see public health as a branch of social work rather than medicine. On this view, public health seeks to promote human rights and social justice in addition to preventing pandemics and pollution.¹

I will argue that we need a clearer conception of public health—one that more closely captures its original mission—in order to distinguish both the theory and practice of public health from related fields. Defending a particular conception of public health will inevitably involve contentious normative judgments since any account of what public health *is* ultimately requires judgments about how we *ought* to conceive of it.

The account of public health I advocate is *conservative* in the sense that it aims to reclaim its historical mission. But it is also *revisionary* to the extent that it seeks to simplify the way we think about public health. The account developed here does not claim to reveal any transcendent essence; rather, it is an attempt to set the agenda so that the goals of public health are clear, and people with different comprehensive moral and political commitments will agree with its goals, even if they disagree about how best to achieve them, or why they're worth achieving.²

The thesis of this essay is that public health should be concerned with the provision of public goods associated with medicine. More specifically, public health should attempt to promote health and prevent disease among populations of people for whom health outcomes exhibit the two characteristic features of public goods: non-excludability and non-rivalry.³ On this view, the

case for classifying a set of health-related goals as *public* health becomes stronger as the purity of the public good and the size of the population to which it applies increase. The point of defending this view is to help us distinguish public health from individual health, and from tangentially related endeavors, such as social work, charity, and human rights campaigns.

The Scope of Public Health

Thoughtful readers of the public health literature are likely to be surprised by the lack of consensus among experts about the scope of public health. Since public health measures ranging from vaccination programs to food inspection have enjoyed such widespread support, anyone interested in influencing public policy has an incentive to use the phrase 'public health' to justify otherwise controversial programs and regulations. A coercive law passed in the name of public health is more attractive than the same law sold as a paternalistic restriction on individual liberty, or a rights violation done in the name of promoting social welfare.

One of the most memorable instances of this can be found in the Supreme Court's 8-1 decision to uphold Virginia's right to sterilize feebleminded citizens. Writing for the majority, Justice Holmes remarked: 'It is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind. The principle that sustains compulsory vaccination is broad enough to cover cutting the Fallopian tubes.'⁴ The principle to which Holmes is referring is a little unclear, but what is clear in the analogy between eugenic sterilization and

vaccination is an appeal to public health as a justification for the use of government power. This case demonstrates that classifying a policy as one that promotes public health is widely considered a powerful justification for state action; it also suggests that devising a plausible, principled account of public health is not just an academic exercise.

In order to motivate my own account of public health as the provision of health-related public goods, it is worth summarizing some attempts by scholars to expand the scope of public health by redefining its mission, or by bundling it with their own parochial views about social justice. In a recent book, Ruth Faden and Madison Powers argue that ‘The foundational moral justification for the social institution of public health is social justice’ (2008: 80). They argue that social justice requires ‘focusing on the needs of the most disadvantaged’ (2008: 82). In another recent account, authors of *The Oxford Textbook of Public Health* contend that in addition to the usual items on the list, public health should aim to ‘reduce health disparities’ and ‘reduce interpersonal violence and aggressive war’ (2010: 4).

Finally, in a frequently cited essay, Jonathan Mann links public health with the promotion of human rights. Mann says ‘promoting and protecting human rights is inextricably linked with promoting and protecting health . . . this is because human rights offers a societal-level framework for identifying and responding to the underlying—societal—determinants of health’ (1997: 10). Although Mann does not use the term ‘public health’ in this excerpt, he explicitly argues that all potential social determinants of the health of individuals within a population are the proper subject of public health. The picture we get, then, is that public health involves promoting equality, human rights and even world peace.⁵

Public Health as Public Goods

To be sure, many scholars have recognized the problem of overly expansive accounts of public health. Powers and Faden worry that ‘public health is sometimes viewed as so expansive in its compass as to have no real core, no institutional, disciplinary, or social boundaries’. Thus, they complain, ‘everything from war, terrorism, and crime to genetic predisposition to disease . . . has been claimed as a public health problem’ (2008: 83). The alternative advanced here—that public health should only be concerned with the provision of health-related public goods—has a number of advantages.

Neutrality

The first advantage of the public goods account of public health is that it is less politically divisive than the alternatives.⁶ The idea that state governments have the right to use coercion in order to supply public goods is consistent with many different moral and political theories, including most versions of classical liberalism, which assign only a minimal role to the state. In contrast, the proposal that governments and non-governmental organizations (NGOs) with a commitment to public health must be concerned with promoting social equality and healthy eating, as well as curbing infectious disease and pollution, is much more contentious. Most would agree that if an NGO wishes to fight inequality in China and tuberculosis in India, they should be free to do so. But not every thoughtful person agrees that governments should do likewise.

In addition to being compatible with a range of moral and political theories, the public goods conception of public health has the virtue of being able to avoid appeals to paternalism. According to Gerald Dworkin, ‘paternalism is the interference of a state or an individual with another person, against their will, and defended or motivated by a claim that the person interfered with will be better off or protected from harm’.⁷ Paternalism is controversial because people are skeptical of giving government agents the discretion to restrict our liberty in order to promote our welfare (as they see it). However, as Dworkin has argued, restricting liberty in order to produce public goods is generally not paternalistic. This is because, in the case of public goods like pollution reduction and disease eradication, each person recognizes the outcome as beneficial but lacks the capacity to unilaterally bring it about:

There are restrictions which are in the interests of a class of persons taken collectively but are such that the immediate interest of each individual is furthered by his violating the rule when others adhere to it. In such cases the individuals involved may need the use of compulsion to give effect to their collective judgment of their own interest by guaranteeing each individual compliance by the others. In these cases compulsion is not used to achieve some benefit which is not recognized to be a benefit by those concerned, but rather because it is the only feasible means of achieving some benefit which *is* recognized as such by all concerned (Dworkin, 1972: 69).

On this view, if a restriction of liberty is necessary to produce a collective benefit, and if it is acknowledged by

those it effects as a benefit, it is not paternalistic. Thus, if we embrace the public goods conception of public health, we can remain neutral on whether paternalistic interventions—especially those that restrict the liberty of competent adults—are justifiable.

Against this view, some have argued that many public health measures are inherently paternalistic. Nancy Kass, for instance, says that ‘in some contexts, public health programs are designed primarily to protect individuals from themselves, revealing that much of public health is unabashedly paternalistic’ (2001: 1778). She may be right that many public health practitioners—especially those who work for NGOs that supply both public and private goods—conceive of their work as paternalistic. For example, a health practitioner working for a religious charity may be concerned with providing private health care, saving souls, teaching racial and religious tolerance, promoting public health, and a host of other things, some of which might be accurately described as paternalistic. But this does not imply any deep or necessary connection between paternalism and public health.

Of course, some public health programs, such as mandatory vaccinations, may appear paternalistic. After all, some people consider the possible side-effects of vaccinations an unnecessary risk; others have religious convictions that condemn vaccines as part of a Satanic attempt by humans to thwart God’s master plan. Compelling these people to get vaccinated looks like a clear case of paternalism. It is important to remember, however, that paternalism is a kind of *justification* for liberty-limiting laws; laws themselves are not paternalistic.⁸ In order for a law to be paternalistic, it must attempt to restrict someone’s liberty, against their will, in order to benefit the person whose liberty is restricted.⁹ However, because people who wish to opt out of vaccination programs threaten the health of others, the usual justification for using state power to override their preferences is to prevent harm to others, not to prevent harm to themselves. If our reason for using force to prevent people from opting out of a vaccination program is to prevent harm to others, our use of force is not paternalistic. Alternatively put, mandatory vaccination may be the only feasible way of achieving the public good of herd immunity against a particular infectious disease.¹⁰ When this is true, and when this is the justification, mandatory vaccination programs are not paternalistic.

Children are different. Since they lack the emotional maturity or cognitive ability to make fully rational choices, we might justify requiring them to be vaccinated for two reasons: to prevent harm to others; and

to prevent them from taking risks which nearly all informed people would wish to avoid. When the second justification is invoked, we might concede that this is a case of paternalism. But the justification in the second case has little to do with public health. It is analogous instead to using state power to overrule the desire of some parents to brainwash their children with intolerant religious propaganda or to malnourish their kids in order to prove a particular theory about what happens to malnourished children. People wish to prevent parents from treating their children in these ways primarily to protect children from exploitation, not because there is a public health risk posed by exploited children.

On the public goods account of public health, then, there’s no need to invoke paternalism to justify government intervention. The public goods framework allows us to restrict liberty or use coercion in the name of public health without resorting to measures that are (in Kass’s words) ‘unabashedly paternalistic’.

Collective Action

A second advantage of the public goods account of public health is that although it is broad enough to include NGOs as providers of public health services, it is narrow enough to explain the common observation that public health goals often require government action to achieve. It is a familiar fact that public goods become more difficult to supply as the number of potential beneficiaries increases, and as the ability to exclude non-contributors decreases. When the costs of contributing to a public good are borne by the individual but the benefits are shared by all, public goods are often difficult to produce without government intervention.¹¹

Assume, for example, that each person can save a bit of time by using non-rechargeable batteries and throwing them in the garbage when they’re done. Assume also that all of us would be better off if most people refrained from doing this, since a predictable side-effect of battery disposal is the seepage of mercury and other heavy metals into the soil and water near landfills, and eventually into drinking water and food. The benefits from a policy that reduces mercury pollution—perhaps by taxing battery consumption to offset the social costs it imposes—would constitute a public good. In the absence of this policy, battery consumers face a typical prisoners’ dilemma in which the individually rational choice is collectively harmful.

Once payoffs are structured in this way—structured so that the benefits of consumption are concentrated but the costs are dispersed—markets are notoriously ineffective at delivering mutual gains from trade, and there is at least a *prima facie* case that the coercive power of government can be used to improve the outcome.

This observation about the connection between public health, public goods and government action is elucidated in an influential review article on the nature of public health ethics:

Public health systems . . . include a wide range of governmental, private and non-profit organizations, as well as professionals from many disciplines, all of which . . . have a stake in and an effect on a community's health. Government has a unique role in public health because of its responsibility, grounded in its political powers, to protect the public's health and welfare, because it alone can undertake certain interventions, such as regulation, taxation, and the expenditure of public funds, and because many . . . public health programs are public goods that cannot be optimally provided if left to individuals or small groups (Childress *et al.*, 2002: 170).

The key claim here is that *many* public goods cannot be optimally provided privately. Some authors have gone further, arguing that *all* public health goals require the use of government power to achieve. On Mark Rothstein's account, 'the existence of a public health threat demands a public response, and in a representative political system it is the government that is authorized to act on behalf of the public' (2002: 74). Similarly, Dan Beauchamp says one of the principles of public health ethics 'is that the control of hazards cannot be achieved through voluntary mechanisms but must be undertaken by governmental or non-governmental agencies through planned, organized and collective action that is obligatory or non-voluntary in nature' (1976: 107). Rothstein and Beauchamp's implicit appeal to the public goods conception of public health is congenial to the view I am defending. However, both fail to recognize that public goods do not always require government action or coercion to supply.

First, some NGOs can provide small-scale public goods through private contributions. For example, a small group of people might volunteer to provide information to a local village about how to prevent sexually transmitted diseases. To the extent that each person's choice to take precautions against the spread of disease produces a good that is both non-rival and non-excludable, the good provided by the NGO is public—indeed, it is a paradigm case of public health.

Second, there are other private mechanisms for the provision of health-related public goods. For example, conditionally binding assurance contracts can be forged to provide public goods when the transaction costs associated with bargaining are low (Schmidtz, 1987). The idea is that if enough people recognize that they can attain a more favorable outcome by having their liberty restricted in a certain way, or by being compelled to contribute to a collectively beneficial endeavor, an entrepreneur can profit from producing a contract which will ensure that everyone's liberty is similarly restricted, or everyone is compelled to do their part. The contract would not, however, come into effect until the minimum number of participants needed to produce the good has signed on. Such contracts solve the free rider problem by compelling each signatory to contribute. They solve the assurance problem by offering a refund to all prospective contributors if the critical threshold of signatories is not reached.

To take an example adapted from David Hume, if members of a community recognize that draining a local swamp will benefit them by reducing mosquito-borne infections, an enterprising person might organize collective action to drain the swamp by creating a conditionally binding assurance contract. How efficient such contracts are at providing public goods is an open question. The point is that NGOs and profit-seeking entrepreneurs can, at least in principle, supply some health-related public goods. This suggests that we should not make government action a defining feature of public health, even if governments are often in a unique position to supply health-related public goods.

Population Health

Another advantage of the public goods account is that it captures and clarifies the widely accepted principle that public health should aim to treat populations, not merely individual people.¹² Nearly everyone agrees that the fundamental difference between public and private health is that 'while [private] medicine focuses on the treatment and cure of individual patients, public health aims to understand and ameliorate the causes of disease and disability in a population' (Childress *et al.*, 2002: 170).¹³ But there is considerable disagreement about what it means to promote *population* health. Does it mean promoting average health within a population? Promoting the total health of a population? Ensuring equal access to basic medical services? More fundamentally, do populations have properties

independent of the individuals that comprise them? Or are populations simply a collection of discrete individuals?

To some extent, determining what constitutes a population is a metaphysical problem without a determinate answer. For the sake of simplicity, I will assume that populations are simply groups of individuals—there is no separate, meta-person that can be benefited or harmed. A precise answer to the question of how we should promote population health will probably depend on our moral commitments. For utilitarians, promoting the health of a population means promoting average or total health across a set of people (including future people).¹⁴ In the context of public health, the utilitarian commitment to maximizing aggregate welfare implies that we should be prepared to sacrifice (or at least refuse to treat) people with expensive ailments in order to increase total utility in the world, or average utility in the world's current population. It also suggests that we should emphasize preventive care, and pay careful attention to the cost-effectiveness of different treatments. In contrast, for those inclined to think of rights as fundamental protections that cannot be overridden for the sake of social utility, public health's focus on populations is generally cashed out as a concern for protecting the rights of everyone in a population by preventing each person from acting in ways that cause significant harm to others.

One of the virtues of the public goods account of public health is that both consequentialist and deontological moral theorists will support its core agenda, even if they do so for different reasons. Since public goods offer benefits that are potentially available to everyone in a population, utilitarians will generally endorse some form of collective action to provide health-related public goods when the benefits of doing so exceed the costs of either forgoing the public good altogether, or allowing entrepreneurs and NGOs to (attempt to) provide the good.

In contrast, those concerned with protecting the rights of each member of a population will support using the most cost-effective means, including government action, to supply a public good when its non-provision will predictably lead some members of a population to harm (or violate the rights of) others. For example, in the absence of pollution regulations, each person's choice to consume products that emit greenhouse gasses, or take antibiotics whenever they have a headache, will lead to the inefficient use of energy and anti-microbial drugs, and will result in predictable harm to others in the form of air pollution and genetic pollution (Anomaly, 2010).

The upshot is that deontological thinkers and utilitarians alike can agree that public health should be concerned with providing health-related public goods to whole populations, even if they disagree about precisely what constitutes a population, and when it is appropriate to use the machinery of government to promote population health.

Objections and Replies

I have argued that the public goods framework helps us set the boundaries of public health by giving us a clear and principled way of distinguishing public health from private health, and from social work and social justice movements. While those concerned to promote social justice may endorse collective action by governments and NGOs to produce health-related public goods, they tend to focus more on promoting equality within a population through measures such as income redistribution.¹⁵ Public health, in contrast, is agnostic about whether we should be concerned about inequality, whether we should endorse utilitarian or deontological moral theories, or whether paternalistic justifications for laws are ever legitimate. If we construe public health as the attempt to provide health-related public goods to populations, we can create a non-arbitrary consensus that public health programs are both distinctive and urgent. As Verweij and Dawson argue, 'Where there are public health benefits for the public as a group, which can only be obtained through collective rather than individual endeavor, public health action is most clearly justified. This is and should be the core of public health' (2007: 27).

Still, it may be objected that the conception of public health offered here is either too vague to be interesting, or too narrow to include much of what practitioners of public health consider an essential part of their field—too narrow, for example, to include the 'social determinants of health'.

Public Goods and Private Goods

The first objection to the public goods account of public health is that it seems too nebulous to serve as a useful demarcation criterion.

If most public goods are at least partly rival or partly excludable, it might be argued that there is no clear line between public and private goods, and that the public goods account of public health is therefore vacuous. For example, suppose the government of the tiny island

nation of Tuvalu decides to run a radio-broadcast education campaign to reduce the incidence of HIV among the island's inhabitants. Assuming few non-inhabitants receive Tuvalu's radio signals, or speak its language, the public good is relatively excludable. Can this impure public good be classified as a legitimate public health program on the account offered here? The answer, I think, is yes. The reason is that *for the population of islanders*, the potentially beneficial information is freely available and non-rival. Of course, outsiders might benefit too, since we can all breathe easier in a world with fewer carriers of transmissible diseases. But since public health is concerned with the health of small populations as well as large ones, it is perfectly reasonable to classify efforts to supply public goods to local populations as public health measures, even if they have no positive spillover effects on other people.

A related and more serious problem is that even if a public good is pure—if it yields completely non-excludable benefits and non-rival consumption of benefits—it may not be especially desirable. Since a 'good' in the strict economic sense is any product that can be used to satisfy a desire, a good can be available to all without being considered a good thing by many of its potential beneficiaries. For example, public parks with pollen-bearing flowers are available for all to enjoy, but people with pollen allergies may consider such parks a nuisance. This suggests that demand for public goods will depend in large part on the tastes and preferences of different people within a population, and that different populations will exhibit different demand schedules for health-related public goods. Public goods can range from goods whose perceived benefits extend across the entire human population to those that reach nobody at all.

For example, an atmosphere with a robust ozone layer is desirable for all people, and one person's consumption of the benefits of an ozone-insulated atmosphere does not diminish anyone else's consumption opportunities (a smaller risk of skin cancer for you does not increase your neighbor's risk of skin cancer). But suppose Prince Harry has a powerful desire to plant the British Flag on Pluto, and broadcast it for all to see. The knowledge that Britain planted the first flag on Pluto is technically a public good, and although it may satisfy the desires of a few eccentric people in the House of Windsor, most people do not value the existence of the Union Jack on an uninhabited planet. Similarly, suppose a gene is found to cause an extremely rare disease, and the person who discovers the link shares his discovery with everyone. This information is a public good, but it may in theory benefit nobody at all (if nobody currently has the disease), and therefore may not be

worth the efforts of NGOs and governments to supply. More importantly, this particular piece of research looks like a health-related public good that is not really the kind of thing that should be called *public health*. However, this contrived example and its real-world counterparts do not impugn the account developed above. Instead, it highlights the need for a caveat. To the foregoing account, we should add that public health should only be concerned with the provision of health-related public goods for which there is significant demand, or *would be* significant demand if potential consumers of the good had accurate information about the likely costs and benefits (both moral and monetary) of providing the relevant public good.

It is fairly clear that some health-related public goods benefit all or most people in a population, and that these should be the focus of public health. An education campaign whose purpose is to inform pregnant women of the link between fetal damage and alcohol consumption, is one for which there is potentially high demand. The reason is that nearly all expectant mothers would prefer to have information that helps them improve fetal health or avoid fetal injury. Still, mothers may not currently demand information about the link between alcohol consumption and fetal development if they lack any indication that there is such a link.

In cases like this it is important to try to disentangle public goods for which there is potential demand (given accurate, accessible information) from public goods for which there is current demand. Both are plausible candidates for collective action, and both are the proper domain of public health. But in the first case, it may be more difficult to justify the use of coercion to supply the good unless there is reasonable certainty that the current lack of demand stems from ignorance rather than informed preference.

This is not to say that the public goods conception of public health is so clear that it can settle every dispute about whether a medical outcome is a private good or a public good, or something else altogether. But it does provide a useful way of framing the debate, in the same way that Mill's harm principle¹⁶ or Kant's categorical imperative,¹⁷ properly understood, are principles for framing the way we think about moral and political questions rather than algorithmic procedures for settling any particular controversy.

Social Determinants of Health

Some argue that public health practitioners should worry about issues like racism and inequality because

they are social determinants of health (Detels *et al.*, 2010: 12). Indeed, Verweij and Dawson argue that ‘the main objection to narrow accounts of public health is that they fail to take into account many of the things that contribute towards public health problems’ (2009: 16). I take their phrase ‘things that contribute towards public health problems’ to refer to what are often called ‘social determinants of health’. Since there are an enormous number of conceivable social determinants of health, I will argue that just making the list of social determinants does not imply that either encouraging or discouraging these things should be considered part of public health.

Consider some examples. In addition to disease prevention, vaccination, pollution reduction and the usual programs associated with public health, *The Oxford Textbook of Public Health* includes homicide, violence and mental illness as problems that reduce population health. In a sense, it is trivially true that violence and mental illness diminish population health: a person maimed by a burglar or paralyzed in a war is less healthy than he would be had the burglary or war never occurred, and having more such people in a population will imply that average health within the population is lower. Similarly, low wages and poor education may lead to fewer consumption opportunities and more health risks for particular people in a population. Children who are so poor that they are compelled to work in a sweat shop 12 h a day, will generally lead less happy and less healthy lives than they would if they worked fewer hours and spent more time in school. They may also be more likely to become thieves.

Does this imply that public health should be concerned with preventing theft and war, or changing labor laws and education systems, in addition to the usual items on the public health agenda? It does not, for at least two reasons. First, as a practical matter, public health practitioners do not have the expertise needed to solve every problem that might make the list of social determinants. The division of labor—especially medical labor—provides benefits that could not be realized if practitioners were generalists trying to solve all of the problems related to human health or human welfare. There are economies of scale associated with dividing up the work of public health, private health, education and economic growth, as well as more ambitious goals like discouraging racism, promoting peace, etc. No person or set of people within a particular field can possibly know how to do all of these things effectively, and bundling them all into a single set of goals under the rubric of public health makes it more difficult to accomplish any of them.

Second, and more importantly, many of the so-called social determinants of health bear little if any relationship to what practitioners and theorists recognize as public health goals. This is partly because many items invoked as social determinants of health—such as literacy, a minimum wage or mental health—look more like social determinants of *private* welfare than *public* health. To the extent that social determinants influence individual welfare rather than population health, or promote a particular social welfare agenda like increasing economic equality, we should consider them outside of the domain of public health.

For example, a recent World Health Organization (2008) report on the social determinants of health focuses on decreasing economic equality in order to increase health equality.¹⁸ There is some evidence that people’s happiness depends to some extent on their relative wealth, in addition to their absolute wealth. So it is likely that relative health also matters to people in the sense that being at least as healthy as those around you is likely to make you happier. But even if we can correlate health equality and aggregate happiness, the correlation is not especially interesting, since public health is not necessarily concerned with promoting aggregate happiness or minimizing inequality. Equalizing resources and maximizing aggregate welfare are fiercely contested social goals, and unless public health practitioners are required to show their egalitarian or utilitarian credentials at the door, we should not assume that the many different social determinants of health and happiness are part of the public health agenda.

Attempts to address the social determinants of health do not, then, constitute an essential part of public health.¹⁹ Accordingly, Larry Gostin argues that ‘Just because war, crime, poverty, illiteracy, homelessness and human rights abuses interfere with the health of individuals and populations does not mean that eliminating these conditions is part of the mission of public health’ (2001: 72). Ruth Faden and Sirine Shebaya agree: ‘There are many social determinants of health – including crime and corruption. But this does not mean that the elimination of crime and corruption are goals of public health.’²⁰ The account of public health as the provision of health-related public goods can help explain why goals like reducing crime and corruption—worthy as they are—should not be considered part of the public health agenda.

A further implication of the public goods account is that unless a policy or practice is *intended* to promote health or prevent disease in a population, it should not be counted as public health, even if it inadvertently tends to bolster public health. This is an important

point because plenty of activities aimed at promoting private welfare also happen to augment public health. Allowing developers to drain swamps in order to build condominiums, for example, may have the effect of reducing mosquito populations, thereby lowering the threat of infectious microbes that use mosquitoes as vectors. But we would hardly describe the developer's activities as public health measures.

Instead, this suggests that in order for a program to count as public health, it must be intended to promote public health. Nancy Kass has accordingly argued that 'if a program has as its goal to increase employment . . . or to strengthen communities . . . then the program is primarily a social program, not a public health program' (p. 17).

Conclusion

Public health practitioners and theorists are as diverse as philosophers, dentists and art collectors. We each have social goals that we'd like to promote. But the unique status of public health can be traced to the fact that most of what it has historically concerned itself with can be classified as the provision of health-related public goods. The public goods framework serves as a useful criterion for distinguishing public health from private health, and it explains why public health goals have special urgency. Public health goals, properly understood, generally require collective action to achieve, and can be endorsed by a wide variety of moral and political theories. Since most people support the goals of public health, so understood, we should take care not to infuse the theory and practice of public health with contentious moral and political commitments.

Notes

1. The title of the 2010 annual meeting of the American Public Health Association was, simply, Social Justice.
2. Disagreement will mainly come over the efficacy of public versus private solutions to public health problems, different weights placed on competing values like liberty, autonomy, etc.
3. A good is non-excludable if nobody can be excluded from consuming it; a good is non-rival when one person's consumption does not diminish other people's consumption opportunities. Richard Epstein (2004) has defended a different (though potentially

complementary) account of public health as public goods.

4. Quoted in Stephen Jay Gould, Carrie Buck's Daughter. *Natural History*, July 2002.
5. For a more comprehensive list of contenders for public health, see Verweij and Dawson (2007, p. 14).
6. Larry Gostin (2001) and Mark Rothstein (2002) agree that including social justice as a core feature of public health makes the field overly-politicized.
7. Available from: plato.stanford.edu/entries/paternalism [accessed May 2011].
8. This is because the same law can be endorsed for very different reasons. For example, a law requiring drivers to wear seat belts may be endorsed by some legislators to protect individuals from harming themselves (paternalism); other legislators might back it because they believe it will save the state money by reducing the medical bills of injured drivers. To take another example, some legislators support social security legislation as a way of forcing individuals to save enough money for their own retirement (paternalism); other legislators construe it as a social insurance policy, or something else altogether.
9. Here again is Dworkin's definition: 'paternalism is the interference of a state or an individual with another person, against their will, and defended or motivated by a claim that the person interfered with will be better off or protected from harm'. Available from: plato.stanford.edu/entries/paternalism [accessed May 2011].
10. Herd immunity occurs when a critical mass of immunized people effectively prevents an infectious microbe from persisting or spreading in a population.
11. Jean Hampton (1987) and Todd Sandler (2004) argue that the provision of public goods can be modeled by a variety of non-cooperative games, many of which generate free rider and assurance problems.
12. Childress *et al.* (2002).
13. Schneider concurs: 'Public health is concerned with the prevention of disease and disability. It is aimed at benefiting the entire population in contrast with medicine, which focuses on the individual' (2010: 6).
14. For the important distinction between total welfare and average welfare, and the deep puzzles it engenders, see Derek Parfit (1984: Ch. 17).
15. The term 'social justice' is in this way misleading. All of us care about justice, but the agenda of those who describe themselves as promoting social justice is fairly controversial.

16. Mill's harm principle is that 'the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others' (2002: 11).
17. One version of Kant's categorical imperative enjoins us to 'act so that you use humanity, whether in your own person or in the person of any other, always at the same time as an end, never merely as a means' (1998: 38).
18. Available from: http://whqlibdoc.who.int/hq/2008/WHO_IER_CSDH_08.1_eng.pdf. See also, Norman Daniels *et al.* (1999).
19. Of course, some of the social determinants of *population* health, such as sanitation and access to contraception, should be considered part of public health. There is a public good associated with providing women with reproductive rights and access to contraception, since without these we all suffer the consequences of an overcrowded planet with (among other things) a greater risk of infectious disease and environmental pollution.
20. Available from: plato.stanford.edu/entries/publichealth-ethics/.

References

- Anomaly, J. (2010). Combating Resistance: The Case for a Global Antibiotics Treaty. *Public Health Ethics*, **3**, 13–22.
- Beauchamp, D. and Steinbock, B. (1999). *New Ethics for the Public's Health*. Oxford, UK: Oxford University Press.
- Childress, J., Faden, R., Gaare, R., Gostin, L., Kahn, J., Bonnie, R., Kass, N., Mastroianni, A., Moreno, J. and Nieburg, P. (2002). Public Health Ethics: Mapping the Terrain. *Journal of Law, Medicine and Ethics*, **30**, 170–178.
- Daniels, N., Kennedy, B. and Kawachi, I. (1999). Why Justice is Good for Our Health. *Daedalus*, **128**, 215–251.
- Detels, R., Beaglehole, R., Lansang, M. and Gulliford, M. (2010). *Oxford Textbook of Public Health*. Oxford, UK: Oxford University Press.
- Dworkin, G. (1972). Paternalism. *The Monist*, **56**, 64–84.
- Dworkin, G. (2010). Paternalism. *Stanford Encyclopedia of Philosophy*, Available from: <http://plato.stanford.edu/entries/paternalism/> (accessed June 2011).
- Epstein, R. (2004). In Defense of the 'Old' Public Health. *Brooklyn Law Review*, **69**, 1421–1470.
- Faden, R. and Shebaya, S. Public Health Ethics. *Stanford Encyclopedia of Philosophy*. Available from: plato.stanford.edu/entries/publichealth-ethics/ (accessed June 2011, Epub on April 2010).
- Gould, S. (2002). Carrie Buck's Daughter. *Natural History*, **93**, 14–18.
- Gostin, L. (2001). Public Health, Ethics, and Human Rights. *Journal of Law, Medicine and Ethics*, **29**, 121–130.
- Hampton, J. (1987). Free Rider Problems in the Production of Collective Goods. *Economics and Philosophy*, **3**, 245–273.
- Kant, I. (1998). *Groundwork of the Metaphysics of Morals*. Translated by Mary Gregor. Cambridge, UK: Cambridge University Press. Originally published 1785.
- Kass, N. (2001). An Ethics Framework for Public Health. *American Journal of Public Health*, **91**, 1776–1782.
- Mann, J. (1997). Medicine and Public Health, Ethics and Human Rights. *Hastings Center Report*, **27**, 6–13.
- Mill, J. S. (2002). *On Liberty*. New York: The Modern Library, Originally published 1860.
- Parfit, D. (1984). *Reasons and Persons*. Oxford: Clarendon Press.
- Powers, M. and Faden, R. (2008). *Social Justice: The Moral Foundations of Public Health*. Oxford, UK: Oxford University Press.
- Rothstein, M. (2002). Rethinking the Meaning of Public Health. *Journal of Law, Medicine and Ethics*, **30**, 144–149.
- Sandler, T. (2004). *Global Collective Action*. Cambridge, UK: Cambridge University Press.
- Schmidtz, D. (1987). Contracts and Public Goods. *Harvard Journal of Law & Public Policy*, **10**, 475.
- Schneider, M. (2010). *Introduction to Public Health*. 2nd edn. Sudbury, MA: Jones and Bartlett.
- Verweij, M. and Dawson, A. (2007). The Meaning of 'Public' in 'Public Health'. *Ethics, Prevention and Public Health*. Oxford, UK: Clarendon Press.
- World Health Organization. (2008). *Commission on Social Determinants of Health – Final Report*, Available from: http://whqlibdoc.who.int/hq/2008/WHO_IER_CSDH_08.1_eng.pdf (accessed June 2011).

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