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"Public Health – Shared Responsibilities"
[1]

The Good Life

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Minister of Health, Jón Kristjánsson, Medical Director of Health Sigurður Guðmundsson, Anna Elísabet Ólafsdóttir director of the Public Health Institute …, speakers and guests,

it is an honour for me to be given the opportunity to address you on this occasion. I see from the program that I have amble time. Anna Elísabet Ólafsdóttir was given 20 minutes, Jón Kristjánsson, Minister of health was given 10 minutes, but my time is, apparently, constrained only by the health promotion at the swimming pool to morrow morning.

I am here as an "unconventional speaker" and I can see from the program that I am supposed to give you some food for thought. I will do my best, and hope that it wont be too hard to digest. **[2]** My talk divides roughly into three parts. First I will talk about rights and spell out two problems that arise in that context. In the second part I make some comparison between public health and conventional health care and conclude that expertise in public health, comparable to expertise in the different medical professions, is impossible. In the third part I turn my attention towards our active nature as opposed to our passive nature and conclude that it is impossible to make people healthy.

1. Rights

[3] The question that I want to begin with tonight is the one you have in the program:

> Question (1) Do we have the right to live our life any way we choose, as long as it does not harm others?

If we answer this question in the positive, are we thereby committed to the view that the state should not take any part in promotion of public health? Perhaps. Here is one way of sustaining this inclination. Public promotion of public health requires that the state the state – through law-making, public policy, and various expenditures – favours certain ways

of living (the healthy ways) at the expense of various other ways of living (the unhealthy or risky ways). But, and here comes the conflict, the citizens should choose their ways of living themselves, the state should not do this for them. That would be unjustified infringement on their private lives, an infringement which is opposed to their right to live their life the way they choose.

So, on the face of it at least, there is a conflict between the rights of the citizens and the idea that it belongs to the state to promote public health. I say "on the face of it" for things are not as clear cut as they may seem. Questions such as our question (1) have a long tradition in political philosophy and philosophers divide, broadly, in two groups depending on how they respond to such questions. On the one hand are those who maintain that the role of the state is first and foremost to prevent people from doing harm to one another by, say, stealing from or killing one another. These are the libertarians. They maintain, further, that the state should not promote general welfare, including public health. And in particular, the state should not express preferences among different ways of living as long as they are compatible with individual liberty.

On the other hand are those who allow for a wider role of the state which might include health care, public schools and social security. These we can call the egalitarians. They maintain that the state has an active role in structuring the life of the citizens and might, in particular, allow the state to take an active role in promoting general welfare, including public health.

Despite strong differences the views of both group of philosophers are rooted in a somewhat similar view about human nature. The libertarians stress that people are active, responsible and creative agents and then maintain that a categorical defence of individual liberties is the best way to respect this. Extending the role of the state to include promotion of welfare is, they maintain, nothing but unacceptable paternalism which treats the citizens as children unable to care for themselves. For this reason, the extended role of the state is seen as demeaning to people as human beings.

The egalitarians also view people as active, responsible and creative agents, but rather than seeing a more comprehensive role of the state as a paternalistic trend, they see it as a tool to create circumstances where people can develop their abilities and exercise their active power.

What seemed to be a straight forward conflict to begin with may now look like one of those questions that one can raise without having to worry that a clear answer is expected.

Such questions are often called philosophical. It is, of course, a philosophical question, but I think that we can do better than this. I think we might be able to make some headway, or at least understand it better, if we try to address it in more concrete terms. Let's first recall what the question is:

> Question (1) Do we have the right to live our life any way we choose, as long as it does not harm others?

What is this notion of a right that figures in this question? It sure is familiar, but I am sceptical that it is equally well understood. Let's take a simpler example of someone holding a right:

> Jones has a right to smoke,

Jones' right to smoke is a three place relation, it includes Jones, the act of smoking, and someone against whom he has this right. When we have a right, we always have a right *against* someone. Now we might ask: Against whom does Jones have this right? Everyone? Well, the question is not clear, since it matters *where* he smokes, also *how* he smokes (he should not blow the smoke into someone's house, his smoking should not cause littering, etc.) and *what* he smokes. We see that it is difficult to answer this question without answering all sorts of other questions as well. Once we think of all such complications, we see that it is rather difficult to define clearly, in positive terms, this alleged right of Jones. That is why rights, such as Jones' right to smoke, are often specified in a negative way: **[4]**

> Jones has a right to smoke if and only if others, including the state, are not permitted to *interfere* with his smoking, as long as he does not *infringe on someone's else's rights*, say the property rights of his neighbours or his kids' right to healthy environment.

Here, having a right consists in a limitation on others' legitimate *interference* with one's actions, provided the rights of others are respected.

Turning back to question (1), we might adopt a similar strategy. Instead of asking directly about people's right to live their life any way they please, we ask whether someone – an individual, a group or the state – might be permitted to interfere with people's lives. In the context of public health the issue is rather complicated. In the case of Jones smoking, the legitimacy of interference was indicated by mention of other rights. And arguably this way of going about might be practical in determining when and how Jones is allowed to smoke or to settle a dispute between Jones and someone offended by his smoking, etc. But how are we to evaluate whole lives in this way? Think about "the other rights" that might

legitimize an interference with someone's way of living: The right to healthy environment, the right to security, the right to privacy, the right to political participation, the right to all sorts of information, children's right to education, rights of minority groups, rights to equal treatment, and so on and so forth. How much can Jones pollute before he infringes on my right to healthy environment, how fast can he drive before he infringes on my right to safe environment, and how annoying can he be before he infringes on my right to privacy? Think also of the rights of future generations. Think also of all the indirect ways of affecting other people, positively or negatively. **[5]** The rights that we have do not come one by one, they come in bundles. And these bundles are messy with all sorts of things tangled together. This is what I shall call the *problem of the web of rights*.

The rights we have – or at least take ourselves to have – are mostly political rights; rights that we have in virtue of being members of one or another community of people. We have very few natural rights. You might think of the right to life as a natural right, but even it is affected by the circumstances provided by the society we live in. Of course we all agree that

> Jones has a right to live.

But what does that mean? It means that, other things being equal, no one is permitted to end Jones' life. But here arise all the familiar issues having to do with euthanasia and abortion, also self defence and capital punishment, sacrifices in war and so on and so forth.

A difficulty we run into when we try to say what it means to have a specific right is not only that rights are defined with respect to one another but also that rights are general, their implications are open-ended but must be interpreted with respect to the very circumstances in which they are held. There is no such thing as having a right in isolation from all other social relations. And when we talk about very general rights, such as the right to live our life the way we choose, it is impossible to say what the substance – the concrete implications – of such a right is in abstraction from more specific circumstances. **[6]** Declarations of rights are general, while their meaning depends on the very circumstances for which such a declaration is made. I call this the *problem of generality of rights*.

This is not to say that there is no substance to questions about specific rights – say questions about the priority of certain rights over others, or what duties come with what rights, or how to compensate for the infringement of certain rights. These are in part theoretical questions for philosophy, political science and legal theory, and in part practical

questions for politicians, law makers, judges etc. But because of the two problems that I have been discussing, the problem of the web of rights and the problem of generality, I think that it is not fruitful to take rights and duties as a point of departure when addressing the issue of what is permissible to do in order to promote public health.

2. Different groups, different approaches

[7] How shall we think about legitimate ways of promoting public health if not in terms of rights and duties? I actually think that there is no such thing as 'the way to think about legitimate ways of promoting public health'. I don't think that the Minister of health should, in his work, think about public health in the same way as the nurse in the local community, or the surgeon in the high tech hospital, or the social worker working with minority groups. These different groups of people enter the issue in very different ways. The Minister of health enters this issue at a distance, so to speak, and for him two things are going to be particularly relevant.

(i) The Minister enters the issue of public health as a member of government, i.e. that part of society which has monopoly on the use of coercive power, and, therefore, as a bearer of very specific rights and duties.

(ii) The Minister must leave his own person out of the picture as far as possible. His narrow personal preferences ought to play little role in his work, i.e. his appetite for good wine, disgust for smoking, the pleasure he gets from reading or hiking or skiing or walking the dog etc. are of no importance. Even his care for his own children must be left out of the picture except in so far as it is reflected in his care for children in general.

The situation with the nurse or the social worker or the surgeon in their professional practice is very much different. They enter the issue of public health from a narrow range and, often, cannot leave their person out of the picture. The work of the nurse treating a patient or giving a teenager advise or helping a young couple with the sleeping habits of their newborn may depend on mutual trust and understanding. In such circumstances rights and duties are not irrelevant, but they are not the things that should be on the nurse's mind and guide her in her relationship with the people she is helping. What is perhaps more relevant for professionals in such situations are certain values or virtues, say autonomy, honesty, sympathy, truthfulness and kindness.

In between the professional, who enters the issue of public health at a narrow range, and the Minister who enters at a distance, are various groups of people and institutions.

Some institutions are primarily concerned with conventional health issues, such as clinics or dentistry or even the fitness clubs, others are only partly concerned with health issues, think for instance of the elementary schools, or the police, or the local planning office, or the workers unions.

Someone might ask whether this is not true of conventional health care as much as it is true of public health. So, one might say, just as there is no such thing as 'the way to think about public health', neither is there such a thing as 'the way to think about conventional health care'. This is, I believe, right up to a point. The difference in this respect between public health and conventional health care lies mainly in that the latter is much narrower in terms of implications for everyday life. Conventional health care revolves, most of the time at least, around particular incidents or limited aspects of the life of particular people. Public health, on the other hand, is much more general. It is about our whole way of living, not limited aspects, and it is potentially about everything we do, not just isolated incidents. And, if I understand the notion correctly, public health cannot be dealt with case by case as conventional health care deals with isolated cases – infection here, broken nose there, etc. – one at a time.

If what I have said so far is right it is going to be impossible to be an expert in promoting public health, as there are, for instance, experts in the different medical professions. This is perhaps obvious. The goal of public health is a healthy life for as many as possible, and healthy life is not just a matter of physical and mental health, it is also a matter of living in a healthy environment. And once the environment is brought in, both its physical and social aspects have to be included. **[8]** The worries are not just viruses and insanity, also polluted air and abusive relationships. The threads that have to come together in public health are so diverse that there is no hope of them forming a unified field of expertise.[1]

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[1] One might question this on the ground that it is very well established how it is possible to affect various health factors. Principles or directives of the form: "By doing X in population Y, factor Z can be affected positively" might be shown to hold, with certain degree of certitude, by standard scientific methods. And couldn't someone be an expert in such directives even if the Xs and Zs are diverse. My point, however, is that the relevant factors (the Zs) are so diverse and open-ended that it is going to be difficult, if not flat out impossible, to be an expert in how to affect these factors in the relevant ways. The problem is aggravated by two additional factors. First, it is not enough to affect the health factors in certain ways, it matters also what means are used to affect them and what it is, in the population in question, that responds to X in such a way that Z is affected positively. Example: One might reduce weight by engaging a part of the population to exercise in fitness centres, but thereby reducing "free time", increasing stress and shortening the quality time which parents spend with their children. This example actually brings out the second complication. Principles of the form: "By doing X in population Y, factor Z can be affected positively" are going to be what is called

3. The paradox of public health: Agents, patients and medicalization

[9]I have been talking about various difficulties related to public health: I began discussing the problem of the web of rights and the problem of generality, I then said that there is no right way of think about the issue of public health and now I have concluded that there can't be experts in public health. On top of this I want to argue that it is impossible to promote public health. And yet, I believe it ought to be done.

Before we go further it is worth while to rehearse a very primitive question, namely: Why do we want public health? or perhaps rather: Why do we want to improve public health? The reason why we want to improve public health is that good health is something good, it is a commodity. But it is not a highest or final good, or as philosophers often say: It is not an end in itself. What makes health a commodity is primarily that it is good *for* something, not that it is good in itself (though it may well be good in itself in some sense). Moreover, and this is why good health is such an important commodity, it is a general commodity. By this I mean that although what makes health a commodity is that it is good for something, it is not just good for some particular things but for all sorts of things. In this sense, it is more like money than, say, a television. A television is a commodity, but it is only good for a narrow range of things, mainly for watching stuff. Money, on the other hand, are good for various things: You can buy all sorts of things for your money, they also give you status, accumulated in an bank account they may make you secure etc. Health is a general commodity in this sense, it is good for all sorts of things and not just for some particular kinds of things. This fact makes good health specially valuable. But even if health is a general commodity in this sense, what makes it valuable is, in the end, that it is good for the good life.[2]

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ceteris paribus laws. They are not universally true, but are true *other things being equal* as we say. But when are other things equal? *Ceteris paribus* laws are, of course, well known from conventional health care. We say: "Other things being equal, bacterial infection is cured by the administration of penicillin." And as we all know, this is not universally true. But now the difference between conventional health care and public health should be clear. Questions about administration of penicillin arise in specific circumstances and the relevance of the *ceteris paribus* clause can be addressed in the individual cases in a clear way. In the case of public health whether a *ceteris paribus* clause is relevant is always an open question and there is no end to the kind of factors that might be relevant for addressing it.

[2] Here I take a lead from the old Greek philosophers, specially Aristotle, and their contemporary followers such as Rosalind Hursthouse. Aristotle says that most things that are valued are valued as means to some end and that the final end, which gives value to other things, is the good life which is valued for its own sake. See Aristotle, *Nicomachean Ethics*, book I, 1094a1–20.

With this idea of good health as a commodity in mind, I now turn to tonight's issue. A promotion of public health involves doing something to make people healthier. This is deliberately vague, both what the 'something' might be and what it is to make people healthier. The problem that I now turn to is that those who have the role of promoting public health – making people more healthy – must let go before they reach their goal, otherwise they may do more harm than good. I shall spend the rest of my talk explaining this.

If I was a plant, what would be good for me would be good for my health. And what would be good for my health, would be good for me. But I am not a plant. If I was a dog, then what is good for me and what is good for my health would be more or less the same. Not quite, but more or less. But I am not a dog. I am a human being, and what is good for me need not at all be good for my health, and what may be good for my health, need not at all be good for me. It might have been good for me to go to medical school, but not because it would have been good for my health. Given the working hours of the medical students in their year of candidacy, it would probably have been rather bad for my health to progress through medical school. But, it might have been good for me nevertheless.[3] Or think of Socrates who judged it to be good for him to drink the hemlock – he knew that it would kill him, but he judged that drinking it would be conducive to his living a good life, whereas avoiding the hemlock by fleeing, which would have been far better for his health, would have eroded his good life. Goodness and health-conduciveness for humans are not the same things.

It is part of our human nature that we experience such feelings as resentment, indignation, ambition, pride, envy, admiration, and so on. And this sets us apart from the higher animals. Moreover, we are not only *passive* receivers of pains and pleasures, we are also *active* beings. The feelings that I just mentioned, especially resentment, ambition and pride, are tied to our active nature more intimately than they are to our passive nature. We are not justified in being proud of ourselves unless what gives rise to the feeling of pride is something we have done – it must be an achievement of ours. Therefore, being proud of one's ancestry is a rather stupid thing. Being active is as much an integral part of what it is to be a human being, as is the ability to suffer pains and receive pleasures. Amartya Sen makes the point in the following way: **[10]**

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[3] See J.J. Thomson, *Goodness and Advice*, p. 55.

> […] we are not only *patients*, whose needs demand attention, but also *agents*, whose freedom to decide what to value and how to pursue it can extend far beyond the fulfilment of our needs.[4]

If we take the complex active nature of people seriously as an integral part of the good life, things are very much different than were we to focus on their passive nature. It may be difficult to fulfil people's needs, but it is not impossible. We can't, however, make other people active, or make them exercise their active power. People can be encouraged to be active, their environment can be made inviting or conducive to various activities, but no one can be made active.

With this in mind let's compare, once more, conventional health care with public health. In conventional health care those needing attention are patients. They are people with specific needs: people with infections, or broken legs, or mental problems etc. And these ordinary people, who go to their local health care institute or to a hospital or to a clinic, are people with specific needs. Once the needs are met, they disappear from the scene – they are not patients any more. It is characteristic of someone in the capacity of a patient – a subject of conventional medical care – that what is good for him is good for his health. And what is good for his health, is good for him. But when we shift from conventional health care to public health, people never disappear from the scene and they are never primarily patients. They are always in the picture – they are there in sickness and in health as one might say – and they must always be seen as much in the capacity of agents as in the capacity of patients. This makes it specially important that the mentality of conventional health care not be dominant in public health.[5]

This fact marks a sharp break between public health and conventional health care. A while ago I said that it was impossible to be an expert in promoting public health as one might be an expert in a conventional medical profession. The reason was that the issues that come together in public health are so diverse that there is no hope of them forming a unified whole which could be the subject of such a profession. But what I am pointing out

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[4] Amartya Sen, "Why we should preserve the spotted owl", *London Review of Books*, 5th February 2004.
[5] There is a view that needs to be mentioned at this point but which I won't discuss much further. According to this view the individuals never disappear from the scene because they are never in the scene. According to this view public health focusis exclusively on a certain population as an indifferentiated mass. Public health, according to this view, is very indirectly related to the health of the particual individuals that make up the group. This view may seem intuitive in many respects but it has, as far as I can see, one serious fault, namely that it leaves questions about public health without out any grounding in questions about the good life. The view that I have in mind in the main text is one where publich health is seen as a measure, even if indirect, of the health of the various individuals which make up the population in question.

now when I say that there is a sharp break between public health and conventional health care is much stronger. Before I noticed a difference in degree, now I have hit upon an essential difference between public health and conventional health care. And this difference makes it specially important that the mentality of conventional health care should not be dominant in the issue of public health. **[11]** If conventional medical mentality would be dominating in public health then people would be reduced to the status of a plant, or perhaps of a dog. But not seen as human beings. When conventional medical mentality permeates work and activities in public health we have the worst appearance of what has been called medicalization.[6]

The heading of this conference is "Public Health – Shared Responsibilities". That refers, I guess, to the shared responsibilities of the various professionals and institutions, official and private, that must join forces to promote public health. But the responsibilities that matter most lie with the ultimate subjects, the healthy or unhealthy individuals themselves.

Living a good life, according to Aristotle, is a matter of developing and exploring the potentiality one has as a human being. If we were plants, this would amount to living a healthy life, and even if we were dogs, the healthy life and the good life would be more or less the same. But we are neither plants nor dogs, and for us the good life and the healthy life are distinct. Living a good life as a human being places heavy weight on us as beings capable of responsibility, in particular, we must be responsible for our own health. But this means that the promotion of a healthy life must stop before it reaches its goal. That is the *paradox of public health*. It is the task of a number of people, you to mention a few, to promote public health – to do something to make people more healthy. But you cannot

[6] Medicalization in this sense is not marked by the expansion of the health care system, or the trend towards professionalism in new aspects of our lives, but in this: A certain way of thinking, which has its proper role in conventional health care where it has proved to be extremely useful, is extended into areas where it is out of place. What is characteristic of this way of thinking is that it sees people as patients rather than as agents. What makes it specially harmful in the present day environment is that there is a strong trend towards this way of thinking in western societies in general. This trend is enforced by the consumer culture which dominates the west. Not only are we constantly reminded of what we don't have and which would make our lives easier if we would have (as if the easy life were the same as the good life), but the message we constantly receive is that if we don't do this or that then we are neglecting our body. This is specially clear in the case of the flood of stuffs – pills, mixtures, lotions, etc., etc. – which are designed to fix whatever might be bothering us and if nothing in particular is bothering us, it will prevent anything such from happening. The message is fairly clear: If we are not already patients, we are certainly potential patients, and the one who does not do something about it, is neglecting his body. And since it is morally wrong to neglect important things, we should have bad conscience.

take every measure to fulfil your duties. That would be treating people as plants, or perhaps dogs.

Those promoting public health can't be responsible for what they are supposed to be responsible for. They may not take the responsibility away from the individual herself for by doing so they take away what is essential for her living a good human life. Their position is much like that of the good matchmaker. Her responsibilities are to make happy couples, but she can't make two people become a couple – they have to do that themselves – nor can she be responsible for others' happiness.