

## Public Health As Social Justice

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Anthony Downs has observed that our most intractable public problems have two significant characteristics. First, they occur to a relative minority of our population (even though that minority may number millions of people). Second, they result in significant part from arrangements that are providing substantial benefits or advantages to a majority or to a powerful minority of citizens. Thus solving or minimizing these problems requires painful losses, the restructuring of society and the acceptance of new burdens by the most powerful and the most numerous on behalf of the least powerful or the least numerous. As Downs notes, this bleak reality has resulted in recent years in cycles of public attention to such problems as poverty, racial discrimination, poor housing, unemployment or the abandonment of the aged; however, this attention and interest rapidly wane when it becomes clear that solving these problems requires painful costs that the dominant interests in society are unwilling to pay. Our public ethics do not seem to fit our public problems.

It is not sufficiently appreciated that these same bleak realities plague attempts to protect the public's health. Automobile-related injury and death; tobacco, alcohol and other drug damage; the perils of the workplace; environmental pollution; the inequitable and ineffective distribution of medical care services; the hazards of biomedicine—all of these threats inflict death and disability on a minority of our society at any given time. Further, minimizing or even significantly reducing the death and disability from these perils entails that the majority or powerful minorities accept new burdens or relinquish existing privileges that they presently enjoy. Typically, these new burdens or restrictions involve more stringent controls over these and other hazards of the world.

This somber reality suggests that our fundamental attention in public health policy and prevention should not be directed toward a search for new technology, but rather toward breaking existing ethical and political barriers to minimizing death and disability. This is not to say that technology will never again

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help avoid painful social and political adjustments. Nonetheless, only the technological Pollyannas will ignore the mounting evidence that the critical barriers to protecting the public against death and disability are not the barriers to technological progress—indeed the evidence is that it is often technology itself that is our own worst enemy. The critical barrier to dramatic reductions in death and disability is a social ethic that unfairly protects the most numerous or the most powerful from the burdens of prevention.

This is the issue of justice. In the broadest sense, justice means that each person in society ought to receive his due and that the burdens and benefits of society should be fairly and equitably distributed. But what criteria should be followed in allocating burdens and benefits: Merit, equality or need? What end or goal in life should receive our highest priority: Life, liberty or the pursuit of happiness? The answer to these questions can be found in our prevailing theories or models of justice. These models of justice, roughly speaking, form the foundation of our politics and public policy in general, and our health policy (including our prevention policy) specifically. Here I am speaking of politics not as partisan politics but rather the more ancient and venerable meaning of the political as the search for the common good and the just society.

These models of justice furnish a symbolic framework or blueprint with which to think about and react to the problems of the public, providing the basic rules to classify and categorize problems of society as to whether they necessitate public and collective protection, or whether individual responsibility should prevail. These models function as a sort of map or guide to the common world of members of society, making visible some conditions in society as public issues and concerns, and hiding, obscuring or concealing other conditions that might otherwise emerge as public issues or problems were a different map or model of justice in hand.

In the case of health, these models of justice form the basis for thinking about and reacting to the problems of disability and premature death in society. Thus, if public health policy requires that the majority or a powerful minority accept their fair share of the burdens of protecting a relative minority threatened with death or disability, we need to ask if our prevailing model of justice contemplates and legitimates such sacrifices.

## **MARKET-JUSTICE**

The dominant model of justice in the American experience has been market-justice. Under the norms of market-justice people are entitled only to those valued ends such as status, income, happiness, etc., that they have acquired by fair rules of entitlement, e.g., by their own individual efforts, actions or abilities. Market-justice emphasizes individual responsibility, minimal collective ac-

tion and freedom from collective obligations except to respect other persons' fundamental rights.

While we have as a society compromised pure market-justice in many ways to protect the public's health, we are far from recognizing the principle that death and disability are collective problems and that all persons are entitled to health protection. Society does not recognize a general obligation to protect the individual against disease and injury. While society does prohibit individuals from causing direct harm to others, and has in many instances regulated clear public health hazards, the norm of market-justice is still dominant and the primary duty to avert disease and injury still rests with the individual. The individual is ultimately alone in his or her struggle against death.

### **Barriers to Protection**

This individual isolation creates a powerful barrier to the goal of protecting all human life by magnifying the power of death, granting to death an almost supernatural reality. Death has throughout history presented a basic problem to humankind, but even in an advanced society with enormous biomedical technology, the individualism of market-justice tends to retain and exaggerate pessimistic and fatalistic attitudes toward death and injury. This fatalism leads to a sense of powerlessness, to the acceptance of risk as an essential element of life, to resignation in the face of calamity, and to a weakening of collective impulses to confront the problems of premature death and disability.

Perhaps the most direct way in which market-justice undermines our resolve to preserve and protect human life lies in the primary freedom this ethic extends to all individuals and groups to act with minimal obligations to protect the common good. Despite the fact that this rule of self-interest predictably fails to protect adequately the safety of our workplaces, our modes of transportation, the physical environment, the commodities we consume, or the equitable and effective distribution of medical care, these failures have resulted so far in only half-hearted attempts at regulation and control. This response is explained in large part by the powerful sway market-justice holds over our imagination, granting fundamental freedom to all individuals to be left alone—even if the "individuals" in question are giant producer groups with enormous capacities to create great public harm through sheer inadvertence. Efforts for truly effective controls over these perils must constantly struggle against a prevailing ethical paradigm that defines as threats to fundamental freedoms attempts to assure that all groups—even powerful producer groups—accept their fair share of the burdens of prevention.

Market-justice is also the source of another major barrier to public health measures to minimize death and disability—the category of voluntary behavior. Market-justice forces a basic distinction between the harm caused by a factory

polluting the atmosphere and the harm caused by the cigarette or alcohol industries, because in the latter case those that are harmed are perceived as engaged in "voluntary" behavior. It is the radical individualism inherent in the market model that encourages attention to the individual's behavior and inattention to the social preconditions of that behavior. In the case of smoking, these preconditions include a powerful cigarette industry and accompanying social and cultural forces encouraging the practice of smoking. These social forces include norms sanctioning smoking as well as all forms of media, advertising, literature, movies, folklore, etc. Since the smoker is free in some ultimate sense to not smoke, the norms of market-justice force the conclusion that the individual voluntarily "chooses" to smoke; and we are prevented from taking strong collective action against the powerful structures encouraging this so-called voluntary behavior.

Yet another way in which the market ethic obstructs the possibilities for minimizing death and disability, and alibis the need for structural change, is through explanations for death and disability that "blame the victim." Victim-blaming misdefines structural and collective problems of the entire society as individual problems, seeing these problems as caused by the behavioral failures or deficiencies of the victims. These behavioral explanations for public problems tend to protect the larger society and powerful interests from the burdens of collective action, and instead encourage attempts to change the "faulty" behavior of victims.

Market-justice is perhaps the major cause for our over-investment and over-confidence in curative medical services. It is not obvious that the rise of medical science and the physician, taken alone, should become fundamental obstacles to collective action to prevent death and injury. But the prejudice found in market-justice against collective action perverts these scientific advances into an unrealistic hope for "technological shortcuts" to painful social change. Moreover, the great emphasis placed on individual achievement in market-justice has further diverted attention and interest away from primary prevention and collective action by dramatizing the role of the solitary physician-scientist, picturing him as our primary weapon and first line of defense against the threat of death and injury. . . .

### **Public Health Measures**

I have saved for last an important class of health policies—public health measures to protect the environment, the workplace, or the commodities we purchase and consume. Are these not signs that the American society is willing to accept collective action in the face of clear public health hazards?

I do not wish to minimize the importance of these advances to protect the public in many domains. But these separate reforms, taken alone, should be

cautiously received. This is because each reform effort is perceived as an isolated exception to the norm of market-justice; the norm itself still stands. Consequently, the predictable career of such measures is to see enthusiasm for enforcement peak and wane. These public health measures are clear signs of hope. But as long as these actions are seen as merely minor exceptions to the rule of individual responsibility, the goals of public health will remain beyond our reach. What is required is for the public to see that protecting the public's health takes us beyond the norms of market-justice categorically, and necessitates a completely new health ethic. . . .

## **SOCIAL JUSTICE**

The fundamental critique of market-justice found in the Western liberal tradition is social justice. Under social justice all persons are entitled equally to key ends such as health protection or minimum standards of income. Further, unless collective burdens are accepted, powerful forces of environment, heredity or social structure will preclude a fair distribution of these ends. While many forces influenced the development of public health, the historic dream of public health that preventable death and disability ought to be minimized is a dream of social justice. Yet these egalitarian and social justice implications of the public health vision are either still not widely recognized or are conveniently ignored. . . .

Ideally, then, the public health ethic is not simply an alternative to the market ethic for health—it is a fundamental critique of that ethic as it unjustly protects powerful interests from the burdens of prevention and as that ethic serves to legitimate a mindless and extravagant faith in the efficacy of medical care. In other words, the public health ethic is a *counter-ethic* to market-justice and the ethics of individualism as these are applied to the health problems of the public. . . .

This new ethic has several key implications which are referred to here as "principles": 1) Controlling the hazards of this world, 2) to prevent death and disability, 3) through organized collective action, 4) shared equally by all except where unequal burdens result in increased protection of everyone's health and especially potential victims of death and disability.

These ethical principles are not new to public health. To the contrary, making the ethical foundations of public health visible only serves to highlight the social justice influences at work behind pre-existing principles.

### **Controlling the Hazards**

A key principle of the public health ethic is the focus on the identification and control of the hazards of this world rather than a focus on the behavioral defects

of those individuals damaged by these hazards. Against this principle it is often argued that today the causes of death and disability are multiple and frequently behavioral in origin. Further, since it is usually only a minority of the public that fails to protect itself against most known hazards, additional controls over these perilous sources would not seem to be effective or just. We should look instead for the behavioral origins of most public health problems, asking why some people expose themselves to known hazards or perils, or act in an unsafe or careless manner.

Public health should—at least ideally—be suspicious of behavioral paradigms for viewing public health problems since they tend to “blame the victim” and unfairly protect majorities and powerful interests from the burdens of prevention. It is clear that behavioral models of public health problems are rooted in the tradition of market-justice, where the emphasis is upon individual ability and capacity, and individual success and failure.

Public health, ideally, should not be concerned with explaining the successes and failures of differing individuals (dispositional explanations) in controlling the hazards of this world. . . .

### **Prevention**

Like the other principles of public health, prevention is a logical consequence of the ethical goal of minimizing the numbers of persons suffering death and disability. The only known way to minimize these adverse events is to prevent the occurrence of damaging exchanges or exposures in the first place, or to seek to minimize damage when exposures cannot be controlled.

Prevention, then, is that set of priority rules for restructuring existing market rules in order to maximally protect the public. These rules seek to create policies and obligations to replace the norm of market-justice, where the latter permits specific conditions, commodities, services, products, activities or practices to pose a direct threat or hazard to the health and safety of members of the public, or where the market norm fails to allocate effectively and equitably those services (such as medical care) that are necessary to attend to disease at hand.

Thus, the familiar public health options:

1. Creating rules to minimize exposure of the public to hazards (kinetic, chemical, ionizing, biological, etc.) so as to reduce the rates of hazardous exchanges.
2. Creating rules to strengthen the public against damage in the event damaging exchanges occur anyway, where such techniques (fluoridation, seat-belts, immunization) are feasible.

3. Creating rules to organize treatment resources in the community so as to minimize damage that does occur since we can rarely prevent all damage.

### **Collective Action**

Another principle of the public health ethic 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. This is for two reasons.

The first is because market or voluntary action is typically inadequate for providing what are called public goods. Public goods are those public policies (national defense, police and fire protection, or the protection of all persons against preventable death and disability) that are universal in their impacts and effects, affecting everyone equally. These kinds of goods cannot easily be withheld from those individuals in the community who choose not to support these services (this is typically called the "free rider" problem). Also, individual hold-outs might plausibly reason that their small contribution might not prevent the public good from being offered.

The second reason why self-regarding individuals might refuse to voluntarily pay the costs of such public goods as public health policies is because these policies frequently require burdens that self-interest or self-protection might see as too stringent. For example, the minimization of rates of alcoholism in a community clearly seems to require norms or controls over the substance of alcohol that limit the use of this substance to levels that are far below what would be safe for individual drinkers.

With these temptations for individual noncompliance, justice demands assurance that all persons share equally the costs of collective action through obligatory and sanctioned social and public policy.

### **Fair-Sharing of the Burdens**

A final principle of the public health ethic is that all persons are equally responsible for sharing the burdens—as well as the benefits—of protection against death and disability, except where unequal burdens result in greater protection for every person and especially potential victims of death and disability. In practice this means that policies to control the hazards of a given substance, service or commodity fall unequally (but still fairly) on those involved in the production, provision or consumption of service, commodity or substance. The clear implication of this principle is that the automotive industry, the tobacco industry, the coal industry and the medical care industry—to mention only a few key groups—have an unequal responsibility to bear the costs of reducing

death and disability since their actions have far greater impact than those of individual citizens.

### **DOING JUSTICE: BUILDING A NEW PUBLIC HEALTH**

I have attempted to show the broad implications of a public health commitment to protect and preserve human life, setting out tentatively the logical consequences of that commitment in the form of some general principles. We need, however, to go beyond these broad principles and ask more specifically: What implications does this model have for doing public health and the public health profession?

The central implication of the view set out here is that doing public health should not be narrowly conceived as an instrumental or technical activity. Public health should be a way of doing justice, a way of asserting the value and priority of all human life. The primary aim of all public health activity should be the elaboration and adoption of a new ethical model or paradigm for protecting the public's health. This new ethical paradigm will necessitate a heightened consciousness of the manifold forces threatening human life, and will require thinking about and reacting to the problems of disability and premature death as primarily collective problems of the entire society. . . .

### **CONCLUSION**

The central thesis of this article is that public health is ultimately and essentially an ethical enterprise committed to the notion that all persons are entitled to protection against the hazards of this world and to the minimization of death and disability in society. I have tried to make the implications of this ethical vision manifest, especially as the public health ethic challenges and confronts the norms of market-justice.

I do not see these goals of public health as hopelessly unrealistic nor destructive of fundamental liberties. Public health may be an "alien ethic in a strange land." Yet, if anything, the public health ethic is more faithful to the traditions of Judeo-Christian ethics than is market-justice.

The image of public health that I have drawn here does raise legitimate questions about what it is to be a professional, and legitimate questions about reasonable limits to restrictions on human liberty. These questions must be addressed more thoroughly than I have done here. Nonetheless, we must never pass over the chaos of preventable disease and disability in our society by simply celebrating the benefits of our prosperity and abundance, or our technological advances. What are these benefits worth if they have been purchased at the price of human lives?

Nothing written here should be construed as a per se attack on the market system. I have, rather, surfaced the moral and ethical norms of that system and argued that, whatever other benefits might accrue from those norms, they are woefully inadequate to assure full and equal protection of all human life.

The adoption of a new public health ethic and a new public health policy must and should occur within the context of a democratic polity. I agree with Terris that the central task of the public health movement is to persuade society to accept these measures.

Finally, it is a peculiarity of the word freedom that its meaning has become so distorted and stretched as to lend itself as a defense against nearly every attempt to extend equal health protection to all persons. This is the ultimate irony. The idea of liberty should mean, above all else, the liberation of society from the injustice of preventable disability and early death. Instead, the concept of freedom has become a defense and protection of powerful vested interests, and the central issue is viewed as a choice between freedom on the one hand, and health and safety on the other. I am confident that ultimately the public will come to see that extending life and health to all persons will require some diminution of personal choices, but that such restrictions are not only fair and do not constitute abridgement of fundamental liberties, they are a basic sign and imprint of a just society and a guarantee of that most basic of all freedoms—protection against man's most ancient foe.