The Goals of Public Health: An Integrated, Multidimensional Model

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While promoting population health has been the classic goal of public health practice and policy, in recent decades, new objectives in terms of autonomy and equality have been introduced. These different goals are analysed, and it is demonstrated how they may conflict severly in several ways, leaving serious unclarities both regarding the normative issue of what goal should be pursued by public health, what that implies in practical terms, and the descriptive issue of what goal that actually is pursued in different contexts. A basic conflict of perspective is handled by integrating the ideas of public health striving for health-related autonomy and equality, resulting in a prioritarian oriented population approach to health-related autonomy. This integrated goal is demonstrated to constrain itself in several ways attractive from the point of view of the classic goal, but several serious problems remain. For this reason, a model where all of the three goals are integrated into one coherent structure where they can be assigned varying degrees of importance relative to the level of population health is described. It is argued that this model avoids the problems set out earlier, and is actually normatively preferable to the classic goal alone. It is furthermore argued that the model may be employed as a useful tool for descriptive ethics, as well as a vehicle for international harmonisation of public health policies. A number of practical implications regarding, e.g., the importance of respecting autonomy and the allocation of public health resources are noted, as are a battery of questions for further research.

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Introduction

The notion 'public health' may be taken to refer to either a state of something called 'the public' (as when public health authorities announce that the public health of a country or region is good, declining, on the rise, etc.), or to a certain *societal practice* that deals with the former. Henceforth, I will be speaking about the latter when talking about *public health*, while using the notion *population health* to refer to the former. Like other societal practices, Public Health in this sense is driven by goals that are expressed explicitly by policy documents and regulations and/or implicitly by the way in which it is organised, structured and motivated by professionals. Such goals express ideas about the values that should be pursued by Public Health, and these values guide what is seen as defensible and desirable Public Health practice. The goals of Public Health thus determine what makes a Public Health measure a success or a failure, as well as specify what to look for when assessing the relative merits of competing Public Health proposals. The subject of this paper is what these goals are, and what they should be. In particular, I will discuss certain recent changes of actual Public Health goals, and present a theoretical model for how such changes should be understood and assessed from a normative ethical point of view. I will also describe some implications of this model for Public Health policy and practice regarding, e.g., resource allocation and political visions about multinational or even global Public Health policy.

In order to get to the points I want to make, I need to sidestep a few conceptual issues about the notions of 'health' and 'public health'. I will simply assume that we all approximately understand what we are talking about when we use such notions in the present context. This is, of course, a simplification.[1] However, I do not believe that making a choice among any of the minimally sensible suggestions in conceptual analytical debates about these notions will affect what I have to say about the goals of Public Health. If anything, the situation is rather the other way around.[2]

The paper proceeds as follows: In the next section, I will present three generic goals that have been suggested for public health, and describe some problems connected with these. The point of this exercise is to show that some sort of choice or prioritisation has to be made among these goals if they are to form a consistent goal structure for Public Health. The question formulated out of this is whether the goals can be integrated into a coherent and normatively valid structure that is practically and

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politically useful. In Section 3, I describe one way of integrating two of the goals (while rejecting two other proposals) into a fourth multidimensional one that seems to meet some of the challenges noted earlier. However, this proposal, which has been adopted in some countries, is also found to suffer from serious drawbacks. For this reason, it is concluded that a multidimensional goal structure integrating all of the three initial goals is desirable. In Section 4, a (rough) model for such a goal structure is set out, and it is described how it may be varied in various respect, used for formulating key normative issues, as well as for describing and comparing existing goal-structures actually in use within Public Health. In the subsequent section, I try to clarify the model further by describing some of its implications for Public Health policy and practice, and after that, I make some comment on the possibility of justifying particular goal structures for Public Health. In the closing section, I summarise the results and make a few pointers regarding remaining issues of interest to address from the perspectives of ethics as well as Public Health.

Three Goals of Public Health

The traditional goal of Public Health is the promotion of population health.[3] Besides noting two key ingredients, I will not go very deeply into what is involved in this goal, partly because it should be rather familiar.[4] First, population health in this context is the idea of an aggregate of individual health levels, states, trends etc., and is thus consequentialist in its basic construction. Second, the goal is compatible with the idea that some constituents of population health are more important than others—i.e., the aggregate just mentioned need not be a simple sum or statistical average of the individual health states in a population, although this may historically have been the most common approach, but something more complicated.[5]

The traditional goal made up the default idea of the point of Public Health for a long time, starting with the issues of basic sanitation in the 19th century, and the subsequent areas addressed during the construction of Western welfare societies. However, during the 1970's, Public Health started to expand to include issues also about the distribution of a given amount of population health within a society. In particular, health inequalities were brought into focus as important problems within Public Health, and actions aimed at empowering various weak or disadvantaged groups were developed. Through this, it transpires that the concern for inequalities is directed at both the distribution of health states and the distribution of health opportunities (such as access to health care, education and information, but also material resources of various kinds). In most cases, this shift of direction occurred in countries with quite high levels of population health and was seemingly made at the expense of further increases. Thus, a further value or additional goal, besides that of promoting population health, was brought into the goals of Public Health. For simplicity, I will refer to this additional goal as *equality*.[6]

Another addition that has started to make its way into the Public Health goal structure in later years seems to have its roots in the growing success of post–World War II medical and research ethics. This development gave ground for criticism against Public Health for its lack of concern for the individual and, in particular, her personal autonomy (e.g., in the form of critical views on paternalist and/or collectivist health policies, screening and vaccination programs, communicable disease management, etc.). Presumably, many other forces were at work as well, e.g., the increasing connection between the Public Health profession and the operative organisations of Health Care. The result was in any case the introduction of exactly that which medical ethicists accused Public Health of lacking. During the 1980's and 90's, the trend grew in Public Health to focus more on the combination of providing health opportunities and information about these, and respecting people's choices with respect to the use of these opportunities in a way implying a corresponding responsibility of people for their fate (even if they chose not to make use of those opportunities). Since a health *opportunity* is something entirely different from the health states thought to make up population health, it is clear that this focus introduced a new idea about what Public Health is for. For simplicity, I will refer to this as the goal of *autonomy*.[7]

There are obvious potential conflicts between these three goals. First, promoting equality may undermine population health, since for several reasons worse off groups may be practically difficult to reach in an effective way with health-promoting measures. Second, also autonomy and equality may conflict in a similar manner, since there is a well-known tendency that the uptake of socially provided health opportunities is better in those groups where there already is a good supply of such opportunities. Something similar, of course, holds also regarding the relationship between autonomy and population health, since groups that score better on the latter are also the ones that more easily can access and make use of provided health opportunities. However, in the case of the traditional goal, the conflict with the goal of

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autonomy goes much deeper than mere practical difficulty, especially in the particular context of Public Health.

First, as remarked above, a health opportunity is something quite different from a health state. Even if we assume that I have the best possible access to many opportunities to improve my health, this is compatible with the fact that I actually am in a lousy state, health wise. Among other things, I may freely choose not to utilise the provided opportunities for furthering my health.

Second, the idea of Public Health aiming only for the promotion of opportunities may seem to transform the point of this practice into nothing more than a thin idea of market freedom that does not connect with any level of population health. This is especially the case unless it is assumed that the basic material conditions of people are such that a formal freedom translates into real and practical opportunities to improve health.[8] Otherwise, the result may be the conservation or further deterioration of such social and material conditions that for many people prevent the use of beneficial opportunities, although these are formally available. Moreover, just holding out as the unqualified goal of Public Health to provide *opportunities*, which people may use (or not use) as they see fit with regard to their health seems to imply that it is the business of Public Health to *create* opportunities for people to make not only healthy choices, but also *un*healthy choices—something clearly at odds with the traditional goal of Public Health.

Several of these tensions between the traditional goal and the additional goal of autonomy seem to connect with a third and very basic conflict of *perspectives*.[9] The goal and ethical basis of Public Health builds on a particular perspective on health issues—a perspective that has *populations* rather than single individuals as its primary focus. This in contrast to the practice of health care and the ethical ideals connected with that, where the person cared for (the patient) is in focus. There are many aspects of this difference of perspective. For instance, health care is concentrating its efforts on people whose health is already in a bad state (with the aim of making things better for them), while in Public Health the scope is in no way limited to that. Another difference is that a large chunk of Public Health is not busy with the business of repairing damage to health, but rather with preventing such damage to occur in the first place. This, in turn, means that public health measures utilise the resources of health care to a rather small degree (although medical knowledge is used). Rather, the main business of Public Health is to secure a 'societal infrastructure' (sanitation, education, economy, etc.), which can uphold a level of population health that makes it possible to have a workable health care system in the first place.[10] The idea of introducing into this perspective the *individualistic* notion of autonomy from medical ethics may therefore look to be a basic category mistake. The perspective of Public Health simply does not allow for goals of that kind, since its goals have to be formulated at a population level. A good example of this tension is the tendency in several countries in recent years to emphasise individual rather than collective preventive strategies as the answer to challenges in population health. These strategies are based on the idea that the individual takes the initiative to seek out and use opportunities for preventing health problems, assuming that those that do not do this behave as they do due to an autonomous choice. My perception of the reaction to this trend among Public Health professionals is sheer disbelief and frustration, partly because such strategies are known not to be very effective with regard to securing a decent level of population health; but not only that. Of even more importance seems to be the conviction that exactly those segments of the population that can be predicted *not* to exhibit the level of initiative needed for undertaking preventive measures in this model are those where health problems and a generally poor socio-economic situation makes it unlikely that their lack of use of the opportunities to secure and improve their health (and that of their children) is due to an autonomous choice. In other terms, while they may have access to these opportunities in a formal sense, there is no *real and practical* availability.

For all of these reasons, and for other ones as well, it is very unclear how any of the suggested additional goals (autonomy and equality) are to be translated into the nitty-gritty of actual Public Health practice. Already the traditional goal implies some problems about how to monitor and assess the performance of Public Health.[11] On top of that, it is highly unclear what practical activities are recommendable from the point of view of the additional goals of equality or autonomy.

One reaction to all of this, of course, may be to reject the suggested additions. In this paper, however, I will take a more constructive route and sketch a model for incorporating these suggestions into an integrated goal structure that takes care of most of the problems indicated.[12] My reasons for this choice will transpire as we go along, but, in short, I find some initial normative plausibility in the suggested additional goals (although I agree there are problems, as we have just seen) and, even if there is in fact no such plausibility, the additions as a matter of fact have an impact on the shaping of Public Health and health policy that ethics needs to be able to describe and analyse. My first step in sketching a model in line with these two reasons is to demonstrate how the idea of autonomy as a goal of Public Health may in fact

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be made to fit into a perspective focusing on populations rather than particular individuals.

A Population Approach to Autonomy

The most basic problem noted above seems to be the tension between the population perspective of Public Health and the individualistic perspective of traditional medical ethical notions of autonomy. A primary task for anyone who wants to bring the additional goals into the goal structure of Public Health thus seems to be to demonstrate how this can be done without forcing Public Health to shift its focus from populations to particular individuals. A population approach to autonomy has to be described, one that still preserves some of the core ethical elements of the individualistic tradition where autonomy has evolved as an ethically important notion. Below, I will first briefly describe two approaches to meeting this challenge that I find implausible, mainly for the reason of making clearer what the third approach *is not*.

One very straightforward way of trying to apply the notion of autonomy to populations would be to simply exchange the individualistic pronouns in autonomy-oriented ethical ideals for collectivistic ones and start talking about the autonomy of the population. That is, in the spirit of Plato,[13] we make a *direct analogy* between what is good or desirable for individual people and what is good for society or the population. In effect, the population is viewed as a sort of *superindividual* with a good or plans of its own that is in no necessary way composed of the good and/or plans of the members of this population.[14] This idea, however, seems to take us far away even from the population perspective of Public Health. Although some important historical anomalies may be noted,[15] the history of the traditional goal of Public Health is about the health of a population that breaks down into a collection of individuals and their respective health states. It is for this very reason that the metrics used for monitoring population health are statistical aggregates of individual health data. For this reason, I will not consider the superindividualistic strategy for achieving a population approach to autonomy further.

However, the idea of ascribing autonomy in any comprehensible sense to the population viewed in this latter way (as the joint members of a set, such as the settlers within a geographical region or the citizens of a nation) seems equally flawed, albeit for other reasons. In this case, 'the autonomy of the population' would have to be construed in analogy with the concept of population health, i.e., as a statistical aggregate of the autonomy states of the individuals making up this population. Even if it makes good sense to talk in terms of more and less when it comes to autonomy,[16] the degree of measurability required by taking the step to an aggregation of individual autonomy states over a population seems so far removed from what any concept of autonomy allows that avoiding this line of thought seems as the obviously sensible choice.[17]

Instead, I want to propose a solution that has been politically introduced by implication in some countries (although not described and rationalised in the way that I do here). The basis of this idea is the combination of two observations regarding the *equality* goal: it is an idea formulated within a population perspective, and it normally invokes *opportunities* as one of the goods that should be distributed in a certain way.[18] These observations lead quite naturally to the suggestion of integrating the two suggested additional goals into one, which holds out *the promotion of equal (and real) opportunities of everyone to be more healthy* as an aim for Public Health.[19] The connection with the autonomy goal is, of course, that the idea of providing opportunities leaves open the option not to make use of these opportunities, but also that these opportunities may be used by people to further whatever plan of life they entertain.[20] None of this is to say that providing opportunities is the same as promoting autonomy, although it does seem to imply much of the *respect* for autonomy requested by medical ethics. But compared to the situation where society just makes people be in certain health states whether or not they want to, or have them choose between the health state provided by society or very bad health, handing out opportunities to promote health, which people can use at their own discretion, seems to be a clear improvement in terms of autonomy, since the opportunities to a larger extent allow and empower people to be the directors of their own lives with respect to health.[21]

This idea, for example, is implied by the recently adopted official main goal of Public Health in Sweden,[22] according to which the aim of Public Health is to 'create societal prerequisites for good health on equal terms for the entire population'.[23] One important implication of this goal is that it stresses the 'multisectorial aspect' of Public Health work, thus underlining the need to separate Public Health policy and work from the individualistic disease- and reparation-oriented focus of health care.[24] In this way, the new goal resumes the overarching ambitions of traditional Public Health that in recent decades has been somewhat overrun by the disease-oriented, biomedical approach of health care. However, at the same time, this goal removes Public Health quite far from the original ideas of what Public Health is for. Obviously, its realisation is compatible with people freely

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choosing whether or not to make use of the created prerequisites, so an implied addition to the just given quote is '. . .if people want to'. This means that even a *perfect* score in terms of this goal is logically and conceptually compatible with a very low level of population health.[25] That is, the implied idea of what Public Health is for seems to be exactly that additional goal integrating equality and autonomy formulated in the preceding paragraph.

This goal leaves a lot more room for individual choice and autonomous pursuing of an individual plan of life than the traditional goal.[26] However, it is of considerable importance to note that this room is restricted in two ways. First, the goal does only hold out the provision of 'health opportunities' as the business of Public Health, thus implying that securing access to *ill* health is not a societal responsibility. So, while people are free to choose ill health without thereby undermining the aim of Public Health, they will have to create the opportunities for ruining their health themselves, should this be what they wish to do. In this way, then, this goal does not imply the above-mentioned free-market view of Public Health, according to which society has as much reason to further a well-functioning market for the unhealthy choices as for the healthy ones.

Second, a result of *integrating* the idea of (health-related) autonomy as a goal of Public Health with the equality goal is that certain ingredients of the latter will *constrain* the practical implications of the former in a way that is technically unproblematic and easy to understand.[27] For, while each individual in one way is left free by the integrated goal to abstain from using the provided means to achieve better health, they are not free to do this at the expense of the *equal opportunities of everyone to use these means*. In practice, this may rule out certain particular liberties, the effective execution of which will impede the equal opportunities of all to further their health. For example, smoking in public places seems to be ruled out for the simple reason that it impedes the equal opportunities of others to choose a smoke-free environment. Other examples may concern the liberty of not abiding by general safety restrictions, or to have access to an alternative infrastructure for things like tap water or sewerage that would jeopardize the efficiency of basic sanitation solutions.

This possibility of constraining the liberty to live an unhealthy life if one wants is, it should be remarked, not due to the application of ideas (potentially) at odds with the autonomy goal (such as the traditional goal). Rather, the idea of this integrated goal is that only autonomy considerations may trump autonomy considerations. So, the reason why it is acceptable to restrict my freedom to smoke in a bar is that my doing so would restrict the autonomy of other people in a certain sense (namely, exactly the way that is of importance according to the integrated goal). Other features that should be observed are that it contains an emphasis on health opportunities rather than health states and an egalitarian or prioritarian focus rather than a maximisation focus (or, at least, the latter is constrained by the former). All these aspects are, of course, important differences to the traditional idea of simply promoting population health.

Reasons for Integrating the Traditional Goal

As mentioned in a footnote above, the actual adoption of this new kind of goal for Public Health seems to have had caused some unease among Public Health *professionals*. Comments from this group on the new goal structure do their best to describe the new goal as a small variation on the traditional goal, which mainly introduces a supplementary idea of what means to use for securing good population health.[28] This may be taken as an indication that not even the integration of the autonomy and equality goals can avoid a clash with the basic perspective of Public Health, in spite of the fact that it assumes a population perspective.

I believe this hunch to be on to something important. The integrated additional goal cannot plausibly *replace* the traditional one—if anything, it is to be seen as some sort of amendment. First, in light of this goal alone, it would seem that many well-established Public Health practices might become obsolete. Since these practices work with typical *collective* utilities (basic social stability, clean air, nutritious food supply, functional housing, etc.) they cannot easily be the object of individual choice. Second, because of this, going for the integrated additional goal alone opens up for the sort of negative health spirals that were highlighted in Section 2, where the joint effect of individual choices as regard health opportunities is a systematic decrease of population health. To be sure, it was pointed out in the preceding section that the integration of the autonomy and equality goal seems to rule out many such scenarios (since it rules out liberties that would impede equal opportunities of all to make healthy choices). However, it is not clear that this excludes all types of negative health spirals.

Both of these points become salient in the case of population health emergencies. Consider, for example, the scenario of a serious pandemic that has been discussed in recent years, and assume that it is actualised in its most severe form (highly effective airborne contamination, substantial incubation period, high mortality rate,

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lack of effective treatment, etc.). The type of measures that would seem appropriate in such circumstances are the classic ones in communicable disease management: isolation of the infected population and restricted mobility of the uninfected population in order to minimise the risk of exposure. It is very difficult to see how such measures could be justified by the integrated additional goal alone. On the contrary, the basic function of these more draconian Public Health measures are to provide health opportunities only to a selected segment of the population, and severely restrict opportunities of the rest to improve their health. Add to this the extra scenario of a limited storage of vaccine, and it starts to look as if the idea of reaching for equal health opportunities is plainly ridiculous rather than merely implausible.[29]

To this example of health emergencies may be added the case of a society in a sort of permanent emergency as regards health. I am thinking, of course, of underdeveloped societies, where the starting point is not a high level of population health that threatens to diminish, but rather lousy population health to begin with. Just as in the case of a serious pandemic, it would seem that considerations of autonomy and equality are clearly secondary in priority in such cases. Just think of the way in which Western countries once upon a time managed to establish the basic structures for securing the level of population health that eventually made us worry about equality and autonomy. In this perspective, it starts to look as the idea of the integrated additional goal as the sole objective of Public Health is mostly an indication of how spoilt we have become. Taking for granted a level of population health that in a global and historical perspective is no less than stunning, we reach out for something additional to garnish that splendid pudding we just baked—not reflecting on the possibility that when we are finished garnishing, there may be no pudding left.

On top of this, however, there is one further weakness of the integrated additional goal to consider. For, while this goal *prescribes* that society have a reason to provide opportunities to promote health, but not opportunities to promote *ill* health; it provides no explanation or justification of this. From a theoretical normative point of view, therefore, it is open to the accusation of being arbitrary. Reflecting ever so little on this problem, however, it is easy to see how the traditional goal may counteract such an accusation. Providing health—rather than ill health—opportunities is an important societal undertaking for the simple fact that population health (but not population ill health) is a basic objective of society.

The conclusion of all of this seems to be that if the integrated additional goal is to have minimal plausibility, it needs to *assume* the presence of good population health. What has just been seen, however, is that such an assumption may be challenged. Now, this fact does not cancel the impression that the integrated additional goal indeed captures something of importance; it merely shows that this goal cannot express the only thing of importance. At the same time, the potential conflicts between the traditional and the integrated additional goal means that the simple idea of merely combining them is difficult, since such a combination would imply conflicting prescriptions.[30]

A Rough Model for Integrating the Competing Goals

Based on the conclusion of the preceding section, my suggestion is that just as it was needed to integrate the autonomy and equality goals, also the resulting integrated additional goal and the traditional goal of promoting population health need to be integrated. The result of this is an *integrated, multidimensional* goal structure that allows for complex trade-offs between competing values in different dimensions.

This description is based on the idea that each of the isolated goals may be seen as expressing a value-dimension, within which there can be more or less of the value in question (population health, equality or health-related autonomy). Since there are possibilities of conflict between these dimensions, they need to be integrated into one coherent model of the goals of Public Health. Such integration will have to involve some type of balancing of not only the magnitudes within each dimension (so and so much population health, equality, health-related autonomy), but also *the relative moral importance of the different value-dimensions themselves.*

There are some standard ways of achieving the latter. A modern classic is the idea of a lexical ordering, employed by Rawls in his theory of justice to balance the reasons to improve the situation of the worse off against the reasons to protect liberty.[31] In this case, what is achieved is a qualitative balancing of competing values, $A, B, C \ldots$, relative to type and some further variable, V (in Rawls' case, the situation of the worst off group in society). When V attains a certain value, v, some of $A, B, C \ldots$ become immune to being outweighed by some others regardless of what magnitude ($a, b, c \ldots$) they show, resulting in a hierarchy of value-dimensions, where the highest value cannot be outweighed by any magnitude of the other values. So, for example, if V is population health, one might suggest that at some level of population health, the value of further increasing it is *always* outweighed by the considerations expressed by the integrated additional goal,

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regardless of what magnitudes of the involved values are at stake.

An alternative to this rather rigid way of integrating different value-dimensions is to go for a model of quantitative (or *continuous*) increases/decreases relative to population health instead. In this way, some values may be allowed to become increasingly important relative to others without the effect that magnitudes make no difference. A simple example: the better population health, the more important becomes the promotion of equal opportunities to become more healthy relative to the promotion of population health. This importance may then be attached as a weight to the magnitudes of value, effecting a balancing of the importance of each value-dimension with the respective magnitude within each such dimension.

A third possibility is to construct a model where these two approaches are combined. Even if I have no business here demonstrating it, I should say that this is the option I myself find the most promising. The combination means simply that the quantitative model just described is complemented by the idea that at some point of population health, the *rate* of the increasing importance of the integrated additional goal increases. The moral importance of this value dimension will still have to be balanced against the magnitude of its value and competing values when deciding how to balance more of health opportunities against more of population health. However, beyond the point just indicated, it would take increasingly smaller magnitudes of further health opportunities to outweigh even quite sizeable further increases of population health.

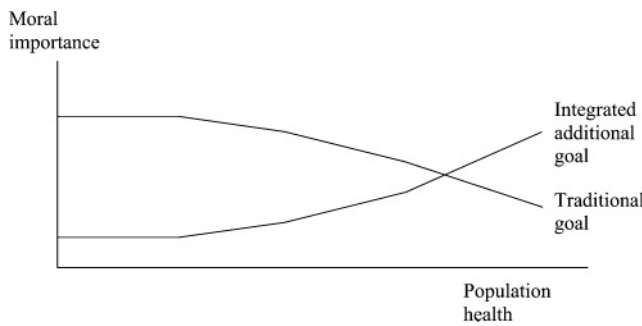
Now, I believe strongly that the first more rigid variant is rather ill fitted for Public Health. Designed by Rawls to protect individuals against infringements motivated by 'the public interest', it is built on the assumption that social welfare may reach such levels where no rational person would be willing to sacrifice even the smallest amount of individual liberty for further social welfare gains.[32] This, in turn, depends on the assumption that autonomy should be treated as an individualistic notion. This last assumption, we have seen above, needs to be abandoned in the Public Health context. Furthermore, Rawls' idea of a qualitative threshold seems to me to be nothing more than an assumption, begging the question as to the issue of the relative moral importance of different value-dimensions. In the two latter models, it is kept open whether or not there are levels of population health such that the relative moral importance of the dimensions of population health, equality and health-related autonomy will be in such a way that a threshold results. It is, therefore, a possibility also in these models, albeit not a guaranteed outcome.

A further reason for avoiding rigidity in the theoretical modelling of the integration of the value-dimensions at stake has to do with what the *function* of such a model should be. One function, obviously, is to describe a framework for formulating a normative position with regard to the goal of Public Health. However, in order to get to that, one needs to develop arguments for preferring such a specific position to competing ones within the framework, and this requires a model of the framework that allows for several competing positions. This descriptive potential of a less rigidly constructed model also has a further important use: it may be employed by empirical researcher when analysing and comparing different Public Health policies and structures from the perspective of descriptive ethics.

The general character of the two last-mentioned ideas with regard to the figure below.

This figure illustrates the combination of the ideas that:

- The more that population health is promoted, the less important it is to promote it further (and *vice versa*)
- The more that population health is promoted, the more important it is that people may choose not to further promote their health (and *vice versa*)
- The more that population health is promoted, the more important it is that people have opportunities



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to further promote their health, which are equally distributed (and *vice versa*)

One important qualification to make at this point depends on the observation made earlier that pursuing the traditional goal, i.e., promoting population health, may involve paying attention to distributive aspects with regard to health states.[33] Although not explicitly mentioned, there is thus room in the model for having the distribution of population health affect how the relative moral importance of the traditional and the integrated additional goal should be described. For instance, if the sum or average of individual health states in a society is very high, the fact that it is very unevenly distributed may mean that the moral importance of the traditional goal is still quite strong relative to the integrated additional goal. Although intuitively attractive, I will not motivate this feature further here, besides mentioning it as an exciting area for further research.

Whether or not a particular Public Health activity is to be *recommended* or not is not settled by these considerations alone, however. As mentioned, the moral importance of each value-dimension has to be balanced against what is at stake *within* each such dimension, and, of course, the joint result of that needs to be compared to alternative activities. That is, the desirability of such an activity is determined by a combination of (i) the extent to which the values in various dimensions are promoted, (ii) the respective moral importance of these value-dimensions relative to actual population health, and (iii) a comparison of how this activity scores in the combination of these two respects relative to alternative undertakings.

Now, in order to preserve the lack of rigidity and descriptive potential pointed out to be of such importance above, this rough model should not be more specific than this. In other words, the exact size of the differences of moral importance will be left undecided, and so will the exact relation of this size to the level of population health, and the exact way in which these differences are to be balanced against the magnitudes within the respective value-dimensions. Anyone wishing to formulate a more specific normative suggestion within this framework would, of course, have to specify all of these factors to some extent.

Applying the Model

In spite of the claim above that one of the points of the integrated, multidimensional model is that it is normatively open, there are obviously some ideas about the goals of Public Health that are ruled out by it. In particular, the two ideas discussed earlier, that the traditional or the integrated additional goal should be the *sole* goal of Public Health, are contradicted by any more specific normative idea formulated within the model. Since this has been a theme in the earlier discussion, it is therefore of interest to note some differences regarding the application to more particular issues between the model and its competitors. Generally, the model seems to give the right answer to many of those questions that above were presented as challenges for the traditional or the integrated additional goal.

One very salient outcome of the model is the general idea that the lower the level of population health is, the more reason there is for treating the traditional goal of promoting population health as paramount. This meets the challenge from the case of underdeveloped countries or regions, and the related appeal to the history of Western Public Health. In such circumstances, then, concentrating on efficiently raising the general health level and not paying much attention to distributive and autonomy-related considerations appears to be perfectly acceptable, although it may (though of course need not) mean that quite brutal and cold-hearted measures are accepted, such as the expropriation of culturally and existentially important property, eviction from traditional housing, manipulation of eating, cleaning, sanitation and child rearing habits through threat of societal force, etc.

Another general implication of the model is that the higher the level of population health is, the more reason there is for treating the integrated additional goal as paramount. That is, the better the health of some population is, the more reason for Public Health to phase out whatever measures of the sort just mentioned are in use, and instead phase in the strategy of creating opportunities for people to further promote their health which, at the same time, allow them to sacrifice this further health for other goods if they so prefer. So, for instance, instead of more state directed propaganda and default solutions, people should be given the ability to decide themselves—implying, perhaps, more of politically stimulated market solutions for potentially health-promoting products and services complemented by societal support, regulation and empowering measures, such as information and education.

Similarly, there is more reason to promote the situation of the worse-off in this respect (in order to approach the ideal of equal opportunities) even when this may be ineffective in terms of population health. Another side of this is that Public Health has as strong a reason to block the opportunities of people to sacrifice their health if these opportunities impede the equal opportunities of

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all to further promote their health, which, as was seen above, may mean that bans on activities such as smoking in public places is a good idea even in the face of uncertain evidence as to the dangers of second-hand smoking. These implications meet the challenges both against the traditional goal from an autonomy and equality perspective, and against the integrated additional goal from the perspective of the traditional goal.

The perhaps most serious challenge to the integrated additional goal pointed out above was the point that its observance may effect a serious deterioration of population health. One of the ways in which this seemed possible was the sort of negative health spiral made possible by systematic choices of people to forsake their health for other goods. As pointed out, since the room for such choices within the integrated additional goal is constrained by the same goal (it must not impede the equal opportunities of all to promote their health), this particular challenge is partly met by the considerations mentioned in the foregoing paragraph. The more serious version of this challenge, the case of health emergencies such as serious pandemics, is not handled in that way, however. Neither is it handled by the fact that if population health were to deteriorate dramatically due to the combination of such an emergency and the inability of the integrated additional goal to justify effective communicable disease management measures, then the traditional goal would immediately become more important. Even if that is indeed true, retrospective action is not what is needed here, since once the emergency has been allowed to have its devastating effects; rebuilding population health may become practically impossible (due to effects on economy and social stability, for instance). The challenge *is* handled, though, by the possibility of using the integrated, multidimensional model for motivating *preventive* action. If a situation where it is appropriate to strongly prioritise the integrated additional goal seriously threatens to deteriorate into a situation where this rather holds for the traditional goal due to the very fact that the integrated additional goal is prioritised, the traditional goal should be given priority. While the model does not necessarily imply this line of thinking, it nevertheless *allows* it (and perhaps this type of challenge is a reason for preferring specific normative suggestions that do imply it). Besides communicable disease management, environmental policy (e.g., regarding the climate) seems to be an area where this pattern of reasoning seems particularly attractive.[34]

Besides meeting the sort of challenges noted earlier, however, the integrated, multidimensional model also seems to have some further implications regarding application that are of interest to note. One of these is that there may be reasons to prioritise the traditional and integrated additional goals differently in different populations or sub-populations. This since the model describes a framework for one single goal of Public Health, which allows this goal to have a built-in flexibility as to what more particular type of objective should be seen as the main point of Public Health depending on the situation with regard to population health. This property of the model is an important one in several respects, not least from the perspective of the political side of Public Health work. For example, this flexibility seems to facilitate the sort of multinational policy integration that to an increasing extent is recognised as one of the main future challenges of Public Health.[35]

A related aspect of a more straightforward normative nature is that the model seems to supply reasons for allocating Public Health resources to areas with lower levels of population health. This seems to hold both within countries and globally. For example, if a comparison is made between the needs in terms of the goal of Public Health in Western Europe on the one hand and, on the other, central Africa, it seems difficult to resist the conclusion that the latter region is the one more appropriate for Public Health activities. For some time, regions of this type may also be expected to be ones where there is strong reason to prioritise the traditional goal. This, in turn, seems to have important implications for what *type* of Public Health activities should be aimed for, making political measures aimed at securing the sort of basic socio-economic stability and development needed to reach higher levels of population health more appropriate than aid in the form of health care resources.

Justifying the Model

The integrated multidimensional model of the goals of Public Health may, as indicated, be justified in three separate ways. One of these is to see the model as a conceptual framework fit for describing and comparing actual goal-structures for Public Health in different areas, countries, regions, etc. from an ethical point of view. The justification of the model then comes from its usefulness in that respect, and it is my hypothesis that it indeed has such usefulness. This, of course, would have to be vindicated by further research in the descriptive ethics of Public Health.

Another source of justification would be that the model could serve a politically pragmatic function as a heuristic device with respect to issues of great importance from a Public Health perspective. Above, I argued this to be the case with regard to the multinational and, eventually, global integration of Public Health

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policy. However, also here, the question of whether or not this claim is warranted can only be settled by empirical investigations. Actual attempts to use the model for facilitating such integration have to be studied and assessed.

Although both of these sources of justification are of great interest from the general perspective of Public Health and Public Health research, the most intriguing and challenging issue concerns the outright *normative* justification of the model. As pointed out above, the model does seem to exclude certain other ideas about the goals of Public Health, and it is, of course, of interest to ponder both whether or not these exclusions are desirable, and whether the model itself really manages to capture all that there is to say about what is desirable in Public Health. Obviously, it is not possible to settle this issue in the present context. However, I will give some hints and pointers to, first, some important distinctions and, second, what I believe to be a promising idea with regard to normative justification on the basis of these distinctions.

One idea would be that the model expresses a distinct idea of what is of *final value* (i.e., desirable for its own sake),[36] and applies this to the specific domain of human activities we call Public Health. This, however, can be interpreted in several ways. On one understanding, the model indeed *says* something about what sort of states have final value. This reading, though, seems rather obviously implausible, as do similar readings of any other views of the goals of Public Health or other specific policy areas in terms of the defining characteristics of these. Simply put: there is more to the good than health and other things related to health, and this holds irrespective of what more specific theory of final value we consider.[37]

Perhaps the model still expresses some such idea by describing at least an *ingredient* of a theory of what is desirable for its own sake? That is, the model could be taken to express claims about what has *contributory* value or, if that term seems unhelpful,[38] claims about what may often be a part of more complex states that are of final value. So, while there may be morally important considerations that could trump the sort of reasons for societal decisions and activities that may be formulated in terms of the model, the model still provides *some reasons* of this sort. The fact that some Public Health proposal scores well in terms of the model *always speaks in favour of acting on this proposal.*

Another solution, of course, is to view the model as a purely *instrumental* theory with regard to what is ultimately desirable (either finally or contributively). In that case, the model expresses the latter kind of ideas in an elliptical fashion, where certain causal connections are tacitly assumed to hold. That is, the model expresses the claim that if the goal it describes is observed (and obtained), this will in practice produce more of that (whatever it is) that is worth producing for its own sake, compared to if Public Health operated from some other set of basic considerations. Of course, this idea can be combined with the preceding one.

Now, I believe, that on the basis of either of the two latter ideas, or the combination of these two, some goal fitting the integrated multidimensional model can be justified on the basis of a broad range of minimally plausible basic normative ethical or political theories. Several versions of consequentialism (not least those incorporating the idea of autonomy as a value and/or the priority view), nonlibertarian autonomy-based theories of rights, Rawlsian inspired theories of justice, and moderate communitarian political theories all seem to be able to do this sort of job. This, it should be observed, is as much a hypothesis as the other justificatory claims I have made above. From the point of view of philosophy and ethics, however, it seems an exciting prospect to explore this suggestion further, since many small details with regard to how a plausible version of this hypothesis should look like would have to be worked out, in turn informing the ongoing quest for well-founded basic ethical and political ideas.

Concluding Remarks

I have argued above that the integrated multidimensional model can handle most of the ethical challenges directed at the traditional goal of Public Health, the suggested additions of the goals of autonomy and equality, as well as a goal integrating both of the latter two. I have furthermore suggested that this model can be of use both for ethics—descriptive as well as normative—and practical Public Health politics. In addition, the prospect seems promising to find a valid normative justification for some goal of Public Health fitting the model, rather than its competitors. At the same time, plenty of work remains to assess these suggestions, not least regarding the normative ethical claims made.

One particular aspect of this work is to bring in more worked-out models of the *traditional* goal that have been presented recently.[39] In these models, as have been mentioned above, some aspects of the equality goal are built into the traditional goal itself by making this goal alone multidimensional as well. An exciting theoretical task, therefore, would be to investigate the ways in which such a multidimensional version of the traditional goal can be combined with the integrated multidimensional model.

One may ask, though, what difference all of this would make from the *practical* Public Health perspective. Perhaps not that much, at least not in any immediately

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foreseeable way. But in as much as Public Health is an expression of more overarching social ideals and norms (as I think it is), it may be seen as one part of that never-ending quest for improving the world in which Public Health seems to be so deeply involved. In more direct terms, however, what seems to be of more immediate interest for Public Health is how the model should be worked out in terms of practical implications. What, for instance, does it mean for the allocation of Public Health resources? What sort of measures should be used and what areas should be targeted? Above, I have suggested that, in light of the model, perhaps the focus of Western Public Health is rather misdirected (addressing problems that on a global scale are minor, and to an exaggerated extent adopting reparative and/or individualistic approaches). More basically, what should be the focus of Public Health *monitoring* (apparently, it should monitor more than mere population health), and what devices need to be developed to accomplish that? Ethics has a role to play here as well, since the understanding of how to distinguish between different variants within the model requires that kind of competence. However, in this case, ethics is no more important or basic than the knowledge and skill brought by the Public Health profession.

The ultimate vision would be that the more theoretical work in ethics and political philosophy described above and the latter more practice-oriented approach could come together. New, more developed ethical and political theories could help the practice to understand the practical requirements better, and the various particulars of the practice of Public Health could help ethicists and political thinkers to improve their theories. Before we get to that, however, as we have seen, some more elementary issues need to be attended to.[40]

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Notes

1. See, e.g., Richardson *et al.*, 2007, and Verweij & Dawson, 2007.
2. Cf. the conclusion in Munthe, 2000.
3. Verweij & Dawson, 2007.
4. Interesting discussions can be found in Brülde, 2008; Shickle *et al.*, 2007, as well as Verweij & Dawson, 2007.
5. Brülde, 2008.
6. Cf. Brülde, 2008; and Verweij & Dawson, 2007.
7. Cf. Brülde, 2008; and Verweij & Dawson, 2007.
8. It is, of course, a serious problem to determine the borderline between mere formal freedom and "real" opportunities. I will not elaborate further on that, however, in spite of the fact that I will in various places underline the moral importance of keeping apart these different senses of the notion of opportunities.
9. This is something that has been pointed out to me in very strong terms by several practitioners and policy makers within Public Health. In particular, the personal correspondance of Kevin Kelleher and Elisabeth Petsetakis within the framework of the EuroPHEN project opened my eyes to the importance of highlighting this tension in the final report of this project (Shickle *et al.*, 2007).
10. Imagine the cost and practical difficulty of running a well-performing Western-style health care system in some of the most underdeveloped countries in the world. . .
11. Brülde, 2008.
12. Taking this route seems to be well in line with the conclusion in Rhodes, 2005, where it is argued that several competing sorts of normative ideas needs to have a place in an adequate ethics of Public Health. Unlike Rhodes, however, due to the reasons that have transpired above, I do not believe it to be a very fruitful idea to include medicine in general in the object of such an ethic.
13. *The Republic*, book IV.
14. Plato has, of course, few supporters in this respect nowadays, and even fewer when it comes to Public Health. However, a strong trend in recent political philosophy is that of communitarianism, which in various ways involves the idea of a good of society that is something over and above an aggregate of the goods of its members (although it does not make the sort of strong analogy that Plato did). In relation to Public Health, it has been suggested quite recently that maybe the goals of Public Health should be conceived of in such terms, rather than the consequentialist notion of an aggregate of individual health states. See Shickle *et al.*, 2007.
15. In particular the sort of eugenic sterilisation policies that were in operation in almost all Western countries for a large part of the twentieth century. Some argue that this anomaly has a contemporary continuation in the practice of prenatal diagnosis and, more recently, preimplantation genetic diagnosis. However, that claim is contested. See Munthe, 2007a, 1999, 1996 for further references.

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16. Cf. Juth, 2005, chapter 3.
17. Cf. Juth, 2005, pp. 189ff.
18. As noted earlier, the goal of equality also normally concerns the distribution of actual health states. As will be briefly mentioned later on, this part of the equality goal may very well be worked into a multidimensional variant of the traditional goal of promoting population health (Brülde, 2008). Since this paper is not concerned with that goal by itself, but rather with its particular relation to the additional goal of autonomy, this aspect will not be developed further in the present context, although it will be mentioned in a few places where it is of some importance to consider it.
19. There is, of course, an inspiration from John Rawls' idea of 'fair equality of opportunity' (Rawls, 1971, chapter 2) here. However, as will transpire later on, there are also numerous differences. Some obvious ones that will not be elaborated on below are that the integrated additional goal is not restricted to the access to positions of public office or authority but rather to health opportunities, and not necessarily connected to what Rawls called 'pure procedural justice', his notion of 'primary goods', or contractarianism in general.
20. One aspect of the notion of autonomy in moral philosophy in general that is not present in this solution is the kantian idea that autonomy requires the desires I act on to be morally adequate—that I act out of 'reverence for the moral law' (Kant, 1785). However, although there are those who seem inclined to think differently (Rhodes, 2000), leaving out that line of thought seems to be as it should, since this aspect of autonomy is not present in the typical idea of respecting autonomy within medical ethics anyway. Another aspect that *is* a part of that idea, however, and that is equally absent in the integrated additional goal, is that of *authenticity* (Juth, 2005, section 2.2), i.e., the idea of an autonomous person is that she is acting out of desires that are *her own* in some more qualified sense than the mere fact that she has them. It seems to me that that there are good moral reasons to disregard that aspect on the population level, however, and this from the point of view of the individualistic notion of autonomy itself. Simply put: the idea of having society review to what extent our preferences are 'our own' before deciding whether or not to create opportunities for satisfying them is rather scary for anyone who thinks that the protection of individual liberty is an important ethical and social value. In this way, then, the absence of the authenticity aspect in the population approach to autonomy strengthens the case for saying that this approach can embody core ideas of the traditional individualistic ethical ideas about the importance of autonomy at work in medical ethics.
21. This, as has been mentioned, assumes that the ability of people to use these opportunities are not only formal or abstract, but involve actual capacities and the presence of societal prerequisites.
22. Similar ideas seem to have taken hold also in some other countries, most notably the Netherlands (Hans Donckers and Marcel Verweij, personal communication).
23. *Mål för folkhälsan*, translation by myself (the original Swedish formulation is 'skapa samhälleliga förutsättningar för god hälsa på lika villkor för hela befolkningen'). This bill was adopted by the Swedish Parliament in 2003. See further Hogstedt *et al.*, 2004, where the new Swedish Public Health policy is presented and analysed in English by several leading Swedish Public Health professionals. It should be mentioned, though, that in this presentation the literal translation *creation of societal prerequisites for good health. . .* is translated as the creation of "social conditions that *will ensure* good health. . ." (Hogstedt *et al.*, 2004, p. 27, my emphasis). This is an obviously unjustified overstatement of the content of the expressed opinion of parliament, perhaps reflecting a wish of the community of Public Health professionals to push the toothpaste back into the tube and hold on to the traditional goal, so that they can attend to "business as usual" in spite of the change of orientation signalled by political authorities.
24. Hogstedt *et al.*, 2004.
25. This holds even if the Swedish goal is interpreted not as aiming for equal health opportunities, but rather for opportunities for equal health. This since the "societal prerequisites" are instruments for attaining better health for the individual or more equal health in society, that are provided by society, but that people are left free to make use of or not.
26. Although this holds as a conceptual or logical consequence, it may be suggested that the practical difference need not be that far-reaching, since the traditional goal may be complemented by side-constraints on what means may be used to attain the traditional goal that, for instance, ban the use of force or manipulation against individuals so that autonomy is respected (Brülde, 2008). However, these constraints then need to be motivated in some way, and if the only base of values available is the traditional goal it is difficult to see how this is to be done (due to the problems involved in harmonising an individualistic notion of autonomy with the traditional goal). Thus, this strategy requires some additional basis of ethical

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considerations, and the integrated additional goal may be seen as a suggestion to this effect.

27. This in contrast to a goal structure where both goals are present but not integrated.
28. Hogstedt *et al.*, 2004.
29. Verweij, 2006.
30. Probably, this is what explains the above-mentioned attempts of Swedish Public Health professional to sneak in the traditional goal as the dominant one by the backdoor. If the integrated additional goal is held to be valid only to the extent that it furthers the traditional goal, obviously no conflicting prescriptions will ensue. This move, however, is dependent on the assumption that population health is the only thing of importance from a Public Health perspective. The model that I present below may be taken as an outright challenge of that belief.
31. Rawls, 1971.
32. Rawls, 1971, §82.
33. Brülde, 2008.
34. I am less sure, however, about whether this pattern of reasoning applies to threats to population health recently highlighted in Western countries, such as obesity and stress-induced depression, that mainly seem to be a result of the affluence of these countries (this is not to contradict that problems of this sort mainly afflict the less affluent segment of the population in these countries). To be sure, these sorts of problems will put a strain on the economy of the health care system or the nation in general. However, it remains to be shown that such prospects are likely to effect a situation that would have population health deteriorating to the point where the traditional goal takes precedence. Moreover, even if that is so, it is still an open question whether or not this would be an effect of prioritising the integrated additional goal rather than the traditional one. For instance, taking preventive action against stress-induced depression may mean that Western countries would have to slow down their economies by lessening the pressure on the work force to continuously increase productivity, thus straining the health care budget from another direction.
35. Cf. Munthe, 2007b, where the specific case of the European Union is discussed a bit further.
36. Korsgaard, 1983.
37. See, e.g., Brülde, 1998 and 2001.
38. Cf. Brülde, 1998, p. 20.
39. Brülde (2008) describes this as the idea of integrating the aggregative and distributive goals of Public Health with regard to actual health states.
40. The chief part of the research underlying this paper was undertaken within the project *European Public Health Ethics Network* (EuroPHEN), funded by the European Commission, and sketches of some of the ideas have been presented as a part of the final report of this project (Munthe, 2007b), as well as at a number of conferences (Munthe, 2007c, 2006, 2004a, 2004b). I owe a great deal to the many penetrating discussions within EuroPHEN and at these conferences, as well as to Petra Andersson, Ragnar Francén, Pia Nykänen, Ingmar Persson, Joakim Sandberg and Anders Tolland at the Dept. of Philosophy in Göteborg for comments on earlier drafts of this paper. Particular debt is owed to Bengt Brülde and Niklas Juth, who both commented thoroughly on the final draft.

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