What Makes Health Public?

John Coggon argues that the important question for analysts in the fields of public health law and ethics is ‘what makes health public?’. He offers a conceptual and analytic scrutiny of the salient issues raised by this question, outlines the concepts entailed in, or denoted by, the term ‘public health’, and argues why and how normative analyses in public health are inquiries in political theory. The arguments expose and explain the political claims inherent in key works in public health ethics. Coggon then develops and defends a particular understanding of political liberalism, describing its implications for critical study of public health policies and practices. Covering important works from legal, moral, and political theory, public health, public health law and ethics, and bioethics, this is a foundational text for scholars, practitioners, and policy bodies interested in freedoms, rights, and responsibilities relating to health.

John Coggon is a research fellow in the School of Law, University of Manchester. His research focuses principally on legal, moral, and political issues relating to health and welfare. He was the winner of the 2006 Mark S. Ehrenreich Prize in Healthcare Ethics Research, awarded by the Pacific Center for Health Policy and Ethics at the University of Southern California, in conjunction with the International Association of Bioethics. From 2007–10 he held a British Academy postdoctoral fellowship.
This series of books was founded by Cambridge University Press with Alexander McCall Smith as its first editor in 2003. It focuses on the law’s complex and troubled relationship with medicine across both the developed and the developing world. In the past twenty years, we have seen in many countries increasing resort to the courts by dissatisfied patients and a growing use of the courts to attempt to resolve intractable ethical dilemmas. At the same time, legislatures across the world have struggled to address the questions posed by both the successes and the failures of modern medicine, while international organisations such as the WHO and UNESCO now regularly address issues of medical law.

It follows that we would expect ethical and policy questions to be integral to the analysis of the legal issues discussed in this series. The series responds to the high profile of medical law in universities, in legal and medical practice, as well as in public and political affairs. We seek to reflect the evidence that many major health-related policy debates in the UK, Europe and the international community over the past two decades have involved a strong medical law dimension. With that in mind, we seek to address how legal analysis might have a trans-jurisdictional and international relevance. Organ retention, embryonic stem cell research, physician assisted suicide and the allocation of resources to fund health care are but a few examples among many. The emphasis of this series is thus on matters of public concern and/or practical significance. We look for books that could make a difference to the development of medical law and enhance the role of medico-legal debate in policy circles. That is not to say that we lack interest in the important theoretical dimensions of the subject, but we aim to ensure that theoretical debate is grounded in the realities of how the law does and should interact with medicine and health care.

Series Editors
Professor Margaret Brazier, University of Manchester
Professor Graeme Laurie, University of Edinburgh
Professor Richard Ashcroft, Queen Mary, University of London
Professor Eric M. Meslin, Indiana University

Books in the series
Marcus Radetzki, Marian Radetzki, Niklas Juth
Genes and Insurance: Ethical, Legal and Economic Issues
Ruth Macklin
Double Standards in Medical Research in Developing Countries
Donna Dickenson
Property in the Body: Feminist Perspectives
Matti Häyry, Ruth Chadwick, Vilhjálmur Árnason, Gardar Árnason
The Ethics and Governance of Human Genetic Databases: European Perspectives

Ken Mason
The Troubled Pregnancy: Legal Wrongs and Rights in Reproduction

Daniel Sperling
Posthumous Interests: Legal and Ethical Perspectives

Keith Syrett
Law, Legitimacy and the Rationing of Health Care

Alastair Maclean
Autonomy, Informed Consent and the Law: A Relational Change

Heather Widdows, Caroline Mullen
The Governance of Genetic Information: Who Decides?

David Price
Human Tissue in Transplantation and Research

Matti Häyry
Rationality and the Genetic Challenge: Making People Better?

Mary Donnelly

Anne-Maree Farrell, David Price and Muireann Quigley
Organ Shortage: Ethics, Law and Pragmatism

Sara Fovargue
Xenotransplantation and Risk: Regulating a Developing Biotechnology

John Coggon
What Makes Health Public?

_A Critical Evaluation of Moral, Legal, and Political Claims in Public Health_

John Coggon
Dedicated to Hosam Bang: a gentleman, scholar, and great friend
Contents

Foreword by Professor Lawrence O. Gostin
Acknowledgements

Introduction

Part I – Basic concepts in public health
Introduction to Part I
1 Health, normativity, and politics
2 The public, and things being public
3 The seven faces of public health
4 Public health policy
5 Public health law and ethics
6 Conclusion to Part I

Part II – Evaluating evaluations: making health public
Introduction to Part II
7 Analysis in the political realm
8 Making health public
9 Conclusion to Part II

Part III – Tackling responsibility: liberal citizens as subjects and sovereigns
Introduction to Part III
## Contents

10 Liberal citizens: defining non-individuated individuals 207

11 Health made public: rights, responsibilities, and shared concerns 235

12 Conclusion 265

*Bibliography* 267

*Index* 283
Foreword

*Lawrence O. Gostin*
Linda D. and Timothy J. O’Neill Professor of Global Health Law
Director, O’Neill Institute for National and Global Health Law,
Georgetown University

John Coggon, in this seminal book, asks a question of such simplicity, but also of such profound importance: What makes health public? The rigor with which he examines this critical question will make this book a classic in the field of public health ethics – an essential reference point for scholars, students, and policy-makers. Coggon's essential claim is that any normative analysis in the field of public health, or argument in favor of, or against, a particular public health measure, is based in political theory. This remains true whether the proponent favors a limited model of public health (with a narrow public sphere) or an expansive model. In both cases, Coggon treats these as political questions, exposing the political nature of public health claims.

What I wish to do in this foreword is to demonstrate why Coggon's question is so significant in contemporary academic and public discourse. In short, understanding the public/private dimensions of health is indispensable for ascertaining the appropriate scope of governmental public health in a liberal democracy. And that issue, as Coggon points out, is as socially and politically charged, as it is important to the population's wellbeing.

To begin with, scholars often refer to “health” with some imprecision. Health, of course, is a *status* of high value to humanity. Health has intrinsic, but also instrumental, value through its contribution to human functioning – happiness, creativity, and productivity. Health is also essential for the functioning of populations – engaging social interactions, participating in the political process, exercising rights of citizenship, and generating wealth.

But what produces health? There is no definitive answer to that question, but one might divide health-producing interventions as including three overlapping spheres: health care (individual clinical services), public health (population-based approaches), and broader socio-economic determinants (fair distribution of income, jobs, housing, and social
support. There are public/private dimensions to each of these, and they are the subjects of pitched political battles.

The public/private dimensions of health care

Much of the discourse about health is devoted to health care—a complex system of primary, emergency, and hospital services designed primarily to diagnose and treat individuals who become ill or injured. Political disagreements about the public/private domains of health care are rife. If health care is a human right, as many argue, the State has a duty to ensure health goods and services that are available, accessible to everyone (including being affordable and geographically accessible), acceptable (including culturally), and of good quality.

The State’s obligation to ensure the right to health under international law, however, has not tamped down the division between those who see health care as a core public obligation and others who see it as a market commodity. Most States broadly accept that health care is a public responsibility, which takes many different forms ranging from a national health service to a single or multiple payer system. The private sphere, however, can dominate in certain countries such as the United States. In the debates over President Obama’s health care reform, political adversaries cast public financing and quality standards (even comparative cost effectiveness) as government-imposed “death panels.” And even in primarily public systems, the tension between public and free market principles is palpable. Consider, for example, the Canadian Supreme Court, which struck down a prohibition on private medical insurance because it violated patients’ “liberty, safety and security” under the Quebec charter.1

Another dimension of the public/private divide is whether individuals have primary responsibility for their own health. In the health care context, conservatives argue that individuals who fail to take good care of their health ought to pay more for their insurance or even be excluded from coverage for certain conditions. Increased premiums for smokers is common in private run systems, but conservative scholars argue that it should extend to persons who are obese, abuse alcoholic beverages or drugs, and even individuals with sexually transmitted infections such as HIV. Those who engage in high-risk activities, such as skydiving, would also have reduced coverage or pay higher premiums. Conversely, many private insurance companies are now offering premium discounts

for those who engage in healthy behavior, such as going to the gym or maintaining a favorable mass/body index.

Consequently, John Coggon’s question, “what makes health public?” becomes exceedingly important in evaluating how health care is financed and provided, and whether and to what extent health goods and services should be governed by free enterprise principles.

The public/private dimensions of public health

One might assume that controversies about the public dimension of public health would be less intense than with health care. After all, health care professionals serve individuals, while public health agencies serve the population as a whole.

The word “public” in public health can be understood to have two overlapping meanings – one that explains the entity that takes primary responsibility for the public’s health, and another that explains who has a legitimate expectation of receiving the benefits.2 The government is the public entity that acts on behalf of the people and gains its legitimacy through a political process. And it is the population that has a legitimate expectation of benefiting from public health services. What best serves the population, of course, may not always be in the interests of all its members, making public health highly political. What constitutes “enough” health? What kinds of services are necessary? How will services be paid for and distributed? These remain political questions.

Almost everyone understands that the level and kinds of services that government offers are political. There are finite resources and public officials will take differing views about the relative value of health as opposed to other public goods, such as energy, defense, transportation, or even tax relief. But it is not only the allocation of public health resources that are within the political realm, but also the very role of government together with its relationship to the individual.

The dominant liberal perspective holds that the State can interfere with individual autonomy only to prevent harm to others. It is for this reason that conventional infectious disease services (e.g., screening, reporting, and quarantine) are relatively uncontroversial. But when the State intervenes in personal choices that are primarily self-regarding (e.g., what to eat, whether to smoke, or even whether to wear a helmet) the political divisions are at their height.

The political fault line is between a government that actively orders society for the good of the people (a “nanny state”) on the one hand, and a government that leaves individuals to make their own personal and economic choices on the other. Arguments over the nanny state range from mandating motor cycle helmets and fluoridating drinking water, through to a tax on sweets, a ban on trans fatty acids, and zoning or taxation to incentivize shops that sell whole foods and disincentivize fast food establishments.

Paternalism remains at the heart of the political debates over the appropriate role of the State in creating the conditions in which people can be healthy. Public health paternalists rely on the fact that people face constraints (both internal and external) on the capacity to pursue their own interests, including cognitive and informational deficits, as well as limited willpower. They may objectively know what is in their best interests but find it difficult to behave accordingly. Finally, individuals face social and cultural constraints on their behavior. Human behavior is influenced by many external factors including parents and family, peers and community, media and advertising.

Perhaps it is not even accurate to think of public health paternalism as directed to the individual at all but instead towards overall societal welfare. Public health practices are “communal in nature, and concerned with the well-being of the community as a whole and not just the well-being of any particular person.”

Public health aims its policies toward the community and it counts its results in improved health and longevity in the population. Even if conduct is primarily self-regarding, the aggregate effects of persons choosing not to wear seatbelts or helmets can be thousands of preventable injuries and deaths.

Again, Coggon’s question, “what makes health public?” becomes exceedingly important in social and political life. Do we allow individuals to make their own choices, even if they will suffer adverse consequences and the population as a whole will bear considerable burdens? Or is this purely a matter of personal choice? So much about what the State does, and its relationship with its citizens, is intricately tied to how these questions are resolved in the political realm.

---

The public/private dimensions of socio-economic determinants of health

A strong and consistent finding of epidemiological research is that socio-economic status (SES) is correlated with morbidity, mortality, and functioning. SES is a complex phenomenon based on income, education, and occupation. Material disadvantage, diminished control over life’s circumstances, and lack of social acceptance all contribute to poor health outcomes. Some researchers go further, concluding the overall level of economic inequality in a society correlates with (and adversely affects) population health. That is, societies with wide disparities between rich and poor tend to have worse health status than societies with smaller disparities, after controlling for per capita income. The World Health Organization’s Commission on Social Determinants of Health concluded, “the social conditions in which people are born, live, and work are the single most important determinant of good health or ill health, of a long and productive life, or a short and miserable one.”

Assume that these data are as robust as the public health community believes them to be. Does it follow that the State is obliged to ensure more plentiful, and more equal, distribution of socio-economic goods? This may be the most politically contentious question of all because it goes to the heart of political life – whether government’s first duty is to redistribute wealth across the population. The Social Determinants Commission, for example, recommends equity across the life span, beginning with child development and education, through to fair employment and housing, as well as social protection for everyone, including the elderly. Must the State tackle inequitable distribution of power and resources, with health equity becoming a marker of government performance?

On one level, it is only the State that can exercise the legitimate power to redistribute socio-economic goods through its power to tax and spend – for example, steeply progressive taxation and generous social welfare programs. On another level, each individual is positioned to provide these goods for themselves in a free enterprise system. Even the most free market advocates often make allowances for particularly vulnerable groups, such as children, the elderly, and persons with physical or mental disabilities – allowing a modicum of State support services.

But they would make no such allowance to able-bodied adults who, in their view, are capable of meeting their own needs. In relation to the fully capable, free market theorists posit that state services actually incentivize less productive activities.

Here, the familiar divide between State and individual responsibility is acute. There are certain conditions of life (e.g., food, housing, education, and work) that are well known for their positive influence on health. Yet, Coggon’s question remains as pertinent as ever – what makes health (in this case mediated through socio-economic conditions) public?

The book’s three broad projects

I have sought to briefly show why the public/private domains involving human health are critically important, and why they are so political. I hope this foreword makes the reader want to know more. John Coggon’s penetrating analysis is essential for understanding the public sphere, and its deep political dimensions.

Coggon engages in three broad projects. First, he offers a thorough conceptual analysis, in particular of the different things people mean when they use the term “public health.” Unpacking the variety of meanings of this much-used term will significantly improve scholarly and public discourse in the field. Secondly, Coggon provides an analytic framing for arguments in public health law and ethics, discussing what he means by politics (as compared with and sometimes opposed to morality), and then using this framing to explain some of the most influential arguments in public health ethics. Finally, he develops his own preferred understanding of political liberalism, and discusses its implications for arguments about public health ethics.

The field of public health ethics – still relatively young – owes a great debt to John Coggon. His book will be much discussed, and highly influential, as the field matures and integrates with broader social and political discourse.

Lawrence O. Gostin
Washington, D.C.
March, 2011
Acknowledgements

Over the course of this project, I have met and discussed ideas with more people than I can possibly thank here individually. I have learned so much, and am deeply grateful. The work between these covers is the result of many hours of (sometimes heated) debate, careful reading, and deep thought. In particular I need to express my profound gratitude to people who have read all or part of earlier drafts of the work. Madison Powers was incredibly generous in the time he took reading the first draft of Part I, and in taking time to discuss the wider aspects of the project during my trips to Georgetown in 2008 and 2010. Thanks also to Stephen John, Ania Pacholczyk, and Elen Stokes for feedback on other incarnations of this part of the book. On top of writing his very thoughtful foreword, Larry Gostin offered kind and careful comments on the first complete draft of the work, as well as finding time to meet and discuss the evolving ideas on both my Washington visits. I must state my thanks too to Barry Lyons, Suzanne Ost, and Adam Tucker, all of whom also read the whole piece and came back with encouraging and insightful comments.

I owe an enormous debt to Margot Brazier, John Harris, and Søren Holm, my mentors in Manchester, who have gone well beyond the call of duty in supporting my work, subjecting it to diligent critique, and helping me through the drafting and redrafting. The environment these three people have created in the Centre for Social Ethics and Policy, and the Institute for Science, Ethics, and Innovation, makes coming to work a pleasure.

Beyond these, there are countless people who have taken the time to discuss the ideas that I explore and arguments that I make. I can not name everyone, but must say thank you to Roger Brownsword, Angus Dawson, Matti Häyrty, Richard Ingleby, Bruce Jennings, Tom Koch, Jean McHale, Jonathan Montgomery, Ollie Quick, Keith Syrett, and Tuija Takala. Each of these people has been a fantastic source of support, and provided much needed critical guidance on a whole range of ideas with which I have struggled. I must thank also organisers and
audiences of various seminars and conferences at which I have been able to test some of the ideas found below, in particular at the Universities of Georgetown, Keele, Liverpool, Oxford, and University College London, the 2008 conference of the International Association of Bioethics in Croatia, the 2008 International Conference of the British Association for Canadian Studies’ Legal Studies Group in London, and the 2010 meeting of the Society of Legal Scholars in Southampton. I must thank my wonderful colleagues at Manchester, especially for the superb feedback they gave to papers presented at the Institute for Science, Ethics, and Innovation’s internal seminar series. Finally, I owe thanks to Cambridge University Press, and would like particularly to express my gratitude to Helen Francis, Finola O’Sullivan, Cheryl Prophett, Sarah Roberts, Elizabeth Spicer, and Richard Woodham.

I have researched and written this book during the course of a British Academy Postdoctoral Fellowship. The freedom and support afforded by this scheme have allowed the experience to be most enjoyable and rewarding. I have been able to visit some inspirational people and places, and enjoyed the processes of scholarship at their most stimulating and intellectually gratifying. As well as expressing my thanks for choosing to support my postdoctoral project, it is important to acknowledge the additional ways in which the Academy has taken care of me throughout my research. The value it gives to nurturing young scholars is something of which all within the academic community, and beyond, should be proud. I would also wish to state my thanks to the Wellcome Strategic Programme on the Human Body: Its Scope, Limits, and Future, which has supported me during the final stages of drafting this work.

Of course I could have done none of this without the love and support of friends and family. Although I can’t thank everyone by name, from my side of the family I must say thank you for the great care and encouragement to Grandma, Granny, Mum and Dad, Ruth, Tim, James, Matthew, and (latterly) Daniel, Roz, Simon, and Lyra, Rattus, and Meredith. And my socio-in-laws have also been superb, and remarkably tolerant, so thank you to Maura and Killian, Jane and Niall, Chuck K. McGuinness (whose health is his wealth) and Lou, Rosemarie, Cathal, and Sarah, and last but by no means least Evelyn.

Too many friends to list have kept me going during this project. I dare not try to name them all, for fear of upsetting those I might forget, but I must mention by name Big Ade, Caroline and Alex, Fatima, Joe, Nash, Stokes (again), and Suzie. I also can’t fail to mention the Thursday lunch club at the Kennedy Institute of Ethics: the warmth
Acknowledgements

and welcome offered by the brilliant people in Georgetown has been truly fantastic.

Finally, and above all, I need to say in woefully inadequate words how thankful I am to Sheelagh, for all her patient support, care, and love. Cursed with a shared interest in the sorts of issues discussed in this book, she has suffered more discussions than anyone should have to do as I’ve tried to straighten out my thoughts on public health law and ethics. Thank you.

John Coggon
Manchester