Int J Public Health 53 (2008) 5–6
1661-8556/08/010005-2
DOI 10.1007/s00038-007-0234-1

Inequity, inequality, and the distributive goals of public health

Bengt Brülde

Bengt Brülde is Associate Professor in Practical Philosophy at Göteborg University, Sweden, and Associate Professor in Philosophy at University West, Sweden

What is the ultimate goal of public health activities, e.g. health promotion or health education? Or rather, what should *these activities try to realize or maximize? One central goal of public health is to improve the average health status (healthy life expectancy, or the like) in the relevant population. This is not the only goal, however; e.g. it can also be argued that public health should try to reduce health inequalities or inequities between groups or individuals. In short, the ultimate goal of public health is both aggregative and distributive. It is unclear whether the goal to create equal opportunities for health ("equal health chances") is* ultimate*, and it will not be investigated in this editorial.*

In health promotion contexts, it is often assumed that the most plausible distributive goal of public health is to reduce health inequities*, i.e. those health inequalities that are unjust or morally unacceptable. This assumption is often accompanied by the idea that a health inequality should count as an inequity if it is due to the fact that the less healthy groups are poor or discriminated against, or that they have less access to education or health care. On this view, all health inequalities that are caused by socioeconomic inequalities should count as inequities. Those health inequalities that are caused by biological variations or freely chosen behaviours are typically regarded as less relevant. The fact that natural health inequalities are less attended to is probably due to a certain division of labour; however: to deal with these inequalities is part of medicine (the "illness services") rather than of public health.*

Both these assumptions can be questioned. It can be doubted (a) whether public health should only concern itself with unjust health inequalities, and (b) whether all socioeconomic inequalities (and the resulting health inequalities) are really unjust, i.e. whether justice requires that they be reduced.

The idea that all socioeconomic inequalities are unjust is often derived from one of two fundamental principles of justice. The first is the idea that everyone has certain positive rights – e.g. the right to health care, to a decent education, or to have his/her basic needs satisfied – and that every society that fails to deliver these goods (given sufficient resources) is unjust. The second is the egalitarian view that all inequalities are unjust unless they can be justified in terms of e.g. need or desert. Both these views can be challenged. For example, neoliberals have argued that the only good that ought to be equally distributed is a set of negative liberal rights. As far as socioeconomic goods are concerned, it is the history of the distribution that determines whether it is just or unjust. According to this procedural account of justice, a certain socioeconomic distribution may well be morally acceptable even if it is extremely unequal, namely if it has been caused by a process where no negative rights have been violated, e.g. by free agreements. (Who is right is a substantive issue in political philosophy that cannot be settled here.)

But should public health restrict itself to unjust inequalities? This question may well be practically useless, regardless of which theory of justice is taken for granted. Suppose that an inequality is unjust if the worse-off are worse off through no fault of their own, but that they are not entitled to compensation if their situation is due to freely chosen behaviours. This idea has no practical importance, partly because it is hard to distinguish socially determined from freely chosen behaviours, and partly because public health work is targeting groups rather than individuals. If we want a workable goal, the goal to reduce health inequities should be replaced by the goal to reduce all *health inequalities.*

This does not mean that the reduction of inequality is the most plausible distributive goal of public health, however. It is also possible to question egalitarianism altogether, and not just from a neoliberal standpoint. On the standard egalitarian view, it is bad in itself that some individuals are worse off than others. This also holds when the worst-off are pretty well off in absolute terms, i.e. egalitarianism is mainly concerned with people's relative standings. However, the most important thing may well be that people's lives are as long and healthy as possible, and not how long or healthy these lives are relative to others. On this view, our legitimate egalitarian concerns are best captured by the idea that we should give priority *to the worse-off. On the maximin (i.e. maximising the minimum gain) version of this view, we should give absolute priority to the worst-off, i.e. the only way to improve population health is to improve the health of the most unhealthy group. A more plausible version of the priority view is the idea that a certain improvement in health has* more value *if it befalls the worse-off, e.g. the worse someone's health status or health chances are, the more important it is to improve them. Health has diminishing marginal value, e.g. a given increase in health is better the further down the health scale it occurs. Every increase has value, however – e.g. a large improvement for the healthy may have more value than a small improvement for the unhealthy.*

The view combines distributive and aggregative concerns, but the two concerns still have to be weighed against each other. Once this problem is solved, however, we should simply maximize people's weighted *health levels (HALE, etc.) – and to get a decent summary measure of population health, we simply have to aggregate these (weighted) values. The higher the average level of this value is, the better, i.e. this is what public health should aim to maximize. We may well get an even better measure if we incorporate some further justice-based considerations as well, but we must not forget that some egalitarian concerns are already incorporated in the priority view. In short, the priority view may take us pretty far, and we may have less need for egalitarianism than we think we have.*

Bengt Brülde

Address for correspondence

Prof. Bengt Brülde, Ph.D.
Göteborgs universitet
Filosofiska institutionen
Box 200
405 30 Göteborg
e-mail: bengt.brylde@phil.gu.se