MUNK SCHOOL BRIEFINGS

Comparative Program on Health and Society

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The Munk School of Global Affairs at the University of Toronto seeks to be an internationally recognised leader in interdisciplinary academic research on global issues and to integrate research with teaching and public education. We place special emphasis on the fostering of innovative interdisciplinary knowledge through the exchange of ideas and research among academics as well as the public, private, and voluntary sectors.

We are delighted to present this collection of research papers from the Comparative Program on Health and Society based on work that our fellows undertook during 2010–2011. Founded in the year 2000, the Comparative Program on Health and Society (CPHS) is a vital and growing research institute based at the Munk School of Global Affairs at the University of Toronto. Generously funded by The Lupina Foundation, the CPHS supports innovative, interdisciplinary, comparative research on health, broadly defined through our extensive range of fellowships, which for 2010–2011 included CPHS Junior Doctoral Fellowships, CPHS Senior Doctoral Fellowships, Lupina/OGS Doctoral Fellowships, Post-Doctoral Top-Up Fellowships, and Research Associate Positions. Our program builds on the scholarly strengths of the University of Toronto in the social sciences, humanities, and public health.

As the CPHS moves into its second decade, we have adopted a renewed vision of the social determinants of health which recognizes the complexity and interrelatedness of domestic, transnational, regional, and global factors that may impact on health conditions and access to health-related services within any country, including Canada. We recognize similarly that emerging and entrenched health inequalities may require policy-makers, communities, and researchers to grapple with challenging ethical, human rights, and social justice questions. We have accordingly expanded the thematic focus of the Comparative Program to accommodate research which specifically focuses on these definitional and operational challenges. The research papers you will read in this year's collection reflect these themes, and demonstrate the variety, complexity, and importance of comparative health research.

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Abstract

Significant interest has recently emerged in the area of public health emergency preparedness and response, largely as a result of events like Hurricane Katrina, SARS, and the presence and threat of influenza pandemics. Such emergencies have demonstrated that our preparedness and response efforts can sustain and even create health inequities. While scholars have developed ethical frameworks to guide our efforts in emergency response (largely based on frameworks found in other public health domains), it has not been made clear whether the moral foundations of public health emergency response are similar to quotidian public health. Thus, in the pursuit of developing ethical frameworks for public health emergency preparedness and response, it is important to analyze and compare the moral foundations of public health emergency response with the moral foundations of quotidian public health, and ask: Are the similarities or differences justified? On what grounds? As humanitarian disasters and infectious disease outbreaks continue to present significant public health challenges around the world, often affecting individuals and populations unequally, there is an impetus to enhance our understanding of the moral foundations of our preparedness and response efforts to ensure that they promote the equal and just consideration and treatment of individuals and populations. It is hoped that this research will enhance our understanding of whether public health emergency response adequately considers the social determinants of health, social justice, and health equity, and suggest how ethical frameworks can be improved in order to promote these values.

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INTRODUCTION

Bioethics is the study of ethics in relation to biological and health issues. It has become a field of significant interdisciplinary interest due in large part to several events such as the experimentation on individuals during the Second World War and the treatment of individuals in the Tuskegee syphilis study (Veatch 2000; Beauchamp and Childress 2001; Baker and McCullough 2008; Baker et al. 1999; Jonsen 1998). The interdisciplinary approach of bioethics has looked mainly at ethical issues in the context of clinical biomedicine and has therefore focused largely on the individual (O’Neill 2011; Nixon et al. 2005; Gostin 2001; Bayer and Fairchild 2004; Upshur 2002; Callahan and Jennings 2002; Thompson, Robertson, and Upshur 2003). Thus, some skepticism exists as to whether bioethical analysis can be adequately applied to issues in public health, where the population, rather than the individual, is the focus (O’Neill 2011; Nixon et al. 2005). This skepticism has led to the emergence of scholarship in public health ethics, the study of moral issues in the theory and practice of public health. In its development as a field of study, public health ethics, much like bioethics, has drawn from concepts in multiple disciplines, with scholars proposing and defending a distinct set of key principles, concepts, orientations, and approaches (O’Neill 2011; Nixon et al. 2005; Gostin 2001; O’Neill 2002; Bayer and Fairchild 2004; Lachmann 1998; Upshur 2002; Callahan and Jennings 2002; Thompson, Robertson, and Upshur 2003; Childress et al. 2002; Kass 2004; Beauchamp and Steinbock 1999).

In the past decade, much interest has emerged in the area of public health emergency preparedness and response, largely as a result of ethically troubling events like Hurricane Katrina, the outbreak of severe acute respiratory syndrome (SARS), the use of anthrax and other threats of bioterrorism, devastating earthquakes in Haiti and Japan, and the presence and persistent threat of pandemic strains of influenza. Scholars, policymakers, and practitioners in public health and public health ethics have produced specific frameworks, guidance documents, and scholarly literature in order to provide ethical guidance in preparing for and responding to such emergencies.

However, it has not been clear whether these frameworks reflect, or ought to reflect, the traditional values and goals of quotidian (i.e., non-emergency) public health, or whether they ought to have distinct goals and values. A cursory review of the literature suggests an uncritical assumption is made that, during public health emergencies, health-related policies and priorities reflect the utilitarian principle of maximizing the greatest health benefits for the greatest number (or, inversely, minimizing the greatest amount of disease for the greatest number); in contrast, this utilitarian principle is balanced with other values and principles in non-emergency scenarios (Kotalik 2006; Ventilator Document Workgroup 2011; Zack 2006; Christian et al. 2006). Such a normative assumption suggests that particular priorities and approaches to justice ought to exist during a public health emergency, and they otherwise may be but one of many approaches in non-emergency environments. This raises the fundamental question, “Do our values in preparing for and responding to public health emergencies differ from our values in addressing non-emergency public health issues, and if so, how?” and the subsequent normative question, “Should we draw upon central values or principles of public health (or public health ethics), in our preparation and response to public health emergencies?”

While we can point to the various political and ethical theories and values that may have contributed to public health as an institution, a tremendous gap exists in our knowledge of precisely what values and goals are reflected in current public health policy and practice, and similarly, in public health emergency preparedness and response. Hence, it is important to first characterize the values, goals, and moral foundations of quotidian public health and public health emergency preparedness and response. However, such an endeavour requires further narrowing of scope.

In order to understand the terrain of values within and between quotidian public health and public health emergency preparedness and response, one must develop an understanding of the terrain of public health as a whole, and public health emergency preparedness and response as a whole. The scope of such an endeavour would necessitate an exploration of many different public health programs, interventions, and policies, an approach that may require many independent yet conceptually related studies that describe the existing values, priorities, and goals of particular public health policies, programs, and practices. Once
combined, these studies would provide a broad illustration of the overarching terrain of values that exist in public health and public health emergency preparedness and response. In order to begin to develop this understanding, this paper takes on the leaner task of surveying the common assumptions, theories, and arguments that have been advanced to describe or prescribe the moral foundations of public health and public health emergency preparedness and response. While not the purpose of this paper, a greater exploration and articulation of the terrain of values within each of these domains (which would include empirical investigation of policies, frameworks, laws, and the opinions and experiences of stakeholders) will then be beneficial to gain a more nuanced and detailed account of the moral foundations of public health and public health emergency preparedness and response.

For the purposes of this paper, “public health emergency preparedness and response” will refer to a commonly used definition developed by Christopher Nelson and colleagues: “the capability of the public health and health care systems, communities, and individuals, to prevent, protect against, quickly respond to, and recover from health emergencies, particularly those whose scale, timing, or unpredictability threatens to overwhelm routine capabilities” (2007, S9). Bruce Jennings’s definition of a public health emergency may also be helpful: “A public health emergency exists when the health consequences of a decision have the potential to overwhelm routine community capabilities to address them” (2008, 41). Such emergencies may be characterized as naturally occurring, anthropogenic, or the result of an acute (i.e., non-chronic or not ongoing) biological disease that may occur in either a localized or global setting. “Quotidian,” “routine,” or “non-emergency” public health will refer to all public health that does not constitute an emergency in this sense. While these definitions and interpretations can be conceptually and even practically problematic, and may certainly be contested on many grounds, they will suffice for the purposes of this paper.

PRELIMINARY THEMES IN THE MORAL FOUNDATIONS OF PUBLIC HEALTH

It is difficult to adequately and accurately characterize the moral foundations of public health for two reasons. First, public health, writ large, is concerned with many different facets of health, employing many different approaches to promote and protect population health. Public health involves several moral considerations, ranging from the production and maximization of benefits, to avoiding harms, to maintaining public trust. Moreover, because there is not necessarily a serial ordering of moral considerations in public health (e.g., whether protecting the health of the public has moral priority over protecting privacy), it is difficult to know what the primary ethical goal of public health is (e.g., to promote benefits? to reduce harm? to distribute benefits and burdens equally?). This could suggest that different moral foundations, theories, and considerations exist in different areas of practice of public health, all perhaps serving different purposes.

Second, there is no consensus amongst scholars and practitioners within public health as to what the moral foundations are, or ought to be. Thus, even where explicit moral foundations are expressed, these positions are often contested. Rosamond Rhodes is likely correct in arguing that several principles, theories, and approaches are used in public health, and that this may be a requirement to achieve its goals (2005). With that said, though, the following presents several of the predominant views found in the literature. While not forming the last word on the subject, this review will hopefully provide some insight into the moral motivations of public health from which a discussion of the moral foundations of public health and public health emergency preparedness and response can be compared and contrasted.

Consequentialism

It seems that, intuitively and upon first glance, public health can be characterized as a predominantly utilitarian enterprise that is concerned with achieving the greatest health benefits for the greatest number within its population (Kotalik 2006, 18; Faden and Shebaya 2010, 9). Indeed, some suggest that the moral justification for public health is mostly consequentialist, or teleological, in nature, as it is concerned with the health outcomes of the public as the primary outcome of measuring success (Childress et al. 2002; Nixon et al. 2006). While this may seem uncontroversial, some communitarians, for example, maintain that public health is one means to producing community (Roberts and Reich 2002), and others contend that
public health is a deontological enterprise, as there is a duty to ensure the public's health as a matter of social justice (Childress et al. 2002; Powers and Faden 2006; Beauchamp 1976), or as a means to satisfy human rights (Mann 1997; Faden and Shebaya 2010; Roberts and Reich 2002).

However, it is difficult to find anyone who is willing to suggest that public health lacks any commitment to consequentialism or utilitarianism. Indeed, the reliance on cost-effectiveness analyses or expert-determined indices of health status, such as those utilized with quality-adjusted life years (QALYs) and disability-adjusted life years (DALYs) in public health, suggests an approach that favours the principle of utility and maximization (Kotalik 2006, 18; Roberts and Reich 2002, 1055). The bias in favour of quantification in public health policy—something that is arguably most easily achieved by measuring health outcomes—reifies the utilitarian, or at least teleological, nature of public health. This is not to say that consequentialism is the only foundation of public health. In fact, it seems that the more one investigates the moral underpinnings of public health, the less utilitarian and ends oriented it appears to be.

Egalitarianism

Madison Powers and Ruth Faden (2006) suggest that the traditional moral justification of public health posits that public health is an institution charged with promoting human welfare in order to bring about the good of health. This justification is based in beneficence and can be considered to be teleological, or goal-oriented, in nature, as previously indicated. Powers and Faden also note that, traditionally, scholars posit that public health has a utilitarian commitment to bring about as much health as possible. Under this view, they argue, concerns of justice are distinct from utilitarian commitments and simply act to balance the general commitment to produce health (Powers and Faden 2006, 81).

In contrast to the notion that public health is fundamentally utilitarian, Powers and Faden suggest that the moral foundation of public health is in fact social justice itself, arguing that an exclusive focus on outcomes derived from considerations of utility alone can be misleading and counterproductive to the public's health. Interestingly, some of the first scholastic articles explicitly exploring the new field of public health ethics focused on social justice (Callahan and Jennings 2002; Childress et al. 2002; Kass 2001), indicating that it is integral to the moral justification of public health. Indeed, others have posited that public health has had a long tradition of social reform, social action, and social justice (Nixon et al. 2006), and that public health can even be considered to be a direct approach to social justice (Beauchamp 1976; Gostin and Powers 2006). As Dan Beauchamp proclaimed, “the historic dream of public health…is a dream of social justice” (1976, 105).

Social justice for Powers and Faden (2006) is still concerned with outcomes: the realization of sufficient levels of particular dimensions of well-being, of which health is one. However, both authors, in addition to Fabienne Peter (2004), suggest that inequalities in health are wrong not because of inequalities in health outcomes per se, but rather because they are a result of unjust economic, social, and political institutions. By addressing injustices at the level of the social structure, an attempt is made to ensure that all individuals, and groups of individuals, are not systematically disadvantaged (Powers and Faden 2006, 67). Thus, an upstream approach is taken to ensure that social, economic, and political arrangements do not lead to social inequalities, including those in health. This characterization of public health suggests that promoting health and bringing about the conditions for people to be healthy is a direct requirement of social justice. It is not health outcomes per se that are the goal of public health. Rather, health outcomes are important only insofar as they promote or contribute to social justice.

It is also argued that liberalism underscores the major philosophical trends of public health thinking (Nixon et al. 2006, 48), in influencing both theories of justice and those committed to human rights (Roberts and Reich 2002). An egalitarian, liberal, rights-based approach to public health might suggest that everyone has a minimum positive right to a particular level of resources and services to assure fair equality of opportunity (Roberts and Reich 2002, 359; Daniels 1985). This implies, as Norman Daniels (1985) argues, that a

1 That is, if we consider this utilitarian approach to be distinct from an approach to justice, or at least just one distinct approach to justice, which is contested. See Rhodes 2005.
minimum level of health (for normal species functioning) is required for individuals to have a reasonable range of opportunity to make life choices.

Sen (2001; 2004), on the other hand, suggests that health care ought to be made available in order to maximize the capabilities available to individuals. Like Daniels, Sen extends Rawlsian liberalism to health, arguing that, while health is morally special, it is important insofar as it creates the conditions necessary to function in society. Like Powers and Faden, Sen goes on to argue that an injustice occurs when the lack of opportunity to achieve good health is a result of inadequate social arrangements. Thus, the capability to achieve good health, and the equality of capabilities to function, is a requirement of justice.

It is clear, then, that there is more to public health than simply aggregating benefits and burdens to determine the most appropriate policies, measures, and interventions. Important considerations stemming from egalitarianism and liberalism either form some basis for the moral justification of public health, or at the very least work to balance the consequentialist goals that may be present. What is clear is that considerations of justice are dominant in the moral foundations of public health.

Social Determinants of Health

In the early 1800s, it was discovered that differences in social conditions led to more than a twofold difference in life expectancy between classes in England (Bloom 2001). Since then, social inequalities in health have been identified around the world (Marmot 2001). Because social conditions can have great impact on health (and even more so than health care access [Kass 2004, 237]), scholars have more recently argued that we ought to pay attention to underlying social inequalities in order to address health status (Daniels 2001). While, historically, public health has focused much of its efforts on the poor and the impact of sanitation and health (Childress et al. 2002, 177), public health has become increasingly concerned with the social structures, arrangements, and institutions that are determinant or indicative of health status.

This interest in the social determinants of health in public health reflects the concurrent interest in philosophy concerning the implications of theories of justice for the social determinants of health (Ruger 2004). Daniels (2002), for instance, claims that health inequalities that derive from social determinants ought to be considered unjust unless the determinants are distributed in conformity with the Rawlsian principles of a “decent minimum” and “fair equality of opportunity.” He suggests that governments ought to develop and implement social policies that equalize life opportunities, such as commitments to promoting education and affordable housing.

According to Ilona Kickbush, in order to improve global public health, we must “address the larger issues of social justice, democracy, and law that are paramount to health in the context of globalization” (2002, 132). It seems, then, that a focus on the social determinants of health and the social structures that create, maintain, or exacerbate inequalities in society, correspond to, and complement, a social justice approach to public health. But can utilitarianism similarly focus on such issues in its pursuit of maximizing utility? While utilitarianism can be considered to be egalitarian insofar as it requires that the happiness of everyone is considered equally, it is objected to on the basis that it may condemn innocent people in the name of producing the greatest benefit (Beauchamp and Steinbock 1999, 15). This, it would seem, would be counterproductive to the social determinants of health and social justice approach.

Preliminary Themes in the Moral Foundations of Public Health Emergency Preparedness and Response

Like the previous section, this section cannot adequately explore the moral foundations of all public health emergency preparedness and response efforts due to the extremely varied approaches and contexts that exist in this domain. Rather, this section briefly presents dominant themes found in the literature that speak to the moral foundations of public health emergency preparedness and response generally, with the use of the recent examples of influenza pandemics and Hurricane Katrina.

Public health emergencies often affect many people at once, can be localized or global, allow for little time to deliberate, and incapacitate certain vital infrastructures such as communications and sanitation. In the case of Hurricane Katrina and the 2010 Haitian earthquake, many infrastructures were severely disrupted,
including police and fire services, communications, and sanitation (Lister 2005). Beyond the impact on key infrastructure, some suggest that public health emergencies and disasters create a “chaotic” environment (Sunseri 2005, 12). Thus, due to the level of uncertainty that exists and in addition to the increased threat to the health of the population, public health emergency preparedness and response is inherently prone to paternalism: it tells people how to behave during an emergency, and can have a great impact on liberty, autonomy, civil and human rights, property, and other fundamental interests due to the inherent involvement of power and coercion (Jennings 2008).

With that said, public health emergency preparedness and response can involve several significant ethical goals, such as protecting health, respecting human rights, and promoting social justice (Jennings 2008, 42). While there is no doubt that these varied goals have a role in the preparation and response to public health emergencies, it is not clear whether one goal takes precedence over others.

If we look to pandemic preparedness and response (such as for a novel strain of influenza), it appears that public health's utilitarian roots become predominant. Kotalik suggests that it is broadly utilitarian, because the goal of national pandemic plans is most often to minimize overall morbidity and mortality from influenza, and because, under such a system, individual rights are contingent upon social arrangements that maximize social utility (2006, 18).

Dominant utilitarian approaches in public health emergency preparedness and response exist for other infectious diseases as well. In describing a smallpox outbreak in New York in 1947, Marc Lappe concludes that vaccination was majorly beneficial, even though some deaths occurred due to its side effects (1986, 1189). Basing vaccination programs on such a model, even though it is not unique to public health emergencies, enables the dominant utilitarian nature of public health emergency preparedness and response to come the fore.

Further, in its pandemic plan, the Federal Department of Health and Human Services in the United States claims that authorities will be guided by epidemiological data in implementing isolation and quarantine measures, pointing to the consequentialist nature of the pandemic plan (Thomas et al. 2007, S29).

Preparation and response in pandemic plans are often consequentialist in their approach. Due to scarcity, perceived need is evaluated and triage is considered in order to determine who ought to be treated or given preventative care. As Kotalik suggests, the usual clinical way to evaluate perceived need is to consider the consequences of what would happen if the need is not met. He states that, “[i]f evaluation of possible consequences of not being supplied with the intervention that is being rationed is required in order to determine the person’s need than [sic] again the need principle is consequentialist and utilitarian” (2006, 20). He goes on to claim that “[t]he closeness of maximizing principles and needs principles will be even more obvious if we postulate that rationings decisions could consider not just individuals but can be made for groups or communities on the basis of aggregate needs of those groups or communities” (ibid.). Thus, it appears quite clear that in pandemic situations, public health measures are largely based on need and the maximization of benefits, which is in accordance with utilitarianism.

Triage and Priority Setting

It seems that a contextual inevitability of public health emergencies and disasters is the scarcity of resources. As such, steps must be taken to set priorities for the allocation of resources and to determine who ought to receive treatment or aid. According to Kotalik, many bioethicists believe that, while rationing is inevitable in any publicly funded system, it is considered “natural” and perhaps even the best possible process to augment available resources during a public health emergency, such as an infectious disease pandemic (2006, 41). Thus, some perceive the very nature of public health emergencies to be unable to realize (strict) egalitarian ideals, as scarcity and rationing is inevitable. Indeed, logistical challenges have been found to exist in order to ensure equality in resource allocation. During Hurricane Katrina, even though supplies were delivered to affected areas, it was found that there was no effective way to allocate them in an equitable manner, especially amongst those with disabilities or chronic medical problems (Ringel et al. 2007, iv).

It is not surprising that medical triage is a widely endorsed approach used in responding to medical emergencies (Rhodes 2005, 17). Indeed, Charlesworth argues that, at a time when utilitarianism has been heavily criticized, it has become “the darling of the health-care resource allocation experts” (1993, 112). Perhaps because there is a strong intuition that nonmedical factors should not come into play when making decisions regarding medical emergency response (ibid., 19), triage is a predominantly utilitarian endeavour that focuses on medical outcomes, where decisions that promote the best outcomes are favoured. Childress (2004) claims that informal and formal systems of triage are implicitly or explicitly utilitarian, as they are designed to produce the greatest good for the greatest number under conditions of scarcity. Social utility is also predominant in public health emergencies, where vaccines, antivirals, and other preventive and responsive treatments are made available for those that may provide an important social function during the emergency response (Kotalik 2006, 19).

Perhaps one of the most explicit distinctions between the moral justifications for public health and public health emergency preparedness response is found in the articulation of triage criteria for an intensive care unit during an influenza pandemic (Christian et al. 2006). This document states that the triage protocol developed is a “tool aimed at maximizing benefits for the largest number of patients presenting to an overwhelmed critical care system” (ibid., 1380). The authors go on to suggest that,

Under normal circumstances, all patients should have an equal claim to receive the health care they need. Unfortunately, during a pandemic it will not be possible for all patients to receive intensive care due to finite resources. A triage protocol will assist in distributing the available resources fairly by triaging patients who will not benefit from treatment to noncritical care management, thereby conserving critical care resources for patients who are more likely to benefit. Although it may be unfortunate that some patients do not receive all that they could possibly “use,” this does not by default make it unfair. Any restrictions placed on treatment must, however, adhere to the value of proportionality, which requires that restrictions to individual liberties not exceed what is necessary to address the essential needs of the community. (Ibid.)

Thus, an explicit rationale to diverge from egalitarian (or other) measures to clearly utilitarian measures demonstrates the unique moral foundations that can justify public health measures during emergency situations. It is important to note that, in addition to pandemic situations, emergency triage protocols of this nature exist in other areas of disaster response, such as chemical, nuclear, and other biological circumstances (ibid., 1378). As public health emergency response often involves medical professionals who are trained to ignore social and economic factors in treating individuals, it may not be surprising that the broader, public health, social justice concept of providing everyone fair equality of opportunity is disregarded (Rhodes 2005, 18).

Social Justice and Public Health Emergency Preparedness and Response

From what is understood of the moral foundations of public health and the commitment to health equity, social justice, and the social determinants of health, an important question to ask is whether public health emergency preparedness and response creates or exacerbates existing health inequities—something that reflects the antithesis of a social justice approach to public health.

Gostin and Powers (2006) note that in the United States there is a focus in emergency preparedness and response on key personnel and sectors such as government, researchers, the pharmaceutical industry, health care professionals, and essential workers or first responders. This focus, they claim, masks injustice by favouring individuals with “high-status employment” when distributing live-saving technologies and treatments (1069). They argue that this type of planning leaves out unemployed individuals or those with “nonessential” jobs, which they view as a proxy for those who are devalued in society.

In the same vein, Naomi Zack states that the “consequences to human well-being are primary factors in deciding what to do in disasters” (2006, 7), and that “it seems to go without saying that in disaster preparation, prevention, and response, the goal is to maximize human life” (ibid., 8). Zack explores the moral philosophical foundations of public health emergency preparedness and response from a liberal justice perspective. She suggests that, in preparing for and responding to emergencies, those who are already
worse off or systematically disadvantaged due to age, infirmity, poverty, or bias against them “ought not, as a result of disaster, be worse off relative to others than they were before” (ibid., 9). She gives the context surrounding Hurricane Katrina as an example, pointing out that “the compounded disadvantages of the black urban poor of New Orleans as a result of Hurricane Katrina, which months later left many jobless, homeless, and without hope of future community, when before they had some measure of all those things, would not be acceptable” (ibid.). As we know the debilitating lasting impact of Katrina on the poor (Wilgoren 2005), it is clear that the preparation and response efforts to the hurricane were unjust from such a justification of public health.

Moreover, Zack suggests that those affected by disasters who are less well-off would require greater per capita compensation than others (2006, 9). This is similar to the social justice approach of Powers and Faden and their argument that those with insufficient levels of health (or other dimensions of well-being) ought to be prioritized. This, Zack argues, could also be justified by Rousseau’s principle of the common good, where part of the function of the government is to further what is good for society as a whole, and not necessarily what produces the greatest well-being for the greatest number (Rousseau 1961; Zack 2006, 9).

A social justice approach to public health may suggest that a key task of public health is to identify which inequalities in health are the most egregious, and therefore determine which ought to be given highest priority in policy and practice (Faden and Shebaya 2010, 17). Powers and Faden contend that, when inequalities exist between socially privileged and socially disadvantaged groups, there is an even greater impetus to address such inequalities as they often occur with other disparities in well-being (2006, 87–92). They point to the extremely poor health and living conditions of those in the poorest populations in the world, and suggest that an obligation exists to address these gross inequalities. When disasters strike such regions, lack of infrastructure can exacerbate the impact that is felt by the poorest and most disadvantaged. Thus, in public health emergencies, it would follow that a public health justified by social justice would require institutions to address issues of infrastructure in order to adequately prepare for disasters. However, as was demonstrated during the response to Hurricane Katrina, considerations for “special needs” populations (e.g., the elderly, disabled, low-income populations, individuals with mental illness) were lacking and disorganized, and public health was shown to be generally ill-prepared to deal with these populations (Ringel 2007).

While many distinctions may lead some to suggest that the moral foundations ought to differ between quotidian public health and public health emergency preparedness and response, it is true in either domain that a disproportionate amount of damage or harm is experienced by vulnerable populations. Social determinants of health ought to play a significant role in both everyday public health and public health emergency preparedness and response. In public health emergencies, those who are systematically disadvantaged are more likely to suffer and sustain a long-term negative impact from disasters. Moreover, the burden of environmental risks is not shared across class lines, both in the developed and developing world. Just like in the public health system more broadly, the “worried wealthy” continue to receive more recourses in public health emergencies (Thomas et al. 2009, E18).

Faden and Shebaya point to the response to H5N1 avian influenza, which neglected considerations of social justice in its efforts (2010, 19). By culling tens of thousands of birds and banning household poultry, many families and women who relied on backyard poultry as their only source of income were devastated. They also note that the placement of hazardous waste facilities and industries in low-income communities and countries greatly affect already disadvantaged populations. Thus, by not considering the interests of disadvantaged people in preparing for or responding to potential disasters, benefits and burdens are not uniformly distributed and social justice is far from realized (ibid.). Moreover, because decisions made during a disaster can have great affects in the recovery process (Durham et al. 1993, 30), response efforts that do not address considerations of social justice can indeed exacerbate inequities and social disadvantage generally. As Beauchamp suggests, perhaps the egalitarian and social justice implications of public health are “still not widely recognized or conveniently ignored” (1976, 105) when it comes to public health emergency preparedness and response.
It is important to remember this insight offered by Nixon and colleagues, which may be extended beyond pandemics to any public health emergency:

Global pandemics, however, are not simply the result of diseases that have spread evenly around the world. Rather, in many cases they are the result of global inequities in wealth and power that have created the conditions in which poverty and disease can flourish. Thus, it is relevant to consider not only the kinds of public health issues that affect developed societies, but also the burden of illness and death that disproportionately affects the poorest parts of the world, and important moral questions about how it came to be this way. (Nixon et al. 2006, 45)

This observation suggests that we ought to be critical of our strongly utilitarian approach to public health emergency preparedness and response, and consider the values of health equity and social justice, which seem to be quite influential in quotidian public health.

A key question to explore is the ethical differences between public health prevention and public health preparedness/response, as this could account for key differences in the moral approaches of preventative quotidian public health and public health emergency response. In *Ethics for Disaster*, Zack suggests that the ethical difference between response and prevention is that the former values saving the greatest number of people, and the later values saving all who can be saved. She claims that saving the greatest number is the operating principle behind many current disaster response plans in the United States, which is clearly utilitarian. She points out that saving the greatest number is limited morally as it is contingent on context; if a disaster is properly planned for and emergency response efforts are adequate, then everyone who can be saved will be saved, especially if the disaster is completely prevented. If the disaster is not prevented, and response efforts are not adequate, then likely a “saving the greatest number” scenario will exist. Thus, the author concludes, while saving the greatest number can be fulfilled in an immediate situation, losses that could have been prevented will also exist. The approach of saving the greatest number is a limited approach, as it is a relative, utilitarian principle (2009, 22). Responsive actions in general, then, may be inherently utilitarian as it is difficult, if not impossible, to address social determinants of health in the pursuit of health equity and social justice when the damage has already occurred as a result of unjust social arrangements or institutions.

Finally, as Kotalik points out, a reliance on estimating consequences in a pandemic situation may lead to mistakes, as the context and perils of pandemics can often be novel and uncertain (2006, 18). During SARS, for instance, many important epidemiological features were unavailable or unknown (Nixon et al. 2006, 51), making the quantification of consequences difficult or even impossible. Thus, one must question the utilitarian approach to disaster response, as the context in which disasters and emergencies occur often involve little empirical foresight from which potential benefits and burdens can be balanced.

**CONCLUSION**

The distinction between the moral foundations of public health and those of public health emergency preparedness and response provided above are oversimplified. Many ethical, social, and political theories, principles, and values influence both domains. However, it is clear that relevant and significant differences may exist between each domain, and this raises interesting and important moral questions.

While everyday public health and public health emergency preparedness and response are similarly influenced by the social determinants of health, consequentialist ethical theories such as utilitarianism and deontological approaches such as egalitarianism, it seems that public health emergency preparedness and response is predominantly utilitarian. While public health increasingly values the promotion of health equity and responding to social inequalities in health, it seems that public health emergency preparedness and response has yet to fully embrace these considerations. Perhaps there are logistical or practical impediments to accommodating such values. While emergency response efforts no doubt strive to consider issues of social justice and health equity, it appears that several logistical challenges, contextual differences, and political and social traditions have made it difficult to fully instantiate these ideals.
Thus, there is a need for a more robust understanding of the values that exist in public health and public health emergency preparedness and response, and to understand why distinct moral foundations or justifications exist in each domain. For instance, temporal aspects might affect and explain the differences in approach. In public health emergencies, there is a tendency to be responsive rather than preventative, to think in the short-term rather than the long-term, and to have to make decisions in the midst of uncertainty due to the little time available for deliberating and gathering scientific data. Finally, there is no doubt that diverse political and social factors influence the approach that is supported in public health emergencies. A further understanding of why different public health programs or measures are justified using different rationale, theories, or principles will enable ethics frameworks to appropriately reflect the moral motivations and preferences for particular efforts.
References


