

JAY ZAMESKA

The Ethics of Public Health:  
Balancing the Interests of  
Populations and Individuals





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Balancing the Interests of Populations  
and Individuals



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## INTRODUCTION TO THE THESIS

This thesis consists of three articles which all address a few distinctive questions of public health ethics. In this frame text, I provide a broad overview of public health ethics, locate these articles within the field, and provide specific background context for each article. Public health ethics is often characterized by a conflict between individual-level and population-level interests. This conflict is the central theme of this thesis, which, through examining various characteristic problems in public health ethics, aims to develop viable solutions that respect the importance of both individuals and populations. Through the articles that make up this thesis, I argue for the compatibility of individual perspectives and interests with a robust public health agenda. I adopt a largely anti-aggregative approach that focuses on the importance of individual justification in order to justify various important public health interventions.

As Callahan and Jennings discuss in an influential early examination of public health ethics, the field faces a fundamental “tension produced by the predominant orientation in favor of civil liberties and individual autonomy that one finds in bioethics, as opposed to the utilitarian, paternalistic, and communitarian orientations that have marked the field of public health throughout its history.” (Callahan & Jennings, 2002, p. 170). This tension is the guiding theme of this thesis, which endeavors to reconcile the importance of individual perspectives and interests with a strong public health agenda. In broad terms, my thesis attempts to navigate this tension while addressing some distinctive central questions of public health ethics.

My aim in this thesis is to demonstrate that focusing on the perspectives and interests of individuals is both essential to and compatible with a strong and successful public health agenda. I contend that philosophical and ethical attention to the perspectives and interests of individuals offers a particularly attractive approach in public health ethics, as there is evidence indicating that individuals are more cooperative with public health policies and other collective decisions when they believe that such decisions are the result of fair processes which have taken account of their interests (Daniels & Sabin, 1997; Pinho et al., 2018; Tsuchiya et al., 2005). My focus on individuals in this thesis attempts to include these considerations when addressing some key problems of public health ethics. As a result, this dissertation aims to answer some distinctive and fundamental questions of public health ethics, with a particular focus on individual justification.

I want to make it clear from the beginning that although a focus on the moral importance of individuals is a recurring and central motif/theme of this thesis, this is not meant to be an uncritical application of a particular strand of liberal thought to public health ethics. Instead, I aim to focus on the importance of considering individual perspectives when justifying public health activities. In doing so, I aim to establish a balance between individual perspectives and the broader contextual factors that contribute to the ethical landscape of public health. Notably, striking such a balance does not necessarily work to undermine many of

the key activities or approaches of public health (e.g. employing coercion to encourage vaccination, screening large populations to prevent disease in a much smaller number, etc.), nor does it necessarily result in a framework that understands our obligations to others in a primarily voluntarist fashion.<sup>1</sup> Instead, it often maintains that we can justify public health interventions precisely by recognizing the role and importance of justification from individual perspectives. As such, in some ways, this thesis attempts to navigate the so-called “liberal challenge” to public health (see Holland, 2015, ch. 3–4; also Steel, 2022). This “challenge” is usually discussed as the idea that predominantly liberal and individualist approaches to ethics are incompatible with the demands of public health (Baylis et al., 2008; Callahan & Jennings, 2002). As Jennings (2007) notes, “[a] liberal framing of public health ethics is [...] ultimately too narrow to provide normative justification for—or adequate moral insight about—the kinds of social change public health must strive to bring about” (Jennings, 2007, p. 31). This challenge is frequently raised in discussions of the now prominent concept of “liberal stewardship,” first promoted by the Nuffield Council on Bioethics (2007) (see also Baldwin et al., 2009; Brownsword, 2013; Coggon, 2011), as well as in more general debates regarding the relationship between public health and (philosophical) liberalism (Rajczi, 2016). Such debates have increased in importance and visibility as a result of the Covid pandemic, which has rekindled questions about the relationship between liberalism and public health (Holm, 2021; Ismaili M’hamdi, 2021; Jayaram & Kates, 2021).

In this thesis, I have tried to chart a different course, one that takes both individuals and populations seriously as loci of moral concern for public health ethics. It is almost a truism of public health that populations are more than mere collections of individuals. However, from an ethical perspective, it must also be remembered that populations are *still* a collection of individuals, and those individuals matter morally. Rather than adopting either an unreflective aggregationist approach or an unreflective liberal individualist approach, this thesis attempts to navigate both. It aims to take both populations and individuals seriously in approaching some key questions and themes in public health ethics. In short, populations are collections of individuals, but they are not *merely* so. Part of my aim here is to show that recognizing this interplay between individuals and populations is the key to a successful, productive, and plausible approach to public health ethics.

Although this thesis is not exhaustive, in the sense that it does not cover the entirety of public health ethics, it is necessarily so: as discussed in the next section, the boundaries of the field are contested, and the exact scope of the field is currently impossible to determine. Public health ethics is a relatively new field

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<sup>1</sup> See e.g., Kenny et al. (2010) for the criticism that public health ethics is already too individualistic, and instead needs to focus on relational approaches to ethics. Similarly, see Bayer and Fairchild (2004) for an argument that the individualistic focus of bioethics makes it a poor starting point for a distinctive ethics of public health. Also see the discussion later in the paragraph regarding the “liberal challenge” to public health.

that still faces significant debates over which frameworks or approaches should be used (Dawson & Verweij, 2007; Venkatapuram, 2022). As a consequence, rather than attempting to take a systematic and theory-developmental approach, I have instead focused on addressing a few specific questions that pertain to some of the most important and distinctive elements of the field: how do we justify interventions with *ex post* population benefits but *ex ante* individual harms? Can we justify a preference for treatment over prevention? How do we justly balance the distribution of harms and benefits within populations? How should we address questions of uncertainty when individual perspectives and population perspective conflict? Do we have special obligations to those at particularly high risk? The primary questions I address in this thesis pertain to *prevention* and *distribution* of health-related risks and harms, particularly in situations of *uncertainty*, with an emphasis on *fairness*. In doing so, I pay particular attention to the importance and role of individuals within the populations that are the primary target of public health intervention.

This thesis consists of three articles: “An Uncertainty Argument for the Identified Victim Bias,” “‘Take the pill, it is only fair!’ Contributory Fairness as an Answer to Rose’s Prevention Paradox,” and “The Sufficientarian Alternative: A commentary on *Setting Health Care Priorities*.”<sup>2</sup> I will use the following abbreviated titles to refer to these articles in the rest of this introduction, “An Uncertainty Argument” “Take the pill” and “The Sufficientarian Alternative.” All of these articles are located within the burgeoning field of public health ethics. In this frame text I aim to explain what public health ethics is, and how the articles I’ve included in this thesis fit within this body of literature. I also aim to provide the necessary background information for understanding each of these articles in context. To that end, I do three things. First, I outline some of the major contours of the still nascent field of public health ethics. Second, I locate this thesis in the existing public health ethics literature. Third, I briefly outline some major points from the individual articles that comprise the majority of this thesis, provide the background necessary to place them in the context of on-going philosophical debates, and connect the articles to the general concerns of public health ethics.

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<sup>2</sup> Zameska (2022), Zameska (2021b), and Zameska (2021a), respectively.

# 1. WHAT IS PUBLIC HEALTH?

Public health ethics is a distinctive and rapidly developing area of applied ethics. The primary focus of the field is addressing the ethical challenges that accompany planning and implementing public health interventions, including implementing vaccination programs, surveilling and controlling infectious disease outbreaks, as well as measuring and reducing health disparities, among many other activities. In broad terms, public health ethics aims to address the complex ethical challenges that accompany public health interventions in order to develop effective and ethical strategies for ensuring the health and well-being of populations.

However public health ethics as a distinct field is a relatively recent development, and there is still considerable debate over how exactly it should be defined, and which, if any, framework should be adopted. As one overview of the field describes,

Several public health ethics frameworks have been introduced since the late 1990s, ranging from extensions of principle-based models to human rights and social justice perspectives to those based on political philosophy. None has coalesced as the framework of choice in the discipline of public health. (Lee, 2012, p. 85)<sup>3</sup>

In this section, I introduce and define public health (although the term itself is not without controversy) and then offer a brief and rough definition of public health ethics. My understanding of public health ethics is relatively broad, and includes a significant amount of work that may be more commonly categorized as “normative” rather than “applied” ethics. This is intentional: much of normative ethics has traditionally focused on similar concerns to bioethics, e.g. concerns with ethics in an interpersonal sense, or with the moral status of individual actions. However, similarly to how the applied ethical literature has shifted to include population concerns in line with the development of public health ethics, normative ethics more broadly has also embraced the need to think about ethics on the population level: ranging from the aptly named subfield of population ethics (Ryberg & Tännsjö, 2004), to broader questions about collective, rather than individual responsibility (Jamrozik & Selgelid, 2020), as well as addressing formal and theoretical questions about the normative status of population-derived statistical knowledge (Bnefsi, 2020; Daniels, 2012; Simons, 2012). My aim, in offering a brief and broad account of public health ethics, is not to exclude this growing body of literature, but rather to leave space for its inclusion. Next, I aim to define “public health” before turning to define “public health ethics.”

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<sup>3</sup> Wilson (2009) argues that due to the fundamental uncertainties of public health ethics, it is not possible to develop one single comprehensive and universal framework, and instead advocates for a multi-level approach employing different frameworks (Wilson, 2009). Regardless, many general principles and frameworks of public health ethics have been proposed: *inter alia*, Childress, et al. (2002), Coughlin, (2008), Holland, (2015), Jennings, (2003), Kass. (2004), Kenny et al., (2010), Lee, (2012), Nuffield Council on Bioethics, (2007), Selgelid, (2009), Upshur, (2002).

Particularly in the context of ethics, it is perhaps easiest and most effective to begin defining public health by distinguishing it from clinical medicine and medical ethics. Medical ethics is a well-established field with a long history, although as a formal academic discipline it is still a relatively recent phenomenon.<sup>4</sup> In contrast, public health ethics is a relatively new field, but one that draws significantly from the methods, concerns, and commitments of medical ethics. Although many lay people seem to have an intuitive understanding of public health, the definition of public health is thoroughly contested in the literature, and there are numerous competing definitions.<sup>5</sup> As such, I will not endorse a single substantial definition as correct, but instead simply aim to distinguish public health from clinical medicine, before turning to sketch out the difference between “broad” and “narrow” definitions of public health.

Whereas clinical medicine typically focuses on individual patients, public health typically targets *populations*. These populations may be defined in a variety of ways, and can range from the entire population for a given country, region, or continent, to significantly narrower subgroups within a larger population. Another important distinction is that the primary goal of clinical medicine is most commonly understood to be treating disease or injury.<sup>6</sup>

Public health, on the other hand, generally aims to maintain and improve the health of various target populations, especially through *prevention*, as well as to measure and explain the health of populations through epidemiological research (Steel, 2022).<sup>7</sup> This means that public health is a complex and multidisciplinary endeavor that must address the wide variety of influences on human health, including social, biological, environmental, psychological, and even economic influences (Holland, 2015).

Another key aspect that separates medicine from public health is the role of statistics in public health practice, something that also appears at multiple points in this thesis. As one overview of the field explains,

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<sup>4</sup> For an extensive overview of this history that pays particular attention to global perspectives, see Baker and McCullough (2008). For an overview that focuses on more contemporary developments, see Kuhse and Singer (2009).

<sup>5</sup> For a historical overview of defining “public health,” see Novick and Morrow (2008), for a philosophical overview see Verweij and Dawson (2007). For a book-length treatment of the meanings of the term “public health” and the various issues that accompany it, see Coggon (2012).

<sup>6</sup> It is worth noting, however, that there is significant debate over the “goals” of medicine within the philosophy of medicine. See e.g. Callahan (2002) for helpful discussions of this debate. My description of “treating disease” as the primary goal of medicine was chosen for purely pragmatic purposes, to help bring out some of the most relevant differences between public health and clinical medicine. In this thesis, I do not take a position on the goals of medicine.

<sup>7</sup> Steel (2022) offers a careful discussion of how both medicine and public health engage in both treatment and prevention, but that there are significant differences in the way these disciplines approach these practices. Specifically, see discussion on pp. 31–32.

the basis of public health is provided by empirical, quantifiable data acquired by epidemiologic research and population surveillance; although the ultimate goal of public health is to save real lives and help real people, its success is measured by statistical lives and rates of incidence of disease. (Holland, 2015, pp. 12–23)

As I will discuss later in this thesis, the fact that public health depends on population statistics requires us to adopt a different perspective and take a different approach than traditional ethics, particularly when considering how such statistical knowledge translates to expected benefits or harms for individuals (see sections 4.1.1 and 4.2.1).

So far, this contrast with clinical medicine has highlighted a few key factors in defining public health. Primarily, it has highlighted a focus on (1) populations; and (2) prevention; (3) the relevance of (population) statistics. There are more features that could be addressed, but these key themes distinguish public health from clinical medicine, and also feature prominently in this thesis. Although these key themes help to mark public health as a distinct field, simply enumerating them is not quite yet a definition. I will not give an in-depth account of the ongoing disputes over the proper domain of public health, however, I will still flag some distinctive standpoints in this debate, primarily by contrasting “narrow” and “broad” definitions of public health. As a starting point for a definition, I’ll begin with one classic and early discussion of the field, Winslow (1920), who defines public health as,

the science and art of preventing disease, prolonging life, and promoting physical health and efficiency through organized community efforts for the sanitation of the environment, the control of community infections, the education of the individual in principles of personal hygiene, the organization of medical and nursing services for the early diagnosis and preventive treatment of disease, and the development of the social machinery which will ensure to every individual in the community a standard of living adequate for the maintenance of health. (p. 183)

Although this seems to offer a functional definition of public health, it focuses too narrowly on specific practices and activities of public health. However, public health is a field that consistently changes in response to a wide variety of factors, including new diseases, lifestyle changes, economic development, technological development, and increasing medicalization. This means that “public health” is a contested term that requires consistent reappraisal and reassessment (Rothstein, 2002). “Old” or “narrow” views of public health, such as those defended by Rothstein (2002, 2009) and Epstein (2003, 2004), typically aim to delimit public health by developing definitions that focus on the state’s coercive abilities.<sup>8</sup>

In contrast, more recent definitions of public health have gone beyond such restrictive definitions and have instead directed their attention to the basic determinants and conditions of human health and well-being. This kind of “broad” or

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<sup>8</sup> Note that Coggon (2012) offers well-argued criticism of such restrictive views, and gives a charitable and succinct overview of both Epstein and Rothstein.

“new” approach is best described as focusing on the *social determinants of health* (SDH), which is defined by the World Health Organization as

the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems. (W.H.O., n.d.)

The public health turn to focusing on the SDH is captured by the Institute of Medicine’s well-known definition of public health as “what we, as a society, do collectively to assure the conditions for people to be healthy” (Institute of Medicine, 1988, p. 19). I believe it is particularly important to address the philosophical and ethical issues raised by public health approaches focusing on the social determinants of health, because, as Wikler and Brock note, “traditional philosophical work in theories of justice has addressed these social determinants without adequate recognition of their impact on health” (Wikler & Brock, 2008, p. 32). A key feature of both public health and public health ethics is a focus on exactly this gap present in traditional philosophical work on both health and justice.<sup>9</sup>

Although I do not intend to defend a particular substantive definition of public health, in this thesis, I generally adopt a “broad” understanding of public health for the purposes of defining public health ethics. However, I want to be clear that this is not the same as endorsing a broad definition of public health generally or for practical use. My interest in definitions of public health in this thesis is limited to their importance for defining public health ethics, rather than defining public health for practical, organizational, or legal purposes.

As noted earlier, broad definitions of public health incorporate significant attention to the social determinants of health (Goldberg, 2009). In this thesis, I adopt this broad perspective in part to address what Goldberg (2009) has named the “paradox of the ethics of health policy” namely that “what policies we ought to pursue may be pragmatically untenable, yet what is pragmatically tenable may fall short of what policies we ought to pursue.” (p. 70). Given that ethics is primarily a normative discipline, my focus here is on the ‘ought’ more than the ‘how.’<sup>10</sup> As such, I place my work in this thesis in the context of a broad understanding of public health, which allows both for the variation and change that comes with new technology and new foci, as well as allowing for a wider variety of ethical considerations than are typically found in narrow views. In short, although I will not attempt to define or defend a particular conception of public

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<sup>9</sup> I return to this briefly at the end of the next section (section 2) when I highlight how public health ethics is also helpful for clarifying and answering questions traditionally considered to be a part of political philosophy, particularly questions of justice.

<sup>10</sup> This is of course, not to suggest that the “how” is irrelevant, but that this broad view is more conducive to fully examine and analyze the philosophical problems embedded in public health.

health, I will assume a broad conception of public health, both to better include the unique ethical issues raised by public health, and to help distinguish public health ethics from bioethics or medical ethics more generally.

I will not address the debate over definitions of public health any further, but will note that there are persistent and serious disagreements in the literature over the exact scope and definition of public health which are unlikely to be settled soon (See Coggon, 2012; Coggon, 2022; Epstein, 2003; Epstein, 2004; Goldberg, 2009; Rothstein, 2002; Rothstein, 2009; Verweij & Dawson, 2007).<sup>11</sup> As a final note, in this section I have so far avoided the further question of what *health* actually is, and how and to what extent health matters morally, as well as the broader question of how we should value health. These are all very important themes relevant to public health, but for brevity's sake, I set them aside here.<sup>12</sup> None of these questions arise directly in the articles included in this thesis.

In the next section, I turn to discussing the relationship between public health ethics, bioethics, and political philosophy. I explain how public health ethics is a relatively new sub-field of bioethics that focuses on the ethics of public health practices and policies, including the distribution of health and healthcare, and the role of the state in promoting health. It has evolved from discussions in bioethics surrounding justice and priority setting, but has also incorporated elements of political philosophy. Towards the end of the section, I highlight the relationship between public health ethics and political philosophy, particularly when it comes to issues of coercion and the legitimacy of the state's role in promoting health.

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<sup>11</sup> The broad contours of this debate have been sketched out earlier in this section by noting the contrast between “broad” and “narrow” views. Establishing the exact scope and definition of public health, and consequently, public health ethics, is outside the scope of this thesis.

<sup>12</sup> These issues are discussed in my MA thesis, which addresses the ethical basis for certain approaches to valuing health. See Hausman (2015) for discussion of the philosophical and ethical aspects of valuing health. See Hofmann (2001, 2002, 2005, 2021) for discussion of the philosophical and ethical problems associated with defining health and disease.

## 2. PUBLIC HEALTH ETHICS, BIOETHICS, AND POLITICAL PHILOSOPHY

Ethics has traditionally been understood as primarily an interpersonal phenomenon. Both medical ethics and bioethics are no exception. Traditionally, they have concerned themselves primarily with questions of the clinic or the laboratory: how should doctors relate to their patients? Must physicians always be honest with patients? What is the ethical status of new technologies, e.g. uterus transplants, or brain organoids? When is it permissible to use pre-implantation genetic diagnosis? Is there a moral difference between treatment and enhancement? How should clinical equipoise be understood? And so on.<sup>13</sup> However, many of the most important improvements in human health have not actually occurred at the level of individual medical intervention. Instead, these changes have come from increased nutrition, various social changes, and the field of public health itself.<sup>14</sup> As such, it is a little strange that it has taken so long for public health ethics to develop as a specific and distinct field. In this section, I locate public health ethics within the broader field of bioethics and explain how public health ethics developed from discussions in bioethics focusing on justice and priority setting.

In general, public health ethics is often understood as a sub-field of bioethics and/or medical ethics, although it is a subfield that has only recently developed (Dawson & Verweij, 2007). Most sources do not offer exact dates, but Kass (2004) suggests that public health ethics as a distinct field formed around the year 2000 (Kass, 2004).<sup>15</sup> Despite its relative newness, it has become fairly well-established, both in public health practice and in philosophical ethics. As one recent introduction to the field describes, “the ethics of public health is a new and developing, but increasingly firmly established, feature on the landscape of medical ethics” (Holland, 2015, p. 16). Although public health ethics is still a young field that is somewhat less developed than medical ethics or bioethics, it has still been incorporated into mainstream public health education and training (Peckham & Hann, 2010, p. 3).

Historically, there has been a tendency in bioethics to focus on the ethics of new and emerging technology at the expense of engagement with questions of social and economic inequality, which are both primary focuses of public health (Callahan & Jennings, 2002, p. 169). Further, bioethics was strongly influenced both by medical professional’s codes of conduct and the patient rights movement,

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<sup>13</sup> These examples are meant to be purely illustrative, and are not an exhaustive list. A good starting point for an overview of many of the major questions, problems, and topics of bioethics can be found in Kuhse et al. (2016).

<sup>14</sup> See Goldberg (2017, pp. 8–13) for discussion.

<sup>15</sup> See Bayer and Fairchild (2004) for discussion of the beginning of public health ethics with a critical view of the individualism present in bioethics. Also see Coggon (2022) for some of the most recent and thorough discussion of the birth of public health ethics as a discipline.

both of which tend to obscure the ethical concerns that arise from a population perspective (Brock & Wikler, 2009, p. 34). Despite bioethics' traditional focus on the clinical encounter, particularly in light of the enormous influence of *The Principles of Biomedical Ethics* (Beauchamp & Childress, 2013), there has always been a subsection of bioethics that has brushed against some of the fundamental questions of public health ethics, namely discussions of distributive justice in health and healthcare. Much of the early work in bioethics that would come to characterize the concerns of public health ethics arises in the context of justice and priority setting in healthcare.<sup>16</sup>

Priority setting threads the line between traditional bioethics and public health ethics. It is not concerned strictly with the domain of public health as traditionally understood—that is, as organizations devoted to population-level health promotion and disease prevention—but it does touch upon many key themes, and perhaps most importantly, it frequently addresses the fundamental moral target of public health ethics: populations, rather than individuals. As work on justice began to focus on the distribution of the conditions of health, it increasingly began to grapple with questions now considered to be central to public health ethics.

Along these lines, Powers and Faden (2006) mark a significant turning point, by bringing together the concerns of justice from a bioethical perspective with the focus on the importance of social groups common to public health. In their own words, they aim to go “beyond issues of distributive justice, microallocational questions of priority setting in medical care, or any number of questions centered on how one individual fares relative to some other individual.” (Powers & Faden, 2006, p. ix) In doing so, they brought attention to the ethical and philosophical importance of the social conditions necessary for health. As such, their work represents an excellent example of early approaches that bridge the gap between bioethics and public health ethics.<sup>17</sup>

So far, I have focused on the relationship between public health ethics and bioethics, but there is also a significant relationship between public health ethics and political philosophy. One important characteristic of public health is that its activities are typically state-directed, and public health agencies are often permitted to wield significant coercive power to meet their ends. As such, public health ethics fundamentally also involves significant elements of political philosophy. The basic elements of *public* health ethics—that of the public as both the object of attention, and the mode of delivery—are essential components of political philosophy, with its focus on how we organize our collective lives (Dawson, 2009; also Verweij & Dawson, 2007). Public health ethics has largely evolved

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<sup>16</sup> See Dawson and Verweij (2007) for an overview of early work on public health issues in the context of bioethics. See also the introduction of Anand et al. (2004) for a similar overview of the emergence of public health ethics from bioethics, but with a specific focus on work addressing (in)equality. Finally, note Kass (2004), who proposes that public health ethics arose largely due to philosophical attempts to answer questions about HIV/AIDS and resource allocation.

<sup>17</sup> See also Bayer and Fairchild (2004) for a critical examination of the bioethical origins of public health ethics.

out of bioethics, but given its broader concerns, it has incorporated a significant amount of what is typically categorized as political philosophy (Wikler & Brock, 2008). This relationship to political philosophy shows up in, for example, public health ethics discussions over the legitimacy of the state (or other non-state actors) to implement various measures that promote health or prevent disease. This is particularly important when such measures involve coercion or when such measures encounter significant public disagreement (Dawson & Verweij, 2007, p. 2). This leads to familiar debates in political philosophy, ranging from general concerns about paternalism (Dworkin, 2020), which feature in both bioethics and political philosophy, to more specific concerns about particular theories or approaches in political philosophy, such as the role and status of Millian liberalism in public health (Herington et al., 2014; Powers et al., 2012), as well as broader discussions about the relationship between individuals and the state (Nuffield Council on Bioethics, 2007, Ch. 2 gives an overview of this discussion in the context of public health). There are a variety of other key questions that overlap both public health ethics and political philosophy, including the role of solidarity (Dawson & Jennings, 2012), the status of global public health (O'Neill, 2002), the role of personal responsibility in justice (Albertsen, 2020), and the nature of (health) justice (Venkatapuram, 2011), among others.

I will not address these other overlapping areas any further here. Although I have primarily focused on the impact political philosophy has had on the development of public health ethics as a distinct field, it is important to note that this is a complementary relationship, and public health ethics has in turn helped to develop key areas of political philosophy. As Sen (2002) points out, philosophical work in public health is also important to elucidating key concepts in political philosophy, most prominently, justice and equity. In Sen's terms, "there are some special considerations related to health that need to come forcefully into the assessment of overall justice.[...] the idea of health equity motivates certain questions and some specific perspectives, which enrich the more abstract notion of equity in general." (Sen 2002, p. 663 as cited in Segall, 2010, pp. 95–96).<sup>18</sup>

I will not spend further time addressing the relationship between public health ethics and other similar (sub)fields, but it is worth noting that many of the concerns of public health ethics have been picked up and addressed in other areas of applied philosophy. Philosophy of medicine, as well as philosophy of science more generally, for example, have engaged extensively with questions of

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<sup>18</sup> I have quoted Sen (2002) here, but Nussbaum's understanding of the capabilities approach is closely related, and also relevant (2000). See Robeyns (2005) for a general survey of the capabilities approach that also examines the similarities and differences between Sen and Nussbaum. Nussbaum's approach also represents an important area of cross-development between public health ethics and theorizing about justice more generally. See Nussbaum (2000) for her version of the capabilities approach, and see Venkatapuram (2011) for a comprehensive application of the capabilities approach to the development of a theory of health justice.

screening and overdiagnosis, which are fundamentally public health concerns.<sup>19</sup> Similarly, work between the ethics of AI and public health is just starting, but is likely to develop into an important subfield of its own (see e.g., W.H.O., 2021).

Although there has been steady work in public health ethics for decades, it has only recently started to engage with, and be engaged by, mainstream bioethics and philosophical ethics. Previously, public health ethics had been the domain of epidemiologists and public health professionals, rather than philosophers and ethicists. This has led one prominent scholar in public health ethics to describe it as “One of the best-kept secrets on the [...] intellectual scene” (Weed, 2004, p. 313). Although this relative obscurity represents an excellent opportunity for philosophical exploration, this lack of integration with mainstream ethics and philosophy has also contributed to the ongoing debate and disagreement over the boundaries of the field of public health ethics. As such, much of the field remains in dispute. In part due to this extensive disagreement, I have chosen to structure this thesis thematically, rather than focusing on developing a comprehensive framework for public health ethics. In the next section, I outline some of the central themes of public health ethics that this thesis addresses: *Prevention*, *Populations*, and *Risk and Risk reduction*.

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<sup>19</sup> See, *inter alia*, Hofmann (2014, 2016, 2017) for careful philosophical discussion of overdiagnosis.

### 3. KEY THEMES OF PUBLIC HEALTH ETHICS

This thesis addresses three prominent and distinctive elements of public health ethics as a field: its focus on *prevention*, *populations* (with an emphasis on balancing individual and population perspectives), and *risk reduction*. All of these themes will be addressed more in depth in section 4, where I give an overview of the articles in this thesis, as well as provide background information for each article. In the remainder of this section, I provide a brief overview and introduction of each of these key themes.

#### 3.1 Prevention

One key difference between public health and clinical medicine is that public health focuses on *prevention*.<sup>20</sup> This may seem obvious, but it is normatively very significant. Prevention is typically driven by public health or other medical authorities, rather than patients themselves. This is in sharp contrast to clinical medicine, where patients usually take the initiative to seek out medical interventions (Dawson & Verweij, 2007, p. 2). Not only does this mark a significant difference between the two fields, but it also raises special moral concerns. Particularly, issues related to paternalism and coercion are especially important in this context. This is not to downplay their importance in clinical medicine or medical ethics. However, the fact that preventive interventions are not typically sought out by individuals, but imposed with varying levels of coercion by health authorities, creates particular moral problems and concerns. Some of the most prominent of these stem from the fact that such preventive interventions are often targeted at ‘healthy’ people.<sup>21</sup> As such, particular ethical and philosophical attention must be given to issues relevant to the unique questions and features of prevention.

The *ethics of prevention* is a thread that runs through all of the articles in this thesis. Both “Take the pill” and “An Uncertainty Argument” directly engage with questions of how to justify preventive interventions, as well as to what extent we may permissibly prioritize such interventions compared to treatment. In doing so, both articles directly grapple with one of the key underlying questions of my research, which involves determining what we should do when population and individual perspectives conflict in the context of preventive interventions. In

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<sup>20</sup> Again, see Steel (2022) for discussion of how prevention is common to both medicine and public health, but with significant differences between the two.

<sup>21</sup> As noted earlier, I will not address the question of how exactly we define “health” and “disease” in this thesis. An accessible introduction to the debate over defining health and disease can be found in Stegenga (2018). See also the work of Hofmann noted in footnote 12. Additionally, consideration of defining health and disease specifically in the context of public health can be found in Smart (2022). The point here is merely that such interventions are typically targeted at people who have not typically sought out medical advice on the basis of symptoms or other indications of illness.

many cases, preventive interventions yield large population-level benefits, but seem to be harmful when viewed from individual perspectives (this problem is discussed in more detail in section 4.2.1, as well as in the articles themselves).

It's worth noting that, at first glance, these two articles may seem to be in tension with one another. In "Take the pill" I argue for a focus on prevention, even in the absence of individual expected benefit. That is, in cases where there are sufficiently large population benefits, I argue that sometimes we may have an obligation to participate in preventive interventions, even if it is not in any specific *ex ante* individual's interest to do so. In contrast, in "An Uncertainty Argument," I argue *against* prioritizing prevention over individual treatment, by arguing that in some conditions of uncertainty, individual rescue (i.e. treatment) is entailed by *ex ante* contractualism. However, these articles do not actually conflict in the way it may first appear.

In both articles, my focus is on moving away from a direct focus on harm (and benefit) to other concerns, most notably, fairness. In both articles, the focus on justifying intervention—whether as treatment or as prevention—stems from particular understandings of our obligations to others as distinct individuals. In "Take the pill" I argue that the obligations of fairness which require us to contribute to public goods also entail that we should engage in certain types of preventive intervention. In this specific case, the preventive intervention is taking a daily "polypill" to reduce the risk of cardiovascular disease, which will ultimately prevent a significant number of deaths. In "An Uncertainty Argument" I focus on an *ex ante* contractualist framework, the centerpiece of which is the idea of *justifiability to others*. In some specific cases of uncertainty, this justifiability requires prioritizing individual intervention rather than prevention. Although not as directly related, in "The Sufficiency Alternative," I take a similar approach, ultimately defending a form of sufficientarianism that prioritizes bringing people above the "threshold" over aggregated smaller benefits, such as risk reduction.

### 3.2 Populations

As noted earlier, a key defining feature of public health is its focus on populations. Some have gone as far as to argue that a focus on populations is the key defining feature of public health. For example, Holland (2015) claims that "although public health is hard to define, its distinctive characteristic is its population perspective" (p. 12). Consequently, a focus on the ethics of populations is also a key theme of the articles in this thesis.<sup>22</sup>

Similar to the discussion in the previous section on prevention, this focus on populations often creates a tension between individual and population perspectives. As one prominent overview describes,

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<sup>22</sup> See Eyal (2008) for discussion and criticism of the view that "population health ethics" can be defined as simply the ethical issues that arise at the population level.

[public health] interventions aim to protect and promote health at a group or population level. Successful programmes will aim to effectively reduce morbidity and mortality rates within a population at a reasonable cost (in terms of any expenditure and negative side-effects). Yet even though the benefits visible at the population level might easily outweigh the costs and possible harms, it may be perfectly reasonable for individuals to make a different evaluation of the costs and benefits for themselves as individuals. Some participants might see only potential inconveniences and burdens, and they might be uncertain as to whether the programme will be beneficial for them as individuals. (Holland, 2015, p. 16)

Since I have already briefly introduced this tension between individual and population perspectives in the previous section on prevention (and because it will be addressed again in 4.2.1), I will not cover it again here. Instead, I will focus on a couple other key features that relate to addressing ethical questions in a population context.

First is a concern with the moral status of *interpersonal aggregation*. Although the original utilitarian basis of public health takes a rather uncritical view of interpersonal aggregation, many post-Rawlsian theorists raise considerable concerns about aggregation's ability to impose great burdens on the few in order to benefit the many.<sup>23</sup> Concerns about aggregation run in the background of all of the articles included in this section, and raise prominent issues in public health ethics specifically, as well as both normative and applied ethics more generally.

In "Take the pill" although the aggregate benefits of the polypill are clear, I argue that we should not justify interventions on the grounds of aggregate benefits, but instead focus on the demands of fairness. In "An Uncertainty Argument," interpersonal aggregation is explicitly forbidden by the *ex ante* contractualist framework I adopt. This ban on interpersonal aggregation is the target of both significant praise and criticism of the theory (Ashford, 2003; Ashford & Mulgan, 2018; Fried, 2012; Kumar, 2011; Suikkanen, 2004). Contractualism's eschewal of interpersonal aggregation is discussed in more detail below, in section 4.1.1. Finally, "The Sufficiency Alternative" also attempts to place significant limitations on the role interpersonal aggregation may play in priority setting, instead arguing for the importance of threshold-crossing individual benefits.

Second, and closely related to interpersonal aggregation, is the status of individuals in populations more generally. This thesis has a particular concern for the individual in the realm of public health ethics. Although public health ethics, as noted, focuses primarily on populations, throughout this thesis I have repeatedly drawn attention to the intersection between populations and individuals, and the

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<sup>23</sup> See Hirose (2015) for a clear, careful, and accessible overview of the discussion of the moral status of interpersonal aggregation.

ethical tensions that arise when we attempt to adequately take account of the interests of both.<sup>24</sup>

Perhaps because of the historical influence of utilitarianism on public health, or perhaps because of the ease of translating the statistical and quantitative basis of public health into consequentialist terms, public health ethics has always had a strongly consequentialist bent, one which often neglects the importance of individuals.<sup>25</sup> As Venkatapuram (2022) explains,

Part of the diffidence in public health education and practice to engaging robustly with ethics may be explained by the strong hold that consequentialist and utilitarian reasoning has in public health. To some within public health, non-consequentialist/non-maximizing ethical approaches to issues can seem irrational, illogical, unscientific, and even unethical for not maximizing health outcomes. (p. 79)

However, in this thesis I have attempted to take account of the importance of individual justification in our thinking about public health ethics. Throughout all of these articles, there is a focus on establishing an important role for individuals in population thinking, with the aim to take both populations and individuals seriously in public health ethics.<sup>26</sup>

As Parmet (2009) notes in her analysis of public health law, “population-based legal analysis must appreciate the importance of populations without overlooking the dignity and interests of individuals” (p. 3). Although Parmet is discussing the need to balance individuals and populations in the context of U.S. public health law, her point applies equally well to the ethics of public health. Particularly in light of public health’s utilitarian origins, there must always be an appropriate balance between the concerns of individuals and the concerns of populations. This in part motivates my focus on contractualism, primarily T.M. Scanlon’s contractualism, which is discussed in more detail in sections 4.1.2 and 4.1.3. Contractualism of this variety is a particularly useful tool for investigating the ethics of public health because it places a focus on individuals in a way that raises critical questions about many widely-accepted assumptions in public health, e.g. that aggregation of benefits across or within populations is always (or at least *prima facie*) morally acceptable. One of the aims of the articles in this thesis is to reconcile the necessary focus on aggregate population benefits with treating

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<sup>24</sup> This is not meant to imply any particular ontological status to populations. I am not arguing for the claim that populations *qua* distinct and discrete entities (1) exist; and (2) are capable of having interests.

<sup>25</sup> Here, I understand utilitarianism broadly as a welfarist distribution-insensitive form of maximizing consequentialism. Utilitarianism will be discussed in more detail in Section 4.3

<sup>26</sup> This should not be interpreted as a defense of *methodological individualism* nor *explanatory individualism* in public health. It is a claim about public health ethics, not about the methodology of public health. See Goldberg (2012) for discussion of methodological individualism in public health, and Venkatapuram (2011, Ch. 2) for discussion of explanatory individualism in public health.

individuals in ways that are justifiable to them as rational and morally-motivated agents. This aim is a central running theme that links all three articles in this thesis.

### 3.3 Risk and Risk-reduction

Much of the work of public health is characterized by a focus on risk management, particularly risk reduction. This is often a part of the field's focus on prevention, but also arises when engaging with questions of how to translate statistical knowledge about populations into individual terms (Callahan & Jennings, 2002, p. 171). Controversy arises over how to properly define risk in an appropriate way, as well as what decision rules should be applied to manage risk.<sup>27</sup>

Many standard public health practices are, at their core, about risk reduction. Screening, various kinds of testing, and even a focus on reducing the harm from disasters all fall under the umbrella of public health agencies' attempts to effectively reduce risk. As John (2011a) explains,

A wide range of public health activities – such as health and safety legislation, food standards monitoring and the emerging field of public health genomics – are explicitly framed in terms of risk-reduction and risk-management. Furthermore, we can use the concept of 'risk' to understand public health policies that are not normally framed in these terms. For example, draining a malarial swamp can be understood as eliminating health-risks, as can a policy of compulsory vaccination. The control, minimization or elimination of health-risks can, then, be seen as the shared concern of the heterogeneous activities that comprise public health policy. (p. 67)

The term risk, however, is the source of significant disagreement, with a variety of meanings common to the literature (See Hansson (2004) for discussion of the most common meanings of risk). In this thesis, unless otherwise specified, by risk I mean the *probability of a negative outcome occurring*.<sup>28</sup> There are a wide variety of philosophical and ethical issues associated with risk (See e.g., Hansson, 2013; Lewens, 2007), but in this thesis I focus largely on ethical questions relating to *social risk imposition* in the context of public health. In this thesis, I understand

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<sup>27</sup> This concern extends beyond public health ethics, and is particularly prominent in discussions of the ethics of climate change, as well as environmental ethics and public policy ethics more generally. See Steel (2015) for a book-length philosophical treatment of the precautionary principle.

<sup>28</sup> See Ferretti (2010) for discussion of this understanding in the context of risk in distributive justice, and Hansson (2004) for discussion of this definition in comparison with other common understandings. Note that this definition should also be understood to mark off *risk* from *uncertainty*, with instances of uncertainty understood as lacking the specific assigned probabilities associated with risks.

social risk imposition broadly, as risks generated by socially valuable activities.<sup>29</sup> I take most public health activities to fall within this spectrum. Despite the fact that the risks are connected to the production of socially valuable activities, there are still serious questions about when, why, and how it is permissible to create and impose such risks. Typically, the most popular approaches to addressing such questions have been various consequentialist frameworks, including forms of utilitarianism (Prah Ruger, 2010; Venkatapuram, 2022), cost-benefit analysis (CBA) and cost-effectiveness analysis (CEA) (John & Curran, 2021; Neumann, 2005), and social welfare functions (Adler, 2019). Some have also argued that even if clinical medicine may be governed by deontological or principle-based approaches, public health policy must be consequentialist due to its central focus on populations, rather than individuals (See discussion in Venkatapuram, 2022; also see Goodin, 1995). Further, as Prah Ruger (2010) notes, utilitarianism “arguably serves as the standard framework for health policy analysis” (p. 19), and as such, has had the most significant impact in this area. Although consequentialist approaches are ostensibly the most prominent and influential, a number of principle-based approaches have also been developed to offer guidance in the context of public health policy (see e.g., John, 2011b; Lee, 2012; Weed, 2004 for discussion).

However, recently *contractualism* has become an increasingly popular approach for examining questions in public health ethics.<sup>30</sup> In line with this recent work, the primary framework I use to address social risk imposition is a contractualist framework, which will be further discussed in sections 4.1.1 and 4.1.2. There is a significant body of contractualist literature attempting to navigate the difficulties of social risk imposition, and this literature plays a major role in this thesis.<sup>31</sup> Although contractualist approaches to risk and uncertainty are relatively recent, the literature around contractualism and risk has grown quickly. Much of the contractualist literature in this area focuses on determining when risk impositions are morally permissible (Ashford, 2003; Frick, 2015; Fried, 2012; Holm, 2018; Lenman, 2008). Along similar lines, the literature examining how contractualism functions in conditions of uncertainty is also quickly expanding (Frick, 2013; Fried, 2012; Ruger, 2018; Zameska, 2022; Żuradzki, 2015; Żuradzki, 2019). “An Uncertainty Argument” contributes to this specific area of the contractualist

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<sup>29</sup> However, see Frick (2015) pp. 178–179 for discussion of more specific features for defining social risk imposition.

<sup>30</sup> “Contractualism” can be understood broadly, as either describing a theory about the legitimacy of political authority, or as a theory about the legitimacy of moral rules. In both cases, the central idea is that the idea of contract or mutual agreement underwrites political or moral legitimacy. It may also be understood more narrowly to refer to a particular moral theory developed primarily by T.M. Scanlon. This thesis focuses on the narrow understanding. See sections 4.1.2. and 4.1.3 for a more detailed definition of contractualism in the narrow sense used in this thesis.

<sup>31</sup> Some important touchstones for contractualist discussions of social risk imposition are Reibetanz (1998), Ashford (2003), Lenman (2008), Fried (2012), Frick (2015), Kumar (2015), Holm (2018), and Suikkanen (2019).

literature addressing uncertainty. In the articles that make up this thesis, I have primarily focused on questions of risk distribution and the justification for various distributions.

A major question in public health ethics, and one that features prominently in both “Take the Pill” and “An Uncertainty Argument” is that of what level of risk is socially acceptable, and how risk reduction must be weighed against other important goals. Further, the question of how to distribute health-risks within a given population plays a major role in much of the ethics of public health. A key part of this question is whether we should focus our preventive interventions on those deemed to be “high risk” or whether we should target the population as a whole (John, 2014; John, 2011b; Thompson, 2018; Verweij & Dawson, 2012), which will be discussed further in section 4.2.1. This question is addressed specifically and directly in “Take the pill” and indirectly in “An Uncertainty Argument” and “The Sufficentarian Alternative.”

### **3.4 Summary of the key themes in this thesis**

In this section, I have explained three central and interrelated themes in public health ethics that unite all of the articles in this thesis. These are (1) a focus on prevention, (2) addressing the ethics of populations, particularly when navigating conflicting individual and population perspectives, and (3) the ethics of risk reduction. Each of these themes will also be addressed in the next section, which provides an overview of the articles in this thesis, as well as relevant background discussion that helps to locate these articles within the broader literature of public health ethics.

## 4. INDIVIDUAL ARTICLES IN THIS THESIS

The articles that comprise this thesis all broadly fall within the realm of public health ethics, and in the previous section, I identified some important general themes or foci that connect them. Despite having a common theme of public health ethics, the articles draw on different philosophical subfields, making it challenging to give a comprehensive and complete overview of all relevant background information. Instead, in what follows I will offer more specific relevant background for each of the articles individually, followed by a brief summary of the article. The aim of this approach is to enable the reader to better understand the unique contributions of each article to the field of public health ethics by placing each article in the context of current philosophical debates. In all, these articles are linked by the common themes described in section 3 of the thesis, but also by a more general aim of reconciling conflicting individual and population perspectives.

### 4.1 “An Uncertainty Argument” Section Introduction

In this section I introduce the concept of “identified” and “statistical” lives and introduce the philosophical discussion over whether we should ascribe priority to identified lives. I start by defining these terms and summarizing the philosophical discussion on whether we should prioritize identified lives over statistical lives, highlighting how most philosophers endorse understanding these two ‘kinds’ of lives as equal. I then turn to introducing contractualism, a prominent contemporary non-consequentialist moral theory, with a particular focus on Scanlonian contractualism. Then, I describe a major split in contemporary contractualist theory: *ex ante* vs. *ex post* contractualism. I provide an overview of the key differences between *ex ante* and *ex post* contractualism. Finally, I offer a brief summary of the article, which argues that in some situations of uncertainty, *ex ante* contractualism gives us a reason to prioritize identified over statistical lives.

#### 4.1.1 Identified and Statistical Lives

The “identified lives bias” or “identified victim bias” is a durable tendency for human beings to prioritize “identified” lives over merely “statistical” lives. For example, charity advertisements that focus on a specific named child in need are more effective than statistics about large numbers of people in need (Jenni & Loewenstein, 1997). Although it is described as a “bias” it need not always be understood in a pejorative sense (Cohen et al., 2015). Initially discussed by Schelling (1968), this bias has been the subject of increasing scholarly attention. As a result, the effect identified individuals have on our moral psychology is well-documented and defined by social scientists and psychologists. However, it is

less commonly discussed by philosophers.<sup>32</sup> Although the existence of the basis is not in dispute, its normative status remains controversial. We may naturally exhibit this bias, but that does not answer the question of whether we are justified to express this bias in our public policy. This question is especially relevant from a public health ethics perspective, as it cuts to the core of much of the defining concerns of the field: how do we balance harms and benefits to populations and to individuals? And further, how should we prioritize between prevention and treatment?

Medicine has traditionally favored the individual: physicians routinely carry out expensive “heroic” medicine procedures for people who are unlikely to live much longer, even though spending this money on preventive care would likely be significantly more cost effective (Cohen et al., 2015).<sup>33</sup> In contrast, public health has typically assumed that we should focus on prevention, and many—if not most—public health interventions take this form (e.g. mass vaccination, controlling water quality, encouraging physical exercise, workplace safety legislation, etc.). The question is more than a tension between the approaches and priorities of two disciplines. It is a genuine ethical question: do we have an ethical reason to prioritize identified individuals over statistical individuals?

On this question, philosophers and ethicists are divided, although there seems to be somewhat greater support for the idea that we should hold statistical and identifiable lives to be on a par (Brock & Wikler, 2009; Hope, 2001; Żuradzki, 2019). Given that both statistical and identifiable individuals are actually existing individuals, there seems to be a *prima facie* case against the bias: the basic assumption of the equal worth of human lives seems to speak against implementing such a bias in our policy making (Brock & Wikler, 2009). Thus, one of the primary questions in this area is, “What might justify prioritizing identified persons?” This is a question that is much more complicated than it may first appear. As one overview of the ethical discussion in this area notes,

[Identified individuals ] are not necessarily poorer or sicker over their entire lives than the rest of us, or otherwise necessarily worse off in their personal outcomes. Priority to identified persons does not necessarily assist the deserving, or the near and dear, or whomever else we may think we should prioritize. Ex hypothesi, focus on those at highest risk does not ensure that more lives or QALYs are saved; on the contrary, it often ensures that fewer are saved. (Cohen et al., 2015, p. 3)

I attempt to answer this question by appealing to the idea of establishing a policy that is justifiable to all under conditions of uncertainty, a central part of contractualist moral theory. As the title of the earliest article on the topic indicates—

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<sup>32</sup> With the notable exception of the excellent volume *Identified vs. Statistical Lives: An Interdisciplinary Perspective* (Cohen et al., 2015). See also Hope (2001); Brock and Wikler (2009); Żuradzki (2019), who have all made notable contributions to the philosophical discussion of the issue.

<sup>33</sup> See Jecker (2013) for a critique of this “rescue medicine” or “heroic medicine” approach.

Schelling's (1968) "The life you could save could be your own"—there is significant uncertainty about who is benefited and who is burdened from adopting a policy prioritizing either identified or statistical lives. I take this point of uncertainty to be a starting point for further investigation. Such uncertainty is common when it comes to thinking about the justification for various kinds of public health related policies. Given that our knowledge of health interventions is primarily statistical and not individual, there is significant uncertainty about who exactly will benefit and who exactly will be harmed, as well as significant uncertainty about how much any given individual will be harmed or benefited.<sup>34</sup> In the next section of this background to the "An Uncertainty Argument," I introduce Scanlonian contractualism, a prominent contemporary non-consequentialist moral theory, and then introduce two variants of the theory that arise, in part, due to differences in how they attempt to resolve questions of risk and uncertainty. Much of this introduction will be brief, as this background information is also covered in the article itself.

#### 4.1.2 Contractualism: a short introduction

Contractualism, as a general moral approach, is quite old. It first appears in some form in the arguments of Glaucon, who Socrates quickly—and perhaps incorrectly—dismisses (Plato & Jowett, c.375 BCE/1998). In the modern era it reappears in the work of Hobbes (1651/2008), Locke (1690/1980), and Rousseau (1762/2004). A distinctively Hobbesian strain of contractualism continues to this day, particularly in the work of Gauthier (1987), and has found significant support in contemporary work by game theorists (e.g. Binmore, 1994, 1998). However, the form of contractualism addressed in this thesis does not hail from this respectable Hobbesian lineage. Instead, it is technically Kantian in origin, although its true contemporary form is developed and presented by T.M. Scanlon, particularly in *What We Owe to Each Other* (1998).<sup>35</sup> The central idea of Scanlon's approach is to seek out principles that no one can reasonably reject. The primary consideration regarding whether some principle can be reasonably rejected is the burden it imposes on individuals compared to the burden alternative principles would impose. When I refer to contractualism in this thesis, unless otherwise specified, I am referring to this Scanlonian form.

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<sup>34</sup> In the next article in this thesis "Take the pill" I address this issue through an appeal to *fairness*: given the difficulties with justifying particular interventions on the basis of cost/benefit, we may still have other reasons, namely fairness, to carry out interventions that may have individually unfavorable *ex ante* cost/benefit ratios, although favorable *ex post* population benefits.

<sup>35</sup> Some may wonder why I have traced this Kantian lineage to Scanlon rather than Rawls. Rawls is also a contractualist, and one who may also seem more Kantian than Hobbesian. However, Rawls is primarily concerned with *political institutions*, whereas Scanlon aims to offer a broad account of interpersonal morality. As such, in my view, Scanlon offers a much more applicable form of contractualism for addressing the variety of questions in public health ethics.

Contractualism, as a general moral theory, offers both an esteemed pedigree, and a wide variety of contemporary advocates and applications.<sup>36</sup> However, I believe it has a special role in the realm of public health ethics, where it offers a useful, and necessary, counterpoint to the population focus of public health. It is easy to get lost in the aggregate statistical approach common to both public health and utilitarianism alike. However, contractualism brings our attention back to the interpersonal basis of morality, and as such, offers an effective and necessary individualist counterweight to the population perspective fundamental to public health.

The centerpiece of contractualism is a process of *individual justification*, which I will discuss in more detail below. What is particularly significant about individual justification in the context of this thesis is that it gives contractualism a unique form of moral deliberation that offers an interesting and plausible framework to address risk and uncertainty in public health ethics (John & Curran, 2021). Individual justification has also recently been proposed as an effective and robust way to make and justify decisions in public health and health care (Cox & Fritz, 2022; Dahlquist & Kugelberg, 2023; Fritz & Cox, 2020). Additionally, contractualism more generally has found application in answering a variety of other ethical questions in health care contexts (Giubilini et al., 2018; John, 2014; Kumar, 2017; Millar, 2012), where it represents a workable compromise between collective and individual interests in a variety of public health activities (e.g. vaccination Giubilini, Douglas, & Savulescu 2018; inequalities in antibiotics (Millar, 2019); and lockdown measures (John & Curran, 2021), among others. Further, there is empirical evidence that such a focus on individual justification is beneficial for compliance with public health efforts (Daniels & Sabin, 1997; Pinho et al., 2018; Tsuchiya et al., 2005). Finally, in line with this, Fritz and Cox (2020) and Cox and Fritz (2022) argue that contractualism offers an attractive way to ensure that vulnerable individual perspectives are robustly accounted for when establishing just and fair policies and practices in health care and public health, particularly in priority setting.

Contractualism's ability to contribute productively to public health ethics is perhaps seen most clearly in contractualism's opposition to unrestricted and unsophisticated interpersonal aggregation, which is well-demonstrated by one of the most famous cases in contemporary contractualist literature: Scanlon's *Transmitter Room*. I present the case here, and will also discuss it again later in this section.

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<sup>36</sup> See *inter alia*, Cox and Fritz (2022), Fritz and Cox (2020), Frick (2013, 2015), Holm (2018), Kumar (1999, 2001, 2017), Otsuka (2006), Steuerer (2021), Suikkanen (2004, 2019) for various discussions and applications of contractualism. See also the citations later in the section regarding applications of individual justification. This list is nowhere near exhaustive, and the extent and influence of contractualism is far too large to adequately represent here.

Transmitter Room: Jones has suffered an accident in the transmitter room of a television station. Electrical equipment has fallen on his arm. and we cannot rescue him without turning off the transmitter for fifteen minutes. A World Cup match is in progress, watched by many people, and it will not be over for an hour. Jones's injury will not get any worse if we wait, but his hand has been mashed and he is receiving extremely painful electrical shocks. Should we rescue him now or wait until the match is over? Does the right thing to do depend on how many people are watching... ? (Scanlon, 1998, p. 235)

For Scanlon and many others, the intuitive answer to *Transmitter Room* is that no number of fans enjoying the world cup could outweigh Jones' suffering. Cases like *Transmitter Room* motivate the inclusion of a couple of key restrictions on our moral reasoning in a contractualist framework, which are discussed in the next section. Similar cases appear in many forms in public health, and some form of concern over aggregation runs through each of the articles of this thesis.

Although only "The Uncertainty Argument" takes an explicitly Scanlonian view, contractualism is present in the background of both other articles. "Take the Pill" implicitly accepts the contractualist-derived argument that some population interventions are not justifiable on the basis of *ex ante* expected benefits for individuals. Instead, it advocates for such interventions on the grounds of fairness, which as Scanlon notes, is an acceptable reason for rejecting a given policy. In Scanlon's terms, "We have reason to object to principles simply because they arbitrarily favor the claims of some over the identical claims of others: that is to say, because they are unfair" (Scanlon, 1998, p. 216). As such, the argument in "Take the pill" can be easily recast in explicitly sufficientarian terms.<sup>37</sup> "The Sufficientarian Alternative" does not adopt a Scanlonian contractualist approach, but it does take a number of contractualist concerns seriously, primarily the concern that a sufficiently large number of small benefits should not outweigh a much more significant individual benefit. Although not couched in the language of contractualism—instead, the article is rather consequentialist—it still carries forward key contractualist commitments. Before continuing, it is also worth noting that although my focus here is on what may be broadly considered to be applied ethics in the analytic tradition, contractualism shares significant similarities with other areas, most notably Habermas' theory of "discourse ethics" and various theorists working in the area of "deliberative" conceptions of democracy and political legitimacy.<sup>38</sup>

In the remainder of this section, I outline Scanlon's contractualism in general, before turning to distinguishing between *ex ante* and *ex post* versions of the theory. The starting point of Scanlon's contractualism is the idea that suitably motivated individuals should aim to justify their conduct to others. In Scanlon's

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<sup>37</sup> "Sufficientarianism" refers to a family of distributive theories that emphasizes the importance of some threshold or thresholds. Sufficientarianism will be defined and discussed in more detail in section 4.3.

<sup>38</sup> See Habermas (1996); Goodin (2003).

terms, “thinking about right and wrong is, at the most basic level, thinking about what could be justified to others on grounds that they, if appropriately motivated, could not reasonably reject” (Scanlon, 1998, p. 5). This notion of *reasonable rejection* is central to contractualism, and as such requires further clarification. Not all reasons are acceptable reasons to reject a principle. The most important restriction on these reasons is that they must be *personal reasons*. For Scanlon, these reasons are those that “have to do with the claims and status of individuals in certain positions” (1998, p. 219). In contrast, Scanlon doesn’t permit impersonal reasons to support reasonable rejection of a principle. This is sometimes called the *impersonalist restriction*, a term coined by Parfit (2000) in his influential discussion of contractualism. This restriction is largely due to the Kantian heritage of Scanlon’s theory, which focuses on the specific concern we owe to others.<sup>39</sup>

Acceptable reasons must be personal reasons, but there are further limits on what kind of reasons can count as such. These reasons must also be so-called “generic” reasons, which are personal reasons individuals have due their circumstances and various general characteristics (Scanlon, 1998, p. 204). For a complaint to count as a reason to reject the principle under consideration, it must not be a purely idiosyncratic desire, but needs to be intelligible to others—to be something that others in the same circumstances would also have reason to desire (Scanlon, 1998, p. 204).

Second, and related to the first restriction, Scanlonian contractualism forbids interpersonal aggregation of reasons. Reasons, in this framework, are not additive and do not aggregate. Many weak reasons cannot be aggregated to outweigh a single stronger reason (see *Transmitter Room*).<sup>40</sup> This ban on aggregation is one of the most distinctive defining features of the theory, and in particular, is often used to set it apart from consequentialist theories. Despite its importance to the theory, it is also one of contractualism’s most controversial elements (Mardellat, 2020; Parfit, 2011; Scanlon, 1998, p. 229). Although neither “Take the Pill” or “The Sufficentarian Alternative” adopt an explicitly Scanlonian view, this concern about interpersonal aggregation is present in both. This requirement that all reasons be individual, personal, non-aggregative reasons is often referred to as the *individualist restriction*. As with the impersonalist restriction, the individualist restriction gets its name from Parfit’s influential discussion (Parfit, 2011). This restriction features most often in questions of (im)permissible interpersonal aggregation.<sup>41</sup>

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<sup>39</sup> See Southwood (2013)’s excellent overview of contractualism for discussion of this Kantian heritage, particularly pp. 53–60.

<sup>40</sup> For a particularly current and pandemic-relevant version of this example, also see “Costa coffee” (John & Curran, 2021)

<sup>41</sup> See, e.g. Frick (2015), Fried (2012), Kumar (2010, 2011), Otsuka (2006), Mardellat (2020) for discussion of this restriction. It also features prominently in “An Uncertainty Argument.”

These restrictions are central to contractualist moral reasoning and give contractualism its distinctive character (Kumar, 2001). To illustrate the reason why contractualist endorse these restrictions, it may be helpful to look again at one of the most well-known cases from the contractualist literature: Scanlon's *Transmitter Room*, introduced above. The impersonalist and individualist restrictions allow contractualism to yield the intuitively correct answer in *Transmitter Room*: we should not sacrifice Jones for the pleasure of those who wish to watch the world cup, regardless of how many fans there are. In contrast, theories like utilitarianism require us to leave Jones under the equipment, at least as long as the (aggregate) pleasure of the fans outweighs his suffering.

In more concrete terms, what this all amounts to is a process of weighing up different individuals' reasons to reject a given principle or its alternatives. This process is often governed by the "Greater Burden Principle."<sup>42</sup> According to Scanlon, "it would be unreasonable, for example, to reject a principle because it imposed a burden on you when every alternative would impose much greater burdens on others" (Scanlon, 1982, p. 111). Generally, this works out to mean that non-rejectable principles are those whose alternatives have more serious personal objections. Or, in Rahul Kumar's excellent phrasing, we aim to find a "principle whose implications are most acceptable to the person to whom it is least acceptable." (Kumar, 2015, p. 31). This process plays a central role in "An Uncertainty Argument" and is influential on my approach in both "Take the Pill" and "The Sufficierarian Alternative." Although there is significantly more that could be discussed regarding Scanlonian contractualism, this is enough for now, particularly because it is also discussed in the article itself. Next I look at a major contemporary schism in the contractualist camp: *ex ante* vs *ex post*.

#### 4.1.3 Justifiability and Uncertainty: *ex ante* vs *ex post* Contractualism

Contractualism requires a process of weighing up different individual's reasons to reject a principle and its alternatives. However, determining the relative strength of individual complaints against a given principle requires deciding on the appropriate epistemological and temporal perspective from which individual complaints should be made and considered. This question arises most often in cases where there is some degree of risk or uncertainty as to what the outcome of the policy or principle will be. Often, we may not know with certainty exactly how the burdens of a given principle will be distributed, nor which individuals will bear such burdens.

In response to this kind of uncertainty, two different camps have developed: *ex post* and *ex ante* approaches. The central question is whether an individual's complaint against a principal should be based on that individual's prospects, or if

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<sup>42</sup> As with the restrictions discussed above, the Greater Burden Principle also gets its name from a discussion of Scanlon's contractualism by Parfit. See Parfit (2003).

it should be based on the full force of the possible negative outcome. *Ex ante* contractualists hold that an individual's prospects under a given principle are what matters, meaning the burden in question should be discounted by its (im-)probability. In contrast, *ex post* contractualists aim to assign complaints based on the strongest burden produced by the principle, without discounting it by its (im-)probability.

*Ex ante* contractualism is currently the most popular approach, although *ex post* versions still maintain significant support (Ashford & Mulgan, 2018). Scanlon himself has also shifted from his original *ex post* view to an *ex ante* view (Ashford & Mulgan, 2018; Scanlon, 2013). It is also worth noting that there have been recent and significant attempts to navigate a middle ground and develop some "hybrid" forms of contractualism (e.g., Suikkanen, 2019; also see Fried, 2012).

*Ex ante* views face significant objections, primarily in resolving complaints against a principle that would impose very small *ex ante* risks on individuals who can expect no benefit from the principle. The difficulty is to explain why such *ex ante* risks can be permissibly imposed without the justification collapsing into some form of aggregative consequentialism (See Ashford, 2003; Kumar, 2015). However, the counterintuitive consequences of *ex post* contractualism are sometimes considered to be more severe. This is because *ex post* views often seem to forbid most instances of intuitively acceptable 'social risk imposition.' Mass vaccination (Frick, 2015), air travel (Ashford, 2003; Kumar, 2015), as well as other socially valuable activities, are all alleged to be forbidden by *ex post* contractualism.

In this thesis, I primarily take an *ex ante* contractualist approach. In this approach, the focus is on an individual's prospects, and thus, expected burdensomeness is taken as the appropriate grounds for rejecting the principle under consideration. This approach features prominently in both "Take the Pill," where it blocks an appeal to individual benefits as the grounds for an obligation to take certain preventive measures, and in "An Uncertainty Argument" where I argue *ex ante* contractualism requires prioritizing individual lives in some situations of uncertainty.

#### 4.1.4 "An Uncertainty Argument" Article Summary

In "An Uncertainty Argument," I address the question of whether we can develop a moral justification for the identified victims bias, and thus, whether we have a moral reason to prioritize identified over statistical lives. Philosophers have largely rejected prioritizing identified lives because of conflicts with various other moral constraints or principles, such as the moral equality of persons. However, in the article, I argue that in some cases of uncertainty, *ex ante* contractualism gives us a reason to prioritize identified over statistical lives. I then examine how such uncertainty is present in "real world" cases, and demonstrate the implications of my argument, by examining the issue of choosing between providing expensive treatment for AIDS patients or increasing the availability of preventive measures

for HIV. I argue that in some cases, the uncertainty argument supports the funding of AIDS treatment, even though HIV prevention may be more cost-effective and save more lives.

## 4.2 “Take the Pill” Section Introduction

In this section, I give an overview of two contrasting approaches to improving population health: the “population” strategy and the “high risk” strategy. I discuss how the population strategy results in a “paradox” whereby it offers the greatest population benefits, but little benefits to individuals. This results in a philosophical puzzle as to how to justify such an approach. This is particularly challenging given my focus on individual justification. I then discuss the notion of public goods, and provide an outline of the discussion over the role of fairness in creating obligations to contribute to the production of public goods. Ultimately, in “Take the Pill” I bring these discussions together to argue that we can justify such population strategies by appealing to individual’s obligations of fairness. At the end of this section, I give a brief summary of the article.

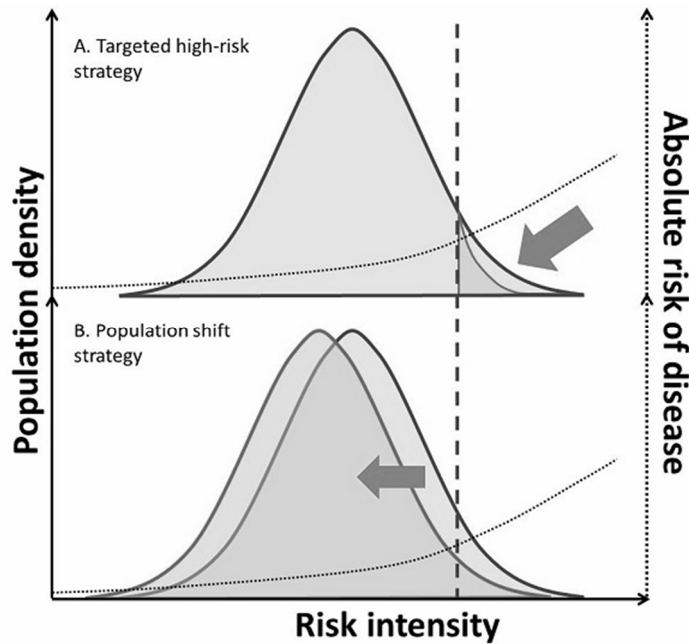
### 4.2.1 Prevention strategies and the prevention paradox

When we want to intervene to improve population health, how should we do so? Should we target everyone? Or should we focus on those who are particularly high-risk? In some ways, this reflects the previous discussion of identified versus statistical lives; as Norman Daniels notes, we may have reasons of distributive fairness to worry about people who are at high risk (Daniels, 2012, 2015). For Daniels, this not only vindicates the identified lives bias to a certain extent, but it also gives us reason to take the so-called “high risk” strategy of population medicine: we should (at least sometimes) focus our efforts on reducing the risk of the highest-risk individuals (Daniels, 2015).

Not all agree, however. Most notably, Geoffrey Rose—a true giant in the development of contemporary epidemiology—advocates for the so-called “population” or “mass” strategy: rather than focusing on the highest-risk, we should sometimes attempt to move the entire distribution to the left (see figure 1) (Rose, 2001).<sup>43</sup> As Rose points out, “a large number of people at a small risk may give rise to more cases of disease than the small number who are at a high risk.” (Rose, 2001, p. 431). As such, the population strategy can often yield greater reduction of disease burden than the targeted high risk approach.

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<sup>43</sup> This is a reprint of the original 1985 article. Also see *Rose’s Strategy of Preventive Medicine* (Rose et al., 2008) for discussion of high risk and population strategies (Ch. 4 and Ch. 7 respectively).



**Figure 1.** Illustration of disease prevention strategies. Inspired by Rose 1985 IJE. From Feldman (2017)

Given that in “An Uncertainty Argument,” I offered a limited argument in favor of the identified victims bias, it may seem like the next article should attempt to support the high risk strategy, rather than the population strategy. But this is not the case. In “Take the pill” I offer a fairness-based argument for adopting a population strategy. This might seem like I’m arguing inconsistently given how closely related the identified victims’ bias and the high risk strategy are. However, these two articles actually take the same line: a focus on considerations of individual costs and benefits alone cannot establish the moral correctness of population-level interventions. As “An Uncertainty Argument” demonstrates, in (some) situations of uncertainty, we should prioritize individuals (or, to extend the argument, prioritize those at high risk). It is difficult to argue for a population intervention on the basis of individual cost-benefit analysis. This is exactly the starting point for “Take the Pill:” as I’ll explain in the coming sections, population-level interventions sometimes offer nothing but *ex ante* harms for the individuals participating. As such, we need to look to other bases for moral justification of such programs. In the remainder of this section, I first explain the prevention paradox that arises when considering what population strategy to adopt. I explain the current philosophical discussion of the problem, and how it has largely given negative answers to the question of whether population strategies are ethically justifiable. I then turn to a discussion of the idea of public goods, and explain the demands of fairness such goods typically entail. Finally, I summarize the article.

The basic structure of the *prevention paradox* has already been hinted at in the introduction to this section, as well as earlier, in the discussion of the central themes of this thesis (specifically sections 3.1 and 3.2). In essence, the paradox arises because, again to quote Geoffrey Rose, “A preventive measure which brings much benefit to the population offers little to each participating individual” (Rose, 2001, p. 432). Things are not actually this straightforward, however. Stephen John, who has likely done more philosophical work on the paradox than anyone else, explains how there are actually at least two distinct versions of the paradox. John distinguishes between *absolute* and *relative* versions of the paradox. In the absolute version, individuals see no reason to participate in a population strategy, because from an individual-level perspective, doing so yields more harm than benefit (John, 2014, p. 29). In the relative version, the tension is not between individual and population level benefits, but rather between two plausible moral principles. The high risk strategy seems to follow from a principle that prioritizes those at greatest risk, whereas the population strategy stems from a principle that requires saving more lives rather than fewer (John, 2014, p. 29).

In my “Take the Pill,” I focus on the absolute version of the paradox. In short, the question is whether individuals have any reason to participate in this strategy, given that they will view it solely as imposing *ex ante* costs. In the article, I ultimately argue that such interventions create a public good—increased health system capacity—and so individuals have reasons of fairness to participate in population strategies.

## 4.2.2 Public goods and the demands of fairness

Angus Dawson summarizes the distinction between public and private goods as: “a private good is a good that benefits only the individual concerned and a public good benefits all of the members of a group or population” (Dawson, 2007, p. 163). Over the past few decades, public goods have been subject to extensive philosophical interest (see, *inter alia*, Arneson, 1982; Cullity, 1995; Klosko, 1987; Olsaretti, 2013; Taylor, 2021; Verweij, 2022). I will not survey the entirety of the literature on public goods here, but instead focus on one important aspect of public goods: they are usually assumed to create demands of fairness, which require individuals who benefit from the goods to also bear some of the cost of producing such public goods.

Perhaps unsurprisingly in light of the extensive debate over public goods, there are a wide variety of competing definitions, and a significant number of characteristics that are claimed to be essential to defining certain goods as public goods. I focus on two features that are widely accepted, and considered to be central to the concept of public goods: *non-excludability* and *dependence on large-scale cooperation* (Klosko, 1987).<sup>44</sup> I leave aside discussion of other proposed

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<sup>44</sup> In addition to these two, *non-rivalrousness* is often considered an essential feature of public goods, particularly in the context of public health (see Nuffield Council on Bioethics,

features, as my discussion of public goods in “Take the Pill” only relies on these two key features.<sup>45</sup>

The problem with public goods is that, largely due to their non-excludable nature, individuals are incentivized to avoid contributing to the good because they will still benefit regardless of individual contribution. This is often labeled as the *free rider problem*, and has generated a significant amount of work in both philosophy and economics. This is an old problem, and is remarked on by, among others, J.S. Mill, who notes that,

...it is a proper office of government to build and maintain lighthouses, establish buoys, etc. for the security of navigation: for since it is impossible that the ships at sea which are benefited by a lighthouse, should be made to pay a toll on the occasion of its use, no one would build lighthouses from motives of personal interest, unless indemnified and rewarded from a compulsory levy made by the state. (1848/1963, p. 968, as cited in Reiss, 2021)

One solution, as Mill notes, is to require that individuals contribute to the production and maintenance of public goods. This strand of thought is later taken up by Hart (1955), who argues,

when a number of persons conduct any joint enterprise according to rules and thus restrict their liberty, those who have submitted to these restrictions when required have a right to a similar submission from those who have benefited by their submission. (Hart, 1955, p. 185)

This line of thought is further developed by Rawls (1971/1999, p. 96) and Klosko (1987). This approach emphasizes the role of *fairness* in grounding our obligations to contribute to the production and maintenance of public goods.<sup>46</sup> It should be noted, however, that this approach has not been without controversy. Most famously, it has been heavily criticized by Nozick (1974/2001, pp. 90–95), whose criticisms have spawned significant discussion addressing the boundaries of our obligations to contribute to public goods.

Despite Nozick’s well-known objections, the idea that fairness obliges us to participate in the production and maintenance of public goods remains popular, both among philosophers and in actual practice, e.g. through requirements that individuals bear the costs of maintaining national security (an archetypal public good), through taxes, conscription, or various other means. As such, although there are significant philosophical disagreements over the nature and extent of our

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2007, pp. 6–7). I discuss the role of non-rivalrousness further in the article itself, but leave it aside here for brevity’s sake.

<sup>45</sup> See however, Cullity (1995, pp. 32–34) for a list of many proposed features.

<sup>46</sup> See Cullity (2008) for contemporary discussion of fairness and public goods. See Nuffield Council on Bioethics (2007, p. 7) for a brief overview of how this intersection of fairness and public goods applies to public health.

obligations to contribute to the production and maintenance of public goods, in functional terms, there is wide acceptance of such obligations. In “Take the Pill” I start from an acceptance of the obligation to contribute to public goods in order to argue that even though the prevention paradox may block an appeal to individual benefit, the notion of contributory fairness still gives us a reason to establish “mass” or “population” strategies in certain cases.

#### **4.2.3 “Take the pill” Article summary**

In “Take the pill” I address the question of how population strategies in public health can be justified in light of the prevention paradox. To do so, I examine the case of the “polypill,” a combination of cheap and easily accessible drugs that significantly reduce the risk of heart disease and have a low risk of side effects. Proposals to administer the polypill to everyone over the age of 55—an archetypal case of a population strategy—have been largely rejected. However, I argue that implementing such population strategies contributes to a key public good, namely health system capacity. As such, population strategies like the polypill carry an obligation of fairness to participate and ensure that costs are distributed equally. In doing so, I challenge previous literature that has deemed such population strategies unjustifiable.

### **4.3 “The Sufficentarian Alternative” Section Introduction**

In this section, I give an overview of the broad area of health care priority setting and distributive justice. I introduce four dominant distributive approaches: utilitarianism, egalitarianism, prioritarianism, and sufficientarianism. I then examine egalitarianism and prioritarianism in more depth, offering a comparative survey of the two approaches. I then turn to introducing the somewhat lesser-known approach of sufficientarianism, with a particular focus on distinguishing sufficientarianism from prioritarianism. Following my discussion of these theories, I briefly describe how these different approaches in distributive justice play a role in public health. Finally, at the end of the section, I give a brief summary of the “The Sufficentarian alternative” where I argue that sufficientarianism represents a plausible theory that is distinct from prioritarianism, and can outperform prioritarianism in certain situations (e.g. in population ethics).

#### **4.3.1 Health care priority setting and distributive justice**

Through the 20th century, the capacity of health care to prevent, treat, and manage disease has increased dramatically. Alongside this increase in effectiveness, there has also been an increase in complexity and cost (Fuchs, 2008). These changes have made the question of how to properly distribute limited health care resources particularly pressing. This improvement in healthcare has brought with it the need

to rationally set limits and establish priorities (Asada & Schokkaert, 2019). Although “priority setting” (or, under its less friendly name “rationing”) is often seen as a wholly negative activity, as Daniels and Sabin remark, “Limits are the price of medical success, not medical failure.” (p. 2) Priority setting is necessary to the functioning of any successful health system, and as such raises distinctive and important ethical problems, only some of which I will address here. It is also important to note that “although, overall, health has improved and life expectancy has increased [...] in the 20th Century, considerable inequalities in health persist, and in some cases these have widened, especially between socio-economic groups.” (Nuffield Council on Bioethics, 2007, p. xv). How to address such gaps between socio-economic groups is a central concern for public health and health care priority setting, and the theories discussed below all represent significant attempts to address this question.

It may seem at first blush that the question of priority setting should be confined to countries with public health care, but this is incorrect: priority setting occurs in both public and private health care systems (Bognar & Hirose, 2014). As such, the question of what theory of justice or theory of distributive ethics should underlie our approach to priority setting is a universal one that all societies must address.<sup>47</sup> Further, questions of priority setting are a central concern for public health ethics, which, as noted earlier, was significantly influenced in its early development by discussions of justice in health care.

No society has yet come to a complete consensus on what principles should guide priority setting in a fair health system. Philosophers have not fared much better, and theories of distributive justice in health care remain controversial and contested (Daniels, 2008; Norheim & Asada, 2009; Powers & Faden, 2006; Prah Ruger, 2010; Segall, 2010; Venkatapuram, 2011). Theorists working on distributive justice interpret the basic questions and problems of distributive justice in very different and very specific ways. Here I will only give a brief and broad introduction to these differences.

Although much remains contested, it is rather common to distinguish three primary questions of distributive justice: *who*, *what*, and *how*. The first question pertains to whom justice is owed. The second asks what we should distribute (e.g. welfare, resources, capabilities, etc.). The third asks what pattern the distribution of such goods should follow. It is this third question that I am concerned with here, and so I shall set aside the other two questions.<sup>48</sup> My focus here is narrow, and pertains specifically to the elements of distributive justice relevant to health care priority setting. As such, broader questions of distributive justice, such as

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<sup>47</sup> I use the terms “distributive justice” and “distributive ethics” interchangeably in this thesis. Similarly, “distributive justice” and “social justice” are often used interchangeably in the philosophical literature.

<sup>48</sup> It is worth noting that not every theorist agrees that such questions can be so easily disentangled as I have done here, with Walzer (1983) perhaps being the most well-known philosopher to argue for a necessary connection between the nature of the good(s) in question and the appropriate pattern(s) of distribution.

the fundamental Rawlsian question of how to organize the basic structure of society (Rawls, 2001, p. 50) or the relational egalitarian question of how we can live together as equals (Anderson, 1999), are outside the scope of my concern in this section.

Even setting aside these fundamental questions of distributive justice, my discussion in this section will be even further limited, and will not address important issues such as the use of Quality-adjusted life years (QALYs) and other similar measures (e.g. DALYs, HALYs, etc.), the status of cost-benefit analysis and cost-effectiveness analysis (CBA and CEA), or the issues of how much public participation in priority setting is appropriate. I will confine my discussion in this section to discussion of the main principles and/or theories in distributive ethics relevant to health care priority setting.

Although much remains unsettled, there are a few major families of theories and/or distributive principles that have dominated most philosophical discussion of priority setting. In the remainder of this section, I outline those theories, and then in the next section I turn to discussing two in particular in more detail. In the next section, I address two prominent families of theories. Both of these are described very roughly, and will be clarified later in this section. First is egalitarianism, which holds that the proper pattern of distribution of benefits is an equal one. Second is prioritarianism, which holds that the worse-off individuals are, the more important it is to benefit them. Both of these approaches are typically understood as attempts to develop alternatives to utilitarianism.

Utilitarianism holds that the proper pattern of distribution is simply whichever pattern maximizes the sum total of benefits.<sup>49</sup> The important thing to note here is that utilitarianism is *pattern-insensitive*: it doesn't matter to a utilitarian what the pattern of distribution actually is, so long as that pattern maximizes the sum total of benefits (Prah Ruger, 2010, pp. 20–22). If multiple patterns provide an equal amount of total benefit, utilitarianism is generally indifferent between them. As such, my focus here is on egalitarianism and prioritarianism, which both hold specific patterns of distribution to have moral importance, and both of which have had significant influence on sufficientarianism, which is the theory I focus on in “The Sufficientarian Alternative.”<sup>50</sup>

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<sup>49</sup> Note that utilitarianism is often used to refer specifically to *welfare* maximization. In this thesis, I use it in a broader sense to cover all forms of maximizing consequentialism that have no specific distributive principles.

<sup>50</sup> See Casal (2007) and Shields (2012) for excellent overviews of the debates between sufficientarianism, prioritarianism, and egalitarianism.

### 4.3.2 Egalitarianism and Prioritarianism: a brief introduction

As Parfit (2000) discusses in “Equality or Priority?,” both Egalitarianism and Prioritarianism favor worse off individuals compared to better off individuals.<sup>51</sup> However, the reasons why they do so are quite different. Egalitarianism typically assumes that inequality is either intrinsically bad, or otherwise unfair, particularly if it is due to no fault of one’s own (Cohen, 1989; O’Neill, 2008; Temkin, 2001; Temkin, 2003).<sup>52</sup> As a consequence, more equal outcomes are typically considered to be better outcomes, all else equal.<sup>53</sup> Egalitarianism is a highly influential approach in public health, and measuring and reducing inequalities in health or in the social determinants of health is typically an important goal for public health programs (Persad, 2019).

In contrast, Prioritarianism holds that the moral value of a benefit increases the worse off the recipient is (Adler & Holtug, 2019). Likewise, the (moral) disvalue of a burden decreases the better off the recipient is. In the remainder of this section, I will discuss each view in more detail, before turning to providing an overview of sufficientarianism. I will explicitly note that the literature on both egalitarianism and prioritarianism is extremely broad, and I cannot do it justice here. Instead, I focus on describing some basic commitments of egalitarian and prioritarian theories in such a way that I can distinguish them from sufficientarian approaches in the next section.

Egalitarianism comes in many forms, with some of the most prominent being various social or political understandings of egalitarianism: e.g. the need for citizens to stand in relations of equality to one another (Anderson, 1999; Lippert-Rasmussen, 2018). Here, I am focused on a somewhat narrower understanding of egalitarianism, which focuses on the idea that inequalities are themselves intrinsically bad. This is often called *Telic Egalitarianism*, following an influential discussion by Parfit, who explains that

There are two main ways in which we can believe in equality. We may believe that inequality is bad. On such a view, when we should aim for equality, that is because we shall thereby make the outcome better. We can then be called Teleological – or, for short, Telic – Egalitarians. Our view may instead be Deontological or, for short, Deontic. We may believe we should aim for equality, not to make the

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<sup>51</sup> See also Otsuka and Voorhoeve (2018) for recent comparative analysis of egalitarianism and prioritarianism, with a particular focus on the context of risky choices.

<sup>52</sup> Here I do not distinguish between *egalitarianism* and *luck egalitarianism*. Typically, luck egalitarianism emphasizes the distributive importance of distinguishing between voluntary and involuntary causes of inequalities, whereas egalitarianism more generally may or may not be concerned with this distinction. See Albertsen and Knight (2015) for discussion. For the purposes of this section, I group them together as simply “egalitarianism.” See also Albertsen (2015, 2020) for further discussion of luck egalitarianism in public health and health care.

<sup>53</sup> This understanding of egalitarianism is sometimes referred to as “telic” egalitarianism, to help distinguish from the wide variety of other forms of egalitarianism, e.g. luck egalitarianism, relational egalitarianism, Rawlsian egalitarianism, etc. Hirose (2014) offers an accessible but still comprehensive overview of these divisions in contemporary egalitarianism.

outcome better, but for some other moral reason. We may believe, for example, that people have rights to equal shares. (Parfit, 2000, p. 84)

After further discussion, Parfit eventually develops a simple and broad definition of this kind of egalitarianism. Although egalitarians may disagree over a great deal, all (telic) egalitarians are at least committed to the following principle:

“The Principle of Equality: It is in itself bad if some people are worse off than others.” (Parfit, 2000, p. 84)

Parfit eventually goes on to discuss serious objections to this principle, which motivates him to develop an alternative: *Prioritarianism* (also sometimes called *The Priority View*). Parfit offers a rough definition,

“The Priority View: Benefiting people matters more the worse off those people are.” (Parfit, 2000, p. 101)

Both Prioritarianism and Egalitarianism care about individuals who are worse off. But, they care about them in different ways. Egalitarianism typically takes a relational view: we care about people who are worse off than others, and we do so because being worse off than others makes the state of affairs less equal. Since inequality is intrinsically bad, this makes the state of affairs worse than a more equal alternative. Prioritarianism, on the other hand, thinks about how well off people are in *absolute* terms. This means that what ultimately matters is not how any individual fares in relation to others, but simply how high or low their level of well-being is in an absolute sense. In Parfit’s own words,

Egalitarians are concerned with relativities: with how people’s level compares with the level of other people. On the Priority View, we are concerned only with people’s absolute levels. (Parfit, 2000, p. 104)

The second important element is something already stated in the definition of prioritarianism: that benefits matter more the worse off (in absolute terms) someone is. This means that benefits with equal prudential value may have differing moral value, depending on how well off their recipients are. Notably, this view does not specify in advance how much priority the worse off should have. This is in contrast to, e.g. a Rawlsian Leximin approach, which assigns absolute priority to the worst off (Tungodden, 1999).<sup>54</sup> Instead, there are a wide variety of prioritarian views, each of which will ascribe a different level of priority to the worst off. It is important to note that although utilitarianism is often taken to be the

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<sup>54</sup> Note that this is *not* meant to imply that Leximin is simply an extreme form of Prioritarianism. It is a distinct theory: Rabinowicz (2002) argues that Leximin is actually fundamentally relational, and so it cannot be a form of prioritarianism. See also Hirose (2014) pp. 96–98 for further discussion of the relation between Leximin and Prioritarianism.

standard approach to health policy analysis, prioritarianism also enjoys significant support among health policy planners (Ottersen et al., 2014; Persad, 2019). In terms of public health, both egalitarianism and prioritarianism are committed to reducing (health-related) inequalities, although they answer the question of “how should inequalities be reduced?” in different ways.

Before moving on, it is worth noting that prioritarianism is sometimes understood as an egalitarian theory, and it is sometimes understood as a form of utilitarianism, but it is most commonly understood as a separate theory (See discussion in Hirose (2014), particularly ch. 4). Some of this depends on how exactly all three theories are understood, but in general prioritarianism shares features of both utilitarianism and egalitarianism. In the next section, I will discuss an alternative theory: sufficientarianism. Ultimately, in “The Sufficientarian Alternative” I argue that sufficientarianism is distinct from prioritarianism, and that it offers its own plausible answers to some key questions in priority setting, and may even perform better than prioritarianism in certain areas (e.g. population ethics), while also respecting the anti-aggregative commitments present in the other articles in this thesis.

#### 4.3.3 Is Sufficientarianism distinct from prioritarianism?

In this section, I first give a brief explanation of sufficientarianism, and then explain how sufficientarian views can be divided into “weak” and “strong” versions, where weak versions are sometimes understood as simply a special kind of prioritarianism. In “The Sufficientarian Alternative,” I ultimately argue that it is worth addressing sufficientarianism in its strong form, as it offers a plausible and distinctive alternative to prioritarianism, which avoids some of the problems that both prioritarianism and weak sufficientarianism face.

The origins of sufficientarianism trace back to the mid-1980’s in the work of Harry Frankfurt. Frankfurt is credited with establishing the basic sufficientarian commitment:

what is important from the point of view of morality is not that everyone should have the same but that each should have enough. If everyone had enough, it would be of no moral consequence whether some had more than others. (Frankfurt, 1987, p. 21)

This canonical statement captures two defining features of sufficientarianism as a theory, typically categorized as the *positive thesis* and the *negative thesis*, an influential distinction first proposed by Casal (2007). The positive thesis is typically understood as establishing a “threshold” level of whatever currency is being distributed. This threshold marks the line where an individual “has enough” from the perspective of justice. This positive thesis is typically understood to be the central defining commitment of sufficientarian theories, namely that it is particularly important to benefit those below the threshold. The negative thesis holds

that our distributive commitments change or cease once the threshold is passed.<sup>55</sup> Some forms of sufficientarianism define the threshold in absolute and universal terms (Ram-Titkin, 2017), whereas others hold that thresholds depend on social context (Powers & Faden, 2006). Finally, some sufficientarian theories adopt multiple thresholds (Shields, 2020).

Sufficientarian theories can be distinguished by how much importance they place on individuals crossing the threshold. These range from “strong” views, which place great priority on the importance of crossing the threshold, to “weak” views which emphasize the importance of benefiting those below the threshold without placing particular emphasis on crossing the threshold. A prominent example of a strong view is Harry Frankfurt’s original “Headcount view” which simply aims to maximize the number of people above the threshold, without any additional distributive requirements (Frankfurt, 1987; see also, Shields, 2012; Shields, 2017 Timmer, 2021; Zameska, 2021a). In contrast, weaker views often do not attach such a strong importance to crossing the threshold itself, but instead focus on the importance of benefiting those below the threshold. Weak sufficientarian views still meet the primary commitment of the positive thesis, but they are sometimes understood as forms of prioritarianism (Tännsjö, 2019). In “The Sufficientarian Alternative” I argue that strong sufficientarian views present a viable alternative to weak versions of sufficientarianism, and represents a distinct theory separate from prioritarianism, which may outperform prioritarianism in some situations.

#### **4.3.4 Egalitarianism, prioritarianism and sufficientarianism in the context of public health ethics**

All of the approaches described earlier—utilitarianism, egalitarianism, prioritarianism, and sufficientarianism—appear in various places in current public health practice and all are influential in public health ethics. For example, utilitarianism underlies a common guiding principle in public health of maximizing the numbers of QALYs saved or created (Cubbon, 1991; Savulescu et al., 2020). Similarly, prioritarianism appears in approaches that aim to increase the importance of QALYs that accrue to worse off individuals (Ottersen, 2012; Ottersen et al., 2014). Egalitarianism frequently appears in public health, especially in attempts to measure and reduce inequality in health, but also in lotteries and first-come, first-served systems of allocation (Emanuel et al., 2020). Sufficientarianism has also been employed in various public health contexts, with the United Nations’ Millennium Development Goals adopting a largely sufficientarian basis (Persad, 2019). Similarly, sufficientarianism also frequently appears in human rights documents related to public health, which often define a right to sufficient (rather than maximal or equal) health (Persad, 2014; Persad, 2019).

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<sup>55</sup> This change in our distributive commitments is also sometimes described as the “shift” (Shields, 2012), but the shift thesis should be understood to be broader than the negative thesis (Shields, 2020). See Nielsen (2017) for critical discussion of Shield’s “shift” thesis.

Although each of these distributive approaches are employed in some fashion in public health, no approach has achieved unanimous acceptance, and in practice all of these approaches play an important role in determining our distributive commitments in public health. As a result, some argue that no single approach can adequately capture all of our concerns, and that some pluralist or multi-principle approach should be adopted. Not all agree that multi-principle approaches are viable, however, and the debate continues (Persad, 2019; Persad et al., 2009). In this thesis, I do not take a position on the higher-level debate of single-principle versus multi-principle approaches in public health ethics. In “The Sufficentarian Alternative,” I do not argue that sufficientarian is the *only* plausible approach, nor do I argue that it is always the *best* possible approach. Instead, my claim is much more limited. I argue that it represents one plausible approach that should be understood as distinct from prioritarianism.

#### 4.3.5 “The Sufficentarian Alternative” Article summary

In this article, I argue that sufficientarianism offers a compelling and distinctive approach to setting health care priorities. To do so, I distinguish between two forms of sufficientarianism, a “weak” form that is not distinct from prioritarianism, and a strong form that I call “revised lexical sufficientarianism.” I develop a problem for the weak form of sufficientarianism, and argue for adopting the revised version on this basis. To demonstrate its viability, I also apply the revised form of sufficientarianism to the area of population ethics, and argue that it outperforms some other prominent views in this area. I conclude that when sufficientarianism is understood as its own separate theory, and not simply a particular version of prioritarianism, it offers a plausible and robust approach to both population ethics and health care priority setting.

## CONCLUSION

This thesis has attempted to address some key underlying questions and themes in public health ethics, but in a way that respects a fundamental commitment to the importance of understanding populations as more than mere collections of individuals, while at the same time, respecting the importance of taking individuals seriously.

This thesis has sought to strike a balance between two important perspectives in public health ethics: the population-level focus that is crucial in the practice of public health, and the individual-centered approach that characterizes the approach to ethical theory employed in this thesis. In doing so, I aim to demonstrate the value of taking both these perspectives seriously in addressing questions in public health ethics. By combining the population-level and individual-centered perspectives, this thesis has aimed to provide a nuanced understanding of the key questions and themes in public health ethics. By taking into account the complexities and interrelationships between these two perspectives, I believe I have been able to offer novel and meaningful insights into some of the most pressing ethical issues in public health.

To do so, I have written and published several articles, three of which are included here as portions of the thesis. In “An Uncertainty Argument” (Zameska, 2022), I examine the moral justification for prioritizing identified over statistical lives in cases of uncertainty. I argue that in some cases of uncertainty, *ex ante* contractualism provides a reason to prioritize identified lives. I demonstrate the implications of this argument by examining the case of prioritizing between AIDS treatment and HIV prevention. While in “Take the Pill” (Zameska, 2021b), I analyze the justification of population strategies like the “polypill,” in light of the prevention paradox. I argue that population strategies such as the polypill contribute to a key public good—health system capacity—and consequently, carry an obligation of fairness that requires an equal distribution of costs. Finally, in “The Sufficiency Alternative” (Zameska, 2021a), I take a broader and more theoretical view, ultimately arguing that when properly understood, sufficientarianism presents a plausible and effective approach to population ethics and health care priority setting.

Even when the specific conclusions drawn in my articles may not be accepted, I hope to demonstrate that an approach to public health ethics that takes individuals seriously as the locus of our moral concern is fruitful, and able to offer defensible and plausible answers to some key distinctive questions of public health ethics.

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## **PUBLICATIONS**

## SUMMARY IN ESTONIAN

### Rahvatervishoiueetika: rahvastiku ja indiviidide huvide tasakaalustamine

#### Sissejuhatus

Käesolev väitekirj koosneb kolmest artiklist ja sissejuhatavast raamtekstist. Kõik kolm artiklit käsitlevad mõnda rahvatervishoiu eetikale eriomast küsimust. Raamtekstis annan ma rahvatervishoiu eetikast laiema ülevaate, näitan, kuhu mu väitekirja artiklid selles uurimisvaldkonnas täpsemalt asetuvad ning selgitan iga artikli konteksti. Rahvatervishoiu eetikat iseloomustatakse sageli üksikisiku tasandi huvide ja rahvastiku tasandi huvide vahelise konflikti võtmes. See konflikt on keskseks teemaks ka käesolevas väitekirjas, kus püüan arendada välja elujõulisi, nii üksikisikute kui rahvastike olulisust austavaid lahendusi, uurides selleks mitmesuguseid rahvatervishoiu eetikale iseloomulikke probleeme. Väitekirja moodustavates artiklites kaitsen ma läbivaldt üksikisiku perspektiivi ühildatavust jõulise tegutsemisega rahvatervishoiu vallas. Ma võtan omaks suuresti anti-agregatiivse lähenemise, mis keskendub mitmesuguste tähtsate rahvatervishoiu sekkumiste õigustamisel just individuaalse õigustamise olulisusele.

Väitekirja kuuluvad kolm artiklit: “*An Uncertainty Argument for the Identified Victim Bias*” [“Ebakindluse argument kindlakstehtava ohvri eelistamise kaitseks”], “*‘Take the pill, it is only fair!’ Contributory Fairness as an Answer to Rose’s Prevention Paradox*” [“Võta see tablett sisse, nii on õiglane!”: Panustav õiglus kui vastus Rose’i ennetuse paradoksile”] ning “*The Sufficentarian Alternative: A Commentary on Setting Health Care Priorities*” [“Piisavusteoreetiline alternatiiv: kommentaar tervishoiu prioriteetide seadmise teemal”].<sup>56</sup> Järgnevas kasutan ma nendele artiklitele viitamiseks lühendatud pealkirju ehk siis vastavalt “Ebakindluse argument”, “Võta see tablett sisse” ja “Piisavusteoreetiline alternatiiv”. Kõik need artiklid asetuvad rahvatervishoiu eetika arenevasse uurimisvaldkonda. Raamtekstis püüan ma selgitada, mis on rahvatervishoiu eetika ning kuidas väitekirja juurde kuuluvad artiklid tolle kirjandusega sobituvad. Samuti püüan ma avada tausta, mida on tarvis iga artikli konteksti mõistmiseks. Selleks teen ma kolme asja. Esiteks visandan ma rahvatervishoiu eetika kui alles tärkava uurimisvaldkonna peamised piirjooned. Teiseks näitan ma, kuidas käesolev väitekirj olemasoleva rahvatervishoiu eetika alase kirjandusega suhestub. Kolmandaks visandan ma lühidalt mõned peamised punktid väitekirja lõviosa moodustavatest

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<sup>56</sup> Zameska, J. A. (2022). An Uncertainty Argument for the Identified Victim Bias. *Journal of Applied Philosophy*, 39(3), 504–518.

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üksikartiklitest, avan pisut tausta, mida on tarvis nende asetamiseks käimas-olevate filosoofiliste vaidluste konteksti ning seon nad üldisemate küsimustega rahvatervishoiu eetikas. Järgnevalt esitan väitekirja igast peatükist (sh igast artiklist) kokkuvõtte.

## **1. ja 2. peatükk: Mis on rahvatervishoid? & Rahvatervishoiu eetika, bioeetika ja poliitikafilosoofia**

Esimeses (“Mis on rahvatervishoid?”) ja teises (“Rahvatervishoiu eetika, bioeetika ja poliitikafilosoofia”) peatükis tutvustan ma rahvatervishoidu ja rahvatervishoiu eetikat ning selgitan, kuidas see uurimisvaldkond eristub bioeetikast ja poliitikafilosoofiast.

Rahvatervishoiu eetika on selgelt eristuv ja kiiresti arenev rakenduseetika alamvaldkond. Selle põhirõhk on selliste eetiliste väljakutsete lahendamisel, mis keruvad rahvatervishoiu sekkumiste planeerimisel ja teostamisel, sealhulgas vaktsineerimisprogrammide läbiviimisel, nakkuspuhangute jälgimisel ja tõrjel, aga ka tervisealase ebavõrdsuse mõõtmisel ja vähendamisel ning paljude muude tegevuste käigus. Üldisemalt öeldes on rahvatervishoiu eetika eesmärgiks tegeleda rahvatervisesse sekkumisega kaasnevate keeruliste eetiliste väljakutsetega, et arendada välja tõhusaid ja eetilisi strateegiaid rahvastiku tervise ja heaolu tagamiseks.

Eetikat on traditsiooniliselt mõistatud eeskätt inimestevahelise nähtusena. Nõnda ka meditsiinieetikat ja bioeetikat. Viimased on traditsiooniliselt tegelenud kliinikus või laboratooriumis tõstatuvate küsimustega: kuidas peaks arstid suhestuma oma patsientidega? Kas arstid peavad patsientidega alati ausad olema? Mis on uute tehnoloogiate, nt emaka siirdamise või aju-organoidide eetiline staatus? Millal on lubatav kasutada implantatsioonielset geneetilist diagnoosi? Kas ravi ja parendamise vahel on moraalselt erinevust? Kuidas tuleks mõista kliinilise uuringu erinevate harude võrdsust [*clinical equipoise*] jne?<sup>57</sup> Ent paljud olulisematest edusammudest inimeste tervise vallas ei pärine õigupoolest individuaalse meditsiinilise sekkumise tasandilt. Paljud muutused on tulenenud hoopis paranenud toitumisest, mitmesugustest sotsiaalsetest muutustest ning rahvatervishoiu valdkonnast endast. Seetõttu on isegi pisut kummaline, et rahvatervishoiu eetika väljakujunemine spetsiifilise ja eraldiseisva valdkonnana nii kaua aega on võtnud. Ehkki rahvatervishoiu eetika alaseid töid on ilmunud aastakümnete jooksul püsivalt, on peavoolu bioeetika ja filosoofilise eetika nendega alles viimasel ajal lävima hakanud. Enne seda oli rahvatervishoiu eetika pigem epidemioloogide ja rahvatervise spetsialistide kui filosoofide ja eetikute pärusmaa. Ehkki selline suhteline tundmatus pakub suurepärast võimalust filosoofiliseks uurimistööks, on lõimituse puudumine peavoolu eetika ja filosoofiaga ohutanud ka jätkuvaid vaidlusi ja lahkarvamusi rahvatervishoiu eetika kui uurimisvaldkonna piiride üle.

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<sup>57</sup> Need näited on mõeldud puhtalt illustratiivsena ega moodusta ammendavat loetelu. Bioeetika paljudest küsimustest, probleemidest ja teemadest ülevaate saamiseks on hea alustada näiteks Kuhse jt (2016) raamatust.

Nõnda on suur osa valdkonnast endiselt vaidluse all. Osalt just sellise laialdase üksmeelepuuduse tõttu otsustasin ma struktureerida selle väitekirja temaatiliselt, mitte aga keskenduda rahvatervishoiu eetikale kõikehõlmava raamistiku arendamisele.

### 3. peatükk: Rahvatervishoiu eetika võtmeteemad

Kolmandas peatükis (“Rahvatervishoiu eetika võtmeteemad”) tutvustan ma peamisi teemasid rahvatervishoiu eetikas, mida kõik mu väitekirja artiklid adresseerivad: *ennetus*, *rahvastikud* ja *risk*. Siin annan ma neist lühikese sissejuhatava ülevaate. Väitekirja tegeleb kolme esileküündiva ja eriomase elemendiga rahvatervishoiu eetikas kui uurimisvaldkonnas: selle keskendumisega *ennetusele*, *rahvastikele* (rõhuasetuseks üksikisiku ja rahvastiku vaatenurkade tasakaalustamine) ning *riski vähendamisele*. Kõiki neid teemasid avatakse lähemalt 4. peatükis.

*Ennetuse eetika* on lõim, mis läbib kõiki käesoleva väitekirja artikleid. Nii “Võta see tablett sisse” kui ka “Ebakindluse argument” käsitlevad otseselt küsimusi, kuidas õigustada ennetavaid sekkumisi ning mil määral on meile lubatav sääraseid sekkumisi ravile eelistada. Selle käigus vastavad mõlemad artiklid ühele kogu mu uurimistöö alusküsimusele, mis puudutab kindlakstegemist, kuidas toimida siis, kui rahvastiku ja üksikisiku vaatenurgad ennetavate sekkumiste osas vastuollu satuvad. Paljudel juhtudel toovad ennetavad sekkumised rahvastiku tasandil kaasa suurt kasu, kuid üksikisiku vaatenurgast näivad kahjulikud (seda probleemi arutatakse üksikasjalikumalt punktis 4.2.1., nagu ka artiklites endis).

Põhiline rahvatervishoidu määratlev tunnus on selle keskendumine *rahvastikele*. Sellest tingitult on rahvastikueetika võtmetähtsusega teemaks ka mu väitekirja artiklites. Kolmandas peatükis arutan ma selle kaht aspekti. Esimene neist on küsimus inimestevahelise agregeerimise [*interpersonal aggregation*] moraalse staatuse kohta. Ehkki rahvatervishoiu esialgne utilitaristlik aluspõhi suhtus inimestevahelisse agregeerimisse pigem ebakriitiliselt, on paljud Rawlsi-järgsed teoreetikud osutanud mitmetele murekohtadele seoses agregaadi võimega paljude hüvanguks väheste õlule suurt koormat asetada. Agregeerimist puudutavad mured kajastuvad kõigis siinmainitud artiklites ning tõstatavad olulisi küsimusi nii rahvatervishoiu eetikas konkreetset kui ka normatiivses ja rakenduseetikas üldisemalt. Artiklis “Võta see tablett sisse” väidan, et ehkki põlvpillist tulenev agregeeritud kasu on selge, ei peaks me sekkumisi õigustama mitte agregeeritud kasu alusel, vaid keskenduda tuleks hoopis õigluse nõuetele. Artiklis “Ebakindluse argument” keelab minu poolt omaksvõetud *ex ante* kontraktualistlik raamistik inimestevahelise agregeerimise juba eksplitsiitselt. Inimestevahelise agregeerimise keelu tõttu on see teooria leidnud nii märkimisväärset heakskiitu kui ka kriitikat. Kontraktualismi hoidumine inimestevahelisest agregeerimisest on täpsemalt kõne all punktis 4.1.1. Viimaks, “Piisavusteoreetiline alternatiiv” püüab samuti seada märkimisväärseid piiranguid sellele, millist rolli inimestevaheline agregeerimine

prioriteetide seadmisel mängida võib, kaitstes selle asemel hoopis lävendit ületava üksikisikute kasu olulisust.

Teiseks ja inimestevahelise agregeerimisega lähedalt seotud aspektiks on üksikisikute staatus rahvastikes üldisemalt. Käesoleva väitekirja eriliseks huviks ongi üksikisik rahvatervishoiu eetika valdkonnas. Ehkki rahvatervishoiu eetika keskendub, nagu öeldud, eeskätt rahvastikele, juhin ma väitekirja jooksul korduvalt tähelepanu rahvastike ja üksikisikute puutepunktidele ning eetilistele pingetele, mis kerkivad siis, kui me mõlema huvisid adekvaatselt arvesse võtta püüame. Sellegipoolest olen ma püüdnud väitekirjas arvestada *individuaalse õigustamise* olulisust rahvatervishoiu eetikast mõtlemisel. Kõiki siinseid artikleid läbiv fookus on üksikisikutele olulise rolli andmine rahvastikest mõtlemisel, mille eesmärgiks on see, et rahvatervishoiu eetikas võetaks tõsiselt nii rahvastikke kui ka üksikisikuid.

Suurt osa tööd rahvatervishoiu vallas iseloomustab *riskide* haldamisele, isearanis *riskide vähendamisele* keskendumine. Sageli kuulub see valdkonnale omase ennetuse-fookuse juurde, kuid kerkib esile ka siis, kui küsida, kuidas tõlkida statistilisi teadmisi rahvastike kohta üksikisikuid puudutavale kujule. Vaidlusi tekitab see, kuidas oleks õige riski määratlada, nagu ka see, milliseid otsustamise reegleid tuleks riskide haldamiseks rakendada. Paljude standardsete rahvatervishoiu praktikate keskmes on riskide vähendamine. Sõeluuringud, mitmesugune testimine ning isegi katastroofidest tingitud kahju vähendamisele mõtlemine kuuluvad kõik rahvatervisega tegelevate ametkondade katsete hulka riske tõhusalt vähendada. Üks suurem küsimus rahvatervishoiu eetikas, mis on esil ka artiklites “Võta see tablett sisse” ja “Ebakindluse argument”, puudutab seda, milline on ühiskondlikult vastuvõetav riski tase ning millist kaalu omab riski vähendamine võrreldes teiste oluliste eesmärkidega. Lisaks mängib suures osas rahvatervishoiu eetikas suurt rolli küsimus, kuidas peaks jaotama terviseriske mõne rahvastiku piires. Selle küsimuse puhul on võtmetähtis see, kas meil tuleks keskenduda oma ennetavates sekkumistes nendele, keda arvatakse olevat “kõrge riskiga”, või sihtida hoopis rahvastikku kui tervikut, nagu punktis 4.2.1. lähemalt kõne all on. Ühtlasi käsitletakse seda küsimust eraldi ja otse artiklis “Võta see tablett sisse” ning kaudselt ka artiklites “Ebakindluse argument” ja “Piisavusteoreetiline alternatiiv”.

#### **4. peatükk: Väitekirja kuuluvad artiklid**

Neljandas peatükis avan ma iga väitekirjas sisalduva artikli tausta ning paigutan nad asjakohasesse konteksti. Artiklid, mis käesoleva väitekirja moodustavad, kuuluvad kõik laias laastus rahvatervishoiu eetika valdkonda ning eelmises jaos tõin ära mõned olulisemad üldised teemad või fookused, mis neid ühendavad. Hoolimata ühisest rahvatervishoiu eetika katustest toetuvad eri artiklid siiski erinevatele filosoofia allharudele, mis teeb asjassepuutuvast taustast tervikliku ja täieliku ülevaate andmise keeruliseks. Selle asemel avan antud peatükis eraldi iga artikli spetsiifilisemat tausta, millele järgneb vastava artikli lühikokkuvõte. Selle

lähenemise eesmärk on võimaldada lugejal mõista iga artikli unikaalset panust rahvatervishoiu eetikasse, asetades kõik artiklid käimasolevate filosoofiliste vaidluste konteksti. Kokkuvõtvalt võib öelda, et artikleid seovad omavahel väitekirja kolmandas peatükis kirjeldatud ühised teemad, aga ka nende üldisem taotlus üksikisiku ning rahvastiku omavahel põrkuvaid vaatenurki lepitada.

#### 4.1: Artikkel “Ebakindluse argument”

Väitekirja selles osas tutvustan ma “kindlakstehtavate” ning “statistiliste” elude mõisteid ning filosoofilist arutelu selle üle, kas meil tuleks eelistada kindlakstehtavaid elusid. Ma alustan nende mõistete määratlemisest ja kindlakstehtavate elude statistilistele eludele eelistamist puudutava filosoofilise arutelu resümeeerimisest, tõstes esile, kuidas enamik filosoofe on selle poolt, et mõista neid kaht “liiki” elusid võrdsena. Järgmiseks tutvustan ma kontraktualismi, silmapaistvat kaasaegset mitte-konsekventsialistlikku moraalteooriat, keskendudes sealjuures konkreetsemalt Scanloni kontraktualismile. Seejärel kirjeldan ma suurt lõhet kaasaegses kontraktualistlikus teoorias, s.o lõhet *ex ante* ja *ex post* kontraktualismi vahel. Annan ülevaate *ex ante* ja *ex post* kontraktualismi peamistest erinevustest. Viimaks annan lühikese ülevaate artiklist, milles väidan, et mõningates ebakindlates olukordades annab *ex ante* kontraktualism meile aluse eelistada kindlakstehtavaid elusid statistilistele eludele.

Artiklis “Ebakindluse argument” käsitlen ma küsimust, kas meil on võimalik leida moraalset õigustust kindlakstehtavate ohvrite eelistamisele ning seega seda, kas meil on moraalset alust eelistada kindlakstehtavaid elusid statistilistele eludele. Filosoofid on kindlakstehtavate elude eelistamise suuresti tagasi lükanud, kuna see läheb vastuollu mitmesuguste teiste moraali põhimõtete või –piirangutega, nagu näiteks isikute moraalse võrdsusega. Kõnealuses artiklis väidan aga, et teatud ebakindluse olukordades annab *ex ante* kontraktualism meile aluse eelistada kindlakstehtavaid elusid statistilistele eludele. Seejärel vaatan lähemalt, kuidas selline ebakindlus esineb “päriselulistest” juhtumites ning selgitan oma argumendi implikatsioone, uurides selleks AIDSi patsientidele kalli raviteenuse osutamise ning HIVi levikut ennetavate meetmete kättesaadavamaks tegemise vahel valimise küsimust. Ma väidan, et teatud juhtudel toetab ebakindluse argument AIDSi ravimise rahastamist, olgugi et HIVi ennetus võib olla kuluefektiivsem ja päästa rohkem elusid.

#### 4.2: artikkel “Võta see tablett sisse”

Väitekirja selles osas annan ma ülevaate kahest erinevast lähenemisest rahvatervise parandamisele: “rahvastiku”-põhine strateegia ning “kõrge riski”-põhine strateegia. Ma arutan, kuidas rahvastiku-põhine strateegia viib “paradoksini”, pakkudes suurimat kasu rahvastikule, kuid vähe kasu üksikisikutele. See viib meid filosoofilise mõistatuseni, kuidas sellist lähenemist õigustada. Mõistatuse

teeb eriti keeruliseks see, et keskendun siin individuaalsele õigustamisele. Edasi arutan ma avalike hüvede mõistet ning annan ülevaate arutelust selle üle, kuidas õiglus tekitab kohustusi avalike hüvede loomisesse panustamiseks. Artiklis “Võta see tablett sisse” toon ma need arutelud kokku ning väidan, et rahvastiku-põhiseid strateegiaid saab õigustada õigluse nõudest tingitud üksikisiku kohustustele apelleerides. Väitekirja selle osa lõpetab lühiülevaade antud artiklist.

Artiklis “Võta see tablett sisse” käsitlen ma küsimust, kuidas rahvatervishoiu rahvastiku-põhised strateegiaid ennetuse paradoksi valguses õigustada saab. Selleks vaatan ma lähemalt “polüpilli” näidet. Tegemist on odavate ja hõlpsasti kättesaadavate ravimite kombinatsiooniga, mis vähendavad oluliselt südamehaiguste riski ning millega kaasneb vaid madal kõrvaltoimete risk. Ettepanekud anda polüpilli kõigile üle 55-aastastele – mis oleks arhetüüpne näide rahvastiku-põhisest strateegiast – on suuresti tagasilükatud. Väidan aga, et selliste rahvastiku-põhiste strateegiate rakendamine panustab ühte võtmetähtsasse avalikku hüvesse – nimelt tervishoiusüsteemi võimekusse. Nõnda kannavad rahvastiku-põhised strateegiad nagu polüpill endas õigluse nõudest tingitud kohustust neis osaleda ning tagada, et kulud jaotuksid võrdselt. Sellega vaidlen ma vastu varasemale kirjan-dusele, mis on pidanud sedalaadi rahvastiku-põhiseid strateegiaid õigustamatuks.

### **4.3: artikkel “Piisavusteoreetiline alternatiiv”**

Väitekirja selles osas annan ma ülevaate tervishoius prioriteetide seadmise ja jaotava õigluse laiaist valdkonnast. Ma tutvustan nelja peamist jaotavat lähenemist: utilitarism, egalitarism, prioritism ja piisavusteooria. Seejärel uurin egalitarismi ja prioritismi lähemalt, esitades neist kahest lähenemisest võrdleva ülevaate. Edasi pöördun ma mõnevõrra vähemtuntud lähenemise ehk piisavusteooria poole, keskendudes eriti just piisavusteooria eristamisele prioritismist. Nende teooriate arutamise järel kirjeldan ma lühidalt, millist rolli mängivad need jaotava õigluse lähenemised rahvatervishoius. Väitekirja selle osa lõpetan ma lühiülevaatega artiklist “Piisavusteoreetiline alternatiiv”, kus ma väidan, et piisavusteooria kujutab endast usutavat teooriat, mis eristub prioritismist ja võib prioritismist teatud olukordades (nt rahvastikueetikas) üle olla.

Kõnealuses artiklis väidan, et piisavusteooria pakub veenvat ja teistest eristuvat lähenemist prioriteetide seadmisele tervishoius. Selleks eristan ma piisavusteooria kaht eri vormi – “nõrka” vormi, mis prioritismist tõepoolest ei eristu ning tugevat vormi, mida ma nimetan “parandatud leksikaalseks piisavusteooriaks”. Ma tõstatan piisavusteooria nõrga vormiga seoses ühe probleemi ning kaitsen selle pinnalt parandatud versiooni. Viimase elujõulisuse näitlikustamiseks rakedan ma parandatud piisavusteooriat rahvastikueetikale ning väidan, et see edestab mõningaid teisi silmapaistvaid vaateid antud valdkonnas. Järeldan, et juhul kui mõistame piisavusteooriat omaette teooriana ning mitte lihtsalt prioritismi teatud versioonina, pakub see usutavat ning jõulist lähenemist nii rahvastikueetikas kui ka prioriteetide seadmisel tervishoius.

## Kokkuvõte

Käesolev väitekirj on püüdnud adresseerida mõningaid peamisi alusküsimusi ja teemasid rahvatervishoiu eetikas, kuid seda viisil, mis austab fundamentaalset sidumust mõista rahvastikke millegi enama kui pelkade üksikisikute kogumitena, ent austab samal ajal ka üksikisikute tõsiseltvõtmise olulisust.

Väitekirj püüdis leida tasakaalu kahe olulise perspektiivi vahel rahvatervishoiu eetikas: rahvastiku tasandi fookuse, mis on võtmetähtsusega rahvatervishoiu praktikas, ning üksikisikule keskenduva käsituse, mis iseloomustab käesolevas väitekirjas rakendatud lähenemist eetikateooriale. Selle käigus püüdsin näidata mõlema perspektiivi tõsiseltvõtmise väärtust rahvatervishoiu eetika küsimuste käsitlemisel. Rahvastiku tasandi ning üksikisiku keskseid vaatenurki ühendades püüdsin väitekirjaga anda nüansirikast arusaamist rahvatervishoiu eetika võtmeküsimustest ja -teemadest. Usun, et nende kahe perspektiivi keerukuste ja vastastikutuste suhete arvestamisega on mul õnnestunud pakkuda uudseid ja sisukaid tähelepanekuid mõningate kõige põletavamate rahvatervishoiu eetika küsimuste osas. Selleks olen ma kirjutanud ja avaldanud mitu artiklit, millest kolm on lisatud käesolevasse väitekirja. Artiklis “Ebakindluse argument” (Zameska, 2022) uurin ma kindlakstehtavate elude statistilistele eludele eelistamise moraalset õigustamist ebakindluse korral. Ma väidan, et teatud ebakindlates olukordades annab *ex ante* kontraktualism meile aluse eelistada kindlakstehtavaid elusid. Ma näitlikustan selle argumendi implikatsioone AIDSi ravi ja HIVi ennetuse vahel valimise juhtumiga. Artiklis “Võta see tablett sisse” (Zameska, 2021b) analüüsin ma aga “polüpilli” taoliste rahvastiku-põhiste strateegiate õigustamist ennetuse paradoksi valguses. Ma väidan, et rahvastiku-põhised strateegiad nagu polüpill panustavad võtmetähtsusega avalikku hüvesse – tervishoiusüsteemi võimekusse – ning kannavad seega endas õigluse nõudest tingitud kohustust kulude võrdseks jaotamiseks. Viimaks, artiklis “Piisavusteoreetiline alternatiiv” (Zameska, 2021a) võtan ma laiema ja teoreetilisema vaatepunkti ning väidan, et piisavusteooriat õigesti mõistes annab see meile usutava ja tõhusa lähenemise rahvastikueetikale ning prioriteetide seadmisele tervishoius.

Loodan, et isegi kui mu artiklite konkreetsete järeldustega ei nõustuta, on mul siiski õnnestunud näidata, et selline lähenemine rahvatervishoiu eetikale, mis võtab üksikisikut meie moraalse hoole keskmeks tõsiselt, on viljakas ning võimeline pakuma kaitstavaid ja usutavaid vastuseid mõningatele peamistele rahvatervishoiu eetika eriomastele küsimustele.

# CURRICULUM VITAE

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## Contact Details

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## AOS/AOC

Areas of Specialization: Applied ethics, normative ethics, bioethics, public health ethics

Areas of Competence: Political philosophy, philosophy of medicine

## Academic Positions

2023– Researcher  
Beyond Bad Apples: Towards a Behavioral and Evidence-Based Approach to Promote Research Ethics and Research Integrity in Europe (BEYOND) (Horizon Project)  
2021– Junior Research Fellow  
Department of Philosophy, University of Tartu  
2022–2023 Visiting Lecturer  
Ragnar Nurkse Department of Innovation and Governance, Tallinn University of Technology  
2020– Researcher  
Ethically Responsible Innovations in reproductive medicine (ERIN) (Horizon Project)  
2020–2022 Lecturer/Project Associate  
ATHIKA (Erasmus+ Project)

## Educational Background

2019–2023 PhD in Philosophy  
Department of Philosophy, University of Tartu  
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Dissertation Title: *The Ethics of Public Health: Balancing the Interests of Populations and Individuals*  
Supervisor: Kadri Simm

- 2017–2019 MA in Philosophy, *cum laude*  
Department of Philosophy, University of Tartu  
Tartu, Estonia
- 2013–2016 BA in Philosophy and Religious Studies, *cum laude*  
Department of Philosophy and Religious Studies  
American University, Washington D.C.

## **Publications**

### **Articles (sole authorship):**

- 2023 “Luck Egalitarianism and Covid-19: the case for compensating children for school closures” *Studies in Philosophy and Education* 42, 65–81.
- 2022 “An Uncertainty Argument for the Identified Lives Bias.” *Journal of Applied Philosophy* 39:3, 504–518.
- 2021 ““Take the pill, it’s only fair!” Contributory fairness as an answer to Rose’s prevention paradox.” *Public Health Ethics* 14:3, 221–232.
- 2021 “The Sufficiency Alternative: A commentary on *Setting Health Care Priorities*.” *Diametros* 18:68, 46–59.

### **Articles (co-authorship):**

- 2022 “Frontline Healthcare Professionals’ Views Regarding the Impact of COVID-19 on Ethical Decision-Making: A Multicentre Mixed-Methods Study from Estonia” (with Kadri Simm and Kadi Lubi) *Healthcare* 10:4, 711.
- 2022 “Psühhosotsiaalsed ja eetilised väljakutsed tervisealases kriisisituatsioonis: eesliini tervishoiutöötajate hinnangud ja kogemused COVID-19 pandeemia esimese laine näitel.” [Ethical and psychosocial challenges and decision-making during a public health emergency: the perceptions and experiences of frontline healthcare professionals during the first wave of the COVID-19 pandemic]. (with Kadi Lubi, Kadri Simm, Kaja Lempu, and Angela Eensalu-Lind) *Eesti Arst* 101:4, 214–223.
- 2021 ““Other patients become a secondary priority:” Perceptions of Estonian frontline healthcare professionals on the influence of COVID-19 on health (in)equality and ethical decision-making.” (with Kadi Lubi, Kadri Simm, Kaja Lempu, and Angela Eensalu-Lind) *Journal of Communications In Healthcare* 15:1, 54–63.
- 2021 “Halbade uudiste edastamine patsientidele: tõerääkimise uuring Eesti arstide ja õdede seas [Communicating bad news to patients: a truth-telling study amongst Estonian physicians and nurses].” (with Kadri Simm, Reet Urban, Külliki Seppel, Dalia Dzaganija, and Liina Animägi) *Eesti Arst*, 100:9, 477–484.

## Conference, Colloquium, and Workshop Talks

- “Counterfactual indeterminacy and the Narrow Person-affecting Principle”  
06/2022 *Nordic-Baltic Philosophy of Medicine Network Workshop*, Greifswald, Germany.
- “How do we distribute risk fairly?: Epistemic Lotteries and the Separateness of Persons”  
06/2022 *Bioethics and Political Philosophy: Nordic Perspectives, workshop on Well-Being, Beneficence, and Harm*, Skalholt, Iceland.
- “Epistemic Lotteries and the Separateness of Persons”  
05/2022 *Practical Philosophy Colloquium*, Department of Philosophy, University of Tartu, Tartu, Estonia.
- “Counterfactual indeterminacy and the narrow person-affecting principle.”  
11/2021 *Practical Philosophy Colloquium*, Department of Philosophy, University of Tartu, Tartu, Estonia.
- “Ethics, children, education and the COVID-19 pandemic”  
09/2021 *Ethics, Children, Education, and the Covid-19 Pandemic*, Centre for Ethics and Poverty Research, University of Salzburg (via Zoom).
- “Luck Egalitarianism and Children”  
09/2021 *EFAK (Estonian Annual Philosophy Conference) XVI*, Tartu, Estonia.
- “COVID-19 as a new indicator impelling health inequalities: the perceptions of frontline healthcare professionals in Estonia.”  
08/2021 *15th European Sociological Association Conference*, Barcelona, Spain.
- “Telling the truth to the patient. An Estonian study.”  
12/2019 *Practical Philosophy Colloquium*, Department of Philosophy, University of Tartu, Tartu, Estonia.
- “A Non-Comparative Notion of Harm as the Basis for Justified Claims in Healthcare”  
11/2019 *Bioethics and Political Philosophy: Nordic Perspectives Workshop on Justice*, Aarhus, Denmark.
- “On Health Evaluation”  
06/2019 *Nordic-Baltic Philosophy of Medicine Network Workshop*, Tartu, Estonia
- “Philosophy of Food for Public Health”  
06/2018 *Nordic-Baltic Philosophy of Medicine Network Workshop*, Aarhus, Denmark

## **Teaching, supervision, and other related activities**

### **Undergraduate courses**

- 2023      *Social and Ethical Aspects of Engineering*, Department of Philosophy, University of Tartu
- 2022      *Political Philosophy* (with Amriouche Moktefi), Ragnar Nurkse Department of Innovation and Governance, Tallinn University of Technology
- 2021      *Public Health Ethics*, Department of Philosophy, University of Tartu
- 2020      *Main Topics in Ethics* (with Semyon Reshenin), Department of Philosophy, University of Tartu

### **Other courses**

- 2017–      Various bioethics courses at the annual *TÜ Philosophy Winter School*

### **Thesis review**

- 2021      MA Thesis prospectus reviewer, Department of Philosophy, University of Tartu
- 2021      BA Thesis reviewer, Department of Philosophy, University of Tartu

## **Academic Service**

### **Conference and Workshop Organization**

- 11/2020    *4th EECF (European Early Career Philosophers' Network) Workshop*, Virtual/Tartu, Estonia
- 10/2018    *"The Ethics of Conduct in Debate" Conference*, Tartu, Estonia

### **University and Departmental Service**

- 2021–      University of Tartu Center for Ethics Council Member
- 2020–      University of Tartu Department of Philosophy MA Program Council Member
- 2018–      University of Tartu Institute of Philosophy and Semiotics Council Member

### **Professional Activities**

- 2021–      Federation of Estonian Student Unions (Eesti Üliõpilaskondade Liit) Council Member

### **Reviewing**

Articles *Journal of Applied Philosophy*; *Cambridge Quarterly of Healthcare Ethics*; *BMC Medical Ethics*; *Diametros*

### **Translations**

- 2020      English translation of an interview between Joseph Raz and Hent Kalmo, on behalf of Michael Sevel, University of Sydney

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### **Akadeemilised ametikohad**

2023– Researcher  
Beyond Bad Apples: Towards a Behavioral and Evidence-Based  
Approach to Promote Research Ethics and Research Integrity in  
Europe (BEYOND) (Horizon Project)  
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University of Technology  
2020– Researcher  
Ethically Responsible Innovations in reproductive medicine  
(ERIN) (Horizon Project)  
2020–2022 Lecturer/Project Associate  
ATHIKA (Erasmus+ Project)

### **Hariduskäik**

2019–2023 PhD in Philosophy  
Department of Philosophy, University of Tartu  
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Department of Philosophy and Religious Studies  
American University, Washington D.C.

## Publikatsioonid

### Artiklid (ainuautor):

- 2023 "Luck Egalitarianism and Covid-19: the case for compensating children for school closures" *Studies in Philosophy and Education* 42, 65–81.
- 2022 "An Uncertainty Argument for the Identified Lives Bias." *Journal of Applied Philosophy* 39:3, 504–518.
- 2021 "“Take the pill, it’s only fair!” Contributory fairness as an answer to Rose’s prevention paradox." *Public Health Ethics* 14:3, 221–232.
- 2021 "The Sufficentarian Alternative: A commentary on *Setting Health Care Priorities*." *Diametros* 18:68, 46–59.

### Artiklid (kaasautorlus):

- 2022 "Frontline Healthcare Professionals’ Views Regarding the Impact of COVID-19 on Ethical Decision-Making: A Multicentre Mixed-Methods Study from Estonia" (with Kadri Simm and Kadi Lubi) *Healthcare* 10:4, 711.
- 2022 "Psühhosotsiaalsed ja eetilised väljakutsed tervisealases kriisisituatsioonis: eesliini tervishoiutöötajate hinnangud ja kogemused COVID-19 pandeemia esimese laine näitel." [Ethical and psychosocial challenges and decision-making during a public health emergency: the perceptions and experiences of frontline healthcare professionals during the first wave of the COVID-19 pandemic]. (with Kadi Lubi, Kadri Simm, Kaja Lempu, and Angela Eensalu-Lind) *Eesti Arst* 101:4, 214–223.
- 2021 "“Other patients become a secondary priority.” Perceptions of Estonian frontline healthcare professionals on the influence of COVID-19 on health (in)equality and ethical decision-making." (with Kadi Lubi, Kadri Simm, Kaja Lempu, and Angela Eensalu-Lind) *Journal of Communications In Healthcare* 15:1, 54–63.
- 2021 "Halbade uudiste edastamine patsientidele: tõerääkimise uuring Eesti arstide ja õdede seas [Communicating bad news to patients: a truth-telling study amongst Estonian physicians and nurses]." (with Kadri Simm, Reet Urban, Külliki Seppel, Dalia Dzaganija, and Liina Animägi) *Eesti Arst*, 100:9, 477–484.

## Konverents, kollokvium ja töötubade ettekanded

- “Counterfactual indeterminacy and the Narrow Person-affecting Principle”  
06/2022 *Nordic-Baltic Philosophy of Medicine Network Workshop*, Greifswald, Germany.
- “How do we distribute risk fairly?: Epistemic Lotteries and the Separateness of Persons”  
06/2022 *Bioethics and Political Philosophy: Nordic Perspectives, workshop on Well-Being, Beneficence, and Harm*, Skalholt, Iceland.
- “Epistemic Lotteries and the Separateness of Persons”  
05/2022 *Practical Philosophy Colloquium*, Department of Philosophy, University of Tartu, Tartu, Estonia.
- “Counterfactual indeterminacy and the narrow person-affecting principle.”  
11/2021 *Practical Philosophy Colloquium*, Department of Philosophy, University of Tartu, Tartu, Estonia.
- “Ethics, children, education and the COVID-19 pandemic”  
09/2021 *Ethics, Children, Education, and the Covid-19 Pandemic*, Centre for Ethics and Poverty Research, University of Salzburg (via Zoom).
- “Luck Egalitarianism and Children”  
09/2021 *EFAK (Estonian Annual Philosophy Conference) XVI*, Tartu, Estonia.
- “COVID-19 as a new indicator impelling health inequalities: the perceptions of frontline healthcare professionals in Estonia.”  
08/2021 *15th European Sociological Association Conference*, Barcelona, Spain.
- “Telling the truth to the patient. An Estonian study.”  
12/2019 *Practical Philosophy Colloquium*, Department of Philosophy, University of Tartu, Tartu, Estonia.
- “A Non-Comparative Notion of Harm as the Basis for Justified Claims in Healthcare”  
11/2019 *Bioethics and Political Philosophy: Nordic Perspectives Workshop on Justice*, Aarhus, Denmark.
- “On Health Evaluation”  
06/2019 *Nordic-Baltic Philosophy of Medicine Network Workshop*, Tartu, Estonia
- “Philosophy of Food for Public Health”  
06/2018 *Nordic-Baltic Philosophy of Medicine Network Workshop*, Aarhus, Denmark

## **Õpetamine, juhendamine ja muud sellega seotud tegevused**

### **Bakalaureuseõppe kursused**

- 2023 *Social and Ethical Aspects of Engineering*, Department of Philosophy, University of Tartu
- 2022 *Political Philosophy* (with Amriouche Moktefi), Ragnar Nurkse Department of Innovation and Governance, Tallinn University of Technology
- 2021 *Public Health Ethics*, Department of Philosophy, University of Tartu
- 2020 *Main Topics in Ethics* (with Semyon Reshenin), Department of Philosophy, University of Tartu

### **Muud kursused**

- 2017– Various bioethics courses at the annual *TÜ Philosophy Winter School*

### **Lõputöö retsensioon**

- 2021 MA Thesis prospectus reviewer, Department of Philosophy, University of Tartu
- 2021 BA Thesis reviewer, Department of Philosophy, University of Tartu

### **Akadeemiline teenistus**

#### **Konverentsi ja töötubade korraldamine**

- 11/2020 *4th EECF (European Early Career Philosophers' Network) Workshop*, Virtual/Tartu, Estonia
- 10/2018 *"The Ethics of Conduct in Debate" Conference*, Tartu, Estonia

### **Ülikooli ja osakondade teenistus**

- 2021– University of Tartu Center for Ethics Council Member
- 2020– University of Tartu Department of Philosophy MA Program Council Member
- 2018– University of Tartu Institute of Philosophy and Semiotics Council Member

### **Professionaalsed tegevused**

- 2021– Federation of Estonian Student Unions (Eesti Üliõpilaskondade Liit) Council Member

### **Artiklite retsenseerimine**

Artiklid *Journal of Applied Philosophy*; *Cambridge Quarterly of Healthcare Ethics*; *BMC Medical Ethics*; *Diametros*

### **Tõlked**

- 2020 English translation of an interview between Joseph Raz and Hent Kalmo, on behalf of Michael Sevel, University of Sydney

## DISSERTATIONES PHILOSOPHICAE UNIVERSITATIS TARTUENSIS

1. **Jüri Eintalu.** The problem of induction: the presuppositions revisited. Tartu, 2001.
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