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Setting limits to public health efforts and the healthisation of society

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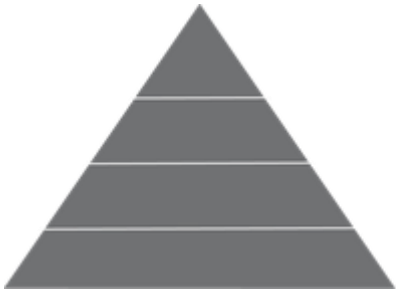

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Setting limits to public health efforts and the healthisation of society

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Public health sets out to promote or improve the health of the population. Where should it stop in such quest? This is the question I would like to explore in this essay. I submit that if there is no threshold set to public health efforts there will likely be ever more "healthisation" of our lives, as there is no internal stoppage when pursuing public health. It is important to challenge healthisation, because it has negative impact on people's lives and potentially the economy as well, as it undermines individual liberty and goes along with opportunity costs; hence the need for a threshold of "enough" population health. One reason why there is no such internal limit in public health efforts is due to the value of health. Since health is deemed to be an intrinsic and an instrumental value it seems that to improve health is always a worthy pursuit. Another reason for expansion of state activity is that public health aims not just at an improvement of the individual absolute level of health of citizens but also at a comparative level of health that is as equal as possible between populations. Since there will always be some amount of health inequalities there will also always be reasons to improve the health at least of some citizens – hence the internally unstoppable effort to health improvement.
A promising theoretical account in setting a threshold to public health efforts is sufficientarianism. It determines a level of what is enough provision for people so that they have sufficiently good conditions to live a decent live. Sufficientarianism is a theory of justice; it claims that the sufficient level of provision is what we owe to each other, hence what citizens can demand as a matter of basic rights. Since public health is a political task, its remit should be based on the proper boundaries of a state's responsibilities. I contend that sufficientarianism is in line with a liberal approach, although it is, in a sense, a minimal theory of justice. In virtue of focusing on absolute levels that each citizen should be able to reach, it is not aimed at equalizing the relative position of citizens and it limits the value of health in the political arena. So sufficientarianism is not affected by the two reasons for health improvement mentioned earlier and can set limits to healthisation.

The paper proceeds as follows. First, I will introduce my understanding of sufficientarianism. This is important, as there are several different versions of such a conception of justice. I will then focus on matters of health. In order to assess different health policies it is vital for public health institutions to be able to say in what sense one policy leads to more health in the population. This requires a gradable measure of health, a measure that differs from the traditional point of view in medicine, where health is simply the absence of disease. In the second section I explain the concept of health in public health and discuss some of the challenges it contains, most notably in making sense of health as a single measure. I argue that because we cannot measure health directly we need proxies, and that these alternative scales point at a need for a "currency", especially when thinking about justice. In the third section I put the debate on justice regarding population health in the context of justice in welfare states. This way of contextualising also points at the wider focus of justified state action. I argue for a sufficientarian notion of the purpose of the welfare state, which is given by the idea of inclusion of all citizens into society. Public health in this respect aims at steering the social determinants of health so that everyone can be able to feel as a member of a society. In the final, fourth, section I elaborate on the currency of public health justice. I develop the outlines of a framework of health-related basic needs. It is important to always see these health-related needs in relation to other basic needs of human beings as well, such as individual liberty and sociality, especially when considering public health policies.

1. Sufficientarianism

Several authors tend to assume that the "world of justice" is altogether divided by three clusters of theories: egalitarianism, prioritarianism, and sufficientarianism (Parfit 1995). They then argue for, say, egalitarianism, by objecting to one of the other theories (Casal 2007). But it seems more adequate to first consider the context of justice that is being discussed. In the case under discussion in this paper, public health, the context is set by institutions of the welfare state, so our question is which theory of justice, if any, would be suitable as a theory of the just welfare state. We are dealing here with a real site of social justice, not with a purely theoretical world of justice.

It is also debatable whether authors who argue against one theory of justice thereby automatically support another one. This only works if there are just these alternatives

and if they are in direct competition. But not all accounts of social justice follow the same logic; most notably for our purposes there is an important difference between comparative and noncomparative justice. I submit that sufficientarianism follows a different logic than egalitarianism, since it is an account of noncomparative justice, whereas egalitarianism is a theory of comparative justice. Sufficientarianism, in virtue of focusing on what is enough, is concerned with determining what is due to people on the basis of a set standard, not on the basis of what other people have. In certain versions, it may even allow for egalitarian demands in addition to sufficientarian ones; at the very least sufficientarianism is not necessarily in direct competition with egalitarianism.

Joel Feinberg describes the difference between comparative and noncomparative justice thus: "In all cases, of course, justice consists in giving a person his due, but in some cases one's due is determined independently of that of other people, while in other cases, a person's due is determinable only by reference to his relations to other persons. I shall refer to contexts, criteria, and principles of the former kind as noncomparative, and those of the latter sort as comparative." (Feinberg 1974, 298)

We can describe a general idea of justice following Feinberg's account: For all X that fulfill criterion Y, Z is due. This can be specified in various ways. For instance, a theory of health justice might claim that for all citizens with a family member who developed breast cancer should have access to free additional early detection programs. This would be a noncomparative principle of justice. Alternatively, we might hold that only 5% of the population with the highest risk of getting breast cancer should get such access. Whether one gets additional screening for free in this second scenario depends on the health risk status of other people. It is therefore a comparative principle of justice.

Sufficientarianism is concerned with the situation of each person, and it demands that everyone should be above a certain threshold. What is due to each person, in sufficientarianism, is determined by the standard set by the threshold of "enough"; hence what is due to people is not determined by the relations of any person to another person – save for complicated cases, which I ignore for the time being. These complications have to do with the fact that what is enough can be based on relational aspects insofar as the level of development within a society might influence the level of sufficiency. Hence what is due to people might be partially due to what others have. Yet this is a derivational or indirect aspect of social justice.

There might be additional concerns of justice where comparative principles are considered, especially in competitive scenarios. Levelling the playing field often involves comparative aspects, such as the level of skills of competitors or their relative advantage. Similarly, there might be concerns of comparative justice when considering the level of health of citizens. For instance, we might hold that it is unjust if rich people live longer than others because they have access to better living conditions and more advanced health care. So there might be egalitarian concerns in addition to sufficientarian ones. This might especially be fitting because health seems to have competitive aspects, which are summarized in its instrumental value.

Although it is not my remit in this essay to discuss the merits of egalitarianism in health care or public health, I nevertheless would like to stress that some of the egalitarian concerns may be sufficiently described either by a sufficientarian perspective or dealt with by other means than reallocation of resources, welfare, or access to advantages. Sufficientarianism can opt for an equal distribution of goods, because it might happen that everyone is owed a certain good. Equal distribution, in these cases, is a consequence of a noncomparative principle. Also, some egalitarian concerns might be dealt with by putting up fences between different "spheres of justice" (Walzer 1983). If access to health care or to healthy environments were not based on ability to pay, there would be fewer concerns about rich people tending to live longer or similar inequalities.

There are several objections to sufficientarianism, some of them are based on confusions, others are more important. For instance, some authors claim that the threshold of sufficiency, which is usually described as aimed at securing a decent life, implies that a life below such a standard is not worth living (Segall 2014, 2; Ram-Tiktin 2012, 343). This is wrong. Whether a live is worth living necessarily is based on subjective evaluation. Sufficientarianism, in contrast, determines external conditions for a decent life, hence is not based on subjective evaluation. Obviously, a life can be not worth living for a person way above the threshold, and all that sufficientarianism claims is that a life below the threshold is facing bad or indecent living conditions.

Another objection that many authors are concerned with is that the threshold set by sufficientarianism would need to be either ambiguous or arbitrary (e.g. Arneson 2000, 56; Casal 2007, 312ff.) Arbitrariness is of course the very contradiction of justice. But surely there is an important difference between indeterminacy and arbitrariness, which is however occasionally confused (Segall 2014, 2). If the threshold should prove to be indeterminate or ambiguous, this is not undermining its rational status within a theory

of justice. What is left indeterminate in a theory of justice can be determined by real decisions within society.

Again, some authors complain that sufficientarianism does not deal with unjust conditions above the threshold and implies dubious allocations below the threshold, because resources might be "wasted" on the aim of bringing people up to the threshold. This objection is based on confusion, although it has to be said that some supporters of sufficientarianism are also guilty of it. It relies on an inadequate description of the very purpose of sufficientarianism, namely as allegedly making comparative evaluations between different possible allocations of goods. Sufficientarianism allegedly assumes that it matters more that people have enough than other concerns, or that priority should be given to the badly off (Freiman 2012, 26; Segall 2014, 1; Huseby 2010, 180; Benbaji 2005; cf. Widerquist 2010). This is correct in a sense, but nevertheless inadequate. It is correct insofar sufficientarianism indeed claims that it is important that people have enough; but this does not imply that it matters *more* than other things or that indeed other concerns of justice do not matter at all. There can be a change in the sorts of reasons when we argue about matters of justice, and sufficientarianism is based on particular reasons (Shields 2012). They concern what is a just distribution of goods, not how it compares to other possible distributions. The latter requires reasons that go over and above the claims of sufficientarianism, for instance regarding the aggregation of different units of goods.

In addition, there is unfortunately a tendency in the philosophical literature to think in numbers (Parfit 1995; Crisp 2003). We then find politically and economically hampered debates on different allocations of fixed amounts of goods, which are supposed to be distributed according to different principles of justice. These different hypothetical scenarios of allocation – which are of course removed from the real world of a welfare state – are then compared and philosophers' intuitions about their justness are called upon. But this cannot be the way forward in thinking seriously about real issues of justice.

In sum, in this section I have defended a version of sufficientarianism, which is a noncomparative theory of justice. It does not rule out additional comparative facets of justice – it is simply not concerned with these as a matter of philosophical theory. Such a sufficiency approach aims at setting a threshold of social justice, of what is enough. Surely citizens might want to secure for everyone a level of provision that is above of what is enough on a noncomparative basis, for instance because they want to live in a

very equal society. Sufficientarianism does not undermine such a desire, it simply states that this is not its concern, and it remains to be seen whether such an additional demand of distributional equality can be based on philosophical arguments, or whether it is more of a matter of political preference. Whether the account defended here is also substantially minimal depends on the level of provision set by the threshold. This will be discussed below. Since we are concerned with the context of health care and the social determinants of health, the first important issue that partially decides the level of sufficient provision is the notion of health.

2. The concept of health in public health

It is important to understand that the concept of health is understood in a special sense in public health. In medicine, health is commonly understood in a negative fashion, as the absence of disease, or as medical normality. This is a minimal and absolute concept of health. A person is either healthy or not, there are no grades of health. In order to be regarded as healthy, it is merely necessary not to be in any pathological condition. To be sure, there are attempts to conceptualise health in a positive way, for instance in the well-known formulation of the World Health Organisation: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". Yet, this definition has had no impact on medical theory or practice and has actually been criticised for its lack of distinction between well-being or happiness and medical health (Callahan 1973).

The concept of health in public health differs from this medical viewpoint in several important respects. It is a relative or gradable notion, and it applies to groups or populations. A person (or group of persons), in this perspective, can be more or less healthy than another person (or group of persons). This might even be the case if there is no disease present; people can be less healthy than others in a public health perspective simply because they belong to a group that is statistically more likely to fall ill. Consequently, it can easily happen that from this point of view we see problematic conditions over and above the absence of disease. After all, some risks of disease are constantly present, and they can be targeted by state action. Because social determinants of health are seen in such close relation to medical conditions it is but a small step to a welfare notion of health (Venkatapuram 2011). This is an interpretation of the notion of health that includes conditions that are internal and external to the

person under the umbrella of health, such as being able to experience nature or have occasions for recreation, which are not seen themselves as health conditions in medicine.

Usually, public health experts focus on particular socio-economic groups, for instance unemployed persons or single mothers. So when epidemiologists refer to population health they refer to a statistically aggregated sum of individual health traits or health statuses. The way these groups or populations are determined depends on the particular purpose of a study. Ultimately these considerations depend on hypotheses about social or socioeconomic determinants of health, or – to use another expression familiar to a public health perspective – the "causes of causes" (of health status). Hence epidemiologists end up with findings about possible correlations between particular circumstantial aspects of citizens and their health conditions. Findings may be sought regarding socio-economic aspects, such as income, educational background or gender, or behavioural aspects, such as lifestyle and diet. With these statistical correlations it is possible to make comparisons between populations regarding their health, even on an international level. Obviously it is also possible to compare different policies in tackling those possible inequalities. In more popular publications, public health scholars then use simple slogans, such as "inequality is bad for your health", or "uneducated people die younger", which only makes sense from a population perspective. Such a collective perspective, though, it needs to be stressed, tends to ignore aspects on the individual level, for instance individual responsibility for health status and also – more importantly for the worries that drive my endorsement of sufficientarianism – individual rights that might conflict with policies to improve the health status of some populations.

The comparative perspective of public health depends, up to a point, on the fact that people can have certain dispositions to fall ill. A smoker, for instance, is more likely than a non-smoker to suffer from any lung disease. A person who works out and is generally fitter than others is less likely to catch a cold than others. Epidemiological research also establishes correlations between external environments and health conditions. For instance, a dark and unpleasant home, or a very stressful work environment, can all enhance the chance to fall ill.

In order to distinguish grades of health the perspective of public health needs measures of comparison. In what respect can a person (or group) be healthier than another? What may be criteria for determining grades of health? These challenges regarding the measurement of levels of health are very difficult to surmount. This is because health is

a complex aggregation of different aspects. We can only compare people in certain respects; we can never say whether they are more healthy than others *tout court* (Hausman 2012). Is someone with an irritable lung but a robust psyche less healthy than a marathon runner experiencing bullying at work? Such questions cannot be answered unless we focus on certain aspects of functioning. Public health usually works with only some particular health aspects, such as mental resilience or physical fitness. It also relies on proxies of these criteria, since they cannot easily be directly measured, hence public health for instance collects data about frequency of visits at a doctor or the number of days on sick leave. Finally, there is a problem of collecting data in epidemiology, which focuses on populations, not individual persons. Epidemiology requires certain abstractions for purposes of generating statistical data. A common statistical measure for comparing health of certain groups is life expectancy. Obviously here it is not individual health that is measured and compared but a heavily modified proxy for health conditions.

I belabour this point about problems in measuring health because it is an issue that also affects any attempt to introduce thresholds of enough health. Hence it is a challenge for my sufficientarian point of view as well. Still, it is a surmountable problem after all, because public health does not directly promote individual health, which would be too difficult to measure. It rather aims at providing the necessary means in order to be able to live a healthy life. So "enough health" will translate into something like "enough resources and capacities to live a minimally decent life in relation to health aspects". The "currency" (Cohen 1989) of cashing out the level of health that everyone should be able to reach as a matter of social justice within a sufficiency approach need not be different from any common public health perspective. One such possible currency would be for instance a capabilities approach (Venkatapuram 2011). The difference, though, to the idea of health promotion we find in public health is that sufficientarianism about public health sets a minimum threshold, which is usually not discussed within recent approaches of public health, at least in rich countries. Here, promotion of health usually allows for improvements over and above the prevention of indecent health-related living conditions, because health is understood as a conditions that is more than just the absence of disease.

The fact that public health allows for grades of health therefore opens the possibility to discuss health promotion in a way that includes enhancing health over and above the absence of disease. This is exactly the area where the worries about "healthism" begin.

Health, understood in a positive sense, like in the definition of the WHO, does not have an internal normative stoppage or threshold of adequate health. More health is always better than less. For egalitarians, more health is also required for some groups as a matter of justice. What is more, the improvement of health is not merely, and maybe not even primarily, a matter of improving the internal resources of a person, such as stamina and nutrition, but also of the social determinants of health, such as quality of work environment, access to leisurely activities and so on. We can think of many ways to – if only indirectly – improve health dispositions of citizens by improving their environment as well as changing their lifestyles. So the possible scope for public health interventions is very wide indeed. If we now add the current value that is attached to health in many societies, we can see how this emphasis on health promotion opens the door for worries about paternalistic interventions, which are even more worrisome if interventions are due to state action, or legal measures. One way to avoid these problems would be to introduce a threshold of "enough" health, hence a sufficient grade of health that every citizen should be able to reach, without overreaching the target of adequate health promotion.

3. The aims of state action

Public health is a political task. It is part of the remit of every welfare state. In order to understand the proper role of public health it is therefore helpful to discuss it in the wider context of state action, particularly the purpose of a welfare state. More concretely, we might want to phrase the question: How much of a concern for the state is the health of the population? The answer to this particular question is related to the more general question regarding the aims of the welfare state, while this latter problem is again related to the even more abstract notion of social justice. We probably would not have any welfare state institutions, such as schools, unemployment benefits, or publicly funded health care, if we would not deem its provision a matter of social justice. So what level of welfare state provision do we owe to each other? I understand these questions not merely to pose problems of normative political theory alone, but I would like to discuss them in the context of the real worlds of welfare states. This commitment to a more realist political outlook admittedly requires more methodological considerations than I can deliver in this paper (but see Waldron 2012, for some interesting discussion; cf. Schramme 2008).

I believe it is important to keep the mentioned context of real welfare states in mind, especially when discussing public health, which targets not directly the health of individual citizens, but the social determinants of health. For the purposes of my argument I will assume that a minimalist understanding of the purpose of the welfare state is to demand the inclusion of every citizen into society. This is itself a highly abstract requirement. The basic idea is that every citizen should be included as a member of a society. It is focused on the absolute, or noncomparative, social status of citizens: being a member of society. Such an abstract description allows for various concrete provisions and different emphases on values that underlie the idea of inclusion. Hence there can be variants of welfare states (Esping-Andersen 1990; Kaufmann 2013). Also, whether people are able to deem themselves to be members of a particular society can require different provisions relative to the level of development. For instance, if the majority of people within a society have access to computers and modern media, it might be possible that some citizens, who cannot provide for access to these media by themselves, are excluded from society in this respect. More pertinent to our discussion, in a society that lives for an average of 80 years, it might be a sign of possible exclusion if some people die in their fifties due to their living conditions. So although there is an absolute threshold set by the idea of inclusion, the exact location of such a threshold can be relative to the societal and historical context.

To focus on the idea of social inclusion in relation to the aims of the welfare state is not an unusual idea. In fact, it can be found in one of the most advanced and renowned theories of the origins of the welfare state: Thomas H. Marshall's *Citizenship and Social Class*. Marshall distinguishes between social rights according to their (idealized) historical development. First, civil or liberty rights, which are often called negative rights, because they restrict the justified use of state and societal power; second, political rights, such as the right to vote and gain political power; third, social rights, which entitle citizens to gaining access to social goods. Together, the expansion of rights can be interpreted as an increasing inclusion of citizens under the notion of citizenship. So citizens become full members of society (Marshall 1950, p. 6; cf. Waldron 1993; White 2003, p. 6). The aim of welfare state institutions is to safeguard citizens' rights by preventing exclusion. The level of such provision is constantly to be debated within society and cannot be set by a philosophical theory of justice. Welfare states are therefore sites of struggles between different conceptions of justice, where there is no

one correct theory of justice (cf. Titmuss 1965, p. 124). Still, theoretical considerations regarding a minimal threshold might be possible.

What might the abstract purpose of inclusion mean for public health? The answer to this question depends on the actual requirements of living a minimally healthy life, hence at least partly on empirical findings. For instance, to provide such necessary means will have educational aspects, such as informing citizens about threats to health and how they can improve health dispositions. More specifically, health education will involve information about nutrition, stress and unhealthy lifestyles – in general such education will aim at "health literacy" (Kickbusch 2001). Providing the means for inclusion will also have circumstantial aspects, such as providing access to recreational activity, for instance by building parks, or protection from hazardous substances and epidemics by way of health and safety regulations and legislation. All of these measures aim at a minimum level of enablement of a minimally healthy life, which allows citizens to feel as members of society, in contrast to improving population health over and above such a threshold.

Note that this sufficientarian perspective on public health is different from the influential account by Ruth Faden and Madison Powers (2006). They see the point of justice in relation to public health as to require "ensuring for everyone a sufficient amount of each of the essential dimensions of well-being, of which health is one" (p.9). Whereas I agree that it is important, when considering matters of public health, to focus on more than just intrinsic health, namely also the social determinants of health, I disagree with their focus on well-being. The state – via its public health institutions– does not have the task to "improve human well-being by improving health and related dimensions of well-being" (ibid., p.10). According to my view, public health measures aim at providing the necessary means to enable people to live a minimally decent life, which is abstractly understood as a matter of inclusion in society, not as a matter of well-being. Certainly there are aspects of human well-being that we need to take into account when thinking about health and social inclusion, for instance basic human needs. But well-being – never mind the constant improvement of well-being – is not the target of state action or the focus of a convincing theory of justice.

A fitting example of a sufficientarian public health measure that stays within the limits of enough health is the public funding of schools meals. A certain amount of food per day is a necessary requirement for human beings to live a healthy life. Another aspect of having school meals is the collective experience of pupils. To be excluded from school

dinners for economic reasons not only means very likely to be less adequately nourished for the affected kids, but also implies not to be part of a group making a valuable experience, maybe with further effects such as being stigmatised that might have long-term consequences regarding psychological health as well. Now obviously these meals could be provided in different ways. They could leave a choice to students, so that they can pick from several options, or they might leave no choice, for instance because of a worry that some kids – possibly suffering from "health illiteracy" – might always choose the less healthy option. This might lead to other considerations: Maybe several options could be allowed but these might not be targeted at kids' preferences but at the nutritional value of the choices. So there is scope for more than sufficientarian choices by attempting to enhance health as much as possible. Sufficientarianism, in contrast, would aim at making school meals a pleasant experience for all children, not a matter of the best possible nutritional outcome.

Screening programs, which are often used as public health measures, are more complex cases. Strategies to encourage citizens, especially high-risk groups, to enrol in these programs, can differ enormously in their intensity. If worried citizens would not be able to participate at all in these precautionary measures for financial reasons, despite the potential severity of a detectable disease, this would be reason to argue that they cannot feel as part of a society. After all, not being able to tackle such health related worries implies that society apparently sees poor people's health and fears as of minor importance. So access to such screening programs for each citizen seems to be demanded by a sufficientarian account of public health, though not any level of such provision, for instance the level of medical surveillance a rich and worried person might chose. Also, attempts to compulsively guarantee full and incessant health related information to all citizens, or to manipulate less worried – some would say: careless – citizens into enrolling on such programs is a different matter, and it is not justified on a sufficientarian basis.

4. Sufficientarianism about (population) health

So far I have offered a brief explanation of the general aim of sufficientarianism, which is, to my mind, the inclusion of all in society. Everybody should be a member of society and no citizen should need to feel excluded. I have also hinted at the requirement for a "currency" of sufficientarianism about health: We have to determine in what way we

should assess the level of enough health for all. In this final section, I would like to explore in more detail what the criteria could be for cashing out sufficientarianism about population health. This can further help in restricting the proper scope of public health interventions.

As I have explained in an earlier section, we cannot directly target the health of people by public health measures. Rather, these instruments aim at the causes of the causes of disease, hence at dispositional aspects of the health status of people. Public health is mainly concerned with the circumstances of choices that might have an impact on health. I have said earlier that one such circumstance is having information about the possible consequences of certain lifestyles, about health dangers due to habits such as smoking, or inadequate diet, and so on. Another circumstance is being able to access recreational activities, to avoid permanent stress, noise, darkness, dampness, pollution, etc. A general description of the goal of public health might therefore be that it aims at providing the necessary means for everyone to be able to make healthy choices, not to actually make people healthy. The level of individual health that citizens pursue, how fit for instance they want to be, is up to them.

The threshold we would probably consider first when thinking about a restriction of public health measures is the traditional medical notion of health as absence of disease. After all, this is a minimal notion of health, as I have explained above. Yet, since public health aims at health dispositions, not at health directly, almost every change in the circumstances of choice might decrease the risk of disease. So even if "merely" the avoidance of disease is our aim – which looks like a minimalist goal – we have not, in virtue of targeting the circumstances of *risks* for disease, restricted the scope of intervention, after all.

One way forward for sufficientarianism about public health will be to acknowledge the value of health as an element – but only one element – of a decent life. There are low levels of health that are perfectly in congruence with living a decent life, and there are risks of disease that are worth taking because of other aspects of living a good life. Health is not usually our only or even our major concern when contemplating how to live.

So we are thrown back to the more general notion of the conditions of a decent life. Sufficientarianism ought to cash out this idea in a minimalist sense. I have most of the time used "decent life", instead of "good life", to allude to the minimalist agenda. Now, a decent life seems at least to require the ability to fulfil basic needs. So this might be the

starting point for introducing a currency of sufficientarianism. Indeed, I believe that the most promising way forward for sufficientarianism is by considering the concept of need. Admittedly, the concept of need is not very popular in ethics and political philosophy. Many deem it too flexible to tell us something of significance about the decent life. It seems that every fancy wish seems to be a suitable candidate for becoming a need. I believe this worry to be wrong, and will therefore briefly discuss the significant difference between desires and needs. In addition, needs seem to be the proper candidate for our concern here, because they usually come along with a powerful claim. After all, we are concerned here with issues of social justice, or what we owe to each other. If we say that we need something we express that its provision is urgent, that we cannot do without it. We therefore refer to a potentially or already harmful situation. Basic needs are absolute in that their determination does not require interpersonal comparison. Human beings have basic needs in virtue of being persons. If these needs cannot be fulfilled, then persons suffer serious harm (Thomsom 1987; Wiggins 1985). It is implied that not every disease is posing a threat to *basic* health, hence to basic health-related needs. This idea stands in contrast to popular theories, such as Norman Daniels's (1985, p. 32), which see requirements to the maintenance and restoration of (negative) health, i.e. the absence of all disease, as an instance of health-care needs.

I submit that public health should aim at providing the necessary means for being able to fulfil basic health-related needs. In order to discuss such absolute, basic needs of people, we should be clearer about the distinction between instrumental and basic, or fundamental, needs. First, here is a general analysis of the concept of need: A needs X in order to φ. Note that there can be non-normative usages of "need", for example: "In order to conduct electricity an element needs a free electron" (Thomson 1987, p.3). I am interested in the normative use only, since I want to highlight the connection of need and living a decent life. The non-normative use lacks the practical necessity I am interested in, which is the urgency of the claim. In contrast, people want to express that there is something harmful happening to them when they are seriously ill. Hence we use the term "need" normatively when we say: "I need to be minimally healthy."

With the help of the general definition of claims of need we can now distinguish instrumental from fundamental needs. An instrumental need depends on the specific, possibly idiosyncratic, goals and aims of the person in question while a fundamental need is not derived from such specific aspects. For instance, a person might say: "I need £100 to buy that coat", but it is a need that depends on her having the aim to use the coat

for a particular purpose. It is possible to challenge the actual need for that coat. The money is just necessary for the goal – to get the coat – but the achievement of the goal itself is not necessarily something needed. The person in the example would have to explain why she needs the coat. To answer the question why a person needs X is to say something about the normative significance of the goal φ, where X is a necessary condition of its achievement. The goal could be seen as always referring to an aspect of well-being (cf. Gustavsson 2014, p. 30), but where needs gain urgency, I submit, is where something is needed to prevent harm; it is therefore a negative perspective, focusing on the avoidance and elimination of harm. This justification of needs can go on until it reaches a point where one cannot give any further reference to a more basic goal, such as protection from cold, but only assert that one just cannot do without it, i.e. that one will be seriously harmed without X. Therefore these needs are fundamental or basic needs.

Basic needs are special because their fulfilment is necessary for the avoidance of serious harm. But now the question is of course what constitutes serious harm. Wiggins suggests that it is relative to cultural beliefs concerning harm. An example, partly drawn from his important work, is that of lacking clothes, which would be a serious harm in most, arguably all, societies. Thomson discusses the concept of harm at length, but I hope we can do without his analysis, since I do not, for the purposes of this paper, want to thoroughly clarify the concept of need in general, but only as far as it concerns health. Instances of health-related serious harms are severe illnesses. I have already said that not every disease equals an impairment of the ability to live a decent life. But otherwise what kinds of diseases constitute serious harms might differ between persons: A farmer, for instance, might deem hay fever to be a serious impairment, since his ability to work in his business is impaired by this condition, whereas others might not be much affected in their ability to live a decent life. In contrast to this variability of normative assessment, if someone has an illness that involves a fundamental threat to survival, an impairment of basic abilities, or severe pain and agony, people will immediately understand her claim of need (and they usually believe it to require an explanation when someone in this situation does not claim to be in need). So there seems to be a difference between cases like the farmer with hay fever and indisputable cases of basic health-related need. While in the latter case everyone would agree that there is a need for restoration of health, or at least for the best possible compensation of the impairment, this does not hold for the former case.

This analysis shows that needs are not due to desires, not even to very strong desires. A desire is intentional; a need is not intentional. That is to say that the content of a desire depends on a mental act directed on an object, while a need depends on a state of the world. If a person, for instance, needs something in order to get rid of a terrible headache, then both Aspirin and Ibuprofen will work as means to fulfil the need, even if the person does not even know that both substances are painkillers or desperately wants to take Aspirin but not Ibuprofen. So what satisfies a need is independent of mental attitudes, whereas what fulfils a desire is not.

Sufficientarianism about health-related needs would probably best start with serious diseases that affect everyone. But it should not restrict its scope in a way that excludes the possible justification of individual basic health-related needs. For the purposes of general health care it is therefore plausible to aim at providing for the treatment of almost all possible diseases. Yet when it comes to public health measures, which are the focus of this essay, there need to be further concerns: First, since public health does not deal directly with the treatment of disease but with risks to be affected by disease, and since it operates on a population level, sufficientarianism about public health would further need an assessment of the severity of risks to citizens generally. It would probably come up with a list of "big killers", such as heart and lung disease and cancer, and the most frequent severely disabling conditions, such as strokes and head injuries. In fact, these are of course already some of the main targets of public health interventions. Second, especially because public health aims at causes of causes, it requires an assessment of the benefits of lowering risks in relation to the possible harms that are not related to health, but to other basic needs of human beings, such as the need of people to be free to decide for themselves, or having access to pleasurable goods. Obviously, not every improvement of health dispositions is worth the effort. This is not only meant economically but also, more importantly, in terms of the costs for citizens' ability to live a decent life. As I have stressed before, health is not their only concern.

It is often said that public health interventions can avoid intruding into people's lives by aiming at enabling conditions instead of interfering with their choices (Wilson 2011). Up to a point I would agree with this assessment. Indeed, for instance the capacity to make informed choices about health-related behaviour is important to enable people to live according to their own conception of the good life. In addition, certain means are necessary to live a decent life, and society should be held responsible for its provision. Yet, particular conditions obviously steer choices, if only by restricting their scope to

choices that are enabled by these very conditions. For instance, if a playground is built on a deserted field in a neighbourhood, it might be possible that some older children now cannot play football anymore and might lose an aspect of their social life. In some sense the potential for healthy choices has been improved, but in other respects choices and the conditions of a good life have been restricted. Enabling people in one respect might go along with hindering them in other respects. Hence I believe public interventions always have to be discussed in a broader context, not simply as a matter of enablement in a certain respect such as health.

Sufficientarianism in public health should therefore be modest in its aims, and only promote the provision of necessary means for general health-related basic needs. Obviously there is a lot of scope for disagreement about what this minimum requires in terms of actual public provisions. Such disagreement is mostly a political issue that cannot be decided by philosophical analysis. Sufficientarianism in public health should also always consider other basic needs of people and how they might be affected by public health policies. This again requires balancing of different possible policies and a public debate about the relative importance of values such as health, security, and individual liberty. Again, there is little philosophy, or a theory of justice, alone can contribute to such a question. My goal in this paper has therefore been to show the normative benefits of sufficientarianism in public health, especially in restricting state action to the provision of enabling conditions so that citizens can avoid severe risks concerning basic health-related needs, and also to analyse the currency in which such a sufficientarian theory can be fleshed out. In respect to the latter task I have merely been able to offer initial thoughts regarding the concept of health-related basic needs. A more thorough analysis would require much more detail, and also a comparison to recently popular theories, such as the capabilities approach (Venkatapuram 2011; Ram-Tiktin 2012) or the perspective of "habilitation" (Becker 2012).

It should be emphasised again that sufficientarianism is a version of a theory of justice; it is concerned with what we owe to each other. Citizens might decide, in political processes, that they would like to grant each other more than just the minimal requirements of justice. This would be a political decision made by a political sovereign. My argument was only to claim that societies that do not fulfil the minimum requirement of providing the necessary means for inclusion of all citizens fail on normative grounds. My reasoning does not exclude provisions that, for instance, aim at greater health equality or an improvement of the health of the citizenry over and above

the avoidance of significant disease. Yet, such further provisions are not imperative on grounds of normative theory.

Conclusion

I have argued in favour of sufficientarianism in public health. Sufficientarianism provides an important benefit in restricting the aims of state action, as it endorses a minimal conception of justice. In virtue of setting such limits to state action it is a minimalist theory of civil and human rights. An expansion of such rights might be achieved in real political processes, but I do not believe that an expansive scope of individual rights, for instance to the best possible health-promoting living conditions, can be justified by normative theory.

Sufficientarianism is especially helpful in respect to public measures aimed at health promotion. Public health policies are difficult to assess in terms of their outcomes and success. They are also notoriously contested in many societies in terms of their impact on people's lives and choices, even where these are allegedly enabling citizens to live a decent life. Public health interventions should not only be restricted in scope and intensity for reasons of sufficiency per se, but also because health ought to be seen as part of a wider context of welfare provision in liberal societies. Other aspects of welfare provision might compromise the legitimacy of health policies.

As a final caveat, it should be admitted that I have almost exclusively developed my argument against the backdrop of seeing health as of intrinsic value, i.e. as avoiding harm. At the same time, I have said that health can also be seen from an instrumental perspective as a means to pursue other good things in life. If we see society as a site of competition, which in many countries, up to a point, is a fitting description, we might need to consider aspects of comparative justice, both in relation to traditional health care and public health. Here, the plausibility of sufficientarianism might come to an end.

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