

# Public Health Ethics: The State of Arts

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## 摘要 Abstract

本文介紹生物倫理學與公共健康倫理學領域，並描述兩者之間的關係；文章尾聲將展望公共健康倫理學論未來既廣泛又多變的方向。本文首先簡介公共健康倫理學的本質，以及如何把其與比之更廣闊的生物倫理學作出區分，因此需要提出公共健康倫理學的定義，以助釐清公共健康倫理的重點。隨後，本文簡述公共健康倫理學文獻的一些最新進展，包括圍繞新冠病毒、大流行病、抗菌素抗藥性、「生活方式」疾病及正義等道德問題。本文同時論及就干預公共健康的「合法範圍」所提出的觀點之間於政治及形而上學的角力。其後本文探討公共健康倫理學所面臨的挑戰，包括其複雜又多元的性質。而且公共健康實踐高度政治化，其政治化的原因是因為公共健康影響整個人口及社區，而很多關於公共健康的決策由政治人物而非公共健康專家所作出。此外，公共健康倫理也因為公共健康的範圍擴展至納入非政府公共健康行動者而面臨進一步的挑戰。本文

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最後闡述有關公共健康的一些未來方向，包括「公共健康觀」的出現，以作為為人熟知的健康與社會問題的形而上學框架、把該領域的認知和道德基礎去殖民化以涵蓋更廣泛的知識，以及一些包括美德在內的公共健康倫理學的理论發展。筆者建議讀者把文章視為對公共健康倫理學領域的一部分介紹，並鼓勵他們閱讀本文所引用的論文，並以這些論文作為進入所涵蓋主題的大量文獻之門徑。公共健康倫理學是一個相對年輕的領域，而該領域有著巨大的成長及發掘更多新概念的潛力。

This essay begins by introducing the fields of bioethics and public health ethics and describing the relationship between them. It ends with some glimpses into the wide-ranging and discourse-changing directions of the literature on public health ethics. To open, the paper describes the field of public health ethics and how it is differentiated from the wider field of bioethics. This requires a brief description of public health to clarify the nature of public health ethics. The essay then provides a brief overview of a few recent developments in the public health ethics literature, including the moral issues raised by COVID-19 and pandemics, anti-microbial resistance, 'lifestyle' diseases and justice. The paper also touches on the political and metaphysical tensions in views on what counts as a 'legitimate area' of intervention for public health. The essay then turns to a couple of challenges in the field of public health ethics, specifically the complex and multi-disciplinary nature of the field and the fact that public health practice is a highly political area. Public health is political both in the sense that it affects entire populations or communities and in the sense that many decisions about public health are made by politicians rather than public health experts. A further challenge to public health ethics is the question of what counts as 'public health', as the scope has been broadened to include non-governmental public health actors. Finally, the essay describes some future directions for research in public health ethics, including 'public health view' becoming a metaphysical framing for familiar health and social issues and decolonising the epistemic and moral foundations of the field to include a wider set of knowledge sources and values. There are also some theoretical developments that integrate virtue into public health ethics. The reader should take this essay as a partial introduction to the field, and they are highly encouraged to read the papers that are cited here

and to use those papers as a gateway into the large literature on the topics covered. Public health ethics is a relatively young field, with an enormous potential for growth and new ideas.

**【關鍵字】** 公共健康倫理學 大流行病倫理學 抗菌素耐藥性  
可變風險因素 健康公平 正義 公共健康遺傳學  
複雜性 美德倫理學 去殖民化 生物倫理學

Keywords: Public health ethics, pandemic ethics, anti-microbial resistance, modifiable risk factors, health equity, justice, public health genetics, complexity, virtue ethics, decolonising, bioethics

## I. Introduction

This essay focusses on bioethics and public health ethics and the relationship between these fields. In framing the paper in this way, a somewhat narrow view of the scope of the work and the political commitments of scholars in these fields may emerge, though I hope to provide a wide overview of public health ethics. While seeking on the one hand to fulfil the remit of describing what public health ethics is in relation to bioethics, and what some of the current and emerging themes in public health ethics are, I will also indicate some ways in which this view could be and is being challenged. Bioethics and public health ethics are both multi-disciplinary endeavours in which ethics and politics are intertwined. Grappling with this entwinement of medical and social, personal and political, is at the heart of these fields.

The essay begins by describing the nature of public health ethics and how it is differentiated from the wider field of bioethics. This requires a brief description of public health itself, to help to clarify the focus of public health ethics. The essay then provides extremely brief overviews of a few recent developments in the public health ethics literature, including COVID-19 and pandemic ethics, anti-microbial resistance, and ‘lifestyle’ diseases and justice, as well as the political and metaphysical tension between views about what counts as a ‘legitimate area’ of intervention for public health. The essay then turns to consider a couple of challenges for the field of public health ethics, which are the complexity and multi-disciplinary nature of the field, and the fact that public health practice is a highly political area, and the broadening scope to include non-governmental public health actors. Finally, the essay describes some future directions for public health ethics, including the emergence of a ‘public health view’ as a metaphysical framing for familiar health and social issues,

decolonising the epistemic foundations of the field to include a wider set of knowledge sources and values, and some theoretical developments to include virtue in public health ethics.

It will become apparent that this essay is leaving out many things. It is an impossible task to summarise a rich and developing field like public health ethics in a single article. No doubt, this paper will gloss things that deserve detailed descriptions, and omit things that warrant discussion and attention. It is not without trepidation that one writes a paper of this kind. The reader should take this essay as providing a partial introduction to the field, and they are highly encouraged to read the papers that are cited here, and to use those papers themselves as a gateway into the large literatures that exist on the topics covered. It is relevant, on this note, to say that this essay is written from my own perspective, as one who has experiences living and working in Canada, the UK, and Australia, and a familiarity with the public health ethics literature in these places. This, therefore, reflects the intellectual atmospheres and the dominant Anglo-Western culture and values in those countries, but also the tradition of philosophy in the West with its roots in Ancient Greece. My knowledge of the field of public health ethics is further limited to my knowledge of the Anglophone ethics literature. So, please read with caution, and with the many limitations of this article and its author in your mind.

## **II. The Relation between Bioethics and Public Health Ethics**

One way of thinking about bioethics and its sub-fields, including public health ethics, is as an area within practical ethics. Practical ethics is a field of philosophy that contains many areas of research, including bioethics, animal ethics, military ethics, environmental ethics, professional ethics, and others. However, bioethicists are not all philosophers. Though philosophy continues to be important in bioethics, bioethics has been a multi-disciplinary field from its emergence around the middle of the last century (McMillan 2018; ten Have 2022). From the earliest statements in the history of bioethics<sup>1</sup>, the field included philosophers, theologians, lawyers, doctors, medical researchers, and policy-makers. While moral philosophy has a significant role to play in the theoretical and scholarly side of bioethics, the field involves many other disciplines as well. Notably, the mainstreaming of the term ‘bioethics’ is frequently attributed to Van Rensselaer Potter, a cancer specialist, who wrote the first book in the

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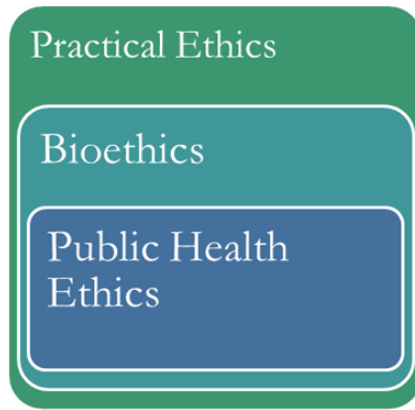
(1) These documents include the Nuremburg Code (1947), the Declaration of Helsinki (1964), and the Belmont Report (1978), all of which focused on developing ethics guidelines for research involving human subjects.

field in 1971 (Potter 1971; ten Have 2012). In this book, Potter presents a very wide view of what falls into this area called 'bioethics'. Though he does not systematically discuss them, he lists six areas that represent what he took to be the major health-impacting issues of his/our time: population, peace, pollution, poverty, politics, and progress. So, not only is bioethics multi-disciplinary to its core, it is also very broad, encompassing large and challenging areas of social life and policy that bear upon people's health.

As is evident from the above, bioethics is a relatively young field. Despite the broad view from Potter, in its first few decades bioethics was almost interchangeable with 'medical ethics,' which roughly delineates the realm of ethical issues that arise in clinical encounters between physician and patient. Lately, however, the field of bioethics has developed and broadened out to include many of the topics Potter initially included plus others, so that it now seeks to investigate all ethical issues within the health and life sciences. Bioethics now involves not just the traditional dilemmas of medical or clinical ethics (e.g. euthanasia, abortion etc.) or issues about the relationship between health care workers and patients (e.g. informed consent, confidentiality etc.), but also includes a much larger set of ethical issues relating to health systems, public health, and global health, as well as at least some environmental, animal, and ecological matters. As bioethics includes many disciplines and a growing scope of interest, it also involves a variety of disciplinary approaches and methodologies. Bioethical research includes empirical studies, historical analysis, legal theory, and philosophical analysis. As such, bioethics is a field that permits of methodologically specialised areas of research, as well as focused areas of inquiry.

As bioethics scholarship grew in volume and scope, some areas of inquiry have coalesced into their own defined and distinct sub-fields, including research ethics, clinical ethics, and public health ethics. The formation of these as distinct sub-fields is represented by the establishment of specialist journals, conferences, and classes that reflect their particular issues, approaches, and methods. These sub-fields are not isolated from each other or from other nearby fields of inquiry in practical ethics, like animal ethics, environmental ethics, or population ethics, yet they have become distinct enough that one can think of them as considering particular issues and employing specific approaches. For example, research ethics involves questions about the morally (in)appropriate ways to treat people and animals in the specific context of biomedical and health research, and the answers that scholars in research ethics develop for the challenges raised in this context will be specifically relevant to that area, perhaps not easily applied to questions of public health ethics or clinical ethics.

So, though the branches within bioethics overlap in some ways and can even employ similar concepts, they often deal with distinct questions and develop particular responses that are appropriate within their specific domain. A graduate degree in the field of bioethics is likely to offer classes on each of clinical, research, and public health ethics, as well as reproductive ethics, genetic ethics, or the ethics of new medical technologies (though these topics can cross research, clinical, and public health domains). One way to conceptualise the relationship between bioethics and public health ethics, then, is as a general field of inquiry and one of its specialist areas of research.



### (1) Public Health Ethics

Public health ethics distinguishes itself from other areas of bioethical inquiry by focussing on a set of moral questions that have to do with health issues that affect large swathes of a society, such as poverty and hunger, and that have to do with policy or other interventions to improve health and well-being implemented at the population-level. Oftentimes, these population-level interventions are undertaken by governmental agencies which are specifically tasked with reducing rates of illness and injury in the whole population, sometimes by targeting specific sub-groups. Interventions of this kind raise unique moral questions about justice, liberty, autonomy, legitimacy, and care. But perhaps to best describe public health ethics, a description of the work of public health is in order.

“Public health” is a generic name for the government (or other) organisations that primarily aim to improve health outcomes of an entire population, as measured by reducing overall rates of illness or injury among the target group. In Canada, for example, the Public Health Agency of Canada has the task of monitoring the health of Canadians and informing government policy; in the United States, this

role is held by the Centers for Disease Control and Prevention, and in China it is the Chinese Center for Disease Control and Prevention. To achieve the goal of reducing rates of illness and injury, public health agencies focus on preventing them through mechanisms like advocating policy changes, creating education campaigns and intervention programs, or conducting disease screening. By contrast, clinical medicine focusses on improving or restoring the health of individual patients (Holland 2015). While clinical medicine, especially primary care, has a preventative aspect to it, medicine is most clearly distinguished from public health by looking at who they focus on: in medicine, the focus is (and should be) the particular patient and their own private health concerns, while in public health, the focus is the population as a whole and the kind of health concerns that affect other (or all) people (Coggon 2012). To address public health issues, then, interventions are made at the population level, where the health of individual people is de-emphasised in favour of population-rates of illness or disease. So, as Stephen Holland writes, “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, 13).

This change in focus from the individual patient in clinical medicine to the entire population in public health is a primary source of the different focus of ethical questions and the form of appropriate answers in public health ethics. As described by Ruth Faden, Sirine Shebaya, and Andrew Siegel, “public health has four characteristics that provide much of the subject matter for public health ethics: (1) it is a public or collective good, (2) its promotion involves a particular focus on prevention, (3) its promotion often entails government action, and (4) it involves an intrinsic outcome orientation” (Faden, Shebaya, and Siegel 2019, 12). I will quickly explain each of these characteristics in turn.

First, the population level health improvements that public health agencies aim to produce is a communal good (Faden, Shebaya, and Siegel 2019). What is meant by this is that, as noted by Holland, above, public health aims at lowering overall rates of disease or injury. In public health, such activities as sanitation, food hygiene monitoring, air pollution monitoring, infectious disease control, screening programmes for diseases (including some kinds of cancer), and addressing risk factors like smoking or drinking alcohol, all aim to produce general reductions in rates of common infectious and non-infectious diseases. However, the aim is not to make the individual healthier, but to improve the rate of health of the whole population under examination. This means that the benefits of lower rates of illness or injury among a population cannot be easily individuated.

There is an interesting epistemic and metaphysical problem here, insofar as “health” is often thought of as a property of individuals (Rickles 2011). In public health interventions, we cannot be sure exactly which individuals are not experiencing a disease that they may otherwise have contracted, or who has avoided an injury. We further cannot, without greater granularity in data collection, see how the data hides disparities in experience of illnesses and injuries within and between groups. Rather, we can only see that there are fewer incidences of a disease or injury among an entire community.

To further complicate things, some of the communal goods of public health are also public goods, in the sense that they are non-rival and non-excludable. In the case of health-related public goods, this means that the benefit that accrues to one person from, for example, having cleaner air neither prevents access by other people, nor does it reduce the availability of this good to others. Herd protection (or immunity) against an infectious disease is similar, insofar as the benefit that accrues to one person from general population-level immunity to a virus does not prevent or hinder any other from benefiting from this good. This further means that many people, or an entire population, can be benefitting from this good at the same time. Not all of the goods that public health produces have this character, though many of them do. We can contrast public goods like clean air with the sorts of goods that produce resource allocation questions, as came up in the COVID-19 pandemic with ventilators. Access to ventilators in general is good for everyone included in a healthcare system, but ventilators are not public goods insofar as the use of a ventilator by one person reduces the availability of ventilators for others, and no two people can benefit from the use of a ventilator at the same time.

Second, public health takes a prevention focus, and, third, does this primarily via government action. The prevention focus is, as noted above, one of the ways in which public health is distinct from clinical medicine. Though primary care also has a prevention focus for individual patients, much of the field of medicine is focused on healing and treating illness. For public health, the balance skews the other way, with most of the work dedicated to preventing disease and injury in the first place. These aims are achieved mostly through mechanisms like policies and community-level programs. Public health is empowered to create and, in some cases, enforce rules, regulations, and bylaws. Public health can inform and promote policy or legislative changes. It also conducts numerous education campaigns about how to prevent injury and to avoid illness, such as water safety or alcohol awareness campaigns. This leads to interesting moral questions about the value of prevention as compared to treatment, contrasting future benefit against more immediate benefit. This also raises an interesting ethical and

political question about the boundaries of public health. Many interventions that are not directly health-related have indirect health effects, including economic or migration policies. As the scope of public health broadens, an emphasis is placed upon the way that health is impacted by many different factors. However, this broadness also risks making the concept of public health less meaningful (because if everything is public health, then the term is unhelpful).<sup>2</sup> Questions of the legitimate scope of government involvement in individual lives also quickly arise, especially in liberal democratic contexts, in which the individual is granted a number of personal rights against government control or interference. So, the question of just how far and in which realms the government may step into individual lives, for the sake of the benefit of the whole community, and for the sake of what may be distant benefits rather than immediate ones, becomes pressing.

Public health is highly political in two senses: the work of public health is conducted among groups, sometimes as large as the entire society (so political in the sense of that its nature is to engage with the whole population or the *polis*, in Ancient Greek terms), and it is intimately connected to government operations including setting policies, regulations, and mandates (so political in the sense of governance). This political nature of public health is important because it helps to delineate what the bounds of public health activity are or should be. Not all interests that we have or which impact our lives are the government's responsibility; typically, interests held by large groups or entire populations are the sort that we think the government should tackle, and so this is the sort of interest that public health should pursue (Angus J. Dawson 2011).

Fourth, public health is oriented toward outcomes. Arguably, other health-related fields are also outcome-oriented. However, in any of these areas (and in life in general), a primary focus on consequences can be morally complex. Some discussions of public health ethics take its outcome-orientation to be the moral justification underpinning any public health activity. However, as noted above with questions of legitimate scope for government interference, some public health activity might be objectionable based on moral grounds other than consequences. As a pertinent example, many in public health consider a central aim of its work to be to improve health equity, as measured by better distribution of illness or injury across groups in a population. One could argue that if it is the role of the government to correct inequalities at all, it is not a central task of public health to do so. However, it is difficult to defend as ethically permissible a case in

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(2) With thanks to Alberto Giublini for raising this point.

which public health achieved low rates of illness and injury in a population by ensuring that those who were better off were made even healthier and safer than they were before, while neglecting to make improvements to the illness or injury faced by a worse-off minority of people. So, while the health equity aim of public health is not universally endorsed by ethicists, at least it is clear that public health should not achieve its aims of reducing illness or injury by making health inequities worse (Powers and Faden 2006; Gostin and Powers 2006). So, justice is an important consideration that moderates a single-minded focus on improved health outcomes. Though public health is mostly considering best consequences in terms of illness and injury when deliberating about how to act, considering how improving equity between groups can lead to improvements in health for the whole of society should be, and often is, a part of these deliberations.

From another perspective, some have argued that while the aim of a health-promoting policy or initiative is to achieve the greatest net amount of benefits over burdens, the pursuit of these benefits is limited by the requirement that the policy or initiative have the least possible infringement of personal liberty (Kass 2001; Nuffield Council on Bioethics 2007; Resnik 2010). This kind of view about the limits of public health is especially prominent among those with a more individualistic or libertarian-leaning perspective. On this interpretation of the limits of public health, the primary moral directive for public health is to achieve best outcomes while respecting liberty. Personal liberty can be justifiably overridden for reasons of protecting others from harm, such as in the case of limiting the exposure to second-hand smoke in the workplace. And, in situations that call for emergency public health response (like a pandemic), there tends to be more leeway for utilitarian justifications for action. However, in everyday public health practice, liberty and the limits it places on what public health is justified in doing, plays a larger role. The burden of proof for overriding liberty is placed upon those who claim that there are harms to explain why an intervention or policy is acceptable and not too burdensome (A. J. Dawson 2016; Griffiths and West 2015).

These four characteristics mean that there are interesting challenges and opportunities that arise in public health, some of which are unique among major social institutions. Despite its large influence, much of public health's work goes unnoticed. We do not typically pay much attention to systems of food hygiene or of sanitation; we may not pay much attention to sanitation or food hygiene, childhood vaccination programs, or cancer screening programs; yet, these are all key areas of public health activity. There are also two population-wide projects of data collection – disease surveillance and epidemiology – that are always happening (by testing sewage or tracking reportable

diseases, like sexually transmitted infections) and most people don't think about these very much, if at all. It is partly because of the nature of this work that public health ethics exists as a field of inquiry, to analyse the moral permissibility and limits on what public health does. Public health's work is morally contentious and sensitive, insofar as it involves various degrees of (beneficial) intrusion into the lives of members of a society.

So, public health ethics tries to answer a set of related moral questions that arise from the character of public health practice. One question focuses on how public health may permissibly pursue the achievement of its aims to improve population health, asking how we should characterise the quality and quantity of consequences, and how they should be weighed against values like liberty, autonomy, or justice, to morally justify public health activities. Another set of questions considers the scope of public health, in terms of population and in terms of actions, asking whose health is being promoted, how public health may permissibly intervene to promote their health, and what are the limits upon public health intervention.

To answer these questions, public health ethics has developed theoretical tools that move away from the tools of clinical or medical ethics, such as the principles of biomedical ethics (though these still appear) (Beauchamp and Childress 2013). Public health ethics is a rich and diverse field, with many rigorous debates about the values that should inform public health practice. However, to paint with a very broad brush, in the early stages of the development of public health ethics as a field of inquiry, utilitarianism and consequentialist and non-consequentialist forms of egalitarianism took centre stage. These are still important, nuanced, and sometimes overlapping moral positions in public health ethics, but as the field has developed, so did positions along liberal or libertarian lines, as well as welfarist and communitarian lines. Lately there has been a proliferation of theoretical positions that begin with relational concepts, such as solidarity. We will now consider some of the current topics and trends in debates in public health ethics.

### **III. Current trends in Public Health Ethics**

This section will present high-level overviews of three recent and developing areas of research in public health ethics. The first area has to do with infectious diseases, especially around the issues of pandemics and vaccination, and antimicrobial resistance. The second area is focussed on non-communicable diseases, and the tensions between health promotion initiatives to address the 'modifiable risk-factors for disease' and questions of justice. The third area has to do

with the way that public health ethics provides a metaphysical orientation to moral questions in health that is being applied in new ways. A metaphysical orientation toward the population primarily (putting the individual in the background) can provide new insights into moral questions around genetics, cancer, global health, and justice questions.

### **(1) Infections disease and solidarity**

An enormous share of the work in public health focuses on preventing and controlling the spread of infectious diseases of various kinds – from sexually transmitted infections, to airborne viruses, to food or waterborne bacteria, and so on. In this section, I'll introduce some of the work that public health ethicists have done around pandemic preparedness, vaccine ethics, and antimicrobial resistance. The COVID-19 pandemic was, to say the least, a moment of great interest for public health ethics. In a way, the pandemic was a litmus test of the many protocols and frameworks that public health ethicists had produced in partnership with community leaders and policy-makers over the preceding couple of decades, in response to outbreaks of viruses with pandemic potential, most notably SARS, but also H1N1 and avian flu. After outbreaks of these viruses, many countries had put together pandemic preparedness plans, with vaccination protocols, guided by ethical commitments. Some countries, like New Zealand, explicitly included the values of Indigenous communities as well as the dominant settler culture's values ("New Zealand Pandemic Plan: A Framework for Action" 2024). These pandemic preparedness plans were supposed to provide roadmaps for managing the next big outbreak of infectious disease.

The main problem that arose with these was that while they were carefully crafted, they were based on influenza and the related assumption that we would be able to quickly develop a vaccine for the pandemic strain (Smith and Silva 2015). When the coronavirus pandemic hit, and we had no vaccine that had been tested and proved effective, the pandemic preparedness plans looked a lot less useful. Despite the fact that they had been well considered and had specifically included consideration of vaccination for vulnerable populations (like elderly people, people with compromised immune systems, children, or communities that were otherwise disadvantaged) that would apply to any pandemic virus, the plans largely seemed to fall by the wayside. There is an ongoing debate in the ethics literature to analyse why the vaccine roll-outs in different countries went so counter to plan, how resources like vaccines or ICU beds should properly be allocated under conditions of scarcity, whether mask mandates, quarantine, or lockdowns were justifiable, and according to which values these

decisions should be made (Silva 2020; Emanuel et al. 2020; Silva and Smith 2020; Savulescu and Wilkinson 2023).

Vaccination ethics, outside of pandemic situations, is its own rich area of debate. Vaccination, as noted above, is a cornerstone of contemporary preventative medicine, both for individuals and for the entire community. However, there are important moral questions about the extent to which we can require others to get vaccinations against common infectious diseases – even when the risks of vaccination are miniscule and the benefits enormous – and whether personal religious or moral beliefs are sufficiently weighty to defend a person’s ability to conscientiously refuse vaccination (Giubilini 2019). Some people, for example, have objected to the development of some kinds of vaccines that have used stem cell lines derived from embryos, on the grounds that using embryos for science is morally unacceptable. So, even the development and production of vaccines can cause moral debate, and perhaps lead to the conviction that participating in vaccination is akin to endorsing the research and development methods behind it. There is also some debate (mainly in the pandemic context) around whether and to what extent governments should prioritise securing enough vaccines for their own populations over sharing the vaccine resources with all other nations (Ferguson and Caplan 2021). Government priority for their own populations might reveal a laudable commitment to taking care of their community; though it may come at the expense of sharing the risk and the burden of infectious diseases with many others in need.

Recent work in public health ethics regarding antimicrobial resistance (AMR) has highlighted the complex ethical challenges surrounding the use and misuse of antibiotics (Rogers Van Katwyk et al. 2023; Jamrozik and Selgelid 2020; Littmann and Viens 2015). AMR occurs when bacteria, viruses, fungi, and parasites evolve to resist the medications designed to kill them, rendering treatments ineffective. This phenomenon has profound implications for global health, as it jeopardizes our ability to treat common infectious diseases and increases the risk of prolonged illness, disability, and death. Public health ethicists have focused on several key issues, including the appropriate use of antibiotics in healthcare settings and agriculture, the economic factors driving overuse of antibiotics, and the disparities in access to effective treatments between high- and low-income countries.

Some of the work of public health ethics on AMR has, interestingly, centred around the role of physicians or patients in preserving antimicrobial efficacy (Jamrozik and Selgelid 2020; Oakley 2020; Coleman 2020). Physicians have important duties as gatekeepers of these crucial medicines, and insofar as we all benefit from the continued efficacy of antimicrobials (with some level of suppression of infectious disease in our environment, as well as their usefulness in

acute infections), this is a public-level health-related good. On the other side of the equation, public health has endeavoured to raise awareness among the public and patients through health promotion campaigns about not asking for or always needing antimicrobials when they feel sick (UK Health Security Agency 2024). Increasing health literacy around the difference between viral and bacterial infections is a key public health aim in combatting AMR. From the moral standpoint, not only do patients have a number of collective and individual reasons stemming from best consequences, a sense of mutual protection and solidarity, and care for each other to only use antimicrobials when warranted, but patients may also have rights to refuse antimicrobials when offered to them (Coleman 2020; Degeling et al. 2018).

Additionally, public health ethics scholars have emphasized the interconnectedness of human health with animal health and environmental health in the context of AMR (Norris et al. 2019). The overuse of antibiotics in veterinary medicine and livestock farming contributes significantly to the emergence of resistant strains of bacteria, which can then spread to humans through food, water, and direct contact. This has spurred discussions on the ethical dimensions of veterinary and agricultural practices, including the regulation of antibiotic use in livestock, the promotion of sustainable farming methods, whether consumers share responsibility and should be held to account, and implications for animal welfare (Giubilini et al. 2017). Public health ethicists have begun to advise and advocate for international cooperation and regulatory frameworks to address AMR comprehensively. The focus in this area tends to be on the development of policies that protect the effectiveness of antimicrobials through responsible use, equitable access to effective treatments, and global collaboration to combat AMR as a shared public health threat, while balancing the interests of human health, animal welfare, and environmental sustainability.

Looking internationally, public health ethicists have debated the source of duties that may or may not arise between nations when it comes to sharing information or resources in cases of infectious diseases. In the global context, wealthier nations hold the balance of resources for medical innovation and pharmaceutical development, while less economically developed nations are more often the first to report and hardest hit by new outbreaks of infectious diseases (Ho 2022). On the one hand, it is in the self-regarding interests of wealthy nations to help the less economically developed ones to prevent and stem outbreaks of new infectious disease, and to encourage antimicrobial stewardship, because viruses and antimicrobial resistant bacteria will inevitably make it across their borders. On the other hand,

as we saw in COVID-19, many of these wealthy nations take an exclusionary approach to infectious disease, believing that they can prevent outbreaks from reaching them if they close their borders and only take care of their own people.

Some public health ethicists have emphasised the role of solidarity and reciprocity in building cooperative relations around both sharing vaccines and protecting the effectiveness of antimicrobials, partly because the goods of public health are best achieved when everyone cooperates (Holm and Ploug 2020; West-Oram and Buyx 2017). Some in public health ethics have taken solidarity between groups and between nations to be a fundamental value of public health, and a key part of infectious disease prevention. Solidarity is sensitive to both justice and self-interest reasons, as well as providing its own justificatory reasons for prioritising issues that cross borders. There is a good deal of conceptual discussion about the meaning of solidarity, but in general, solidarity is a kind of attitude that we act upon or express when we are helping others due to a context-specific similarity, such as when strange hikers work together to get through sudden bad weather (Prainsack and Buyx 2017) or in the case of communities working together in COVID-19 (Krishnamurthy 2013). Solidarity can be formed between people or groups for a variety of reasons, and can be short-lived, lasting only as long as the specific issue being faced. Or, it could be more long-term, such as when “citizens of a shared state can be said to stand in [a relation of political solidarity] when they have attitudes of collective identification, mutual respect, mutual trust, loyalty and mutual support toward one another” (Krishnamurthy 2013)(p.129). The ideas of mutual respect, mutual support, and mutual aid underpin the normative claim that when people stand in solidarity with one another they will help each other. Furthermore, solidarity between nations – requiring a sense of mutual respect, trust, and aid – means that one nation is willing to help another when they need it, because the nations share the confidence that they will help the other in turn. Even if a very wealthy nation never needs help from a particular less-developed nation, solidarity means that the wealthy nation knows that the less developed nation is willing and would do what it could to help if it was ever called upon to do so.

From the perspective of justice and infectious disease management, one argument goes that wealthy nations are such because of a history of extraction from nations that are currently less developed, and these nations are less economically developed precisely because of the history of extractionism and colonial rule. Therefore, the wealthy nations have a duty of justice as restitution to help those that are less developed because the wealthy nations have become wealthy at the expense of those less developed. While this is a compelling argument,

a counterargument (especially within wealthy nations that are themselves former colonies) would say that there is a significant amount of injustice, some of which stems from the same colonial processes, within these wealthy nations that governments ought to prioritize before correcting unjust relations with other nations. Ultimately, it seems that wealthy nations owe justice to both those nations that have been and continue to be economically exploited for the benefit of the wealthier, and to those groups within their borders who also experience economic and other exploitation for the benefit of the wealthy classes. Even nations who are owed justice by other, wealthier, nations may owe justice to the people within their borders for the hierarchies of privilege and power that disadvantage them and make them more exposed to infectious diseases.

## **(2) Non-communicate disease and justice**

Public health ethics has increasingly turned toward analyses of the moral and political questions around the so-called ‘lifestyle’ diseases, or the modifiable risk-factors for non-communicable disease, as public health itself has increasingly prioritised their prevention. One of the earliest such issues for public health was smoking. Though the primary health effects of smoking accrue to the smoker, there are serious health effects associated with second-hand smoke. As more evidence was compiled about the links between smoking and pulmonary diseases, and tobacco companies were forced to reveal the evidence about cancer that they had been suppressing, public health took greater steps to prevent people from starting to smoke and to help smokers quit (Voigt 2010). The anti-tobacco initiatives became blueprints for public health’s approaches to a variety of other, though not quite similar, modifiable risk factors for disease, including consumption of lower-quality diets, lack of physical activity, and alcohol consumption.

Smoking is an interesting example here, because while there is plenty of evidence that it can lead to health harms, governments have acted on smoking with greater force than, say, drinking alcohol, which has just as much evidence (or more) of associated harms. One source of this difference is that judgments about the ‘riskiness’ of a particular behaviour and whether or not taking the risk is justifiable are both value-laden judgments. Two important moral questions, then, are how risky something must be for it to become impermissible, and who gets to make this judgment (the person themselves, or the government in a paternalistic move). Smoking cigarettes brings a risk of lung disease, including emphysema and cancer, as well as cancers of the mouth or throat, and these are serious illnesses. In Australia and New Zealand, governments have decided that smoking is so significant in terms of risk to public health that it is worthy of being very heavily restricted

through taxation, limits on age of purchase, limits on marketing, and limits on the places in which a person could smoke. Despite the fact that alcohol carries very significant risks of cancer, as well as a plethora of harms to the drinker and to other people (through violence or accidents, mainly), these governments and others that take strong stances on smoking have not made similarly significant moves to restrict access to alcohol. So, it is evident that judgments about the value of drinking alcohol compared to the value of smoking cigarettes is influencing policy, rather than merely being a matter of looking at ‘evidence.’ This has generated much work in public health ethics, especially around justified paternalism and personal liberties to engage in risky behaviour.

A significant area of this debate has been around public health’s engagement with anti-obesity work. Public health ethics has been actively engaged in debates around whether public health should engage in this kind of work and if so, how and with what justifications (Carter 2017; MacKay 2017; 2019; Anomaly 2012; Arneson 2007; Lowenberg 1995). Public health has approached this mainly as a matter of health education, running campaigns about healthy eating and physical activity, as well as considering taxes on sugar-sweetened beverages and the like in order to disincentivise their consumption. However, part of the moral debate around anti-obesity initiatives centres on the fact that obesity is the result of many factors beyond individual choice, and so is not merely the result of a person eating too much food. Of course, personal eating choices are a part of this puzzle, but obesity has been linked to genetic predispositions, environmental factors, and working conditions (e.g. night-shift workers are at higher risk for obesity (Williams 2017; Boini et al. 2022)). Thus, merely telling people to eat healthier in public health campaigns is insufficient and unfairly blames individuals, when public health should be more sensitive and responsive to the other pressures upon people’s health, including from factors that they cannot directly control. Since obesity seems to be correlated with lower socio-economic status, this could be an argument for public health intervention at a systemic level.

Lower socio-economic status seems to be correlated with many illnesses, which makes addressing social inequity both a matter of health and of justice. There is a wealth of evidence now about the way that poverty contributes to illness through poorer diets, lower incomes, higher stress, fewer employment options, poorer quality housing, and so on. From the perspective of ethicists who think social justice is central to public health work, public health should take initiatives to improve health by contributing to lower poverty levels through the mechanisms it has control over (Powers and Faden 2006; de-Shalit and Wolff 2007). James Wilson (2021) has argued for the stronger position

that there is a right to public health, and that governments that fail to provide certain health-related goods are neglecting an important duty. Executing this duty to provide baseline public health to the population could mean requiring safer and cleaner working environments, less air and water pollution, and restricting low-quality ingredients from getting into the food system. Furthermore, since there are large health disparities within wealthy nations between the best-off and the worst-off groups, rights and justice arguments both demand that such inequities are corrected, or at least not worsened.

However, a more libertarian perspective in public health ethics argues that across these issues, it is not the role of public health (or governments more generally) to get involved in changing people's lifestyles. To do so is unjustifiably paternalistic (Flanigan 2013; Anomaly 2012). This perspective places priority on the value of liberty and argues that adults who know their own preferences and interests ought to be left alone to pursue these, up to the point at which their behaviour puts others at risk or begin to trespass upon their rights. Liberty is not sacrosanct, but it is very weighty, and it can only be overridden in a limited set of public health circumstances where other people (and especially children) are at particular risk. In some variants of this view, then, anti-smoking policies can be justified because second-hand smoke is harmful to other people, and interferes with their right, for example, to work in a safe environment. However, laws requiring motorcycle riders to wear helmets, or penalising the consumption of certain kinds of food, are overstepping the bounds of what is morally permissible for public health to do.<sup>3</sup> Scholars like Wilson would counter this view, however, by pointing out that providing baseline public health to the entire population is in fact a condition of facilitating greater liberty for all those people. Part of what it means to have freedom is to be unassailed by injuries or illness that are beyond the ability of individual people to control or avoid. In many ways, our freedom is made possible by the existence of policies and regulations that establish the background conditions for health.

Ultimately, this debate in public health ethics questions the boundaries of legitimate public health action. Is public health overstepping by getting involved in non-communicable diseases and the modifiable risk-factors for disease, or are these closely connected to health determinants like poverty that public health can and ought to address? Should public health be limited to the work on sanitation, surveillance, and infectious disease containment that it has traditionally focussed on, or is it appropriate for public health's scope to change as we eradicate or bring under control the infectious diseases

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(3) This debate is closely tied to questions of political legitimacy, and interested readers should see (Faden, Bernstein, and Shebaya 2022) for further details.

that plagued us in the past? These questions remain hotly debated in the public health ethics literature.

## **IV. Challenges and Limitations in Public Health Ethics**

This section introduces two particular areas in which public health ethics must grapple with challenging and unwieldy facts about public health. The first is that public health practice, as introduced above, is inherently multi-disciplinary. This means that the public health ethicist must have some comprehension of a number of different disciplines, and that scholars from different disciplines must find ways to communicate with each other. The second is that public health is, also as noted above, a very political undertaking. Public health practitioners are significantly limited by the ambitions of the government of the day, and this means that public health ethicists must be sensitive to the limitations placed on practitioners when critiquing initiatives or policies. Further, as public health actors begin to move beyond the government, knowing which agencies we are talking about (or critiquing) when we say ‘public health’ becomes increasingly challenging.

### **(1) Complexity and multi-disciplinarity**

One challenge for public health ethics arises from the sheer complexity of the issues that public health tackles, and the multi-disciplinary nature of the field (Silva, Smith, and Norman 2018). As is illustrated by the discussion of modifiable risk factors, above, public health issues often involve complex interactions between personal, social, economic, environmental, and biological factors. Ethical analyses must navigate these complexities, which can make it challenging to develop clear-cut ethical guidelines or recommendations. In many cases, such as controlling an infectious disease, a public health issue can most effectively be managed through cooperative efforts of different parts of government and the community. Infectious disease control can require cooperation from housing agencies, immigration agencies, social services, medical services, and education systems all working together to achieve a public health goal. So, the complex nature of public health issues and the fact that they reach into these different areas of communal life means that effectively coordinating a response can be practically difficult. For public health ethics to provide useful moral analysis and relevant moral critique, it must be attentive to the coordination problems that public health might face in trying to achieve its goals. Public health ethics must also

consider how the critiques of public health might extend or apply to critiques of these other systems, of housing, education, or medicine.

Further, as introduced at the outset of this piece, public health ethics has been a multi-disciplinary field from its emergence. It includes philosophers, historians, epidemiologists, sociologists, public health physicians, and researchers in infectious and non-communicable diseases, among others. Within public health ethics, people who come from different disciplines and have differing methodologies must find a way to communicate with each other and ‘speak the same language’ between their disciplines. Aside from this being a logistical challenge for public health ethics, it is also a substantive problem for the kinds of ethical analyses that the field produces. Without robust communication between disciplines, the field is at risk of having an over-abundance of simplistic moral analysis and a dearth of nuanced analysis that pushes the field – and public health itself – forward. This challenge is present in bioethics more generally, as it shares the complex and multi-disciplinary nature of the moral issues it examines. Public health ethics, and bioethics broadly, are at risk of becoming a rote application of a set of thin principles or ideas to a variety of issues. This is not to malign papers written in the style that takes something like solidarity, egalitarianism, or utilitarianism, and applies it to some new issue; such papers can be useful and open up new ways of thinking about a problem. However, as we have also seen in bioethics as a broader field, this kind of paper can be simplistic and too many papers of this kind lead to stagnation. I return to this at the end of the next section.

## (2) Politics

As I noted above, public health agencies are often government agencies, or government-supported arms-length bodies, which are closely scrutinised by elected officials and political parties. Governmental decisions made about the public’s health can be influenced by political agendas, economic interests, and industry stakeholder pressures. These influences can sometimes conflict with ethical principles held amongst public health professionals or the public health agencies themselves, potentially compromising the integrity of public health interventions. This is a very challenging context for public health professionals, and it makes public health ethics difficult in some ways too. It can be unclear who exactly is responsible for certain decisions regarding public health. For example, during the COVID-19 pandemic, some decisions were made for purely political reasons and were made by elected officials, possibly with the consultation of public health agencies, though it is hard to know what the consultation involved. This is a challenge for ethicists when criticising public health agencies, since the responsibility that should

have been theirs may have been usurped or overridden. For a moral critique to be properly placed and make the most impact, it should target the appropriate agent. While most public health ethicists prefer to see themselves as critical friends to public health professionals, and to hold governments responsible when they make mistakes, it can still feel to those professionals like they are being unfairly critiqued when decisions were made for political reasons and perhaps not on the advice of the public health agency.

Relatedly, there is also a good deal of political, cultural and contextual variability in public health that impacts how public health ethicists consider their analyses. Ethical norms and principles can vary significantly across cultures and contexts, and what is considered permissible in one society may not be perceived similarly in another. However, like most ethicists, public health ethicists wish to avoid sliding into moral relativism. So, public health ethics must balance the complexity of the socio-political settings of public health and the health issues they address with the desire to provide sound moral judgments that transcend the immediate time and place in which they are made. At the same time, public health ethicists recognise that cultural variability complicates the development of universal ethical guidelines in public health, and pose a challenge to cross-cultural moral agreement about issues like AMR or infectious disease control, which cross borders so easily. This is becoming further complicated as ‘who counts’ as a public health agent increasingly expands beyond governments to involve other actors, such as the Bill and Melinda Gates Foundation, the World Health Organisation, Médecins Sans Frontières, and others (Kuznetsova 2020).<sup>4</sup> This opens up the question of who exactly is public health, and therefore, who is subject to the ethical analyses that public health ethics provides.

Finally, despite the complexity of the issues public health tackles and the array of actors who work within the field, public health ethics risks losing its critical edge if its moral analyses become too simplistic or too mainstream to give important and strident critiques of public health activities. Since public health is political and governmental, it can seem risky to provide strong critique because of the chance of alienating important stakeholders. Further, since public health ethics is multi-disciplinary and involves many different disciplines and fields, it can be challenging to incorporate different methodologies and disciplinary standards to provide deep and nuanced moral arguments.

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(4) I note here that public health (ethics) and global health (ethics) begin to overlap in some of these questions. I do not have the space to get into the topic of global health, and it is a separate field, so not the remit of this paper. However, the two seem to be increasingly converging on some matters of international justice and infectious diseases, among other issues, and this will be an interesting area of development in coming years.

However, there are risks that come along with making small and friendly criticisms. Consistently avoiding severe critiques or consistently providing moral frameworks that largely accept the status quo and make small adjustments from there put public health ethics at risk of becoming a legitimating tool for public health activity, at the cost of being a visionary field that can guide the way to much better states of affairs.

## V. Future Directions in Public Health Ethics

In this section, I will provide sketches of some of the future directions and possibilities for the field of public health ethics. As these are currently developing, I will focus on the kinds of questions they might ask and the ways in which they might enrich the public health ethics literature. The first of these is the increasing use of ‘public health’ as a metaphysical frame for thinking about health issues, such as domestic violence, that have hitherto been considered a matter of individual or private health. The second area of development lies in the epistemic resources public health ethics relies on, and the amplification of voices from knowledge traditions outside of the Western Tradition, especially within Indigenous cultures across Europe, North America, and Australia. The third area lies in the theoretical development of a virtue ethics suitable to public health ethics, with a focus on populations that matches the focus of public health practice.

### (1) Public Health as a metaphysical framing

An interesting new avenue for public health ethics brings a population-level perspective to questions that have typically been approached with a clinical or individual focus. Taking a population-level view means approaching health-related issues from a collective perspective and moving the individual into the background. This is a different way of seeing issues from a clinical perspective where health issues are approached by focusing on the individual, with the collective in the background. This toggling between collective view and individual view can reveal new things about familiar health issues. What changes if we consider domestic violence, some cancers, or genetic conditions from the level of population health, instead of as matters of individual health (Newson 2022; Dive and Newson 2021; Kumar 2020; Chandan et al. 2020; Burris and Gostin 2004; Ballantyne 2019)? For one thing, concepts like privacy and consent shift in scope and substance, and for another thing, we can see patterns emerge that link what might seem like individual instances or behaviours to much larger social trends.

For example, in light of patterns that were revealed during COVID-19 lockdowns, some public health ethicists have recommend implementing a population surveillance model for domestic violence, to allow the linking of data sets between hospitals and police agencies that could identify individuals at risk (Chandan et al. 2020; Kumar 2020). Much like a cancer screening program, this screening for individuals at risk of domestic violence would trigger a system of care services to follow up with the individuals who were identified, and it would also allow for patterns in location, timing (around holidays or other events), and other demographics to be measured. From the ethical perspective, the benefits of a public health approach to domestic violence include that the move away from thinking about it as a problem of individual relationships to a more systemic problem also moves away from victim-blaming and holding individuals responsible for not getting themselves out of violent or controlling relationships. It could also make services for people experiencing domestic violence better integrated and easier to access. However, such an approach also means thinking about privacy differently, since domestic violence has often been considered a private problem that happens inside the home, and therefore not the business of anyone else (let alone the government). Some may strongly object to a public health incursion into their personal lives for the prevention of domestic violence.

As is evident from this example, the metaphysical views behind public health ethics, and particularly the collective ontology of health and disease, can lead to broadening our understanding of health beyond the medical model. A medical ontology of health might say that health is constituted in the individual by the absence of disease, or species-normal functioning, for example, and one might think that simply aggregating the health of each person in a society is all that is meant by collective health. However, we might also consider a collective ontology of health that is more than merely aggregative (Brülde 2011). When thinking about health promotion, one might understand health along the lines of the World Health Organisation, who define health as a state of complete physical, mental, and social well-being. Or, we might think of collective health as a property of an entire society, where a variety of public goods related to health are achieved and no one group experiences higher rates of illness or injury than any other. The ontological framing of 'health', whether the individual or the collective is considered primary, and whether health is considered to be an aggregative property or something beyond aggregation can influence how health problems are defined and what counts as a solution. Again, domestic violence is a useful example here, because while thinking about it as a private problem, it seems like the only solutions are individual-level ones, like treating injuries as they occur, and

supporting a person when they are ready to leave or to press charges. However, once viewed as a public health problem, domestic violence looks like a scourge that affects certain groups disproportionately and under predictable conditions, and solutions begin to appear that may not otherwise be conceivable, such as early detection and systematic intervention.

A further way in which the metaphysics of public health raises interesting questions is in justice and equity. What is an ethically acceptable distribution of health resources and disease burdens amongst members of a population? Typical answers to this question conceptualise individuals as the holders of certain ‘bundles of goods,’ and imagine that resources or burdens can be shifted amongst them like tokens. Such an approach misses two things. The first is the sort of goods that are not distributable in the usual sense. Such goods include access to healthcare, since access is not the sort of thing that can be handed out. Rather, access is constituted by a variety of factors related to the availability of appropriate care in an area, the ability of the people to get to that care, and whether or not there are links to any necessary follow-up care or services. Because it de-emphasises the individual, the metaphysical framing of public health ethics can explore concepts of distributive justice and equity in access to healthcare in ways that conceptualise the entire system of health care, rather than individuals as goods-holders.

Overall, thinking about health-related issues through a metaphysical lens that is focussed on the population, with individuals considered but de-emphasised, involves reflecting deeply on the fundamental ethical principles and values that should guide decisions and policies aimed at promoting health and well-being at the population level. It encourages a broad approach to understanding and addressing ethical challenges in public health practice and policy-making. And, it can provide a new perspective on topics that we have become familiar with, perhaps allowing a reconsideration of what the problem is and what an appropriate solution could look like.

## **(2) Decolonising public health ethics**

Another area of rapid development in public health ethics lies in efforts to decolonise the epistemic and moral foundations of the field. The near-by field of global health (see note 4) has produced a lot of scholarship considering the effects of Western colonial thinking on knowledge production and policy formation and contesting its hegemonic epistemic position. Similarly, systems of moral thinking from the Western tradition are being challenged by Indigenous and other scholars. I will say more about how virtue ethics, though from the same roots as other Western moral traditions, has the potential to

expand public health ethics, below. In this section, I'll focus on the potential for decolonising public health ethics' epistemic foundations, and its ethical basis in Western thinking.

In public health, decolonial scholarship is increasing, and more researchers are looking toward building relationships of knowledge exchange between intellectual traditions, including American, Canadian, Australian, New Zealander, and European Indigenous elders, scholars, and communities (Hendl and Roxanne 2022). Just as a metaphysical orientation from public health ethics can broaden and change the way individual health problems are conceived, so incorporating knowledge from Indigenous communities around the world into public health ethics can broaden and improve the concepts that public health uses to think about what it means to be healthy.

Though I suggested above that the metaphysical orientation toward the community or entire population as the first unit of analysis in public health ethics can provide a new perspective on what counts as a health issue, it is still the case that the current model of 'health' that public health ethics works with is a Western one, with a particular social, historical, and cultural background. The public health ethics view of 'health' still has a tendency to overemphasize personal choices, biological factors, and social determinants at the expense of environmental or cultural determinants (Crowe et al. 2024). Though it is broader than the typical medical view of health, it may nonetheless reinforce the medicalization of normal human experiences or cultural differences, or inadvertently reinforce individualism in how health issues are addressed. For example, the dominant public health approach to substance use and harm reduction employs what it considers to be best practices on a Western understanding of health, healing, and evidence. While such an approach will help many people, it may also deny some Indigenous people the resources for healing that would be most effective and culturally appropriate for them, by not recognising other understandings of health, healing, and evidence (Marsh et al. 2015). Public health practice and public health ethics have certain blind spots caused by the epistemic orientation they share, which makes them (and their medical counterparts) resistant to incorporating knowledge or ideas of health and healing that fall outside of the Western notions of evidence and efficacy. Indigenous perspectives often view health holistically, including spiritual and environmental dimensions (Durie 2004), and healing incorporates all of these aspects of a person, their family, and their community. While public health ethics is certainly more amenable to these perspectives on health and healing, there is still work to be done to broaden the medical- and Western-dominated interpretations of these concepts.

If the epistemic foundations of public health ethics were decolonised, then one suspects that the field could guide the way toward more culturally responsive and effective public health interventions. A decolonised public health ethics could offer a more robust understanding of population or community health and a vision of better engagement with communities that have different health concepts. This would require balancing openness to alternative concepts with the need for standardized, evidence-based practices. Decolonisation does not mean replacing one knowledge system with another, but finding ways to integrate diverse health concepts into existing methods, approaches, practices, institutional structures and policies (Marsh et al. 2015). Some examples include incorporating traditional healing practices into community mental health services, and considering environmental health in a broader context, including spiritual connections to land in Indigenous communities. This work is underway, but is in somewhat early stages, so there is a great deal of development still ahead for the epistemology of public health ethics.

Similarly, the moral foundations of public health ethics can be interrogated for their Western roots and expanded to include a greater breadth of thought. I'll discuss a Western-oriented development in public health ethics below, but first, bioethics as a general field has been criticised at times for sharing the hegemonic and blinkered Western orientation to moral problems. Like the epistemic case, in the ethical case the decolonial project asks bioethics to reflect on the source of values, understanding of their place in our value-orderings, and judgments about right action that predominate the field (Garvey et al. 2004; Kotalik and Martin 2016; Bardill and Garrison 2016). Interestingly, many cultural traditions, including Western and Indigenous traditions, share certain value concepts like justice, truth, trust, and courage. A decolonial project in bioethics does not seek to replace wholesale the systems of ethics that are present, but it does aim to broaden them and improve them where they fall short. The process of decolonising the moral foundations of bioethics has perhaps made its greatest advances so far in the clinical space, in part as a result of perceived conflict between the assumptions of doctors working in a Western-oriented healthcare system and their Indigenous patients. However, there have also been some advances to incorporate Indigenous values into research ethics as well (Eastal et al. 2020; Hendl and Roxanne 2022). Public health ethics has plenty of room to develop in this area.

### **(3) Virtue in public health ethics**

Relatedly, the final development in public health ethics that I will discuss here is a theoretical one: the inclusion of virtue ethics into

public health ethics. This has been a rather slow and marginal project so far, with only a handful of theorists involved, but it has the potential to make interesting contributions to the field (Rozier 2015; Nihlén Fahlquist 2019; Meagher 2011; MacKay 2022; Wiczorek and Rossmair 2023). The focus on practical wisdom and careful deliberation of virtue ethics is particularly well-suited to public health ethics, insofar as public health is always having to balance the interests and costs to individuals against the interests and the benefits of the collective when it is making decisions about implementing new initiatives (MacKay forthcoming). Additionally, virtue ethics is one area in which Western and Indigenous moral philosophies are more closely aligned (Kotalik and Martin 2016), which may offer opportunities for incorporating more Indigenous moral philosophy into public health ethics.

There are two main ways in which virtue ethics is being explored in public health ethics so far. The first is around professional roles (Nihlén Fahlquist 2019; Meagher 2011). Virtue ethics has not featured heavily in bioethics in general, but when it has, it has tended to focus on the role of physicians and the development of virtuous characters in medicine (McDougall 2013; Oakley and Cocking 2001). This is a worthwhile endeavour, and creating more virtuous doctors seems like a proper aim of medical schools. A similar approach has appeared in public health ethics. Jessica Nihlén Fahlquist, for example, has argued that there are particular virtues that public health professionals ought to develop: responsibility, compassion, and humility (2019). The idea behind this kind of role-focussed virtue ethics is that some professions carry specific sets of obligations and responsibilities, and carrying these out takes more than just an ability to follow rules. It takes a good character, properly developed around specific virtues relevant to the role, and the practical wisdom to deploy the virtues in the right way. As a highly professionalised area, with specific practices and methodologies, educating public health professionals in a virtue-oriented practice seems, again, highly worthwhile.

The second way in which virtue ethics is being explored in public health ethics is around the kinds of social structures that public health contributes to, and its overall influence in creating the conditions of a society in which virtue flourishes or struggles to take root (Rozier 2015; MacKay 2022; forthcoming). This approach focuses on developing a virtue ethics for the institutional level, just as public health scales-up its approach to health and healing from the individual to the population. Since public health concerns itself with the health of collectives, and tries to make society healthier by putting interventions in place that affect the health behaviours of many people at once, I have argued that public health ethics needs a virtue ethics that looks at how such

institutional agents can be virtuous or contribute to the conditions of virtue in a society (MacKay 2022; forthcoming). This work is informed by thinking around structural conditions that maintain and reinforce injustice, poverty, and hardship from feminist ethics and political theory, as well as moral theology (Young 2011; Daly 2021; Anderson 2012). It also builds upon the writings of Aristotle, who argued that good laws are conducive to the development of virtue. Individual effort is always required for a person to develop a virtuous character, because it takes the effort of the will, but the existence of good laws and a society that is overall more amenable and encouraging of virtue, and more resistant to corruption or viciousness, will certainly be a helpful environment for the individual who aims for moral excellence (Aristotle 1999).

So, when considering institutional agents and their impact on society, we should be looking at whether or not they are contributing to moral excellence with their policies, rules, laws, or practices (MacKay forthcoming; 2022). Public health is a very powerful public institution that plays a significant role in setting the conditions for everyday life for the millions of people who live under its purview. The things that public health does mostly go unnoticed, being so much a part of the social fabric. However, this largely unnoticed but powerful influence can help to create conditions for a more just, cooperative, and caring society, or it can create conditions of injustice, oppression, suspicion, and unwillingness to work together. Since public health has this power and ability, it ought to be using it to create the conditions conducive to virtue. Moral excellence in the practice of public health means developing institutional virtues like justice, civic friendship, and epistemic humility. These institutional virtues are not merely the aggregate result of the virtue that individuals working within public health might have, but something beyond that. Institutional virtues inhere in the structures that form the practices and processes that establish the institution itself, and the means by which it is maintained. This style of collective-level virtue ethics analysis is very different from what has been developed so far in the field, and there is much still to be done in this area.

Finally, while some work in bioethics has tried to provide a virtue-based approach to some particular issues (Hursthouse 1991), that has not become a common way to think through moral problems in the clinical or research space, and it has not made any headway at all, as yet, in public health ethics. This may yet be on the horizon, as a further development of the collective virtue ethics approach that I just introduced. Once a public health virtue ethics is fully theorised, we will be able to think through a public health virtue ethics approach to a problem like setting a policy for mandatory vaccination. Virtue ethics

seems less suited to giving rule-like judgments on moral questions, and more favourable to giving context-sensitive judgments that may vary according to the details of a scenario. Virtue ethics is attentive to the particularities of different situations, and practical wisdom always has the final say about what is the right thing to do in a particular context. That said, it is worth remembering that virtue ethics is sensitive to both the outcomes of actions and the means by which those outcomes are achieved; both of these forms a part of the process of deliberation and discernment, which partly inform practical wisdom (along with in-depth knowledge of people, social conditions, facts of the matter, and so on). So, for policy purposes, virtue ethics would advise carefully weighing the benefits and costs of a proposal, aiming for the best possible consequences for society, while at the same time ensuring that the finest means are chosen to achieve a noble goal. If the proposed means, a policy of mandatory vaccination (e.g.), is not the finest way to achieve the noble goal, of herd immunity against an infectious disease, then other means ought to be pursued. Developing good judgment, discernment, and practical wisdom takes effort, education, and attention, and it is absolutely essential to making ethically sound and effective policy.

There is much work to do in developing a public health virtue ethics, and these are very early days in this new area. As this research continues, it has the potential to open new avenues of inquiry in public health ethics, both empowering public health to think of itself more in terms of a collective moral agent, but also developing new critiques of current public health practice. As mentioned above, there is also a great potential to incorporate Indigenous and other non-Western moral philosophies into a public health virtue ethics. My work in this area is grounded in philosophy of Ancient Greece, but I welcome the critiques from and dialogues with scholars with different intellectual groundings, and hope that this will become a deep and rich area of intellectual and practical development.

## **VI. Conclusion**

This paper has tried to give an overview of the current state of the field of public health ethics, its relationship with bioethics, some of the recent areas of work, some limitations of the field, and possible future directions. As I noted at the outset, I have surely missed a number of new developments or important critiques. I hope that this essay will be read as an opening, and an invitation to explore the literature more deeply. It is just a glimpse of what the diverse and brilliant array of public health ethicists around the world are doing

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