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Proportionate Universalism and Public Health

An Analysis of WRR Policy Brief From Disparity to Potential

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Abstract

The article analyses the public health policy brief *From Disparity to Potential* by the Dutch Scientific Council for Government Policy (WRR). It argues that the WRR brief presents a distinctive and novel brand of proportionate universalism, a theory proposed by Sir Michael Marmot (2010). The article situates the brief in the wider debate on proportionate universalism and offers an evaluation from an ethical perspective. It argues that the WRR's version of proportionate universalism exhibits three flaws: (1) the definition of socio-economic status is unduly focused on education levels and thus ignores important, health-relevant disparities; (2) whilst the policy brief endorses subsidiarity, it remains focused on governmental and economic actors, ignoring the importance of voluntary associations such as churches and faith-based organizations; (3) the focus of proportionate universalism is quantitative and needs supplementing with theories of the good life, typically associated with theological and philosophical forms of ethics originating in the premodern era.

Keywords: public health policy, proportionate universalism, socio-economic status (SES), health disparity, health potential, ethics, Marmot Review, WRR

Introduction

The present article analyses the policy brief *From Disparity to Potential* by the Dutch government's think-tank, the 'Scientific Council for Government

Policy' (WRR).¹ This brief is the WRR's latest contribution to the debate on public health policy; the English translation was published in November 2019, and thus only a few months before the outbreak of the Covid-19 'pandemic'.

For many readers interested primarily in theology, the topic may come as a surprise. Undoubtedly, theologians and scholars of religion are by and large accustomed to discussing religious texts rather than policy papers. However, *From Disparity to Potential* merits close attention. This is due to three factors: the innovative and provocative content of the policy brief; the international context in which it is situated; and, finally, the position of the WRR in the Netherlands, which ensures that it will influence future policy.

To begin with its content, *From Disparity to Potential* argues that over the past decades Dutch health policy has focused unrealistically and ineffectively on the reduction of health inequalities caused by socio-economic injustice. Instead, public health policy should be refocused to target 'the greatest possible health gains (...) to keep health losses to a minimum', irrespective of the beneficiaries' socio-economic position.² In short, the brief is a clear attempt to steer Dutch public health policy away from egalitarian goals, which are presented as unrealistic and counterproductive. The brief is also notable for its use of an ethical theory, namely 'proportionate universalism', which was proposed by epidemiologist Michael Marmot as recently as 2010. While there is a rapidly growing secondary literature on proportionate universalism, there is to my knowledge no evaluation of it in the context of theology and religious studies.

As to the international context, Marmot's position has been influential in the World Health Organization and has been endorsed by agencies within the European Union. By resorting to proportionate universalism, the WRR connects to a wider international trend. We shall see, however, that *From Disparity to Potential* offers a distinctive and novel interpretation of proportionate universalism that merits discussion.

Finally, it is perhaps worth explaining the status of the WRR, specifically for readers from outside the Netherlands. The 'Wetenschappelijke Raad voor het Regeringsbeleid', as its Dutch name goes, is a think-tank serving

1 D.W.J. Broeders, H.D. Das, R.P.W. Jennissen, W.L. Tiemeijer, M. de Visser, *From Disparity to Potential: A Realistic Perspective on Socio-Economic Health Inequalities*. WRR Policy Brief 7, The Hague 2019. This is the translation of an earlier Dutch version: *Van verschil naar potentieel: Een realistisch perspectief op de sociaaleconomische gezondheidsverschillen*, WRR Policy Brief 7, The Hague 2018.

2 Broeders et al., *From Disparity to Potential*, 1.

the Dutch government. Founded in 1972, the WRR's objective is 'to identify and advise the government on "future trends and developments" on issues that are of great importance for society by taking a multidisciplinary approach'.³ As of 2017, the WRR had nearly 34 full-time equivalent employees.⁴ On its website, the WRR lists 103 policy reports (65 of which were also published in English) and 7 policy briefs (6 of which were also published in English). This goes toward showing that WRR is an active, outward-looking research hub that is financed by, and connected to, the Dutch government. The chances are that its advice will influence the thinking of current and future administrations on societal issues, and even more so if the advice is connected in many ways to a broader international policy trend. Whether we like it or not, *From Disparity to Potential* is policy advice that matters. Theologians and scholars of religion who want to stay abreast of political developments should take note.

In what follows I shall first provide an introduction to the ethical theory of proportionate universalism through a 2010 policy report in which Marmot proposed his theory for the first time. Then I shall present key critiques and refinements of proportionate universalism. The first two steps form the background for an interpretation of the WRR policy brief. I shall then argue that the WRR offers a distinctive and novel version of proportionate universalism. In a fourth step, I shall offer a brief evaluation of the WRR's theory. I conclude with thoughts on the place of public health policy in times of Covid-19.

The Marmot Report and proportionate universalism

When sketching the background to the WRR policy brief, I can do no better than begin with a highly-regarded UK public health report, *Fair Society, Healthy Lives*. Commissioned by the Labour government in 2008, the report was published by the Conservative and LibDem coalition under David Cameron in 2010.⁵ It is generally referred to as the 'Marmot Review', after

3 Wikipedia, article 'Scientific Council for Government Policy', https://en.wikipedia.org/wiki/Scientific_Council_for_Government_Policy#cite_note-NIRA-2, last accessed 20th of October 2020.

4 W. Bijker, B. Cantillon, T. Joustra, B. ter Weel, P. de Goede, *Meer dan ooit nodig: Evaluatie van de Wetenschappelijke Raad voor het Regeringsbeleid 2013-2017*, The Hague (no year), 12.

5 Regardless of its being embraced by the new government, however, its findings were not implemented in the context of austerity politics following the global financial crisis. See M.

the commission's chairman and main author, Sir Michael Marmot, the director of the Institute of Health Equity at University College London. In many ways, the Marmot Review is a continuation in the UK context of earlier work that Marmot undertook for the World Health Organization (WHO), especially its Commission on Social Determinants of Health, which delivered its report in 2008. Already in 2005, at the beginning of his WHO advisory work, Marmot had identified his intuitions by stating that there was 'no necessary biological reason' why life expectancy should vary so much between Japan and Sierra Leone or between the Aboriginal and other members of the Australian population.⁶ Such differences in life expectancy and health must therefore be caused by 'social determinants' (hence, 'social determinants of health'). Whilst Marmot recognized the importance of risk factors such as 'being overweight, smoking, alcohol, and poor diet' his contention was that it would be hardly helpful to ask a deprived population to adopt healthier lifestyles. What Marmot wanted to focus on was what he called, contentiously, 'the causes of the causes' of ill health and poor life expectancy: 'the social conditions that give rise to high risk of non-communicable disease whether acting through unhealthy behaviours or through the effects of impossibly stressful lives.'⁷ This led to policy recommendations with a strongly *egalitarian* focus: what was important was not so much an absolute gain in longevity or in health but combatting the health gap between rich and poor, which was perceived as the major injustice. That gap should be addressed by redistributive social policies to reduce inequalities in wealth and resources as much as possible. The aim was to reduce or to flatten the 'social gradient' in health and longevity between rich and poor. As might be expected, Marmot's program of social and political change found its critics. We return to their objections later on.

For the moment, though, we focus on the policy recommendations that the Marmot Review issued for the UK. Just as the Commission on Social Determinants of Health saw striking health inequalities throughout the world, so the Marmot Review found that similarly striking differences exist

Marmot, 'Health Equity in England: The Marmot Review 10 Years on', *BMJ* 2020, 368, 1-4, 1. The article summarizes the findings of Marmot's follow-up study (Institute of Health Equity, *Health Equity in England: The Marmot Review 10 Years On*, London 2020; available online: <http://www.instituteofhealthequity.org/the-marmot-review-10-years-on>).

6 M. Marmot, 'Social Determinants of Health Inequalities', *The Lancet* 365 (2005), 1099-1104, 1103.

7 Marmot, 'Social Determinants', 1102.

within a single country, and even within the same city: ‘In the wealthiest part of London, one ward in Kensington and Chelsea, a man can expect to live to 88 years, while a few kilometres away in Tottenham Green, one of the capital’s poorer wards, male life expectancy is 71. Dramatic health inequalities are still a dominant feature of health in England across all regions.’⁸ In this context, Marmot proposed the position of proportionate universalism: ‘To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. We call this proportionate universalism. Greater intensity of action is needed for those with greater social and economic disadvantage, but focusing solely on the most disadvantaged will not reduce the health gradient, and will only tackle a small part of the problem.’⁹ At the most generic level, the Marmot Review formulated six key policy objectives: (1) give every child the best start in life; (2) enable all children, young people and adults to maximize their capabilities and have control over their lives; (3) create fair employment and good work for all; (4) ensure a healthy standard of living for all; (5) create and develop healthy and sustainable places and communities; and, finally, (6) strengthen the role and impact of ill-health prevention.¹⁰ It should thus be clear that the Marmot Review – owing to its perspective on health inequalities as caused by social inequalities and its intention to focus on the reduction of the latter inequalities – was wont to issue policy advice that goes way beyond health policy as traditionally understood. We see this at the most generic level with the Review’s emphasis on human autonomy (‘control’) and on the social sustainability of communities that goes above and beyond reducing pollution levels in their surroundings. This expansive view of health policy is even more visible in the more specific policy recommendations touching on, for instance, the tax system. According to the Marmot Review, research showed that the UK tax system is not progressive, once direct and indirect taxation are taken together, and the report urges the adoption of a duly progressive tax system.¹¹

8 M. Marmot, *Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England post-2010*. The Marmot Review 2010, 35.

9 Marmot, *Fair Society*, 16.

10 Marmot, *Fair Society*, 15.

11 As the Marmot Review argues, the lower quintile of the UK population pay 38% of their income in tax as opposed to 35% for the top quintile (Marmot, *Fair Society*, 74).

The Marmot Review: Critiques and interpretations

As indicated above, the expansive view of public health policy necessitating a highly redistributive social policy has been critiqued. Unsurprisingly, such critiques have been voiced from opposed political standpoints.¹² It is significant, however, that the basic assumptions of the Marmot Review have also been questioned by commentators who claim to support redistribution as a matter of social justice but reject the role of redistribution in matters of health care. For instance, the epidemiologists and public health specialists David Canning and Diana Bowser have pointed to historical precedent, arguing that the most significant health gains in developing countries and in deprived areas of the developed world alike 'have come from new health interventions that improve health at each level of income rather than from income gains (...). The health story is not really about moving along a fixed income-health relationship, rather it is the upward shift of the whole curve with rising levels of health at each income level over time'.¹³ This gestures towards a public health policy that is far more narrowly focused on the provision of clean air, water and food, and looks towards innovations in terms of medical treatments that will benefit everyone in society equally.

Whilst Canning and Bowser thus question the effectiveness of far-reaching redistribution for public health gains (however much it might be a matter of fairness and thus be valued for other reasons), philosophers such as Adina Preda and Kristin Voigt have questioned the conceptual basis of the redistributive focus that underpins the Marmot Review as well as other work on the social determinants of health.¹⁴ In their view, redistributive health policy is reliant upon a specific framework that Preda and Voigt call the 'health equity through social change model' ('HESC', for short).¹⁵ Preda and Voigt argue that the causality between social and health status that is assumed in HESC is far less straightforward than its proponents seem to think and that empirical studies finding a correlation between social and health status ignore the fact that there is a wide variety of behaviours

12 See e.g. C. Nathanson, K. Hopper, 'The Marmot Review – Social Revolution by Stealth', *Social Science and Medicine* 71 (2010), 1237-1239.

13 D. Canning, D. Bowser, 'Investing in Health to Improve the Wellbeing of the Disadvantaged: Reversing the Argument of *Fair Society, Healthy Lives* (The Marmot Review)', *Social Science and Medicine* 71 (2020), 1223-1226, 1224.

14 A. Preda, K. Voigt, 'The Social Determinants of Health: Why Should We Care?' *The American Journal of Bioethics* 15 (2015), 25-36.

15 Preda, Voigt, 'The Social Determinants', 25.

within social groups. They further argue that claims issued by Marmot and other ‘social determinants of health’ scholars, to the effect that membership of a social group leads to ‘patterning’ of behaviour and makes behaviour ‘largely determined’, bear witness to an unwarranted determinism that over-interprets statistical correlation as causation.¹⁶ They point in this context to empirical data demonstrating ‘that in European countries social inequalities in health have persisted and in some cases even widened, even where expansions of the welfare state have reduced inequalities in income and wealth.’¹⁷

Moreover, Preda and Voigt take issue with a key idea of HESC, namely that social – and only social – health inequalities are unfair and necessitate (radical) societal action. In the HESC model, health inequalities are presented as social and unfair if they can be prevented. The authors argue, however, that there is good reason to suppose that what really matters about inequality is ‘amenability to change’, i.e. ‘whether or not an inequality can be redressed’.¹⁸ If amenability is the issue, however, any inequality that persists even though it could be redressed, should be considered an unfair (social) inequality. This shows that there are no clear lines between social and natural inequalities and between health and other inequalities.

The question that arises from all of this is whether or not the very specific types of health inequality that are statistically correlated with socio-economic group membership merit being singled out in this way and being made the exclusive focus of large-scale redistributive policies, as envisaged by Marmot and his allies in the ‘social determinants of health’ movement.

These harsh political and conceptual critiques of the Marmot Review might mislead readers into thinking that I must have exaggerated its status. Nothing, however, could be further from the truth. We should note the limited nature of the critiques presented above: granted, they take issue with the redistributionist fervour of Marmot’s thinking and the social determinants of health movement more broadly. Whatever the Marmot Report’s exaggerations, however, the basic idea that a combination of universal and proportionately targeted measures might be a good idea for a public health system has enjoyed wide currency. To take only one example, it is

16 Preda, Voigt, ‘The Social Determinants’, 32, referencing M. Marmot, ‘Achieving Health Equity: From Root Causes to Fair Outcomes’, *The Lancet* 370 (2007), 1153-1163.

17 Preda, Voigt, ‘The Social Determinants’, 33, referencing J. Mackenbach, ‘The Persistence of Health Inequalities in Modern Welfare States: The Explanation of a Paradox’, *Social Science and Medicine* 75 (2012), 761-769.

18 Preda, Voigt, ‘The Social Determinants’, 29.

no coincidence that in 2013 the European Commission embraced proportionate universalism as the go-to strategy for improving the life-chances of disadvantaged children and their families.¹⁹ The Marmot Report's idea of proportionate universalism has thus had, and continues to have, an undeniable influence and importance beyond the radical redistributive ideas of its authors.

This is not to claim, however, that the Marmot Review has led to a closure of thinking about proportionate universalism. On the contrary, as with any new idea it would be highly unlikely if all details of the theory and especially its practical implications were thought through in advance and were agreed upon by practitioners. Unlike Athena, who sprang from Zeus' head fully formed and fully armoured, the making of theories is a more gradual and more piecemeal affair. Yet, arguably it is precisely the status of proportionate universalism as a theory-in-development that has increased its acceptance among policy makers, leaving open as it does a range of 'legitimate' proportionate universalisms. Whilst it is clear that proportionate universalism advocates a combination of general measures (universalism) with specific measures geared towards those most in need, there are at least four areas of debate about proportionate universalism that indicate variables allowing for such a variety of proportionate universalisms. The four areas are: (1) the type and reach of the general measures envisaged (*universalism*), (2) the kinds and reach of targeted measures (*proportionate actions*), (3) the specific *balance* between universalism and proportionate actions and, finally, (4) best ways of organizing *governance* in a differentiated modern welfare state. In what follows I shall briefly address the four areas in turn, drawing on an extremely helpful literature overview by Gemma Carey, Brad Crammond and Evelyne De Leeuw.²⁰

(1) Universalism: Carey and colleagues distinguish two main ways of understanding the 'universalism' pole of the theory: on the one side, a 'general universalism' that offers "flat-rate" benefits (...) to all, irrespective of citizenship, class, means or need'; on the other, a 'specific universalism that makes coverage dependent on preconditions such as citizenship'.²¹

19 M. Dierckx, J. Devlieghere, M. Vandenbroeck, 'Proportionate Universalism in Child and Family Social Work', *Child and Family Social Work* 25 (2020), 337-344, 338.

20 I draw on the literature overview provided in the important article by G. Carey, B. Crammond, E. De Leeuw, 'Towards Health Equity: A Framework for the Application of Proportionate Universalism', *International Journal for Equity in Health* 14 (2015), 81.

21 Carey et al., 'Towards Health Equity', 2.

(2) Proportionate actions: a key variable will be the method of prioritizing the most disadvantaged. Carey and colleagues distinguish between 'negative' and 'positive selectionism', the former meaning that services and assistance are given on the basis of preliminary means testing (e.g. 'low income health cards'), whereas the latter would entail the provision of 'additional services and resources for certain groups on the basis of need (e.g. without means testing).²² Another vector is the extent of choice on the part of the recipients. Carey and colleagues argue that ideally, while there may be variation, proportionate universalism should give 'funds (...) directly to individuals so that they may "purchase" a service from providers, which meets their particular needs'. They refer to this arrangement as 'particularism'.²³

(3) Balance: on this issue, there are decided differences of opinion among advocates of proportionate universalism. As we have seen above, even Marmot, the author of proportionate universalism, saw targeted interventions as fraught with difficulties to do with the potential stigmatization of specific groups. That is why he advocated a strongly redistributive society and universal measures in preference to targeted ones. There are other proponents of proportionate universalism who see targeted interventions as far less problematic. For instance, a 'dose-response approach' has been proposed, according to which those at the lowest level of the gradient receive more 'health action' than those at higher levels.²⁴ An example of this might be the provision of GP services or pre-natal services that are sufficient for, and accessible by, the whole population but are intensified in less well-to-do areas. Of higher visibility would be targeted actions in which the services and support offered to those in different positions on the social gradient differ *in kind*. Examples of this would be the provision of specific GP or pregnancy counselling services for low-literate groups or specific home nursing arrangements for migrant groups. In short, this is a variable that allows a lot of choice, from a strong reticence in respect of targeted services for fear of possible stigmatization to the full endorsement of a separate provision for those with specific needs.

(4) Governance: Carey and colleagues argue in favour of a social ethical concept that is well known in the field of Christian ethics and beyond: the principle of subsidiarity, i.e. seeking to ensure 'that decisions and actions

²² Carey et al., 'Towards Health Equity', 3.

²³ Carey et al., 'Towards Health Equity', 3-4.

²⁴ Carey et al., 'Towards Health Equity', 1.

are taken as closely as possible to citizens through a multi-layered system'.²⁵ In spite of this advocacy of subsidiarity, there can clearly be variation in the degree to which advisory roles and decision-making power are ceded by central government and as to who will perform those roles.

As we survey our progress so far, we note how the Marmot Review launched a new ethical position in public health care policy: proportionate universalism. The 2010 report is part of a larger current of social determinants of health research. While the left-wing redistributionist ideas of the 2010 Marmot Review have found their critiques, the idea of proportionate universalism continues to be relevant and has been adopted *inter alia* by the European commission. At the same time, proportionate universalism as an idea is still in flux; the relative indeterminacy of the theory might even have aided its adoption, since it can be interpreted in different ways and thus can be adjusted to different political circumstances. In what follows, I shall analyse the specific adjustments to the Dutch context made by the authors of *From Disparity to Potential*.

The WRR's adaptation of proportionate universalism

As I have explained above, *From Disparity to Potential* states explicitly that it wishes 'to tap into an approach that Marmot refers to as "proportiona[te] universalism".²⁶ The report highlights as an advantage of proportionate universalism that it 'does not focus unilaterally on lower socio-economic groups, it is also more inclusive with respect to shifts between and within groups with differing SES [socio-economic status, CJ]. While the size of the various groups changes over time, so too does their practical socio-economic significance. The groups themselves are therefore also fluid, lending further weight to the importance of a universal approach as a foundation'.²⁷

Reconstructing the argumentative structure of the WRR report in more detail, we can distinguish three generic steps that are common in policy reports: the report indicates a problem; it identifies, at a higher level of abstraction, a solution to the problem; and it offers more specific policy recommendations that follow from the solution it has advocated.

²⁵ Carey et al., 'Towards Health Equity', 4.

²⁶ Broeders et al. *From Disparity to Potential*, 18. It should be noted that the English version of the report does not render Marmot's terminology correctly, and uses 'proportional' instead of 'proportionate' universalism. I correct the error throughout.

²⁷ Broeders et al., *From Disparity to Potential*, 18.

As to the *problem*, the report claims that Dutch public health policy has been strongly egalitarian. It also claims that 35 years of intense policy work have not achieved a reduction in the health disparity between the lowest social-economic groups in Dutch society and the highest groups. The lowest SES groups have gained better health, but the highest SES groups have profited even more.²⁸ This lack of tangible results, the report claims, is motivationally unsustainable (presumably for policy-makers themselves, but the report is silent on whose frustration is given so much weight): it is ‘a millstone that leads to despondency and the complaint that “nothing works”’.²⁹ The root cause of the problem is that policy-makers have approached public health, and especially the disparity in health between low and high SES groups, with a wrong type of ethical theory: the egalitarian ideal behind previous Dutch public health policy is focused on outcomes and assumes that health is a ‘transferable’ good. This would mean that one could channel health gains away from a privileged group and use them to ‘level up’ a disadvantaged group just as one could redistribute money. However, as the lack of tangible policy success shows, health should not be approached as a transferable good.³⁰

This analysis paves the way to the *solution* advocated in the report: if health is seen as the non-transferable good it really is, it makes far more sense to focus policy not on health *outcomes* but rather on the health *potential* that different groups in society may have. Proportionate universalism is the report’s preferred strategy to focus on that health potential.

From Disparity to Potential offers a helpful illustration of the available policy options and the shift it advocates in the form of a table (see Table 1).

Table 1 ‘Six moral stances’, *From Disparity to Potential*, 16, additions CJ

	Egalitarianism	Sufficientarianism	Prioritarianism
Focus on health outcomes (insensitive responsibility)	1. Everyone has the right to the same number of healthy life years and life expectancy.	2. Everyone should have at least x years of good health and reach the age of [y].	3. The number of healthy life years and life expectancy of those who score the lowest should increase.
Focus on opportunities (sensitive responsibility)	4. Everybody should have equal opportunity to maximise health potential.	5. Everyone should have a <i>decent minimum</i> of opportunities to maximize health potential.	6. People whose potential is the least activated should receive more and better opportunities to do so.

²⁸ Broeders et al., *From Disparity to Potential*, 13.

²⁹ Broeders et al., *From Disparity to Potential*, 35.

³⁰ Broeders et al., *From Disparity to Potential*, 35.

The three main columns show the key ethical positions in public policy: egalitarianism (commitment to an expansive set of goods for everyone, making sure that everyone reaches the same 'level'); sufficientarianism (guaranteeing only a minimum set of goods for everyone); and prioritarianism (giving priority to the worst-off). Traditionally, these three theories focus on (health) *outcomes*, but *From Disparity to Potential* suggests that the three main positions can be applied to *opportunities* as well (Table 1, lower row). The proportionate universalism advocated by the WRR policy brief is a combination of egalitarianism and prioritarianism. Thus, the solution advocated in *From Disparity to Potential* lies in a shift of perspective from the egalitarian, outcome-focused position (position 1) of the past decades of Dutch public health policy to a combination of opportunity-focused versions of egalitarianism and prioritarianism (positions 4 and 6).

Two aspects are noteworthy in this overview of available positions: (1) The overview makes no reference to utilitarianism, which is clearly an important ethical theory and clearly relevant for public policy-making. The policy brief does not use the term 'utilitarianism' at all, although it argues against the utilitarian concept at quite some length before presenting the overview of 'six moral stances'. The brief argues against an exclusive focus on 'economic efficiency', referring to it as 'a purely mathematical approach'.³¹ That approach would focus on realizing maximum health gains, irrespective of whose health gains they are. It would also use a decision-making procedure that would take into account the 'likelihood of realizing the improvement'.³² This is, however, a good description of the utilitarian position. Without further amendments, utilitarianism would favour investing in those who are exceptionally good at transforming resources into health gains. In a world in which those with a low SES are often markedly inefficient at transforming extra resources into health gains, this might lead to an anti-egalitarian conclusion, namely that society should invest the most in high-SES groups, since they are far more efficient at producing health gains. The WRR policy brief takes a nuanced stance vis-à-vis this utilitarian position. On the one hand, it rejects the utilitarian recommendation to divert public health investment from low-SES to high-SES groups. The brief argues that many 'are likely to perceive such outcomes as unfair'.³³ On the

31 Broeders et al., *From Disparity to Potential*, 15.

32 Broeders et al., *From Disparity to Potential*, 15.

33 Broeders et al., *From Disparity to Potential*, 15. Broeders and colleagues are right about this: empirical studies show that egalitarian intuitions are widespread and inefficiency is preferred if the goal is to help the more disadvantaged groups (see e.g. M. Otsuka,

other hand, extra investment for the sake of lower-SES groups cannot wholly be separated from considerations of efficiency, so there must be a limit to such investment. The brief is not explicit where exactly the line should be drawn, but it takes as a given the lower likelihood of disadvantaged SES groups realizing health gains.³⁴

(2) However, the differences between the Marmot Review and the WRR policy brief go further than levels of public health investments; they are also different, at least conceptually, as far as envisaged target groups for public health care policy are concerned. The Marmot Review was focused on outcomes; its ambition was to reduce the social gradient in health by increasing the socio-economic situation of the least advantaged. The WRR brief argues precisely against such egalitarian commitments in terms of results. It focuses instead on groups in society with the greatest health potential, i.e. as-yet-unrealized health gain or as-yet-unrealized prevention of health deterioration. The brief does not highlight the differences between its own version of proportionate universalism and the one employed in the Marmot Review. It should be clear, however, that they are different at the conceptual level. Whether or not the reports can justifiably result in policies targeting the same groups is, therefore, a matter of *empirical, contingent fact*. At any rate, there are good reasons for doubting that low-SES groups will actually turn out to be the groups with the highest unrealized health potential. Perhaps the authors of the brief are aware of the possible difference, since they present the targeting of low-SES groups and of the young as separate proposals.³⁵ I shall return to this issue in the next section. In the present context, it is enough to say that in outlining *specific policy recommendations* the brief shows a clear overlap with the Marmot Review: both recommend targeting young people and lower-SES groups and targeting risk factors such as smoking, obesity, poor diet, lack of exercise and problematic alcohol consumption.³⁶ Both call for an increased focus on mental illness.³⁷ Just as Marmot had been concerned that measures heavily targeting low-SES groups might counterproductively stigmatize those most in need of help, so the WRR policy brief is adamant that universal measures might work best. In that vein, the brief suggests that financial incentives

A. Voorhoeve, 'Why It Matters that Some Are Worse Off than Others: An Argument against the Priority View', *Philosophy and Public Affairs* 37 (2009), 171-99).

34 Broeders et al., *From Disparity to Potential*, 15.

35 See Broeders et al., *From Disparity to Potential*, 1.

36 Broeders et al., *From Disparity to Potential*, 1, 19-21.

37 Broeders et al., *From Disparity to Potential*, 1, 19-21.

'appear to be effective in reducing smoking' during pregnancy. Whilst such incentives might be offered to all pregnant women who smoke, irrespective of their SES, and would thus not stigmatize low-SES groups, their financial attraction would be felt most powerfully by (and might be specifically effective in) lower-SES groups.³⁸

On the basis of the discussion so far, we can attempt to draw up a schematic representation of the main positions and of the WRR's brand of proportionate universalism. For ease of comparison, I focus on unrealized health potential. We can then represent the different positions in an xy-coordinate system, in which the x-axis represents, progressively, the unrealized health potential.³⁹ The y-axis represents the level of public health expenditure. The resulting graph looks as follows (Figure 1):

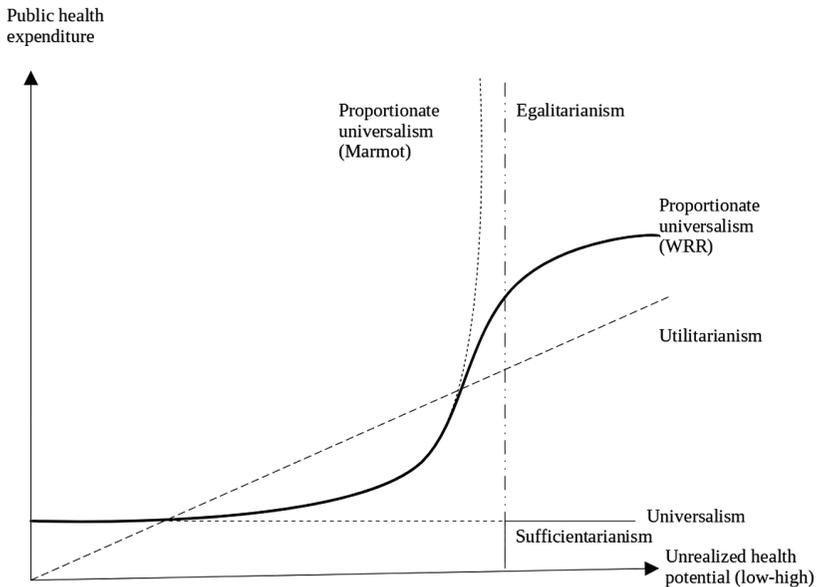


Figure 1 Key ethical positions for public health expenditure (CJ)

38 Broeders et al., *From Disparity to Potential*, 29. An interesting question which is, however, beyond the scope of the present article is how the framework of Healthy-Life Years presupposed in the WRR brief relates to the internationally dominant concept of Quality-Adjusted Life-Years (QALYs). On QALYs, see e.g. E. MacKillop, S. Sheard, 'Quantifying Life: On the History of Quality-Adjusted Life-Years (QALYs)', *Social Science and Medicine* 211 (2018), 355-366.

39 On the (as indicated above, questionable) assumption of a simple inverse relation between unrealized health potential and SES level (the lower the SES level, the higher the

Utilitarianism is represented by a linear progression: it will invest more to obtain higher health gains, irrespective of whose health gains they are. Egalitarianism is represented by a vertical line: it 'kicks in' at a certain level of unrealized health potential or SES-disadvantage, while its commitment to realizing equality is, as it were, infinite. Universalism demands an equal expenditure for all SES positions, it is therefore represented as a horizontal line. Sufficientarianism, which is represented in the lower right corner, is a special case of universalism: it 'kicks in' at a certain level of disadvantage but provides only a minimum of health expenditure, just as universalism does. The ethical positions represented so far provide a grid in which the two versions of proportionate universalism can be located. Marmot's proportionate universalism is represented by an exponential function: its universalist component ensures that there is an untargeted public health expenditure for everyone, so the curve begins with positive values. The sharp upswing of the curve represents the egalitarian aspect of Marmot's proportionate universalism: in principle, there is no limit as to what Marmot's proportionate universalism would do to produce health equality. The WRR's version of proportionate universalism is partly distinct from Marmot's version: the beginning of the curve is the same, but in the WRR's version the curve flattens towards the right-hand side: there is a limit to what the WRR recommends should be done to realize health gains.⁴⁰ Although there is a commitment to help, that commitment is not unlimited. The flattening of the curve in the WRR's version of proportionate universalism results in an interesting difference from utilitarianism. Furthermore, utilitarianism has no easy way of halting the linear trend of health care investment: it is an ethically correct choice to invest more, so long as increasing health gains can be realized. There will therefore be a point on the right-hand side of the coordinate system at which the utilitarian will outspend the WRR-style proportionate universalist.

Regardless of all the complexities inherent in this discussion, there is a simple conclusion: the representation makes clear that the WRR policy brief proposes a new form of public health ethics which differs from the theories presented so far. The question remains: is the WRR's theory any good?

unrealized health potential), the x-axis also represents SES positions. The o-position on the x-axis marks non-existent disadvantages vis-à-vis the highest SES position (i.e. it is equal to, or identical with, the highest SES position); the further we move along the x-axis, the more disadvantaged the respective SES position becomes.

40 Again, on the assumption of a simple inverse relation, this limits expenditure for more deprived SES levels.

Ethical evaluation

In evaluating the WRR policy brief's proportionate universalism from an ethical perspective, I should immediately clarify my favoured style of ethical reflection: I am convinced that ethics should be careful not to 'over(p) reach'. Quite a few ethicists have succumbed to that error, offering as ethics a thinly-veiled radical political activism. In my view, this is not a reasonable attitude to take: ethics should try to be a constructive discussion partner, addressing specific and remediable injustices while not discounting piecemeal but realizable improvements. This is a style of doing ethics that takes its cue *inter alia* from Martin Honecker's Lutheran theological ethics.⁴¹ It seeks to employ criteria for ethical judgment that have credence beyond the narrow confines of specific religious communities and have the capacity for engagement with secular political reason. It thus prioritizes publicly accessible reasons.⁴²

To give an example: it is probably correct that the big pharmaceutical companies could make many of their discoveries available much more cheaply than they do; and it is probably also correct that the lobbying activities of pharmaceutical companies have led to the approval of drugs whose health value is questionable.⁴³ Of course we ought to address this waste of scarce resources. However, it would be intellectually dishonest to point to this type of (hypothetical) saving as a panacea for the incontrovertible scarcity of our resources.⁴⁴ We should recognize that the research and development for a new therapy, a new drug or a new Covid-19 vaccine costs

41 See e.g. M. Honecker, *Grundriß der Sozialethik*, Berlin/New York 1995. In secular philosophical ethics a similarly 'pragmatic' stance has been spearheaded by (otherwise radical) thinkers such as Michael Walzer and, more recently, Torbjörn Tännsjö. See M. Walzer, *Political Action: A Practical Guide to Movement Politics*, New York 1971; M. Walzer, 'Political Action: The Problem of Dirty Hands', *Philosophy and Public Affairs* 2 (1973), 160-180; T. Tännsjö, *Setting Health-Care Priorities: What Ethical Theories Tell Us*, Oxford/New York 2019. Tännsjö proposes an eirenic style of reasoning that tries to establish common ground for public health policy improvements among the otherwise competing theories of utilitarianism, egalitarianism, prioritarianism and maximin/leximin (exclusive focus on the worst off).

42 In Luther's words '*Politia et oeconomia est subjecta rationi. Ratio prima*'; see M. Luther, *In epistolam S. Pauli ad Galatas Commentarius [1537] 1535* (Weimarer Ausgabe 40 I), Weimar 1911, 305; see also Honecker, *Grundriß der Sozialethik*, 31.

43 See e.g. S. H. Kaufman, *Ordinary Medicine: Extraordinary Treatments, Longer Lives, and Where to Draw the Line*, Durham/London 2015; J. Stegenga, *Medical Nihilism*, Oxford 2018.

44 See also Tännsjö, *Setting Health-Care Priorities*, 103, who attacks denials of the limitation of our resources as follows: 'This reaction is intellectually dishonest, but demagogically effective, and hence it is almost irresistible.'

immense sums of money. It is questionable whether such activities will be stimulated by monitoring the pharmaceutical companies in close detail. Even if we could implement a very different, more highly regulated market system and actually manage to save money, it would probably be wrong to spend all that money on *domestic* public health as opposed to health in the poorest regions of the world and on global problems such as combatting, or adapting to, climate change.

Evaluated from this perspective, the WRR policy brief's pragmatic approach is commendable. Its application of proportionate universalism maintains a distance from the radical demands of the Marmot Review. For Marmot, health disparities are only an epiphenomenon of economic and political disparities and the main focus of the Review was to address the underlying layer of the 'causes of the causes', in effect declaring public health policy irrelevant.⁴⁵

It is also commendable that the WRR policy brief does not bypass individual responsibility, as the Marmot Review tended to do. This is absolutely in line with theological ethics which will, for better or worse, always have to allow for the importance of the individual person as the addressee of the gospel, the recipient of divine grace, and thus as a person who is up to a point in charge of their own life.⁴⁶

At the same time, the WRR brief strikes the difficult balance between individual responsibility and unqualified support from society. There is no suggestion that lower-SES people might be 'themselves to blame' for

45 If anything, we might say that the WRR policy brief errs on the side of caution: it delineates public health policy too narrowly and is silent about the place of public health policy in the broader field of health-related expenditure. We need to accept that overall health expenditure in the Netherlands, as well as in other countries of the Global North, has probably reached a peak; new challenges such as combatting climate change must result in a reduction of health budgets. In other words, there is a real and increasing urgency to rethink the overall level of health budgets. In this context it will also be necessary to rethink the balance of preventive health policies vis-à-vis other health related expenditure (see also Tännsjö, *Setting Health-Care Priorities*). Tännsjö, himself a utilitarian, has provocatively suggested a need to divest expenditure from marginal life extensions at the end of life towards preventive public health care and mental health care. He also suggests that assisted suicide should be made freely available in addition to palliative sedation for those with incurable terminal conditions. I cannot discuss these wide-ranging issues here, but they underscore the importance of rethinking public health policy in a broader context, yet without diffusing public health into social policy.

46 See e.g. M. Honecker, *Einführung in die theologische Ethik*, Berlin/New York 1990; N.P.G. Austriaco O.P., *Biomedicine and Beatitude: An Introduction to Catholic Bioethics*, Washington DC 2011.

disparities in health. By advocating proportionate universalism, the WRR brief remains committed to helping lower-SES groups. Theological ethicists will easily recognize the 'preferential treatment of the poor' that has been a key concern in their discipline. At the same time, the WRR brief shows full awareness of the dangers of stigmatizing specific groups. The suggestion of using financial incentives, for instance, as universal in reach yet particularly attractive and motivating for disadvantaged groups seems to get that difficult balance right. It is also worth pointing out that the universal aspect of such measures is likely to have the added benefit of increasing support of health care expenditure from higher-SES groups, who are predominantly net contributors to redistributive schemes.

Although the WRR policy brief should be praised for all of the above features, I think there are good reasons to urge further thinking. In what follows I want briefly to address three issues:

(1) The WRR policy brief advocates special consideration for lower-SES groups. As pointed out above, it is not clear how lower-SES groups relate to groups with higher unrealized health potential. The problems inherent in this lack of clarity are exacerbated by the choice of a particular method of identifying SES groups. The WRR brief works from a concept of SES groups that is widespread in the Netherlands, but is at odds with the ways SES groups are identified elsewhere, for instance in the Marmot Review. The WRR distinguishes three SES levels according to level of education: (a) low, i.e. with maximally three years of senior general or pre-university secondary education; (b) medium, i.e. with maximally a vocational (management) training, and (c) high, i.e. with a university or polytechnic degree.⁴⁷ I would argue that tying socio-economic status in this way to levels of education leads to an unbalanced view of disadvantage and might even undermine a sense of urgency in public health policy. Since the educational level of younger generations is rising, this has the clear effect on the size and composition of the lower-SES groups: older citizens are overrepresented in them and the lower-SES groups are shrinking naturally. This unrecognized bias may have led to the WRR's view that lower-SES groups have a lower efficiency at turning health expenditure into health gains; it is hardly astonishing that older and less highly-educated people will experience greater difficulty in changing their lifestyle. And if the disadvantaged groups are shrinking anyway, this may make a cap on extra funding particularly attractive. At the same time, we should realize that this peculiar method of

47 Broeders et al., *From Disparity to Potential*, 9-10.

identifying SES groups could also disadvantage younger people, because it excludes the possibility that younger (often more highly-educated) citizens could ever be disadvantaged. In short, the way in which the WRR identifies SES groups misses something essential: the identification of SES groups should rely on a wider array of factors such as income, the number of working hours needed to create that income, the quality of one's housing and surroundings in a broad sense, the presence or absence of pollution in one's environment, and so forth. In all of these ways, even a highly educated young person can be disadvantaged in the Netherlands today. Nurses (low income), Protestant clergy (part-time contracts, low income, long working hours) and students (low income, long working hours, often living in highly crowded and polluted inner-cities) would be prime examples, yet they do not register as disadvantaged in the WRR's classification.

(2) The WRR policy brief emphasizes the importance of subsidiarity. In doing so, it follows and quotes the article by Carey and colleagues 'Towards Health Equity' (see above). Welcome as the insistence on subsidiarity will be for theologically and politically interested readers, I deplore a lack of imagination in the WRR policy brief's thinking on this point. Where it discusses subsidiarity, it focuses on the three levels of national government, local government and 'the private sector', exemplified by 'food manufacturers and supermarkets, and health insurers'.⁴⁸ With this reduction to government and the economic sector, the WRR policy brief fails to consider a wide array of relevant actors: that array should include voluntary associations of very different types, from the field of sports to cultural, ethnic and religious organizations. Indeed, religious communities and faith-based organizations more generally are important societal partners for any public policy task where the political and administrative realm has difficulties in reaching out to society.⁴⁹ The WRR policy brief acknowledges the importance of culture and language but views this only as a problem for the effectiveness of governmental action.⁵⁰ There is no reflection on voluntary associations in civil society as important positive forces for realizing health gains.

(3) It would be unfair to fault the WRR policy brief for its clear focus on adding more healthy years to people's lives. Without doubt, proportionate universalism is an ethical theory that aggregates outcomes and thus

48 Broeders et al., *From Disparity to Potential*, 38.

49 See e.g. A.L. Molendijk, J. Beaumont, C. Jedan (ed.), *Exploring the Postsecular: The Religious, the Political and the Urban*, Leiden/Boston 2010.

50 See Broeders et al., *From Disparity to Potential*, 36.

prioritizes quantitative considerations. However, viewed from the perspective of Christian ethics (as well as from other forms of ethics which have their roots in premodern times), it is not so clear that this should be the main ethical focus. Those ‘premodern’ forms of ethics are typically ‘eudemonistic’: they investigate the best possible shape of human life. Health may be one important consideration in this, but it is certainly not the only one. In addition to focusing on *adding years to our lives*, we should also aim at *adding life to our years*.⁵¹ Arguably it is in this regard that today’s policy-making stands to gain the most from traditional forms of ethics, religious and philosophical.⁵²

Postscript: Before and after the pandemic

In this article I have argued that the WRR Policy Brief *From Disparity to Potential* offers a version of proportionate universalism that is both novel and intuitively attractive. In contrast to older, overly radical redistributionist schemes of public health it argues for a special consideration of disadvantaged groups as well as for the eminently plausible need to limit public health spending. I have also identified shortcomings in the WRR’s development of the theory, to do with the identification of SES groups and the lack of a clear plan for including cultural and religious resources and networks. Overall, however, I would repeat that this version of proportionate universalism in public health is attractive.

Nevertheless, I can imagine that readers may have been waiting for a discussion of our present health emergency. As I finish this article, we are living through another Covid-19 wave in the Netherlands, and chances are that we shall still be in the grip of the pandemic when the article is published. In this situation it is easy to doubt the relevance of public health policies from before ‘the’ crisis. Will they all have to be rewritten?

I want to caution against implicit assumptions that Covid-19 must be a game-changer and must mark a ‘singularity’ in public health efforts. As Richard Horton, editor-in-chief of *The Lancet*, has provocatively noted in a recent column, Covid-19 ‘is not a pandemic’, but rather a ‘syndemic’. In

51 I have adapted here a formulation by T.D. Cosco, K. Howse and C. Brayne, ‘Healthy ageing, resilience and wellbeing’, *Epidemiology and Psychiatric Sciences* 26 (2017), 579–583, 581 on adding years to life.

52 See also in this issue Catrien Santing’s article on the medieval model of wellbeing and my own analysis of Cicero’s treatise on old age.

other words, it would be too simple to see in Covid-19 primarily an infectious disease whose spread must be stopped by cutting the 'lines of viral transmission'. The gravity of Covid-19 infections stems rather from the interaction (hence *syndemic*) of the viral infection and 'an array of non-communicable diseases': 'hypertension, obesity, diabetes, cardiovascular and chronic respiratory diseases, and cancer'.⁵³ What Covid-19 does in effect, Horton argues, is to expose social inequalities that must be addressed with public health policy. And in the Netherlands, the broadsheet *de Volkskrant* has argued in a similar vein that since Covid-19 exacerbates health disparities, far more attention is needed to health prevention.⁵⁴ These are only two examples of a growing chorus of voices that underscore the importance of lifestyle and ultimately of socio-economic inequalities, even on the course of Covid-19 and on the impact it will have on our society. In this regard, the time after the crisis will be remarkably similar to the time before.

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53 R. Horton, 'Offline: COVID-19 Is not a Pandemic', *The Lancet* 396 (2020), 874.

54 M. van der Geest, 'Arme mensen gaan zes jaar eerder dood – waarom doen we daar niets aan?', *Volkskrant*, online version 2nd of October 2020, <https://advance-lexis-com.proxy-ub.rug.nl/document/?pdmfid=1516831&crd=5bf5773d-f504-4961-9f9c-1647efe24805&pddocfullpath=%2Fshared%2Fdocument%2Fnews%2Furn%3AcontentItem%3A6100-GP21-JBHV-K33N-00000-00&pdcontentcomponentid=467100&pdteaserkey=sr1&pditab=allpods&ecomp=fzx2k&earg=sr1&prid=481dabba-900d-4ef6-b944-7c51257d85e8> (last accessed 1st of November 2020).

