

Feminism and public health ethics

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J Med Ethics 2006;32:351–354. doi: 10.1136/jme.2005.013466

This paper sketches an account of public health ethics drawing upon established scholarship in feminist ethics. Health inequities are one of the central problems in public health ethics; a feminist approach leads us to examine not only the connections between gender, disadvantage, and health, but also the distribution of power in the processes of public health, from policy making through to programme delivery. The complexity of public health demands investigation using multiple perspectives and an attention to detail that is capable of identifying the health issues that are important to women, and investigating ways to address these issues. Finally, a feminist account of public health ethics embraces rather than avoids the inescapable political dimensions of public health.

in public health ethics. A feminist approach to health inequities leads us to examine the connections between disadvantage and health, and the distribution of power in the processes of public health, using gender as an analytic category. The complexity of public health demands investigation using multiple perspectives; feminist methods lend themselves to this kind of messy complexity. Finally, a feminist account of public health ethics embraces rather than avoids the inescapable political dimensions of public health, recognising that the barriers to good health that exist at the individual level require political solutions.

HEALTH INEQUITIES AND FEMINIST ANALYSIS

Equity is a central issue in public health ethics, grounded in our understanding of the inescapable nexus between poverty, disadvantage, oppression, and poor health. Relative poverty is a major risk factor for increased morbidity and mortality, both nationally and internationally.⁷ The conditions for health (however we define health) are best met in societies with least inequity.⁸ A concern for equity must therefore be central to public health ethics, for without such concern, ethical attention will be diverted away from one of the most pressing threats to the health of the public. Concern about inequities is a dominant theme in feminist bioethics. Sherwin writes: “Questions about dominance and oppression are essential dimensions of feminist ethical analysis”; and Wolfe takes a similar view: “a feminist bioethics should begin with attention to those historically least served and most harmed”.^{9 10} This requires an explicit commitment to a moral view of society, the view that all people deserve to be treated in such a way so as to have the greatest opportunity for good health. Economic and material disadvantage are important dimensions of inequity in the genesis of ill health; however, the less tangible aspects of inequity are equally important. These include lack of power, oppression, diminished opportunities, and discrimination; this is familiar territory for feminists.

The arguments for placing equity at the heart of public health ethics have been made by others, but these scholars have not used the lens of gender analysis.^{11 12} Using this lens, we find that female gender is a risk factor for increased inequity. The effects of gender, discrimination, and poverty can all be linked to the ill health of women.^{13 14} Gender inequality and discrimination harm girls’ and women’s health directly and indirectly, throughout the life cycle.¹⁵ Female infanticide, inadequate food and medical care, physical abuse, genital mutilation, forced sex,

Public health plays an important role in protecting and promoting the health of populations. The activities of public health are complex, performed by multiple professionals, and range from the innocuous to the intrusive. Ethical analyses in public health reflect some of this complexity and fragmentation, with competing accounts capturing different parts of the ethical landscape.^{1–3} To date, there has been relatively little feminist analysis of public health ethics.^{4 5} This is, however, an important task, given the relevance of public health activities to the health and wellbeing of women.⁶ Some of the activities of public health are directed toward redressing the health effects of poverty and oppression; these activities have the potential to make important differences for women and their children who are over-represented in the ranks of the disadvantaged. Other public health activities are aimed at screening, raising significant questions about autonomy, paternalism, and the regulation of bodies with potentially “dangerous” features (breasts, cervixes, pregnant uteruses, adipose tissue). Justice in the allocation of resources is another area in which women have a stake, in that they form the majority of both carers and the aged—two groups who are significantly affected by funding and allocation decisions. Finally, many of the preventive aspects of public health—for example, diet, personal hygiene, or childhood exercise—are activities that are traditionally mediated through the actions of women as family carers and custodians of health and wellbeing.

There are several reasons why feminist ethics may be particularly relevant to public health ethics. Feminism is concerned with equity, oppression, and justice, which are central themes

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Received 4 July 2005
In revised form
15 August 2005
Accepted for publication
16 August 2005

and early childbirth are directly responsible for the deaths of many women across the globe.^{16–18}

Poverty is a risk factor for poor health that applies irrespective of race or gender. Poverty, and the effects of poverty, are, however, gendered.¹³ Women are more likely than men to be poor, and within poor households, non-negotiable responsibilities and limited access to resources, including health care, have a greater relative impact on the health and wellbeing of women than men.^{17 19}

These fairly stark observations ground the claim that gender inequities are directly and indirectly linked to causes of ill health for women. In theory, public health efforts to decrease inequities would have a greater impact upon women than men, given their over-representation among the ranks of the oppressed and economically disadvantaged. This might justify a human rights approach to public health ethics on the grounds that protecting everyone's rights will lead to women benefiting in greater numbers than men, in direct relation to the current lack of protection of women's rights. We have good reasons, however, to fear that a gender free commitment to equal rights may not deliver the expected benefits for women. Historically, commitments to human rights entail problematic assumptions about both the abstract characteristics of rights bearers such as independence, rationality, impartiality, and autonomy, and about their lived experiences.²⁰ This can lead to two problems. First, particular groups may be "invisible" as the bearers of rights that are otherwise extended to individuals in that society. A legal right to physical safety—for example, does not extend to women in cultures that, overtly or covertly, condone gender based violence.¹⁸ In these cases, rights based protection fails women because either their harms do not qualify as the kind of harms prohibited by law, or the law is not enforced.²¹ Second, the assumption that all people are equal bearers of rights ignores important differences between people and their abilities to exercise their rights. A woman employed on a casual contract might be reluctant to exercise her right to make a legitimate complaint about unsafe work practices if she fears losing her job and being unable to find another.

For these reasons, a general commitment to human rights may not provide the kind of equity gains that are necessary in public health. Rather, a commitment to eliminating specific inequities, including gender inequities, should be a central theme in public health ethics. Attention to gender has the potential to deliver direct health benefits to women. In addition, the process of identifying and eliminating gender related inequities, especially those related to oppression and discrimination, is likely to raise awareness of these issues, with subsequent benefits for men who suffer similar inequities.

Distributive justice

One part of addressing inequities relates to questions of distributive justice: where should public health funds go, into which services, for which people? Utilitarian thinking has been influential in the distribution of healthcare goods, driven by a desire to obtain maximum benefits for the greatest number of people in the face of limited budgets. This is manifest by the widespread use of tools such as cost effectiveness analyses, disability and quality adjusted life years, and evidence based medicine (EBM). These tools and techniques are blind to the distribution of benefits to individuals, and thus take no account of the degree of inequality in different distributions.¹² EBM—for example, focuses solely on the effectiveness of treatments, rather than the seriousness of the condition, distribution of disease, gender of the patients, or likely impact on health inequalities.^{22 23}

Iris Marion Young has identified two major shortcomings of distributive accounts of justice that are relevant here.²⁴

First, the focus is upon allocation of material goods with the distribution of non-material goods such as those located within decision making processes or divisions of labour largely ignored. Second, non-material goods such as power or autonomy are represented as static "things" rather than as functions of social relations and processes.

Procedural justice: oppression and domination

Young's alternative account of justice focuses on procedural issues of participation in deliberation and decision making. This account is based upon two values: developing and exercising one's capacities and expressing one's experiences, the denial of which is oppression; and, participating in determining one's actions and the conditions of one's actions, the denial of which is domination.

Using Young's account, we can pinpoint some of the moral shortcomings in typical public health interventions. The first example, in relation to community consultation, is from a public health intervention in Scotland.²⁵ This public health project was committed to improving child health, through a child home visiting programme, and by strengthening and supporting the community. As part of the latter, the community was consulted, in a series of public meetings, about what other services they would like. Given the extreme levels of deprivation, poverty, and social exclusion, attendance at meetings was poor, but the community members who did attend identified baby massage as one of the health services they wanted for their children. The conditions for funding, however, required that all interventions had to meet certain evidence based standards; as this was lacking for baby massage, it could not be provided despite the community's request.²⁶

The Scottish government was committed to reducing health inequalities yet, despite its good intentions, this project provides a compelling example of oppression and domination in Young's terms. Community members had little opportunity to develop and exercise their capacities because of their poverty and lack of resources, which in turn contributed to the ill health of the children. This was the cycle that the project sought to break. Yet the project did not aim to alter the circumstances of the families, but rather to ameliorate the effects of such circumstances upon the health of the children. The intervention risked simply enabling people to better tolerate deprivation without changing the material or non-material injustices that led to the deprivation.

The importance of determining one's own actions was recognised at some level in the project as there was considerable emphasis placed upon community consultation. Yet despite encouraging participation, the community's expressed desire for baby massage was ignored due to externally derived rules about levels of evidence and acceptable uses of public monies.

Such an approach not only confirmed the powerlessness of the parents, but also ignored their experiences and desires in favour of expert evidence.

A feminist response to this situation will include questioning the genesis of the current situation in terms of women's roles and opportunities for escaping from deprivation, and the differential impact of the decision upon men and women. This request for a gentle physical therapy needs to be seen in the context of a community with high levels of family violence, and many single mother families. Weighing these factors against the requirement for evidence based interventions, evidence that may not have included gender or socioeconomic status as relevant variables in evaluating the "success" of the treatment, might lead to a different response. Meaningful agenda setting and support for women's agency in identifying their own needs is a more likely route to gender equity than adherence to rigid requirements for evidence.²⁷

Divisions of labour

Social divisions of labour are relevant to justice and public health ethics. Many preventive aspects of public health occur in the domestic sphere, such as diet, exercise, and regulation of children's activities. The domestic sphere is traditionally the area for which women are considered responsible. The public/private division creates a frame through which problems such as childhood obesity are seen as ones that mothers should solve, by offering better diets or encouraging their children to play outside rather than on the computer. This framing takes no account of the social context in which parenting takes place, such as the pressures exerted by television advertising or the lack of safe, appropriate open spaces. Instead this framing labels the problem as one of inadequate maternal skills and control rather than lack of public regulation and resources. A feminist approach to this problem would investigate the kinds of power and influence that allow the health interests of children to be undermined by unfettered advertising of products that lead directly to health problems, and the poor structural supports for parents to counter these.

Providing care for others is a traditional female role. One form of this is dependency work (work that enhances the power and activity of others). The lens of gender analysis applied here identifies the particularly cruel inequality that sees most dependency workers, who have spent a lifetime providing care to others, neglected in their old age.⁴ The moral issues go beyond simple resource allocation; we have to take into account the gendered nature of dependency work. It is largely men who receive this kind of care, and women who provide it. This leads us to question the institutions that permit this kind of distribution, and to demand that some account be taken of moral entitlement and desert in relation to dependency work.⁴

RESEARCH METHODS IN PUBLIC HEALTH

Epidemiological methods are the lynchpin of modern public health. Epidemiology provides the tools to collect data at a population level, and to identify potential causes and effects (such as smoking tobacco and lung cancer). This aggregated approach can deny the particularity of situations, reducing the experiences of many people to one conclusion.¹⁹ Such an approach can lack the necessary detail for public health measures to effectively address the issues that are most burdensome to the population in question.

Epidemiological methods tell us—for example, that babies born to Indigenous mothers in Australia are more likely to be of low birth weight (12.9% compared with 6.2% of babies of other mothers), and more likely to die; the perinatal mortality rate for babies born of Indigenous mothers is 17.2 per 1000 compared with 9.5 for babies of other mothers.²⁸ These bare figures, however, cannot tell us what kind of services will be effective in creating the conditions for healthy pregnancies and babies, nor the contribution that cultural dispossession makes to these figures. To date there has been little acceptance of solutions that are acceptable to and supported by Aboriginal and Torres Strait Islander women themselves.²⁹

How might feminism fill the gaps left by epidemiological methods? Feminism advises us to use a “rich empiricism” to investigate how different aspects of disadvantage impact on the lives of those affected, and, more importantly, to identify effective ways to alleviate disadvantage.¹⁰ This kind of approach suggests that public health research needs a local focus, involving those who are affected and the circumstances of their disadvantage.¹⁹ Understanding local particulars is crucial to breaking down the institutions and hierarchies between—for example—professional and patient, or researcher and participant, that in and of themselves

contribute to oppression and domination. Developing skills in listening to and working with local communities would require significant changes in public health methods. Yet it is only by valuing the perspective of the disadvantaged that we can come to understand the problems as they face them, and the kinds of solutions that are possible.³⁰

Rich empirical methods can take us part of the way, but to go further, to implement locally empowering programmes, requires political vision.

POLITICS

Feminism has always recognised the need to engage with the political. Public health has inescapable political elements; the activities of public health are funded directly from the public purse and achieved through the organised efforts and institutions of society. The need for explicit political commitments in public health are perhaps greater now than they have ever been, given the threats to public health posed by disadvantage and inequity. Rather than fostering engagement with the political, however, public health is subject to a number of constraints that act to inhibit political involvement. Health departments are responsible for ameliorating the health effects of exclusion and disadvantage, but only in accordance with certain conventions governing legitimate spending. Health researchers may—for example, investigate ways to decrease the child health effects of poverty through home visiting programmes or increased antenatal care, but cannot boost maternal incomes or create jobs as legitimate health interventions. Public health decisions have to be justified scientifically rather than politically, using the allegedly objective gender blind language and methods of epidemiology or EBM, based upon research evidence that is increasingly provided by commercial funding. Finally, as a society we are wedded to the biomedical model of health and disease that seeks the solution to health problems within the individual. This focus on the individual allows researchers and politicians alike to ignore the social and political context, leading to increased risks of ill health. Many of the current discussions about obesity reflect this, with a focus on control of individual diets rather than engaging with the health harms inflicted by exposing children to the full force of consumer capitalism.

A feminist account of public health ethics demands explicit political commitment to actions that are grounded in concern for the wellbeing of women, and that aim to achieve the goals that they themselves determine. Unfortunately we are a long way from such a vision. Around the world, much of the infrastructure of public health has been dismantled or is insufficiently funded, leading to severe impacts upon the health of the mostly female most vulnerable.³¹

ETHICAL CHALLENGES IN PUBLIC HEALTH

In this paper, inequity has been described as the major ethical issue in public health ethics. I have suggested that a feminist approach to inequity provides a way forward, and that political will is necessary for such action. What about the traditional ethical challenges of public health, such as the rights of the individual versus the rights of the community? This central dilemma plays out in a number of ways, including the rights of people to refuse vaccination versus the benefits of herd immunity, the right to privacy versus data needs for epidemiological research, and individual freedom versus detention and compulsory therapy for contagious diseases such as tuberculosis.

All of these dilemmas rely upon the notion of common good or community benefit, for which we ask (or coerce) individuals to give up some of their freedoms. How can feminist ethics rise to these challenges? Feminism recognises the limits that are placed upon our individual freedoms

through our relationships, with other individuals and with the wider community.³² In analysing the common good, feminists pay careful attention to such factors as: the criteria for community membership; the power relations that constitute the community; the rules that regulate it; where the benefits of community membership fall, and who pays the price for these. Let us consider a hypothetical communal decision to adopt compulsory vaccination, to prevent the spread of a particular infectious disease, with financial penalties for non-compliance. This decision may bring benefits to those at increased risk of exposure to potential infection, through their frequent participation in public events such as films, concerts, or sports matches. Those same people, who are sufficiently resourced to participate in public life, are also likely to have the resources to get vaccinated (time off work, transport to the clinic, medication for side effects). Such a decision may, however, impose a significant burden on those who lack similar resources, and this same group may not share the benefits of herd immunity as their lack of resources may also limit their participation in public events. In this example, it is those who are well off who are most easily able to comply with the vaccination requirement, and who reap the most benefits, whilst the disadvantaged have the greatest burdens and least benefits.

The individual rights versus common good dilemma is not usually couched in terms of inequity, but examining the particulars of each case, such as who has the decision making power and how are the goods, non-material as well as material, distributed, may offer a way out of the seeming impasse. From a feminist perspective, this kind of analysis, with its focus on the most disadvantaged, has advantages. First, political and structural solutions are sought for problems that manifest at the individual level, and, second, these solutions will decrease gender inequities just because women are so over-represented among the disadvantaged.

CONCLUSION

The main purpose of an ethical framework is to clarify the moral justifications for public health, and to provide a moral standard against which to evaluate interventions. An effective ethical framework will provide the theoretical tools to determine which kinds of societies will best provide the conditions for health, and which interventions will achieve these aims. Feminist ethics goes some way toward providing such a framework through: addressing inequities by attending to specific issues; procedural justice that focuses upon exercising capacities and determining actions; fair shares of resources and just rewards; rich empiricism in research, and political solutions for problems.

Feminist public health ethics will not provide blanket solutions to the ethical challenges of public health, but does provide guidance on substantive as well as procedural issues. This guidance is grounded in the belief that discrimination, oppression, and domination are wrong, and that attention to these wrongs is a necessary part of preventing disease and promoting health.

ACKNOWLEDGEMENTS

I am indebted to Vivienne Moore and Richard Ashcroft for helpful remarks on earlier drafts, to the respondents and audience at the Feminist Approaches to Bioethics 2004 World Congress, Sydney, where a version of this paper was presented, and to Donna Dickenson for useful comments and suggestions on this draft.

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