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## The Concept of “Public Health” – A Critical Assessment

### SUMMARY

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The article discusses the fundamental differences between an orientation towards individual health and the concept of health on which public health systems are built. It is shown that health in its original sense, as the “virtue of the body” (Aristotle), has to be understood as the ability to realize purposes in the actions of individuals. In public healthcare on the other hand, “health” has always been conceived as a public good and as an expression of certain public interests, a conception which does not have to be consistent with the interests of the individual in any way. “Public health” is normally designed in a utilitarian way and can be highly susceptible to ideology. In extreme cases the individual becomes subject to a “health obligation” which is to be rejected on legal, philosophical and ethical grounds. In place of a “scientific” medicine that reduces people to a statistical magnitude, a self-understanding of medicine should be restored which defines “health” from the point of view of the task of enabling real interpersonality in the space of the empirical existence of individuals self-determined as free.

**Keywords:** health, public health, sanitary movement, *homo hygienicus*, autonomy, interpersonality.

*“... that also the physical in man is calculated  
for his higher moral determination.”*

(Christoph Wilhelm Hufeland, 1797)<sup>1</sup>

Since the days of Aristotle it is one of the basic duties of philosophy to be aware of the problem of possible *homonymies* in the use of our words. In his *Metaphysics* Aristotle asserted that even the word “being” can have very different meanings and refer to

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1 “... dass schon das Physische im Menschen auf seine höhere moralische Bestimmung berechnet ist“.

different concepts – τὸ ὄν πολλαχῶς λέγεται, “being is said in many ways” (Met. IV, 2, 1003 a 33)<sup>2</sup>. Moreover, he also demonstrated that other fundamental terms such as “nature” (φύσις) and even “the one” (τὸ ἓν) can have different meanings and therefore may cause misunderstandings and confusion.<sup>3</sup> It is the task of philosophy to resolve such misunderstandings and possible confusion, which it typically does with careful categorical clarifications showing how to differentiate for instance between “being” as the aspect of the substantial identity of something (e.g. the human nature of Socrates) and “being” referring to an accidental property (e.g. the hair of Socrates “being” grey at a certain time).

One of the examples the philosopher from Stagira uses to show what is meant by his famous phrase τὸ ὄν πολλαχῶς λέγεται, “being is said in many ways”, is the term “healthy”: τὸ ὑγιενόν. (Met. IV, 2, 1003 a 34 – 1003 b 4) With the word “healthy” we can refer to a person, the complexion of this person’s skin, a lifestyle, or to mineral water from a special location that keeps people healthy, etc. It is evident that the adjective “healthy” cannot have the same meaning when we use it about a person or for an environment, a food or a way of life. Instead we have to distinguish between the categorical structures and reference contexts that come into play here. Nevertheless, all possible uses of the word “healthy” are in fact connected in one basic meaning that can be found in the idea of “health” (ὑγίεια).<sup>4</sup> Only if we know what “health” is can we distinguish healthy and not so healthy ways of living, healthy from harmful food, healthy people from the sick and so on. I will come back to Aristotle’s concept of health soon, but first I want to explain what the intention of this lecture is. It is to discuss the homonymies that we encounter today *in the concept of health* itself, homonymies which are the result of a certain historical development that necessarily confronts us with new tasks of disambiguation which did not exist in Aristotle’s time. Our thesis is that the homonymy between the terms “individual health” and “public health” is much more fundamental than we are inclined to believe at first glance, and that ultimately the two terms have much less to do with each other beyond the common name than is often assumed. A corollary of this is that a large number of the social irritations in the current “Corona crisis” arise because we have not yet sufficiently learned to differentiate between the logic of individual health and that of public health, something which not only leads to false expectations of public healthcare (falsely considered as caring immediately about individuals), but which also to a lack of understanding of what the natural limitations of the responsibilities

2 . Cf. also VI, 4, 1028 a 5; VII, 1, 1028 a 10 and Phys. I, 2, 185 a 21 passim. For a deeper discussion with special regard to the problem of homonymy in this context cfr. Aubenque (1983), pp.163-206.

3 Regarding the in some sense paradoxical plurality of meanings of τὸ ἓν cf. Aristotle. Phys. I, 2, 185 b 6. Different meanings of φύσις are discussed e.g. in Phys. II, 1.

4 In this sense there is a (categorical) difference in meaning but no total homonymy; cf. Bonitz (1849), p. 173.

of a public healthcare system are.<sup>5</sup> In its practical dimension the problem is a matter of appropriately relating the competing claims of individual freedom and (sometimes massive) state intervention into this freedom in the – supposedly justified or so-called – interests of public healthcare. I will start here with the Greek idea of individual health and its lasting importance. I will then – at least in a short overview – study the emergence of the idea of “public health” historically and the manner of its administration. Finally, I will try to elaborate the main differences between the two concepts systematically and conclude with a few statements on this matter.

## **I Individual health and the need to guarantee interpersonality in medical practice**

In his *Rhetoric*, Aristotle calls health the “virtue of the body”, σώματος ἀρετή (Rhet. I 5, 1361 b 3). Health thus refers to the “best shape and form” of the body which for Aristotle of course includes opportunities for the pursuit of “happiness”. Health, as he goes on to say, should “bring about pleasure and life”, and like all other “virtues” it should ultimately lead to *eudaimonia*, the highest end of human existence. Aristotle knows that health alone is never sufficient to achieve this end and to become happy. He illustrates this by reference to Herodicus of Selymbria, the teacher of Hippocrates, who did a lot for his health but was not envied by anyone for that because he abstained from all the pleasures of life solely in order to remain healthy. Herodicus is also mentioned in Plato’s *Republic* where we read:

“But Herodicus was a trainer and became a valetudinarian and blended [406b] gymnastics and medicine for the torment first and chiefly of himself and then of many successors... Living in perpetual observance of his malady which was incurable, he was not able to effect a cure but lived through his days unfit for the business of life, suffering the tortures of the damned if he departed a whit from his fixed regimen, and struggling against death by reason of his science he won the prize of a dotting old age” (Resp. III, 406 a-b).

Aristotle states further that health is associated with obvious physical benefits like beauty, strength and good temperament of the person which all indicate the good order of their bodily existence and which are all at stake in illness. The aim of medicine is the restoration and maintenance of health as this good order (NE I, 1, 1094 a 8), which as a bodily prerequisite will allow us to also develop our *personal*

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<sup>5</sup> At the deepest level this question – I can only mention it at this point – has to do with the fundamental philosophical problem of universals, i.e. the question of mediating the general or universal with the individual. According to the (nominalistic) logic of public health individuals are only “cases” of health or sickness, whereas from the (realistic) point of view of individual health they are the sole instances where health or sickness really exists.

virtues that include the soul in all its aspects. In this sense we can say that health as the virtue of the body is an *intrinsic normative instance* because its real determination is to enable us to pursue our ethical, i.e. *rational* purposes. Health is not an end in itself but *a means* of being what we ought to be at least to the extent possible for the given individual. To put it in non-Aristotelian and more modern terms: “*health*” is *nothing other than the capability, both physical and psychological, to live one’s own life to the greatest extent possible*. Health in this view is connected to the idea of individual freedom but also with reason, insofar as the practical use of our reason in rational agency is an integral component of our human nature which we strive to express not only in our thoughts but also in our actions. An observation might be appropriate here about the concept of medicine, which philosophy has often regarded as her own sister since both try to answer the general question of human well-being. (Plato, p. 59-86). The standard role of *medicine* in this context is to show individuals a way of leading a healthy life while also in particular cases offering help to suffering individuals. This help is offered in a *personal relationship* between the individual and the doctor – at least that was the general idea of how medicine should work in the Hippocratic tradition; it was committed to the practice of medicine embedded in a personal relationship.

This general idea prevailed even in times when a “scientific” idea of medicine prevailed, at least as long as authors like Karl Jaspers tried to remind the public that medical treatment can never be reductively informed by a supposed concept of scientific objectivity, for it has to stay aware of the specific form of interpersonality at play here, in which “limit situations” (*Grenzsituationen*) arise and medical practitioners have to answer not only scientific, but also existential questions facing suffering human being. (Rehbock, 2014; Hoffmann, 2020). All medical treatment is about individual human interaction, something Paul Ricœur highlighted in his attempt to restore the Hippocratic tradition by reminding us that, even in the modern world, the underlying concept of all medical treatment includes “*a pact of trust*” between the interacting individuals, a pact that is especially important in view of the unavoidable asymmetries between patient and doctor. (Ricœur, 2006). We have to keep in mind remember Aristotle’s memorable statement: “The doctor does not heal the human being in general... he heals Kallias or Socrates” – οὐ γὰρ ἄνθρωπον ὑγιάζει ὁ ἰατρούων ... ἀλλὰ Καλλίαν ἢ Σωκράτην (Met. I, 1, 981 a 18-19). Here the Stagirite makes it clear that for medicine *as* medicine it is not enough to have a scientific concept of man if you do not have a general concept of a specific illness. Fundamentally speaking, it is science (ἐπιστήμη) that possesses general concepts, but it is skill (τέχνη) that possesses a general concept able to guide *action*. The carpenter realised this table here starting from the general concept of the table, the poet writes a tragedy from the general concept of man and of human

destiny – but the doctor does things differently. The doctor helps *this Kallias here*, not the *species of homo sapiens* – and with this we have articulated an important difference between individual medicine and public health, for the latter can only operate with artificially generalized concepts of health and general concepts of the person, which immediately implies that the individual as such in his individual situation gets left behind. In the Hippocratic tradition the commitment of medicine to individual and interpersonal situations was not simply expressed by specifying a “medical ethics”; again this can be formulated without any contact to real persons or interpersonal obligations in real situations. In the Hippocratic tradition there was a clear awareness that what is required is not an ethics in books but an actual and living doctor’s ethos. From this starting point a very definite and unmistakable pattern of medical activity follows – that of an active taking of responsibility for guaranteeing interpersonality in the context of the concrete, individually given physical conditions. This is not to say that the doctor has to be any kind of expert in the good as such; neither does he have to know what a putatively “complete” human existence would be *sub specie aeternitatis*. But he certainly does have to be capable of being addressed by “this Kallias” and to be sympathetic to Kallias’ motivation to secure his own conditions of existence, which are in fact always also conditions for the coexistence of the two individuals involved.

## II The emergence of public healthcare and the idea of “Public health”

Once again, the thesis is that we have to become very clear about the homonymy lying in the terms “individual health” and “public health”. The difference between the concepts is not only quantitative but also qualitative. It cannot be reduced to that between the single individual of “individual health” and the large number, if not all, individuals addressed in “public health”. I have already stated that “public health” institutions can only operate with *generalized* concepts of what may be called health, as well as generalized concepts of the person, which immediately implies that the individual as such – this Kallias – gets left behind. Other important differences between individual and public health will emerge soon enough. Let us start with a short history of public health and its institutions.

The modern concept of public health is quite recent. Its origin lies in the age of Enlightenment. We should keep in mind from the very beginning that the ideological background of public health institutions is usually an enlightened *utilitarianism*. It is said that Benjamin Franklin liked to use the phrase “health is wealth”.<sup>6</sup> Ralph

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6 The famous phrase is attributed to Franklin by von Engelhardt (2000), p. 111.

Waldo Emerson repeated it a hundred years later (1860, p. 47),<sup>7</sup> at a time when the so-called “sanitary movement” had started to change lifestyles fundamentally at least in the Western world.<sup>8</sup> Of course basic sanitary rules can be found in every culture and in this sense there might even be initial indications of public health activities in very early times. From the Old Testament we have the rules on defaecation and the quarantine of lepers which had to be administered by the priests (Dtn 23, 12-14; Lev. 13-14). Further examples include ritual washing in the Islamic world and food regulations in Judaism. Rules like these, apart from those relating to mere cultic purity, usually try to establish protective measures against risks which could possibly represent threats to individuals by other individuals but they are not meant to actively improve the health of individuals or the community as such. Things change in Plato’s so-called “eugenics” where we encounter for the first time the idea of imposing *positive* arrangements on society for the procreation of healthy offspring, with the goal of creating a good and more “healthy” state. Later utopian ideas like those of Thomas More, Tommaso Campanella, Francis Bacon or Johann Valentin Andreae were usually at least to some extent inspired by Plato and fostered the view that the ideal state should include active health policies (Siefert, 1970).

Apart from this “idealistic” or utopian tradition only at the end of antiquity do we really find the beginnings of real public health *institutions*. It was the cities of the late Roman world where the first councils of physicians were established, councils presided by an ἀρχιατρός – the German word “Arzt” derives from this title – who was responsible for something like a medical *quality assurance* within his district. Much later new options for the *education* and control of physicians emerge in medieval Southern Italy, especially under Emperor Frederic II (in his *Liber principalis* of 1241/51), where an academic education, a practical year and a final official license to practise medicine became mandatory for physicians – conditions which in Europe have remained more or less the same to this today (Labisch & Paul, 2000, p. 123).

In addition to these formal regulations for doctors’ education there is another development initiated in Italy which is significant here. In response to the Black Death of the fourteenth century, the cities of Italy were leaders in establishing protective measures to secure and promote what now was called the *sanitas terrae*, the “health of the territory” (Labisch & Paul, 2000, p. 124). It was of course not by chance that the cities then became aware that they had to care for “health” in a new, no longer just individual sense. For one thing those cities with people involved in a great deal of travelling and trading appeared to be the places where the Black

7 “The first wealth is health. Sickness is poor-spirited, and cannot serve any one: it must husband its resources to live. But health or fullness answers its own ends, and has to spare, runs over, and inundates the neighborhoods and creeks of other men’s necessities.”

8 For this movement in general see Snowden (2019), especially pp. 184-203.

Death raged at its fiercest. For another those cities were keenly aware that they were dependent on such commercial activities, on travelling and trading, so they needed urgently to take precautions against the plague if they wanted to remain not only prosperous marketplaces but also the great cultural centres of their time. This is the first time that the concept of public health acquires an association with economic aspects: *sanitas terrae* is regarded as a prerequisite not only for the lives of individual citizens but also for the *economic* life and success of the city itself. "Public health" is a matter of public interest much more than of individual interest and as such requires public administration. The republic of Venice for instance instituted its "Magistrato alla Sanità" in 1490, a public health office composed not of physicians but of three nobles who had to be members of the Senate.<sup>9</sup> We can take this as emblematic of the fact that public health measures and activities are *essentially* political in nature, not medical. I shall return to this aspect of the homonymy between individual and public health below.

In subsequent centuries new branches of medical policy were established in the military as well as in the cities, now with special reference to the poor if not as yet enshrined in legislation on the poor. That happens in the eighteenth century when Rousseau claims it is modern culture and the modern state that make people sick. Governments do indeed establish new medical administrations in line with their rational cameralistic and population policies. The state begins to understand that for its own purposes it was not only necessary to prevent foreign infections (as the Italians had tried to do), but also to keep its own population healthy. The first document embodying this new way of thinking for Germany and Austria, but also with broad significance for other parts of Europe, was the "System einer vollständigen medizinischen Polizey" published in eleven volumes from 1779-1819, written by Johann Peter Frank (1745-1821), professor at diverse universities and sometime personal physician to the Russian Tsar. By the beginning of the nineteenth century things had begun to change in other countries. It is not by accident that the first appearance of the word "sanitaire" in the French language is from the year 1801. It was the early nineteenth century when the so-called *sanitary movement*, especially in France and Great Britain, started to produce new world views, if not ideologies, centred around a strong idea of social hygiene and a new role for public medicine in the development and administration of clean and well-functioning societies. Perhaps the most important innovation in all this was that for the first time "health" was understood as a goal now to be achieved by often quite simple technical measures employed in the public administration of everyday life and not so much by the individual medical treatment of individuals.

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9 Regarding the sanitary policies of Venice cf. Vanzan Marchini (2011).

To be brief here some steps in the gradual emergence of *homo hygienicus* will be described; he was the younger brother of that very famous son of the eighteenth century, *homo oeconomicus*. In Paris the French physician Louis-René Villermé (1782-1863) started in 1820 a journal with the title “Annales d’hygiène publique et de médecine légale” (*Annals of Public Health and Forensic Medicine*) which was intended to become an instrument in Villermé’s campaign against waste and dirt in the city. (Snowden, 2019, p.186). Villermé was a devotee of the so-called *miasma hypothesis* which maintained that the cause of disease was unhealthy vapour (*miasma*) produced by all kinds of waste. Villermé’s activities were greatly admired by Edwin Chadwick (1800-1890), a British barrister and, of special significance here, a disciple of Jeremy Bentham (1748-1832). (Snowden, 2019, pp. 187-189). Chadwick promoted new poor laws for Great Britain while also being an activist in creating a strong sanitary movement – the two activities belonged together since poverty was linked to disease. We recall Franklin’s motto “health is wealth” and in that spirit immediately understand why a learned utilitarian like Chadwick was so interested in health policies. Getting rid of poverty meant two things: establishing “workhouses” for the poor, especially for those who seemed to be unwilling to work, and studying the living conditions of the poor, now regarded as objects of scientific investigation. In his “workhouses” Chadwick recommended a lot of “social distancing” – parents were separated from their children and husbands from their wives in order to fight their laziness – and the result of his studies of the living conditions of the poor were published in 1842 in his “Sanitary Report”. This report underlined the central importance of *social statistics* for the new approach to public health. To this day statistics are among the most important ways of transmitting public health messages. We all remember how at the beginning of the current Corona-Crisis we were asked to “flatten the curve”, that is to change the statistics, whatever that might mean for our own and our children’s individual, including psychological, health. One very interesting point in this context that Frank M. Snowden points out, in his extensive struggles against poverty and disease Chadwick was not only not directly interested in the personal well-being of individuals, he had no interest either in something we would call “health for all”. As a utilitarian:

“his preoccupation was with the longevity and productivity of young and middle-aged working males. ... Women, children, and the elderly, together with their diseases, were of no major interest in the *Sanitary Report*. Even the middle classes were largely ignored”. Chadwick’s main interest according to Snowden was “an economy strengthened by a healthy workforce” (Snowden, 2019, p. 195).

Clearly *one* possible answer to the question about the “public interest” behind the “public good” of “public health” was, and still may be: the economic interest. Modern public health administration right from the start may have had more in common

with the *ideas of social engineering* than with old-fashioned medicine understood as an art offering help to suffering *individuals*. It is surely no coincidence that that happened precisely when medicine began to change its self-understanding and became a *science* located more or less exclusively in the laboratories of universities and research institutes. It was Josef Dietl (1804–1878), a representative of the “second Vienna school” of medicine, who in the nineteenth century became well-known for the following statement. “The ultimate goal of the old school (i.e. of medicine) was healing and its knowledge was only the contingent result of attempts at healing. The ultimate goal of our new school is knowledge and the healing that is a by-product of such knowledge. Our power lies in knowledge and not in action” (Sauerbruch, 1927, p. 1083). And it was Charles Bernard in Paris who predicted that the laboratory bench was fated to become the emblem of a new kind of medical science and the locus of medical epistemology (Snowden, 2019, p. 229). But full-time medical scientists like Louis Pasteur and Robert Koch not only became the new role model for medical professionals, they also defined the understanding and function of medicine within a “modern society” and especially within modern public health administration. If in the current situation in Germany not one of the personnel who is really important in political decision making is a clinician or a doctor with contact to real people and suffering individuals, this is nothing other than the result of Dietl’s openly declared “therapeutic nihilism” and the new self-understanding of medicine as essentially theoretical knowledge. It is a logical result of the new concept of “health” as a function of the public administration of “social goods” and not of individual interests.

One more point on the emergence of the currently prevailing idea of public health. It is based not only on a very new concept of medicine as a “neutral” natural science; it also refers to a certain new way of human self-understanding. *Homo hygienicus* represents that new idea and he now appears on the stage in different forms. *Homo hygienicus* was proposed by various authors as representing the idea of a human being completely dedicated not only to the ideal of corporeal and psychological *cleanliness*, but also to the strategies of realizing this ideal by using primarily technical and social engineering means. Philosophers may remember that Nietzsche emphasized or reframed the moral meaning of “cleanliness” a number of times. Nietzsche (1908, p. 275) affirms of himself that he has “a totally uncanny irritability of the instinct for cleanliness” (“Eine vollkommen unheimliche Reizbarkeit des Reinlichkeits-Instinkt”). Nietzsche’s Zarathustra mentions the fact that he nourishes himself on food that the “unclean” are not allowed to enjoy and that he does not maintain “homes for the unclean” (1883, p. 126). This corresponds to what Nietzsche called “star morality” in his *Gay Science*: a morality which does not care about “the misery of time” because it does not belong to this but to the “most distant time” and which sums itself up in the

one sentence: “Only one commandment applies to you: be pure!” (“Nur *Ein Gebot* gilt dir: sei rein!”) (Nietzsche, 1882, aphorism 63, p. 367). Modern *homo hygienicus* can then be explained as a combination of a morality of cleanliness and pureness on the one hand and an adherence to new hygiene techniques on the other. The latest version of *homo hygienicus*, i.e. the current inhabitant of the Corona-world, has been described by the German educational philosopher Matthias Burchardt as follows:

“In reversing the hygienically risky Christian principle ‘Love thy neighbour!’, *homo hygienicus* generalizes the presumption of illness and takes for himself the motto ‘Fear thy neighbour!’ Every other person he meets appears to be an embodiment of the infection curve, a deadly virus thrower distributing the tiny spiked balls from the daily chart in its environment. *Homo hygienicus* has lost confidence in his own perception, he acts against the background of inner images that have overlaid his world of experience. (...) In his way of life this results in an attitude of avoidance which certainly has parallels with the state of mind and the behaviour of people with anxiety disorders. Avoiding contact, distance, isolation, mistrust or even excessive caution shape his social behaviour. The ideal of purity is pursued through ritual practices of washing and disinfection while simultaneously being used for the social classification of the ‘unclean’. Sensible cleanliness is thus elevated to symbolic purity and social superiority – also from a moral point of view. The idea of antiquity that nature in us (φύσις) can be a source of strength and healing (defence forces) no longer characterises the ‘new man’. Risk calculation now calls for hygienic do-it-yourself initiatives and obscures the view of what healing actually is” (Burchardt, 2020, pp. 117-127).

Let us move on to some basic views on what may be problems endemic to the modern idea of a public health administration, views expressed more than twenty years ago in the German *Lexikon der Bioethik*, published by Wilhelm Korff et al. I am referring to the article “Gesundheitswesen”, especially to its first part, written by the two medical scientists and bioethicists Alfons Labisch (Düsseldorf) and Norbert Paul (Mainz) (Labisch & Paul, 2000). Labisch (1992) is one of the authors who coined the expression “homo hygienicus”.

In their article on the world and the logic of “public health” Labisch and Paul emphasise that the redefinition of “public health” as a “public good” and a matter of public interest at the beginning of the twentieth century not only led to public health provision as an obligation of the welfare-state to its citizens, especially the poor (which was the case after World War I), but also to the model of a “totalitarian health protection” (“totalitäre Gesundheitssicherung”) implemented in Germany especially during the period of National Socialism (Labisch & Paul, 2000, p. 126). Of course in the extreme case of the Nazis the idea of “public health” was based on crude racist theories; nevertheless, Labisch and Paul stress that this is where we can study what happens “when a quasi-untrammelled modernity prevails against basic human rights” (“eine gleichsam losgelassene Moderne sich gegen elementare

Menschenrechte durchsetzen kann"). (Ibid.) One of the central aspects of National Socialist public health strategies was the predominance of *collective* health, so that the individual who might be an obstacle to the fulfilment of this obligation could or even should be excluded from the "public body", the "Volkskörper". But even if modern health policies in other contexts are fortunately not tied to the extermination of so-called harmful individuals, the question still remains as to where our priorities lie in the case of conflict: the primordial interests of the individual or the "public interest"? In 2020 we witnessed situations where people died because cancer surgery was denied to them to offer *free beds* for *possible* Covid-19 patients – I repeat: treatments of real patients were denied for the sake of *beds* for *possible* patients. In this very act a differentiation is made between a *private* disease and a disease of *public interest*; the individual is asked to forget about his cancer and to act from the perspective of the public interest in preventing *possible* infections of people who are not yet sick. Labisch and Paul go on to write that "the concept of *public* health is linked to the idea that a given or future *normality*, not only of individual but also of collective health, can be perceived and then also be consciously shaped under normative aspects" (Labisch & Paul, 2000, p. 127). This again reminds us of the fact that the idea of "public health" perhaps will never be able to avoid the tendency of combining medicine with social engineering. For this reason the authors declare – and this statement, published more than 20 years ago as mentioned, of course still remains very important today – that the "implementation of public health measures is usually not oriented to the logic of disease or even to that of science" (Labisch & Paul, 2000, p. 128)<sup>10</sup>. Instead it follows a *political* logic and is guided by ideological or utopian aims. It is *politics* that decides which diseases should be "scandalized" and which not. "Public diseases" are embedded in a "social field", "private" diseases are not. One last point: "public health" is a concept that exhibits a tendency to permeate all societal areas. It therefore offer options for reshaping society as a whole – and that without asking members of the society whether they agree or not. Notice once again the difference between on the one hand the "old school medicine" based on (a) Aristotle's idea that "medicine heals Kallias", (b) Ricœur's "pact of trust", and (c) individual interaction, and on the other the new "public" medicine as a societal and political project which does not treat persons but objects of politics and which cannot be stopped from thinking of society as such as a *laboratory* instead of a real "*realm of ends*" as Kant would oblige us to do. Now let us summarize our results in a more systematic way.

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10 For Gadamer (2010) individual health is always something "hidden", an "enigma" facing both conceptualization and public planning.

### III Individual and public health: The differences

One relatively formal aspect to start with: individual and public health offer *different perspectives* on the physical or psychological well-being of people. In order to avoid all homonymy, I would add that we are not talking about two different perspectives of health and health issues, because the concept of health as such is itself dependent upon the respective perspective. There are several aspects to this issue.

#### 1) Intrinsic vs. extrinsic motivation

Aristotle tells us that “health” refers to the “virtue of the body” and that it is connected to individual happiness (εὐδαιμονία). Health enables us to pursue our ethical and rational purposes, it allows us to express our very human nature in a manner appropriate to our individual existence. The *interest* in our health therefore is primarily a personal one; persons consider their personal health as a means to attain their moral ends. Persons are intrinsically motivated to maintain their health or to restore it when lost.

The concept of “public health” on the other hand asserts that “health” is a “public good” and therefore deserves and requires public administration. Health as a public good refers to a given public interest which, as I have explained, is not necessarily identical with the interest of individuals. “Public health” may require us to sacrifice our individual interest for the “common good”, i.e. the public interest. It may also command us to do so, i.e. it forces us by means of extrinsic motivations to fulfil its purposes.

#### 2) Interpersonality vs. asymmetric compliance

According to the Hippocratic tradition, individual healthcare is located within interpersonal relationships, not in mere agent/subject – patient/object relations. The doctor is not just fulfilling but participating in the patient’s self-interest and intrinsic motivation to maintain his health. The patient in this should be able to understand that the doctor’s motivation to treat him originates in a mutual recognition and that his intention is to maintain the possibility of this recognition by shielding the patient from being overwhelmed by physical forces. In this sense the goal of maintaining the mutual recognition of subjects whenever it is threatened by physical forces or influences has to be an integral component of the very definition of medicine in general as a science.

In contrast public health measures do not address individuals, or at least when they do so they do it anonymously. These measures do not aim at mutual recognition

but at compliance. Their general structure is essentially asymmetric: they are based on power not on trust. The power they represent is the power of a political will and a whole apparatus established to realize this will. This apparatus normally includes the existence of health professionals serving the state not the individual citizens. It includes institutions like medical faculties at universities, public health offices at different levels of the political administration; it also involves legislation, guaranteed public spending, insurance, even military resources and so on. This is all very familiar to us now and we are used to measuring the degree of progress a given society has achieved not the least by referring to its public health services.

### **3) Autonomy vs. public interest**

As we have already seen the perception of and care for individual health belongs to the self-understanding of the human individual. If health is nothing else but the physical and psychological capability of living one's own life to the fullest extent possible, then health is associated with the idea of the autonomy of the individual: health makes it possible to act autonomously.

Public healthcare contrasting with that as an expression of a certain public interest usually shows an inclination to restrict individual freedom by imposing rules of conduct heteronomously. One of the most disturbing experiences in the current crisis consisted in the fact that even political bodies that saw themselves as “constitutional states” in many cases borrowed their catalogues of measures directly from totalitarian China (forced isolation of healthy people, curfews, drone surveillance of citizens in France, etc.). Some felt that their basic rights were no longer respected and that the “rule of law” as such had been ended by an unexpected re-emergence of the power-state. In this context it is important to be very clear about the fact that all decisions of public health administrations are political not medical decisions. Christoph Lütge and Michael Esfeld have shown in a recently published book that when we compare the reaction to the Asian flu in the fifties of the last century and the Hong Kong flu in the 1960s, with both those epidemics showing more or less the same numbers as Covid-19, we find that whereas in the earlier epidemics medical treatments were applied to infected persons and vulnerable groups, in the current case political measures like lockdowns, visiting and travel bans and closing schools and universities were preferred even without any real empirical evidence of their effectiveness (Lütge & Esfeld, 2021, pp. 7-8). This of course led to serious questions and to a loss of confidence in politics, especially when people were no longer able to understand the connection between the public health measures and their own individual health interest, which is always an interest in one's own autonomy.

#### 4) Existential limit situation vs. external fear induction

Finally, the last aspect here: preoccupations with their own health may lead individuals to come up against the “**limit situation**” Jaspers was speaking about. Even when that happens the individual is never left alone, at least if they are treated by a person who still knows what the classical doctor’s ethos meant and is capable of initiating substantial interpersonal communication at the boundaries of our “normal” experience. According to Jaspers communication is excluded solely by the act of suicide, the real meaning of which is always: I don’t want to communicate. From this point of view, the experience of sickness may always also contain the opportunity to grow as a person. The “limit situation” can be the one where we discover or rediscover our own personality, where we may enrich our humanity.

Things are completely different when we are confronted with the method of “fear appeal” or “fear induction” which regrettably is very often used in public health policies. The fear appeal, or the conscious “**fear induction**” associated with it, has no interest in the personal growth of the individual addressed. It sees the person as a bundle of affects which *as such* should be subjected to external control through suitable affects. Such a practice is completely incompatible with the basic concept of a free constitutional state which regards its citizens as original sources of freedom and establishes an order of freedom that is based on an act of mutual recognition of all citizens as such sources of freedom (subjects).

### IV Some conclusions with special regard to the idea of public health

1. Modern public health as we have seen can be regarded as a rather complex form of the socio-political institutionalisation of health as a “public good”. This “public good” refers to public interests that are in general not identical with individual interests but instead normally overrule them. Insofar as modern human rights are determined to protect the individual against being overruled in his basic interests we can see where conflicts may arise.
2. Modern public health administration combines diverse dimensions and elements. Historically it is based on the utilitarian “sanitary movement”. “Purity” and “cleanliness” are not aims in themselves but *abstractions* from real life, so one of the dangers of “public health” as a “public good” is that of sacrificing real life, even the real life of individuals, to idols.<sup>11</sup> To be clear: I am not arguing against

<sup>11</sup> For Gadamer (2010) individual health is always something “hidden”, an “enigma” facing both conceptualization and public planning.

the water toilet here, but I am arguing against the idea that the logic of the water toilet is sufficient adequately to describe the logic of human individual and social life.

3. The perspectives and elements public health systems rely on are *science* in the sense of *statistics* and *laboratory science*, large *bureaucracies*, *legislations*, sometimes *utopian ideologies*, but always the institutions of *law enforcement* and even those of the *military*. In this sense “public health” is not a mere “idea” but a massive social reality which not only needs control and legal limitation but also permanent awareness of the problems which may rise from an imperceptible anonymous concentration of power – a concentration which possibly only in the crisis of these days has become evident and recognisable.
4. The European Enlightenment was deeply convinced that power as such has no intrinsic value and that moreover power will not be able to resist the authority of reason in the long run. It is quite clear that nowadays we have to discuss what “reason” means, what can be considered to be reasonable and what not, and even what different kinds or paradigms of rationality there might be. In this spirit integrative bioethics does not generally deny the specific rationality of public health institutions and policies, at least as long as they are not mere expressions of a *will to power* concealing its real interests. But integrative bioethics will always emphasise that there are “rationalities” and reasonable realities to be taken into consideration *beyond* the perspective of “public health”, starting from the – sometimes of course dialectical – rationality of life. We all know that we cannot substitute the immediacy of our own reasonable thinking with the thinking of external authorities without denying our own identities. Similarly, the immediacy of our life cannot be replaced by societal activity and mediation and nobody should attempt to do that. Integrative bioethics knows that life as such is the horizon of being human and human activity as such. This also reminds us of the unity of life and freedom, and moreover of the constant challenges of finding the right equilibrium for both. But it never forgets that there is no such thing as artificial life or artificial freedom, that life and freedom can never be replaced by “social constructs”. Life and freedom have to be lived and exercised authentically. And it is this authenticity which integrative bioethics seeks to foster and to increase.

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# Koncept „javnog zdravstva” - kritička procjena

## SAŽETAK

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Članak se bavi temeljnim razlikama između orijentiranosti k zdravlju pojedinca i konceptu zdravlja na kojem se sustavi javnog zdravstva temelje. Prikazuje se da se zdravlje u svom izvornom značenju, kao „vrlina tijela” (Aristotel), mora poimati kao sposobnost da se ostvare svrhe u postupcima pojedinaca. S druge strane, u javnom se zdravstvu zdravlje oduvijek shvaćalo kao javno dobro i izraz određenih javnih interesa, što je ideja koja se nimalo ne mora preklapati s interesima pojedinaca. „Javno zdravstvo” inače je uređeno utilitaristički i može biti iznimno podložno ideologiji. U ekstremnim slučajevima pojedinac postane podložan „zdravstvenoj obavezi” koju treba odbiti pravno, filozofski i etički. Umjesto „znanstvene” medicine koja svodi ljude na statističke podatke, trebalo bi obnoviti samopoimanje medicine koje definira „zdravlje“ s gledišta omogućavanja prave interpersonalnosti u prostoru empirijskog postojanja pojedinaca koji su sami sebe odredili slobodnima.

**Ključne riječi:** zdravlje, javno zdravstvo, sanitarni pokret, *homo hygenicus*, autonomija, interpersonalnost.

“... i ono fizičko u čovjeku je izračunato  
za njegovo više moralno određenje.”  
(Christoph Wilhelm Hufeland, 1797.)