The Expressive Function of Public Health Policy: The Case of Pandemic Planning

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Many legal scholars well recognize that, in some instances, support for a law or policy may be primarily because of its expressive function, i.e. the statements it makes about underlying values. In these cases, the expressive content of a law or policy may actually overshadow its central purpose. Examples of this phenomenon, according to Cass Sunstein, include, for example, regulations against hate speech in the USA. He suggests that achieving the consequence (prohibiting hateful speech against certain groups) may not be the real focus (central purpose) of the law. Rather, the real focus is on the social meaning of these regulations—that bigotry is unacceptable in a liberal society. In this way, a particular law or policy can operate on many levels—while aiming to achieve a particular objective or behavior, it can also be a valuable tool for achieving other important social goals through its expressive function. This article applies this insight to the realm of public health policy, with particular attention to the case of pandemic planning, and suggests that public health policy and its overall goals may be well-served by deliberate regard for, and appropriate utilization of, the expressive function.

Introduction

While legislation and policy pronouncements typically are designed to achieve a particular purpose or outcome, there are instances in which achieving the target objective or behavior is only one of the motivating reasons for enacting a specific law or endorsing a specific policy option. Another motivating factor is the symbolic or communicative effect of law or policy—*viz.*, the expressive function—where shared symbolism converts mere state action (in the form of law or policy) into a statement, a message about underlying values, which intentionally or not, is likely to influence attitudes and behavior of the public.

Indeed, as legal scholars well recognize, in some instances, support for a law or policy may be primarily because of its expressive function, i.e. the statements it makes about underlying values (Sunstein, 1996). In these cases, the expressive content may actually overshadow its central purpose. Examples of this phenomenon, according to Cass Sunstein, include regulations against hate speech in the USA. Sunstein suggests that achieving the consequence (prohibiting hateful speech against certain groups) is not the real focus (central purpose) of the law. Rather, the real focus is on the social meaning of these regulations—that bigotry (or bigoted acts, including speech) is unacceptable in a liberal society (Sunstein, 1996). In this way, a particular law or policy can operate on many levels. While aiming to achieve a particular objective or outcome, it can also be a valuable tool for achieving other important social goals. Distinguishing the expressive function of a law or policy from its central purpose is not always a clear enterprise. (Feinberg, 2004) And it is, in part, precisely because of this virtually intractable entanglement that policy should give deliberate regard to the expressive function *in addition to* the central purpose in the crafting of policy.

To be sure, a focus on immediate outcomes is essential, particularly regarding health. It is also insufficient, however. Moreover, there are instances where policy-makers should not only consider the expressive function of law and policy, but also arguably should extend their regard in order to: (i) affirmatively and deliberately employ the communicative power of law and policy to enhance short- and long-term effectiveness in achieving public health goals, both narrowly and broadly defined; and (ii) maximize the impact of public health policy over the long term to create the kind of collective awareness that is essential to effective management of public health crises and strengthening support for and compliance with public health objectives and measures over the long term. In fact, in the context of public health planning, regard for the social meaning of law and policies may be of heightened importance given the need to rely on public support and

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cooperation, particularly for those measures that may temporarily subordinate or contravene individual rights and entitlements, or involve changes of behavior that cannot be directly monitored or compelled.

Public health policy arguably carries responsibilities that extend beyond the narrow targeting of individual solutions typical of public health actions and responses. Indeed, there has been much debate about which aspects of community and individual life are appropriately considered within the domain of 'public health'. Moreover, critical questions regarding the goals (Munthe, 2008) and appropriate scope of responsibility of public health policy challenge mainstream approaches that narrowly target specific problems. These approaches often engage in various forms of quantification and balancing (usually of private and public interests) to justify a reluctant intrusion on individual autonomy in circumstances of crisis. For example, imposing mandatory vaccinations on a particular group of workers or refraining from imposing mandatory vaccinations at all, convey various messages about role responsibilities and priorities, while centrally aimed at achieving a particular public health objective. Identifying individuals, rather than family or community clusters for priority vaccination also carries an important expressive content. In the case of priority vaccination of individuals, statements about social grouping and the non-relational nature of persons are communicated. Regardless of the intention to do so, these policies communicate certain values and arguably engender, modify or entrench norms that intersect with the 'regulated' domain. Failure to attend to this expressive function of policy bypasses valuable opportunities to accommodate and promote shared values that could further the common good in terms of improved health, equity and, ultimately, the well-being of all members of the community.

This essay briefly examines the expressive function as a concept as it operates in law and policy and looks specifically at how the expressive function could be utilized to further public health policy goals. I first explore the concept of expressive function, as applied in such fields as law (Sunstein, 1996; Feinberg, 2004) and bioethics (Asch and Geller, 1996). Second, I discuss both principled and pragmatic reasons for consideration of the expressive function in the making of public health policy. Lastly, I consider the case of pandemic planning and analyze how some recent approaches to public health policy, by not attending to the expressive function, may miss important opportunities to further the goals of public health.

I conclude that mere problem-solving guided solely by ethical notions of efficiency and utility (see discussion in Silva *et al.*, 2010) not rooted in a broader vision that also recognizes the value of the expressive function is a profoundly short-sighted and ultimately counterproductive approach to public health policy. Moreover, this broader vision requires an underlying ethical framework that can optimally and equitably support the goals of public health as well as utilize the power of the expressive function to enhance the overall effectiveness of public health measures. A relational ethics framework presents one viable option to achieve these goals fairly and effectively over the short and long term, in part due to its insistence on contextual regard, but also in part due to its ability to capitalize on the power of the expressive function.

The Expressive Function

The concept of expressivism is one that can be viewed across contexts and disciplines. There is an expressive aspect to all policy measures regardless of whether the statement they make is deliberate or merely collateral, an unintentional side effect (Sunstein, 1996). To the extent that a policy or law, or even a technology implies a particular view, value or morality, this 'message' is communicated in the enactment of a particular policy, law or even the uptake and integration of a particular technology. But the expressive function here can be understood as an articulation of values embedded in policy measures taken in the pursuit of a specific (public health) goal. Policies may reinforce an existing norm or they may seek to refine, modify or create a norm. It is important to emphasize that the expressive function usually does not stand alone; the 'intrinsic value of the statement alone' is insufficient (Sunstein, 1996). Sunstein stresses that the expressive function has a great deal to do with the effect of law or policy on prevailing social norms. He suggests that the expressive function makes more sense in connection with efforts to change norms. (Sunstein, 1996: 2025, 2048).

In the case of public health policy, there is an inextricability of public health consequences from the expressive function, if it is to be utilized responsibly in policy-making. That is, policy use of the expressive function that results in foreseeably bad consequences is poor policy-making. Or, as Sunstein succinctly puts it, 'good expressivism is also good consequentialism' (Sunstein, 1996: 2047).

Accordingly, this analysis adopts a meaning of the expressive function that refers to its use as a tool that can be used to achieve public health policy goals given that effective use of this tool can influence behavioral

and attitudinal norms over time. To the extent that shifts in these norms can lead to improvements in health outcomes, the expressive function, as the motivation of these shifts, can be viewed as instrumental in achieving public health goals. Consequently, if values such as individual forbearance in the interest of reducing (or at least not exacerbating) existing inequalities are incorporated into policy this may, over time, serve to reduce the long-acknowledged, but little-changed state of health disparities among groups.

Yet, recognition of the expressive function as a third level of consideration presents another public health opportunity (or challenge) in which effectiveness should also be achieved. Moreover, to the extent that the 'message' has the potential to influence attitudes and, over time, behavior, the expressive function operates as another mechanism of policy. In the case of public health policy, the chance to influence attitudes and behaviors that ultimately have the effect of improving public health in an equitable way is an opportunity that many societies cannot afford to pass up. In the context of public health policy, the charge to protect and promote public well-being has been granted to policy-makers, and thereby serves as a basis for the permissibility of utilization of appropriate mechanisms to achieve these goals and justify efforts to influence health-promoting behavior. This can be seen, for example, in policies regarding treatment of people with mental illness that also incorporate measures likely to reduce stigma.

Expressivism has also been explored in the bioethics literature, particularly pertaining to the need to consider 'messages' that might be sent suggesting attitudes toward segments of the community. For example, in the ethics and disabilities literature, the issue of genetic testing and prenatal diagnosis (PND) and preimplantation genetic diagnosis (PGD), in particular, raised considerable concern that the uptake of these technologies sent messages that devalued and threatened persons with disabilities (Taylor and Mykitiuk, 2001). Moreover, expressivism, in this case, was making a claim about 'representational or symbolic harm' and, on that basis, declares that consideration of symbolic content is required (Gedge, 2010).

While the argument can be made that the multiplicity of possible motivations for or interpretations of a particular policy or law precludes an expressivist inference, the precise and deliberate crafting of policy and law leave less ambiguity as to the underlying values and can, arguably, rely to a greater degree on a shared symbolic value. For example, prohibiting hate speech or augmenting the punishment for hate crimes are measures that are unambiguous about their intolerance for certain kinds of racially motivated behaviors. Similarly, assigning priority to persons in circumstances that make them particularly vulnerable to the spread of disease rather than utilizing a random queue for the dispensing of medicines also sends a message that clearly says that the worst off should not be made even more worse off by the current crises. While opinions about policies based on such values may differ, the unwillingness to exacerbate existing inequalities is clear.

The next section explores the role of the expressive function in public health planning, and particularly how the inconsistent messages about values that are communicated in emergency versus non-emergency situations arguably can result in reduced effectiveness over the short and long term. These are among the pragmatic advantages of considering the expressive function.

The Expressive Function: An Underlying Ethical Framework

Public health policy, by definition, seeks to address the welfare of populations and, at times, may compel people to act in the interests of the collective even when it appears to be in tension with individual rights and interests. In essence, when public health policy is implemented in response to some public health threat, it alters the obligations, duties and rights of individuals. Moreover, this altering of orientation of interests involves other important shifts—e.g. from self to others, from narrow impact to broad, and from short-term well-being to short- and long-term well-being. When considering the role of the individual, two interpretations offer plausible explanations for what happens in this shift and why. The first is based on the notion of sacrifice. In times of public health concern or emergency, the intrusion on individual rights requires a sort of 'compelled self-sacrifice' for the common good. However, an alternative interpretation is based on the notion of relational identity. That is, the self is, at least partially, constructed by its relationships to others. Thus, an incursion on individual rights constitutes not 'self-sacrifice', but rather recognition and prioritizing of aspects of one's relational identity in a particular context. It is this second interpretation that serves as the basis for the following discussion of the importance of the expressive function of health policy and an underlying ethical framework as illustrated by the case of pandemic planning.

For example, the decision by some policy-makers to include children on priority lists in national preparedness plans, deviating from WHO guidelines, even though WHO recommended against this strategy, citing a lack of evidence of its effectiveness in reducing the spread of pandemic (Uscher-Pines *et al.*, 2006). Indeed, a policy that prioritizes certain groups for reasons rooted in non-epidemiological bases are clearly value-laden, at once reflecting the values of the community, which are further promoted and entrenched by policy. Uscher-Pines and colleagues, authors of a comparative study of pandemic preparedness plans, suggest that the decision to prioritize children in these circumstances may reflect different socio-cultural values (Uscher-Pines *et al.*, 2006.) Alternatively, some policies, out of recognition of the social behaviors of children, recommend school closures as a way of curbing pandemic spread by children. Here, two different types of policies are plausibly aimed at minimizing the impact on children, but the first policy that prioritizes children for vaccines arguably sends a different message because of the hierarchical nature of the policy (in addition to the fact that it is not supported by epidemiological data).

A different type of issue arose with how to ensure that health workers did not ultimately operate at cross purposes with their professional duties. In this regard, the argument has been made that health workers should be required to be vaccinated in order to minimize risk of infection to patients, particularly those at high risk. However, this remained a highly controversial issue because of deep-seated allegiance to individual rights and respect for the autonomy of a health care worker to refuse the vaccine. Clearly, any policy that declared vaccination of health care workers as mandatory was sending a clear statement about the priority of the collective well-being, at least in times of crisis. Not insignificantly, it also sends a message about what it means to be a health care worker.

Public health ethics frameworks that tend to privilege individual entitlements such as autonomy and privacy over the common good, result in policies of individualistic orientation. And, indeed, the justification for intruding on individual autonomy and rights must be exceedingly strong based on the severity and magnitude of the potential harm to the collective in order to outweigh the presumption of deference to the will, wishes and interests of the individual. Two problems, in particular, arise from this approach. First, the mainstream approach to public health policy communicates a very high threshold for directing individual forbearance in the interest of the collective good, thereby missing countless opportunities for moving forward a range of shared interests that would enhance community well-being. Second, the mainstream approach overlooks the significance of delivering a coherent message that recognizes the common good as a priority as a general principle in the approach to public health, and not only in times of crisis. In the public health context, a greater deliberate shoring up of norms that encourage actions for the common good in policy could, at least theoretically, result in the achievement of many public health goals without the force of law (see Ellickson, 1991), thus creating a climate of voluntary compliance, which is preferable to compelled compliance, generally speaking.

Coherence: Emergency and Non-Emergency

Public health policy is charged with promoting and protecting the health of the community at all times, and not just in times of emergency. Consequently, messages about individual responsibility and community regard that are communicated in normal circumstances ideally should form a coherent message with those communicated in non-emergency times, even as they may call for different types of responses. The importance of coherence is related to a comprehensive long range view of achieving public health goals.

Pandemics, as circumstances of emergency, present a range of social, legal and ethical challenges. The measures that sometimes need to be taken in times of pandemic often involve intrusions on individual rights and interests. These measures, e.g. quarantine, surveillance and reporting, or mandatory vaccinations, impinge on individual freedoms with a goal of protecting and promoting the health of the collective. These policies, sometimes codified, are solution-oriented, designed to achieve a specific goal or purpose. Indeed, if the policy as implemented achieves its central purpose to a reasonable degree, it is generally deemed a success. Yet, a simple calculation of QALYs or other relevant measures of quantifiable outcomes, while important, arguably short changes the opportunity to do more than achieve the central purpose.

Given that states of emergency are recognized in some jurisdictions to trigger 'special powers' (arguably based on different values), it may appear that emergency and non-emergency situations would require different underlying ethical frameworks. This may not necessarily be the case. For example, while individual rights-oriented frameworks, e.g. libertarian, might support a first come-first served approach, such a framework would be unlikely to serve many crises situations well. However, in contrast, a relational ethical

framework, for example, that is rooted in the concept of relational persons, could accommodate 'special powers' or, as I have described it elsewhere in this work, necessary forbearance of individual entitlements and rights in times of emergency and could also accommodate individual needs for respect, dignity, and equality in non-emergency. Thus, a fundamental view of the individual as 'part of the whole', interrelated in social facets and futures, is essential to any ethical framework that could underlie both crises and non-crisis policy-making in a coherent way.

Policies that deal with public health emergencies tend ask people to behave in ways that are contrary to the values they hold in non-emergency situations. In this way, there is a certain incoherence in the ethical framework that underlies public health policy generally and in the overall message about individual responsibility for community well-being. This lack of consistency arguably renders policy approaches to both non-emergency and emergency public health situations less effective than they could be if a more coherent approach to the underlying ethical framework were taken in that individual situational or ad hoc reactions may be less likely to engender public health-promoting norms simply by virtue of the plurality of directed responses and priorities. Downstream, this arguably reduces the effectiveness of measures taken in response to crisis situations due to higher non-compliance (borne out of conflicting values) or the need for compulsion motivated by an almost exclusive concern for individual rights. In the context of public health planning, both the deliberate and unintentional messages can have an important effect on the ability to successfully meet public health challenges.

Public Health Ethics: A Substrate of Public Health Policy

There are two principal concepts of justice at the base of public health ethics: distributive justice and social justice (Baylis *et al.*, 2008). Much of the discussion of public health ethics has focused on the distribution of scarce resources. Social justice has received somewhat less attention, but this concept provides a lens through which we can explore the multiple forces that are at work when addressing collective health interests. In 1990, philosopher Iris Marion Young articulated the distinction between social justice and distributive justice, observing that while distributive justice is concerned with the distribution of finite quantifiable goods to individuals, social justice is primarily concerned with fair access to social goods such as rights, opportunities, power and self-respect. (Young, 1990) Therefore, social justice requires consideration of the context and how members of different social groups may be collectively affected by policies and/or practices that ultimately result in the creation of inequalities in access or opportunity, for example. Social justice, as it is understood here, is an essential component of a socially responsible public health ethics framework that does not tolerate the exacerbation of existing inequalities arising from patterns of systemic injustice experienced by different groups.

Consequently, given the public health mandate 'to advance human well-being by improving health' (Boston and Powers, 2006), it is clear that social justice is at the heart of public health. Indeed, it is the foundational moral justification for public health (Powers and Faden, 2006). Inequalities in one dimension can often result in deficiencies in other dimensions, with the cumulative effect of negatively impacting the outcomes of public health strategies for already disadvantaged groups. Recognition of disparities in social and environmental determinants of health is essential to a social justice approach to public health (Edwards, 2009). Just as the expressive function has been utilized to address issues of racial and gender fairness and equality generally, the expressive function, with a long range view, could conceivably be used as a tool to address various types of inequalities affected by public health strategies.

The tension between individual rights and interests and the common good is at the heart of many public health policy challenges. Indeed, some approaches to public health ethics instead adhere to various utilitarian configurations, sometimes tempered by liberal notions (e.g. the Difference Principle) that attempt to somehow address the challenge of fair distribution in the presence of background inequalities. This shift from individual rights and interests to privileging the 'greater good' and collective interests in the public health emergency context does not, by itself, produce a coherent ethical framework for public health if the quantification that determines what constitutes the greater good is narrowly constructed. Rather, a coherent framework that also can accommodate the expressive function requires consideration of interests that cannot be quantified. Stand on Guard for Thee, an ethical framework cited as the foundation for the Canadian Pandemic Influenza Plan in 2004, explicitly embraced such values as individual liberty, protection of the public from harm, privacy, duty to care, solidarity, trust, stewardship and equity. Yet, Melnychuk and Kenny (2006) have observed that it still resulted in a classic utilitarian bias for the protocol.

What a given policy communicates to the members of that society is important in defining how people in that society regard themselves in relation to others. If those policies communicate a reluctant regard for the welfare of the larger community or the privileging of individual interests except in the most dire of circumstances, this can reasonably be expected to influence individual regard for the collective well-being or common good. Moreover, even dire circumstances will require some showing that there is sufficient justification for intrusion on individual rights rather than a willingness to act in the interest of the common good on one's own volition. This leads to a general view of public health as one in which the individual and the public are somehow at odds with each other, a dichotomous view of interests in which if one wins, the other must lose.

If the broad ethical framework that underlies the approach to the development of public health policy, in general, also supports and is consistent with policy approaches to specific public health challenges, like emergency preparedness, it is more likely that all measures will be more effective in achieving their goals because each arises out of the same coherent ethical underpinning that does not call for conflicting value orientations. Consequently, the identification of an appropriate ethical framework is crucial to the development of policy that can achieve both its central purpose as well as inspire and encourage a sense of commitment to the common good, as a matter of general practice rather than as a matter of exception in crisis. This ethical framework must incorporate values that are or can be widely embraced and, at the same time, support state action and policy decisions that promote such goals as equality, justice, solidarity and the common good. Thus, in this way it is possible to envision a policy approach to public health that clearly signals an embrace of values that supports policy decisions that lead to good health for all segments of the population and, specifically, does not exacerbate existing health disparities (see e.g. Gostin, 2009a). The expressive function can serve as an integral mechanism in effectuating both the central goal and reinforcing societal values that are conducive to overall population health over the long term.

Pursuit of policy that is rooted in a broad picture view that recognizes the relational nature of persons requires two things: (i) the development of policy from a coherent ethical framework; and (ii) deliberate attention and regard for the expressive function of both the framework and any derivative policies. For example, a relational approach to public health ethics could provide the type of a framework that not only enables and facilitates achievement of the central purpose, but can also attend to the expressive function and, moreover, can assume responsibility for the resulting impact on social norms. Indeed, a relational account of public health ethics places in center stage the relational aspects of personhood including both relational autonomy and social justice as well as giving highest importance to the notion of relational solidarity (Baylis *et al.*, 2008). Moreover, some have argued that the traditional approach to public health ethics is ultimately too narrow to provide normative justification for the kinds of social change that public health must bring about (Jennings, 2007).

In many ethical frameworks, the traditional concept of personhood is based on an ideal of an independent rational self-interested individual whose values are transparent to him or herself. In contrast, the concept of relational personhood recognizes that individuals are not totally independent and separate persons, nor are they purely rational, unconnected and self-interested (Baylis *et al.*, 2008). Rather, there is a social aspect to all persons. The concept of relational personhood enables us to see how issues of social justice are central to many aspects of personhood. For example, it allows us to consider the ways in which membership in particular social groups contribute to the formation of identity by shaping the ways in which others see and respond to each of us. Therefore, it is more than understandable that characteristics that are socially salient in certain societies, like race, class and disability, and the resulting privilege or lack thereof, merit regard both in our concept of social justice and in our concept of relational personhood. Regard for these patterns of privilege and disadvantage as they operate in concepts of social justice and personhood must necessarily extend into any responsible framework of public health ethics.

Thus, a public health ethics framework must somehow accommodate the relational nature of persons, and any social justice component of public health ethics must specifically tend to the ways in which patterns of systemic discrimination operate in terms of the goals and activities of public health (Powers and Faden, 2005). Consequently, in considering the notion of autonomy, which even in a relational framework remains an important value but is viewed in both its individual and relational form, it is important to recognize that systemic discrimination may negatively affect one's ability to exercise autonomy. In the case of pandemic planning or other public health emergencies, while it may be essential to show that group interests actually do outweigh the interests of individuals where policy requires intrusions on individual autonomy, the relational approach also requires close attention to the various forces

that contribute to shaping an individual's decisions and decision-making capacity. The importance of these social forces has been noted in other aspects of public and global health. For example, Paul Farmer (2003) emphasizes how critical it is to understand the ways in which oppression can affect the background or baseline conditions under which choices are to be made. Moreover, such an approach requires regard for the ways in which policy limits or expands options that may be available to individuals who must make decisions or otherwise navigate social and political systems under circumstances of disadvantage and vulnerability (see e.g. Mastroianni, 2009).

The relational approach to solidarity is actually found within public health, inasmuch as public health exemplifies recognition of solidarity as a central commonly held value (Baylis *et al.*, 2008). The notion of solidarity that lies at the foundation of a relational framework is not based on a 'circling of the wagons' or categories of 'us' and 'them'. Rather solidarity should extend to include strangers and those whom we may regard as 'the other', which historically in many societies has included the vulnerable and systematically disadvantaged. Given that health risks are generally higher among those with the lowest social status and power, public health ethics requires a careful and deliberate regard for the needs of members of these groups. Yet, public health practices that are aimed at a particular health threat without regard for background inequalities miss important opportunities to act with a long range view toward systematic reduction of these inequalities. Attention to the expressive function is one mechanism for doing so.

Public policy has the responsibility and, in some instances, the obligation to make a statement. Moreover, in certain instances, public policy must boldly assume a role in the creation or changing of norms as in the case of racial and gender equality. Public health policy should take its expressive role seriously and, the expressive function of health policy should consistently be among the considerations of public health policy planning and development. Furthermore, the development of policy to address issues like pandemic planning also occasions, if not demands, a reconsideration of the ethical framework on which that policy rests.

Expressive Function: The Case of Pandemic Planning

Among the many challenges that arose in the recent H1N1 pandemic wave were (i) priority lists and (ii) donations to poorer countries. Instead of a coherent approach rooted in a broader ethical framework, each of these issues was addressed in an ad hoc manner and seemingly without regard for the expressive function of health policy. In the recent H1N1 threat, some of the shortcomings of various policy approaches became apparent and further underscored the need for attention to the expressive function of health policy. Here, I discuss how a relational ethics framework, not only would guide optimal promotion of health in pandemic, but also utilize the opportunity provided by the expressive function to communicate an overarching set of values that (i) places social justice (equality and the reduction of health inequities) as a core value and (ii) consistently recognizes the ways in which shared interest in the common good in the form of relational solidarity ultimately operates in everyone's best interests.

The three foundational elements of relational ethics framework—relational autonomy, social justice and relational solidarity, provide a sound basis for developing policy regarding the three aforementioned pandemic challenges, and moreover, can assume active/deliberate responsibility for the expressive function of policy based on it.

Priority Lists/ Sequencing

One of the bigger challenges that confronted public health officials dealing with the threat of an H1N1 pandemic was assigning priority to groups and individuals for receiving the vaccination either as a result of limited supply or simply the need to vaccinate (and, hence, protect) the most vulnerable. CDC issued a list of priority groups, including pregnant women, children, and healthcare workers. Several national and international agencies adopted a similar priority list. In some cases, where resources were sufficiently allocated such that no shortage was anticipated, the process of deciding who should receive the vaccines first was referred to as "sequencing", as was the case in Canada. Beyond the fairly universal three priority categories, many jurisdictions devised their own lists, either creating or adapting existing pandemic preparedness plans (see Uscher-Pines *et al.*, 2006 for comparative analysis of priority setting in national preparedness plans).

Applying a relational ethics framework to the development of policy would suggest some clear departures from some of the policies that were adopted. For example, from the standpoint of social justice, a recognition of existing inequities coupled with a commitment to avoid exacerbation of those background inequities would require that certain mechanisms be incorporated

into the priority or sequencing system. Zarychanski and colleagues have called attention to the plight of an aboriginal population in Manitoba, Canada and confirmed suspicions that systematically disadvantaged persons were disproportionately affected by the onslaught of H1N1 (Zarychanski *et al.*, 2010). Recognition and consideration of these existing inequities could have resulted in policy measures that would have prospectively addressed the impact of poverty on vulnerability to H1N1, and led to a more nuanced sequencing policy accordingly.

A perhaps more obvious example of the probable impact of a relational approach is the prioritizing of groups or clusters rather than individuals. Vaccination of a single individual in a household still leaves that household vulnerable. Similarly, in places where living conditions are overcrowded or lacking optimal infrastructure (e.g. basic services like clean water), vaccination of a single individual, for whatever reason, still leaves the rest of the 'cluster' vulnerable. Virus carried on equipment, personal items or other inadvertent vectors, expose the non-vaccinated members of that cluster. In this case, recognition of the relational nature of persons could result in an arguably more effective policy by prioritizing family units or other relevant 'clusters' rather than individuals. For example, a 2006 analysis of national pandemic preparedness plans showed that fewer than five countries prioritized 'contacts of high risk' and 'contacts of infants' (Uscher-Pines *et al.*, 2006)

The communicative function of a policy that views persons as members of a relevant community (family unit, neighborhood, province, country, etc.), serves to acknowledge the interconnectedness of people. This, in turn, encourages a certain awareness of a relational identity and interest beyond the individual. This heightened awareness in turn, can generate a sense of relational solidarity with others both within one's 'cluster' and beyond given that 'clusters' are also interconnected. This heightened sense of relational solidarity can then motivate less individualistic inclinations and orientation, and do so without the threat of compulsion. This shift arguably would serve the common good in general and facilitate voluntary promotion of collective interests and those of the disadvantaged in times of emergency.

Donations to Poorer Countries

Another of the challenges that arose during the H1N1 wave was the call for donation of vaccine from richer nations to poorer ones (see U.S. White House Press Release, 2009; Gostin, 2009b). Many wealthy nations heeded the call and gave of their supplies. Some nations did not (see e.g. BBC, 2009). For example, some countries, e.g. Canada, did not take a position until several months after the call (Canadian Press, 2009). There were also countries that did not anticipate a shortage of vaccines and, in fact, anticipated a surplus, but nevertheless adopted a policy to sell surplus vaccines back to the supplying company that would then have the discretion to donate them, as opposed to donating vaccines outright, as had been called for (Greenway, 2009).

Clearly, the taking of such a position, particularly when it goes against a collective call to act contains a powerful expressive component. But as a public health issue, any position taken should be able to find a place in a coherent public health strategy.

The expressive function takes on a somewhat different nature in this case. While policy generally, can be viewed as a public statement of the collective opinion and values (through representation), this type of decision comes out of a different process and, therefore, is supported on a different basis. In this case, leadership and the power vested in governmental entities to make decisions and act on behalf of the people provide the basis of the force for the expressive function of such decisions. Therefore, the expressive function in this example constituted a message about how this particular country participates in and supports the global community in times of distress.

It is relatively easy to envision how a relational public health ethics framework would support a different approach. Indeed, social justice would demand recognition of the heightened vulnerability of citizens of poorer nations to infectious disease due to infrastructural deficiencies, poorer baseline health states, and less access to adequate health care, on average. Relational solidarity would invoke a sense of shared interests and, in this case, shared vulnerabilities in that infectious disease does not recognize national borders.

This issue highlights the work that can be done by the 'expressive function' of policy and law. A policy or position that directs the donation of vaccines to poorer countries communicates a recognition that the threat of pandemic is not a national one. It communicates a sense of solidarity with all people, including the most disadvantaged. Yet, it also communicates an awareness and sophistication about the interconnectedness of persons. Since, as noted earlier, infectious disease does not recognize borders, protecting anyone from infection reduces the risk of infection to oneself. The willingness to donate a national resource in recognition of this interconnectedness and out of a broader commitment to share resources signifies and expresses membership in the global community and a sense of shared

responsibility for the welfare of disadvantaged persons, especially in times of crisis.

In contrast, a willingness to *sell* surplus vaccines sends a very different message. Such a policy communicates to members of the 'selling' community that they are somehow to be compensated for sharing in the global response. Moreover, relinquishing the opportunity to participate in the global effort to aid poorer countries communicates that there is clearly no recognition of any interconnectedness or shared interests or vulnerabilities, as the transfer of the protective resources occurs if, and only if, there is payment, albeit to the commercial manufacturer. This, in turn, contributes to an overall individualistic approach to public health that ultimately undermines the common good and the welfare of all.

Conclusion

Many have argued that a coherent ethical framework is needed as a foundation for policy-making in public health. Additionally, as argued here, this framework should be applicable beyond emergency-preparedness and other types of extraordinary situations, even though it should be keenly effective in such situations. Beyond successfully achieving the central purpose, e.g. distribution of scarce resources in the interests of protecting and promoting public health, policy-makers must accord some attention to the expressive function of public health policy and law, and give careful consideration to the messages that are being communicated (and taken up) in the adoption of particular policies. In view of the fact that policies communicate messages regardless of intention on the part of policy-makers, it is important to identify and harness these opportunities in order to engender the kind of public regard that promotes the welfare of all members of society in emergency and non-emergency situations. While measures may be taken at times without specific regard for effects beyond the central purpose, in many instances, a lack of regard for the expressive function can result not only in missed opportunities, but also in reduced effectiveness.

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