Still Special, Despite Everything: A Liberal Defense of the Value of Healthcare in the Face of the Social Determinants of Health

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Abstract: Recent epidemiological research on the social determinants of health has been used to attack an important framework, associated with Norman Daniels, that depicts healthcare as special. My aim is to rescue the idea that healthcare has special importance in society, although specialness will turn out to be mainly limited to clinical care. I build upon the link between Daniels's theory and the work of John Rawls to develop a conception of public justification liberalism that is applicable to the field of justice and health. I argue that, from the perspective of public justification liberalism, (clinical) healthcare deserves special status.

Keywords: specialness; healthcare; social determinants of health; Norman Daniels; John Rawls; public justification; liberalism

The idea that healthcare has special importance is very influential in public policy debates, and constitutes the starting point of many prominent theories of justice in the distribution of health resources.[1] As clearly explained by Shlomi Segall, the idea that healthcare has special importance is not limited to the claim that healthcare should be publicly funded. To endorse specialness means believing that society should distribute healthcare resources in isolation from the way in which other social goods are distributed and more equally than most of them. For example, the specialness thesis divorces access to healthcare from income, requiring that neither the poor nor the rich should have restricted access to healthcare because of their financial situation.[2]

[1]Classic proponents of specialness include Norman Daniels, "Health-Care Needs and Distributive Justice," *Philosophy & Public Affairs* 10 (1981): 146-79; and Michael Walzer, *Spheres of Justice* (Oxford: Blackwell, 1983), pp. 84-91. Sudhir Anand, "The Concern for Equity in Health," in Sudhir Anand, Fabienne Peter, and Amartya Sen (eds.), *Public Health, Ethics and Equity* (Oxford: Oxford University Press, 2004), and Leonard Fleck, *Just Caring: Health Care Rationing and Democratic Deliberation* (Oxford: Oxford University Press, 2009), pp. 103-12, are more recent examples. For a list of supporters of specialness, see Shlomi Segall, "Is Health Care (Still) Special?" *Journal of Political Philosophy* 15 (2007): 342-61, p. 342.

[2]Segall, "Is Health Care (Still) Special?"

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Within the philosophical debate on justice and health, views on the specialness of healthcare have been shifting. Indeed, a consensus appears to be emerging that the epidemiological research on the social determinants of health has disastrous implications for the idea that healthcare has special importance. More specifically, the impact of the social determinants of health seems to have refuted the idea of specialness, at least in its most intuitive version, according to which healthcare is special because it protects health. This version of the idea is most famously associated with Norman Daniels, who is the main target of the critics of specialness.

The criticisms of specialness threaten one of the pillars of the welfare state, namely, a publicly funded system of universal healthcare that offers health assistance without discriminating on the basis of social condition. In this paper, my aim is to challenge the consensus and provide an original argument that can rescue Daniels's idea of specialness, even though much of the special importance of healthcare will turn out to stem from *clinical* healthcare, or, more specifically, a central range of clinical care interventions. I believe that there is something special about the way in which clinical care protects health that the epidemiological literature on the social determinants of health cannot put into question. Specifically, clinical care is uniquely able to implement the concern for individuals that lies at the core of any liberal approach to justice and health and, in particular, of public justification liberalism.

My argument is organized as follows. In section 1, I define healthcare, social determinants of health, and other important terms before describing Daniels's argument for the special importance of healthcare. In addition, this section explores why it is believed that the social determinants of health have falsified the idea that healthcare has special importance, at least if the idea of specialness is linked to the protection of health. Section 2 explains why existing attempts to rescue the idea of specialness, which tend to ground this idea in something other than the protection of health, are unconvincing. Next, section 3 provides the first step of my response to the critics of specialness. I build upon the close link between Daniels's theory of just distribution of health resources and the work of John Rawls in order to develop a conception of public justification liberalism that is applicable to the field of justice and health. Section 4 argues that public justification liberalism vindicates the idea of specialness by distinguishing clinical care from social determinants, while section 5 specifies my argument and discusses future research directions.

1. Specialness of Healthcare and the Challenge Posed by the Social Determinants of Health

Healthcare is generally taken to be the sum of clinical care and public health. Roughly speaking, clinical care is delivered by medical personnel and places a great deal of emphasis on the diagnosis and treatment of disease and injury. Public health interventions are preventative measures that address the most immediate causes of bad health, as in the case of sanitation and workplace safety. This is an important distinction because even though the debate has so far been focused on the special importance of healthcare, my argument is intended to demonstrate that specialness is mainly limited to clinical care. More specifically, I aim to demonstrate that, together with certain exceptional public health measures, it is what I will call the "central range" of clinical care interventions that deserves special status.

Interventions on the social determinants of health are preventative, but differ from public health measures because they address the systemic causes of disease and injury, for example, social inclusion, the distribution of income, and the position occupied in the workplace hierarchy.[3] I acknowledge that any definition of these terms, including the one that I have proposed, is bound to have fuzzy borders. Still, nothing in my argument hinges upon my ability to draw a clear line between clinical care and public health or public health and social determinants. This is because my argument aims to contrast clinical care and social determinants, which can be distinguished rather clearly.

The idea that healthcare has special importance is most famously associated with the work of Daniels, who is generally taken to be the most important theorist of justice in the protection and promotion of health. According to Daniels, healthcare has special importance because it protects health, which is understood as normal species functioning. In turn, health protects the range of opportunities that are open to individuals. Indeed, good health protects the ability to choose from a range of life plans and to pursue the life plan one prefers, while bad health threatens to restrict the array of activities that one can pursue.

At this point, Daniels draws on the case for an egalitarian distribution of opportunities that is integral to Rawls's conception of justice as fairness, which is Daniels's preferred theory of justice. While Rawls's principle of fair equality of opportunity requires that persons who are born with the same level of talents and skills should have the same opportunities in the competition for jobs and offices, Daniels argues that this principle should be extended so as to include the choice and pursuit of life

[3]Segall, "Is Health Care (Still) Special?" pp. 353-57.

plans in general, beyond the pursuit of one's career. Given the support offered by Rawls's model (as well as alternative theories of justice, such as the capability approach) to an egalitarian distribution of opportunities, Daniels concludes that isolation and equality should govern the distribution of healthcare resources, justifying specialness.[4]

The epidemiological research on the social determinants of health poses a major threat to the idea of the specialness of healthcare. Until a few decades ago, it was widely assumed that public health programs and universal access to comprehensive and good-quality clinical care sufficed to improve aggregate population health and create greater health equality among groups. This assumption was dealt a major blow in 1980, when the Black Report was published in the U.K. Although more than 30 years had passed since the establishment of the National Health Service, the Black Report demonstrated that health inequalities between socio-economic groups had been growing rather than diminishing.[5] Over the following decades, research carried out by epidemiologists such as Michael Marmot and Richard Wilkinson established that, to a large extent, health inequalities among groups are determined by socio-economic factors such as income, housing, employment and place in the workplace hierarchy, education level, and social inclusion.[6]

The same socio-economic factors have been shown to be by far the most important contributors to aggregate population health, while healthcare is estimated to account for no more than one fifth of the life years gained in the last century.[7] Socio-economic factors strongly affect our susceptibility to disease and injury. Furthermore, the fact that the ill have access to treatment has a much smaller impact on population health than the socio-economic factors that make individuals ill in the first place.

Building on the research into social determinants, Shlomi Segall and James Wilson separately propose arguments that follow a similar structure, which is particularly effective in highlighting the challenge faced by the proponents of the idea that healthcare has special importance. Segall and Wilson point out that if many factors other than healthcare protect health, many social goods other than healthcare are to be valued on a par with it. What are the implications for the idea of specialness? A choice needs to be made between two equally problematic options.

On the one hand, each determinant of health might be taken to be

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[4]Norman Daniels, *Just Health: Meeting Health Needs Fairly* (Cambridge: Cambridge University Press, 2008), pp. 29-78.

[5]Department of Health and Social Security, *Inequalities in Health: Report of a Research Working Group* (London: Department of Health and Social Security, 1980).

[6]Michael Marmot and Richard G. Wilkinson, *Social Determinants of Health*, 2nd ed. (Oxford: Oxford University Press, 2006).

[7]Segall, "Is Health Care (Still) Special?" pp. 353-54.

special. Each social determinant should be distributed in an egalitarian fashion and in isolation from other social goods. The problem is that from the perspective of justice, we have reasons to care for virtually all the social determinants in themselves and not only because they protect health, but Rawls's and other appealing theories give strong priority to equality of opportunity over other considerations of justice. Therefore, the idea that every determinant of health should be regarded as special is implausible because it implies that equality should govern the distribution of each of them, dictating that the just distribution of, say, income as it affects health should override what justice would require for it if considered on its own.[8]

On the other hand, health might be considered to be special. Thus, healthcare and social determinants should be allocated so as to create an egalitarian distribution of health. However, an egalitarian distribution of health can only be achieved if the distribution of each determinant of health is sensitive to the way in which the other determinants are distributed.[9] Consequently, those who are disadvantaged with respect to some social determinant can now be compensated by means of extra rights to healthcare, contradicting the idea that healthcare is special and therefore should be distributed in isolation.

Some critics of Daniels's idea of specialness mainly focus on the second option, proposing arguments that are even more damaging than those put forward by Segall and Wilson. For example, Gopal Sreenivasan points out that the specialness of health is compatible with the complete exclusion of whole social groups from healthcare, provided that those excluded are compensated by means of a generous distribution of social determinants.[10]

2. Why Existing Attempts to Rescue the Idea of Specialness Fail

The research on the social determinants of health poses a formidable challenge to the idea that healthcare has special importance, threatening not only the notion of distribution in isolation, but also universal access. At this point, it is natural to ask whether anyone has been able to meet this challenge. Before answering this question, I would like to add a note clarifying what the specialness thesis is about and, therefore, what does not qualify as a valid response to its critics. The point of the debate over

[8]James Wilson, "Not So Special after All? Daniels and the Social Determinants of Health," *Journal of Medical Ethics* 35 (2009): 3-6, p. 5.

[9]Segall, "Is Health Care (Still) Special?" pp. 358-59.

[10]Gopal Sreenivasan, "Health Care and Equality of Opportunity," *Hastings Center Report* 37 (2007): 21-31, pp. 27-28.

the supposed specialness of healthcare is to determine whether a relevant difference exists between broad areas of government activity. If a relevant difference between healthcare and other areas is discovered, this discovery will lead to the identification of differences in the rules governing resource allocation within each area. Also in the arguments proposed by Segall and Wilson, to reject the specialness thesis simply means denying that healthcare provision should be governed by equality and isolation; the aim is not to contrast single interventions from different areas in order to suggest that there are numerous interventions on social determinants that, thanks to their impact on health, should take priority over healthcare measures.

It would be misguided to use as a counterexample to the criticisms of specialness any pro-healthcare intuition that we might have about a scenario in which decision-makers are forced to choose between a healthcare intervention and an intervention on social determinants. Analogously, it would be misguided to use as a counterexample to my defense of specialness any intuition that, in a different scenario, may go against (clinical) healthcare. To start with, the issue of how to choose between single interventions from different areas seems conceptually distinct from the issue of specialness, which concerns the rules governing healthcare resource allocation and other resource allocation areas taken as wholes. Moreover, if we narrow our focus to the models that aim to uphold specialness, these sorts of contrasts between single interventions are taken off the table by the conclusion that such models aim to reach, namely, that there is a difference between the broad areas of activity under consideration, and therefore healthcare resource allocation (or a part of it) should be set apart and subject to a different set of rules.

Having clarified the meaning of specialness, I can return to the attempts to rescue it. Daniels has never provided a detailed answer to the arguments that use social determinants to attack his idea of specialness. Before these arguments appeared in the debate, Daniels had already acknowledged that a good theory of justice and health must not focus exclusively on healthcare; it must also discuss how the social determinants of health should be distributed by virtue of their impact on health.[11] Since commentators started noticing that his focus on the social determinants is in tension with the specialness of healthcare, Daniels has limited himself to asserting that unlike social determinants, healthcare is to be regarded as special because persons will always fall ill, regardless of how justly social determinants have been distributed. Hence, healthcare will always

[11]Norman Daniels, Bruce P. Kennedy, and Ichiro Kawachi, "Why Justice Is Good for Our Health: The Social Determinants of Health Inequalities," *Daedalus* 128 (1999): 215-51.

be needed to safeguard fair equality of opportunity.[12]

If properly elaborated, Daniels's brief comment may help justify the specialness of (at least some forms of) healthcare. As it stands, however, this comment is unsatisfactory, because it does not explain why the fact that healthcare will always make a contribution to health makes it special while socio-economic factors that will always have a much greater impact do not deserve the same status.

Several commentators worry about the apparent demise of the idea of specialness, which threatens the role of one of the pillars of the welfare state, that is, a publicly funded system of universal healthcare that does not discriminate on the basis of social condition. Under the circumstances, those who share my idea that there is something special about healthcare are ready to sacrifice the notion that the main point of healthcare is to protect health. Therefore, their accounts of specialness link the value of healthcare to something other than health. For example, Jonathan Wolff argues that access to healthcare has special importance because of its impact on our feelings of anxiety. In other words, a publicly funded system of universal healthcare is necessary to manage our anxiety about the diseases that we may contract and the money that would be needed to pay for treatment.[13] Analogously, Daniel Engster maintains that the special importance of healthcare is not explained by its contribution to health, but by the relationships of care that are established in the medical context.[14]

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[12]Norman Daniels, "Just Health: Replies and Further Thoughts," *Journal of Medical Ethics* 35 (2009): 36-41, p. 38.

[13]Jonathan Wolff, "Health Risk and Health Security," in Rosamond Rhodes, Margaret P. Battin, and Anita Silvers (eds.), *Medicine and Social Justice: Essays on the Distribution of Health Care*, 2nd ed. (Oxford: Oxford University Press, 2012).

[14]Daniel Engster, "The Social Determinants of Health, Care Ethics and Just Health Care," *Contemporary Political Theory* 13 (2014): 149-67. It may be objected that when Engster argues that the specialness of healthcare is to be explained in terms of care, he is not only thinking about *relationships*, but also about specific *outcomes* that can still be achieved "when good health is not a realistic goal" (ibid., p. 157). For example, he mentions the alleviation of pain, the mitigation of the symptoms of a disease, and the power to slow physical and mental decay. The problem with Engster's idea of "care outcomes" is that it rests on the assumption that when the restoration to full health is not a realistic goal, the improvements to physical and mental functioning that can be achieved do not count as health improvements. Engster does not provide any reason in support of this assumption, which is counterintuitive and clashes with standard methods of measuring the outcomes of healthcare interventions. When a measure like the quality-adjusted life year (QALY) is used to measure the *health* outcomes of healthcare interventions, no distinction is made between a QALY that is gained by someone who can return to full health and a QALY that is gained by someone else because the symptoms of her chronic disease can be alleviated or her irreversible decay can be slowed down. For the QALY, see Richard Cookson and Anthony Culyer, "Measuring Overall Population Health: The Use and

Wolff and Engster seem to think that the only way to rescue the specialness thesis is to stretch shared ideas about the value of healthcare very far, leading to counterintuitive accounts of the point of healthcare systems. If we explore our intuitions about the importance of a publicly funded system of universal healthcare, it is not anxiety management nor the intrinsic value of care relationships that will come to mind. Indeed, it is fair to say that the intuitions that many of us share about the special value of healthcare are focused on the ability of healthcare to reduce mortality and morbidity or, in other words, protect health.

Moreover, anxiety management and the value of care relationships strike us as offering shaky grounds for justifying levels of public expenditure that are in any way comparable to the portion of the GDP that the governments of industrialized countries currently spend on healthcare. As stressed above, the debate over specialness concerns rules of distribution, not the amount of money to be spent on areas of government activity. However, Wolff and Engster contribute to this debate at the most fundamental level, by rejecting that health is the good that grounds the value of healthcare, and the implications of this rejection reach beyond specialness. Specifically, what they propose instead of health sits uncomfortably with the levels of public expenditure that industrialized countries adopt.

In 2012, the governments of OECD countries devoted an average of 6.7 percent of their GDP to healthcare, with countries like Denmark, France, and Germany investing between 9 and 10.3 percent of their GDP on publicly funded healthcare. Even in the U.S., where most healthcare is purchased privately, 8 percent of the GDP is spent on publicly funded healthcare.[15] An account of the special importance of healthcare that is grounded in the protection of health seems much better suited than Wolff's and Engster's proposals to justify public expenditures of this order of magnitude, especially in the light of Daniels's argument that good health is an important determinant of our opportunities. Indeed, compelling arguments can be made from within a range of theories of justice that demonstrate that one of the main aims of just institutions is to secure equality of opportunity.

Abuse of QALYs," in Amanda Killoran and Michael P. Kelly (eds.), *Evidence-Based Public Health: Effectiveness and Efficiency* (Oxford: Oxford University Press, 2010). Moreover, the outcomes mentioned by Engster do not make any exception also in the sense that interventions on the social determinants of health have a great impact on them, presumably greater than the impact of healthcare. In sum, I did not mention care outcomes in the main text because restricting the focus on relationships allowed me to depict Engster's argument at its most appealing.

[15]See http://www.oecd.org/els/health-systems/oecd-health-statistics-2014-frequently-requested-data.htm (last accessed 01/02/2015).

In sum, an argument that rescues the idea of specialness while upholding the link between healthcare and health would be in reflective equilibrium with widespread intuitions and offer a more solid justification for healthcare expenditures than Wolff's and Engster's proposals. The next two sections aim to demonstrate that there is room to develop such an argument if we build upon the liberal underpinnings of Daniels's theory.

3. From Daniels's Theory of Justice and Health to Public Justification Liberalism

In section 1, I mentioned that Daniels's theory of justice and health rests on a commitment to liberalism and, in particular, to Rawlsian liberalism. Indeed, one of the main aims underlying Daniels's work is to extend Rawls's theory of justice as fairness so as to cover the problems of justice that are posed by disease and disability. This extension is meant to increase the power of Rawls's views.[16]

The element of the liberal framework that I intend to employ to respond to the critics of specialness is the strong concern for individuals as such that contributes to forming the basis of liberal theories. More specifically, I argue that this concern for individuals needs to be developed in the direction of public justification liberalism. Public justification liberals believe that the principles grounding political decisions should be acceptable to each reasonable individual, where reasonable individuals are those who are ready to consider themselves and everyone else on the same footing when discussing terms of cooperation.[17]

A first reason why we should develop liberalism in the direction of public justification is that we know that one of Daniels's main aims is to translate Rawls's work into the domain of health, and Rawls is widely recognized as the most important proponent of public justification liberalism.[18] More importantly, public justification constitutes a compelling way of implementing a strong concern for all individuals that aims to safeguard people's ability to direct themselves in light of their own intelligence despite the coercive nature of political decisions. Public justifica-

[16]Daniels, *Just Health*, pp. 29-30.

[17]John Rawls, *Political Liberalism*, paperback ed. (New York: Columbia University Press, 1996), pp. 48-58. Reasonable persons also acknowledge the burdens of judgment, but this aspect of reasonableness is not relevant to my argument.

[18]For example, see the review of public justification liberalism offered by Kevin Vallier and Fred D'Agostino, "Public Justification," in Edward N. Zalta (ed.), *The Stanford Encyclopedia of Philosophy* (Spring 2014), http://plato.stanford.edu/archives/spr2014/entries/justification-public/ (last accessed 1 February 2015). For Rawls's model of public justification, see *Political Liberalism*, and "The Idea of Public Reason Revisited," *University of Chicago Law Review* 64 (1997): 765-807.

tion plays a key role in so many contemporary liberal theories that Stephen Macedo labels public justification as the "moral lodestar of liberalism."[19] Along similar lines, Jeremy Waldron defines liberalism as the commitment to explain the social order "at the tribunal of each person's understanding."[20]

This paper aims to use the framework of public justification to determine the importance of clinical care relative to public health and, more importantly, social determinants. To do that, I need to understand what is required by public justification when it is applied to issues of justice in the distribution of health resources, where the term "health resources" refers to all resources that are devoted to the protection and promotion of health, therefore encompassing both healthcare and the resources spent on socio-economic factors specifically because of their impact on health.[21]

When it comes to distributing health resources, the question is typically one of allocating scarce goods among many possible beneficiaries. I argue that, in this context, the commitment to principles that are acceptable to every reasonable individual leads public justification to require that attention must be paid to the strength of the complaints of individuals against resource allocation arrangements. More specifically, it is most important to satisfy the strongest individual claim to aid. The justification for this conclusion is that even if a person is reasonable and, therefore, is willing to consider herself and everyone else on the same footing, she

[19]Stephen Macedo, *Liberal Virtues: Citizenship, Virtue and Community in Liberal Constitutionalism* (Oxford: Clarendon Press, 1990), p. 78.

[20]Jeremy Waldron, "Theoretical Foundations of Liberalism," *The Philosophical Quarterly* 37 (1987): 127-50, p. 149.

[21]Arguably, the most important objection to my argumentative strategy comes down to the fact that Rawls and several other public justification liberals believe that the scope of public justification should only include constitutional essentials and issues of basic justice, excluding the majority of issues of justice and health. Their main argument seems to be that if we applied public justification more broadly, it would become indeterminate, i.e., unable to provide any answer to many political questions (Rawls, *Political Liberalism*, p. 227). In "The Scope of Public Reason," *Political Studies* 52 (2004): 233-50, Jonathan Quong provides a compelling answer to the narrow view of the scope of public justification while remaining within a broadly Rawlsian framework. First, Rawls's claim that many issues that fall outside the scope of public justification as he defines it cannot be given a determinate answer is largely unsubstantiated and could not be otherwise. If you have not tried to give an answer to a specific issue on the basis of public justification, you cannot possibly tell if public justification is indeterminate with respect to that issue. Second, from the perspective of public justification liberalism, there is nothing to lose and everything to gain if we first attempt to apply public justification to all political issues and turn to other methods only when public justification fails. Following Quong, this paper sets out to apply public justification to the issue of specialness. My aim is to demonstrate that there is no need to turn to other methods, because public justification has all the necessary resources to reach the determinate conclusion that clinical care is special.

can only accept that she will not get any of the resources that may have benefited her health if this resource is necessary for someone with a stronger claim to intervention to benefit.

My argument that universal acceptability involves a commitment to the strongest individual claim has much in common with the method of pairwise comparisons as developed by another prominent supporter of public justification liberalism, namely, Thomas Nagel. According to Nagel, when it comes to determining which possible distribution of scarce resources is acceptable from the perspective of all potential beneficiaries, the perspective of each individual should be compared with the perspective of everyone else, searching for the strongest claim anyone may make. In turn, giving priority to the strongest claim leads to paying special attention to the lower member of each pair, therefore placing priority on the worse off and ultimately on the worst off.[22]

Nagel's argument brings up the important issue of the valid bases for an individual's claim to health resources. It does not matter whether we are discussing distributive justice in general (which is the focus of Nagel's argument) or the distribution of resources for health. When the question concerns the shape that the strongest claim to beneficial resources may take, being the worst off appears to be the most natural answer. In the field of justice and health, a person who suffers from poor health and has a bad prognosis if not helped strikes us as having a strong complaint against any distribution of health resources that does not address her problems.

Here I do not mean to say that being badly off is the only valid basis for a claim to health resources. That a person could gain great benefits from intervention imposes itself as a strong claim to available resources. Importantly, how badly off an individual is and her ability to benefit from intervention provide two distinct bases for a claim to health resources. Indeed, it seems fair to argue that if two individuals are equally badly off, but one could benefit more than the other from intervention, the former has a stronger claim to available resources.

A note on evaluative space is in order. My argument understands the worst off as being the persons with the worst health, while an individual's ability to benefit refers to the size of the health gain that she could realize from intervention. Here I follow the convention of narrowing the focus on health, as opposed to overall well-being, when it comes to specifying how badly off individuals are and how much they can benefit from intervention for the purposes of distribution of health resources.[23]

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[22]Thomas Nagel, *Equality and Partiality* (Oxford: Oxford University Press, 1991), pp. 63-74.

[23]That the worst off should be understood in terms of health is generally taken for granted even among those scholars who discuss the specification of the notion of the

At least at first glance, there seem to be important similarities between this convention and the specialness thesis, which calls for the isolation of healthcare from other social goods. Does my choice of evaluative space presuppose the specialness thesis, therefore begging the question of the specialness of (clinical) healthcare?

The evaluative space that I adopt and the idea that clinical care has special importance are distinct notions. The idea that clinical care is special constitutes a very specific notion, both in the sense that it only applies to clinical care and because it involves determinate principles (equality and isolation) for the distribution of the resources that fall within its purview. In contrast, my conception of evaluative space concerns the perspective to be adopted when identifying distributive principles not only with regard to clinical care resources, but also in the case of public health spending and when it comes to the resources devoted to socio-economic factors because of their impact on health. Importantly, such a perspective does not entail equality, isolation, or any other determinate principle for the distribution of any of those resources: it only requires that, to the extent that priority to the worst off and ability to benefit contribute to determining the right framework of distributive principles, how badly off individuals are and how much they could benefit from interventions should be understood in terms of health.

That I am not begging the question of specialness is confirmed by the fact that my conception of evaluative space can be used to attack the specialness thesis. Indeed, all the criticisms of the specialness thesis that I have discussed observe the above-mentioned convention concerning the evaluative space. The reason why the critics of specialness reject equality and isolation is not that they believe that extra entitlements to healthcare are owed to the socio-economically disadvantaged in virtue of their being badly off overall. Analogously, their point is not that the rejection of specialness would create great non-health benefits. When Segall and Wilson consider whether health (as opposed to healthcare) should be considered to be special, the suggestion that those who are badly off with regard to income and other social goods should be provided with extra entitle-

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worst off for the purposes of health resource allocation. See, e.g.: Samuel J. Kerstein and Greg Bognar, "Complete Lives in the Balance," *The American Journal of Bioethics* 10 (2010): 37-45; Erik Nord, "Concerns for the Worse Off: Fair Innings versus Severity," *Social Science and Medicine* 60 (2005): 257-63; and Govind Persad, Alan Wertheimer, and Ezekiel J. Emanuel, "Principles for Allocation of Scarce Medical Interventions," *The Lancet* 373 (2009): 423-31. While proposing one of the few arguments that cast doubt on the idea that only health benefits should count, Kasper Lippert-Rasmussen and Sigurd Lauridsen explain how widespread that idea is in the literature ("Justice and the Allocation of Healthcare Resources: Should Indirect, Non-Health Effects Count?" *Medicine, Health Care and Philosophy* 13 (2010): 237-46).

ments to healthcare is grounded in a concern for the poor health associated with socio-economic disadvantages and the willingness to identify the most effective ways to produce health improvements in society.

There are things to be said for my choice of evaluative space beyond the fact that I am following a widespread convention. Focusing on something other than health when specifying the worst off and ability to benefit would contradict the purpose of putting resources aside to protect health through healthcare and interventions on social determinants. Putting resources aside specifically for health seems justified in light of an early step in Daniels's original argument, which is not targeted by any of the criticisms of specialness. Health is not simply a good among others in that health has a major effect on the opportunities open to individuals. Indeed, a great many life plans are rendered unviable by certain diseases and injuries. Rawls's as well as several other appealing theories of justice demonstrate that we should place particular importance on opportunities. Rawls's argument that equality of opportunity should take lexicographic priority over the distribution of goods such as income and wealth is paradigmatic here, but Daniels also discusses the capability approach and those influential theories that interpret justice as requiring that everyone should be given equal opportunities for welfare or advantage.[24]

How badly off an individual is in terms of health and the size of the health gain that she could realize from intervention provide two valid bases for her claim to health resources. It may be asked whether an individual's claim to health resources could be grounded in other considerations beyond how badly off she is and her ability to benefit from intervention. For example, it may be suggested that personal responsibility contributes to determining the strength of an individual's claim, leading to the conclusion that priority should only be given to the worst off if they suffer from bad health through no fault of their own.[25] There is no need for me to take a stand on this sort of issue and attempt to create a full list of bases for a claim to health resources. How badly off an individual is and how much she could benefit from intervention suffice to identify a key difference between clinical care and social determinants that explains why only clinical care is special.

In sum, those who wish to side with Daniels on specialness should develop the concern for individuals that lies at the heart of liberalism in the direction of public justification liberalism. With regard to the distribution of health resources, public justification liberalism requires that priority should be given to the strongest individual claims, where an in-

[24]Daniels, *Just Health*, pp. 29-78.

[25]For example, see F.M. Kamm, *Bioethical Prescriptions: To Create, End, Choose, and Improve Lives* (Oxford: Oxford University Press, 2013), pp. 510-11.

dividual's claim is stronger the worse off she is and the more she could benefit from intervention. The next section aims to demonstrate that clinical care is better placed than social determinants to implement this commitment to attending to the strongest individual claims.

4. Individual Claims and Specialness

Let us go back to the two problematic options that, according to Segall and Wilson, are open to Daniels: given the sheer volume of the contributions of social determinants to population health and health equality among groups, either each determinant of health is considered to be special, or health—but not healthcare—is.

This section aims to demonstrate that if we look at the issue of specialness from the perspective of public justification liberalism, it becomes clear that Segall and Wilson fail to notice that at least one of the two main components of healthcare has a different function from social determinants. I intend to show that clinical care interventions protect health beyond their contribution to aggregate population health and the reduction of health inequalities between groups. Indeed, clinical care protects health by attending to claims that (a) most clearly come from individuals and (b) include the strongest claims that any individual may make in relation to health. This function places clinical care uniquely close to public justification, proving that clinical care is special, while interventions on social determinants are not.

Imagine that a society has decided to commit a great amount of resources to interventions on social determinants. Consequently, aggregate population health and health equality among groups have greatly improved. Can this state of affairs satisfy a public justification liberal who is concerned about the detrimental effect of bad health on equality of opportunity? The answer is negative, because public justification liberalism is essentially concerned with *individuals*, while the arguments proposed by Segall, Wilson, and the other supporters of interventions on social determinants get all their traction from the impact of social determinants on the health of *groups* and the population at large.

Public justification liberalism develops its concern for individuals in terms of a commitment to attending to the strongest individual claim to intervention. Thus, regardless of how much is invested in social determinants, there will always be instances of the core problem that public justification has with poor health—namely, individuals falling seriously ill. Facing premature death, extreme suffering, or severe disability, each of them is in a position to make an extremely strong claim to help based on the fact that without intervention, they will have many fewer opportunities

than most other members of society.

Now, interventions on social determinants cannot possibly react to any instance of the core problem that public justification has with bad health. Generally, not even public health measures can react, because they focus on prevention. This is why I need to distinguish between public health and clinical care, essentially restricting the idea of specialness to the latter.[26] Clinical care is unlike social determinants and public health in that it can try to enhance the health prospects of those individuals who turn out to be ill. Clinical care can make the difference at the level of individuals by avoiding premature death and making recovery from extremely serious disabilities possible, including extreme pain. Special importance should be placed on clinical care, because it appears to be unique in being able to attend to the claims of individuals as such, and therefore give effect to the project of public justification.

One answer is available to the critics of specialness. Interventions on social determinants are preventative. Like public health measures, they are often described by their own proponents as interventions that aim to improve the health of groups and populations, as opposed to individuals.[27] Still, there is a way to reinterpret the point of preventative interventions that moves individual claims to center stage. Imagine that we know that a redistributive scheme aimed at increasing the wealth of those at the bottom of the income ladder will reduce the number of deaths from cardiovascular disease over the upcoming decades. If decision-makers decide against the scheme, is not the complaint raised by each statistical individual who could have been saved by it as strong as the one raised by, for example, a patient whose life can be saved by dialysis? It seems that not only do interventions on social determinants respond to individual claims, but some of these claims also qualify as the strongest health-related claims that anyone may make.

This answer overlooks a difference in the concentration of risks and probabilities.[28] The concentration of risks and probabilities marks a key

[26]This restriction is not without exceptions, which are discussed in the next section.

[27]See Marcel Verweij and Angus Dawson, "The Meaning of 'Public' in 'Public Health'," in Angus Dawson and Marcel Verweij (eds.), *Ethics, Prevention, and Public Health* (Oxford: Clarendon Press, 2007), chap. 2; and Ruth Faden and Sirine Shebaya, "Public Health Ethics," in Edward N. Zalta (ed.), *The Stanford Encyclopedia of Philosophy* (Summer 2010), http://plato.stanford.edu/archives/sum2010/entries/publichealth-ethics/ (last accessed 1 February 2015).

[28]The concentration of risks and probability of benefiting is used to distinguish prevention from treatment by Norman Daniels, "Treatment and Prevention: What Do We Owe Each Other?" in Halley S. Faust and Paul T. Menzel (eds.), *Prevention vs. Treatment: What's the Right Balance?* (Oxford: Oxford University Press, 2012), chap. 8, pp. 187-90; and Paul T. Menzel, "The Variable Value of Life and Fairness to the Already Ill: Two Promising but Tenuous Arguments for Treatment's Priority," in ibid., chap. 9, pp. 201-2.

difference under both possible approaches to when claims to a resource allocation arrangement should be evaluated. A first approach is to evaluate claims ex ante, that is, before the resource allocation arrangement is implemented. Alternatively, resource allocation arrangements could be evaluated ex post, focusing on the claims that individuals will end up making after an arrangement has been put in place and has taken effect. Whether decision-makers should adopt an ex ante or an ex post approach is a subject of debate and I do not have the space to address such a difficult question here.[29] By adopting the ex ante and ex post perspectives in turn, I intend to demonstrate that regardless of which approach is used, the concentration of risks and probabilities sets clinical care apart from public health and even more so from social determinants.

Let us start with the ex ante approach. When interventions on social determinants are planned, both the risk of bad outcomes and the expected benefits from intervention are spread throughout a group, typically a large group. In the case of clinical care, the risk is typically concentrated, to the point that some patients are virtually certain that if they do not receive treatment, they will die. Also, single individuals can expect benefits that are typically greater than what can be expected by any recipient of interventions on public health and social determinants.

This difference in the concentration of risks and probabilities is very important. In their search for the strongest claim to a certain intervention, decision-makers committed to public justification are supposed to look at the intervention from the perspective of every affected individual in order to measure how badly off each of them is and the size of the health benefit that each can expect. The example of the redistributive scheme was meant to suggest that if we first applied this process to the redistribution of money and then to the provision of dialysis, we would find that the strongest claim to redistribution is just as weighty as the strongest claim to dialysis. However, this suggestion is mistaken.

Consider first the redistributive scheme. Among the perspectives of all affected individuals, there is no position from which one can make a claim based on the loss of a *whole* statistical life and the ability to be saved. All individuals in the lowest income bracket are in a position in which, at most, each can point out a small risk of premature death by cardiovascular disease—the expected sum total of lives lost to cardiovascular disease in the lowest income bracket discounted by the improbability that the individual in question will be one of the victims. Relatedly,

[29]Among others, see Stephen John, "Risk, Contractualism, and Rose's Prevention Paradox," *Social Theory and Practice* 40 (2014): 28-50; and Michael Otsuka and Alex Voorhoeve, "Why It Matters That Some Are Worse Off than Others: An Argument against the Priority View," *Philosophy & Public Affairs* 37 (2009): 171-99, pp. 195-98.

no individual can point out more than a modest expected benefit from intervention—a decrease in one's (already limited) chance of death from cardiovascular disease. Now, consider dialysis. The patient in need of dialysis can point out a very high risk, perhaps even a 100% risk, that she will die if untreated. Moreover, she may be in a position to demonstrate a solid ability to benefit. In sum, even though public health and interventions on social determinants can be depicted as reactions to individual complaints, there is a deep imbalance between the strongest of these complaints and the strongest complaints that clinical care can respond to. Hence, it appears that only clinical care can attend to the strongest complaint that any individual may have in relation to health, giving full effect to the project of public justification.

It might be suggested that the imbalance disappears as soon as we abandon the ex ante approach. If we look at the redistributive scheme *ex post*, there seem to be positions from which an individual can build a claim based on the fact that she would have been dead without the scheme and therefore her life has been saved by it. Several philosophical analyses seem to support the idea that individual claims to typical preventative measures are greatly strengthened by the adoption of an ex post approach. For example, Sophia Reibetanz discusses an example in which a field contains a landmine. If nothing is done, one out of 100 peasants will lose a limb. However, the only technician decides not to intervene, because to go out into the field would give her pneumonia, which is 10 times better than losing a limb. From an ex ante perspective, the technician's complaint against going out is stronger than the claim that any peasant can make for intervention. However, if we adopt an ex post approach, the peasant who turns out to step on the mine is in a position to raise a very powerful complaint, based on the loss of a whole limb and the claim that the technician could have prevented the accident.[30]

Reibetanz's example is different from typical interventions on social determinants (and public health). Although the *recipients* of interventions on social determinants may be identifiable, *beneficiaries* remain generally unknown, even if we look at them ex post.[31] Going back to my example, imagine that a drop in deaths from cardiovascular disease in the

[30]Sophia Reibetanz, "Contractualism and Aggregation," *Ethics* 108 (1998): 296-311, pp. 301-4. See also Tony Hope, "Rationing and Life-Saving Treatments: Should Identifiable Patients Have Higher Priority?" *Journal of Medical Ethics* 27 (2001): 179-85, pp. 183-84.

[31]For the idea that the knowledge of beneficiaries is almost exclusively the "province" of medical treatment, see Menzel, "The Variable Value of Life and Fairness to the Already Ill," pp. 199-201. In "The Meaning of 'Public' in 'Public Health'," Verweij and Dawson explain that even with hindsight, it is often impossible to know who has benefited from preventative interventions.

lowest income bracket has resulted from the adoption of the redistributive scheme. We cannot know specifically who has benefited, since each person who has not suffered from cardiovascular disease could have been free from disease anyhow. Can we identify beneficiaries counterfactually by looking at the scenario in which the redistributive scheme has not been enacted? The answer is still negative. Typically, interventions on social determinants do not aim to eliminate a cause of death or disease altogether. Thus, if we have decided against redistribution and a person dies of cardiovascular disease, we cannot know whether she would have died of the same disease regardless.

The nonidentifiability of beneficiaries is not relevant in itself. Moreover, it does not take anything away from the fact that there are perspectives from which individuals can complain that without the redistributive scheme, they could have ended up losing their life to cardiovascular disease and, therefore, being very badly off. This fact makes ex post complaints against the scheme much stronger than their ex ante counterparts. However, even ex post, many recipients of clinical care can point out a concentration of ability to benefit that is unavailable to any recipient of typical preventative interventions.[32] Hence, such interventions do not react to individual complaints that are as strong as the ones that highly effective clinical care responds to.

Given that the beneficiaries of interventions on social determinants are unidentifiable, the ex post probability that one would have been spared from death if the redistributive scheme had been enacted remains thinly spread among the numerous victims of cardiovascular disease who fall in the lowest income bracket. Therefore, each victim can only complain that the redistributive scheme would have brought a limited decrease in one's chance of death, which is not comparable with the size of the benefits that access to dialysis would have provided to each victim of certain forms of renal failure in a society that has not been covering the treatment in question.

In other words, given that no one can be certain who the beneficiaries of the redistributive scheme would have been, all complaints that individuals can raise ex post must resort to a certain probability that one's life would have been saved by the scheme. However, preventative measures do not fare well when it comes to the concentration of probabilities of benefit. Even when a preventative measure can save a large number of lives, it generally works by targeting a much larger number of persons

[32]See also the "Prevention Paradox," famously formulated by Geoffrey Rose, "Sick Individuals and Sick Populations," *International Journal of Epidemiology* 14 (1985): 32-38, pp. 37-38: "a preventive measure which brings much benefit to the population offers little to each participating individual."

who are at risk of death from certain causes, many of whom will end up dying from those causes regardless. Therefore, the ex post probability that one would have been spared from death if that preventative measure had been enacted will be spread rather thinly throughout a large group of victims of a certain cause of death.

In sum, clinical care has a different function from social determinants. Clinical care protects health by attending to claims that (a) most clearly come from individuals and (b) include the strongest claims that anyone may have in relation to health. This function places clinical care uniquely close to public justification, which involves a commitment to the strongest individual claims. The conclusion to be drawn is that clinical care is special while none of the interventions on social determinants are. In the next section, I clarify how nuanced this conclusion is.

5. Specification of my Argument and Future Research Directions

While contrasting them with clinical care, in the previous section I often spoke in terms of *typical* preventative interventions. By definition, interventions on social determinants target the least immediate causes of bad health; such interventions operate at a deep level, by addressing the socio-economic status of certain groups, with the aim of generating reactions that ultimately promote health. The more steps between the level of a preventative intervention and its effect on health, the more thinly the health risk and ability to benefit of individuals are likely to be spread throughout a group, leading to weaker individual claims. Therefore, it seems virtually impossible that someone might come up with an example of an intervention on social determinants that differs from typical preventative measures in that it responds to some of the strongest health-related claims any individual may have. However, these sorts of exceptional cases are not to be excluded when it comes to public health. Imagine a group of public health inspectors who discover that, in a certain factory, extremely dangerous chemicals are being handled so improperly that anyone working in contact with them for a prolonged period can be virtually certain to develop a certain disease. The choice to close the factory closely resembles typical clinical care interventions, which respond to high concentrations of risk and whose beneficiaries are identifiable.

In a similar way, not all clinical care interventions display all the features that explain the specialness of clinical care. Of course, many clinical care interventions respond to claims that clearly come from individuals and are so strong as to be unmatched by any claim to social determinants. Consider a GP who diagnoses a patient with a serious disease and refers her to the relevant specialists who will be able to provide effective

treatment. To cite another example, consider the emergency surgery needed by someone who is admitted to a hospital after an accident that threatens to leave her severely disabled. Still, there are clinical care practices, such as the prescription of statins to large numbers of individuals at moderate risk of heart attack, that share important similarities with typical preventative interventions.

Let us start with the implications of the point about clinical care. The idea that clinical care is special should be taken to mean that equality and isolation must govern the allocation of resources within its *central range of application*, which is the range of clinical care interventions that actually address individual claims that point out a high concentration of risk and a considerable ability to benefit from treatment. As for interventions falling outside the central range, societies do not contradict the requirements of public justification if they decide that access to care should be allocated in a way that is sensitive to the distribution of social determinants. I borrow the idea of a central range from Rawls's classic account of the priority of basic liberties. According to Rawls, each basic liberty has a central range of application, within which it most effectively supports the development and exercise of our moral powers. Similar to what I have argued with regard to clinical care, it is only within its central range that a basic liberty has lexicographic priority over other goods.[33]

Turning to public health interventions that resemble clinical care in those respects that make it special, the agencies responsible for allocating public health resources should be ready to single them out and treat them as special. This suggestion is not in conflict with the rest of my argument. This paper aims to vindicate the specialness of at least some forms of healthcare in the face of social determinants. If anything, the idea that certain public health interventions are to be regarded as special furthers the aim of my paper.

Another important point is that interventions that are meant to protect health make up a spectrum that runs from individualistic interventions that respond to the single strongest claim anyone can make in this area to preventative interventions that work at the level of populations and offer very little to individuals. There is no gap in this spectrum that clearly separates interventions that should be regarded as special from those that should not, raising the question of what exactly ought to be placed within the central range of clinical care and which specific instances of public health interventions ought to be considered special.

My argument for specialness clearly indicates that interventions close to one end of the spectrum are special (and, conversely, that interventions

[33]Rawls, *Political Liberalism*, pp. 289-371.

close to the other end are not). However, the issue of whether an intervention qualifies as special becomes less and less clear the more we move away from the end of the spectrum populated by interventions that can provide large benefits to individuals who are very badly off, and come to the fuzzy cases. It seems implausible to claim that the question of whether fuzzy cases should be regarded as special can be given a determinate answer solely on the basis of my argument for specialness. The judgment of decision-makers in relevant institutions is bound to play a role, even though my argument constrains it by requiring that the question that decision-makers strive to answer should be whether a fuzzy case at hand looks more like the interventions at the individualistic end of the spectrum or those at the other end. This inability to identify the exact limits of the central range of clinical care and of the range of exceptional public health measures that are special does not constitute a flaw in my analysis of specialness. My analysis has operated at the philosophical level, not at the level of public policy. Moreover, its main goal has been to identify the *basis* of the special importance of healthcare, not to classify specific interventions according to whether they are special.

I conclude this section by discussing future research directions opened by my argument for specialness. This argument provides the basis for doing what Daniels wanted his theory of specialness to achieve when he started working on the topic in the early 1980s. Daniels thought that his work on specialness would lead not only to an explanation of our intuition that access to healthcare should be governed by equality and isolation, but also to an account of which healthcare interventions are "more special" than others, providing guidance for rationing resources and, therefore, for deciding which healthcare interventions should only be provided to certain patient groups, should be limited by long waiting lists, and so forth.[34] Over the years, Daniels realized that his theory of specialness was not suitable for this task. Therefore, he devised "accountability for reasonableness," an account of fair process for rationing resources that gives very little guidance regarding the substance of decisions.[35]

It would be interesting to explore the potential of my account of specialness to go beyond accountability for reasonableness, while at the same time moving back towards Daniels's original goals. The issue of whether "badly-offness" and ability to benefit are the only valid bases for a claim should be explored, together with the way in which different bases for a claim should be combined to determine its strength. Once these issues have been settled, the recommendation for rationers would

[34]Daniels, "Health-Care Needs and Distributive Justice."
[35]Daniels, *Just Health*, pp. 103-39.

be to distinguish the more from the less important among special healthcare interventions according to the strength of claims that they respond to. Of course, many questions would arise in the pursuit of such a project, but this rough outline already highlights the interest of the research directions opened by the argument of this paper.

6. Conclusion

This paper has demonstrated that Daniels is right in thinking that there is something special about healthcare and that the value of healthcare is linked to the protection of health. The central range of application of clinical care and certain exceptional instances of public health have turned out to protect health in a way that places them uniquely close to public justification, vindicating the idea of specialness. As far as this subset of healthcare interventions is concerned, equality and isolation are therefore required.

Of course, to say that social determinants and typical public health measures are not special is not to say that they are not legitimate areas of government activity. There is a parallel to be drawn here with Segall's and Wilson's criticisms of the specialness of healthcare: to reject the specialness thesis does not mean believing that public expenditures on healthcare should be slashed. Typical public health measures and interventions on social determinants can be thought of as reactions to individual claims. Some claims seem to have considerable strength, although the dispersal of ability to benefit prevents them from being as strong as many of the claims that clinical care reacts to. Therefore, public justification requires that resources be spent on typical public health interventions and social determinants, although there is no obligation to distribute those resources according to equality and isolation.[36]

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