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Intuitions about Just Public Healthcare Versus Liberal Political Theory

– Thaddeus Metz –

Abstract: I argue that strong intuitions about how the state ought to allocate healthcare are incompatible with quite influential autonomy-centric and neutral strains of liberal political theory. Specifically, I maintain that it is uncontroversial that we should routinely distribute medical treatments in public hospitals in ways that have little to no bearing on patients' ability to pursue a wide array of ends and further that we cannot easily avoid making judgments of which ways of life are good (or bad) when making such distributions. These intuitions tell against the principles that the state in general should aim merely to protect individuals' rights to choose their own ways of life and should not take sides on which lives are good (or bad) when adopting policy or law. I show that this tension, which has not been addressed in the literature, manifests in at least three types of healthcare decisions, viz., which types of treatments should be offered to patients, how to prioritize among types of treatments, and who should receive a certain type of treatment. I do not prescribe how to resolve the tension, that is, whether to reject autonomy-centric and neutral forms of liberalism or revise judgments about how public medical facilities should allocate healthcare, but instead I establish the point that one must choose between them.
Keywords: autonomy, healthcare justice, liberalism, medical treatments, neutrality, primary goods, rationing

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1. Introducing Liberal Principles as They Bear on Healthcare

It is commonly held that healthcare is a primary good. Not long after John Rawls published *A Theory of Justice*,[1] other thinkers[2] suggested that healthcare should have been included in the list of social primary goods or otherwise deemed to be "means necessary to attain human ends"[3] that the basic structure can substantially influence. If liberty,

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[1] Rawls (1971).
[2] E.g., Green (1976); Veatch (1981); Dworkin (2000); and for a recent instance in this journal see Gibson (2021): 18.
[3] Rawls (1975): 542–543.

wealth, and self-respect (what we more often call "self-esteem") are well construed as instrumentally useful for achieving a wide array of conceptions of the good life, so is healthcare. Rawls himself came to accept the friendly amendment, and in his last book, *Justice as Fairness: A Restatement*, grants that "health care….can (if necessary) be included in the index of primary goods."[4]

However, in this article I argue roughly that healthcare is not a primary good. More carefully, I show that, while many medical interventions are plausibly understood as consisting of the provision of general purpose means, this is not true for all the ones that are intuitively appropriate. There are some forms of healthcare that the state should surely offer citizens that are not well characterized as protections of autonomy, by which I mean the ability to choose one's own way of life, and that instead appear best justified as elements of a certain good life. This claim is an instance of a broader point that I aim to make here, namely, that strong intuitions about how the state ought to allocate healthcare are incompatible with influential strains of liberalism advanced by not just Rawls, but also Ronald Dworkin, Bruce Ackerman, Gerald Gaus, Joseph Raz, David Johnston, and many others in the post-war era. According to the cluster of political views that I target, the state must not take sides on which lives are good (or bad) when adopting policy or law, and instead should merely enable people to choose their own ways of life in an autonomous fashion. In this essay I show that if a state's sole aim were to protect rights—even positive ones—to live as we see fit, then public hospitals could not distribute medical interventions in uncontroversially acceptable ways, which are indeed often grounded on judgments of which lives are good (or bad) and do not particularly serve to foster autonomous choice.

I do not prescribe how to resolve the tension, that is, whether to reject autonomy-centric and neutral kinds of liberalism (albeit not liberalism as such) or to revise judgments about how public medical facilities should allocate healthcare. Instead, my aim is to establish the point that one must choose between them.

However, positing the tension does naturally invite one to doubt autonomy-centrism and neutrality as distributive ideals, and to do so for a new reason. Others have critically addressed whether these strains of liberalism—including egalitarian/redistributive variants—are compatible with public funding to promote the arts,[5] culture,[6] love,[7] knowledge,[8] virtue,[9] environmentalism,[10] and retribution.[11] The broad concerns have been that neutrality among conceptions of the good life or a strict focus on protecting rights to autonomy cannot account well for the intuitive contours of a just state policy in respect of these ends. In addition, such concerns have been raised by one theorist in the context of medical ethics, with Ezekiel Emanuel arguing that a commitment to neutrality renders adherents unable to determine how to treat a permanently mentally incompetent

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[4] Rawls (2001): 172.
[5] Feinberg (1994).
[6] Kymlicka (1989).
[7] Arneson (2003).
[8] Sher (1997).
[9] MacIntyre (2007).
[10] Vincent (1998).
[11] Metz (2007).

individual and how to limit medical services in the face of resource shortages.[12] After expounding the kinds of liberalism that are of interest in this essay (section 2), I extend Emanuel's insight to three additional facets of medical ethics, namely, which types of treatments should be offered to patients (section 3), how to prioritize among types of treatments (section 4), and who should receive a certain type of treatment (section 5). Beyond applying the point to new topics and with fresh argumentation, I also reply to major objections from Emanuel's key critics, aiming to provide all the more reason to believe that a state the sole aim of which were to protect (negative and positive) rights to autonomy, or that otherwise abjured basing policy on a conception of the good life (other than autonomy), could not offer the intuitively right medical interventions to its citizens.

I briefly conclude by discussing some next steps to take in respect of theorizing about healthcare justice, supposing the argumentation made here is sound (section 6). Regardless of whether one opts for a kind of liberalism less centered on autonomy or neutrality, on the one hand, or for an utterly non-liberal view altogether, on the other, it appears that a conception of just healthcare must include reference to certain objective goods beyond autonomy.

2. Liberalism, Autonomy, Neutrality

Here I clarify which variants of liberalism I will maintain fail to cohere with relatively uncontroversial judgments of how to allocate resources to patients at public medical institutions. It is not liberalism as such that faces this problem, but rather its forms that prescribe either a neutral constraint on state choice or a strictly autonomy-based aim for it, as analyzed below. Along the way, I point out that such understandings of liberalism have been influential, are prima facie plausible ways to capture liberal ideals, and hence are worth taking seriously.

The problematic sorts of liberalism include ones according to which the sole purpose of the state should be to protect the equal rights of (innocent[13]) persons to live autonomously, understood as the ability to adopt and pursue their own ways of life. An implication of this account of the state's proper final end is neutrality, the view that public policy and law must not be based on particular conceptions of the good life or of the bad life (at least any one other than autonomy[14]), instead serving the function of enabling citizens to choose the lives they see fit. If the only aim of the state should be to enable people to live as they judge best, then the state should not take sides between competing views of how to live otherwise, in the sense of striving to promote some over others or justifying state action on the basis of some and not others. However, one could hold a neutral constraint on state action for a reason other than a prior autonomy-centric aim, with some for example contending that it follows from a fair or impartial approach to political justification.[15]

[12] Emanuel (1991).

[13] By "innocent" I mean those parties not liable to defensive, corrective, or punitive force.

[14] Meaning that I take Raz's (1988) view, according to which the state must promote autonomy as constitutive of the best life, to be a target in this essay.

[15] For just two examples, see Larmore (1987); Barry (1995).

Some political philosophers explicitly advance both principles to a comparable degree, with John Rawls for instance advocating "full autonomy" as a political ideal[16] and also maintaining that a state must "satisfy neutrality of aim in the sense that basic institutions and public policy are not to be designed to favor any particular comprehensive doctrine,"[17] where a comprehensive doctrine is a philosophical conception of which lives are desirable and which are not. The early Ronald Dworkin also clearly holds both principles insofar as he posits that the proper "general aim of distribution" for a state is "satisfying the ambitions of each"[18] and moreover that "political decisions must be, so far as is possible, independent of any particular conception of the good life."[19]

In contrast, some self-described liberals tend to focus more on one principle than the other. For example, those who focus squarely on neutrality include Bruce Ackerman, Charles Larmore, Brian Barry, Gerald Gaus, and Jonathan Quong,[20] while straightforward defenders of autonomy, without much if any explicit support for neutrality, include Loren Lomasky, Joseph Raz, and David Johnston.[21] Below I aim to show that either principle is sufficient to make it difficult to accommodate intuitions about just healthcare. To accommodate them, I argue, we need conceptions of the good and specifically ones that transcend the category of autonomy.

My targets are thus certain views of when state action is just, views according to which, negatively, the state may not base policy and law on a particular conception (or conceptions) of the good and, positively, the state must instead base them on facilitating citizens' autonomy, construed as being able to adopt and pursue their own conceptions of the good. These views are common ground among a large array of liberals who otherwise have various disagreements. For example, as I have already alluded to, my targets include both libertarian and egalitarian/redistributive conceptions of liberalism; regardless of whether the state must protect only negative rights to autonomy or also positive ones, it will be difficult to show that it should provide the kind of healthcare that is intuitively just. For another example, my targets include both liberals who eschew any paternalism and those who would justify paternalism insofar as it would promote the beneficiaries' autonomy. Relatedly, my targets include those liberals who think in terms of state protection of rights to autonomy or respect for the capacity for it, on the one hand, as well as those who instead prescribe state promotion of autonomy as a final good, on the other. For a fourth and final example, my targets include those with a wide range of ultimate justifications for their conceptions of state action, e.g., whether they are ultimately grounded on a philosophically justified ethic or instead on what is widely taken for granted in certain societies.

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[16] Rawls (1993): 77–81.
[17] Ibidem: 194.
[18] Dworkin (2003): 32.
[19] Ibidem. See also Nozick (1974: esp. 48–51, 272–273); Richards (1989); and Rakowski (1993).
[20] Ackerman (1980); Larmore (1987); Barry (1995); Gaus (2003); Quong (2011).
[21] Lomasky (1987); Raz (1988); Johnston (1994). Sometimes the word "autonomy" is not used, but the concept is operative, e.g., in Lomasky's appeal to "personal projects" or Johnston's to being an "effective agent."

Beyond a neutral constraint on state action and an autonomy-centric aim for it being familiar and held by many who label their views "liberal," they are also well-motivated as able to capture salient dimensions of liberal thought. For instance, viewing the sole purpose of the state as the facilitation of autonomy neatly contrasts with: welfarist paternalism, aiming to stop people from making themselves worse off; moralism, concerned with reducing the extent to which people exhibit vice; and still other non-liberal views such as theocracy. By the same token, a state that must be neutral in respect of the good or bad life will not appeal to notions of what would make a person worse off, lack virtue, or be impious.

The characterization of liberalism in terms of the proper aim of the state, and then as what would enable all individuals to pursue their (permissible) self-chosen conceptions of the good life, also makes sense of the kinds of state action normally associated with liberalism. For example, it explains why a state must protect citizens from foreign invasion, on the one hand, as well as from domestic crimes such as murder, theft, kidnapping, and battery, on the other. Relatedly, both this characterization of liberalism and the neutral one account for why it would be unjust from a liberal standpoint to punish citizens for contraception or abortion, as they can be performed in ways that do not interfere with the ability of other persons to make autonomous decisions, while objections to such choices invariably appeal to a conception of the good or bad. Still more, an autonomy-centric state aim as well as the neutrality principle further entail that it would be unjust for a legislature to spend tax money distributing Bibles or to facilitate only heterosexual marriage.

With this analysis of liberalism, we can easily differentiate libertarian from egalitarian (redistributive) forms that are commonly distinguished. The former holds that the relevant rights to make autonomous choices are merely negative ones to be free from interference, while the latter maintains that, in addition to an array of negative rights, the state must also protect positive ones, where individuals are provided means, such as food, shelter, or education, that would enable them to make a wide array of choices. Friends of autonomy or neutrality who accept a major state role for redistribution favor the allocation of instrumental goods that would be useful for pursuing a wide array of visions of the good life or self-chosen ends. For salient examples, consider that John Rawls advocates the allocation of social primary goods,[22] Bruce Ackerman proposes manna (defined as that which "can be transformed into any of the familiar material objects"),[23] David Johnston suggests primary goods plus mental and physical powers,[24] and Ronald Dworkin prescribes resources,[25] all of which are meant to facilitate achievement of a wide array of goals selected by individuals as they see fit. What they all have in common is the idea that the relevant way for a state to fight poverty is not to enable people to live in certain desirable ways, but rather to enhance their ability to choose their own ways of life. What I do in this article is argue that this approach applied to healthcare has counterintuitive implications.

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[22] Rawls (1971, 1993).
[23] Ackerman (1980).
[24] Johnston (1994).
[25] Dworkin (2000).

The above motivations might tempt one to think that liberalism as such is well construed as the doctrine according to which the only just aim of the state is to protect people's equal rights to live as they see fit, thereby remaining neutral in respect of conceptions of the good.[26] However, there are other views reasonably entitled to the "liberal" label that do not fit this description. Broadly speaking, these exceptions include the claim that the state must protect an array of human rights while maintaining either that some of these rights are to live in objectively good ways or that, in addition to enforcing human rights, the state justly enables citizens to live in such ways if they choose. Martha Nussbaum's capability-based specification of minimum rights that the state must protect that would enable citizens to pursue objectively good human lives is the most salient recent instance of an approach to state action that merits the "liberal" label but is not neutral and does not solely prescribe the protection of autonomy (as defined in this essay).[27]

Although liberalism *simpliciter* is implausibly captured by the view that state action should aim only at protecting people's equal rights to live autonomously, such an interpretation, along with its neutral implication, have been enormously influential, capture much about liberal thought, and, at least for those with liberal sympathies, have done what appears to be a decent job of grounding judgments about the proper function of a state and its institutions. However, I now argue that these principles are incompatible with intuitions about how public medical facilities ought to allocate healthcare.

3. Which Treatments to Offer

In the rest of this essay, I consider how public medical facilities ought to make certain kinds of decisions in respect to patients. In the present section, I consider which kinds of interventions they should offer patients, and I argue that the autonomy-centric and neutral forms of liberalism from the previous section entail counterintuitive answers to the question.

If the sole legitimate goal of state action were to secure or enhance people's autonomy, then it could admittedly support many kinds of treatments that everyone agrees should be offered, supposing they accept the justice of some public healthcare system (and hence redistributive taxation) at all. As Immanuel Kant pointed out long ago, "(C)ultivating the *powers of the body*….is looking after the *basic stuff* (the matter) in man, without which he could not realize his ends."[28] Lung cancer, blindness, heart disease, sciatica, Alzheimer's, drug addiction, and agoraphobia all impair people's ability to reflect on, choose, and pursue a wide array of ends. In addition, as Rawls insightfully pointed out,[29] removing great pain counts as a primary good for a person, since when in great pain one is unable to deliberate about, revise, or realize a variety of goals; instead, a person's attention is all on the pain. Autonomy-centric liberalism can indeed entail that public hospitals ought to prevent and treat such conditions, and it provides a plausible explanation of why as well.

[26] The view suggested by a former self: Metz (2007, 2016).

[27] Nussbaum (2011). For broadly similar approaches, see Galston (1991); Arneson (2000); Metz (2024).

[28] Kant (1797): Ak. 445.

[29] Rawls (1988).

One readily sees why Rawls and other thinkers have been inclined to deem healthcare as such to be a primary good, that is, what assures people "greater success in carrying out their intentions and in advancing their ends, whatever these ends may be."[30]

The problem is that those entailments and explanations are insufficiently inclusive. There are a variety of medical interventions that virtually no one doubts the state ought to offer patients but that would be implausibly construed as primary goods or any other form of autonomy enhancement.

For a first batch, consider some body parts. Surely a public hospital ought to enable women to retain a breast. Of course, breast cancer can often spread to other parts of the body, but suppose for the sake of argument that it would not and further that it would affect only one breast. Even if only a single breast were at stake, the state ought to enable women to avoid having to undergo a mastectomy. In addition, supposing that one has lost a pinky toe or pinky finger from an accident, the state would be right to offer reattachment of the originals when feasible. Still more, if one had been born with a vestigial tail, it would be just for the state to offer to remove it. That is the case not just for adolescents who would face stigma upon sporting a tail in the gym locker room, but also for adults who no longer face substantial exclusion but still would like it detached.

Retaining, reattaching, and removing body parts need not involve or promote general purpose means, and yet are incontestably treatments that state medical facilities should offer. That claim about the just distribution of healthcare is in serious tension with a political philosophy according to which the only purpose of the state and its institutions should be to foster autonomous choice.

One might suggest that autonomy is in fact at stake in these cases, where individuals have set particular ends that would be harder to realize without (or in some cases with) the relevant body parts. A woman missing a breast would be somewhat less able to nurse a child, and it would be more difficult to play the clarinet without a pinky finger.

To respond, note first that this reply does not use the sense of "autonomy" that has been operative so far, viz., as the ability to reflect on, adopt, and achieve a wide variety of ends, not a very narrow range of ends. The reply equivocates, failing to align with distributive ends of primary goods, manna, powers, or resources, that is, general purpose means.

A tempting response to this point might be that what counts as autonomy ought to be widened. However, I argue that doing so would be poorly motivated. To begin to see why, consider that it would be impossible for a public hospital to offer literally all treatments that would enable individuals to achieve their respective and varied single ends. It might then be suggested that the hospital should offer treatments that would satisfy the greatest number of ends held by patients or accord with the decision of a democratic body. Norman Daniels suggests this sort of approach in response to Emanuel's claim that if "liberalism must be 'neutral' about competing conceptions of the good…. it cannot solve the termination of treatment problem" in respect of the permanently comatose, pointing out that "there may be an 'overlapping consensus' on some central features of what count as benefits and burdens, permitting at least a partial solution."[31]

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[30] Rawls (1971): 92.

[31] Daniels (1992): 42.

There may be and then there may not be. If not everyone agrees on what is good and bad in a medical context, then public policy would be held hostage to majoritarianism, with intuitive individual rights to important kinds of healthcare insufficiently recognized. After all, the highly ranked ends among most in a particular society might turn out to be, say, religious or idiosyncratic, e.g., orienting life around a certain shade of pink. (This problem would also plague a proposal to use a lottery to specify which of the massive variety of particular ends to satisfy.) This approach to how to deploy public medical resources no longer seems either liberal or plausible.[32]

There are some who would at this point deny that there should be public hospitals at all. For example, in response to Emanuel's claim that a neutral state could not determine how to treat a irreversibly mentally incompetent individual, Baruch Brody advocates a voucher system whereby people could choose private medical facilities as they accord with their various conceptions of the good.[33] Responding thoroughly to the prospect of such a large-scale institutional shift is beyond the scope of this essay, but I note that basing healthcare decisions merely on market demand would likely risk failing to secure legitimate objective interests of individuals in certain kinds of treatment, in the way I suggested above that basing them on the ends of a majority (or on a lottery) would.

Taking a public healthcare system for granted, then, the natural way to specify which ends it ought to facilitate would not be to base it on the numbers of people who seek them (or on a random procedure), but instead to consider their content. Nourishing an infant and playing an instrument are ends that merit public support, whereas enabling a majority to make everything a certain shade of pink as much as possible does not. At this point, though, we are unavoidably appealing to a conception of the good to make such judgments. We are now in the domain of capability theory, which explicitly invokes an ability to live an objectively desirable human life,[34] having departed from the domains of autonomy and neutrality.

Still more, it is worth noting that trying to rescue autonomy by prescribing medical treatments that would facilitate the achievement of particular ends contingently held by citizens does not even entail that the intuitively correct treatments should be offered. Suppose that, in lieu of the original pinky finger, the state could attach a shiny new robotic prosthesis in its place. Then, the patient would be able to play the clarinet to no less a degree. If "autonomy" construed as the ability to achieve the specific goal of playing the clarinet were what mattered, there would be no reason for public hospital to offer to attach the original finger if it could. However, I presume the reader will agree that it must be an option.

My aim in this essay is to show that certain strands of liberalism cannot account for intuitively correct healthcare decisions, not yet to provide an alternative theory that does better; however I point out here that the capacity to maintain bodily integrity

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[32] Another concern with this move is that, even if literally all members of a society shared a certain conception of the good that the state promoted, there would still be an intuitively illiberal injustice towards members of the next generation; their ability to choose their own ways of life would have been limited by the state pursuit of a particular way of life.

[33] Brody (1993).

[34] E.g., Nussbaum (2011).

would plausibly be a central element of one. That would hardly be conclusive, though, given the intuitive attractiveness of being able to remove a vestigial tail! There is much complicated work to be done elsewhere.

Let me instead offer another reason to think that it is worth searching for an alternative to autonomy-centric and neutral principles of state action in the healthcare sector, presenting additional intuitions that such an alternative would have to accommodate. A second batch of cases has to do with familial relationships, about which I maintain that some medical treatments appear justified as ways to facilitate not autonomy, but precisely such relations. For one powerful example, few doubt that the state ought to enable people to procreate if they are having difficulty. Public hospitals ought to help ensure that sperm counts are raised and eggs are dropped, when the owners of these gametes would like to reproduce.[35] In addition to treating bodily infertility, it would be apt for public hospitals to treat people suffering from mental illnesses that preclude romantic bonds. Such include those inclined to have sex with the dead or with humanlike dolls, as well as those with narcissistic or psychopathic tendencies.

There is a third, perhaps even more compelling cluster of intuitions indicating that appropriate healthcare is not always a function of protecting autonomy, understood as the ability to reflect on, adopt, and realize a wide variety of ends. Consider those suffering from extreme Alzheimer's to the point where self-consciousness is gone. Sometimes these human beings are in great pain, and, when that is the case, it is incontrovertible that a public hospital ought to do what it can to relieve them of it. Although relieving us of great pain would foster our autonomy, as Rawls has pointed out, relieving these individuals of great pain would not, since their capacity for any sort of self-governance or end-setting has been lost. Similar remarks regarding the aptness of palliative care apply to newborn infants, at least in those cases where their being in great pain would not be expected to impair the development of their capacity for autonomy down the road. They, too, surely merit pain relief, despite it not having any bearing on a person's ability to reflect on, revise, or adopt a broad array of ends.

Since neither creating children, acquiring a loving spouse, nor relieving the pain of non-persons consists of or promotes a general ability to pursue one's goals, an autonomy-centric liberalism cannot prescribe medical interventions designed to bring about these states of affairs. Yet few would doubt that public medical facilities ought to offer the interventions mentioned above, where many are straightforwardly justified as ways of making lives go better, not enhancing autonomy *qua* being able to evaluate, choose, and pursue a broad array of goals.

The two natural replies to make to many of these cases mirror the logic of those made to the first batch regarding body parts. First off, it is tempting to point out that

[35] Some liberals admittedly do "bite the bullet" when it comes to having to pay for the childcare of others, denying that tax money should be used for such a purpose. See, e.g., Rakowski (1993): 153; and Casal and Williams (1995). It is unclear whether they would take the further step of denying that public hospitals ought to help with the creation of children in the first place. For an in-depth treatment of the conflict between liberalism and a right to procreate, see Meijers (2020). He argues that liberalism can support such a right, but he appeals to conceptions of the good life to do so, ones that he describes as "thin" but that flout the logic of autonomy-centric and neutral kinds of liberalism.

insofar as patients have adopted the end of, say, procreating, a public hospital that went out of its way to realize such an end would indeed be acting for the sake of its patients' autonomy in a broader sense. In addition, those who care for Alzheimer's patients will surely have adopted the end of seeing them avoid great pain. It is not merely the provision of general purpose means that enhances autonomy of the relevant sort, but also the advancement of particular purposes, so goes the reply.

Again, though, the trouble with this response is that its logic "proves too much," that is, it entails that a public hospital ought to go out of its way to realize specific ends that it clearly should not. If protecting a right to autonomy meant that a public hospital ought to help realize any contingent end a patient might have, then, beyond enabling people to be devout Christians or orient their lives around a pink color, it should also, say, enable one to commit suicide when not suffering from an incurable, fatal, and horrific illness because one thinks that doing so will enable one to ride a UFO hiding behind a comet that will take one to Heaven.[36] Or it would also follow that a public hospital ought to offer plastic surgery to the already gorgeous who want to become downright stunning. It would moreover follow that a public hospital ought to graft hair onto people who want to become as much like werewolves as possible. Physicians would be well placed to advance these kinds of ends, but a public hospital would be unjust to deploy them to do so.

The second sort of reply to be made is that a state *qua* liberal could and should facilitate autonomy by advancing not idiosyncratic particular purposes of individuals such as killing oneself to get to Heaven, looking stunning, or becoming something of a werewolf, but rather ones that are widely shared in a society and so are the object of an "overlapping consensus." Since our society generally aims to enable women to retain their breasts, people to procreate, and human beings to avoid great pain, a state *qua* liberal ought to promote these ends and thereby advance citizens' autonomy, as opposed to much less widely shared ends. Perhaps what is required is *not* "that the state should be neutral with respect to all conceptions of the good life, but only with respect to those actually disputed in the society."[37]

However, as above, this move also "proves too much." If all or a very large majority of the populace had adopted the end of advancing Christianity, then there would be license for the state to fund churches, marry only heterosexuals, punish people for impiety, and put New Testament verses on its money. That's not liberalism; something has gone wrong.

At this stage, one might suggest that a distinction between therapeutic treatments and enhancements would be of service to the friend of autonomy. Therapeutic treatments are interventions undertaken to cure a disease or injury, while enhancements are done to improve the quality of a human life beyond the norm. Becoming even more gorgeous, looking like a werewolf, and purportedly going to Heaven would not count as therapeutic treatments, and nor would becoming more pious or better able to detect a shade of pink. Perhaps autonomy is relevant only insofar as the choice is among *therapies* that a public hospital would offer.

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[36] See the cult Heaven's Gate (https://www.history.com/this-day-in-history/heavens-gate-cult-members-found-dead).

[37] Larmore (1987): 67.

Below (in section 5) I in effect argue that even the concept of a therapy is value laden in a way that flouts the neutrality principle, but, here, I mount a different reply. Consider that autonomy-centric and neutral forms of liberalism are advanced as all-inclusive accounts of a just state action; they are meant to indicate why a certain kind of public institution should be created, viz., to protect and promote people's ability to choose a wide array of ends as they see fit, and how it ought to function, namely, without being designed to favor one (non-autonomy-centric) conception of the good over others and instead enabling people to critically judge, set, and achieve any number and sort of self-chosen conceptions. The argument on the table is that an additional autonomy-centric consideration to establish and guide a public institution is to help individuals or a society achieve their particular ends, whatever they happen to be, but the logic of this position does not easily prescribe a therapy/enhancement distinction in what a public hospital offers citizens, as either one might be the object of people's contingent goals. There is no reason *on grounds of autonomy* for a public hospital to offer only therapies.

4. How to Prioritize Among Treatments

Suppose that a public hospital has determined which treatments it shall offer to patients. A logical next step would be to consider how to prioritize among them, by which I mean ascertaining which treatments should be provided when not all of them can be. Again we see that autonomy-centric and neutral forms of liberalism prima facie appear to ground a sensible answer to this question, but, upon reflection, are vulnerable to serious counterexamples.

On the face of it, considerations of autonomy do well when it comes to ranking treatments. Surely people's lives should above all be saved, at least when those rescued from death would not lose their personhood by remaining in a vegetative state for the rest of their lives. After that, it would be reasonable to treat substantial memory loss, where a particular person is at risk of forever disintegrating (setting aside the debate about whether it would count as her "death"). Next in line is plausibly treating addiction to a drug such as cocaine or heroin, which substantially stunts the ability to make reasoned decisions. Then would seem to come preventing the loss of a limb, where the inability to use an arm or a leg would greatly impair one's ability to pursue an array of ends. Lastly we sensibly put things such as chronic halitosis and alopecia, which, if they are to be treated at all, should be treated only if the other ailments listed above had been attended to, plausibly since their effect on end-setting is minimal by comparison.

So far so good for the friend of autonomy-centric liberalism. However, there are some treatments that should be ranked highly despite not having much of a bearing on our ability to choose from a variety of conceptions of the good. Of course the treatments mentioned in the previous section trivially count as precisely that; if my argumentation is sound, then autonomy-centric and neutral kinds of liberalism cannot entail that they should be offered at all by a public hospital, beyond failing to give them much of a priority. More revealing at this point, therefore, would be treatments that would have some bearing on our capacity for free choice but should be prioritized out of proportion to that.

For a first example of such a treatment, consider the senses of smell and taste. I accept that losing these senses would affect our autonomy. Beyond of course no longer being able to achieve ends pertaining to experiencing pleasant scents and tastes, reports from those who have suffered such losses are well-known for indicating a tendency towards a less vibrant life. However, my intuition is that preventing or correcting the losses of smell and taste would be more important than their reduction of autonomy would suggest. I am inclined to rate doing so as of comparable importance to treating loss of limb or addiction, conditions that involve noticeably greater reductions of autonomy than the sensory disability considered here.

A second example concerns the loss of limb. Suppose that the state were indeed able to offer a shiny new robotic prosthesis in place of a leg or an arm. Imagine further that this prosthesis would in fact be in some straightforward senses "better" than the original—it would be stronger, faster, more agile, and less prone to damage. Then, on grounds of autonomy, the provision of prostheses should be prioritized, at least before, if not altogether instead of, the protection or reattachment of the original limbs. I submit, though, that the priority should be provision of the original limb, even if that would mean a somewhat reduced ability to realize one's ends by comparison with a prosthesis.

For a third sort of case, consider those who are presently unable to empathize and sympathize with others in any robust manner. They have difficulty imagining what it is to be like another person and, consequent to that, feeling something of the same kind and degree as what this person feels. Of course ends that involve the participation of (*via* consideration for) other persons would usually be more difficult to achieve with such emotional deficits. However, suppose that our subject were good at not only apprehending information about other people's feelings, but also feigning sympathetic responses to them. So, although he cannot easily put himself in another person's shoes, he can readily detect from another's face that she is in pain, and although he does not himself then feel something of the pain, he adeptly acts as though he does. Supposing such cognitive-behavioral props were available, no social-related ends need be forsaken, meaning that an autonomy-centric kind of liberalism would prescribe randomizing between perfecting them and undertaking psychological interventions that would make more feeling accessible to the patient. I presume the reader agrees with me, however, that the latter is what should be offered in the first place; something like the former would be apt only if the latter did not work.

Fourthly, think about which to prioritize between a person who will suffer a fate worse than death, on the one hand, and someone who will face death, on the other. In the former case, we imagine that the person is in horrific pain that would unavoidably continue in the absence of medical intervention. In the latter, we suppose that he or she simply has some very high chance of passing away in their sleep. If a public hospital could not afford to treat both at the same time with current available resources, which should it pick? On grounds of autonomy, one should randomize, since being in great pain and dying are both equivalent in respect of the inability to reflect on, adopt, and pursue a wide array of ends. Or perhaps there is some slight reason to prevent one from dying in his sleep, since the one in agony could presumably still do *something*. However, my intuition is that priority should go to the one in agony. Preventing a fate worse than death that lasts indefinitely must come before preventing death, so it is natural to maintain.

In response, it is tempting to suppose that Rawlsians and those like them could appeal to the primary good of self-respect or what we instead tend to call "self-esteem." To have self-esteem in the present context means judging that one's self and one's plans are worthy and having confidence in one's ability to carry them out. Rawls revealingly argues in *A Theory of Justice* that self-esteem, so construed ("self-respect" in his terms), is vital to being an autonomous chooser, indeed labelled "perhaps the most important primary good."[38] It is reasonable to suggest that those who were to lose their senses of smell and taste as well as those offered a prosthesis in lieu of an original limb would suffer some substantial losses of self-esteem and hence have their ability to live autonomously reduced.[39]

There are two problems with this move. For one, it applies only to the first two cases, and does not apply to the cases of psychopathy or agony, which are left untouched. For another, even in respect of the first two cases, the response does not satisfy. Suppose that, upon losing the senses of smell and taste as well as being offered only a prosthesis to replace a lost arm, one were prescribed a pill that would effectively impart self-esteem. Then, no loss of autonomy would be expected. However, I presume the reader agrees that first choice should still be to protect those senses and the original limb.

5. Who Should Receive a Treatment

At this stage, we presume that a public medical facility has determined which treatments it shall offer to patients and has also developed a list for how to prioritize them. We now imagine that, despite the ranking of treatments, there is still scarcity such that not everyone can receive the most highly ranked sorts. With a very large majority of the field, I focus on the need to ration life-saving treatments such as kidney dialysis and organ transplants. Supposing that not all lives can be saved, which ones should be saved in the context of a state funded hospital?

The way I answer this question differs from the way I answered the previous two questions about the just allocation of healthcare. In the other sections, I advanced specific kinds of treatments that I expected readers to find intuitively rightly provided by a public hospital and that fail to cohere with the views that the state's sole aim should be to protect people's ability to live as they see fit and that its institutions may not be oriented to foster certain conceptions of the good/bad. In contrast, in this section I do not indicate exactly which lives should be saved when not all can be. Instead, my strategy amounts to showing that any plausible principle one might invoke to answer the question of how to ration life-saving treatments appeals to a conception of the good life, a move that autonomy-centric and neutral forms of liberalism imply is unjust.

To start, consider the following four widely invoked principles that bear on the question of which life to save in a situation when not everyone's life can be saved. First off, there is the principle that public resources ought not be spent saving a life that would not be worth living. Second, there is the principle that one should favor the person who would have the most quality adjusted life years (QALYs), where the quality is construed in

[38] Rawls (1971): 396.

[39] Inspired by DeGrazia (1991).

terms of subjective well-being, that is, the positive *experience* of a healthy life. Third, there is an appeal to the dignity of human life to prescribe randomizing which life to save, say, with a lottery or on a first-come, first-served basis. Fourth, there is the principle that those with dependents such as children should be saved before those without such attachments, the idea being that it is right not to let die the one whose death would cause more harm.

What is striking about these familiar principles for rationing life-saving treatments is that they wear value judgments on their sleeve. They all involve some (contested) view of what is good or bad in a life. A life worth living, a quality of life, a superlative non-instrumental value (dignity), and a harmed condition (in the sense of one that is badly off) each involves the sort of appraisal that autonomy-centric and neutral kinds of liberalism instruct the state to avoid making. A focus on protecting autonomy implies that the state ought to be neutral among competing conceptions of the good and bad, with a strict focus on enabling people to choose and pursue their own such conceptions. However, it appears that salient principles that might be invoked in a public medical setting to decide which lives to save are shot through with conceptions of what is good and bad.

There are two responses to consider, one prima facie more forceful than the other. The weaker response is to invoke other principles that might be used but that are obviously incomplete. For example, autonomy-centrism is consistent with the view that those responsible for needing their lives saved should not have their lives saved, if doing so would come at the cost of death for those who were not responsible for needing their lives saved. Roughly, non-smokers should be rescued from lung cancer instead of smokers, supposing not all can be rescued. For another example, it might be consistent with autonomy-centrism to save the lives of those who had made great sacrifices for others, perhaps out of gratitude or fairness to the sacrificer or as a way to encourage autonomy-protecting sacrifices on the part of others. My claim is not that these are implausible principles, but that they are too limited; there are many situations in which they simply would not apply and a choice would still have to be made between lives at risk.

The stronger response, at least on the face of it, is to appeal to principles about how to ration life-saving treatments that appear both to be fairly broad in scope and to avoid a value judgment. These include the principle that one should favor the person who would have the least disability-adjusted life years (DALYs), where disability consists of the absence of health. Also relevant here is the "fair innings" principle, stating that those who have already lived a sufficiently long and healthy life should not be saved if doing so would come at the cost of death for those who have not yet lived a sufficiently long and healthy life. It is perhaps not surprising that Kantians such as Daniels[40] have appealed to the fair innings principle, as it appears to be neutral toward conceptions of the good. Although that principle is limited, as there will still be hard choices to make among the class of persons who have not yet had long and healthy lives, the criticism I want to focus on is different and more interesting at this stage.

The criticism takes the form of a dilemma. Either health is a non-instrumental good or it is not. If it is, then, despite the apparent neutrality of an appeal to health, doing so in fact consists precisely of invoking a conception of what is finally good in life. If it

[40] Daniels (1988); cf. Dworkin (2000): 314–315.

is not, and health is instead well understood in value-free terms such as what is normal for a human being, then advancing health so construed still would not be equivalent to protecting autonomy.

As for the first horn, it is enormously plausible to think that health is something good for its own sake and moreover that it merits pursuit at considerable cost to other goods. The "normative" understanding of what health essentially is, in terms of a weighty final value, has been extremely influential in the philosophy of medicine. Such a reading (along with the normative view of disease as what is bad in itself) captures certain compelling intuitions more easily than the "naturalist" understanding, a value-free construal of health in terms of statistical regularity or characteristic biological function (as well as disease as what is abnormal). For example, supposing that homosexuality is not an illness, that judgment is much more readily captured by the normative understanding of health than the natural one; for homosexuality is statistically irregular and not a characteristic biological function. Insofar as it is plausible to judge health to be a non-instrumental good (and disease a non-instrumental bad), then even the DALY and fair innings principles can be seen to appeal to conceptions of what is good (and bad) in life.

Suppose, though, that the naturalist understanding of health were correct, such that both health and disease can be adequately captured without value judgment and in merely descriptive terms. If to be healthy were simply a matter of normality, then, although protecting health would not flout the neutral principle, it would continue to flout an autonomy-centric form of liberalism all the same. Why? Because promoting health *qua* what is normal for human beings is not the same as protecting their autonomy. We need merely return to some earlier cases to drive the point home: retaining a breast or a pinky toe would be to maintain health *qua* statistical regularity or characteristic biological function but not to facilitate the ability to make a wide array of choices.

I conclude that even those principles that appeal to health as the way to determine which life to save when not all can be saved are inconsistent with an autonomy-centric sort of liberalism. Either health is a final value or it is mere normality, and, either way, promoting health is not identical to protecting people's ability to live as they see fit or act in accordance with their own conceptions of the good.

6. Concluding Remarks on Some Ways Forward

Recall that the aim of this article has been to indicate that one has to choose between influential and prima facie powerful versions of liberal political theory, on the one hand, and intuitions about how to allocate healthcare justly, on the other. I have not indicated which choice to make, but I close with some reflections on how to go about that.

I confess that I find some of the counterexamples to autonomy-centric and neutral kinds of liberalism pretty compelling—surely, a public hospital must relieve the agony of an Alzheimer's patient, despite no prospect of enhancing her (or anyone else's) autonomy, and indeed it must prioritize such treatment to boot. However, I do not suppose that this case is sufficient on its own to reject those sorts of liberalism. Perhaps its other variants (see note 27) or non-liberal views face even more weighty counterexamples, for all that has been said here.

What is true is that the more often we were to encounter these kinds of counterexamples in a range of fields, the more reason there would be to doubt autonomy-centric and neutral versions of liberalism. If there were important facets of, say, providing education, supporting the arts, and protecting nature that are also difficult to conceive of as ways of protecting or enhancing autonomy, then the case for seeking an alternative political philosophy would become fairly strong.

What that alternative might look like is an enormous question. A thoughtful answer would require appraising a principle of the proper ends of state action in the light of its implications for a large range of policies, including education, environmentalism, healthcare, welfare programs, and so on. A more limited goal, attainable in the shorter term, would be to consider a principle that looks attractive for healthcare settings. The sorts of cases advanced in this article suggest trying to develop an objective alternative to subjectivist appeals to preference satisfaction or QALYs. I have not tried to do that here, but a natural next step would be to make headway on that project. Concretely, what, if anything, do the above counterexamples to autonomy and neutrality have in common? Can the ability to avoid great pain, to procreate, to retain one's original body parts, to lose a vestigial tail, to be able to smell and taste, to sympathize with others, and to be romantically intimate with persons all be plausibly conceived of as various manifestations of a single property? Many of these are well construed as objective final goods, and, so, is there one aspect of non-instrumental value they all manifest or must we instead be pluralists? If the argumentation here has been approximately true, these are some of the next important questions to answer in order to find a political philosophy that coheres with intuitions about the just distribution of healthcare.

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