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The sufficiency theory of justice and the allocation of health resources

Dick Timmer

Institut für Philosophie und Politikwissenschaft, Technische Universität Dortmund, Dortmund, Germany

Correspondence
Dick Timmer, Institut für Philosophie und Politikwissenschaft, Technische Universität Dortmund, Dortmund 44227, Germany.
Email: dick.timmer@tu-dortmund.de

Abstract

According to the sufficiency theory of justice in health, justice requires that people have equal access to adequate health. In this article, I lay out the structure of this view and I assess its distributive implications for setting priority (i) between health needs across persons and (ii) between health care spending and other societal goods. I argue, first, that according to the sufficiency theory, deficiency in health cannot be completely offset by providing other societal goods. And, second, that it can prevent the medicalization of societies by stressing that improvements beyond the level of adequate health have relatively little weight, if any, from the standpoint of justice.

KEYWORDS
distributive justice, health, health care, sufficientarianism, threshold

1 | INTRODUCTION

According to the sufficiency theory of justice in health (from now on: "sufficiency theory"), justice requires that people have equal access to adequate health.[1] In this article, I lay out the structure of the sufficiency theory and assess its distributive implications for setting priority (i) between health needs across persons and (ii) between health care spending and other societal goods. My aim is clarificatory rather than justificatory. I do not defend any particular version of this view, and I will assume that a threshold for adequate health can be justified as a matter of health care justice.[2] Instead, I focus on conceptualizing and examining the family of views that fall under the umbrella of sufficiency theories of health justice and on assessing how such views can be most plausibly understood.

This article is structured as follows. In Section 2, I lay out the structure of the sufficiency theory, which, I argue, consists of a health threshold and three types of allocative principles. In Section 3, I examine the distributive implications of the sufficiency theory for setting priority between health needs across persons.

[1]See also Schramme, T. (2019). *Theories of health justice: Just enough health*. Rowman & Littlefield International; Fourie, C., & Rid, A. (Eds.). (2017). *What is enough? Sufficiency, justice, and health*. Oxford University Press; Wouters, S., van Exel, N. J. A., Rohde, K. I. M., Vromen, J. J., & Brouwer, W. B. F. (2017). Acceptable health and priority weighting: Discussing a reference-level approach using sufficientarian reasoning. *Social Science & Medicine*, *181*, 158–167; Schramme, T. (2015). Setting limits to public health efforts and the healthisation of society. *Zeitschrift Für Menschenrechte*, *9*(2), 50–68; Powers, M., & Faden, R. R. (2006). *Social justice: The moral foundations of public health and health policy*. Oxford University Press. On the sufficiency theory more generally, see Shields, L. (2012). The prospects for sufficientarianism. *Utilitas*, *24*(1), 101–117; Casal, P. (2007). Why sufficiency is not enough. *Ethics*, *117*(2), 296–326. This article focuses on the distributive dimensions of justice in health. For discussion and a relational egalitarian paradigm, see Voigt, K., & Wester, G. (2015). Relational equality and health. *Social Philosophy and Policy*, *31*(2), 204–229.

[2]We can distinguish at least five possible justifications for the sufficiency theory, namely that (1) securing basic needs is particularly urgent, Freiman, C. (2012). Why poverty matters most: Towards a humanitarian theory of social justice. *Utilitas*, *24*(1), 26–40; Shields, op. cit. note 1, p. 115; Casal, op. cit. note 1, pp. 304–305; that (2) an impartial spectator would recommend sufficiency, Crisp, R. (2003). Equality, priority, and compassion. *Ethics*, *113*(4), 745–763; that (3) sufficiency is required to participate as an equal in society, Anderson, E. (1999). What Is the point of equality? *Ethics*, *109*(2), 287–337; that (4) sufficiency is necessary for human dignity, Nussbaum, M. C. (2000). *Women and human development: The capabilities approach*. Cambridge University Press; or that (5) sufficiency is simply preferable to or assumed in alternative distributive principles, Timmer, D. (2022). Justice, thresholds, and the three claims of sufficientarianism. *Journal of Political Philosophy*, *30*(3), 298–323. Here, I do not take a stance on which (if any) justification holds but I will simply assume that a justification can be given.

I distinguish three possible aims of such views: (i) maximizing the number of people who have equal access to adequate health (I refer to this as "headcount sufficiency"), (ii) benefitting people who lack equal access to adequate health (I refer to this as "nonheadcount sufficiency"), or (iii) headcount sufficiency *and* nonheadcount sufficiency. In Section 4, I examine the distributive implications of the sufficiency theory for setting priority between healthcare spending and other societal goods. In particular, I argue that, according to the sufficiency theory, deficiency in health cannot be completely offset by providing other societal goods. Moreover, I argue that the sufficiency theory curtails the medicalization of societies, which refers to the inflation of health as a personal value, by stressing that improvements beyond the level of adequate health have relatively little importance from the standpoint of justice, if any.[3] Section 5 concludes.

2 | THE SUFFICIENCY THEORY OF JUSTICE IN HEALTH

The sufficiency theory of justice in health consists of two elements, which together establish the distributive implications of justice as equal access to adequate health.[4] The first element is the *health threshold*, which specifies the point at which someone has *adequate health*.[5] Having adequate health is good because it promotes one's well-being and contributes to one's participation as an equal in society, among other things. But sufficiency theories typically say that adequate health is also intrinsically good, meaning that it is good for its own sake.[6] Part of what is valuable about adequate health is explained by the fact that having adequate health is valuable in and of itself.[7] Put differently, justice is concerned with adequate health because of the value of adequate health as such and because of the goods that adequate health provides access to.

My analysis of the sufficiency theory will assume that a health threshold can be identified. But identifying the threshold for adequate health is a major source of disagreement, and the stakes in identifying it are high.[8] The threshold is directly relevant to determining what health justice requires. It is also relevant to the political and economic challenge of controlling escalating healthcare costs. If the threshold is set too low, then healthcare costs will be well controlled. However, health justice would be seriously compromised because anything above that threshold would have much less moral weight, meaning that access to needed health care above that threshold would depend on ability to pay or some kind of charitable response. On the other hand, if the threshold is set too high, healthcare justice might be well served, but healthcare costs would escalate uncontrollably, meaning that other important social goods would be underfunded. In some cases, this would result in significant injustices, even if they are not health-related injustices. The threshold for adequate health, then should be neither too low nor too high.

Three further questions about the threshold for adequate health merit attention. First, there is disagreement on what "health" and related concepts such as "disease" denote precisely.[9] For example, some stress that health is a biostatistical norm of organismic functional ability, and that disease is a subnormal deviation from that norm. Others focus on health as the positive evaluation of a person's bodily and/or mental condition and consider disease to be a negative evaluation thereof. Advocates of the sufficiency theory have proposed different examples of such a threshold. Here, I follow the account of Thomas Schramme, who defends that sufficiency theory should be embedded in a more general conception of what it means to live a "decent life."[10] He argues that "sufficientarianism in public health should be modest in its aims and only promote the provision of necessary means for general health-related basic needs."[11] This view is embedded within a minimalist understanding of the general purpose of welfare states, which is "to demand the inclusion of every citizen into society."[12]

Second, we must ask whether the sufficiency theory is concerned with *adequate health* or *equal access to adequate health*.[13] The sufficiency theory is compatible with both outcome ("adequate health") and opportunity-oriented ("equal access to adequate health") specifications of sufficiency. Here, I will assume that it is concerned with equal access to adequate health. This could mean various things, such as that there is an adequate supply of the resources necessary for adequate health, or that there are no financial, social, or cultural barriers to acquiring the resources necessary for adequate health.[14]

[3]Schramme, op. cit. note 1, pp. 96–98, refers to this as "healthization".

[4]Alternatively, Fourie, C. (2017). The sufficiency view. A primer. In C. Fourie & A. Rid (Eds.), *What is enough? Sufficiency, justice, and health* (pp. 11–29). Oxford University Press, pp. 16-25, distinguishes the (1) currency of sufficiency; (2) positive and positioning claims; (3) justifications for sufficiency principles; (4) weighting rules; (5) setting sufficiency thresholds; and (6) scope of sufficiency. I discuss (1) and (5) under the header of the "health threshold." I believe (2) and (4) are best captured under the label of "allocative principles." I do not take a stance on (3) and (6).

[5]This analysis draws on my conceptual framework of threshold views in Timmer, D. (2021). Thresholds in distributive justice. *Utilitas*, *33*(4), 422–441; see p. 424 for a graphical representation of threshold views. The sufficiency theory could also specify multiple thresholds, see Gustavsson, E., & Juth, N. (2019). Principles of need and the aggregation thesis. *Health Care Analysis*, *27*(2), 77–92; Ram-Tiktin, E. (2017). Basic human functional capabilities as the currency of sufficientarian distribution in health care. In C. Fourie & A. Rid (Eds.), *What is enough? Sufficiency, justice, and health* (pp. 144–163). Oxford University Press.

[6]I say "typically" because some sufficientarians might reject that adequate health is intrinsically valuable. They might say that if intrinsic value is not necessarily weightier than instrumental value, and if the array of ways in which health has instrumental value is so rich, a sufficiency theory provides distinctive and valuable guidance even without seeing health as having intrinsic value. I thank a reviewer for this point.

[7]On the intrinsic value of sufficiency, see Shields, op. cit. note 1, p. 106. On the special moral urgency of sufficiency, see Davies, B., & Savulescu, J. (2020). From sufficient health to sufficient responsibility. *Journal of Bioethical Inquiry*, *17*(3), 423–433.

[8]For discussion, see Schramme, op. cit. note 1; Fourie, Rid, op. cit. note 1; Schramme, T. (2016). The metric and the threshold problem for theories of health justice: A comment on Venkatapuram. *Bioethics*, *30*(1), 19–24.

[9]See Murphy, D. (2021). Concepts of disease and health. *The Stanford Encyclopedia of Philosophy*. https://plato.stanford.edu/archives/spr2021/entries/health-disease/; Schramme, op. cit. note 1, pp. 1–32; Khushf, G. (2007). An agenda for future debate on concepts of health and disease. *Medicine, Health Care, and Philosophy*, *10*(1), 19–27.

[10]Schramme, op. cit. note 1.

[11]Ibid: 112.

[12]Ibid: 116.

[13]I thank a reviewer for urging me to clarify this.

[14]See Gulliford, M., Figueroa-Munoz, J., Morgan, M., Hughes, D., Gibson, B., Beech, R., & Hudson, M. (2002). What does 'access to health care' mean? *Journal of Health Services Research & Policy*, *7*(3), 186–188.

I will also assume that people should have "equal access" to adequate health rather than mere "access," because the latter would allow for significant inequalities in access to adequate health. The reason for defending an opportunity-oriented principle over an outcome-oriented principle is that it leaves more room for individual freedom and responsibility regarding health.[15] However, my analysis of the sufficiency theory does not depend on this. Advocates of sufficiency might equally well defend an outcome-oriented principle, saying that justice requires that people have "adequate health" (or some adjacent notion) rather than "equal access to adequate health."

Third, as I understand the view, the sufficiency theory is agnostic between specific ways of promoting equal access to adequate health, such as by publicly funding and providing treatments, buying medicinal products and medical equipment, investing in the development of new technologies, by offering free meals or providing education in nutrition and lifestyle, by interventions in work, infrastructure, and housing, and so forth.[16] Health outcomes at specific points in time and over the course of someone's life are determined by nonhealthcare goods from birth to death, and from local to global processes and institutions.[17] And so, what is required to keep individuals and populations at a certain level of health is not an input-once scenario but requires constant efforts. The sufficiency theory maintains that such efforts should be directed at pursuing equal access to adequate health.

The second element of the sufficiency theory is its *three allocative principles*, which specify how resources should be allocated. First, *(non-)headcount principles* specify how to allocate resources *between* the ranges above and below the threshold.[18] Headcount principles maintain that resources should be distributed so that as many people as possible have equal access to adequate health (or that as few people as possible lack equal access to adequate health).[19] Such headcounting seems plausible in triage cases but is controversial for higher thresholds.[20] Nonheadcount principles, on the other hand, hold that how *many* people have equal access to adequate health is not of particular relevance to justice. Instead, what matters when allocating resources above and below the threshold is benefitting those who lack equal access to adequate health. Rather than maximizing the number of people who have equal access to adequate health, a nonheadcount principle can focus benefitting those furthest away from having equal access to adequate health or on minimizing the total deficiency below the threshold.

Second, *range principles* specify how resources above *or* below the health threshold should be allocated. One range principle applies below the threshold whereas another range principle applies above it. A common sufficiency view is that the allocation of resources below the threshold should give weighted priority to those furthest away from that threshold, but that above the threshold justice is indifferent about the allocation of resources (the so-called "negative thesis").[21] But sufficiency theories can adopt other range principles as well.[22]

One might wonder why a sufficiency theory should be concerned about health *above* the health threshold. If justice requires equal access to adequate health, why do we need a range principle to tell us how to allocate resources among those who meet that threshold? Sufficientarians who endorse the negative thesis, for example, can say that justice is indifferent about the distribution of resources among those who have equal access to adequate health.

However, an example by Paula Casal suggests that a sufficiency theory cannot be entirely indifferent to how resources are allocated among those above the health threshold:

> suppose that having provided every patient with enough medicine, food, comfort, and so forth, a hospital receives a fantastic donation, which includes spare rooms for visitors, delicious meals, and the best in world cinema. If its administrators then arbitrarily decide to devote all those luxuries to just a few fortunate beneficiaries, their decision would be unfair.[23]

Not all sufficiency theorists will agree with Casal that it would be unfair to arbitrarily decide to provide these luxuries to a few beneficiaries. Some might say, for example, that it is not a matter of justice to whom the luxuries are provided, as long as all patients have equal access to adequate health. But if one agrees with Casal that the distribution of such luxuries is a matter of justice, this raises the question how resources above the health threshold should be distributed. More generally, if health improvements beyond the threshold for adequate health are possible (which is a reasonable assumption if, as I have argued above, the threshold should not be too high), and if such improvements matter from the standpoint of justice, then sufficiency theories must be concerned with how resources are allocated above the health threshold. To be sure, this does not mean that the allocation of resources among those above that threshold is as important to justice as the question whether others can reach the health threshold. But in some circumstances, it may be an important question nonetheless.

[15]For discussion, see Davies & Savulescu, op. cit. note 7, pp. 423–433.

[16]See Schramme, op. cit. note 1, p. 118.

[17]For example, see Braveman, P., Egerter, S., & Williams, D. R. (2011). The social determinants of health: Coming of age. *Annual Review of Public Health*, *32*, 381–398.

[18]Davies and Savulescu, op. cit. note 7, p. 426, distinguish "headcount sufficientarians" and "weighted sufficientarians" and hold that the weighted view can give the interests of those below the threshold either absolute or weighted priority. However, this analysis neglects (i) that headcounting might be given absolute *or* weighted weight as well (Timmer, op. cit. note 5, pp. 435–439; Wouters, van Exel, Rohde, Vromen, Brouwer, op. cit. note 1, pp. 164–165); and (ii) that sufficiency theories can combine headcount sufficiency and nonheadcount sufficiency (see Section 3). Hence, there is an important difference between (non-)headcount principles, specific range principles above and below the threshold, and priority principles. Therefore, their distinction is better described as the distinction between "headcount sufficiency" and "nonheadcount sufficiency," which leaves open the range principles and the type of priority accorded to (non)headcounting.

[19]See Fleck, L. M. (2017). The insufficiency of the sufficiency principle in health care. In C. Fourie & A. Rid (Eds.), *What is enough? Sufficiency, justice, and health* (pp. 223–243). Oxford University Press.

[20]See Shields, op. cit. note 1, pp. 102–103; cf. Timmer, op. cit. note 5, pp. 435–439.

[21]As Casal, op. cit. note 1, p. 298, puts it, the negative thesis denies "the relevance of certain additional distributive requirements" above the threshold.

[22]See Wouters, S., et al., op. cit. note 1, pp. 164–165.

[23]Casal, op. cit. note 1, p. 306.

Third, *priority principles* specify which distributive aims have priority in cases of conflict.[24] Such conflicts may arise, for example, if we can provide a few more people equal access to adequate health or bring many people closer to that threshold; if we can provide health-related benefits to a few people without equal access to adequate health or to many people above that threshold; or if we have to choose between additional spending on health care and other societal goods.[25] Priority can be specified in various ways.[26] The view that is commonly attributed to the sufficiency theory is that benefitting people below the health threshold has absolute priority over benefitting people above that threshold. However, such benefits might also have weighted rather than absolute priority, in which case equal access to adequate health typically but not necessarily outweighs providing health-related benefits beyond that point.[27]

The sufficiency theory, then, says that justice requires that people have equal access to adequate health (or some adjacent notion). And it specifies allocative principles that say how resources should be distributed in light of that commitment. This gives us four axes along which sufficiency theories might differ. First, they can disagree on the relevant *threshold*. Second, they can disagree on whether *headcounting* is a relevant consideration. Third, they can disagree on the *range principles* above and below the threshold. And fourth, they can disagree on the type of *priority*, both between considerations regarding justice as equal access to adequate health, and between sufficiency in health and other societal goods. Given that the sufficiency theory can be specified along these different lines, it is more accurate to speak of it not as a single view but as a family of views. Members of this family all hold that there is a health threshold that should play an important role in the allocation of resources. But they differ in how they specify this threshold and the allocative principles.

3 | SETTING PRIORITY BETWEEN HEALTH NEEDS ACROSS PERSONS

The first role that the sufficiency theory can play in the allocation of resources concerns the allocation of resources across persons. It can be concerned with two distinct goals (or both):[28]

> **Headcount sufficiency**. The allocation of resources should provide equal access to adequate health for as many people as possible.
>
> **Nonheadcount sufficiency**. The allocation of resources should optimally benefit those lacking equal access to adequate health, where what is "optimal" is specified by the range principle below the health threshold.

Let me examine headcount sufficiency and nonheadcount sufficiency in more detail. Headcount sufficiency refers to maximizing the number of people who have equal access to adequate health. Leonard Fleck, for example, says that the sufficiency theory maintains that "the goal of justice is to bring as many people as possible up to that sufficiency threshold."[29] If we recall the distinction between three types of allocative principles, namely (non)headcount principles, range principles, and priority principles, it becomes clear that sufficiency theories which aim to maximize the number of people that have equal access to adequate health give strong priority to a headcount principle.

Headcounting is closely linked to a specific set of allocative cases, namely *triage cases*.[30] For example, shortages of adequate medical resources in the COVID-19 pandemic have given rise to numerous "triage protocols," which determine how resources must be allocated during public health emergencies.[31] Triage cases are also relevant when health emergencies occur due to natural disasters or acts of terrorism, among other things. In such cases, headcount sufficiency seems to be a particularly compelling distributive principle. Moreover, elsewhere I have argued that if a threshold is intrinsically valuable for people to reach (which sufficiency theories are committed to if they hold that having adequate health is valuable in and of itself), then we should attach distinct weight to people reaching the threshold.[32] This means that sufficiency theories should attach at least *some* weight to providing equal access to adequate health for as many people as possible, even outside of emergency cases where triage seems particularly suited.

Subsequently, nonheadcount sufficiency refers to optimally benefitting those lacking equal access to adequate health. What this requires depends on the range principle below the threshold, meaning that nonheadcount sufficiency can take various forms. For example, it could pursue a distribution in which the weighted interests of people below the threshold must be balanced according to some prioritarian function. But it could also mean that the total amount of "insufficiency" below the threshold is minimized. To illustrate, if the threshold is set at 10, the first proposal would

[24]See also Timmer, op. cit. note 5, p. 431.
[25]See Schramme, op. cit. note 1, p. 56; see also Section 4.
[26]See Timmer, D. (2023). Weighted sufficientarianisms: Carl Knight on the excessiveness objection. *Economics and Philosophy*, *39*(3), 494–506; Davies & Savulescu, op. cit. note 7, p. 426; Fleck, op. cit. note 19, p. 226; Fourie, op. cit. note 4, pp. 22–23.
[27]See Ram-Tiktin, op. cit. note 5, pp. 144–163; Shields, op. cit. note 1, pp. 101–117. Gustavsson and Juth (op. cit. note 5, pp. 77–92; for a similar idea, see Timmer, op. cit. note 22, pp. 494–506; in Timmer, D. (2024). Intergenerational justice and freedom from deprivation. *Utilitas*), *36*, pp. 168-183, I defend a two-threshold view which applies weighted priority above and below each threshold, but gives absolute priority to benefits below the low threshold compared to above the high threshold.
[28]See also Fourie, op. cit. note 4, p. 18. If sufficiency is about "adequate health" rather than "equal access to adequate health," the two distinct goals read as follows: *Headcount sufficiency*. The allocation of resources should bring as many people as possible at or above the health threshold. *Nonheadcount sufficiency*. The allocation of resources should optimally benefit those below the health threshold, where what is 'optimal' is specified by the range principle below the threshold.
[29]Fleck, op. cit. note 19, p. 226.
[30]Note that in such cases, "adequate health" rather than "equal access to adequate health" might be the most salient sufficientarian concern.
[31]See Iacorossi, L., Fauci, A. J., Napoletano, A., D'Angelo, D., Salomone, K., Latina, R., and Iannone, P. (2020). Triage protocol for allocation of critical health resources during the COVID-19 health emergency. A review. *Acta Bio Medica: Atenei Parmensis*, *91*(4), e2020162.
[32]See Timmer, op. cit. note 5, pp. 435–439; Timmer, op. cit. note 26, Sec. 2.3.

arguably prefer distribution *C*(5,8,8,8) over distribution *D*(3,9,9,9) because *C* gives more weight to the worst off. Instead a range principle aimed at reducing the total amount of insufficiency prefers *D* over *C* because the total insufficiency in *C*(11) is higher than in *D*(10).

Finally, headcount sufficiency and nonheadcount sufficiency could be combined into a single view. Wouters et al. propose something along those lines when they say:

> Drawing on our own analysis above, a hybrid with both prioritarian and sufficientarian elements may assign higher priority weights to people who are worse off than to people who are better off, in line with prioritarianism, and give additional weight to people below a sufficiency threshold and an additional weight to people who are lifted from below to above the threshold, like sufficientarianism.[33]

I believe the "prioritarian" and "sufficientarian" elements of their view can be adequately captured by the structure of the sufficiency theory I have proposed. The view that they propose defends prioritarian range principles both below and above the health threshold, which assign higher priority weights to people who are comparatively worse off. Moreover, they defend a headcount principle which gives additional weight to lifting people from below to above the threshold. And finally, they give additional weight to benefits below the threshold, meaning that sufficiency in health has priority over benefitting those above the health threshold.

This view leaves open what priority principle applies to the headcount principle. Given that they advocate a sufficiency theory, maximizing the number of people above the threshold will outweigh benefits above the health threshold, all else being equal. But is headcount sufficiency more, less, or equally valuable as nonheadcount sufficiency? They do not address this question, but a fully fleshed out account of justice as sufficiency in health must take a stance on this.

Let me make two general comments about headcount sufficiency and nonheadcount sufficiency. First, both headcount sufficiency and nonheadcount sufficiency are compatible with a wide variety of range principles above the threshold, such as the negative thesis or other principles that apply above the health threshold.[34]

Second, headcount sufficiency and nonheadcount sufficiency may have radically different implications for the allocation of resources. Suppose the health threshold is at 10 and we must choose between distribution *A*(1,10) and distribution *B*(9,9). In that case, *A* maximizes the number of people who have equal access to adequate health, whereas, arguably, *B* optimally benefits those lacking equal access to adequate health. Whether headcount sufficiency or nonheadcount sufficiency is more plausible here depends on what the threshold denotes. For example, if the threshold denotes the difference between life or death, then headcount sufficiency is preferable to nonheadcount sufficiency. But this need not be the case for higher thresholds.

Hence, if the sufficiency theory is a criterion for setting priority between health needs across persons, it can focus on providing equal access to adequate health for as many people as possible, on optimally benefitting those lacking equal access to adequate health, or both.

4 | HEALTHCARE SPENDING AND OTHER SOCIETAL GOOD

The second role that the sufficiency theory of health justice can play in the allocation of resources concerns the prioritization between healthcare spending and other societal goods (e.g., infrastructure, education, housing, and safety.).[35] The sufficiency theory says that there are particularly strong reasons to consider equal access to adequate health as an important goal when allocating resources between different societal goods. Because many determinants of health, such as people's social, economic, and physical environment, education, and income, directly affect other societal goods, we can often promote *both* equal access to adequate health and other societal goods. However, this is not always the case, and the sufficiency theory offers guidance in how to prioritize between health-related concerns and other societal goods in cases of conflict.

There are two cases where resources should be allocated to societal goods other than equal access to adequate health.[36] First, our reasons to increase the health care spending might be outweighed by other concerns. Because resources are scarce, not all societal goods can be maximally provided, and trade-offs between societal goods are necessary. Second, we may lack justice-relevant reasons to increase the healthcare spending. Those who endorse the negative thesis, for example, hold that this is the case when claims to resources are made to improve health above the threshold for adequate health. This is because according to the negative thesis, justice is indifferent about the allocation of resources above the threshold.

I want to highlight two implications of the sufficiency theory in the allocation of resources between societal goods. First, it typically maintains that people have intrinsic and weighty reasons for having equal access to adequate health. This implies that at least some of what renders equal access to adequate health valuable cannot be substituted by providing other societal goods.[37] Allocating resources to, say, education, social security, or safety, may also be valuable, but

[33]Wouters et al., op. cit. note 1, p. 164.

[34]For discussion, see Gustavsson & Juth, op. cit. note 5, pp. 77–92; Fourie, op. cit. note 4, pp. 18–20; Ram-Tiktin, E. (2012). The right to health care as a right to basic human functional capabilities. *Ethical Theory and Moral Practice*, *15*(3), 337–351.

[35]See Fourie, op. cit. note 4, pp. 22–23; Schramme, op. cit. note 1, pp. 73–74.

[36]See Ibid: 69.

[37]This argument might hold even if a sufficiency theory does not see health as having intrinsic value (see footnote 6). If the array of ways in which health has instrumental value is rich and weighty, this equally suggests that deficiency in health cannot be substituted by providing other societal goods.

it does not offset insufficient access to adequate health. This does not mean that equal access to adequate health should always outweigh these other concerns. It also does not mean that these other societal goods are less valuable than equal access to adequate health; in fact, they may be *more* valuable. However, it does mean that lacking equal access to adequate health cannot be fully compensated for by having more access to or provision of other goods.

Second, the sufficiency theory might curtail the medicalization of societies, which, as Schramme defines it, refers to the inflation "of health as a personal value" in which case, people may be "criticized or deemed irrational if they attach a relatively lower value to health."[38] According to the sufficiency theory, the reasons to promote equal access to adequate health are particularly weighty. In line with this, Schramme argues that the sufficiency theory provides a minimal conception of justice, which focusses on sufficiency rather than improving individual or population health above that point.[39] The aim of the sufficiency theory is *satiable*, meaning that its requirements can be completely met.[40]

Here, we must distinguish between two ways in which the sufficiency theory might curtail the medicalization of societies. First, proponents of the *negative thesis* hold that justice is indifferent about health inequalities above the health threshold. The implication of this is that once no further improvements toward equal access to adequate health are possible, there are no justice-relevant reasons for providing further healthcare improvements.[41] This does not mean that health improvements would be impossible beyond this point nor that there are *no* reasons for desiring them. It only means that such improvements have no weight from the standpoint of justice. There is an internal stoppage point to the pursuit of individual health, namely, the point at which equal access to adequate health is provided.

Second, advocates of sufficiency who reject the negative thesis can still maintain that the reasons to promote health beyond the health threshold are significantly less weighty than the reasons to provide equal access to adequate health. As I have defended elsewhere, one of the core claims of the sufficiency theory in distributive justice is that we should prioritize benefits below the threshold over other benefits, which may or may not be benefits in that specific metric (e.g., health).[42] The benefits below the threshold have priority over benefits above the threshold, but they must *also* be weighed with benefits in other metrics. This also prevents medicalization, not because of some internal stoppage point to the pursuit of health, but because of a shift in the moral weight of health improvements once people have equal access to adequate health. Above that point, improvements in health will be much easier outweighed by improvements in other societal goods, provided these other improvements have sufficient weight from the standpoint of justice.

Let me illustrate this with an example. Consider a society that must allocate resources between two important goods: education and healthcare. This society has a bundle of resources that can be converted into *health resources* if they are used to promote health-related goals and *educational resources* if they are used to promote goals relevant to education (e.g. making education accessible to everyone, etc.). Now let us assume that the sufficiency theory is concerned with maximizing the number of people that have equal access to adequate health ("headcount sufficiency"). Let us assume, furthermore, that educational justice is solely concerned with providing equal access to education and that we can disregard any other justice-relevant goods.[43] In that case, there are three aims that must be balanced, namely, (i) headcount sufficiency, (ii) improving health above the health threshold, and (iii) providing equal access to education. What the sufficiency theory says is that the importance of headcount sufficiency is significant, whereas the importance of improving health above the health threshold is much less weighty. For this reason, under the assumption that providing equal access to education is relatively weighty, the conversion of resources into health resources or educational resources must take into account the comparatively little weight that providing benefits above the health threshold has. If resources are scarce, this too prevents the medicalization of society. Equal access to adequate health is a weighty moral concern, but health improvements beyond that point are much less weighty, meaning that they are easily outweighed by other societal goods.

5 | CONCLUSION

In this article, I have examined the sufficiency theory of justice in health, according to which justice requires that people have equal access to adequate health. I argued that two elements make up the core of this family of views: a health threshold and allocative principles. Drawing on this conceptual framework, I argued that the sufficiency theory is concerned with headcount sufficiency, that is, providing equal access to adequate health for as many people as possible, and/or nonheadcount sufficiency, that is, optimally benefitting those lacking equal access to adequate health, where what is "optimal" is specified by the range principle below the health threshold. I argued that lacking equal access to adequate health cannot be completely offset by providing other societal goods. And I argued that the sufficiency theory can

[38]Ibid: 96.

[39]See Ibid: 53-56; 116-123.

[40]See Nielsen, L. (2019). Sufficiency and satiable values. *Journal of Applied Philosophy*, *36*(5), 800–816.

[41]However, the sufficiency theory might take into account the risk of people falling below the health threshold. See Kanschik, P. (2015). Why sufficientarianism is not indifferent to taxation. *Kriterion—Journal of Philosophy*, *29*(2), 81–102.

[42]Timmer, op. cit. note 2, pp. 298–323.

[43]On justice and education, see Brighouse, H., & Swift, A. (2009). Educational equality versus educational adequacy: A critique of Anderson and Satz. *Journal of Applied Philosophy*, *26*(2), 117–128; Anderson, E. (2007). Fair opportunity in education: A democratic equality perspective. *Ethics*, *117*(4), 595–622; Satz, D. (2007). Equality, adequacy, and education for citizenship. *Ethics*, *117*, 623–648.

prevent the medicalization of societies by endorsing the negative thesis or by stressing that improvements beyond the threshold for adequate health have relatively little importance, if any, from the standpoint of justice. However, because on any sufficiency theory equal access to adequate health (or some adjacent notion) has significant moral weight, the demands of justice as sufficiency in health will always be significant.

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ORCID

Dick Timmer http://orcid.org/0000-0002-0337-3369

AUTHOR BIOGRAPHY

Dick Timmer is assistant professor at TU Dortmund University. He works in political philosophy and ethics, with a particular focus on distributive justice, climate ethics, and moral status.

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