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THE POLITICAL ETHICS OF HEALTH

DANIEL WEINSTOCK
CRÉUM

ABSTRACT

This paper seeks to provide an overview of some of the main areas of debate that have emerged in recent years at the interface between theories of justice and health care. First, the paper considers various positions as to what the index of justice with respect to health ought to be. It warns on practical and principled grounds against conceptual inflation of the notion of "health" as it appears in theories of distributive justice. Second, it considers how various standards according to which goods ought to be distributed in a just society apply to debates within health care.

RÉSUMÉ

Le présent article vise à fournir un aperçu de certains des principaux débats qui ont émergé ces dernières années entre les théories de la justice et la réflexion sur les soins de santé. L'article examine tout d'abord des arguments qui prennent position sur la définition de la justice dans des contextes de santé. Une mise en garde se fondant sur des motifs pratiques et théoriques est ensuite émise à l'encontre d'une inflation conceptuelle de la notion de « santé » telle que celle-ci apparaît dans les théories de la justice distributive. L'article examine en second lieu comment divers standards relatifs à la redistribution juste des biens s'arriment aux débats en soins de santé.

INTRODUCTION

A sea change has occurred in the preoccupations of health ethicists in recent years. Whereas medical ethics had previously been dominated by discussions of micro-level decision-making contexts, be it in the area of clinical ethics (e.g. at what point is the line of “medical futility” crossed in the case of patient x?), research ethics (e.g. how do we ascertain that the consent provided by research subject x meets the standard of free and informed consent?) and distributive justice (should limited medical resources be provided to patient x or patient y), there is a move to macro-level ethical-philosophical discussions of the broader institutional and political contexts against the backdrop of which these questions are set (Anand, Peter and Sen, 2006).

The move to a more political approach to health ethics has been due to a number of factors. First, it has become increasingly obvious that micro-level ethical decision-making contexts are heavily constrained by broader institutional contexts. When ethical reflection focuses on the former rather than the latter, there is the risk that the real determinants of decisions escape ethical scrutiny (Cribb, 2005).

Second, a number of factors have contributed to researchers taking an independent interest in the politics of health. Pressures that are increasingly being brought to bear upon publicly funded health systems such as Canada’s, and the continued inability of more market-driven systems like the United States’ to respond adequately to the medical needs of their members, have promoted much reflection on the requirements of justice in the area of health-care, and the relationship between the value of justice and that of efficiency (Faden and Powers 2006). Other macro-level contexts have also captured the ethical imagination of researchers. For example, it has become clear that the concepts of “health” and “illness” far from being objective, scientific, “value-neutral” notions, are heavily invested with often unspoken cultural and moral assumptions that need to be unearthed and discussed.

Ethical scrutiny must also be devoted to a number of crucial political issues: for example, what are the “drivers” of medical and biotechnological research, and what *should* these drivers be? Or again, what role should the public have in shaping policy in the area of health care, and what form should public participation and consultation take?

This paper seeks to provide an overview of some of the main areas of debate that have emerged in recent years at the interface between

theories of justice and health care. It is by no means exhaustive. It merely seeks to identify some main lines of discussion, and to trace their interrelations. The hope is that researchers will be able to use it as a springboard to identify and pursue new research avenues, or to deepen existing lines of inquiry.

WHAT IS HEALTH ?

Many institutional and political debates have to do with the ethically best ways in which to distribute health, or at least the resources that are necessary in order to access health. Lurking in the background of these discussions are taken-for-granted conceptions of what health *is*. The direction that these debates take, and to a degree the conclusions that they arrive at, are driven by these tacit conceptions. An example to fix ideas: if what is meant by health is simply the absence of serious illness, then the requirements of fairness in the allocation of health-care resources will be quite different, and potentially significantly less onerous, than they would be were health to be thought of more ambitiously as requiring a certain level of social, psychological and physical thriving.

The move towards a more socially and politically reflective health ethics has given rise to a greater awareness among health ethicists that the very *definition* of health is not an ethically innocent exercise. Almost all theorists agree that health is a multi-dimensional concept, and so definitions of health involve in part decisions about what to prioritize among the goods included within the range of the term. And given the importance that health has on the public policy agenda, including (or excluding) a good from the purview of health has an impact on the relative priority which the good will enjoy relative to other public policy objectives. There are therefore strong incentives to “overload” the concept of health to have it cover just about every item on the public policy agenda. We therefore cannot look for an “objective”, “scientific” conception of what health is, and then spell out the ethical implications of that conception. Ethics is always already present in our definitions of health, and so debates about how to understand health are already full-bloodedly ethical debates.

Two criteria are standardly invoked by participants in this debate in order to help organize the search for an adequate definition. Unfortunately, these two criteria pull in different directions, militating for quite different understandings of what health is. First, there is an appreciation that conceptions of health should be *inclusive*, and

should capture all of the phenomena that are commonly taken in ordinary language as belonging to the area of health. Health according to this criterion involves “normal” human functioning along the diversity of dimensions that characterize human agents. So health connotes physical well-being, but also to some degree psychological, cognitive and emotional well-being as well.

On the other hand, there is a concern among theorists working at the interface between theory and public policy that our conception of health be *operational*. If health is something that must be distributed equitably, then we must have some way of *counting* increments of health, lest our deliberations about how various regimes of allocation are performing in delivering health give rise to hopelessly indeterminate judgments.

It is important to note that concerns of operationalizability have an irreducibly ethical dimension. It is not just being able to *count*, but also of laying the groundwork for ethically *accountable* judgments in matters of allocation. According to theorists who emphasize the importance of a conception of health being operationalizable, judgments about relative advantage in the area of health will be irredeemably subjective and impressionistic unless health statuses can be ranked cardinally, as identifiable quanta.

If we imagine conceptions of health as ranging on a continuum, the two poles of which are represented by these two criteria, we can organize conceptions of health that can be found in the present literature as emphasizing these two criteria to greater and lesser degrees. At one extreme, we would find maximally capacious conceptions, that essentially equate health with *well-being*. The WHO definition would be a fairly good example: according to its 1946 constitution, health is to be understood as “a state of *complete physical, mental and social well-being* and not merely the absence of disease or infirmity” (my emphasis).

At the other extreme lie the kinds of quantitative conceptions that attempt to reduce all aspects of health to some meta-value in terms of which they can all be given quantitative expression. Quality-adjusted life years (or QALYs, disability-adjusted life years (or DALYs), and other such measures belong to this family.

Both types of extreme conceptions appear problematic when viewed from the point of view of the other. A partisan of a conception of health focused on the operational will tend to find broader conceptions hopelessly amorphous, conceptually confused, and difficult to

use, whereas those who defend inclusive conceptions will accuse conceptions based around a unit of measurement reductive, and untrue to the full range of phenomena that we commonly include under the rubric of health.

It is important to see however that both kinds of extreme conceptions are vulnerable to other criticisms as well, ones that do not depend upon taking the rival criterion for granted. Excessively capacious conceptions risk bundling together things that perspicuous judgment would require that we distinguish. For example, it is important from within a public health framework that we be able to maintain a distinction between health on the one hand, and determinants of health on the other. Though this distinction is contestable and possessed of fuzzy edges (is teenage pregnancy a health problem, or is it for contingent reasons causally correlated to such problems?), it is essential that it not be done away with entirely within a conception of health that is excessively inclusive.

There are other reasons to resist overly inclusive conceptions of health, aside from their tendency to make judgments and decision-making more difficult. For example, given the urgency that is in modern societies associated with claims made on the public policy agenda on the basis of health, conceptions of health that attempt to make too many claims that might be made on behalf of individuals or groups matters of *health* risk paradoxically undercutting this urgency. The urgency associated with health claims requires that health be circumscribed in a manner that justifies its priority relative to other public policy goals. If all public policy objectives can be folded into health due to an overly inclusive definition, this priority is no longer possible. This is so both for the conceptual reason that an excessively broad conception of health makes prioritizing difficult, and for the pragmatic reason that subsuming too many policy goals under the rubric of health risks, as it were, devaluing the currency of health both among policy-makers and in the public generally, and squandering the sense of urgency that is traditionally associated with policy issues connected to health.

Problems associated with reductive conceptions such as QALYs and DALYs are also legion. The idea that all states of health and illness can be uncontroversially expressed in terms of a single unit of measurement remains unvindicated. Methodologies employed by researchers in order to give quantitative expression to all dimensions of health often rely upon collecting the impressions of health-care

professionals, and so they do not avoid the charges of impressionism and imprecision that bedevil more inclusive conceptions, or they do so only superficially, by producing the appearance of precision.

What's more, concerns have been raised that the kinds of calculation that these highly operationalizable conceptions lend themselves to are deaf to considerations of justice between individuals. They tend to be used in the context of aggregating, maximizing exercises that do not pay much attention to *distributional* issues. (This point will be returned to below).

So we seem stuck in a dilemma. On the one hand, we want the conception of health with which we operate to capture all the phenomena that should be associated with health, even if they do not end up constituting a tidy bundle unified by some overarching meta-value that might ultimately be quantifiable. On the other, we want, for ethical reasons to do with accountability, to be able to make determinate judgments about what policy levers are most efficacious in generating health, and this requires that we be able to make fine-grained comparisons.

One way of softening the dilemma is for each family of conceptions to take on board the criticisms that are, as it were, independent of the rival conception. So, for example, even someone who wants no part of an excessively "scientific" conception of health will have to agree that it is important for a broader conception not to become so broad as to hide from view important distinctions. The distinction between health and social determinants of health seems in particular an important one to hang on to. Now, it is far from being an easy distinction to get a clear grasp of. Intuitively, it seeks to capture the difference between states that *constitute* morbidity or that *inevitably lead to* morbidity, on the one hand, and ones that only *constitute* or *contribute* to ill health given certain cultural and institutional decisions made by particular societies. Thus, to return to a classic example, teenage pregnancy, while it represents a normal functioning of the human reproductive system, correlates highly with health problems given broad civilizational decisions that have been taken over time as to the appropriate age for procreation.

Though the distinction is intuitively clear, it becomes elusive when particular cases are examined. As with many distinctions, it probably operates more like a continuum than like a stark dichotomy, and where particular states will lie will probably not be a matter that can be settled with scientific certainty. But the fact that the distinction is

elusive should not hide the fact that such a distinction does exist. And the awareness of such a distinction should guard against excessively inclusive conceptions of health. It might also throw critical light on the normative approach favored by CCN PPS. Indeed, though it is important that attention be drawn to areas of public policy such as education, housing, and the like that have an impact on health but that have a hard time making it on to the policy agenda because they are perceived as lying at a distance from health, it is also essential that the claims made on behalf of these areas be backed up by plausible causal accounts that allow for the measurement of impacts upon health, *narrowly construed*. Thus, it is important even for the partisan of a capacious conception of health, and of the reach of health policy, not to lose completely from view a more narrow conception that targets states that would be considered as indicators of health given *any* mode of social organization or cultural context.

Defenders of a quantitative conception of health must on the other hand also be reflective about the limits of their own favored conceptions. In essence, they must recognize that an easily quantifiable state *should* not in virtue of its ready quantifiability be deemed to belong to the core conception just alluded to. To put it bluntly, just because you can measure something doesn't make it important. They must also recognize the limits of any attempt to bring certain states into the ambit of quantification. The method that consists in polling health-care professionals so as to obtain a consensus of the degree of disutility associated with different states risks smuggling professional and class prejudice into what is then presented as resulting from the application of a scientific, "objective" methodology. Finally, they must recognize the "value-ladenness" of all seemingly objective measurement methods. All measurement tools carry assumptions about what to measure and how to measure it, and about ways of effecting trade-offs (Asada, 2007). These assumptions are not value-free, but rather bring with them normative assumptions that are by their very nature contestable.

Thus, far from being polar opposites, the richer, more inclusive conceptions of health, and narrower, more quantifiable ones depend upon one another to a significant degree for their plausibility. A more capacious conception must be able to give more than simply an impressionistic account of causal impacts of social determinants of health upon health, but to do this they must presuppose a core conception, impacts upon which can at least to some degree be meas-

ured and ranked. And defenders of a narrow conception must acknowledge that elements of a broader conception might form part of a more narrow conception even when they are not readily quantifiable, and that attempts at bringing them into the sphere of quantification carry highly value-laden assumptions, ones that must be discussed and validated, lest they play themselves out unnoticed by those that make use of them.

It would be a mistake to expect that we might be able to come up with a conception of health that best corresponds to some independently existing state. Clearly, the decision to adopt this or that conception of health is just that – a decision. And it is one that is governed by normative considerations. We ask ourselves: “what are the advantages, ethical and otherwise, to adopting one conception rather than another?” Among the ethical considerations that need to be taken into account, the impact of our conception of health upon distributional issues looms large. It is to the range of issues surrounding distributive justice in the area of health that we now turn.

WHAT IS JUSTICE IN HEALTH CARE ?

1

Distributive justice, that is the study of the principles that should govern the distribution of resources in a just society, has been a central part of post-war political philosophy. A limitation of philosophical debates on distributive justice is, however, that they have been abstract, in the sense that less attention has been paid to the manner in which particular goods such as health, education, housing and the like should be allocated, than they have to the more general question of what the general goal of resource distribution (and redistribution) should be, and the general principles according to which such distribution should occur.

Two questions have been at the heart of debates about distributive justice. First, philosophers and other theorists have been in disagreement about what the *goal* of distributive justice should be. Along what dimension should individuals be compared in order to determine whether justice obtains between them, and what is it that should be redistributed between them when there are found to be injustices? As the Nobel-Prize winning economist Amartya Sen pithily put it some years ago, equality is a laudable ideal, but equality of what? (Sen 1980).

A second question has to do with the *criteria* according to which distributions should be assessed. Should a just society aim at strict equality? What place should be given to individual's own responsibility in determining how well or poorly they will do? In other words, the first question has to do with *what* the goods are that public policy ought to aim for the equitable distribution of. The second question has to do with the *manner* in which the good (or goods) in question ought to be distributed.

With respect to the first question, we can identify a spectrum of positions. At one extreme lie positions that we might term “libertarian”, according to which a just society is one that ensures that basic civil and political rights are in place for all members of society, but that leaves the distribution of material resources, including health care, housing, education, and the like, entirely up to the market (Nozick, 1974). The basic moral impetus at the heart of such positions is anti-paternalism. Individuals should on this view be able on the basis of their own preferences and values to determine how to make use of their resources. In the area of health, for example, libertarians believe that the operation of a just society's institutions will give rise to the creation of an insurance market that will present health “consumers” with a full range of options among which they can choose in order to best fit their circumstances. Different people value health differently among the range of goods toward which they might want to direct their resources. Some are highly risk-averse, and might want to choose comprehensive coverage. Others might have high tolerance for risk, and may choose differently. Again, different people discount the future at different rates. Some ascribe a high priority to the satisfaction of present preferences, while others are more sensitive to the need to make provision for the satisfaction of their future preferences. There are a range of differences among individuals that reflect their different values, and it is on this view just and appropriate that people be able to make choices even within the domain of health care that reflects their legitimate differences. That this way of distributing the good in question will give rise to inequalities is to be expected, and to some degree, desired, for these inequalities are simply a reflection of the different weights attached by different individuals to different goods.

More reflective libertarians recognize that there will inevitably be areas of market failure. The public nature of certain goods, that is

the fact that people cannot be excluded from them once they are produced (security and clean air are among the most important public goods) means that the market will not produce them reliably. If such goods are to be had at all, the state must produce them, or at the very least incentivize their production by private actors. In their view, the market will not necessarily resolve all coordination problems, which is why the state is seen by some as having an ineliminable role to play in setting up institutions that will produce and distribute goods efficiently (Heath, 2001).

Many libertarians have also accepted that a concern for the future freedom of children must to some degree dictate that the state pay for the educational system. Indeed, though they recognize that different parents may value education differently, their choices have an impact upon determinate others, namely children. Even the fairly minimal state that libertarians privilege requires that the state prevent harm being done by some to others. This justifies in the eyes of some philosophers and economists, otherwise quite confident in the market's ability to allocate goods equitably and efficiently, a responsibility on the state's part to see to the equitable distribution of goods, such as education, pertaining to the welfare of children (Friedman 1962, Lomasky 1987).

Moving along the spectrum, we find theorists who believe that the libertarian's emphasis on choice is defensible only against a background of fair distributions of resources. It is on their view very well to celebrate individuals' ability to determine how they will lead their lives according to their preferences, but fairness only obtains if individuals have equal access to resources with which to make these choices and attempt to bring them to fruition. A just society should therefore according to this second view distribute resources fairly.

Talk of resources is still quite abstract, and the question therefore arises of what the resources are that a just society ought to distribute fairly. According to the most influential formulation of this position, that of John Rawls (1971), there are three distinct kinds of resources, called "primary goods", that ought to be at the heart of a society's institutions of distributive justice. These are goods that any rational person would need, no matter what particular choices she would then go on to make as to how to lead her life.

Let me elaborate the Rawlsian perspective a bit further. First, there are the civil and political liberties that libertarians, as we have seen,

had viewed as exhaustive of the domain of justice. It is clear that these have to be distributed equally. Second, there are material resources, that Rawls equates to money. In Rawls' highly influential view, a just society should not aim to distribute material resources equally. Nor however should it allow the market simply to allocate resources. Rather, distribution of material resources should satisfy what he called the "difference principle": material inequalities should be allowed if they improve the material situation of the least well-off. In other words, if allowing the luckiest or most talented members of society to benefit from their luck and talent creates incentives that end up creating more resources for everyone, including the least well-off, then these inequalities are deemed acceptable, and may even be required.

Finally, in Rawls' view, members of a just society should benefit from fair equality of opportunity. Opportunities are understood as access to desirable roles and positions. A just society should ensure that all have an equal chance at such roles and positions, and it should also attempt to neutralize those circumstances that tend to "tilt the playing field" in ways that give some people more of a chance to access these positions, even when formal equality of opportunity obtains.

While Rawls' formulation of the resource-centered position has been enormously influential, it does not provide clear guidance on the question of how particular resources ought to be distributed. Though Rawls' theory marks an important advance in political philosophy in that it integrates the thought that there are a diversity of types of goods to be distributed by a just society, talk of "rights and liberties", "resources", and "opportunities" remains quite abstract, at a significant remove from particular goods such as education, health, and the like.

That Rawls' theory underdetermines the way in which particular goods can be distributed can be appreciated by looking at debates couched within a Rawlsian vocabulary, that have attempted to draw conclusions in specific policy domains from the abstract theory. For example, it might be argued that education is the type of good that falls entirely under the purview of the "difference principle". To the extent that the private funding of education increases the total amount of resources available to the educational system, and that the ensuing surplus is used in a manner that ensures that the least well-off

are as well-off as they can be as compared to any other system, then justice would seem to permit, perhaps even to require, a two-track educational system.

Others have however argued that the “correct” Rawlsian principle under which to place the resource of education is the principle that seeks to ensure real equality of opportunity (Weinstock 2007). Indeed, it could be argued that educational equality is so central to the ability of a society to ensure equal opportunity that it should constitute a central public policy objective, even if in so doing we end up decreasing the total amount of resources available to the system, and even if the least well-off find themselves in absolute (though not in relative) terms less well-off than they would under an appropriately designed two-track system.

In the area of health, similar disagreements can be observed. The most influential extrapolation of Rawls’ resource-based theory into the area of health care has been due to Norman Daniels (1995). In Daniels’s view, health care should be thought of within the Rawlsian framework as intimately connected with the idea of fair equality of opportunity. Differentials in health matter because they can lead to people having quite radically different opportunity ranges. Health care provision should be aimed at people being possessed of roughly equal ranges of opportunities. Note that this does not require that people have equal access to health care. The goal of fair equal opportunity might very well be attainable without equal access to health care. There may in Daniels’ view be threshold effects at work here. That is, it could be that equal opportunity is attained as long as all members of society have secure access to an adequate level of care. Additional increments of care may be subject to marginal diminishing utility, at least as far as access to opportunity is concerned.

It is important to note that in his recent reformulation of his theory (Daniels 2007), Daniels has moved away from thinking of the *distribuans* in the area of health as being health *care*. Instead, he has argued that a just society should be concerned with all of the social determinants of health, and not fetishize those institutions that explicitly deliver health services. This much more inclusive conception of what justice in the distribution of health-related resources involves comes close to affirming that a just society is a healthy society. By adopting a maximally inclusive view of what is involved in producing health, Daniels has arguably reduced the theory of justice in the allocation of health resources to a theory of justice, *tout court*.

Resource egalitarians have been criticized, most notably by Amartya Sen (1999) and by Martha Nussbaum (2000), for being insufficiently sensitive to the differences between individuals’ capacities to transform resources into functionings. In their view, we care about the kinds of resources that are at the heart of Rawls’ view because of what they allow us to do. Yet different individuals will, because of social or personal circumstance, be quite differently situated in their abilities to make use of the resources with which they are provided in order to develop their capacities. The view developed by Sen and Nussbaum is therefore that what ought to be allocated fairly is not just resources, but capabilities. When people have an adequate range of capabilities, they will be able on the basis of their values and preferences to choose to actualize some capabilities rather than others into actual *functionings*. If a just society is one that seeks to provide individuals with the wherewithal required to conceive of and to actually be able to carry out a life worth living according to their own lights, then we should aim to distribute capabilities fairly, not just resources.

The capabilities approach has been embraced quite widely in the area of public health and of international development. At the same time, it must be recognized that its implications for the distribution of health care are quite indistinct. Should health be viewed, in a more limited manner, as among the circumstances that allow people to extend the range of their capabilities? In this case, the logic would be quite similar to that which we have already seen in Daniels’ case. Distributive justice would require that individuals be provided with health care resources to the point that they have adequate sets of capabilities. Or, alternatively, should adequate ranges of capabilities – cognitive, physical, emotional – be viewed as part of health? These two alternative ways of drawing Sen and Nussbaum’s theory out into the area of health have quite different policy implications. The first, as in Daniels’ original way of formulating his project, can be satisfied by the relatively modest goal of removing inequalities in access to health care that act as obstacles to fairness in the allocation of sets of capacities. The second is much more ambitious, and would require that a just society view the attainment of a full range of capabilities across the full range of human experience as in itself an objective for health care.

Finally, positions labeled as “welfarist” (Arneson 2000, Cohen 1989) hold that a just society ought to attempt to equalize citizens’

opportunities for welfare. Resources, capabilities, opportunities are all freedom concepts. That is, they are all ways of specifying goods that people must have at their disposal in order to exercise meaningful *agency*. Of course, the exercise of agency can make people's lives go well if their choices and actions have positive consequences for them, and poorly if the reverse happens. Now, to be sure, how a person's choices turn out depends upon the quality of those choices and the prudence (or lack thereof) that people manifest in their exercise of agency. But it also depends to some degree at least on factors that lie entirely outside the agent's control, namely on luck. Welfarists believe that a just society should make people's welfare to as great a degree as possible insensitive to the operation of luck, and as sensitive as possible to those factors over which people can exercise responsibility. It must in other words equalize *opportunities for welfare*.

Why not simply opt for a more thoroughgoing welfare egalitarianism, one that simply attempts to equalize welfare, regardless of whether obstacles to welfare come from the operation of luck or from an individual's failure adequately to exercise his agency? The answer should be fairly clear: the attempt to overcome all obstacles to the achievement of welfare is by definition a Sisyphean undertaking, and what's more, any attempt to embody it in policy would risk generating perverse incentives. Why exercise prudence, when the state will treat my failure to do well just as generously if it stems from my choices or whether bad luck is to blame. Thus, a focus on welfare as the *egal- isandum* of a theory of justice quite naturally gives rise to an emphasis on the equalization of the effects of luck. As we will be considering luck-egalitarianism in some depth below, I put off its discussion to this later point.

One thing should be quite clear at this point. Theories of justice pitched at a high level of abstraction do not provide us with ready-made ways in which to settle relevant philosophical disputes. First, as we have seen in the case of education, they do not automatically generate an answer to the question of whether a specific good ought to be subjected to egalitarian principles, or whether it is the kind of good that can be distributed according to the vagaries of market processes once background conditions have been equalized. In other words, given that all theories of justice assume that there is some set of background conditions (resources, luck, capabilities) that must be equalized as a condition for other social processes to be seen as morally legitimate,

they do not provide us with a ready set of tools to determine whether a specific good should be thought of as belonging to the background, or to the set of goods that need not be equalized.

Second, they do not provide us with a perspicuous specification of the goods in question. Milton Friedman famously opined that there is a distinction between *education* and *schooling*, the latter being merely an instrument for the former, which should be the real object of the state's concern (Friedman 1962: 86). Yet there is a tendency for theories of justice in the area of education to focus on the just delivery of schooling rather than of education.

Similarly in the area of health, theorists and policy-makers have had a tendency to equate health with those services delivered by institutions that are narrowly defined as lying in the health sector. This perspective leads theorists to focus on the allocation of resources within the health-care system, the rules governing trade-offs among health-care goods as defined by the health-care system, and at the most macro level, with the way in which macro-budgetary allocations might be made as between the health-care system and other public policy sectors (see for example Dworkin 2000).

Friedman observed many years ago that schooling is just an instrument serving what ought to be seen as the goal of public policy, namely education. It is thus in his view an error to focus exclusively on justice in the area of educational resources, narrowly understood. Rather, we should look at the totality of instruments that contribute to, or detract from a child's education in public policy debates. Similarly, it has been argued by an increasing range of voices that the health-care system should not be viewed as the focus of theories of justice in the area of health, but just as one among a variety of instruments and determinants of the health states of a population. A theory of justice in the area of health that came to focus on the totality of public policy levers that impact on the population's health would have a very different logic from one that focused on health-care as one among a variety of goods that agents must have at their disposal to be able to meaningfully exercise their agency (as in Daniels' original formulation of his theory). Health would be conceived, to employ the jargon of theories of distributive justice, as an end rather than a resource. Allocation of resources and policy decisions more broadly within all public policy areas, including the health-care system, but not limited to it, would be judged in function of the contri-

bution they make to health. An interesting area that reflects this re-focusing of theories of justice with respect to health has been with respect to the evaluation of egalitarian policies. In the wake of the Whitehall studies, that tended to show that there is some correlation between health and equality, inequality seeming to correlate with worse health-states *even for those who find themselves privileged by unequal distributions of resources*, there has been a flurry of activity seeking to determine how different distributional regimes affect health (Daniels 2006).

Taking a step back, we can see that there are two debates about health that cut across one another, and that are both importantly relevant to the way in which health fits into the purview of theories of justice. First, there is the definitional debate touched upon in the first section, which is constituted by partisans of a narrower, more quantifiable conception of health on the one hand, and partisans of a more inclusive, holistic approach on the other. Second, there is the debate as to whether theories of justice should view health narrowly as a set of identifiable resources, largely allocated by the health-care *system*, or whether health should be seen as a benchmark on the basis of which all areas of public policy are evaluated. That these two debates are distinct can be seen by observing that settling one does not automatically settle the other. Thus, for example, one can argue that all public policy areas ought to be evaluated with respect to their impact on health, while restricting those impacts to health narrowly construed. In practice, it is, however, likely that there will be affinities between the broader approaches to both debates on the one hand, and the narrower ones on the other. That is, it is more natural, once one has decided to examine the impact of all public policies upon health, to focus on a broad conception of health, and conversely, to focus on a narrow conception once one has decided to limit one's purview to the area of narrowly-defined health care resources.

2

It was mentioned earlier that theories of distributive justice focus on two interrelated questions. The first has to do with the *goal* of distributive justice. What is the dimension along which we should be treating people equitably? A second question has to do with the principle in function of which we ought to be distributing the goods that a society's institutions of distribution and redistribution ought to be allocating.

Two debates seem relevant from the point of view of the development of an adequate theory of distributive justice in the area of health. First, a very complex debate has been occupying philosophers and social theorists as to the conception of equity that ought to be employed as a criterion to evaluate the distribution of a given good. Let me distinguish four positions:

1) *Equality*: This principle simply requires that the good be distributed equally, or as close to equally as is practicable.

2) *The Difference Principle*: This principle, associated with the work of John Rawls, requires that a good be distributed equally, unless an unequal distribution can be seen to be to the advantage of the least well-off.

2) *Sufficientarianism*: As has already been seen, this principle claims that equity requires that an ethical priority be given in distributing a resource to ensuring that no individual falls below a threshold deemed to be sufficient. Inequalities that may obtain once the threshold of sufficiency is achieved for all are seen as being of no moral importance (Frankfurt, 1987).

4) *Prioritarianism*: This principle (Parfit 1997) holds that in distributing resources the interests of the least well-off should be given some degree of priority. The position differs from the latter among other things in that it does not specify a threshold beyond which relative positions of individuals with respect to a good cease to matter.

Clearly, each one of these positions can be employed to develop a *prima facie* plausible view of what is required ethically in the distribution of goods in the area of health. Some might hold that there is irreducible importance that certain goods be distributed equally, even when both aggregate gains *and* gains for the least well-off could be achieved by allowing some degree of inequality. Equality with respect to the good in question would stand as an independent moral constraint preventing any total improvement in a society's position with respect to a good that was purchased at the cost of diminishing equality. To fix ideas, John Stuart Mill once famously argued that though it is morally required that each citizen have a right to vote, it does not follow that each person's vote should weigh equally in an election. The more educated, Mill thought, should have votes that determine democratic outcome to a greater degree. This position is abhorrent to the modern democratic sensibility. We have come to form the view that equal voting rights matter not just in virtue of the result that elections yield, but because they are an emblem of our equality

as citizens. It would be an interesting exercise to chart how different goods should be perceived with respect to the equality requirement. Are they of such symbolic importance that they ought, like voting rights, to be distributed equally independently of consequences? Alternatively, does equality with respect to certain goods have broad positive consequences that might offset losses of efficiency that an insistence upon equality might occasion more locally? (Material equality is seen by some as contributing to overall public health; educational equality is viewed by some as contributing to a more robust sense of shared citizenship and equal opportunity, etc.). Are there goods with respect to which, on the contrary, an insistence upon equality at all costs might be seen as counter-productive?

The Canadian debate over health can be seen quite plausibly as taking place on this terrain: are unequal health states across the population a token of unequal citizenship, or on the contrary should we be ready to countenance inequality on the condition that it leads to better health states overall?

Among the positions that allow for departures from strict equality, some are more plausible than others when a focus on health is introduced. Thus, for example, there is no limit in principle to the amount of inequality that sufficientarians would allow, provided that all people within a society find themselves above a threshold of sufficiency. That this position is intuitively unacceptable can I think be seen by the fact that, unlike some other goods, health is unavoidably relational and comparative. Let us as a simplifying hypothesis take life expectancy as an index of health. Is a life expectancy of 75 “sufficient”? It is if the life expectancy of the broader, reference population is, say, 80, and if there is no socio-economically defined sub-section of the population whose life-expectancy is significantly higher in virtue. But it is not if, for example, some segment of the population has managed to use its socio-economic status to achieve a life-expectancy of, say, 125. Thus, sufficiency with respect to health cannot be established on absolute terms. Whether an individual or group meet the sufficiency standard depends upon what health states are being achieved elsewhere in society. It is an open question whether other specific goods delivered by public policy (education, housing, security, etc.), admit of an absolute threshold of sufficiency.

Thus, when a focus on health is introduced, debate would seem most naturally to focus around an egalitarian position on the one

hand, and a position, such as the “difference principle” and the “prioritarian” position (the difference between these two last positions need not detain us here) on the other. The plausibility of these positions would seem moreover to depend upon the position one takes on the two debates about the nature of health and about the focus of health-related public policy. Egalitarianism seems, all things equal, more plausible the narrower the conception of health one adopts. Indeed, if, for example, it is argued that all areas of public policy impact health, the demandingness of an egalitarian theory increases correspondingly. Of course, it would be highly simplistic to expect that because, say, housing has an impact on health, health egalitarianism would require housing egalitarianism. It might be found that a broad range of resource sets in the area of housing above a certain standard will all have the same impact upon health. Empirical work is required in order to determine how differentials in different policy domains impact the ability of a society to achieve equity with respect to health outcomes, and thus, in order to determine just how demanding health egalitarianism, understood as equality across society with respect to health outcomes, really is. Egalitarianism with respect to the specific goods that are allocated by the health-care system is, conceptually and empirically, a far simpler goal, no matter how great the political obstacles to its achievement.

One further complication needs to be introduced in order to complete this thumbnail sketch of the implications of contemporary theories of distributive justice for discussions about allocation of resources in the area of health. Most positions are, to use the technical parlance in vogue among philosophers, “luck-egalitarian” (Arneson 1989). That is, they believe that significant redistribution ought to occur within a society in order to compensate for the operation of luck, both good and bad. Some people are born in favorable circumstances, and are possessed either due to upbringing or because of genetic happenstance with talents that are highly prized in the society of which they are members. Others are born less fortunate, both in terms of the circumstances of their birth and as far as their native endowments are concerned. And quite obviously, luck affects us quite differently over the course of our lives, irrespective of what our initial circumstances are. For example, some people are afflicted with debilitating, painful diseases at the height of their productive lives, while others seem to sail through life blissfully unaffected by any but the most trivial ailments.

Luck-egalitarians believe that a just society is one that to some degree makes of the operation of luck both good and bad a collective responsibility. Resources should be distributed so that all members of society benefit from circumstances that are immunized from the potential ravages of bad luck. The flipside of this position however is that individuals should be held responsible from the consequences of their freely undertaken choices and actions, even when they result in quite wide resource disparities. The indolent individual who wastes away his resources cannot justly complain when his resources are depleted and he finds himself with no provision for the future. He certainly has no claim against the prudent and hard-working person whose industry provides her with great riches.

On the face of it, the luck-egalitarian position would seem to generate quite a generous position in the area of the distribution of health and health-related resources. After all, health catastrophes are often a paradigmatic example of the operation of bad luck.

Appearances are, of course, misleading. It has been a central theme of writing in the area of health over the course of the last generation or so that one's health status is also powerfully determined by lifestyle choices (Wikler 2005). Smoking, inactivity, reckless recreational activity, be it sexual or otherwise, and a host of other factors that are well within the individual's area of autonomous choice are important determinants of health. To the extent that public health authorities make information available about the negative correlation between health and such types of behaviour, can we not see one's health state as to a large degree the result of one's choices rather than of brute bad luck? As such, should the consequences of one's poor lifestyle choices not be borne by the individual rather than by society as a whole?

There are risks moreover that as the genetic revolution advances, the range of health states that will come to be seen as resulting from one's choices will broaden, crowding out the range of states that the individual will be able to claim as resulting from brute luck. For example, as it becomes possible to screen for an increasing set of diseases, children born with these diseases may come to be seen by society as having resulted from parents' decisions not to screen, or not to abort pregnancies where genetic abnormalities are detected, and thus as making less of a claim upon societal resources as would have been the case prior to the discovery of the genetic basis of many diseases and of the ability accurately to screen for the presence of muta-

tions responsible for disease. To refer to the title of a book devoted by four leading American bioethicists to the ethical implications of genetic technology, such diseases might be in the process of moving "from chance to choice" (Brock, Buchanan, Daniels and Wikler 2000).

The "personal responsibility" argument may enter in more insidiously even in health systems that are on the face of it more committed to collective provision of health resources than others. In Canada, for example, as the "basket" of what is considered to be "medically necessary" shrinks under increasing budgetary pressures, a greater proportion of the resources necessary for health are being left up to individual responsibility. Individuals must provide themselves with supplementary private health insurance in order to access health resources ranging from dental care to prompt diagnostic testing. As access to such resources comes to be seen as discretionary, failure to provide oneself with them, and the health consequences of such failure, comes to be seen as resulting from individuals' imprudent choices.

A closer look reveals that it is more difficult than these argument sketches would suggest to draw a clear red line between the effect of choice and that of circumstance with respect to health outcomes. To take but one example, though smoking rates have declined sharply in modern economically advanced societies, this decline has led to a stark class division. Well-off, educated people hardly smoke anymore at all, whereas there are still high rates of smoking at the lower reaches of the economic ladder. This suggests that class circumstance may have as much of an impact upon the decision to smoke as does freely undertaken individual deliberation. Again, were society to have more of a case in making diet and its consequences an individual matter, it would have to do a lot more than it currently does in sending consumers mixed messages, e.g. by promoting healthy eating while regulating the market for unhealthy foods quite feebly. In general, individuals do not make choices in a social and cultural vacuum. Their choices are not determined by circumstances, but they are to a great degree inflected by them. Separating out the portion of responsibility that stems from social causes beyond the individual's capacity for choice from that which can be traced back to individuals themselves is a difficult, possibly intractable affair. Neither the position that sees health states as entirely attributable to circumstance nor that which sees certain consequences as entirely due to individual choices do the complexity of the issue justice.

A final note is necessary before leaving the range of issues surrounding justice in the distribution of health-related resources. We have up to this point been examining positions that seek to determine the most ethical way to distribute scarce health-related resources to the individual members of a society. Some positions in this area, broadly inspired by utilitarian ethical principles, hold that justice in the use of health-related resources requires that we put aside distributional concerns, and use these resources in order to achieve the greatest aggregate amount of health with the limited resources at our disposal. We ought to try to generate as much of the good in question, regardless of how this good is distributed. The ethical impulse at the basis of this range of positions is that health institutions have an ethical responsibility to produce as much of the good as possible with the resources that have been entrusted to them for the production of that good.

Health measurement tools such as QALYs and DALYs have been constructed with this kind of maximizing exercise clearly in mind. For any given allocation choice, the question is how efficient is it in generating increments of quality-adjusted life years, or disability-adjusted life years (though proponents of these kinds of measures have recently attempted to build distributional concerns into them, for example by factoring in people's preferences for levels of equality/inequality in distribution). Choices are made that yield the greatest numerical value, irrespective of how the marginal increase is distributed across individuals and groups.

Criticisms of this view have held that, in essence, aggregative conceptions such as these are alternatives to justice, rather than variants thereof. Justice requires that each individual in a society be considered as an irreducible source of moral claims (that is, the import of the claim they make upon social resources does not depend upon the contribution that the satisfaction of their interests makes to the aggregate). Aggregative conceptions of the ethics of the allocation of health resources on the other hand hold that a loss suffered by an individual is morally compensated by an equal or greater gain to another individual or group of individuals.

Critics moreover hold that the individuals and groups that will tend to see their health interests sacrificed for the good of the whole will tend to be the most vulnerable in society – the elderly, the very ill

and those whose diseases are through no fault of their own very costly to treat, who cannot be counted on to “generate” much health, whatever the level of resources expended upon them – thus adding to the general unfairness of the approach.

In response to this criticism, some defenders of maximization have argued that distributional notions are tacitly built in to the approach. For example, the tendency of the approach to privilege the claims of the young can be justified on the basis of what has been termed the “fair innings” argument (Williams 1997). We have reason according to this view to give priority to the health claims of the young, because older individuals have already had a greater share of years of life than younger people. And so, looking at the matter more broadly, it seems fair according to this view to give more importance to the claims of the young than to those of the old, not only from the point of view of efficiency in the use of resources, but also from the point of view of intergenerational justice.

CONCLUSION

My intention in this essay has not been to settle any debates. Rather, I have attempted to engage in some conceptual ground-clearing that is in my view a necessary prolegomenon to the evolution of theories of justice in the area of health. Though the paper does not draw any substantive conclusions, it does sound some cautionary notes.

First, work still needs to be done in order to determine what the *distribuandum* of such a theory should be. Moreover, we also need to think about the kind of argument that will settle the issue. Is the determination of the conception of health that should lie at the center of theories of justice in health above all a conceptual issue, amenable to the kinds of analytical tools that philosophers standardly bring to bear in defining the contours and contents of a concept? Or is the decision to delimit health in one way rather than another just that, namely, a *decision*, one that is answerable to a number of normative moral and political considerations.

Second, we still need clarity on the question of the degree of inequality that a just society can or should be able to tolerate. Clearly, the question of how to distribute the resources, services, and/or states of being that should be at the center of our theories and institutions

of health is partially dependent upon our decision concerning what health is. But there are irreducible questions to do with the status of health as a marker of equal citizenship, with the question of whether health is somehow “special”, for example in not being amenable to the kinds of tradeoffs that we standardly make with respect to other goods that should constitute at least part of the debate about how a just society should go about organizing the distribution of health.

My hope is to have contributed at least somewhat to making clearer the conceptual and practical grounds upon which these two inter-related sets of debates should proceed.

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