

Vulnerability, Health Care, and Need

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Introduction:

That we have duties to protect those most vulnerable to our actions, choices, and policies is difficult to deny. The concept of vulnerability has thus come to play a central role in various debates in applied ethics and political philosophy, and has been relied upon to articulate the ethical duties owed to patients, research subjects, children, the elderly, women, future generations, and the global precariat. It has also, and importantly for our purposes here, been engaged to ground the collective duties of justice owed to recipients of liberal welfare and social insurance programs.

Philosophers who appeal to the concept of vulnerability see it as a valuable tool, not only with which to identify a class of individuals who are particularly susceptible to the harmful actions and choices of specific others or specific social institutions, but also to ground the normative duties they are owed.

For political philosophers who engage the concept, normatively salient vulnerabilities derive not merely from the fact of our embodiment, but as a result of the actions and choices of others and the social institutions they erect and maintain. We are thereby called upon not just to respond humanely to suffering as such, but to stop using our relational authority to take advantage of vulnerable others, and to build and maintain the kinds of social structures that do not arbitrarily deprive, discriminate, or exploit the vulnerable. The question we are interested in here is whether vulnerability as a concept can in fact carry the kind of normative burden it

has been given by proponents who employ it as a ground for duties of justice and thus for the central institutions of the welfare state.

We begin in part one of the paper by asking how vulnerability theorists have justified the claim that we share institutional duties to alleviate vulnerability. The answer we propose is that they have almost universally done so by appealing to the concept of basic needs. That is, in identifying the foundations of our collective obligations to the vulnerable, the harm to which they are susceptible due to a deprivation in their basic needs proves central. Diverse vulnerability theorists appeal respectively to accounts of exploitation, autonomy, or flourishing to cash out the kinds of harms to which the vulnerable are susceptible when their basic needs go unmet. But what they share is a view according to which our duty to the vulnerable is generated by the imperative of preventing the relevant harm from befalling them, and that its content thereby consists in meeting their basic needs.

This approach is problematic, we aim to demonstrate, on two grounds. The first, which will be the subject of part two of this paper, is that vulnerability becomes a mere middle-man, philosophically speaking; in the final analysis, the justificatory work it does is of a wholly rhetorical variety. According to vulnerability theory, a deficit of basic needs leaves one vulnerable to some kind of specific harm, and we must meet basic needs in order to prevent this harm. Vulnerability itself does not therefore seem to do any normative work in vulnerability theory: basic needs, and the harms to which a deficit therein gives rise, appear to do all the heavy lifting. What we will show in part two is thus that vulnerability theory accomplishes its justificatory goal without any normative appeal to vulnerability whatsoever.

The second problem we identify with vulnerability theory, and to which we turn in part three of this paper, pertains specifically to the content that vulnerability theory yields for our collective obligations of social justice. Whether vulnerability per se is ultimately a foundational concept or, as we argue, a mere middle-man, the account it yields of social welfare institutions, and public health care provision in particular, is inadequate. Vulnerability theory holds that our collective obligations are limited to preventing certain kinds of harm by meeting basic needs, and this implies a tightly circumscribed role for social welfare institutions, including the health care system. In particular, vulnerability theory fails to account for three significant and appealing features of the health care systems we see throughout the developed world: their universality, comprehensiveness, and mandatoriness. As such, we contend in part three that not only the foundation, but the content of the obligation generated by vulnerability theory is not up to its institutional task.

Our ultimate aim is to question the ability of vulnerability theory to ground our duties of justice, specifically as they pertain to health. And our conclusion is that it is only able to ground duties of justice by reliance on the concept of basic needs, and as a result not only renders vulnerability itself normatively superfluous but also fails to provide grounds for the central features of a just health care system. We do not deny the value of vulnerability theory in accounting for our duties of virtue to provide care for those who depend on us, or to not exploit those with whom we stand in asymmetrical relationships. It is with respect to grounding the institutions of the welfare state – and specifically those pertinent to satisfying health needs – that we find vulnerability theory to be lacking. And that is what we will show here.

Part 1: Vulnerability Theory and Necessary Goods

It is incumbent upon vulnerability theorists to answer certain key questions, namely, what is it that makes us vulnerable (and why does this matter), and what obligations are thereby imposed (and upon whom)?¹ There are a number of different answers vulnerability theorists have supplied to these questions, and thus a variety of vulnerability theories. As to what makes us vulnerable, ontological vulnerability theory identifies the sheer fact of our embodiment as the source thereof.² On this approach, the extent to which we are vulnerable, or more vulnerable than others, will depend on physical characteristics and natural endowments, such as gender, age, physical ability and the like. Ontological vulnerability is occurrent, or something we all experience to some extent at various points in our life, albeit some more than others, or for longer periods of time, or in more pronounced ways. While this type of approach has a straightforward answer to the question of what makes us vulnerable, it struggles to ground any correlative duties. Because ontological vulnerability is no one's fault, it isn't clear who bears a responsibility to lessen it, and because it is an inescapable fact of the human experience it is equally unclear (since ought implies can) that we can coherently have a duty to do so.³

1 Catriona Mackenzie, Wendy Rogers, and Susan Dodds, "Introduction: What is Vulnerability, and Why Does it Matter for Moral Theory," in *Vulnerability: New Essays in Ethics and Feminist Philosophy*, eds. Mackenzie, Rogers and Dodds (New York: Oxford, 2014): 1-29, at 4-5.

2 Martha Fineman, "The Vulnerable Subject: Anchoring Equality in the Human Condition," *Yale Journal of Law and Feminism*, 20, 1 (2008). Judith Butler. *Precarious Life: The Powers of Mourning and Violence* (London: Verso, 2009).

3 Fineman argues we can in fact derive considerable implications of social justice from the fact of human embodiment and its associated vulnerabilities. See "The Vulnerable Subject: Anchoring Equality in the Human Condition." If our treatment here of ontological views therefore strikes

Relational theory, on the other hand, contends that the source of our vulnerability lies in our dependence on specific others. That is, in order to be vulnerable in a normatively relevant sense, it must be the case that one is vulnerable to the actions and choices of others who are capable of affecting one's interests in concrete ways. As Mackenzie et al., put it 'Whereas the ontological response to the question "What is Vulnerability?" stresses our common embodied humanity and equal susceptibility to suffering, this second response stresses the ways that inequalities of power, dependency, capacity, or need render some agents vulnerable to harm or exploitation by others.'⁴

As for the obligations engendered by vulnerability, relational theorists have offered answers interpersonal or institutional in nature. On the first account, our duties to the vulnerable are to care for specific others with whom we stand in asymmetrical relations of power. On the second account our duties are to erect and maintain social institutions that do not arbitrarily deprive, exploit or discriminate. Whether a relational theory emphasizes our interpersonal or institutional duties tends to relate back to how its proponent understands the source of our vulnerability. According to interpersonal vulnerability theory, since the source of an agent's vulnerability is her relational dependence on a specific other with whom she stands in an asymmetrical power relationship, that concrete other has a duty to care for the vulnerable agent, and to protect her interests. According to institutional

readers as too brief, or our dismissal too curt, our twofold critique of vulnerability theory in the pages to come can be thought to apply equally to institutional views grounded in ontology and relationality alike.

⁴ Mackenzie et al., "Introduction: What is Vulnerability, and Why Does it Matter for Moral Theory," 6

vulnerability theory, because the source of an agent's vulnerability derives from an exploitative, exclusionary, and/or discriminatory institutional order, an obligation falls upon those who participate in those institutions to erect and maintain a just alternative order.

It is these latter accounts of vulnerability theory we are primarily interested in here. What we refer to as institutional vulnerability theory is undeniably relational but identifies particular social arrangements as the source of vulnerability, and as such cashes out our duties to the vulnerable in social justice terms. On the institutional view it is a concern with the kind of social scaffolding we build and support that provides the answer to why vulnerability matters normatively speaking, and why it imposes correlative duties of justice. We are interested in these kinds of arguments precisely because they make vulnerability theory relevant to political philosophy, as a potential justificatory source for the primary institutions of the welfare state.

To further illuminate the distinction between interpersonal and institutional relational accounts, consider the origins of vulnerability theory. The work of care ethicists and feminist ethicists was central in bringing vulnerability to the foreground of moral philosophy, by drawing attention to the imperative created by the concrete and particular needs of those most dependent on us.⁵ For care ethicists, our duty is to respond caringly to those whose interests are most vulnerable to our

⁵ Nel Noddings, *Caring: A Feminine Approach to Ethics and Moral Education* (Berkeley, University of California Press, 1994). Carol Gilligan, *In a Different Voice: Psychological Theory and Women's Development* (Cambridge: Harvard, 1982). Joan Tronto. *Moral Boundaries: A Political Argument for an Ethic of Care*. New York, NY: Routledge, 1994; Eva Kittay, *Love's Labour: Essays on Women, Equality, and Dependency* (New York: Routledge, 1999).

particular actions and choices. Many care ethicists are drawn to the view because of the challenge it poses to universalist moral doctrines that celebrate impartiality whilst ignoring the concrete duties we have to those most dependent upon us. The Kantian view has taken the brunt of this critique. But as Sarah Clark Miller has recently argued, what is at stake when we are vulnerable is our dignity as agents; she thus motivates our duty to care for the vulnerable by drawing a link between care ethics and the very moral view it originated to challenge.⁶

Care ethicists also regard their view as posing a serious challenge to traditional thinking about social and distributive justice, and particularly contractualist bargaining models thereof according to which social entitlements depend on one's ability to negotiate.⁷ In their commitment to maintaining this critique, however, care ethicists have shied away from explaining or addressing institutional vulnerability as a problem of social and distributive justice. As Miller acknowledges, care based approaches stand accused of paying too little heed to the extent to which vulnerabilities are created through broader social systems, institutions, and patterns of oppression, and fail to appreciate that individual responses, no matter how well intentioned or executed, cannot solve the underlying causes thereof.⁸

6 Sarah Clark Miller, *The Ethics of Need: Agency, Dignity, and Obligation* (New York: Routledge 2014).

7 Michael Slote, "The Justice of Caring" In *Virtues and Vices*, eds. Paul, Miller, and Paul (New York: Cambridge University Press, 1998). And Martha Nussbaum, *Frontiers of Justice: Disability, Nationality, Species Membership* (Cambridge: Harvard University Press, 2006).

8 Miller, *The Ethics of Need*, 139. For Miller this critique derives from the claim, essential to care ethics, that we have moral reason to show partiality to those dependent on us specifically. But she also argues that while this means care ethicists must be innovative in their thinking about structural issues of both domestic and global justice, they need not and ought not remain silent on these issues. Virginia Held offers the most well-developed version of care ethics as a theory of global justice. See Held's *Ethics of Care: Personal, Political, Global* (Oxford: Oxford University Press, 2006). But the

While care ethics certainly inspired, and provided many of the conceptual tools employed by those who have since taken a more institutional approach, the view itself remains decidedly and determinedly interpersonal. It was arguably by way of response to the failure of the view to provide institutional analyses and solutions that the institutional model arose. It should be noted, however, that for the majority of vulnerability theorists who we regard as taking the institutional approach, both personal and collective duties are warranted by the accounts they offer. That is, those who are concerned to motivate institutional duties of justice tend nonetheless to be concerned with motivating interpersonal duties of virtue as well, even if the reverse is not the case. We will nonetheless focus explicitly on the duties of justice generated by theorists we see as taking an institutional approach, given that our interest is to determine how (and how successfully) these views justify social welfare programs, and specifically public health care.

The obligations imposed by vulnerability, according to those who take the institutional approach, are precisely to render just our social institutions. But how do they propose we do so? What must we do to address vulnerability? Institutional accounts have in common a recognition that our duties to the vulnerable entail the provision of certain essential goods. On this view, it is an institutionalized deprivation in their basic needs that render them vulnerable and our duty is to erect and maintain institutions that meet their needs. But which of their needs? And

tension between the partiality demanded by care ethics and the impartiality required for global justice remains unresolved, in our view, precisely because in extrapolating care and vulnerability to the realm of justice it either loses its novelty or its normative force, as we go on to show.

why do their needs inspire obligations at all? And what does a deficit in basic needs render them vulnerable to? A word on basic needs theory, then.

In his highly influential foray into the matter, Harry Frankfurt argues that in unpacking the concept of 'needs' we must acknowledge their sheer intuitive force: "Claims based upon what a person needs frequently have a distinct poignancy. They are likely to arouse a more compelling sense of obligation, and to be treated with greater urgency, than claims based merely upon what someone wants."⁹ Frankfurt continues, however, that not all need-claims inspire the same kind of urgency and thereby the same kind of obligation. For him "the moral importance of meeting or of not meeting a need must therefore be wholly derivative from the importance of the end that gives rise to it."¹⁰ When something is a matter of need, Frankfurt argues, it must always be possible to specify what it is needed for. All necessities, he claims, are in this sense conditional; nothing is needed except in virtue of being an indispensable condition for the attainment of a specific end.

For Frankfurt, it is the linkage to harm that differentiates needs that are morally interesting from those that are not. A person's need has moral interest only if it will be a consequence of his failure to meet the need that he thereby incurs or continues to suffer some harm.¹¹ Frankfurt is therefore arguing that we can distinguish needs from wants, and basic needs from non-basic ones, by applying a certain relational formula: X needs Y in order to Z. When something is needed it

⁹ Harry G. Frankfurt, "Necessity and Desire," *Philosophy and Phenomenological Research*, 45.1 (1984): 1-14, at 1.

¹⁰ Frankfurt, "Necessity and Desire," p. 2.

¹¹ Frankfurt, "Necessity and Desire," p. 4.

must always be possible to specify what that thing is needed for. And in order for a need to be morally relevant and inspire correlative and coercible obligations (such that the need must be met even if doing so would frustrate another's desires) it must be the case that the need in question has as its end the avoidance of harm.

Frankfurt's approach to thinking about needs and their normative force is echoed by countless needs theorists. David Copp claims that, "there seems to be a conceptual connection between the basic needs and the avoidance of harm; if a thing is a matter of basic need for a person, then the idea is that the person requires it in some quantity and in some form in order to avoid harm."¹² Garrett Thompson concurs: "the central pillar of an analysis of the concept 'fundamental need' must be a characterization of its antecedent, i.e., what the object of a fundamental need is necessary for - the avoidance of...harm."¹³ Copp continues, however, that if "Matters of basic need are things anyone would require in some quantity and in some form in order to avoid a blighted or harmed life....We require an account of what is meant by a blighted or harmed life in order to unify, and provide a theoretical justification for [an account] of basic needs."¹⁴

What qualifies as a need therefore depends on the nature of the harm it prevents or alleviates. And for the majority of needs theorists, as with relational vulnerability theorists, the harm in question pertains not just to our lives as embodied beings but to our lives as social and cooperative beings. The relevant

12 David Copp, "Equality, Justice, and the Basic Needs," *Necessary Goods*, ed. Gillian Brock, (Lanham: Rowman & Littlefield, 1998) 113-134, at 124.

13 Garrett Thompson, *Needs* (London: Routledge & Kegan Paul Ltd., 1987), 36.

14 Copp, "Equality, Justice, and the Basic Needs," 124.

needs will thus include not just the stuff of life, as it were, but goods directed to promoting certain essential aspects of our lives as social beings. Some needs theorists therefore prefer the term necessary goods to the term basic needs, precisely so as to differentiate that which we require to avoid merely physical, or ontological harm, from that which we require to avoid moral or social harm.¹⁵

That institutional vulnerability theorists appeal to needs - or necessary goods - to cash out both the foundations and the content of our obligations to the vulnerable does not save them from the task of identifying the harm to which a needs deprivation gives rise. We turn now to evaluating the various accounts of harm that institutional vulnerability theorists have offered, and to demonstrating a consistent and problematic pattern of argumentation that calls into serious question the justificatory value of their approach to grounding our duties of justice. More specifically we will argue that in relying on the concept of basic needs, and the harm to which we are rendered susceptible by a deprivation therein, institutional vulnerability theory renders the concept of vulnerability itself normatively moot.

Part 2: Vulnerability Theory and Harm

Vulnerability theorists might assert that the harm we seek to avoid when we meet others' needs is vulnerability itself. But this would make for poor argumentation, as all we have to ask is 'vulnerability to what' to put the normative burden back on their shoulders. Vulnerability describes the *state of being susceptible*

¹⁵ Gillian Brock, "Introduction" to *Necessary Goods: Our Responsibilities to Meet Others' Needs*, ed. Gillian Brock (Lanham: Rowman & Littlefield, 1998): 1-18.

to harm, it does not constitute the harm itself. We are not harmed simply in virtue of being vulnerable; we are at risk of harm. The disvalue of being vulnerable thus derives from the disvalue of the harm to which we are susceptible. Some account must therefore be supplied as to the nature of the harm to which we are rendered susceptible to when our basic needs go unmet.

Different vulnerability theorists cash out the nature of this harm in diverse ways, just as needs theorists themselves do. Some explain it in terms of exploitation, still others in terms of impaired agency, and others still in terms of an inability of the vulnerable to flourish. We will look now at each of these views in turn. In the process we will identify and demonstrate a consistent pattern of argumentation that we take to be definitive of institutional vulnerability theory. The pattern is this:

- 1. Some members of our society are more vulnerable than others to harm X because their basic needs are going unmet;**
- 2. Our duty to the vulnerable is generated by the imperative of preventing harm X;**
- 3. Our duty to the vulnerable consists in the requirement that we erect and maintain institutions that meet basic needs.**

We will argue that although different theorists supply different values for X, it is nonetheless the type of harm they respectively identify that does the normative work their view requires; vulnerability simply comes to describe the state of our susceptibility, but it is the harm itself that obliges others to act.

A. Exploitation

According to Robert Goodin's seminal account of vulnerability theory we suffer harm when we are rendered dependent, due to a deprivation in our basic

needs, on those who might exploit our vulnerabilities. Exploitation, on Goodin's view, constitutes a violation of the moral norm to protect the vulnerable. This norm lays upon us a strong moral responsibility not to take unfair advantage of those who are particularly vulnerable to our actions and choices.¹⁶ It is because we are in a position to exploit them that we have a special moral obligation not to do so.¹⁷

Goodin continues, *pace* care ethicists, that while the duty to protect the vulnerable may indeed justify the sorts of special obligations we have towards those close to us, it does not justify these obligations alone. Our duty to protect the vulnerable requires not only that we refrain from exploiting the vulnerabilities of those who depend on us, but also that we do everything we can to prevent the exploitation of the vulnerable in general. Goodin continues that it is those in dire need who are most vulnerable to exploitation. Their need renders them dependent on others, and thereby vulnerable to exploitation at the hands of those upon whom they depend. Since our duty to protect the vulnerable requires that we prevent exploitation, it thus requires that we meet their basic needs.¹⁸

It is imperative, for Goodin, that we meet these obligations via the institutions of the welfare state and that we do so in-kind whenever possible. This is because our social institutions are non-discretionary in a way that personal and private associations are not. State agencies apply rules universally; the mere fact of a claimant's need suffices to ensure satisfaction thereof where an institutional rule

16 Robert E. Goodin, *Reasons for Welfare: The Political Theory of the Welfare State* (Princeton: Princeton University Press, 1988), 149.

17 Goodin, *Reasons for Welfare*, 125.

18 Robert E. Goodin, *Protecting the Vulnerable: A Reanalysis of Our Social Responsibilities* (Chicago: University of Chicago Press, 1985), 111.

exists to this effect. And our job is to institute such a rule, because if instead we leave the meeting of needs up to personal associates and private associations, claims may be denied arbitrarily and thus in such a way that renders the dependent even more vulnerable.¹⁹ Needs claims must also be met in-kind and not in cash, argues Goodin, precisely because the relevant provisions aim to prevent exploitation, not to satisfy preferences or enhance market autonomy.²⁰

Goodin's argument clearly exemplifies the pattern of institutional vulnerability theory. Some members of our society are rendered vulnerable to the harm of exploitation due to a deprivation in their basic needs, he argues. Our duty to the vulnerable thus consists in the requirement not only that we desist personally in exploiting the vulnerabilities of those dependent on us, but that we protect the vulnerable from this potential harm at the hands of others by erecting and maintaining non-discretionary institutions designed to meet their basic needs in-kind.

B. Autonomy

On a second account of institutional vulnerability theory, it is an impairment of autonomy to which we are rendered vulnerable when our basic needs are unmet, and which thereby gives rise to correlative duties of justice. For theorists who take this route, the capacity to exercise some degree of self-determination is crucial for

19 Robert E. Goodin, "Vulnerabilities and Responsibilities: An Ethical Defense of the Welfare State," in *Necessary Goods*, ed. Gillian Brock, (Lanham: Rowman & Littlefield, 1998): 73-94, at 88. See also *Reasons for Welfare*, 15-17, 184-196.

20 Goodin, *Reasons for Welfare*, 8.

leading a meaningful life, and vulnerability describes the state of being in a position whereby we can't exercise this type of self-determination. As Catriona Mackenzie argues, we have a profound interest in making sure our society is one in which we are all able to lead a life that expresses our distinctly human capacities for choice and self-reflection, and in which we are able to exercise these capacities in line with our beliefs, values, wants, goals, and self-identity.²¹ Sarah Clark Miller puts the point in more Kantian terms when she argues that we cannot realize our properly human capacities when we suffer a deprivation in our fundamental needs, and that these needs are constituted precisely by that which dignified agents require by way of determining and seeking ends for themselves.²²

Importantly, for Mackenzie, as for many vulnerability theorists, agency is relational. In the hands of institutional vulnerability theorists this concept has been used to demonstrate not just how our decision-making can be supported by those with whom we stand in concrete and interdependent relationships but by the social institutions that at once both presuppose and promote autonomous decision-making. Mackenzie takes the concept of agential relationality to mean that we make choices through deliberation with others, and that we need to feel included in discussions of this kind to regard our choices as worthwhile.²³ Joel Anderson agrees that social recognition is essential to robust agency, and argues further that we are rendered vulnerable by what he calls imposed infeasibilities, or policies that impose

21 Catriona Mackenzie, "The Importance of Relational Autonomy and Capabilities for an Ethics of Vulnerability," in *Vulnerability: New Essays in Ethics and Feminist Philosophy* (London: Oxford, 2014): 33-59, at 41.

22 Miller, *The Ethics of Need*, 23-31.

23 Catriona Mackenzie, "The Importance of Relational Autonomy and Capabilities for an Ethics of Vulnerability," 44.

duties upon us while presupposing autonomy competencies we don't possess. The extent to which we are autonomous depends, he argues, on what is institutionally expected of us, thereby making our agency socially dependent.²⁴

The upshot for institutional vulnerability theorists who see the relevant harm in terms of autonomy deprivation is that we must include among the basic needs required for a meaningful life the kinds of social supports and relational opportunities necessary for developing and exercising our autonomy. For Mackenzie, these cannot be ensured merely by taking special care of those close to us, precisely because constructing the type of social scaffolding necessary for social inclusion is inevitably a collective project. Anderson argues further that since our autonomy competencies must be bolstered to lessen our vulnerability to imposed infeasibilities, the relevant correlative duties must clearly fall on those who impose or benefit from the policies in question. Once again we see the pattern of institutional vulnerability theory: the harm to which the vulnerable are rendered susceptible due to a deprivation in necessary goods is impaired autonomy, and the promotion of autonomy requires that we erect and maintain institutions that guarantee these goods.

C. Flourishing

A third strategy cashes out the harm in question in terms of impaired flourishing. This strategy is one to which a great many needs theorists are

²⁴ Joel Anderson and Axel Honneth, "Autonomy, Vulnerability, Recognition, and Justice," in *Autonomy and the Challenges to Liberalism* eds. John Christman and Joel Anderson (Cambridge: Cambridge University Press, 2015): 127-149. See also: Joel Anderson, "Autonomy Gaps," in this volume.

themselves partial. According to Garrett Thompson we are harmed when we are rendered unable to flourish due to a needs deprivation.²⁵ The good that the satisfaction of our basic needs makes possible consists in our having the ability to engage in certain types of intrinsically valuable activities, and a deprivation in our basic needs is harmful precisely because it thwarts us in this regard. David Braybrooke gives further content to this concept. He argues that the specific kind of harm we suffer if our basic needs go unmet is that we are unable to carry out the tasks associated with the basic social roles of parent, householder, worker, and citizen. To flourish, or to function normally as a human being, on his view, is to perform the tasks associated with these basic social roles, or more precisely, to be able to perform these tasks without derangement.²⁶ What he calls course-of-life needs are those needs essential to carrying out the four tasks essential for a flourishing human life. That our duty to meet these needs is a duty of justice, for Braybrooke is established on the straightforwardly consequential basis that more people will meet others needs when these duties are enforced.²⁷

Although neither a self-described vulnerability theorist nor basic needs theorist, Martha Nussbaum offers an account of our duties to the vulnerable that appeals precisely to the injustice of impaired flourishing imposed by institutional deprivations in certain necessary goods. On her account, to flourish as the kinds the beings we are, and thus to live the life of a dignified human agent, we require the

²⁵ Thompson, *Needs*, 39.

²⁶ David Braybrooke, *Meeting Needs* (Princeton: Princeton University Press, 1987).

²⁷ David Braybrooke, "The Concept of Needs, with a Heartwarming Offer of Aid to Utilitarianism," in *Necessary Goods*, ed. Gillian Brock, (Lanham: Rowman & Littlefield, 1998): 57-72.

capabilities relevant to self-determination, and to experiencing our embodiment without suffering or deprivation. The goods, or capabilities, necessary to alleviating vulnerability are those essential to the leading a distinctly human life of value, which involves having the freedom to function in various choice-worthy ways, including ways that celebrate and recognize our embodiment.²⁸

For Nussbaum, vulnerability arises when one's achievement of meaningful human goals and the exercise of one's distinctly human capacities is impaired due to an absence of the relevant capabilities for functioning, and thus for flourishing. That these impairments are experienced by some more than others is not the result of nature, or the mere fact of differential embodiment, but of an unjust global institutional order. Indeed vulnerability, understood as a deprivation in essential capabilities for functioning, serves as an indicator of injustice for Nussbaum.²⁹ The relevant duty of justice is a duty to enable equal flourishing by working to guarantee the capabilities essential for valuable functionings wherever, and for whomever, we find them to be lacking. Once again the pattern of institutional vulnerability theory: the harm to which the vulnerable are rendered susceptible due to a deprivation in necessary goods, understood as central human capabilities, is impaired flourishing; our correlative duty is not simply to respond interpersonally in caring ways, but to erect and maintain institutions that guarantee the necessary goods.³⁰

28 Martha Nussbaum, *Frontiers of Justice*, 278.

29 Martha Nussbaum, *Women and Human Development: The Capabilities Approach* (Cambridge: Cambridge University Press, 2000).

³⁰Martha Nussbaum, *Creating Capabilities* (Cambridge: Harvard University Press, 2011).

According to each of the three preceding versions of vulnerability theory, the vulnerabilities that give rise to collective obligations are the result of particular social deprivations that put some in a more precarious position than others with respect to a particular harm. The purpose of this survey was to demonstrate a pattern, whereby the collective duty generated is one according to which we must meet needs to prevent the relevant harm, be it exploitation, or impairments in agency, or flourishing. We sought to demonstrate this pattern to show that vulnerability as a concept is not in fact doing the justificatory work of institutional vulnerability theory. Reconsider the pattern:

- 1. Some members of our society are more vulnerable than others to harm X because their basic needs are going unmet;**
- 2. Our duty to the vulnerable is generated by the imperative of preventing harm X (exploitation, impaired agency, impaired flourishing);**
- 3. Our duty to the vulnerable consists in the requirement that we erect and maintain institutions that meet basic needs.**

It is not vulnerability as such that is normatively relevant here, it is the harm to which we are put at risk due to a deprivation in our basic needs. Without an appeal to one of the normatively weighty concepts that serve as a stand in for harm X, vulnerability theory cannot justify a duty to meet needs. It describes the state of being deprived and thereby at risk. What it provides, therefore, is a useful rhetorical device by which we might better identify the needy and discuss the goods required by those most at risk of relational harms. But it cannot normatively ground the relevant duty without appeal to basic needs and the end to which their satisfaction aims. Conceptually speaking, therefore, vulnerability looks like a mere middle-man, and vulnerability theory like basic needs theory with a different name.

Why is this problematic? Not just because it looks like philosophical smoke and mirrors, but because it is one of moral and political philosophy's most significant tasks to differentiate between concepts that *describe* and concepts that *oblige*. Terms like vulnerability (along with exploitation, commodification, and propaganda, to name a few) have an enormous amount of rhetorical force. They are used liberally to describe a wide array of actions and scenarios that happen to strike us as morally troubling. And their use alone is presumed to be adequate to explain and justify our moral condemnation, and even in some instances social regulation and criminal legislation.³¹ But it is precisely when handling concepts that carry such significant rhetorical force that philosophers themselves have to be the most careful.³² The philosopher should instruct us with respect to their proper application and give us the tools with which to determine their frivolous or clumsy use. Consider, for example, Alan Wertheimer's trenchant analysis of exploitation, and the distinctions

31 Consider legislation which criminalizes the sale of bodily goods and services on the grounds that they exploit women. See for example Canada's Assisted Human Reproduction Act (S.C. 2004, c.2) which criminalizes paid surrogacy, or Canada's Protection of Communities and Exploited Persons Act (S.C. 2014, c.25) which criminalizes prostitution under described circumstances. Both acts condemn the exploitation of women, but neither supplies an account as to why paid gestation or paid sexual encounters are inevitably exploitative. The rhetorical force of the term is left to do the moral persuasion and legal justification, and we are left with what are arguably unjust restrictions on women's choices regarding both their bodies and their professions.

32 Vulnerability, as a concept, has been made much of in bioethics. It has been called forth both to identify those most susceptible to poor health outcomes or to unjust exclusion from health care systems, and has also served as valuable tool by which to cash out the ethical duties of medical and clinical researchers to their test subjects, and of physicians and hospital administrators to their patients and clients (See Wendy Rogers, "Vulnerability and Bioethics," in *Vulnerability: New Essays in Ethics and Feminist Philosophy*, eds Mackenzie, Rogers, and Dodds (London: Oxford, 2014): 60-88). But the concept has also, and more troublingly, been used as a label to exclude certain groups, such as pregnant women, from participating in clinical research of potentially significant value both to themselves and other members of their social group. See Toby Schonfeld, "The Perils of Protection: Vulnerability and Women in Clinical Research," *Theoretical Medicine and Bioethics* 34,3 (2013):189-206. Vulnerability, therefore, like exploitation, is a double-edged sword: while the term's rhetorical force might enable us to call for the protection of needy populations, its clumsy or unjustified use can come at significant cost to them.

he offered between cases in which we can identify exploitation but not condemn it, and still others in which we can condemn but not regulate.³³

What practical philosophy offers are the tools to think more carefully about morally laden concepts, and how and when they are rightly employed – or deployed. It is not that institutional vulnerability theory fails to do this entirely. But while the concept's use adds something interesting of both critical and descriptive value to our thinking about social and distributive justice, it does not *thereby* add anything of normative value. Our task in part one of this paper, then, has been to show that foundationally speaking, when it comes to grounding our duties of justice, institutional vulnerability theory doesn't seem to get us anything we don't already have. We turn now in part three to articulating a second troubling aspect of institutional vulnerability theory, namely that in its appeal to basic needs it not only fails to offer novel foundations for our duties of justice, but also to provide adequate content to these duties.

Part 3: Vulnerability Theory and Health Care

Whether the concept of vulnerability proves to be normatively foundational or, as we argued in the previous section, a merely descriptive concept that alerts us to obligations grounded elsewhere, institutional vulnerability *theory* nonetheless offers a distinct account of our duties of justice, an account that many of its proponents see as a viable alternative to contractualist views. A closer look at the content of our duties of justice according to institutional vulnerability theory,

³³ Alan Wertheimer, *Exploitation* (Princeton: Princeton University Press, 1999).

however, calls this ambition into question. We focus here on institutional vulnerability theory's implications for health care justice in particular, in part because we recognize the significance of vulnerability theory's many important contributions to micro-level bioethics in spelling out the duties of doctors to patients and researchers to subjects. These contributions are extremely valuable, and yet for vulnerability theory to play a foundational role in bioethics, it ought to be able to say something about macro-allocations as well; it ought to be able to provide a justification for the provision of health care in general.

To provide an adequate justification for a robust health care system, it is not enough to articulate a set of reasons why it is morally desirable that we meet citizens' health needs. Any moral theory worthy of the name can say something in favour of the proposition that, all else equal, it is a good thing when people are able to access needed medical care. Importantly, though, the specific reasons proffered for meeting people's health needs will also determine the shape and scope of public health care institutions. This is where institutional vulnerability theory falls short. We argue that, inasmuch as institutional vulnerability theory holds that our obligations of justice are to prevent certain kinds of harm by meeting citizens' basic needs, the theory yields a surprisingly limited set of duties of justice, and these limited duties prove particularly insufficient to justify an adequate health care system. This finding may be unexpected to those who imagine vulnerability theory as a more demanding account of social justice than rival bargaining models.

In particular, we will argue that institutional vulnerability theory cannot justify health coverage that has three important features. First, institutional

vulnerability theory cannot justify the *universal* provision of health care or health care insurance. Wealthy liberal democracies extend health care coverage to all citizens, not just a select few. Second, institutional vulnerability theory cannot justify health care coverage that is *comprehensive*. Public health care or health care insurance systems tend to cover all of an ordinary person's health care needs, rather than a bare minimum. Third and finally, it cannot justify the *mandatory* provision of health care coverage. Citizens in liberal democracies may not opt out of their health care benefits in exchange for their present cash value, regardless of how much they might prefer it or how much more they might need something else entirely.

We argue that, as a theory of health care justice, institutional vulnerability theory is unable to justify a health care system with all of these features. In the rest of this section, we take up each in turn and show that institutional vulnerability theory is unable to account for it. Of course, not all forms of institutional vulnerability theory discussed in the previous section struggle with each to the same degree, as we will see, but none can explain them all, and thus none can properly account for the health care systems we know and value.

This is problematic for at least two reasons. First and most obviously, we take it that these three features—universality, comprehensiveness, and mandatoriness—have obvious intuitive appeal. Indeed, they form the core of our shared understanding of what a just health care system should look like, and a theory that cannot account for them is to that extent normatively deficient. Second, these features are already firmly entrenched in the health care systems of existing liberal democracies. To the extent that institutional vulnerability theory aspires to provide a

theory of the welfare state, it ought to be able to ground these features. We do not mean to suggest that normative political philosophy must be hostage to the real; as vulnerability theorists know all too well, existing health care systems are often plagued with inequities and inefficiencies, and in the face of these, political philosophy should be able to provide space for critique and guidance for reform. But we take it that these three important features of existing health care systems are, as it were, “fixed points” which a theory must accommodate.³⁴

A. Universality

The health care systems that we see throughout the developed world are typically universal in scope, and a theory of health care justice ought to be able to justify this. Making the political case for universal health care has everywhere meant advocating for the extension of health care access *down* the income scale, toward the most vulnerable members of our society. Indeed, this remains a matter of pressing moral concern today, even in the developed world. And yet if we are looking for a theory of health care justice that justifies *universal* access, we must be careful not to focus too much on the case for helping the disadvantaged, lest we lose sight of the rationale for covering the well-to-do and the middle class as well.

This is precisely where institutional vulnerability theory runs into trouble. As we saw in the previous section, institutional vulnerability theory holds that, because some members of our society face basic needs deficits which leave them vulnerable

³⁴ For an interesting discussion of some of these issues, see Joseph Heath, “Three Normative Models of the Welfare State,” *Public Reason* 3.2 (2011): 13-43, at 13-15.

to specific harms, such as exploitation or loss of autonomy, we therefore have a collective obligation to protect those individuals from those specific harms by erecting and maintaining institutions to meet their basic needs. Rich and middle-class persons do not face basic needs deficits, and thus they are not vulnerable to the specific harms that follow from them. According to institutional vulnerability theory, therefore, our obligations to meet basic needs simply do not extend to them.

It does not help to point to the fact that all citizens, even rich ones, have basic needs. According to institutional vulnerability theory, it is not the mere fact that people have basic needs that generates collective obligations to erect institutions to meet those needs. What triggers collective obligations is rather the prospect of a basic needs *deficit*, which leaves an individual vulnerable to a specific kind of harm. All citizens have basic needs, but *only some have needs that are going unmet*. Thus even though all citizens have nutritional needs, for example, institutional vulnerability theory does not imply that nutritional assistance programs should be universal in scope. These programs are properly restricted to the truly disadvantaged, those who may come to harm because of a lack of nutrition. In principle, the same considerations should apply to health care.³⁵

The scope of health care provision is narrowest on a view like Goodin's, on which the purpose of welfare state institutions is to prevent relationships of

35 For the reasons glossed in this paragraph, a pure basic needs view might fare better than a vulnerability-based view at justifying universal health care. On the other hand, if the mere fact of having basic needs (as opposed to having an actual or potential *deficit* of basic needs) triggers a collective obligation to meet those needs, then basic needs theory would appear to mandate not only universal health care but also universal programs providing food, water, housing, clothing, and so on. We would regard this as an embarrassing implication of the theory, but some might see it otherwise.

dependency from becoming exploitable. If it is only the dependent who require collective protection, then it seems like we only have a justification for providing health care to them.³⁶ But even on a view that understands vulnerability in terms of potential harms to autonomy or to flourishing, there is simply no case for covering the truly well-off. Again, the reason is simply that the well-off have ample means to purchase their own health care; they are not at all vulnerable to a basic needs deficit, and so *a fortiori* they are not vulnerable to any further harms that such a deficit might cause.

To be clear, we are not suggesting that there is any serious danger that the rich might be shut out of access to health care institutions. Nor do we mean to posit some kind of false moral equivalency between advocating for the interests of the vulnerable and advocating for those of the well-to-do. But advocacy is one thing and theory is another, and if we are looking for a theory of health care justice that fits existing health care institutions, it ought to justify the provision of health care for rich and poor alike. Institutional vulnerability theory cannot justify the universal provision of health care.³⁷ If vulnerability theory were the correct theory of health

36 For what it's worth, Goodin himself acknowledges this implication of his view; he does not intend his theory to extend to universal programs like health care. Goodin, *Reasons for Welfare*, 5-7, 368-369.

37 It might be suggested that the problems glossed in this section could be circumvented by shifting from an institutional to an ontological understanding of vulnerability. Institutional vulnerability theory's problems in justifying universal access to health care stem from its focus on the *particularly* vulnerable, so an account of vulnerability that focuses on the ways in which we are all vulnerable might fare better. Martha Fineman's account, for example, focuses on the ways that institutions can promote resilience in the face of universal vulnerability.

The most important thing to notice about Fineman's view is that, insofar as she circumvents the problems that institutional vulnerability theory faces in justifying universal access, she does so by appeal to an independent norm of equality. Fineman argues that there is something valuable in ensuring that access to social institutions that promote resilience is equally distributed. Absent this appeal to equality, she would have no answer to the question of why access has to be universal and comprehensive. It may be that we are universally vulnerable to ill health, but only

care justice, we should expect to see public health care only for the poor and vulnerable, leaving rich and middle-class persons to obtain their health care on the market, from their own resources.³⁸ But this is not what we see, nor (we would suggest) is it something we should want.

B. Comprehensiveness

Another important feature of public health care systems in the developed world is their comprehensiveness. Political philosophers and bioethicists often talk about the moral imperative of guaranteeing everyone at least a “decent minimum” of health care, but in fact rich-world health care systems typically provide for all of the health care needs of an ordinary person. This is not what we should expect if the purpose of our public health care institutions were merely to meet the basic needs of vulnerable people in order to prevent certain specific types of harm. Indeed, depending on the nature of the harm we are obliged to prevent, institutional vulnerability theory predicts a very stingy level of health care provision indeed. Just how stingy, though, will depend upon the harm we have to prevent.

An autonomy-based account of vulnerability would have trouble justifying any important health care services that do not protect or restore patients' autonomy. Consider, for example, the case of palliative care and other end-of-life services. By one oft-cited estimate, some 30% of health care expenditure in the United States

some of us are vulnerable to going without health care. See Martha Fineman, “The Vulnerable Subject and the Responsive State,” *Emory Law Journal* 60.2 (2010): 251-275.

³⁸ Of course, in certain places it might prove pragmatically necessary to extend health benefits beyond the truly disadvantaged in order to secure political support for covering for the truly vulnerable. We do not doubt that as a matter of coalition-building such trade-offs may be necessary, but this would provide only a contingent and indeed tenuous reason for covering the non-vulnerable. It would not be a principled reason, and it would certainly not show that the well-off were entitled to such benefits as a matter of right. cf. Goodin, *Reasons for Welfare*, 19.

goes toward patients in the last six months of life.³⁹ We grant that we do not always know until after the fact when a patient has entered the last six months of her life, and some care delivered in that interval is genuinely intended to restore a patient to autonomous functioning. But often it is known that death is imminent, and care is administered merely for the sake of relieving pain or postponing the inevitable.⁴⁰ On an autonomy-based view of health care, such care would be completely unjustified.

Indeed, the problem is even worse, for depending on how autonomy is construed, an autonomy-based view could have trouble justifying almost any kind of care that does not directly protect our cognitive capacities for reflection and choice. A person is not necessarily less autonomous just because there are some things she cannot physically do; we are not less autonomous for being unable to sprint like an Olympic athlete, and in principle the same point applies to someone who is unable to do any number of other things due to disease or disability. No doubt we have a collective obligation to treat these impairments (and/or to provide functional replacements where needed), but we question whether such care can truly be described as protecting patients' autonomy.

A view grounded in flourishing can avoid some of these problems. At least, such a view would find it easier to explain why we treat “merely” physical diseases and disabilities in addition to those diseases that merely affect people's capacities for autonomous choice. Even if we are not less autonomous for being unable to engage in certain characteristic human activities, these impairments do affect our

39 Jonathan Gruber, *Public Finance and Public Policy* (New York: Worth, 2005), 443.

40 Shlomi Segall, “Is Health Care (Still) Special?,” *Journal of Political Philosophy* 15.3 (2007): 342-361 at 347-8.

ability to flourish. But a flourishing view will have the same difficulties as an autonomy view with justifying palliative and end-of-life care, since such persons have passed the point at which they can lead a flourishing life.

A flourishing view will suffer further defects as well. Consider Braybrooke's claim that our obligation is to satisfy the course-of-life-needs of parents, workers, homeowners, and citizens.⁴¹ What of the health needs of those individuals who are unable (or unwilling) to participate in some combination of those social roles? Treatment of these needs would not appear to protect their flourishing in those roles, and so would appear to fall outside the scope of justice, at least according to institutional vulnerability theory. And if that worry speaks more to the problem of universality than comprehensiveness, then we reiterate our concern that this type of view seems unable to justify meeting the end of life health needs of those who once occupied these roles but who will never do so again.

A theory of health care justice grounded in the importance of protecting patients from certain very specific harms should in principle justify only such care as actually prevents the relevant harms. And yet what we see in the real world are health care systems that are, with some exceptions, quite comprehensive in scope. It is true that services like dentistry, optometry, and fertility are often excluded from public health care systems, and we would join those who advocate for expanding access to these services; but this would only appear to move the justificatory bar further from the reach of institutional vulnerability theory. By and large citizens of

41 Braybrooke, "The Concept of Needs, with a Heartwarming Offer of Aid to Utilitarianism," 60-61.

wealthy countries expect and receive far more than the “bare essentials” when it comes to health care, and rightly so.

Before closing this section, however, it is worth pointing out that while on the one hand autonomy and flourishing-based views appear to justify too little by way of health care provision, particularly with respect to end of life care, in another important respect they threaten to justify too much. Existing health care systems are comprehensive, but only with respect to services properly regarded as treatments, not enhancements. Treatments are geared toward preventing departures from, or restoring a patient to, their normal range of functioning, while enhancements seek to expand an otherwise normal range of functioning.

That our health care systems are characterized by their comprehensive with respect to treatment but not enhancement, is captured by the mandate that covered services be ‘medically necessary,’ that is, reasonable and effective for the treatment or prevention of disease and disability. On autonomy-based and flourishing-based accounts of institutional vulnerability theory, however, the mandate is to meet needs defined as those things we require to avoid harms to our agency or our capacity to flourish. It is easy to see that autonomy needs or flourishing needs need not map neatly onto the concept of medical need. Arguably there are a great many cognitive and physical enhancements that could improve our capacity for rational reflection or expand our potential range of meaningful activities, and thereby enable us to avoid the harm of limits to agency or constraints on available avenues to a meaningful life. If, therefore, we understand health care provision as intended to provide those goods required to avoid harms to agency or flourishing rather than to

treat disease and disability *per se*, we may lose sight of any rationale for providing services on the basis of medical necessity, and we may have to abandon the treatment-enhancement distinction altogether. Thus while for the most part we worry that these views justify too limited a package of covered services, we note that they also have the potential to overshoot the target and get us too much in some ways, even as they deliver too little in others.

C. Mandatoriness

The flip side of the fact that health care systems in the developed world are universal is that they are also typically mandatory. We do not mean that health care is mandatory in the sense that sick persons are forced to submit to treatment against their will. Rather, we mean that citizens of wealthy liberal democracies are not usually allowed to opt out of their health care coverage and take an equivalent cash benefit or tax credit instead, and this is so regardless of how much they might prefer the latter (or indeed how much more they might need it).

It might be thought that vulnerability theory can readily explain this particular feature of health care delivery. There is a widespread intuition in moral philosophy that meeting basic needs is somehow more important or more urgent, morally speaking, than merely satisfying people's preferences. Many people think that this greater urgency justifies providing certain forms of social assistance in-kind only. T.M. Scanlon captures the intuition aptly: "The fact that someone would be willing to forgo a decent diet in order to build a monument to his god does not mean that his claim on others for aid in his project has the same strength as a claim for aid in obtaining enough to eat (even assuming that the sacrifices required of others

would be the same).⁴² Goodin seems to appeal to something like this intuition when he suggests that welfare state benefits are appropriately provided in-kind rather than in cash; on Goodin's view, this is because the aim of these benefits is not to promote citizens' autonomy or to satisfy their preferences but to prevent exploitation, and this aim is accomplished by making sure citizens basic needs are met.⁴³ The underlying idea must be that preventing exploitation by meeting basic needs is a more serious or urgent task than simply helping citizens get what they want.

The problem with this line of reasoning is that it does not necessarily support mandatory provision. It may well be true that a person has a stronger claim for aid in satisfying her basic needs than she has for aid in fulfilling her other projects, but that is a claim about the relative urgency of various *ends*; it does not necessarily entail anything about the best *means* for realizing those ends. The greater urgency of satisfying basic needs does not yield a presumption in favor of mandatory, in-kind provision unless there is good reason to think that mandatory provision is a more effective means to that end than the available alternatives, such as cash transfers. It is difficult to imagine why this must be the case, unless we are prepared to assume that vulnerable people are not actually willing or able to use their money to obtain the things that they need. This assumption is dubious, resting as it does on a rather dim view of the rationality of vulnerable people. We are generally suspicious of

42 T.M. Scanlon, "Preference and Urgency," *Journal of Philosophy* 72.19 (1975): 655-669, at 659-60.

43 Goodin, *Reasons for Welfare*, 11.

arguments that smack of paternalism, particularly when such paternalism is directed towards the vulnerable.⁴⁴

Giving people money is usually not an alternative to meeting their basic needs, but an alternative *way* of meeting their basic needs. And may prove to be a better way, at that. Here it is important to keep in mind that vulnerable people are often vulnerable along more than just one dimension. Thus while forcing vulnerable people to devote a certain portion of their public benefits to health needs can be an effective way of making sure their health needs are met, it is often an equally effective way of making sure that some of their other needs go *unmet*. Goods provided in-kind can meet one kind of need only, but families can direct their cash benefits wherever they are needed most, whether that is health care, nutrition, housing, or what have you.⁴⁵ In this respect, cash benefits would be better able to protect the vulnerable and thereby to satisfy the requirements of institutional vulnerability theory.

The difficulty of justifying the mandatory provision of health care on autonomy-based views is particularly acute. These views would appear to generate a strong presumption in favor of cash benefits, allowing individuals to choose for

44 Mackenzie, "The Importance of Relational Autonomy and Capabilities for an Ethics of Vulnerability," 46-47

45 It may be objected here that vulnerable persons should not have to choose between paying for medical care and paying for other basic needs. We would agree. But while the mandatory provision of health care does indeed preclude this choice, it does so without necessarily doing anything to ensure that people's other basic needs are met. In light of this, one might suggest retaining mandatory provision of health care and adding additional social programs to ensure all other basic needs are met in-kind. But an equally promising solution might be to dispense with mandatory provision altogether in favor of a more generous cash transfer. Our point is only that the choice between these policies ought to be made on the basis of which most effectively protects the vulnerable.

themselves how best to deploy their share of social resources. Of course, there is always a tension between protecting people's capacities for autonomous choice and respecting particular exercises of those capacities, particularly because people will sometimes make choices that tend to undermine their choosing capacities. This tension may seem to speak in favor of paternalistic measures like the mandatory provision of health care, but in a thoroughly equivocal way; overriding someone's autonomous choice in the name of protecting her autonomy is both conceptually and morally fraught territory.

Our aim in this section is not to reject the mandatory provision of health care benefits; we see this as an important feature of health care provision. Our aim has been to show that, for a view which treats social benefits like health care as instrumental to meeting basic needs, which in turn is treated as instrumental to protecting the vulnerable from certain specific harms, it is not clear that the mandatory provision of health care will prove the most effective means. Presumably the choice between a policy of mandatory health care provision and a policy which allows citizens to opt for a cash benefit instead should be made on the basis of which can be expected to best protect the vulnerable from the relevant harm to which they are susceptible. What we hope to have shown is that it is at least *possible* that cash benefits might do better, at least in certain circumstances, and thus a positive case for mandatory provision ought to be forthcoming. Few vulnerability theorists have attempted to make that case, perhaps because they have assumed that establishing an obligation to meet people's basic needs entails an obligation to meet them directly and in-kind. On our view, no such conclusion necessarily follows.

We have argued that institutional vulnerability theory is ill-suited to justify three of the most intuitively appealing and ubiquitous features of health care systems throughout the developed world: their universality, their comprehensiveness, and their mandatoriness. To justify these features, it is necessary to appeal to the benefits of health care to all, not just to those most vulnerable to certain kinds of harm. This is true even though helping the poor and vulnerable is a more urgent task, morally speaking, than ensuring that wealthy and middle-class persons can access care.

By way of concluding this section, it is worth pointing out that the three features of health care systems that we have isolated are significant not only for being intuitively powerful and entrenched in liberal-democratic practice; they also enjoy widespread support from other existing theories of health care justice. A number of theories of health care justice converge on the importance of a health care system with these features, including Norman Daniels' influential opportunity-based account and Ronald Dworkin's theory of equality of resources.⁴⁶ These views sometimes attract criticism for their individualistic foundations, but their robust egalitarianism yields attractive accounts of justice in health care, at least along the three dimensions that have been our focus here. While vulnerability theory may therefore provide a compelling critique of the foundations of contractualist views,

⁴⁶ Norman Daniels, *Just Health* (New York: Cambridge University Press, 2008); Ronald Dworkin, "Justice in the Distribution of Health Care," *McGill Law Journal* 38.4 (1993): 883-898; Ronald Dworkin, *Sovereign Virtue: The Theory and Practice of Equality* (Cambridge, Massachusetts: Harvard University Press, 2000).

our analysis here suggests that it looks less able to ground the central features of the welfare state, and certainly our duties of health justice.

Conclusion:

Our aim in this paper has been to question the ability of what we have called institutional vulnerability theory to ground our duties of justice, specifically as they pertain to health. Our conclusion is largely a negative one. As we argued in part one, institutional vulnerability theorists are able to ground duties of justice only by relying on a pattern of argumentation that takes basic needs as central and thereby appeals to the normative importance of preventing the harms to which a deficit therein gives rise. The upshot of this argumentative pattern, we argued in part two, is that vulnerability itself is rendered normatively irrelevant to vulnerability theory. This should strike us as significant if we expect our moral and political doctrines to properly distinguish between concepts that describe and concepts that oblige.

We went on to show in the second part of the paper that institutional vulnerability theory is not only unable to provide distinct grounds for our duties of justice in a theoretical sense, but also fails to ground the three central features of a just health care system. The view is ill-suited, we argued, to justifying the fact that public health care systems tend to be universal, comprehensive, and mandatory. We close by avowing that we do not question the ability of relational vulnerability theory to account for our interpersonal duties of virtues. It is with respect to grounding the institutions of the welfare state – and specifically those pertinent to

meeting health needs - that we found vulnerability theory to be lacking, and that is what we hope to have demonstrated here.