

## Reading SAL: Week 11

### SAL's introduction to Allocation, Social Justice and Health Policy (pp. 173-179)

We are 'created equal' with respect to being equally entitled to respect and dignity. We are not created equally healthy—the 'natural lottery' gives some people good health, some catastrophic diseases.

Nor are we equal in access to health care. Access to h/c in the US depends upon availability of insurance, either privately purchased, through an employer, or through government sponsored programs such as Medicaid and Medicare. As a result, the 'social lottery'—one's financial resources—can also contribute to inequalities. People who rely on Medicaid can suffer from a pattern of constant reduction in reimbursement to providers, which can imperil the quality of care—hospitals that deal with a predominantly Medicaid population are notoriously understaffed and undersupplied. In addition, there are approximately 47 million people who are not poor enough to qualify for Medicaid but cannot afford to purchase health insurance.

How should we think about the results of these inequalities in the natural and the social lotteries? Are they misfortunes, or injustices?

One form this discussion takes is the question of whether there is a 'right' to health care. Most of the people we read this week deny that there is such a 'right.'

(1) There may be a moral obligation on the part of a society to provide a "decent minimum" of health care to citizens, and what counts as a decent minimum in a given society depends upon its resources and technological sophistication. (cf. President's Commission, Daniels.) But: a decent minimum does not necessarily equate with all the care that a person might want—or need. Nor is health care necessarily the only contribution to equality of opportunity that a society must concern itself with—schooling, housing, nutrition and jobs also have a claim on social support. Daniels justifies the obligation to provide a decent minimum of health care by arguing that society does owe its citizens equality of opportunity—and that health needs have a foundational role in access to equality of opportunity.

Different concepts of equality generate different answers to that question. They suggest four concepts of macro-level justice: (a) the total sum of health for society; (b) equalizing the level of health between classes; (c) maximizing the health of the least advantaged; (d) priority to the sickest, regardless of class.

The typical liberal position – eg Rawlsian (or Daniels') liberalism--wishes to maintain that social and economic inequalities can be allowed to exist so long as the result is not inequality in basic liberties, and that the existence of inequalities works for the betterment of the worst off. But if the society is too inequitable, it threatens the justice of the society.

(2) Engelhardt rejects liberal egalitarian theories of health care justice. He maintains that free and equal individuals should not be coerced into accepting (much less paying for) others' priorities in health care—or, for that matter, the social priorities of others.

The idea of a 'right' to health care is unfounded (because it relies on one of the possible understandings of justice, none of which are universally accepted) and dangerous (because it threatens the rights of others with a different vision). Society has the right to tax citizens for any purpose (including healthcare for the needy, if it chooses) but that does not give anyone a 'right' to such care.

(3) Growing evidence of the correlation of social indications with lower health status raises the question of whether it is more effective to direct attention to healthcare, or to direct attention to ameliorating the social inequalities with which lower health status is correlated. Gopal Sreenivasan's contribution to the volume raises this question explicitly.

### Daniels(1988): Equal opportunity and health care

The issue Daniels is considering is access to health care.

We can't figure out what principles of justice should govern access to healthcare by consulting general philosophical theories of justice. First we need to specify what kind of 'good' health care IS. Is it a commodity, like computers, to be governed by market logic? Or does it have a special status due to its fundamental effect on wellbeing?

The 'normal opportunity range:' The normal opportunity range for a given society is the range of life plans reasonable persons in it are likely to construct for themselves. *Fair equality* of opportunity requires that opportunity be equal for persons with similar skills and talents. (This doesn't mean 'equal' opportunity, necessarily—but it does mean opportunity consonant with skills and talents.) And: impairment of normal function (through disease and disability) restricts individuals' opportunities relative

to that portion of the normal range their skills and talents would have made available to them if they were healthy. Thus, considering the impact of impairment of disease and disability suggests that the principle that should govern the design of the health care system is the principle guaranteeing fair equality of opportunity. It should be applied on the macro level: the moral function of a healthcare system must be to help guarantee fair equality of opportunity.

Looking at how that might play out, we can see that it need not exclude a two-tier system. The basic tier (a) should include services that meet important health care needs that impact the opportunity-range, and (b) should be considered a 'decent basic minimum,' (c) to which there should be NO obstacles (financial, racial or geographical) to access. There can still be a second tier—less important needs or preferences, like cosmetic surgery, to which there can fairly be eg. financial obstacles. Social obligations are focused on the basic tier, the 'decent basic minimum.'

This principle requires emphasis on preventative measures and on public health measures.

It does not give individuals a 'right' to have all their health care needs met.

The principle of justice guaranteeing fair equality of opportunity shows that individuals have legitimate claims or rights when their opportunity is impaired in particular ways—against a background of institutions and practices which protect equal opportunity.

The scope and limits of these rights—what they can be spelled out as requiring—is relative to resource scarcity and technological development for a given society. We cannot infer from the fact that a person has a 'right' to healthcare that s/he is entitled to some specific service. That is true only if it is or ought to be part of a system that appropriately protects fair equality of opportunity.

**Engelhardt (1997): Freedom and moral diversity: the moral failures of healthcare in the welfare state.**

*The problem with Clinton's health care plan is that it would have established a welfare right to health care, and forbidden a two-tiered system. Engelhardt (Kass's successor as head of Bush's Bioethics Commission) argues that (1) it is bad to establish a uniform health care welfare right, and (2) it is wrong to forbid people to use their private resources to purchase better-than-minimum health care.*

We disagree about equality, fairness and justice in this society; and there is no resolution to such disagreements in a secular and diverse society. If/since persons are the source of secular moral authority and it is their right to disagree, there is no 'right' to health care.

1. medical welfare: needs do not generate rights. And health care is not basic; unlike food, clothing and shelter, there is no limit on the amount that can be invested and no guarantee that even with infinite resources good results will be achieved. We are finite, vulnerable and mortal.

2. bad luck, unfairness and inequality: Autonomy—people's authority over themselves—sets limits to what governments can decree about human flourishing. To be free means I can risk death or disability by my choices. To have resources means I can spend them as I choose.

A devoted egalitarian would prioritize research on the health of men, children, the poor and 'people of low status' [whatever that means]. But not everyone would agree with that policy, because we don't all have the same understanding of equality.

Three worlds (=three concepts of equality): equality of outcomes, equality of envy, equality of altruism. Even if you could settle on one of these different concepts, like equality of outcomes, you'd still have to specify which outcomes were the relevant ones. To say nothing of problems in determining what the range is of things that government is allowed to control.

An outcome can be unfortunate without being unfair. Which outcomes are unfair rather than just unfortunate, and who should decide that? And why should governments (rather than organizations on other levels) be responsible for welfare?

3. healthcare welfare: a uniform right to health care involves endorsing and establishing one among a number of competing concrete moralities of life death and equality. It risks medically politicizing all elements of personal conduct, and constraining free choice of those with disposable resources.

4. why we are not one moral community: The attempt to develop a uniform, encompassing healthcare welfare right reveals our moral differences concerning the proper understanding of reproduction, suffering and death. Secular morality is procedural, and its legitimacy is limited by the consent of those who participate in common endeavors.

**WHO: Social Determinants of Health: The Solid Facts (2003)**

Much of the variation between (and within) nations in health data is explained not by access to health care, but by independent social factors that constitute a wider material disadvantage: being poor, unemployed, socially excluded, or otherwise stigmatized. The report compares nations with and without universal access to health care in terms of a variety of social factors.

1. Life expectancy is shorter and most diseases are more prevalent in the lower steps of the social ladder.
2. Stressful circumstances lead to worry, anxiety and inability to cope, damage health and may lead to premature death.
3. Maternal and infant health—a good start in life—have profound implications for later health.
4. Life is short where quality is poor. Poverty, social exclusion and discrimination cause hardship and resentment and shorten life.
5. Unemployment : job security increases health, well being and job satisfaction.
6. Friendship, good social relations and strong supportive networks improve health.
7. Drug use is a response to social breakdown and a contributing cause to it.
8. Good diet and adequate food supply are crucial: a diet of fruits, vegetables and legumes.

The article contains social policy recommendations around each of the factors discussed.

### **Daniels: Justice, Health and Healthcare (2001)**

*Daniels has been arguing for 30 years that Rawls' theory of justice provides justification for special attention to health care. Although considerable attention to social determinants of health in recent decades appears to weaken that conclusion, Daniels argues here that the theory, especially the difference principle, remains an important argument for health care.*

There are three questions a theory of justice for health care must answer: (1) Is health care special? (2) When are health inequalities unfair? (3) How can we ration fairly?

Daniels answers the first question by claiming that the role of healthcare is to maintain normal functioning; disease and disability restrict the range of opportunities open to individuals. In the last 20 years it has become increasingly clear that social inequalities—race and class effects—are as important to maintaining health and reducing disability as health care.

In particular: universal access to health care is not a magic bullet.

So how can Daniels/Rawls maintain their argument that his theory of justice is the best solution to the particular problem of unfair distribution of health?

Rawls' theory of justice argued that equal basic liberties, guaranteeing equal political participation, and limiting inequalities to those that benefit the least advantaged promote social and political wellbeing. Daniels applies this to health outcomes, although Rawls himself didn't specifically do so, and argues that promoting social justice also promotes health. He supports this by empirical evidence of correlation of income inequality and health outcomes. Other correlated factors are literacy rates and high school drop-out rates, social capital and political participation.

Rawls' 'difference principle' – inequalities are justified only if they result in benefit to the least well off—suggests that the inequalities that contribute to worsened health incomes are not among those that benefit the least advantaged—on the contrary, they are among those for which there is the best justification for remediation.

Daniels points out that his position converges with that of Amartya Sen's (and Nussbaum's) capabilities-based account of the proper target of justice.

### **Sreenivasan: Opportunity is Not the Key**

Daniels argues that health care is special because health is special. Health is special because it is required in order for an individual to have a fair opportunity for the goods of the society. Daniels connects health with healthcare, which he interprets as requiring universal access.

But: IF introduction (or presence) of universal health care (as in the UK) does not alter a society's gradient in health status; and IF introducing a universal health system would seriously erode the society's capacity to deal with the other determinants of health status—is a society really required to devote a disproportionate amount of the society's funds to a small percentage of the society's members—the diseased or disabled??

