

Reading Interrogations for Equality Seminar

Session 9. Health

November 5, 2009

Alex Hyun

One idea that I'd like to discuss in class is Norman Daniels' argument from equal opportunity for universal healthcare. I found this argument really interesting, and it seems correct to me that universal access to appropriate healthcare is necessary to achieve "equal opportunity" in some sense of that term. A question I had after reading Daniels' essay is, What sort of "equal opportunity" should our society promote? Daniels understands "equal opportunity" in an extended Rawlsian sense. By ensuring universal access to appropriate healthcare, we "protect an individual's fair share of the normal range of opportunities (or plans of life) reasonable people would choose in a given society." And later, Daniels suggests that we should understand the "normal range of opportunities" as being relative to one's age (p. 5). So, the suggestion is that we should distribute healthcare in such a way that protects a person's fair share of those opportunities that are both: (1) within the normal range of opportunities for somebody of that person's age, and (2) would be chosen by reasonable people in that person's society. But if this is the sort of opportunity we want to protect with healthcare, it seems to me that Ronald Green's objection is a good one: Daniels cannot account for the moral obligation to provide healthcare to a 90-year-old, for it seems that the *normal* range of opportunities for a 90-year-old doesn't even include being alive (assuming we understand "normal range of opportunities for a person of age X" as meaning the range of opportunities that most people of age X have; most people don't make it to the age of 90). Is there some other conception of "fair equal opportunity" we could have that is such that a distribution of healthcare meant to protect that sort of "equal opportunity" avoids problems like the one that Green raises? Or alternatively, should Daniels just say that protection of equal opportunity is but one of multiple grounds for universal access to healthcare, and that the sort of justification for providing the elderly with healthcare is different from the sort of justification for providing non-elderly with healthcare?

Ben Kilbarger

I'm interested to hear more about the proper good for distribution relative to health care. Is it *health* itself? That certainly has the advantage of getting right at the very thing that we're concerned to equalize. I wonder if there is a definition of health that is applicable to all persons in a society. Certainly there should be some consensus on a biological definition of what it is for a human animal to be healthy. But individuals decide for themselves how much biological health fits into their personal definition of holistic health, as part of their life-plan, right? This points to a more general point about human freedom that I'll come back to in a bit. Maybe we should focus on distributing *healthcare*. That has the advantage of being much more clearly quantifiable than "health." It's easier to say who has access to healthcare and

who does not, and to equalize that. But again I worry, along with Dworkin, that this is too restrictive of individual freedom. Is health something that can be abstracted from an individual's preferences and life plan? Daniels is right that health affects freedom more generally and can properly be conceived of as an extension of considerations of equality of opportunity. But this just pushes the question back to whether we want to restrict individuals's freedom to restrict their own freedom. Doesn't equality of opportunity include the opportunity to limit my own freedom (by, among other means, neglecting my own health)?

For example, we might follow Dworkin and talk about equalizing resources necessary for acquiring health care. So everyone won't have equal health or equal healthcare, but equal opportunity to acquire health care. Different individuals will value biological health differently, and so spend different amounts of resources on healthcare. Bob likes cigarettes way more than he likes being healthy, so he chooses to spend his resources on the former rather than the latter.

This strikes me as intuitively very plausible. The question remains open as to how the good should be distributed, and its proper relation to other goods to be distributed. But it seems right that the good itself is the resources rather than healthcare or health itself.

Catherine Willis

Like Anita Silvers, I have a hard time with the expression 'normal functioning'. It seems to largely ignore that illness (and normality) are socially constructed and can importantly affect the way people see themselves and the medicalization (or not) of certain health conditions. At first, I thought this term could be replaced by something less problematic, such as flourishing, however this does not seem to solve the problem either (a child who is naturally short may flourish more if we intervened medically to have them be taller). I would also suggest that our society's obsession with normal functioning has meant that we regard aging and the resulting bodily changes as an illness. To me, using these notions of normal functionings to base ideals of justice are intuitively incorrect. The only way I see around this problem is perhaps by looking at the bodily functioning as what is normal the individual level as opposed to societal level (not everyone's normal functioning is the same). This would allow us to see that differences in bodies do not necessarily imply illness, but that it would be a disfunction within ones' body that implies an illness. There are however many medical treatments that aren't really the result of dysfunction but desired bodily function (birth control, removal of large moles) and perhaps introducing individual preference is necessary. This would allow for the fact that someone who was born deaf is seen as being normal but may choose to have cochlear implants. Individual preference is however also unsatisfactory in that it may allow one to decide that being "petite" is a medical condition.

I have a hard time placing Daniels essay as a tool to help us move forward. This is largely because I believe his recommendations to be based on a set of theoretical problems, notably, that we can't decide on principles of distributive justice. While this certainly does have real world implications, I can help but wonder why he selects only this issue from which to derive policy implications. Other issues are clearly important (power/capitalism, medical literacy, inequality etc.). From reading his recommendations we almost come to the conclusion that if insurance

companies only wrote policy more clearly (and we had a conflict resolution system) that we would be that much closer to achieving better health care.

Lastly, I was happy that the focus in much of the readings was on the distribution of health, and not health care. One of the questions that I think that I need more information on is inequality itself as a source of lack of health. Daniels cites social mechanisms by which class is translated into health, but I feel that there is more to it. Esteem for example has important effects on health. Furthermore, a study conducted a few years ago suggested that in Canada poorer Canadians with their doctors were less likely to decide to get heart surgery than their richer counterparts, given similar health conditions.

David Calnitsky

With respect to the essay by Marchand et al, I thought the distinction between “equity as maximization” and “equity as equality” was in part misleading. In their discussion of maximizing health—the premise of which is borrowed from welfare economics and utilitarianism—the authors critique the view noting that “[f]rom this perspective, an improvement in health for the well-off is just as valuable and carries the same moral weight as an improvement in health for the worst off”. They argue that this amounts to distributive neutrality because it “directs us to maximize sum total amounts without regard to how that total is distributed” (456-7).

I think this view is rooted in the unnecessary assumption that interpersonal utility comparisons are impossible. Once we allow for interpersonal utility comparisons there is a potentially more radical interpretation. That is, if there are X units of health to be distributed, the worse-off might value one unit far more than the well-off. In that sense a real maximization in the authors’ terms would both benefit the worse-off and thus reduce class inequalities in health.

I also thought the decision by the authors to discuss “health” rather than “health care” was a bit unclear. First, I don’t think they define health very well; it is clearly a broader concept than health care, but I think it starts to collapse into other concepts, for example, welfare. Second, if health care is susceptible to Arrow’s “bottomless pit” critique of the Rawls’ maximin principle, I didn’t understand why the concept health necessarily evades it.

Jeffrey Grigg

It seems essential—and quite challenging—to maintain discipline about the distinction between health and health care. I was pleased that Marchand and her colleagues started out with this distinction (1998: 450), but I was disappointed with the way they developed the point. Health is a state of being, and although it certainly can be thought of as continuous, most of the discussion seems to emphasize sufficiency. That is, one could certainly observe differences in health among those who are not diseased or disabled (I may be “healthy” but my neighbor could be healthier), but the moral concern seems to emphasize those with a health deficit or pathology below a certain threshold (which Daniels refers to as “normal functioning” [2001: FN 1]).

Health care, on the other hand, is a good or service which is intended to benefit one's health and which can be distributed justly or unjustly. Although the observed distribution of health could be unjust if it corresponds to ascribed characteristics such as race or class, it's hard for me to conceive of distributing health (at least in way that isn't perverse; I suppose one could distribute poor health by poisoning people). Health care, on the other hand, can be distributed, and equal access to health care is essential. Similarly, one can distribute education, but it's hard to think of distributing literacy (Daniels explores this a bit, 2001: 6). Given that health is distributed differently in different health care regimes (universal and otherwise) and different economic contexts, it seems that health and health care are empirically distinct.

Green (2001: 22) suggests that Daniels makes a category error by considering the distribution of health care as a fair equality of opportunity matter rather than a primary good one. Given that primary goods include some opportunities, I would appreciate a review of the distinction between primary goods and fair equality of opportunity as well as some discussion as to how we should classify health and health care in the framework. Is health settled as a primary good; if so, does the health care question hinge on how instrumental one considers health care to be to health status?

Justin Lonsbury

Marchand, Wikler, and Landesman state, "If health is correlated with less inequality in income, then a maximin principle applied to income could come at the cost of losses in health" (463). I don't understand this. It seems as though applying a maximin principle to lift the income of the least advantaged would have to close income gaps between groups, thereby lessening inequality and increasing health. I have a feeling I'm missing something. How could lifting the least advantaged, even if others are still not in a great position, lead to a net loss of health, especially if health is correlated with relative positions rather than absolute levels of income? Is it because the money spent on the least advantaged could be spent differently to maximize instead of maximin health? Still, I'm not sure if that follows from their statement. If someone could make sense of this for me, I'd appreciate it.

I'd also be interested in talking about whether or not people think Daniels' reliance on public processes and procedures is a good idea when it comes to deciding how to ration health care. Given that health is a basic need, it seems as if all people should be healthy before we can expect them to be active and full participants in public decision making. If we decide to deliberate publicly before all have their basic needs met, not everyone will be in the conversation. It is not likely that those who already have their needs met will be willing to voluntarily sacrifice enough to ensure that others have adequate care. Even if they were well intentioned, I doubt that the rich/powerful/healthy would be able to empathize and care enough to offer the amount and quality of care that the underserved deserve. I guess I just feel like a retreat to procedural justice should happen after more principle-based efforts succeed in establishing and providing a basic level of care, even if it's hard to work out and choose among competing principles.

Kelly Robbins

Marchand, Wikler, and Landesman offer an exploratory discussion of the problematic correlation of income inequality and health deficiencies. They give several compelling reasons why this correlation should not lead us to think that these two issues are the same, or morally require the same kind of treatment. Some of these arguments are the usual correlation-causation complaints, some of them point out that we might have different intuitions about the nature of the health and income disparities.

While there seem to be compelling arguments for thinking the health and income problems should be distinguished, I am concerned about what this will mean when we get around to deciding what we're going to do about these things. We can try to equally distribute resources and we can try to equally (not) distribute barriers, but we cannot distribute health per se. Some of these distributable resources could be parts of income, like equal access to healthy foods, some of them could be tax-driven services or policies, like public education about obesity, healthcare, or regulations about ingredients and transparency about food processes. All of these are socio-economic factors, arranged to drive a change in health disparities. Doesn't it seem like divorcing health and income inequalities will at best come down to the same policies as not doing so, and at the worst, distract us from realizing the best policies?

Maybe something sympathetically similar to the authors' conclusions about the (possible) fundamental differences between the two inequalities can be drawn out of this, though. At some point, more resources won't improve the health of any given person. Not just because of the bottomless pit problem regarding the unhealthy, this will be so for the fortunate too. Eventually, more additional resources will do nothing to make a healthy person healthier. So, when justice is concerned with absolute, not relative, levels of health, this is a very different kind of thing than being concerned with absolute levels of income (which could be indefinitely high).

Paul Hanselman

How do we define health? I didn't find a satisfactory answer in the admittedly small group of readings, and yet what we mean by health seems a) slippery and b) consequential for distributional decisions as well as the relative importance of health compared to other goods. Perhaps part of the problem is that health is a concept particularly defined by its opposite, and therefore the term seems precisely characterized as "not sick" or "not un-healthy," which strongly leans towards "not not-normal;" some problems with this are helpfully revealed in Daniels' project. The trouble is with "normal" (which sociologists I believe are contractually obligated to view as the most suspicious word in the English language), how it comes to be defined, and whether the exclusionary character of "normal human functioning" can be justified as coherent within a broader egalitarian agenda. Daniels is aware of some of the problems, given that he discusses that "normal functioning" is a contingent property of a particular society, but I (like Silvers') do not think that he sufficiently addresses how to demarcate "deficiencies in functioning" rightly eradicated through access to healthcare (such as the pneumonia) from "deficiencies in functioning" that society should not in principle be unequal with respect to (such as being wheelchair-bound).

And finally, is there a sensible positive definition of health? I guess I don't see how any positive definition could be crafted outside of the capabilities framework.

Gina Schouten

I'm interested in talking and thinking more about Daniels's claim that healthcare is of special concern in matters of distributive justice because of the effects it has on the opportunities available to people and their ability to maintain normal functioning. I think I agree that healthcare (health?) is "special," but I'm not yet convinced that it's special only in virtue of its impact on opportunities for normal functioning.

Daniels claims that his analysis of why healthcare is special is more intuitively plausible than welfare accounts. He asks us to consider the case of people who have long-standing health impairments, but who have adjusted their goals and expectations such that they are satisfied with their lives, and their health impairment doesn't cause a welfare deficit. Unlike a welfare account, Daniels's opportunities account of the specialness of health directs us to compensate these people for the loss of opportunity that their condition causes them, even in the absence of a loss of utility.

I agree that we ought to be concerned about health impairments even when they're unaccompanied by a utility deficit, but I think that we should *also* be concerned about health impairments when they're unaccompanied by an opportunity range deficit. I have in mind some sort of pain condition that does not affect one's opportunity range, but that nonetheless causes suffering. Daniels's account doesn't imply that the suffering is of no concern, but I think it does imply that the suffering contributes nothing to the specialness of healthcare. This implication troubles me.

Tatiana Alfonso

The nature of injustice in health access and quality—as Marchand Wikler and Landesman point—is difficult to determine. That is a difficult task for philosophers, policy makers and also for the communities involved in the democratic deliberation. I would like to discuss the relation between different sorts of injustices related to the health system.

The recent debate about healthcare in the United States seems to exemplify how difficult is to bring together the principles of justice into the public debate about the allocation of resources for everyone in the healthcare system. This difficulty to create an universal health care system seems to be evidence against Fleck's conclusions, particularly, against the use of rational democratic deliberation to improve quality and access to healthcare. On the other hand, the case also seems to be an example about how difficult is to determine whether or not the injustice is coming either from the condition "health" of a particular group of population because of its conditions of life (poverty for example) or from the inequality in access to the healthcare system. For me, answering that general question requires to analyze the viability and fairness of equity as maximin, as maximization, as equality or as priority. However, the meaning of maximin principle

in every case is not absolutely clear. For that reason, it would be important to clarify first, what is the real meaning of it in the comprehension in the context of the healthcare debate.

Eunhee Han

Daniels (2001) raised three questions: is health care special? When inequalities in health are unjust? How can we meet competing health care needs under resources constraints? I wonder why Daniels asked “is health care special?” I think that he should ask first “why health special?” For the first question, Daniels argued, “health care is of special moral importance, because it helps to preserve our status as fully functioning citizens.” This statement, however, does not fully convince the special importance of health care partly because health, not health care, preserves our status as fully functioning citizen (health care “help” to preserve them) and we are not sure about health care is the only important determinant of health. We know there are other significant social determinants rather than health care. Daniels should have convinced that health care itself of specialty to preserve the social right of citizens or should focus on health.

In addition, although Daniels defined health care broadly including public health, environmental measures, and medical services, he actually didn't pay attention to the quality and range of health care. We care about not only fair distribution of education but also the quality of public education in order to ensure access to the equal opportunity. Like this, we may have to care about quality and range of health care as well as access to the health care. If only minimum health care (minimum medical treatment) is distributed equally and most other important determinants (e.g., good foods, clean air and water, quality of services) are left in market, health care cannot help to preserve the right of citizen.

As Marchand et al (1998) pointed out that health has been easily considered as outcomes like welfare or satisfaction so there has been no reason for resourcist to care about health inequalities. Therefore, we may have to clarify first whether and why health matters. Is health is not only the outcomes but also an important mean for outcomes (e.g. welfare or becoming full functioning citizens, etc)? Capability approach by Amartya Sen provides answer to this question?

Sarah Bruch

Concern about health in terms of resources and means (equality of opportunity, primary goods, health care) seem more feasible than concern about health in terms of welfare and outcomes. Because one cannot distribute health directly, one must limit one's attention to the resources and means through which people come to have good health. Although one might want to equalize the outcome of health, really the best one can hope to do is to equalize the resources and means to this end. Following Rawls' principle of justice as fairness in the distribution of primary goods, Daniels and others argue for the importance of opportunity. Many of the arguments sound similar to those from the education readings. I think one of the themes we discussed during the education week might be interesting to discuss in relation to health – paternalism. Do you provide “opportunity” in a way that it is a like a supermarket where everyone can walk through the door, browse the selections, and choose their own adventure? Or do you provide opportunity in a way that structures people's choice sets in ways that we (society) think are beneficial?

Miriam Thangaraj

Arguments about health distributions are reminiscent of how education is argued about, as a resource and as an intrinsic good. The authors we read broadly for this week employ three ways of thinking about health distributions and justice: inequality in terms of health per se; disparity in health resulting in inequality; inequality resulting in disparate health outcomes. The approaches each assume how health distributions relate to other “spheres of justice”.

Unlike education, however, the empirical evidence for inequality in health per se leading to overall lower health outcomes for all seems quite solid. The question of a trade-off between reducing inequality and maximizing benefits for the aggregate appears to be less critical, therefore. If this idea is at the core of deliberative democracy concerning the distribution of health resources, procedural justice may in fact result in just health outcomes. Else, effective rights of political participation, which are constrained by reinforcing disparities of education, income and health, can not be equal in practice, no matter how transparent/accountable the decision-making process.

Daniels’ fair opportunity justification for health seems to contradict his distinction between health ‘need’ and ‘enhancement’. If fair opportunity is leveling the field, then irrespective of whether a disability is ‘normal’ or requires treatment that is “medically necessary”, both ought to be seen as indistinguishable; considerations of resource constraints that distinguish between the two are not justified. Procedural justice may settle matters one way or other, but the distinction cannot be pre-decided.

Ill-health, in the accounts we read, is understood as a deprivation of welfare or of opportunity. But ill-health is most frequently measured as a deprivation of time (life expectancy). How robust are arguments about just distributions of health given different ways of measuring/understanding it?

Also, while class inequalities structure health risks, gender (and race to lesser extent) is perhaps an even more significant category. How robust are arguments about just distributions of health given it is gendered?

Justin Horn

I'm hoping that we will talk more about the idea of responsibility for health. The issue is clearly important for luck egalitarians who want to eliminate all (and only) those inequalities for which people aren't responsible, and for any view like Daniels', which holds that justice in health is concerned with promoting equality of opportunity. (If someone is unhealthy solely as the result of their autonomous life-choices, can they really claim they've been denied equal opportunity?)

Clearly, many inequalities in health do not result from factors for which individuals are responsible. So the question may be largely academic. Still, I found a view attributed to Roemer

very thought provoking: “unhealthy choices made by large numbers of people in a particular social structure ought to be regarded as products of that class structure, and the individual should not be held responsible” (Marchand, 464). There seems to be something intuitively right about this; there's a point at which we can no longer regard people's choices as autonomous when they are so heavily influenced by social factors. But as Scanlon points out, such a view risks the implication that many people are acting unfreely (and thus are not responsible for their actions) a very large percentage of the time. Are we prepared to base social policy on such a permissive principle?

The issue of responsibility for health also raises difficult issues about how to shape policy in the face of uncertainty and imperfect information. It is often very difficult to trace the causes of particular health problems in particular individuals, and therefore nearly impossible to consistently and reliably distinguish between health problems for which individuals are responsible and those for which they are not. How to respond to such uncertainty? Should we always err on the side of providing undeserved benefits, or strike a balance somehow?

Noel Howlett

Daniels' casting of health and healthcare as an issue of justice is an effective tool in arguing for a more equality-driven system of healthcare, at least in the US. That said, I am suspicious of any new claim to justice for that very reason: most people will struggle to argue against justice, so tying one's claim to justice makes one's point equally hard to argue against in public discourse. See for example No Child Left Behind; an arguably poor education policy that garnered strength in part by casting educational inequality as an issue of justice. I would hold that Daniels, like many of the supporters of NCLB, is not using a rhetorical trick. That is, his intentions are far more honest than to just gain acceptance by claiming a justice violation. However, my concern remains that his good sense may be corrupted by elements of bad sense in the same way as NCLB.

Silvers raises an interesting point in her response to Daniels in the form of the negative aspects medical judgments have sometimes carried with them in history and currently. The State's ability and authority to problematize anything outside of “normal” functioning and address it through medical or healthcare policies is truly frightening to me. It is a level of interference and potential harm I am not convinced outweighs the benefits of the healthcare proposed by Daniels. Especially considering Daniels believes that health outcomes are tied to class and race, which themselves could be medically problematized.

Loewy also poses an interesting objection when he says that there are currently obstacles to a fair process of action that Daniels suggests. This is echoed in Silvers' concerns that personal choice is respected. I wonder though if this is fair. Daniels is concerned with healthcare in a sense that extends beyond medical treatment. His concern is with outcomes, and thus with many contributors to overall health. It may be that Daniels fails to adequately lay out this argument, but I think that Loewy's objection may not be very strong if indeed Daniels means to include, as part of healthcare, such democratic enhancements as Loewy suggests.

Ed Connery

Marchand, Wikler, and Landesman lay out several perspectives to help examine the issue of equity in health. It seems fair to argue that the biggest theme in their piece is the unresolved question of whether health – not *healthcare* – and its distribution constitute a special case vis-à-vis other goods (though many seem to favor the intuition that it does).

I am inclined to agree that it *is* special but feel that the issue needs significant development or “unpacking,” as I like to say. Health, that is functional wellness rather than overall happiness or flourishing, can be defined in so many ways that the issue seems frustratingly complex. Is being “healthy” simply a matter of having all one’s organs and vital signs maintained within a stable and appropriate range? What about mental and emotional health? Could we extend the discussion to include a sort of social health, such as mature, safe relationships? If we accept that equal *healthcare*, that is seeing a physician when ill or for routine check-ups, isn’t enough to define equity what must we include?

One’s health is impacted by almost every factor of life: working conditions; environmental conditions; relationships; nutrition; social, cultural, and capital resources to secure care; knowledge.... Marchand et. al. point out the paradox that absolutely levels of health – the more important measure – are linked with relative levels of other goods. And they seem to suggest that resolving this requires a certain level of pluralism. I wonder if – in the non-ideal real world – one might also need to accept a plurality of values *within* the realm of health measures rather than simply placing health at large within a global plurality. That is, in examining equity in health *must* we consider all-things-considered health (physical, mental, and otherwise) or is there a just argument for choosing, for example, to favor physical health over mental health given limited resources and the myriad factors that impact our health?

Kevin Cunningham

One idea we might want to talk about in class is how health is special. To me, it seems wholly distinct from, and perhaps incommensurable to, other kinds of goods we have so far talked about. Here are a few reasons why I think so. First, more than other goods, health is a primary good necessary for pursuing any reasonable conception of the good. Some individuals’ conceptions of the good might not include one-size-fits-all approaches for goods like education and wealth (people might want to spurn higher education to pursue some goal, etc.). However, few conceptions of the good life allow for chronic illness or early death. If all individuals desire health in pursuit of their own conceptions of the good, then state intervention seems justified.

Second, health, to me, seems qualitatively more important than many other goods. When we are talking about health, we are not only talking about the quality of individuals’ lives, but we are also often talking about distributing the possibility for life. Of course, failure to distribute some other good might also lead to death, but the just distribution of health seems more pressing. If my neighbor was sick and I could help her at no great personal expense, surely I have a duty to do so. I’m not sure if I have the same obligation, though, to help her ailing business. Third, health is

complicated; it is intertwined with other goods. Marchand et. al make this point particularly salient when they note that places that have great wealth disparities are more closely correlated with inadequate health care than places with lesser disparities, even when the worst off in the latter place are absolutely poorer than those worst off in the former. Though health is bound up with other goods, people seem awfully unwilling to value it as commensurable with such goods. Most individuals seem willing to perform cost-benefit analyses with other goods like education. Indeed, individuals often choose to sacrifice time with loved ones or educational opportunities for wealth. However, few seem comfortable valuing health in monetary terms or even as a good that should be centrally rationed. The stickiness of this intuition was highlighted during the recent public dialogue about health care.
