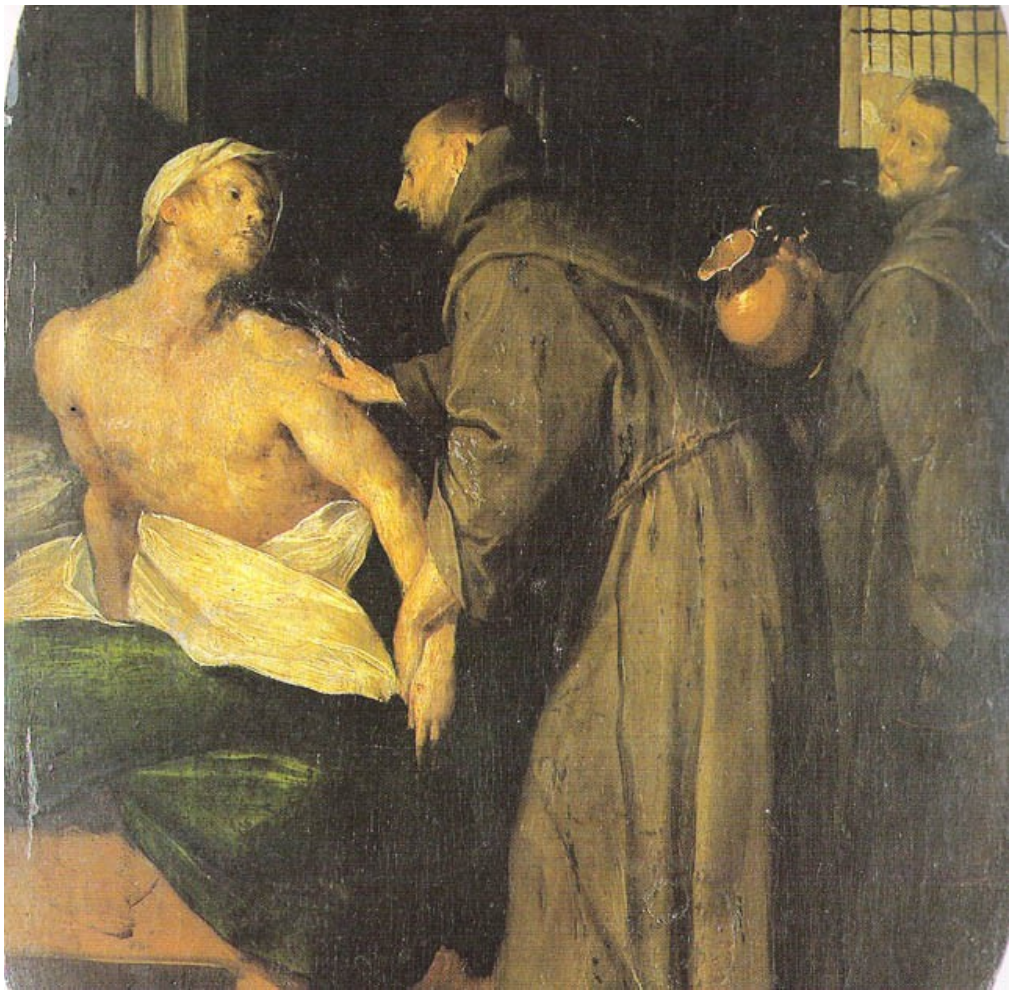
A Just Distribution of Health

How to distribute health fairly when resources are scarce?



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Content

Introduction:

" ..the preservation of health, which is without doubt, of all the blessings of this life, the first and fundamental one ..."(Descartes 1637)

The idea that health is important has been acknowledged throughout the ages by many different philosophers (Anand 2000, 486). The underlying intuition behind it is that suffering is bad and we have a duty to try to relieve that suffering (Mayerfeld 1999, 111). Good health is highly desired and in an ideal situation society would try to attain the highest possible level health for everyone. Although this ideal sounds very attractive, it would be very difficult to achieve in real life. Society only has a limited amount of resources and if everything needed for this end was to be distributed towards health, there likely would be very little left for other important issues. A society where its citizens are very healthy, but where there is little left for education or proper roads, does not seem like a paradise. Choices have to be made on how much resources should go towards health and health care.

Most of the public health care systems that can be found in developed countries are very expensive and their costs are continuously rising (Erixon and van der Marel 2011, 5). With the current economic crisis governments have to lower their expenditures, budget cuts have to be made and health care systems are not spared from such cuts. [1] The rising cost of health care is not a new phenomenon. Where in the 1950s the health care expenditures were slightly less than 4% of the national income (GPD), by 2005 costs related to health and health care made up about 9,2% of the national income. The income per capita has also increased in that same period, but it has not grown enough to cover the rising health related expenditures (Erixon and van der Marel 2011, 4).

Health related expenditures have also been strongly increasing in absolute terms since the 1970s. Although the amount of expenditure is different in each

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1 Torsoli, Albertina. 2013. "France's Health-Care System Is Going Broke." http://www.businessweek.com/articles/2013-01-03/frances-health-care-system-is-going-broke

country, there is a general overall increase. Countries like the Netherlands and Canada are relatively on the lower side when it comes to the amount of growth, and Norway and Spain are on the higher end of the scale (Erixon and van der Marel 2011, 4).

The current trend in Europe (and globally) is to lower the costs of the health system through privatization (Maarse 2006, 1008).

The term privatization is used to indicate the transfer of activities from the public to the private sector, which is accompanied by a decrease of services and goods provided by governments (De Alessi 1987, 24). Through privatizing health care and health related policies, governments hope to break the trend of growing costs. The resources that become available through privatization can then be used for other purposes (De Alessi 1987, 24). Even though privatization has become the trend in policy regarding health care, this does not mean that it is uniformly embraced. Many people are critical about allowing privatization in the health sector. One critique is, that by making health care more and more private it becomes less accessible for many people (Daniels 2013, 18). Although almost all developed countries continue to offer their citizens universal access to a broad variety of public health and personal medical services, what is offered by the public health care system gets downsized in favour of privatization (Daniels 2013, 19).

The consequence of this is that the people in society who do not have the means to attain private health care (in most cases private health care is more expensive) can be denied access to the medical care they need. This is especially problematic because it has been empirically proven that precisely the people who lack the resources to attain private health care, have a greater likelihood at suffering health problems, meaning they are faced with health inequalities (Daniels 2013, 2).

The public debate about health and health care is not merely focused on how governments can cut their budgets. The underlying problem is of course the question why health care costs are high and are continuing to rise. A major concern at the moment is that health care costs will rise to new heights because of the demands of the aging population (Pammolli et all 2012, 624). Getting older generally also means a frailer body with a higher risk at medical problems. Of course, the steep rise of elderly people who are in need of medical care is of itself not necessarily a problem in regard to cost.

What makes it problematic is that life expectancy has gone up, but fertility rates have not increased in the meantime. The fastest growing segment of the

population in most developed countries now consists of individuals over the age of sixty-five (Etzioni 2003, 170). Whereas the number of young people that can support this growing group of elderly people is declining (Maestas and Zissimopoulos 2010, 139). With the first part of what is known as the baby boom generation now reaching the age of sixty-five and starting their retirement, there are fewer people working to pay for the health system.[2]

In addition there are also more people who are in need of health care.[3] The cost for the younger generation to provide the elderly the care they need, will increase as a consequence. The question is how to deal with this issue?; how to distribute resources in such a way that people have access to the care they need, but not overburdening others with a cost that hinders their life. While it is highly desirable to give everybody the care they need, it may not be fair if the lives of other people are seriously impaired by doing so.

When looking at causes for the high health care costs, attention is also paid to personal responsibility. Besides the genetic factors that have a large influence on whether or not people are prone to diseases, lifestyle choices contribute significantly to the number of diseases in societies (Cavallero 2011, 387). People who smoke or suffer from obesity are more likely to need medical care than people who lead a healthier lifestyle.

Through the system many of these costs are transferred away from the individuals that make the unhealthy choices towards other patients and taxpayers (Cavallero 2011, 388). In other words these others can end up paying the bill for the unhealthy choices of others. This invites the question of whether others in society should pay the costs for the choices people willingly make, and whether it might be more fair if people paid the costs for their own choices? There is the question of whether people should be held accountable for the choices they make in life. Although the debate about personal responsibility has sparked discussion, holding

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2 http://edition.cnn.com/2013/11/06/us/baby-boomer-generation-fast-facts/

3 Bar, Paul. 2014. The Boomer Challenge." http://www.hhnmag.com/display/HHN-news-article.dhtml?dcrPath=/templatedata/HF_Common/NewsArticle/data/HHN/Magazine/2014/Jan/cover-story-baby-boomers

individuals accountable for their health is still a controversial subject. It is often seen as too harsh a response (Cavallero 2011, 390).

Clearly, the question of how to provide everyone with optimal health and health care is complex. In the literature, normative theories on how to distribute health all give differing answers on how to provide everybody the care they need. Some theories argue that personal responsibility should play a role in distributive justice. Other theories argue that it should play no role at all (Anderson et al. 2013, 7). The central issue that will be addressed in this thesis is how to fairly distribute health in a society where there is a scarcity of resources. In order to see which theory offers a stronger response to this complex question different normative theories on this subject will be discussed. Accordingly, the central research question that this thesis will try to answer is:

What is a just distribution of health?

As research indicates that socioeconomic inequalities have a large influence on health and that reducing such inequalities improves health (Brock 2000, 22), I will make the assumption in this thesis that a distribution of health must be an egalitarian distribution in order to be a just distribution. The theories that will be considered are, therefore, all egalitarian theories of justice.

The debate on justice in health is a small niche in the debate on social justice. Considerably more has been written on the just distribution of welfare, where health is sometimes mentioned. Given that the parameters of space in this thesis do not allow for a discussion of all the different theories on justice in health, this paper will look at four theories that have been very influential in the debate about justice in health.

In order to answer the main question, there first should be looked at whether responsibility should play a role in a just distribution of health or not. The two theories that will be examined are Ronald Dworkin's equality of resources and Shlomi Segall's luck prioritarianism. Dworkin presents an overall luck egalitarian theory about the just distribution of resources in which he also devotes some time to the matter of health (Dworkin 2000). Segall offers a very extensive theory of justice in health based on luck egalitarian premises (Segall 2007). Although there are many similarities between these two theories, they have different outcomes when it comes to the distribution of health. Therefore they give two different perspectives on how personal responsibility can play a role in justice in health.

The second part of this thesis, on the other hand, will look at two theories that do not use responsibility as a criterion for a just distribution of health. It will consider Elizabeth Anderson's democratic equality theory and Norman Daniels fair-opportunity account. Unlike Daniels, Anderson did not write specifically about how to distribute health in society fairly. Her theory is a general egalitarian distribution theory, but she does argue that her theory is superior in regard to the provision of health care to people, compared to luck egalitarian theories or Rawlsian based theories (Anderson 1999).

When comparing and discussing these theories, two questions will be asked for each theory, which are essential to answering the main question of this thesis. These two questions are:

-*When are health inequalities unjust?*

-*How should society compensate for these unjust inequalities?*

The answers the different theories give to these questions help provide an answer to the focal question, allowing us to make a judgement about which theory might be morally superior.

However, before the different theories can be discussed there needs to be clarified why the focus is on justice in health and not solely on justice in health care. Justice in health care is part of justice in health, but the concept of health contains much more than only medical care.

Chapter 1: Health or Health care?

It has only been in recent years that the focus in the literature has shifted from health care to the more general concept of health (Segall 2010a, 90). In the early 1980s the central topic of the debate was health care and a universal right to health care. It became clear at that time that in the United States there was a growing problem with providing access to health care. In one of the richest countries in the world many of its citizens could not get the help they needed because they were uninsured, and the number of people that were not insured was only rising (Brock 2000, 22).

This was seen as a failure and authors in the field of bioethics started trying to defend a moral right to health care. One of the most outspoken scholars who tried to do this was Norman Daniels. He was one of the first who attempted to establish moral foundations for a universal right to health care (Daniels 1979; Daniels 1985). Throughout the years he continued to write articles about this subject, joined by people like Larry Churchill and Allen Buchanan (Churchill 1987; Buchanan 1984).

However as time passed medical insights grew and there was an increase in empirical evidence that suggested that health care does not play such a prominent role in determining health as was previously assumed (Daniels 2008, 2). Inequalities in health are not primarily caused by a lack of access to health care, but are mostly determined by social factors. Socioeconomic inequalities play a large part in determining health (Brock 2000, 31). All in all, being poor is disadvantageous to one's health. Even in the case where there is equal access to health care, each step higher upon the socioeconomic hierarchy shows an improvement of health (Daniels 2008, 84).

Not only absolute levels of income have an effect on health, but there is also evidence that significant income inequality within a country also has an effect on health. Evidence suggests that if there's a high degree of income inequality in a society, that this also has an effect on the health and life expectancy of the whole society. Research has shown that the highest social class in England has a higher infant mortality rate than the lowest social class in Sweden, where income inequality is much lower (Brock 2000, 33).

However this is a much debated issue in the literature, for further research has shown that this correlation is not found in all countries. The alternative explanation is that income inequality by itself is not a cause of health inequalities, but that it affects other social and political factors that have an impact on health (Daniels 2008, 87).

Besides social determinants, things like preventive medicine and public health policies (like anti-smoking policies, anti-pollution policies) also have an impact on health (Brock 2000, 31). Last but not least, is of course people's genetic makeup. The genes people are born with influence whether they are prone to diseases or not.

This does not mean that health care does not play a role in health and life expectancy at all. For individuals who are in need of health care it plays a very important role in their well-being. However, when looking at the overall life expectancy and health of society it has a limited impact (Brock 2000, 31). These new insights into factors that determine health have broadened the debate from justice in health care to justice in health. By solely focussing on health care the debate was too narrow. Health inequalities in a society cannot only be addressed by looking at health care, one needs to look at health in general. The titles of Norman Daniels' books show the change of the focus of the debate nicely. In 1985 he named his book *Just Health Care*. In 2008 the title became *Just Health* (Daniels 1985; Daniels 2008).

At first the shift from health care to health in general may not seem noteworthy, but it does have a significant impact on the way we think about health. The knowledge that health care only plays a limited role in determining health can influence ideas about how society should distribute resources to its health system. If the overall health in society could be much more improved by policies that focus on decreasing socioeconomic inequalities, thus the discussion might be about whether to invest more money in those kind of policies instead of health care. The medical costs in society are increasing rapidly and the argument could be made that that money should be redistributed to other areas.[4] However giving less money to health care systems is a very sensitive political topic, and it is not a very popular measure among politicians.

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4 Lee, Robin and Gillian Davies. 2013. " Technology: The Cure for Rising Healthcare Costs?. " http://www.technologyreview.com/view/518946/technology-the-cure-for-rising-healthcare-costs/

The shift to justice in health has had more impact on some authors who write about this subject than others. For Norman Daniels in particular this shift poses a problem because his theory is built on the assumption that health care is of special moral importance. (Daniels 2008, 29). With empirical evidence indicating that it does not play such a major role when it comes to health, the foundation of his theory is threatened. This possible problem with Daniels' theory will be discussed later on.

Since inequalities have a larger influence on overall health than health care and public policies, I will follow Segall's plea for a theory of justice in health that is separate from an overall theory of justice. This is in regard to why philosophy should still be interested in justice in health, instead of focusing solely on social and income equality. Segall argues that this broader focus is necessary because theories about justice in health and health care can help create guidelines for the pursuit of a just distribution of health.

Furthermore when it comes to health care philosophy could help create guidelines and policies that determine the just distribution of goods that are part of the health care system (Segall 2010, 93). Although there are other factors that have an impact on the general health of the population besides health care, this does not mean that thinking about health care and broader health policies has no value at all.

Chapter 2: Responsibility sensitive theories

This chapter will look at the question whether or not personal responsibility can play a role in a just distribution of health. The two theories that will be examined here are known as luck egalitarian theories. There are different versions of luck egalitarian theories, but what they all have in common is that these theories are concerned with compensating inequalities that are caused by outcomes for which individuals themselves cannot be held responsible (also called outcomes of bad brute luck) (Segall 2010, 10).

2.1 When are health inequalities unjust?

Before compensation can be given to individuals that are faced with health inequalities, there first needs to be determined when health inequalities should be seen as unjust. Segall and Dworkin both argue that health inequalities are not by definition unjust. If Person A has less health than Person B, then it does not automatically mean that this situation is unfair or unjust. The luck egalitarian position is that the health inequality would be unjust only if Person A is less off than Person B through misfortune or a case of bad luck for which Person A cannot be held responsible. Dworkin was the first author that made the distinction between two different kinds of luck. Bad brute luck is where the outcomes are being caused by factors where individuals cannot be held accountable for. Option luck is a matter of how freely chosen gambles turn out. (Dworkin 2000, 73).

Although Dworkin himself denies being a luck egalitarian, he is seen as one of the main authors defending this kind of theory.[5] The view that Dworkin defends, is that health inequalities are unjust when they are the result of brute luck and not when they are the result of option luck. This means that health inequalities that are caused by a person's genetic makeup should be considered as unjust, but if a person gets injured while skiing, this health inequality is not unjust according to luck egalitarians. What Dworkin, as well as Segall, therefore defend is that all health inequalities,

5 It was one of his main critics, Elizabeth Anderson, that named it luck egalitarianism and mentioned him as one of the main defenders. However, Dworkin has always denied being a luck egalitarian theorist (Dworkin 2003).

natural and social, caused by brad brute luck are unjust. Therefore, these health inequalities should be compensated by society.

However using this distinction between option luck and brute luck to determine when health inequalities are unjust, can also lead unrealistically harsh results outcomes. The health inequality of a policeman who get injured in the line of duty could in that case be seen as just.

The policeman made a deliberate decision for a profession that has a high risk at injuries. Therefore, according to luck egalitarians, his health inequality is the result of option luck. A different example would be a pregnant woman who has health inequalities related to her pregnancy. In many cases women choose to be pregnant, and therefore the pregnancy health inequality would be called just (Segall 2010, 21).

Although Dworkin himself makes the distinction between bad brute luck and option luck, he does not defend the claim that people should be held strictly responsible for all option luck outcomes and therefore deserve no compensation. Dworkin argues that only in an ideal situation where all other considerations are equal and people are fully informed of all options, people should be held accountable for all outcomes of option luck. In other words, only in a society without any inequalities, and where people are all-knowing, all outcomes of option luck will be considered just (Dworkin 2000, 76-79).

Since this ideal situation does not exist, Dworkin defends that some cases of option luck do deserve compensation. People will have to insure themselves against possible option luck outcomes. When the choice is made not to insure against possible outcomes of option luck, then people are left to face the outcome of that option luck (Dworkin 2000, 73-78). However there are some luck egalitarian authors who do argue that people should always be left to deal with the consequences in case of bad option luck (Rakowski 1991).

These possible harsh outcomes of bad option luck are precisely what Elizabeth Anderson criticises in her article "What is the point of equality?" (Anderson 1999). She argues that the punishment people get for making a wrong choice, is unnecessarily harsh. The policeman who causes an accident with his car because he is chasing a thief, does not deserve to die because he deliberately drove like a maniac while chasing the thief. This critique that the emphasis on personal responsibility in luck egalitarian theories leads to unjustified harsh outcomes, is now commonly known

as the abandonment objection (Segal 2010, 60). Luck egalitarian theories abandon individuals who are faced with bad option luck.

This is one of the main problems with trying to incorporate responsibility within a just distribution of health. Authors who place responsibility at the centre of their egalitarian distribution theory, all have to find ways to overcome this abandonment objection. One of the ways Segall tries to overcome the abandonment objection, is by slightly altering the formulation of when health inequalities are unjust. He argues that: "It is unjust for individuals to be worse off than others due to outcomes that it would have been unreasonable to expect them to avoid (Segall 2010, 13)." What Segall has done, is broaden the definition of bad brute luck.
It is not merely a case of bad brute luck when the outcome is not the result of a conscious decision, but it should also be called brute luck when it would have been unreasonable to expect someone to avoid that possible outcome.

By broadening the definition of brute luck, Segall avoids many of the harsh cases of the abandonment objection. Segall's argument of when health inequalities are unjust, does proclaim that the policeman who gets injured should get the medical care he needs. For society could not reasonably expect that a policeman who does his job properly never gets injured.

Segall softens the abandonment objection through broadening the definition of brute luck, his solution is not sufficient to overcome the abandonment objection. There are still situations where an individual is left to deal with a health inequality after taking a deliberate risk, which he reasonably could have been expected to avoid, but where the punishment of not compensating that health inequality is too high. For example, not giving medical care to an athlete who gets inured in doing extreme sports, does not seem fair.

The same objection applies to Dworkin. There are situations where people choose not to insure themselves against a possible risk, but not compensating health inequalities in those situations can be too harsh. Segall and Dworkin are both very aware of their theories being possibly too harsh on victims of option luck, but are both convinced that their theories can ultimately overcome this objection and provide a just distribution of health.

2.2 How should society compensate for these unjust inequalities?

Now that there has been established when health inequalities are unjust, according to Dworkin and Segall, the next section will focus on how society should compensate for these unjust health inequalities. Furthermore, there will be examined whether this compensation is enough to overcome the abandonment objection.

2.2.1 The prudent insurance scheme:

Dworkin's theory about how health should be distributed in society and how health inequalities should be compensated, is based on his overall theory of a just distribution of resources. Dworkin developed his egalitarian theory as a reply to Rawls' theory of Justice (Rawls 1971). The two problems he saw with Rawls' theory were that it does not take personal responsibility into account, and Rawls' theory offers no compensation for people who suffer from natural inequalities (Kymlicka 2004, 74).

As a reply, Dworkin formulated an egalitarian distribution theory that is both responsibility sensitive and takes natural disadvantages into account.

Dworkin defends equality of resources, instead of equality of welfare (Dworkin 2000).[6] His equalitarian distribution is a distributional scheme where people trade to gather the resources they want. Once the division of resources is complete, it will be subjected to the envy test. The distribution passes the envy test when "no person would prefer someone else's bundle of resources to his own bundle" (Dworkin 2000, 67). In other words, everyone is completely satisfied with the resources they posses and they want no other resources anymore.

However, some people have more expensive taste than others. While some people would be content with a simple lifestyle, other people prefer a more luxurious lifestyle. In order to meet the requirements of the envy tests, it would mean that society would have to provide those people with more resources to accommodate these tastes. The equality of resources that Dworkin defends, requires however that people pay the cost of the lives they lead (Dworkin 2000, 76). It is okay if a person has an expensive taste, but the individual himself is responsible for paying that cost.

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6 Other prominent luck egalitarian authors are: G.A. Cohen (Cohen 2011a; Cohen 2011b), Richard Arneson (Arneson 2000), and Shlomi Segall (Segall 2010). They each defend a different version of luck egalitarianism.

The scheme Dworkin uses to distribute the resources is a hypothetical auction where individuals can bid on the resources they want in their life. Everyone gets the same amount money, or clams in his example, to buy the resources they need. When the auction is complete and the auction went well, everyone will have the goods they want. There are no preferences for the goods that other people have. In that case the distribution has met the envy test. If the envy test is not met, then this hypothetical auction can be redone indefinitely until the envy test is met (Kymlicka 2004, 75).

Even if the auction would meet the envy test, then there would still be two problematic issues. The first issue is that people who are born with handicaps have a disadvantage at the auction. Although every person gets the same amount of clams to buy resources at the auction, the costs of buying resources would be much higher for a person with a disability then a person without handicaps. They would have to invest a lot more in order to acquire the life they want compared to people without disabilities or people who are naturally very talented (Kymlicka 2004, 76).

The second issue is that people live their lives after the distribution at the auction has met the envy test.

People do not prefer anyone else's bundle of resources to their own after the initial auction, but circumstances in life can alter their preferences. Individuals take deliberate risks in life. They either win or lose with their deliberate gambles, or sometimes they are struck with bad brute luck. These changes in situation can mean that people want a different bundle of resources than the one they originally bought at the auction (Dworkin 2000, 73).

Dworkin offers one solution for these two problems. The solution is that people insure themselves against the possible disadvantages that they may suffer in life. For example, a person can choose to insure himself against the risk of being blind or being otherwise physically handicapped (Kymlicka 2004, 77). What Dworkin does here is that with the insurance scheme he turns outcomes of bad brute luck into option luck. For if people make a deliberate decision to not insure themselves against certain possibilities, then the argument can no longer be made that it is bad brute luck. Altered preferences for resources are, therefore, compensated by the insurance scheme. People insure themselves against the possibility that someday the may need different resources than the ones they have after the envy test.

However the insurance scheme itself does not completely compensate for the higher costs that individuals who are born with natural handicaps have. They would

still have to buy much more insurance than healthy people. What Dworkin argues is that when the hypothetical auction and the choosing of hypothetical insurance occurs, people do not know what disadvantages in life they will have and how their life will turn out. This is very similar to Rawls's idea of the veil of ignorance (Kymlicka 2004, 77). People choose the insurances they might need in life without knowing what kind of disadvantages they will have.

The insurances that people would buy in the hypothetical situation can be used to determine how the naturally disadvantaged should be compensated in real life. The amount that people would be willing to spend on insurance could be collected through taxes and redistributed to the naturally disadvantaged people. For example, the money collected through tax could be used for welfare policies. That is how the naturally disadvantaged are compensated through the insurance scheme (Kymlicka 2004, 77-79).

This prudent insurance, Dworkin argues, is the best solution to resolve the two issues that are present in the hypothetical auction. People who have natural disadvantages will be covered for these handicaps through prudent insurance. Important to note, however, is that the amount of resources the naturally disadvantaged get is limited by the amount of insurance people would buy at the auction (Dworkin 2000 73-78).

This limitation ensures that not all available resources will go to the people who are disadvantaged, because trying to compensate for all handicaps would be virtually impossible. The final result would be that all other people in society would have to give up so much of their resources that they would be unable to have a good life (Kymlicka 2004, 79).

The naturally disadvantaged are also compensated in a different way. Foremost it will be the people who are naturally advantaged, who will be paying for the taxes that provide the welfare schemes. Through their talents and efforts they have better opportunities in society and a better off position. For Dworkin argues that these talents are undeserved in the same way that natural handicaps are undeserved. The difference in talents can be neutralised so far as possible through taxing (Dworkin 2000, 89-92).

The just distribution of health that Dworkin envisions is based on the prudent insurance scheme. The health institutions that are present in society and the insurance the state is obligated to provide, are based on what people would hypothetically insure

themselves against, and what part of their resources they would be willing to spend on their medical care.

Dworkin argues that rational people would first decide that they would want to insure themselves against all possible illnesses they could get. The costs of doing so, however, are so high that there would be no resources left for other things in life.

A prudent person would decide for which possible risks they would want to insure himself (Dworkin 2000, 313). The tastes and preferences of every individual are different, but that does not mean that there cannot be any general judgements made, according to Dworkin. There are things that everyone would want to insure themselves against and things no rational human being would insure themselves against. No sensible person would insure themselves for expensive life-sustaining treatment, in case they get in a vegetative state, Dworkin claims. (Dworkin 2000, 313-314). In his opinion people would prefer to spend their resources on other things that would enrich their lives, rather than spending it on expensive insurance they may not need.

Dworkin himself only focuses on health care and not health in general, but to move to a just distribution of health is not a big step. Instead of merely focusing on what part of the resources should go to health care, there should also be asked how much of those resources should go to public health policies. Each society has to decide for themselves own how many resources should go to health. This can be different because the health needs are not the same in every country.

The distribution of health can be either really narrow (if society decides not to spent many resources on it), or very broad (in the case society decides to distribute a lot of resources to it. Theoretically there could also be a situation where society could decide that they do not want any health care or health policies at all. The emphasis, however, lies on *prudent* insurance, and it would hardly be called prudent or rational to have no health care facilities or health policies at all. In that case individuals who have a health problem would be very bad off.

Dworkin therefore argues that equality of resources provides a minimal insurance that covers basis medical care (Dworkin 2002, 114). This means that there is no situation where people who are in need of urgent medical care, would be denied the care they need because their health needs are caused by a wrong choice they made. Under equality of resources a society is justified to demand that people buy a

minimal mandatory insurance that covers basic medical care (Dworkin 2002, 114). The costs for treating a uninsured person would otherwise fall on society. Therefore a mandatory insurance is allowed. However, this mandatory insurance scheme does mean that the personal responsibility aspect is taken out of the equation when it comes to providing basic health care.

This mandatory insurance scheme is Dworkin's answer to Anderson's abandonment objection. Through this way a minimum amount of health is guaranteed, but personal responsibility still plays an important role when it comes to the distribution of health. All the health inequalities that aren't covered by the mandatory insurance, are only compensated if the injured people has decided to insure themselves against those possible risks.

Anderson rejects this solution to the abandonment objection because the mandatory insurance is a paternalistic solution. Paternalism is a term used to indicate interference by a state or an individual against a person's will. The argument that is used to justify this interference is that that interference protects a person from harm (Dworkin 2010).

For Anderson, therefore, the mandatory insurance is not a suitable solution because it threatens individual liberty (Anderson 1999, 301). The state is telling people how to spend their resources and what risks they can and can't take. According to Anderson, this is an attack on people's self-respect, for it gives the impression that they are not capable of making those decisions for themselves. Dworkin countered this objection by saying that equality of resources does not exclude limited forms of paternalism (Dworkin 2000, 75).

He further argued that in this case the paternalism objection does not even apply because people would choose this insurance themselves. Nobody would want a life where they could not get the basic health care they need (Dworkin 2000, 75-76). I think Dworkin's reply to the critique of paternalism is sound on this point. A rational human being would most likely choose some kind of basic insurance that provides a minimal amount of health care. Especially when they know that there's the possibility they someday will need some form of health care. There will always be people that would rather spend those resources on other things than health care insurance, but endangering one's life by not willing to pay for health care can not be called prudent.

However, there are other difficulties with the mandatory insurance and with the prudent insurance scheme in general that makes Dworkin's theory very

problematic to use as guideline for a just distribution of health. One of the underlying arguments for implementing personal responsibility in a just distribution of health is that people who make bad choices can be held accountable for them.

The first objection is that by partly removing the responsibility criterion from the distribution of health by the mandatory insurance, the insurance also takes away societies ability to complain about imprudent persons. With mandatory insurance people get the care they need whether or not the injury is the result of their own choice (Segall 2010, 61). If a person with a donor heart wastes away his new heart by deliberately making choices that damage his new heart, then society could not begrudge him for that because he has antecedently insured himself against that possibility. In fact, the imprudent patient is obliged to insure himself against the possibility that he threatens his own health (Segall 2010, 61).

Even more problematic is the possibility that the insurance scheme may take away the incentive that individuals have to take responsibility for their own health. The reason why people buy extra insurance against option luck is because otherwise they have to pay for the very expensive medical care themselves. It is this process of deliberately buying specific kinds of insurance that ensures personal accountability for lifestyle choices (Cavallero 2011, 393).

However, for people living on social minimum there is very little incentive to buy extra insurance. In the situation where they are faced with an health inequality, for which they are not insured, they can always fall back on the safety net of the mandatory insurance. The cost of the added insurance may very well be higher than the resources they would lose in such a situation, and they can then rely on the access to free health care (Cavallero 2011, 393). This way there barely is an incentive for people living on or around social minimum to take personal responsibility for their lifestyle choices, as they are guaranteed to receive basic health care.

For example, if a dentist insurance is expensive, then there is a possibility that many people would not buy it. They would simply not go to the dentist. However, when someone's develops an infected tooth, they would need medical care and they would be entitled to the medical care covered by the mandatory insurance.

A different objection is that even with the mandatory insurance that guarantees a minimum of health, Dworkin's prudent insurance scheme is still vulnerable to the abandonment objection. There is still the possibility that a person needs medical care because of a bad choice he made that does not fall under the mandatory insurance, and

for which he himself is also not insured. For example, someone, who only has got mandatory insurance, loses his eyesight because he played with illegal fireworks. He is entitled to the medical care he needs for his eyes, but the damage is irreversible and because he did not insure himself against possible blindness, he cannot get a guide dog. Society owes him nothing because he deliberately made the choice to buy and use illegal fireworks. His quality of life, however, could be much improved if he did get the dog.

I would argue that even though that person is entitled to health care, the punishment for his imprudent behaviour still seems to be very harsh for the onetime foolish choice this person made. Of course, this does not mean that there should be no limit to the compensation a society should offer those individuals that are faced with an health inequality. However the point made here is that basing the decision to compensate health inequalities solely on the criterion of responsibility, leads to very harsh outcomes.

Dworkin's distribution is also harsh in a different way because it expects people to be able to look into the future. People have to choose insurance and if they are faced with a problem for which they are not insured ,then that misfortune falls under option luck. But especially when it comes to health, it is very difficult to predict the future.

In "Sovereign Virtue," there is an example of elderly people who are getting medical treatments in the last months of their lives. Dworkin argues that although everybody would probably want to get extensive treatment when they are ill, no prudent person would actually insure himself for it. They would instead invest their resources into other things where they would get a longer enjoyment from. This is mentioned as one of the easier decisions to make when it comes to health care (Dworkin 2000, 314-315). Instead of getting treatment that is aimed at restoring their health as much as possible, they should only get basic care to live as painlessly as possible, and society is not obligated to provide the more expensive care that these elderly people want or need.

That someone of twenty-five would not want to insure himself against life-longing treatment when they are old is understandable, but as one gets older, preferences and people's outlook on life changes. However in real life the auction cannot be re-run (Kymlicka 2004, 81). Life is unpredictable and people make choices based on their current situations, but if in later situations they find out that they made

the wrong choice, then it would mean that justice owes them nothing. Which I would consider harsh, especially in the case of health harsh.

Therefore, what is argued here is that Dworkin's prudent insurance scheme is too problematic to be used as a guideline for a just distribution of health. The theory cannot overcome the abandonment objection without moving away from its luck egalitarian principles. Even in the situations where the luck egalitarian distribution does apply, the punishment for outcomes of option luck still seem too harsh.

2.2.2 Segall's luck prioritarianism

What Segall attempts to do when it comes to justice in health care is to provide a luck egalitarian distribution that is both responsibility-sensitive and provides universal basic health care (Segall 2010, 58). In order to provide unconditional basic medical care, Segall needs to show that his theory can overcome the abandonment objection. He already softened the abandonment objection by broadening the definition bad brute luck, but it did not remove the abandonment objection completely.

He suggests a rather unconventional approach to overcome the abandonment issue by looking at value pluralism rather than focusing solely on equality. The reasons for treating imprudent patients should be sought outside of distributive justice. Egalitarian justice is primarily focused on fairness, but sometimes fairness doesn't offer the best solution and other values should be considered (Segall 2010, 64-65). Luck egalitarian theories are not incompatible with this trade off of moral considerations, Segall argues.

The moral consideration that takes precedence over fairness when it comes to health care is taking care of basic needs. Meeting basic needs, is the foundation for universal basic health care (Segall 2010, 68). Based on a prior duty to meet basic needs, Segall's theory offers a sufficient level of health care, which meets all the basic medical needs in society. This medical care is public good, nobody can be excluded from it and people can not choose to decline either (Segall 2010, 78-80).

This way the objection that luck egalitarian theories abandon imprudent patients is countered, according to Segall (Segall 2010, 68).

Luck egalitarian theories are forced to treat patients who end up needing medical care for reasons society could have reasonably expected them to avoid, based on the prior

moral obligation to tend to basic needs. In the case where two equal patients end up needing health, then priority should always be given to the innocent patient according to luck egalitarianism. Segall argues, however, that this would be too harsh on the imprudent person. Therefore, what Segall suggests is a weighed lottery system, where the system favours the innocent patient, but the imprudent patient also has a chance at receiving care (Segall 2010, 72).

What the weighed lottery does, could be imagined as giving the prudent person an 80% chance of getting the help, and the imprudent 20% chance (Nielsen 2013, 413). This way it would be less harsh for the imprudent person because otherwise being imprudent would automatically be a death sentence (now there is a possibility it is not). In case the weighted lottery does fall in favour of the imprudent person, then that would mean that the innocent party is left to die, while the responsible person gets off for free.

The problem with the weighed lottery system thus is is that it seems to end up overriding luck egalitarian justice (Nielsen 2013, 413). Imagine a situation where two people are involved in an accident. One is the innocent party and the other one is responsible for the accident. The victims have the same injuries, but there are only enough resources at the moment to treat one. Standard luck egalitarianism would argue that the innocent party has a higher claim to those resources than the person who is responsible for the accident. Segall argues that always favouring the innocent person is unnecessarily harsh on the imprudent person and that is why he argues in favour of a weighted lottery system.

Nevertheless, the method that Segall uses to overcome the abandonment objection is sensitive to the same kind of critique that was given to Dworkin's mandatory insurance.

The moral requirement to meet basis health needs, takes away some of the incentive for personal responsibility. It does not matter whether a person has acted imprudently or not, his or her basic health needs are met. Therefore, there is little reason for people to take to act prudently. The solution that Segall presents for this problem is to tax certain activities ex-ante (Segall 2010, 78). This way, imprudent persons can be forced to pay at least part of the cost of the medical care they most likely will need as result of their imprudent behaviour, because they have already indirectly paid for it.

This solution is, however, not as easy as it sounds. Certain resources can be taxed when people purchase them. For example, cigarettes or alcohol are relatively easy to tax.
Yet there is other risky behaviour that cannot be ex-ante taxed easily.
For example, lack of exercise or stress which causes health problems would be very difficult to tax before the behaviour happened (Cavallero 2011, 393). In fact, the government would be forced to take very intrusively measures in order to try tax people for their lifestyle this way (Cavallero 2011, 393). What the consequence of this will be, is that many or even most of the risky behaviour will still be paid by the overall society, and not by the imprudent persons.

When Segall applies luck egalitarianism to justice in health in general, he makes a rather surprising turn towards prioritarianism which he combines with luck egalitarianism. Prioritarianism stipulates that priority should be given to the people in society who are the worst off. In other words, people who have the worst health in society, should be given priority when it comes to providing medical care (Segall 2010a, 111-112).

He uses the following definition to describe his main principle for his theory of justice in health, which he calls *prioritizing* the opportunity for health of the worse off:

"Fairness requires giving priority to improving the health of an individual if she has invested more rather than less effort in looking after her health, and of any two individuals who have invested equal amounts of effort giving priority to those who are worse off (health-wise)(Segall 2010, 112)."

The reason he shifts from luck egalitarianism to prioritarianism is because he argues that seeking equality is not the right way to go when it comes to health. When seeking to equalize health, there is the problem of levelling down. What is meant by levelling down is that better off people are reduced to the position of the worst off in order to equalize their position (Mason 201, 246). Which could mean that a healthy person should be made sick for the unhealthy person to be equal. However, that is an unacceptable solution because it could imply hurting other people or damaging their bodies in order to make them equally unhealthy.

The defence Segall gives for switching from seeking equality in health to prioritizing in health, is that he argues that when applied to health, equality has no instrumental value. Equality has instrumental value when it is valuable as a means (Cupit 2004, 124). For instance, income inequalities are said to undermine fellowship in society. The reason for reducing the income inequalities would in that case be an instrumental argument. Equality has in that situation instrumental value when the inequalities are reduced (Cupit 2004, 125). In situations where equality has instrumental value, levelling down to equalize the situation is justified.

However, levelling down is not a suitable option when it comes to health. Equality has therefore no instrumental value when applied to health. In situations where equality has no instrumental value, it is better to give priority to the worse off in society than to seek equality (Segall 2010, 114-115).

Luck prioritarianism does not imply that the worst off in society should always be given priority. The first aim of luck prioritarianism is still to neutralize bad brute luck. If someone has health inequalities that could not have been reasonably avoided, then that person should get priority. Only in the case where there is no difference between a prudent and imprudent people, then society should give priority to the worse off (Segall 2010a, 119).

Luck prioritarianism, however, only applies when the health deficits that need to be treated fall under the category of restoring normal health. This restoring to normal health is called 'treatment', whereas treatment that goes beyond returning a person to full normal health is seen as an 'enhancement' When it comes to a just distribution of health enhancement, Segall argues that the regular luck egalitarian account of justice applies. (Segall 2010a, 122).

For in case of enhanced health equality does have an instrumental value. If for example there was a society where a group of people got health enhancement and benefited greatly from it, while the rest society could not get those enhancements done, then there is a chance that it could lead to social division. In that situation equality would have instrumental value and levelling down could be beneficial (Segal 2010, 133). That is why luck prioritarianism can only be applied to health deficits and not enhanced health. What Segall argues, is that when it comes to health enhancement luck egalitarian justice applies.

Health enhancing treatments can be compensated in Segall's luck egalitarian distribution theory, if the condition is considered to be caused by brute luck. A person

with a crooked nose could be entitled to a surgery that adjusts the shape of the nose. Segall argues that this does not mean that all enhancement treatments will be compensated. Not all enhancement treatments are the same and luck egalitarian theory can make a difference between them (Segall 2010, 131). A probable reason why a breast reconstructive surgery should be given priority over a breast enlargement surgery is a limited amount of resources, according to Segall (Segall 2010, 131).

There could also be other ways through which a person's health is improved, that does not involve providing the enhancing treatment. If a person is a member of a socially disadvantaged group and that person wants to change his appearance to look more like a white person, then his or her situation would most likely be better improved through measures that remove the social inequality than through surgery (Segall 2010, 134).

That Segall argues that not only health deficits should be treated, but also enhancements, opens his theory up for the critique that the luck egalitarian distribution is too wide. As it attempts to compensate all natural disadvantages, this also means that a lot of health needs seem to be considered for deserving compensation. It is questionable whether it is right that society should provide all those enhancing treatments. Lasse Nielsen argues that the problem with luck egalitarianism is that it "seems to imply that we also ought to compensate for disadvantages that are not at all urgent (Nielsen 2010, 410)." A lot of natural disadvantages may seem preferable for people to compensate, but that does not mean that these disadvantages are in dire need of treatment. Luck egalitarianism seems to require of society that people should get what they desire, but what someone's desire is not always the same as what they need to function properly in life (Nielsen 2010, 410).

Segall could respond to this criticism in two ways. There can be argued that there can be exceptional cases where society should provide the wanted health procedure, for it meets the requirements of luck egalitarianism. Furthermore, there could be argued that the surgery does not fall in the category of basic health needs and therefore should not be compensated. However that does not seem like the way Segall would argue (Nielsen 2013, 411).

The first option does not seem preferable because it would still imply that society would be obligated to provide health procedures that are basically unnecessary. If someone is extremely unhappy about a physical aspect of their body, it

would be more logical to send them to a psychologist first to try to change their mind about their physical appearance. That someone desires a certain treatment, does not make it necessary or urgent.

The second option to respond to the criticism undermines the basic premise of luck egalitarianism. Using this argument, would imply that Segall's luck egalitarian theory could only be applied to basic needs. The luck egalitarian premise is that all inequalities for which people can not be held accountable are unjust and deserve compensation. If the argument is made that many of the enhancement treatments do not deserve compensation because they do not fall in the category of basic needs, then that argument goes directly against the main luck egalitarian premise. Luck egalitarian theory argues that more health inequalities than basic needs should be compensated. Therefore this is not the way that Segall would argue.

What is argued here, is that Segall's luck prioritarianism distribution can not be used as a guideline for a just distribution of health. First of all, Segall has to remove responsibility as a criterion for distributing health in order to provide a minimum amount of health care . Which proves that placing responsibility at the centre of a just distribution of health is problematic.

Secondly, another problem is that Segall's distribution seems to provide too much health care in the cases where the luck egalitarian premise does play a central role. It seems to prescribe that societies are obligated to provide people with medical treatments that are not urgent nor necessary.

2.3 Can responsibility play a role in a just distribution of health?

Dworkin and Segall offer two different perspectives on how responsibility can play a role in a just distribution of health. The problem they both have to deal with is how to compensate for the harsh outcomes of letting responsibility be the criterion for when to compensate for health inequalities. They both choose non-luck egalitarian solutions for trying to deal with the abandonment objection. For both theories there has been argued that they are too problematic to provide a guideline for a just distribution of health, by letting responsibility be the main criterion for a just distribution.

The main issue with responsibility in a just distribution of health, besides the abandonment objection, is that luck egalitarian theories assume that in a situation where all other factors are equal, responsibility should always be the deciding factor

(Nielsen 2013, 414). However, when all other things are equal that does not automatically mean that the only thing that can be looked at is whether someone has been imprudent or not. There are examples where it is the case that the reckless person deserves compensation before the prudent person (Nielsen 2013, 415).

For example, two different groups go hiking. The first group of young, well-experienced hikers has chosen the difficult and dangerous path. The second group consists of elderly tourists that meant to take a brief walk, but accidently ended up on the same dangerous path. As often happens on dangerous paths, a landslide happens and both groups are stuck, needing rescue. When only one group can be rescued, luck egalitarianism would say that the innocent group (the elderly tourists) would have to be rescued first. They are the victims of brute luck, while the experienced hikers made a conscious decision to climb that path. It could very well be that the decision will be that the group of elderly tourists shall be rescued.

However, responsibility is not the only criterion in this situation that could be used. The decision could also be that the young hikers should be rescued because the loss of their young lives could be considered worse than the loss of the lives of the elderly people.

There are other considerations than the question of whether someone is responsible for their situation that decide who gets help.

Especially when it comes to the subject of health and health care, responsibility should not be the deciding factor that determines who gets help first.

Something to consider when taking responsibility as the main criterion of a just distribution of health is that it is not always easy to determine whether an outcome is the result of bad brute luck or whether it was option luck (Buyx 2009, 873). Take, for example, an overweight person with diabetes; if that person has a family history of diabetes, then it can not be determined what exactly is the cause of that person having diabetes. It could be because that person is overweight, it could be because that person's genetic makeup is burdened with a high risk at diabetes, or most likely it is a combination of both. Therefore it is very difficult to make a judgement about whether this person is responsible or not.

Chapter 3: Non responsibility sensitive theories

Since there has been argued that theories on justice in health should not be responsibility sensitive, the next part will examine two theories that are not responsibility sensitive. I will examine Elizabeth Anderson's democratic equality theory and Norman Daniels fair equality of opportunity theory in this chapter.

3.1 When are health inequalities unjust?

The democratic inequality theory that Anderson defends is a response to luck egalitarian theories.[7] She argues that those authors are trying to defend the wrong kind of equality. Anderson argues that the goal of egalitarian justice is to end oppression and create a community where all people are in equal relations with each other (Anderson 199, 288-289). Her theory focuses solely on social inequalities, as oppression is always socially imposed, where as luck egalitarians also try to compensate for natural inequalities.

The focus of democratic equality is to insure that every citizens in society can function and participate in society as an equal (Anderson 1999, 315-316). This means that if a person is forced to deal with an health inequality, this inequality is unjust so long as it prevents the person from participating in society as an equal. If an individual is faced with an health inequality, but is perfectly capable of participating in society as an equal, then that health inequality could be called just. However, if the standard for participating in society is set low, then many people could be excluded from attaining compensation for their health inequalities. Consequently, in that situation it could mean that the range of health inequalities that could be called unjust, is rather narrow.

Norman Daniels fair equality of opportunity account argues that health inequalities are unjust when they affect normal species functioning (Daniels 2008, 43). Normal species functioning is important because it is plays an key role in determining the amount of life plans that people can pursue (Engster 2014, 150).

7Anderson is seen as the main defender of this approach, but there are other authors who have earlier argued along the same lines. For example, Michael Walzer (Walzer 1983) and Samuel Scheffler (Scheffler 2003).

Therefore health inequalities that affect normal species functioning are seen as unjust. Compared to Anderson's theory, Daniels' concept of when health inequalities are unjust is clearly broader.

3.2 How should society compensate for these unjust inequalities?

In this section the distribution schemes of Anderson's democratic equality and Daniels' fair equality of opportunity will be examined to see which one provides a better guideline for a just distribution of health.

3.2.1 Democratic equality:

In her article "What is the point of equality," Anderson gave the following summary of her theory of democratic equality:

> "In seeking the construction of a community of equals, democratic equality integrates principles of distribution with the expressive demands of equal respect. Democratic equality guarantees all law-abiding citizens effective access to the social conditions of their freedom at all times. It justifies the distributions required to secure this guarantee by appealing to the obligations of citizens in a democratic state. In such a state, citizens make claims to one another in virtue of their equality, not their inferiority to one another. (Anderson 1999, 289) ."

What Anderson defends (and other authors who defend this kind of theory) is that what citizens owe each other is access to the social conditions of their freedom. Freedom is here defined in terms of capabilities. Egalitarians, Anderson says, should seek equality for all in the space of capabilities (Anderson 1999, 316). This does not mean that there are no limits to the kind of capabilities people are obligated to provide to their fellow citizens. Capabilities like being a good dancer or a great singer can be desired by a person who wants to be an artist, but unfortunately lacks these capabilities. However democratic equality does not state that because that person lacks those capabilities, society is obligated to provide them or give compensation to that person.

There are two guidelines that tell when society is obligated to provide capabilities to its citizens based on the proper aim of egalitarianism. First, people should be provided with capabilities when these capabilities are needed to help

someone escape an oppressive relationship. Secondly, people should be given capabilities that help them function as equal citizens in a democratic state (Anderson 1999, 316).

The first guideline is relatively clear. A situation where people are abused in their marriage would be a relationship that would fall under the first guideline. The second guideline states that people should be able to be an active participant in political and civil society.

Civil society is a very broad concept that includes all parts of social life that is open to the general public. It includes using public services, such as making use of the public transport system, using the telephone network, or going to restaurants and theatres (Anderson 1999, 317). If some citizens are excluded from parts of social life, then they are basically second-class citizens and democratic equality states that society should compensate them for that position. It should do everything in its power to give them access to civil society (Anderson 1999, 317).

When it comes to the subject of health, democratic equality aims to provide a broad range of health care services to citizens, whenever they have health needs that make them unable to function in civil society or political society. Personal responsibility plays no role whatsoever in this theory. People who get ill by their own fault still have the right to be treated, which is not surprising, as the focus on personal responsibility which is prominent in luck egalitarianism, is what Anderson sees as the great flaw in that particularly theory (Segall 2010, 37-38).

What is important to note, is that democratic equality does not claim that all people should be functioning at the guaranteed level of functioning (Anderson 1999, 318). Society is not obligated to ensure that everyone reaches that level of functioning that is necessary in order to participate equally in society. Society only has to provide effective access to health care (Anderson 1999, 318). People are not required to enjoy all the different options that civil society provides. For instance, not everyone has to be active in politics. People can choose to function at a lower level. They can, however, not choose to function at such a low-level that it can hardly be called functioning anymore. Anderson uses Kant's theory on human dignity to argue that every individual has the unconditional obligation to protect the dignity and moral equality of others and themselves (Anderson 1999, 319).

When it comes to health, individuals have a claim on society when their health affects their functioning as participants in civil society. However, when they do

not claim that right, society does not have to go out of its way to provide it. For example, a society can ensure that there are hospitals available, but a society can not force sick people to use the hospital when they are ill. Only when an individual is unhealthy to such a degree that they are barely functioning anymore and they refuse help, then society has the obligation to interfere. Anderson herself does not state this as clearly in her article, but this follows from her supporting Kant's statement about dignity. Not interfering when an individual loses their dignity and moral equality is not being respectful. Therefore, society should intervene in situations where that is the case.

Of course, determining when someone is at such a low-level of functioning where they lose their dignity, is a normative question. It will not be the same for every individual.

Democratic equality provides a fairly extensive amount of health care, as long people are limited in their functioning. However, the theory is less inclined to provide public health policies. Some policies, like providing clean water and anti-pollution policies, can be defended with this theory. Human beings need clean water and if the air is so polluted that people can barely breath, then individuals have a claim on society for compensation. However, in the case of anti-smoking policy, there is less of a case to be made. Most people know that smoking is bad for one's health, increasing the risk at lung cancer. Nevertheless, people who smoke are not by definition unhealthy. Up until the point where the smoker gets sick, they would be perfectly capable to function in society. In case the smoker does get sick, then they are entitled to health care.

Society spending resources for instance in order to try to prevent people from buying cigarettes, would be difficult to justify in a society based on democratic equality. That is because smokers are capable of functioning as equals in society. Thus there would be no justification for spending additional resources on that group. The other objection to public health campaigns would be that those kind of policies are paternalistic and Anderson does not favour paternalistic policies.

A different example would be governments campaigns against unhealthy food. Individuals can become very unhealthy when they eat too much food, but eating unhealthy food does not necessarily prevent people from being an equal participant in society. Most people can live a normal life and function in society despite the fact they are overweight. Therefore it would be difficult to justify public campaigns

against unhealthy food with the democratic equality theory. Since these kind of lifestyle choices play a part in determining our health as well, it is a weakness of democratic equality that the theory does not provide anything above the point where someone is capable of functioning in society as an equal.

This critique against democratic equality was also made by Richard Arneson and Shlomi Segall. Arneson argues: "Whatever exactly participation as equals requires, it evidently does not require much by way of desirable quality of life. We could function as democratic equals, while life is bleak, even squalid, for all of us (Arneson 2004, 28)." This is because democratic equality barely considers the absolute level of resources a person has. Whether a person is well off or poor is not a relevant question for democratic equality.

The distribution scheme is only concerned with the question if individuals have enough capabilities to participate as equals into society, it compares their relative status to see if they are equal or not.

I agree with Arneson and Segall that democratic equality allows for a situation where everyone in society is miserable. That kind of society would still be just because democratic equality would allow for situations where a large part of society barely manage the sufficient level of participating in society as equals, and the remaining part of society could be extremely wealthy, without there being any injustice. "Once all citizens enjoy a decent set of freedoms, sufficient for functioning as an equal in society, income inequalities beyond that point to not seem so troubling in themselves (Anderson 1999, 326)," is what Anderson argues.

The fact that democratic equality is only concerned with reducing inequalities up until the point that people can function as equal citizens, is a disadvantage when it comes to a just distribution of health . It has been mentioned several times that socioeconomic inequalities greatly the overall health in society Therefore by allowing for there to exist a huge gap between incomes in a society, democratic equality also allows the existence of large health inequalities. It even risks making people worse off when it comes to health (Segall 2010, 39). As was mentioned earlier, research has shown that even people in the highest social groups of society are worse off in a situation where there is much income inequality. Only striving for a sufficient level of equality, as is the case with democratic equality, can be detrimental for the overall health of society (Segall 2010, 40).

Segall also argues that democratic equality can be compatible with providing no health care at all. He argues that people can be of equal democratic capabilities when they are all equally physically incapacitated. Therefore there would be no need to provide health care at all (Segall 2010, 38). Although I do acknowledge that this can indeed be true, I do not believe it completely undermines the notion that democratic equality provides full health care for people who cannot participate as equals in society.

Theoretically, there could be a situation where everyone suffers from the same health inequality. For example, a scenario where every person on earth is born with one leg. Yet the fact that everyone has one leg does not prevent them from functioning in society as equals. In that scenario Segall would indeed be right with his critique that democratic equality is compatible with no health care at all. The physical handicap does not limit their functioning as citizens and, therefore, no person would deserve compensation.

This is however a hypothetical situation that is extremely unrealistic. There will never be a situation where everyone has exactly the same health inequality.
It can not be called a health inequality when every person has the same disability. In the situation where everyone has one leg and can function with it, then having a second prosthetic leg would be something like getting plastic surgery done. A compensation from society would be unnecessary and there is no strong reason why society would have to pay for it.

The main problem with democratic equality is that it is too narrow, it only provides health for situations that are related to functioning as democratic equals. Segall mentions infertility in women as an example of a condition that would not be covered with democratic equality (Segall 2010, 41). I do agree with Segall that there are many medical conditions that do not deserves compensation from society according to democratic equality, where our intuition would argue that that is unjust.

However, the example that Segall mentions may be overcome by democratic equality.
Infertility in women may fall under the category of the unconditional obligation to respect the dignity and moral equality of others. Being unable to have children, I would argue is a loss of dignity for women who strongly desire to have children. Therefore society is obligated to provide these woman help if they need it. The

problem however remains that democratic equality is quite limited when it comes to the health it provides. For it still allows a very minimum amount of health.

The problem with democratic equality is that a democratic equalitarian distribution of health seems too narrow in regard to compensating for health inequalities. Additionally, the fact that democratic equality is not committed to reducing inequalities beyond the point of functioning in society as an equal citizen, makes it an unsuitable theory to use as a guideline for a just distribution of health, I would argue. What Anderson's theory has shown, is that a just distribution of health should be broad and that is precisely what Daniels' theory is.

3.2.2 Daniels' fair equality of opportunity account

Norman Daniels' theory for a just distribution of health and health care is based on Rawls' theory of social justice (Rawls 1971). He gives an alternative Rawlsian account based on Rawls' fair equality of opportunity principle. So before Daniels' theory can be discussed it is useful to first briefly discuss Rawls' theory of social justice.

Rawls's theory is a contractarian theory where the principles of justice are based on what rational people would choose in a hypothetical situation with supposed impartiality.

In the original position rational human beings choose the principles that should govern their society.

From this original position two principles arise: the principle of equal liberties and the principle that determines how resources should be distributed in society. The second principle consists of the difference principle and the principle of fair equality of opportunity.

The principles are lexically ordered with the liberty principle ranked first, followed by the principle of fair equality of opportunity and ranked lowest is the difference principle (Kymlicka 2006, 55-57).

Once the principles that need to govern the society have been established, the next course of action is to distribute the primary social goods in society. Social primary goods are the goods that every citizen needs (Daniels 2008, 50). The principle of equality of opportunity is the principle that determines how the social goods are going to be distributed.

By allowing fair equality of opportunity (FEOP) to be the guiding principle, people's fate in society will be determined by their own choice and not by chance.

Individuals are free to choose the life they want, and to determine which goals they want to pursue. If they fail, then they can have no one to blame but themselves. This means that under the FEOP there can be inequalities within a society because they are the result of individuals' own choices. The third principle, the difference principle, slightly modifies that last claim for although there can be inequalities in society that are just, they are only just when they are to greatest advantage of all in society (Kymlicka 2006, 57-59). Only when the inequalities benefit the worse off people in society ,they can be called just and are they allowed to remain in society.

The problem with Rawls' theory is that he measures the worst off people in society through measuring the amount of social primary goods they have (Kymlicka 2006, 70).

Two individuals in society can have exactly the same amount of social primary resources, and they may be called well-off in society, but whether they are well off also depends on how their natural resources are distributed. Someone who is physically handicapped and is suffering from multiple chronic diseases, is not on the same level of well-being as someone without these handicaps, even if they have the same level of social primary goods. Or someone could have a slight advantage when it comes to social primary goods, but needs to spend so much of his resources on medical care that he is actually at a very low-level (Kymlicka 2006, 71).

What Norman Daniels has done, is apply this Rawlsian theory of justice to the matter of justice in health and health care, something Rawls never attempted to do. In the original position, behind the veil, diseases where irrelevant (Rawls 1971). Daniels' theory starts from the notion that health is the absence of pathology. As pathology is any deviation from normal functioning, it follows that meeting health needs is to maintain normal functioning and protecting normal functioning in turn helps with protecting the range of opportunities (Daniels 2008, 46). What he strongly defends, is that this is what makes health and health care so special and morally important.

The next step is that Daniels places the distribution of health under the principle of fair equality of opportunity (Daniels 2008, 47). Making individuals as healthy as possible is good for equality of opportunity when it comes to jobs and careers, but he does revise Rawls' FEOP principle. Instead of focusing on jobs and

careers, he broadens the principle by including life plans. What he means by life plan is every dream and goal an individual has in life and which they wish to pursue. It includes leading a long and painless life (Daniels 2008, 61-62). Daniels defines his revised FEOP principle as:

"*The fair equality of opportunity principle applied to health needs does not rectify or level all inequalities in function among people. It aims only to keep people functioning normally and thus assure them the range of opportunities they would have in the absence of disease or disability* (Daniels 2008, 58)."

The first problem with the principle of fair equality of opportunity of health is Daniels' claim of the moral importance of health care. It has been mentioned several times that health care plays only a limited role when it comes to health, therefore the reasons for seeing it as special and morally important have gone away as well. However, Daniels clings to the moral importance of health care, arguing that it still plays a very important role when it comes to health, along with other social determinants (Daniels 2008, 97). Authors like Segall and Engster have questioned this continued defence of the moral importance of health care (Segall 2010b, 345; Engster 2014, 155).

Daniels has admitted that the overall health could be much improved through social investments, rather than only through health care (Daniels 2011, 16). However, he does not change his claim that health care is of special moral importance. A possible solution to this problem could be the suggestion made by Daniel Engster. He argues that instead of arguing in favour of universal health care by looking at the role it plays in health, philosophers should argue for universal health care because of its contributions for caring for people, relieving their suffering (Engster 2010, 164-165). He claims that that would be a better defence for continuing to provide public health care than arguing that health is of special moral importance. Yet, this is not a very satisfying answer to Daniels' problem because justifying health care in terms of care instead of health has major implications on those who should get priority in health care systems. The people who are worst off in society should always get priority, according to Engster (Engster 2010, 164) . Prioritizing in health care is however not something Daniels' theory aims at (Daniels 2009, 38).

The disagreement about the moral importance of health may be caused by a different interpretation of when something can be called of special moral importance (Daniels 2009, 37). Daniels argues that health and health care are important because they protect opportunity. He does not claim (anymore at least) that they are the only factors that protect equality of opportunity. What the critics of the special moral importance of health seem to imply is that health care can only be of special moral importance if it is the *only* factor that protects equality of opportunity.

Yet there seems to be no good reason why health care could only be called of special moral importance if it is the only factor that protects equality of opportunity. When looking at society as a whole health and health care may only play a small part in protecting equality of opportunity, but at the individual level it plays a much bigger role. Suffering from a medical disease has a strong influence on people's opportunity range. Therefore I would argue that health and health care can still be seen as of special moral importance.

There is no denying that the claim of the special moral importance of health care is weakened, but his critics try to downplay the role of health care too much. Blank and Bureau argue that in order to maximize health, resources should be spent on changing lifestyles, reducing poverty and other social policies, as "the healthy person does not need medical care" (Blank and Bureau 2007, 217). I would definitely agree that a healthy person does not need medical care, but social policy to reduce poverty will not help a person who is suddenly faced with a disease. Even high educated, rich people, who live a healthy lifestyle, will most likely need health care at some point.

The second issue with Daniels' theory is that his theory compensates for ill health, but not for poor talent. Daniels' improvement of Rawls' theory is that, unlike Rawls, he does compensate for natural inequalities. Daniels compensates for them because they enable people to pursue their life plans. The question is why people with limited talents should be treated different than people who have low health.
If someone who is very short because of a medical issue deserves compensation, then why should a person that is equally short, but has no illness, not deserve the same compensation (Kelleher 2013, 396-397)?

Daniels admits that this is a complicated issue in his theory. What Daniels tries to avoid in his theory is catering to expensive tastes. Since that was one of his main criticisms on luck egalitarian theory. He argues that compensating individuals with

limited talents is catering to expensive tastes (Daniels 2008, 151). The young man that wants to be tall in order to be a good basketball player, but who has no medical problem related to his height, may be better off with psychological counselling that helps him deal with the fact that he will never be tall, is what Daniels argues (Daniels 2008, 151). In this situation the wish to be tall is an expensive taste, and society is not required to compensate expensive tastes.

This outcome seems rather unfair to people that are faced with limited talents. They are informed that their life plans are too expensive and that they should choose new life plans. Consequently, people should hope that they have a disease instead of having limited talent, because if they are diseased then they will get compensated.

There has been argued here that responsibility should play no part in a just distribution of health, but what has been rejected is the luck egalitarian notion of responsibility, that argues that people should bear the cost of a risky lifestyle. Within Daniels' just distribution of health, there is room for responsibility, but in a different way. Daniels argues that there is nothing wrong with encouraging personal responsibility for health through incentives and education (Daniels 2008, 69).

People should be encouraged to take responsibility for their health, but forcing them to pay the costs of health care that they need as a result of their imprudent behaviour, is too harsh. I would argue that stimulating people to take responsibility for their well-being is in the end much more effective than the way luck egalitarian theory tries to promote personal responsibility.

Conclusion

The central problem that was addressed in thesis was how to distribute health in society fairly when resources are scarce. The research question was: *What is a just distribution of health?* The issue that was examined, was whether responsibility could play a role in a just distribution of health. The argument that has been made in this thesis, is that the luck egalitarian version of responsibility can not play a role in a just distribution of health. The outcomes that follow from letting people pay the cost of their imprudent behaviour punish the imprudent person too harshly. The only way that luck egalitarian theories can overcome this critique, is by partly removing responsibility out of the equation. The theories by Dworkin and Segall both provide a minimum amount of health care without the criterion of responsibility present. This proves that responsibility in a just distribution of health is problematic.

Furthermore, the abandonment objection is still present in situations where they do allow responsibility to be the main criterion for distributing health. There are other considerations besides responsibility that can be used to determine who should get priority when health is distributed. What has been argued in this thesis is that a different criterion for distributing health, especially restoring a person to normal functioning , is a better criterion for distributing health than responsibility.

The just distribution of health that comes closest to a just distribution of health is Daniel's fair equality of opportunity account. His theory for a distribution of health consists of restoring the normal functioning of individuals. The theory is broad in the sense that it allows a large range of health inequalities to deserve compensation from society. In addition, the theory is also not too broad, because it does not demand that all health inequalities should be compensated. The fair equality of opportunity distribution denies compensation to inequalities that are the result of expensive tastes. Society is obligated to restore health to the level of normal functioning, but not above that point.

Daniels thus gives priority to treatment over enhancement, but he does not rule out that in exceptional cases, enhancement treatments also require compensation. If a society is willing to provide that treatment, then there is no reason why that should not be possible. What he argues is that the first aim of society should be to restore health

and to treat medical conditions, and then there can be decided whether additional resources should be spend on enhancement. However, since in real life most societies have a scarcity of resources, there is a greater chance that only health treatments are provided by a society.

Despite the fact that the fair equality of opportunity principle does not use responsibility as a criterion for health, Daniels' theory does allow room for encouraging people to take personal responsibility for their health. Personal responsibility can be stimulated by education and through financial incentives.

The argument that has been made in this thesis is the direct opposite of what the current policy decisions in regard to health care stipulate. Implementing more and more privatization in the health system and putting more emphasis on personal responsibility does not contribute to a fair health system. If a government wants to distribute health in a fair way, then responsibility can not be used as a criterion for distributing health. Instead, governments should aim at a health system that focuses on restoring health to a level where people can function normally.

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