

## Introduction

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What is the just distribution of health and health care? The answer this book seeks to offer is deceptively simple perhaps: Differences in health and health care are unjust if they reflect differences in brute luck.

The invocation of luck in accounts of egalitarian justice has become increasingly salient in recent years. In fact, “luck egalitarianism” can be said to be the main rival to John Rawls’s dominant theory of justice. According to luck egalitarians, distributive justice requires correcting disadvantages for which individuals cannot be held responsible. In other words, the theory seeks to compensate individuals for the effects of bad luck on their lives. (I shall say more about the difference between Rawlsian and luck egalitarian justice in the first chapter). It may be surprising, perhaps, but despite the prominence of this egalitarian theory, to date there has not been any systematic attempt to apply luck egalitarianism to the study of justice in the distribution of health and health care.<sup>1</sup> In fact, some critics have commented in passing that the application of luck egalitarianism to health and health care leads to counterintuitive results.<sup>2</sup> That is precisely the challenge that this book seeks to meet: to offer and defend a luck egalitarian account of justice in health care and health.

The intersection of the luck egalitarian conception of distributive justice with health and health care raises two main ethical issues. First, how ought we to treat patients who have not taken good care of their health? According to luck egalitarians, distributive justice requires mitigating only eventualities for which individuals are not responsible. It follows, then, that luck egalitarianism arguably requires that patients that *are* responsible for their own illness (say, lung cancer patients who have smoked, or injured motorists who have driven recklessly) are not entitled to medical treatment. Could this be right? Most of us recognize that some people are “worse” patients than others. Some people have a less healthy lifestyle than others, they ignore their doctors’ orders, they smoke, drink, and eat too much, and exercise too little. Such imprudent behavior not only worsens one’s own health,<sup>3</sup> but also places unnecessary burdens on the health care system.<sup>4</sup> Why should the rest of us pay for their avoidable reckless behavior? If, in turn, health care *is* to be universal and unconditional, as egalitarians typically believe it should be, then what, exactly, justifies (on the luck egalitarian reading) medical treatment for citizens who are to blame for their medical needs? (By “unconditional health care” I simply mean a health care service that does not condition the provi-

sion of care on the prior prudent conduct of the patient. I elaborate on this in chapter 5.) That is the first of the two main issues with which this book is concerned.

The second issue is this. We often witness considerable disparities in health and life expectancy across society (let alone *between* societies, which is the subject of the final chapter). Not all of these inequalities can be explained in terms of access to health care (I shall say more on this in chapter 6). Some of the inequalities in health itself are due to social factors other than health care, and yet some other part of them is explained by genetic differences. Much of the inequality in individuals' health status, then, is owed either to social circumstances over much of which they have no control (social circumstances they were born into), or to natural genetic factors (which philosophers appropriately refer to as the product of a "natural lottery"). How, then, would a theory of justice that seeks to abolish the effects of differential brute luck from people's lives treat such inequalities in health and life expectancy? In other words, if health is, at least to some extent, a matter of luck, then what is it to distribute health justly, that is, independently of luck?

The first part of the book, then, deals primarily with health care, whereas the second part concerns health proper. A subsidiary concern for the book is to examine the interplay between political borders and the discussion in the first two parts. How does luck egalitarian justice in health and health care apply within and beyond the political boundaries of the state? The application of the theory of luck egalitarian justice in health care and health to the issue of political borders may serve two purposes. One is to point out some important policy implications of the theory, while a second is to reveal some further potential facets of the intersection of luck egalitarianism and health not yet explored in the first two parts of the book. The book is therefore divided into three parts (after the introductory chapter, discussing luck egalitarianism itself), dealing with health care, health, and the importance of political borders to these first two issues. I turn now to outline how the argument unfolds.

*Chapter 1* begins by sketching the main components of the luck egalitarian conception of distributive justice. It then contrasts luck egalitarianism with the Rawlsian conception of justice. Later still it pursues and develops two important features of the luck egalitarian theory that seem to be in dispute among luck egalitarians. First, I attempt to establish that luck egalitarian justice considers only inequality, not equality, as potentially unjust. Second, I argue for a certain understanding of what are eventualities for which the individual is not responsible. The chapter is meant to provide a working definition of the theory of distributive justice to be employed throughout the book.

The main concern of the *first part* of the book, as I have said, is: How ought society to treat patients who can be said to be responsible for their own poor medical condition? The luck egalitarian conception of justice says that distributive justice does *not* require society to compensate members for disadvantages that result from their own voluntary actions. It is easy to see, then, why some political philosophers have suggested that the luck egalitarian conception of justice appears untenable when applied to health care. A luck egalitarian health care system will arguably not provide medical treatment to patients who can be said to be responsible for their ailment. That seems wrong: we are allegedly not required to treat an injured reckless driver or a smoker who contracts lung cancer, since their bad luck is what luck egalitarians call bad “option luck.” That is, it is the result of these patients’ “gambling,” so to speak, with their own health. But to not treat these patients would clearly be harsh and wrong. This objection to luck egalitarianism is known as the “abandonment of the imprudent.” It purportedly shows the luck egalitarian account of justice, and of justice in health care in particular, to be too narrow: it cannot justify treating the imprudent. (In a different way, the account may be said to be *too broad*: it arguably justifies treatments that go beyond what we traditionally associate with health policy. I address that worry in chapter 9.) The first challenge for the book, then, is to explain how a luck egalitarian account of justice in health care can defend itself against that “abandonment” objection.

*Chapter 2* begins the defense of a luck egalitarian account of justice in health care by seeking to establish the need for a fresh examination of justice in that area. More specifically, it seeks to show that standard, responsibility-insensitive accounts of justice in health care are inadequate. The chapter critically examines two prominent models for justice in health care: Norman Daniels’s fair opportunity account, and Elizabeth Anderson’s democratic capabilities account. I argue that these accounts have some decisive shortcomings in providing a theory of justice in health care. Among other problems, Daniels’s emphasis on safeguarding opportunities for the pursuit of life plans ends up not justifying medical treatment for those who can be said to have completed their life plans, namely the elderly. The democratic capabilities account, in turn, has its own distinct faults: the fact that it makes the just claims of individuals for medical care contingent on the prevalence of a democratic regime, to name one. For these and other reasons I conclude that these two responsibility-insensitive accounts of justice in health care are inadequate.

After arguing against these two dominant accounts of justice in health care, I then turn in the rest of part I to developing and defending a luck egalitarian

account of justice in health care, focusing on whether or not it can escape the abandonment objection and justify universal and unconditional health care.

In the past five years or so, philosophers sympathetic to the project of developing a luck-sensitive conception of justice have sought to address the abandonment of the imprudent objection by giving the luck egalitarian ideal a radical interpretation. These radical luck egalitarians, whom I term “all-luck egalitarians,” propose an innovative interpretation, according to which imprudent patients need not be abandoned. The kernel of these philosophers’ proposal is that justice requires taxing imprudent activities (smoking, say), and using the revenue to care for imprudent individuals who turned out to be unlucky (i.e., who have fallen sick). The idea, then, is one of pursuing justice between lucky and unlucky imprudent agents. In *chapter 3* I examine this proposal and demonstrate that it cannot offer a viable account of distributive justice in general, and one in health care in particular.

After rejecting the “all-luck egalitarian” attempt to address the abandonment objection, *chapter 4* turns to examine how standard luck egalitarians may respond to that objection. I argue that such recent responses by standard luck egalitarians are inadequate for one reason or another, and I then provide a different solution to the abandonment problem. That solution involves trading off the requirements of justice with those of other values. One moral requirement that is particularly relevant here is that of meeting a person’s basic needs, including her basic medical needs. I show how the trade-off of luck egalitarian distributive justice with the more general requirement of meeting basic needs yields a plausible and attractive account of justice in health care.

*Chapter 5* seeks to complete the defense of the luck egalitarian account of justice in health care. While *chapter 4* effectively seeks to demonstrate that luck egalitarian justice does not require abandoning reckless patients, *chapter 5* seeks to show how the concern for basic needs yields an attractive account of justice in health care. I develop an account of health care as a normatively nonexcludable public good. This understanding of health care spells a responsibility-sensitive, yet still unconditional, health care. The chapter concludes part I by demonstrating how luck egalitarians may justify a universal, *in-kind* provision of health care, whereas Daniels’s account does not.

The *second part* of the book shifts the focus from health care to health proper. It seeks to offer an account of justice in the distribution of health, and moreover one that is sensitive to luck. Many people find it difficult to imagine how we would even begin to distribute health itself, let alone do it in a luck-sensitive fashion. We normally think of health *care* as something society can distribute more or less equally. But can we really redistribute health itself? We generally think of health as what economists call a nondivisible

and nontransferable good.<sup>5</sup> Moreover, even if we could redistribute health, ought we to do so?

Two facts make that task not only possible but also urgent (I elaborate on this in *chapter 6*). First, even societies that feature universal and free access to health care may display considerable disparities in health. For example, people living in some neighborhoods of the Scottish city of Glasgow have a life expectancy that is twelve years shorter than those living in the more affluent parts of that city.<sup>6</sup> Unequal access to universal care, much as it obtains, cannot account for such striking disparities.<sup>7</sup> It follows that if we care about equality and about health, providing free health care to all cannot possibly be enough.<sup>8</sup> The second point is that epidemiologists have been telling us over the past twenty years or so that it *is* possible to mitigate the disparities in health by redistributing some other goods, such as income, housing, employment, and workplace autonomy. In fact, some philosophers have suggested that if we really cared about justice and health we would do well to scrap health care altogether and invest those resources in the social determinants of health.<sup>9</sup> So although health itself is a nondivisible and nontransferable good, the distribution of other goods (that *are* divisible and transferable) can affect the way in which health is distributed across society. This lesson, that inequalities in health itself ought to be of moral concern independently of inequalities in access to health care, and that they ought to be curbed by redistributing the social determinants of health, has now also been recognized by policy makers.<sup>10</sup> Giving attention to health in addition to health care therefore seems warranted, as I shall argue in *chapter 6*.

The rest of part II of the book, then, seeks to offer a luck-sensitive account of justice in the distribution of health proper. *Chapter 7* begins tackling that central task by inquiring what it may mean to redistribute health justly, and what it may mean to do so in a way that neutralizes brute luck inequalities. My discussion there contrasts a Rawlsian approach with a luck egalitarian approach to justice in health, and attempts to show that a fair distribution of health is one that safeguards individuals' opportunity to be as healthy as they choose to be.

A problem that is common to both Rawlsian and luck egalitarian approaches to health equity (or justice in health—I use the terms interchangeably) is the “leveling down objection.” The problem, namely, is how to offer a fair account of justice in health that does not end up lowering some individuals' health prospects in the name of equality. In *chapter 8* I attempt to demonstrate that a modified luck egalitarian account, namely one that seeks to prioritize the health of the worse off rather than to equalize everyone's health, successfully averts that problem. To justify this prioritarian approach I inquire into the value of equality in health. I argue that it has only negligible

instrumental value, and therefore that justice in health allows for priority (to the worse off), and does not necessitate a strictly equal distribution.

Chapters 7 and 8 combine to provide a “luck prioritarian” account of justice in health. More accurately perhaps, these two chapters discuss justice in the distribution of health *deficits* (e.g., illness broadly conceived). *Chapter 9* moves from discussing the distribution of health deficits to discussing the distribution of enhancements to full normal health. I argue in that chapter that a luck-sensitive account of egalitarian justice compels us to broaden our traditional concern in health from deficits to full health into enhancement of human functioning (e.g., through genetic intervention). I suggest that luck egalitarianism explains our intuitions about the role of medical intervention better than Daniels’s “fair opportunity” approach.

The luck egalitarian theory of justice in health and health care having been outlined, the *third part* of the book applies the theory to the particular issue of political borders. There are two pertinent issues here: justice in the distribution of health and health care below state level, and beyond it. The first question asked is whether it is appropriate to delegate the responsibility to deliver health care to subnational regional authorities (say, from London to Edinburgh), while the second task is to examine our global obligations with regard to health.

*Chapter 10*, then, asks how we should allocate health care in plurinational societies. Does distributive justice require a unified health care system or a devolved one? Some have suggested that in culturally divided societies health care systems (and perhaps other welfare services as well) should be divided along regional lines. The argument grounding such proposals seems to run as follows: since members of homogeneous regional communities have relatively similar needs and tastes, it is easier for them to agree on a rather comprehensive distributive scheme. Against this suggestion, I argue that the policy of devolution in fact upsets distributive justice. A just health policy, I claim, need not cater to expensive communal tastes in medical consumption that were voluntarily developed.

*Chapter 11* examines the implications of the luck egalitarian account of justice in health and health care for our obligation to meet the health needs of people outside our own political community. When, then, are inequalities in health and life expectancy that exist between nations justified? Luck egalitarian justice has a distinctive input here, I want to argue. It stresses that the nation one happens to be born into is a fact of pure brute luck, and thus should not affect one’s health prospects. But there are further peculiarities to the global perspective on health that make that judgment somewhat more complicated. We now know, for example, that GDP is not such a good indicator of popula-

tion health. As pointed out by Daniels in his most recent work, although the GDP per capita difference between Costa Rica and the United States is huge (\$21,000), life expectancy is almost the same between the two countries. Correspondingly, in 1995 although Cuba and Iraq were equally poor (GDP per capita \$3,100), life expectancy in Cuba exceeded that of Iraq (notice, prewar) by 17.2 years!<sup>11</sup> These figures may suggest that the health of nations is not a matter of global justice, since it seems to be primarily determined by domestic policies. If so, a consistent luck egalitarian account, one that is committed to holding agents (in this case nations) responsible for their choices, does not identify an obligation on the part of the healthy and wealthy nations to boost the health of nations that are less healthy and wealthy. I attempt to show in this final chapter why that conclusion is largely unwarranted. There are four complicating conditions that may prevent us from holding residents of developing unhealthy nations responsible for their nations' poor health. These are: the question of whether or not the nation is a democratic one; the question of whether or not the global economic order allows developing nations to pursue policies that are good for their health; the question of holding dissenters accountable for health-related policies to which they actually objected; and the question of holding children responsible for policies they could not have affected. For all these reasons, I propose, it is seldom just to deny members of poor and unhealthy nations (what we may call) a "global health dividend."

The last two chapters mirror the division that is made earlier in the book between health care and health, with chapter 10 dealing with health care, and chapter 11 returning to health proper. More importantly, these two chapters provide insight into two potentially interesting aspects of luck egalitarianism touched upon but not quite explored earlier in the book. The crux of the matter in chapter 10 is the issue of communal (that is, of a subnational community) responsibility for collective tastes and preferences in medical care. A theory of justice that is sensitive to luck (the opposite of responsibility) may have an interesting input in that respect. Luck egalitarianism also has a unique input in dealing with global health. One difference between Rawlsian justice and luck egalitarian justice is that between what we may call a "political," on the one hand, and a "natural" or "cosmic" conception of justice, on the other. (I shall explain this distinction in the next chapter). Discussing global justice in health might help us bring out this difference between the two theories.

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The defining feature of luck egalitarianism is no doubt the distinction it draws between eventualities for which we are responsible and ones for which we are

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not. In the course of the next eleven chapters I shall attempt to show that the centrality of that distinction to distributive justice is confirmed by many of our intuitions about justice in health care and health. If that proves to be the case, then this book may well say something not only about the nature of justice in health and health care, but also about the nature of justice itself.