Chapter 6
Justice and Responsibility in Health Care: General Discussion and Conclusion of Part I

Antoon Vandevelde

6.1 Introduction

Most contributions to the first part of this book – with the exception of Jeroen Luyten's article, which focuses on the difference between deontological and consequentialist reasons for obligatory vaccination – defend some form of egalitarian justice. This is, however, both an evident point of departure and a highly contested issue.

In this short conclusion I will try to indicate the most salient features of egalitarian justice as it applies in the field of health and health care.

6.2 Equality as Starting Point

No matter how greatly different individuals are, whether they are strong or weak, intelligent or stupid, rich or poor, powerful or dependent, healthy or chronically ill, disabled or able-bodied, basically, they are all human beings, endowed with equal dignity. Now, if we put aside the issue of animal rights, this means, in principle, that equal concern and respect should be shown to all human persons.

However, in actual reality, we are far removed from that mark. We know that human rights can only be enforced and realized by particular institutions and that these tend to protect primarily their own members, the insiders, not the outsiders. As the quality of these institutions is very unequal, it is sheer luck whether one is born in a society (or in a family) that grants its members maximal opportunities to develop their basic capabilities, or in a society (or family) that refuses to do so. In reality, we discover much inequality between human beings.

A. Vandevelde (✉)
Institute of Philosophy, Catholic University of Leuven,
Kardinaal Mercierplein 2, box 3200, 3000 Leuven, Belgium
e-mail: antoon.vandevelde@hiw.kuleuven.be

Y. Denier et al. (eds.), *Justice, Luck & Responsibility in Health Care*,
Library of Ethics and Applied Philosophy 30, DOI 10.1007/978-94-007-5335-8_6,

6.3 "Why Are You Entitled to Have More Than Me?"

Suppose that one day, someone who has less than me approaches me and asks the question: "Why do you have so much more than me?" This is a just question. For after all, when looking at our *prima facie* principles, we are very much committed to the value of equality. However, in some instances I may tend to think that I am entitled to have (much) more than this person, because in general, two divergences from strict equality are accepted by most ethicists.

I may answer to him: "I am entitled to have more than you for two reasons: The inequality between us can be justified (1) if you would have less if there was no inequality and (2) if your relatively unfavorable situation is due to your own fault.

6.3.1 Efficiency Considerations

First, inequality is permitted in order to avoid leveling down. If everybody would earn the same income, probably only a minority of intrinsically motivated people would work hard. There would be a huge loss of efficiency in society. It would be poverty, rather than wealth that we distribute evenly. Hence inequality of income and wealth is permitted if and only if it maximally improves the fate of the least advantaged. This is the rationale behind John Rawls's Maximin Principle (Rawls 1971, 1999).

Do efficiency considerations also justify inequalities in health and access to health care? This is less obvious. We tend to think that, at some very basic level, all human beings are equally confronted with vulnerability and mortality and that society should respect the human condition at least by providing equal access to health care to all human persons. However equal access to health care is no guarantee for equal health. Take the example of the difference in life expectancy between men and women. We can try to correct this insofar as it is a consequence of the more risky life style adopted by most men, and clearly, there is some scope for health information campaign policy. However, differential survival rates between men and women are mainly due to social and natural determinants that are not easily corrected. In such cases, a differential treatment can be justified.

Indeed, the Aristotelian principle of distributive justice makes clear that equality implies that *equal cases should be treated equally and unequal cases should be treated unequally* (*Nichomachean Ethics*, Book V in Aristotle (2000)). In the case of disabled persons for instance, it may be impossible to correct nature, but then we try to soften or even eliminate the consequences of this inequality. We give additional support to handicapped people in order to permit them to achieve the most important basic capabilities. However, in the case of the difference in life expectancy between men and women we tend to think that a differential treatment is inappropriate. Either it would lead to leveling down of women's health, or it would necessitate a huge investment in order to improve exclusively men's health. The first alternative is clearly unattractive. We do not want to worsen the situation of half of mankind with-

out improving the situation of the other half. The second alternative is no better because – apart from the information campaign we mentioned above – more important gains in health for the general population can be reached without such an exclusive targeting on male population. Hence, inequality in health between men and women does not justify inequality in access to health care. It is a form of inequality that can be justified in an overall scheme of distribution of opportunities and assets that is broadly inspired by egalitarian ideals.

Another example of acceptable inequality on the basis of the search for maximal efficiency (for the least well-off) can be found in the provision of new pharmaceuticals and new medical treatments. Egalitarianism could mean that these can only be introduced on condition that they can be provided to all patients who could profit from them. Hence, it would be unjust to apply new treatments as long as they are not accessible to all, i.e. as long as they are not integrated into the obligatory package of universal health insurance. However general provision of new treatments and new pharmaceuticals can probably be achieved much earlier if, for a certain period of time, we permit them to be provided at expensive prices, only to those who can afford them. After some time, when expenditures for research and development are more or less paid back, the treatment could be reimbursed by general health insurance. Moreover, the whole process should be thoroughly monitored by social institutions in order to make sure that the right type of efficiency is being aimed at.

6.3.2 Individual Responsibility?

"Am I entitled to have more than you?" In my answer to the poor person I may use individual responsibility as the basis for justification: "Maybe I work harder than you. If I make more efforts than you, why couldn't I have more?"

Inequalities based on some form of merit are supposed to be just(ified). They do not need compensation. Arbitrary inequalities on the other hand for instance between citizens of poor and rich countries – are to be compensated. Chance or choice? It makes a difference from an egalitarian perspective. Responsibility-sensitive egalitarianism should create equality of opportunities rather than equality of outcomes. It should offer people the opportunity to develop fully their capabilities. Whether people make good use of these opportunities is their own responsibility.

However, application of the cut between chance and choice to the sphere of health and health care is tricky. Of course, some inequalities in health are the result of bad choices. Some people are obviously not responsive to sound health advice. Their bad health is caused by an imprudent life style and this is a matter of personal responsibility. From a liberal, anti-perfectionist perspective, society should inform people about health risks, but should not compensate people for their stupid choices.

However, many authors have shown that it is difficult in actual practice to disentangle choice and circumstances. Most ethicists are not inclined to go into deep metaphysical considerations about freedom and determinism. They rather try to find a practical

thumb rule, like Shlomi Segall's proposal: "an individual is responsible for an outcome if it would be unreasonable for society to expect the individual to avoid it" (Segall 2010, p. 20). However, like Daniel Hausman shows in his article in this volume, the appeal to reasonableness is far from solving all problems in this respect.

Many of our choices seem to be determined by circumstances that we do not control. One of the most striking examples of this phenomenon in the sphere of health is the social gradient Michael Marmot discovered in his Whitehall Study (Marmot 2004). Marmot found that life expectancy and the occurrence of health problems among British civil servants whose health condition has been followed during 25 years reflects almost exactly the social hierarchy on the work place and in remuneration. We knew already for a long time that poverty makes sick, but these civil servants were not poor. They were all white collar workers, in stable employment. Apparently, it is not just poverty, but inequality in itself that makes sick. Marmot wages the hypothesis that the social gradient in mortality and in morbidity that he discovers among British civil servants is to a large extent determined by the degree of control they have on their environment. A lower place in the social hierarchy simply means a lack of control and hence a lack of free choice. Responsibility-sensitive justice cannot blame these people, simply because their health is determined by circumstances beyond their control. To the extent that society can hardly function without some form of social hierarchy, it is predictable that public policy can only mitigate, but never eliminate the ensuing inequality of health.

Luck egalitarianism is the ethical theory that tries most consistently to track individual responsibilities. However it has to face the abandonment objection (Anderson 1999). If someone gets into a life-threatening situation due to his own imprudence, should we then abandon him to his fate? Our spontaneous intuition revolts against this suggestion. Even Shlomi Segall, the most audacious defender of luck egalitarianism in recent philosophical literature, admits that we cannot refuse to help the smoker with lung cancer or the drunken driver who has been injured in an accident. When our most fundamental needs are at stake, the question of individual responsibility does not apply anymore. Of course, this concession severely restricts the scope of luck egalitarianism, as it only applies beyond a certain threshold of basic needs.

6.4 Conclusion

Ultimately, the policy conclusions of the various theories of Norman Daniels, Shlomi Segall and Ronald Dworkin concerning the provision of health care diverge only marginally (Daniels 2008; Segall 2010; Dworkin 2000). All of them agree that smokers with health problems should not be abandoned, but that they should be made to pay for their unhealthy life style through high taxes on tobacco. Also, all of them seem to advocate a more or less generous system of compulsory health insurance, eventually to be supplemented by optional private insurances. Maybe this convergence is not so surprising, as they all refer to a form of egalitarianism that is not merely formal.

However the rise of very expensive forms of individualized medicine in the near future will challenge these theories of egalitarian justice ever more seriously. Probably the hardest choices about the use of scarce resources in health care will concern medical decisions at the beginning and at the end of life. Already at this moment, prenatal genetic diagnosis makes it possible to predict chromosomal deficiencies of the baby to be born. Does egalitarian justice require solidarity with parents who, knowingly and willingly, choose to give birth to a handicapped baby? And what does justice require towards the end of life? Medicine has become capable to delay natural death for a very long period, at a considerable financial cost for society and with important emotional and (often) financial consequences for the family. Do we as individuals become morally required to take up responsibility for the moment we will die? Is there, in some occasions, a duty to die? These are the issues that are discussed in the second part of this volume.

References

Anderson, E. 1999. What is the point of equality? *Ethics* 109: 287–337.

Aristotle. 2000. *Nichomachean ethics.* Trans. and ed. R. Crisp. Cambridge: Cambridge University Press.

Daniels, N. 2008. *Just health – Meeting health needs fairly*. Cambridge: Cambridge University Press.

Dworkin, R. 2000. Justice and the high cost of health. In Id., *Sovereign virtue – The theory and practice of equality*, 307–319. Cambridge: Harvard University Press.

Marmot, M. 2004. Social causes of social inequalities in health. In *Public health, ethics, and equity*, ed. S. Anand, F. Peter, and A. Sen, 37–62. Oxford: Oxford University Press.

Rawls, J. 1971. *A theory of justice*. Cambridge: Harvard University Press.

Rawls, J. 1999. *A theory of justice* (rev. ed.). Cambridge: The Belknap Press of Harvard University Press.

Segall, S. 2010. *Health, luck and justice*. Princeton: Princeton University Press.