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THE SIGNIFICANCE OF THE CONCEPT OF DISEASE FOR JUSTICE IN HEALTH CARE

ABSTRACT. In this paper, I want to scrutinise the value of utilising the concept of disease for a theory of distributive justice in health care. Although many people believe that the presence of a disease-related condition is a prerequisite of a justified claim on health care resources, the impact of the philosophical debate on the concept of disease is still relatively minor. This is surprising, because how we conceive of disease determines the amount of justified claims on health care resources. Therefore, the severity of scarcity depends on our interpretation of the concept of disease. I want to defend a specific combination of a theory of disease with a theory of distributive justice. A naturalist account of disease, together with sufficientarianism, is able to perform a gate-keeping function regarding entitlements to medical treatment. Although this combination cannot solve all problems of justice in health care, it may inform rationing decisions as well.

KEY WORDS: disease, justice, rationing, egalitarianism, sufficientarianism, naturalism, normativism

INTRODUCTION

In most European countries there is an ongoing debate on how to distribute scarce resources in health care. It seems obvious that no health care system, even in the richest countries, can provide for *all* indicated medical treatment. Medical resources seem scarce almost by definition. Therefore, the issue of their just distribution must be raised. Although many European governments still hold officially that every health care need can be met, and that only more efficient ways of spending are called for, it transpires that cuts in the provision of apparently necessary, and at least effective, medical treatments is inescapable. Rationing, as it is commonly called, is therefore presumably our inevitable future.

Health is one of the most important values in Western societies. It should therefore not come as a surprise that restrictions on the provision of health care resources are fiercely debated. It seems that

many people believe in an entitlement to all means that are necessary to maintain individual health. They seem to support a theory of justice which calls for a provision to meet all health care needs. But there are other possible criteria of justice like desert, equality or free choice etc., which may conflict with the need principle.

The amount of resources which are necessary to meet entitlements clearly depends on which theory of distributive justice we endorse. Hence there is a normative aspect to the scarcity of resources: the more entitlements to resources, the more supply is needed in order to secure a just distribution. In this essay I want to ask which justified claims, i.e., entitlements, citizens may expect to have in a society that collectively provides for health care. In particular, I will examine the significance of different theories of disease for the conceptualisation of just health care.

It seems obvious that a just public health care system ought primarily to cover cases of *disease*, whereas it is more difficult to justify treatments which do not involve instances of disease, or do not at least entail a certain likelihood of becoming ill without medical intervention. "Judging that some condition is a disease commits one to stamping it out. And judging that a condition is not a disease commits one to preventing its medical treatment."[1]

Hence, the way we conceptualise disease has important consequences for the scale of resource demand. A theory of disease may support a potential gate-keeping function by clearly defining a condition of justified claims on health care resources. However, although I certainly see a contribution of the discussion about the concept of disease for the problem of medical distributive justice, I believe that the gate-keeping function of disease can only evolve in conjunction with a specific theory of distributive justice. I will argue in favour of a combination of a minimalist, non-egalitarian theory of justice with a naturalist, non-normative theory of disease.

WHICH THEORY OF DISEASE?

What disease is, how it should be defined, has been discussed in modern philosophy of medicine at least for a couple of decades, although it is, of course, a much older question. It has become customary to distinguish theories of health and disease in terms of two ideal-types:[2] a) a value-neutral or objective approach and b) an evaluative or normative approach. According to the first kind of

theory, often called 'naturalism', disease is a subnormal deviation from a bio-statistical norm of organismic functional ability.[3] According to naturalism, whether a certain condition *is* a disease is independent of evaluative issues. Whether a disease is bad for us has to be decided by further considerations, not by definition.

In contrast to this, the second approach, normativism, defines disease in relation to a negative evaluation of the bodily or mental condition of a person. Hence, a representative normativist writer states: "The concept of disease acts not only to describe and explain, but also to enjoin to action. It indicates a state of affairs as undesirable and to overcome."[4]

For most supporters of normativism, a certain state is an instance of disease only if there is an individual-subjective or a social-cultural disvaluation of it. In contrast, naturalists assert that disease can be identified independently of any such evaluation, especially by reference to biological findings. To be sure, naturalists agree that to have a disease is indeed very often regarded as undesirable or harmful, but they insist that the question whether it *is* a disease can be settled without reference to the well-being of an affected individual. It is determined only by objective features of biological organisms. This contrast between a naturalist, purely 'bio-statistical', approach and one which draws on evaluative considerations is sometimes transferred into a terminological distinction between the 'theoretical' notion of disease and the 'practical' concept of illness.[5]

Although this description of rival theories of disease is a brief sketch, it is sufficient for the aims of this paper. The justification of specific claims on resources in health care is influenced partially by the kind of theory of disease endorsed, but it is also dependent upon which particular purpose is served by a theory of disease. It seems to me that not all possible purposes of such theories are compatible with the specific task of backing entitlements to resources. A pathologist, for example, who is interested in the functions and dysfunctions of the human organism, a doctor who writes a report on a person applying for early retirement, or a judge who needs to find a verdict on a case of a patient who sues for funding of Viagra—they are all engaged with the concept of disease in direct or indirect ways. But their different purposes seem to ask for different conceptualisations of disease. Since I focus on the possible employment of the concept of disease to function as a gate-keeper in the distribution of medical resources, it makes sense to ask which of the two approaches in

philosophy of medicine, i.e., naturalism or normativism, is more congenial to fulfil this task.[6]

For health care professionals the problem of whether someone has a disease or not is only a derivative problem. They want to help sufferers or people in need. If they are able to treat a suffering person, they will probably even try to help in cases where they themselves are certain that the person asking for help does *not* have a disease. But since public medical funding usually depends on a rationale asking for a professional certification of disease, there is clearly an inclination to define undesired, treatable conditions as diseases. So the entirely understandable professional motivation to alleviate suffering and the reasonable desire of patients for medical support result in a situation in which both 'supply' (i.e., health care professionals) and 'demand' (i.e., patients) fuel the expansion of the concept of disease.

The normativist theory is particularly apt to fulfil the humanist purposes of medical practice, since it allows for an explanation of disease in relation to value-judgements. But, because it is founded upon evaluation, it is prone to an expansion of the concept of disease. Or so I claim. Especially in its most radical form—which defines disease in complete independence from biological considerations as socially unwanted and medically treatable conditions of persons—there are almost no limits to a pathologisation of all kinds of human problems of living.[7]

The mentioned entanglement of interests points at a possible instrumentalisation of the concept of disease. A straightforward solution of this problem would consist in a total disconnection of entitlements on medical treatment from the requirement of diagnosed disease. But as mentioned previously, this would clearly clash with the common intuition that publicly funded medical aid should only be granted if someone is really ill or likely to develop a disease. Therefore, it is more promising to firstly scrutinise different theories of justice in health care in order to establish a foundation for entitlements, and then to see which of the two theories of disease suits this account.

WHICH THEORY OF JUSTICE?

The concept of social justice is probably even more disputed than the concept of disease. What we owe to each other has been defined by philosophers over and over again, without a consensus in sight. But

again, we may order the debate by setting two ideal types of theories in opposition.

On the one side there are egalitarian theories which—broadly speaking—agree that the moral equality of human beings entails distributive equality in some respect. Different egalitarian theories may opt for equality of individual welfare, equality of primary goods, equality of opportunities or equality in other respects, but the distribution of goods ought to reflect the equality in moral status of all persons.[8] Unequal distributions have to be justified, according to egalitarianism. Although there is, again, no consensus on the justificatory grounds for unequal distribution (e.g., individual need or merit), egalitarians agree that undeserved social and economic disadvantages ought to be rectified in order to guarantee each citizen at least fairly equal life conditions. Differences in these circumstances should ideally result only from autonomous choices. Since disease is usually a matter of brute bad luck, ill people have a justified claim on health care resources, according to egalitarianism. After all, they are worse off than healthy people due to circumstances beyond their control.

An important feature of egalitarianism is that it determines justified claims subject to comparisons between people. If someone is worse off than someone else in a certain respect, this has to be justified. For health care, the comparative perspective implies that every single disease founds a claim on resources because every disease can be interpreted as a comparative disadvantage. Furthermore, if the concept of disease cannot be defined in a rigid way, egalitarianism opens its gates to claims for individual enhancements as a means to achieve greater equality. After all, e.g., lack of cognitive abilities is an unchosen disadvantage, which might call for amendment by medical means on egalitarian grounds.[9]

In opposition to egalitarianism, there is a theory of social justice that does not aim at equality but sufficiency. Everyone ought to have enough to have the chance to live a good life. This does not mean that a happy life for everyone ought to be guaranteed—an aim that is impossible to achieve anyway. Sufficiency merely implies that necessary conditions of a minimally good life for every person are met. Obviously, there are different possible interpretations of what 'enough' might mean in this context or what the necessary conditions of a minimally good life exactly are. But so much seems to be clear: the removal of serious harm and the fulfilment of basic needs are part of

it.[10] Hence the demands of sufficientarianism at least call for securing a minimal standard of human well-being.[11]

In contrast to egalitarianism, sufficientarianism generates individual entitlements without taking comparative assets of other people into account. What we owe to each other is determined here in terms of absolute standards, because what a person needs is not influenced by the circumstances other people live in, but by her situation. Absolute harm is, in contrast to disadvantage, not determined by an interpersonal comparison.

Sufficientarianism is not concerned with whether persons are worse off than others, but with helping those who are badly off. Disease is regarded as a foundation for a justified claim on health care resources if and when it is harmful in absolute, not comparative, terms to the person who is affected by it. Not every disease, however, must involve this kind of absolute harm. A beef allergy, for instance, which befalls a vegetarian, might even be welcomed. Nevertheless, most diseases are harmful and would therefore justify a claim for usage of health care resources. It is at this stage where a restricted theory of disease does its useful work, namely by preventing the expansion of the concept of disease on grounds of social or individual evaluations.

So it seems that sufficientarianism is more congenial than egalitarianism to the basic idea of a public health care system. After all, treatment of disease is usually regarded as justified because it relieves or even removes harm or suffering. Whether we need medical help does not depend on the life-conditions of our fellow citizens, but only on our own personal bodily or mental condition.

Nevertheless, the goals of health care can also be captured in an egalitarian fashion: prevention and treatment of disease is then interpreted as maintenance of equality of opportunity. In terms of social justice, disease is not seen as an absolute harm, but as a comparative disadvantage. Norman Daniels is an important representative of this egalitarian interpretation of health care justice.[12]

There are no restrictions on possible combinations of the two discussed theories of justice with the two respective theories of disease. For instance, Daniels endorses a naturalist theory of disease which he explicitly adopts from Christopher Boorse.[13] There are therefore altogether four combinations, which are summarised in the table below. In the following, I will primarily defend a combination of sufficientarianism and naturalism. My critical remarks on alternative approaches are of a more incidental nature. With every

Table 1. Combinations of theories of disease and Justice.

	Egalitarianism	Sufficientarianism
Normativism	Bodily and mental impairments, defined by subjective or societal disvaluation, justify claims on health care resources, if they are disadvantageous (problematic case: shyness)	Bodily and mental impairments, defined by subjective or societal disvaluation, justify claims on health care resources, if they are non-comparatively harmful (problematic case: sadness)
Naturalism	Pathological conditions, defined by biological dysfunctions, justify claims on health care resources, if they are disadvantageous (problematic case: harmless diseases)	Pathological conditions, defined by biological dysfunctions, justify claims on health care resources, if they are non-comparatively harmful (no problematic case)

alternative combination in the table I have included an example, which would justify a claim on health care resources according to the respective theory of health care justice. To my mind, these examples speak against the competing combinations.

WHY A NATURALIST THEORY OF DISEASE CAN RESTRICT ENTITLEMENTS

In this section, I will defend the claim that a naturalist theory of disease can indeed help to restrict excessive demands on health care resources put forward in the name of social justice. To be sure, I do not believe that this approach alone can serve the function of determining all individual entitlements in a just system of health care. But the concept of disease, if defined by a convincing theory, can provide a regulating function and serve as a starting point of discussions on rationing.

It seems straightforward to hold that health care, if publicly financed on a rationale of solidarity, primarily serves to protect people from common kinds of harm caused by disease. Nobody should suffer from treatable pain, lose capacities, etc., solely because they do not have the financial means to pay for medical treatment themselves. By slightly amending John Rawls's famous expression,

we can express this point of view by saying that justice demands that we protect people from negative consequences of the 'natural lottery'.[14]

Disease, according to naturalism, is a precondition of 'medical harm'.[15] Pathological conditions are not yet sufficient for absolute medical harm, because they might be harmless. Disease itself is not determined by subjective desires of persons, but by objective standards drawn mainly from nature. This approach is able to restrict common expansions of the concept which are merely based on social interests; it can sustain the scientific status of the main concept on which the entire system of health care stands. From the naturalist point of view, health is negatively defined as absence of disease. It can therefore prevent medicalisation and the 'tyranny of health', which is, in contrast, a likely outcome if we endorse the notorious definition of health offered by the World Health Organisation or some other positive conception.[16]

There are, of course, several problems for naturalism as a basis of restrictions on health care resources, which I will discuss and eventually reject in the remainder of this section. Firstly, there is a straightforward way to justify a claim on publicly funded health care resources—even if a specific treatment cannot be regarded as treatment of disease—namely, by interpreting some medical interventions as instances of preventive treatment. It could be argued, for example, that if a certain condition like unwanted pregnancy were not treated a clinical depression might likely develop in consequence. Of course, clinical depression then had to be accepted as pathological on naturalist premises. Even an enhancement, such as breast enlargement, could be justified by the same rationale as an instance of a justified claim on publicly funded health care resources. The restrictive function of the naturalist account would be undermined by this indirect justification of claims.

A second problem for the naturalist point of view is posed by cases where no dysfunction can be proven but it is assumed that a person has a disease anyway, probably a disease yet unknown to medical science. This line of reasoning provides a possible foundation for the expansion of the concept of disease by inventing new kinds of dysfunctions—an alleged anticipation of their scientific discovery.

Thirdly, one might object to a naturalist foundation of health care justice that entitlements to medical resources are not only based on treatment and prevention of disease. The treatment of many unwanted and unpleasant conditions is publicly funded, although they

are not instances of disease. For example, doctors perform abortions and they treat conditions related to the normal and natural process of aging, like postclimacteric osteoporosis, which is not pathological according to naturalism.

I believe that none of these objections establish the superiority of normativism, but only that the naturalist theory of disease needs to be supported by genuinely evaluative considerations in order to be utilisable for issues of health care justice. The naturalist theory of disease is not suited for the task of restricting entitlements to medical services by itself. To find a way to relieve the problem of the ever increasing scarcity of medical goods in modern societies, I argue, we need an evaluative point of view. And it seems that the main shortcoming of the naturalist account now is the very lack of such a perspective. Prima facie, every pathological condition, even very minor dysfunctions, seem to justify a claim on medical treatment, since the treatment of disease may be regarded as basic need. The combination of the value we usually attach to health and the naturalist definition of health as normal functional ability apparently leads to an approach that includes treatment of every pathological condition in the package of basic health care supply.

But since naturalism does not include evaluations it does also not provide a foundation for the direct justification of the treatment of every disease as individual entitlement. Naturalism does not include a premise that every disease needs to be regarded as an instance of harm, only normativists claim that disease is harm by definition. Hence naturalism is utilisable for restrictions on health care demand by an appropriate evaluative supplement.

To be sure, it is possible to maintain that every impairment of functional ability causes a disadvantage, hence a kind of comparative harm. This is Daniels's opinion who, as I noted before, also subscribes to a naturalist theory of disease. But, again, only egalitarianism would regard every disadvantage as a potential injustice. Since I want to defend a combination of naturalism and sufficientarianism, the mentioned objection that it is not possible to restrict entitlements with the help of a naturalist theory of disease does not apply to my claim. The restriction of justice to relieve absolute (i.e., non-comparative) harm, together with a scientific definition of potential medical harm in terms of dysfunction, can indeed be utilised to limit justified claims in health care.[17]

Whether disease is a condition of absolute harm cannot be decided by definition. It has to be conceived of as an open question, to be

answered by human evaluations. Normativism, because it considers disvaluation as a defining criterion of disease, suffers from shortcomings in two ways: firstly, it cannot explain why certain conditions which involve grave disfigurements or other impairments, but do not happen to be disvalued—e.g., because of certain religious beliefs—ought nevertheless to be regarded as instances of disease and indeed harm. Secondly, normativism has to count some conditions as disease merely on the basis that they are disvalued, although they clearly do not involve any organismic impairment. In order to avoid these problems, normativists commonly employ a naturalist supplement. But why not start from a naturalist account of disease, which restricts it to potential medical harm, and then ask the evaluative question whether dysfunctions need to involve absolute harm?[18]

It has been shown in this section that a naturalist theory of disease indeed needs an evaluative supplement in order to be utilised for a plausible account of health care justice. Clearly health in the sense of normal biological functional ability, i.e., medical normality, is not necessary to be able to live a decent life. Therefore, health care sufficientarianism, which aims at entitlements to basic medical care, is not propagating a right to health in the sense of medical normality but an entitlement to the treatment of harmful diseases.

HOW OUGHT WE TO RATION MEDICAL RESOURCES?

So far my considerations on justified claims in health care have not been influenced by concerns regarding any recent crisis in health care provision. It has been an examination of justice under idealised conditions. It seems clear that, from my point of view, treatment of minor diseases and medical services that do not deal with pathological states at all, do not generate entitlements. However, we know that even if legitimate demands are more limited than they are according to other theories of justice like egalitarianism, it is still highly unlikely that every claim, which is justified on the combined theory of naturalism and sufficientarianism, can be fulfilled under current conditions. Therefore we need further considerations of justice, which ultimately ought to lead to a valid model of rationing.

So yet again it can be seen that the specific amount of actual scarcity of goods is, at least in the case of health care, a variable, which is highly influenced by political and societal decisions. After all, we *could* of course pour so many financial resources into a health

care system that every health care claim that has been justified under idealised conditions could actually be fulfilled. But this is not desirable, because we also have other aims like education or culture and the arts which we would like to support by public money. Hence it is improbable that we would supply health care with enough means, where 'enough' is specified by the resources necessary to treat all harmful dysfunctions.

To develop a theory of just rationing, the first question to ask from the perspective defended in this paper would be which diseases cause non-comparative harm. These constitute the sphere of justified claims. It is interesting to note that this question is answered without further ado both for normativism and egalitarianism. Every disease would count either as disadvantage or as harm by definition. Secondly, under non-ideal conditions it would be necessary to restrict entitlements even further. This is what is usually called rationing, i.e., the rejection of claims that would be regarded as justified under more favourable conditions. Rationing itself, of course, ought to lead to a just distribution of the actually available resources. I will spend the rest of the paper to deal with this latter problem of rationing.

I believe that rationing should be carried out by a ranking of diseases according to their significance in terms of well-being. This can only be achieved in a collective effort. Additionally, there need to be comparisons of the costs of different treatments. I am of the opinion that especially high-cost treatments ought to be publicly financed, because it is then that we usually need to rely on the solidarity of our fellow citizens. The less grave in terms of absolute harm and the less expensive a specific treatment is, the more justified it is to cut its collective funding and transfer it into a scheme of individual provision.

It seems obvious that the naturalist theory of disease cannot help with the task of evaluating diseases in terms of their grade of harm. Naturalism fulfils its task by restricting entitlements to impairments of functional abilities and curbing medicalisation. What we further need is a theory of well-being and harm, which cannot be provided in this paper. However, the evaluation and eventually the ranking of these pathological conditions might, yet again, gain from a naturalist theory of disease, because the grade of harm involved with a certain disease does not seem to be completely unrelated to the functions affected. Generally speaking, we could say that the higher or more complex an affected organismic function is, the graver the harm,

because higher organismic functions like mobility, memory or cognition can be considered as foundational in terms of well-being.

Nevertheless, although this relation between natural functions and well-being may even constitute a basis for an objective theory of minimal well-being, it seems clear that collective considerations and evaluations need to be involved. How to ration collectively funded health care is ultimately a communal and political task.[19] Although more could be said on that issue from a theoretical point of view, especially on the concept of harm, it is a task for a different paper.

In this paper, I have defended a combination of a naturalist theory of disease and a specific theory of justice, sufficientarianism, which argues for a provision of goods which are necessary for the chance to lead a decent life. Health care justice, according to this combined approach, means that everyone ought to be entitled to the treatment of harmful dysfunctions. If this is not possible for reasons of shortage of resources, then health care resources should be rationed in relation to their significance for the well-being of patients and to their costs of treatment.[20]

NOTES

[1] Lawrie Reznek, *The Nature of Disease* (London and New York: Routledge & Kegan Paul, 1987), p. 171.

[2] I am aware of the fact that this way of contrasting two types of theories brushes over important details of the philosophical debate. However, I assume that the particular focus of this paper justifies such simplification. For a much more sophisticated recent view on the debate, see George Khushf, "An agenda for future debate on concepts of health and disease," *Medicine, Health Care and Philosophy* 10 (2007): 19–27.

[3] Cf. Christopher Boorse, "Health as a Theoretical Concept," *Philosophy of Science* 44 (1977): 542–73; Christopher Boorse, "A Rebuttal on Health," in *What is Disease? Biomedical Ethics Reviews*, eds. James M. Humber and Robert F. Almeder (Totowa, NJ: Humana Press, 1997), pp. 3–134.

[4] Hugo Tristram Engelhardt, Jr., "The Concepts of Health and Disease," in *Evaluation and Explanation in the Biomedical Sciences*, eds. Hugo Tristram Engelhardt, Jr. and Stuart F. Spicker (Dordrecht: Reidel, 1975), p. 127.

[5] Cf. Christopher Boorse, "On the Distinction Between Disease and Illness," *Philosophy and Public Affairs* 5 (1975): 49–68.

[6] This might appear to be an overly instrumental approach. Should we not ask for the *correct* theory of disease? I do not believe in the notion of a true theory of disease, but for reasons which I have put forth on a different occasion I endorse a naturalist theory of disease for non-instrumental reasons as well.

[7] Cf. Peter Sedgwick, "Illness - Mental and Otherwise," *Hastings Center Studies* 1 (1973): 19–40.

[8] For an influential egalitarian theory of distributive justice see Ronald Dworkin, *Sovereign Virtue: The Theory and Practice of Equality* (Cambridge, Mass.: Harvard U.P., 2000). In the following I disregard the problem of international justice. Although moral equality ought to apply to every person, most egalitarian theories of distributive justice are nevertheless restricted to a view in national borders.

[9] Cf. Allen Buchanan et al., *From Chance to Choice* (Cambridge: Cambridge U.P., 2000): pp. 61ff. "(...) it is not inconceivable that we would come to reclassify as a disease any correctable genetic condition that has a significant adverse impact on equality (...)" (ibid., p. 101).

[10] Needs must not be identified with strong desires (Garrett Thomson, *Needs* (London: Routledge & Kegan Paul, 1987).) This common misinterpretation might be dubbed 'children-theory of needs', because children quickly learn how to pose their wishes in a normatively stronger language. But a peculiar feature of needs is their independence from subjective preferences.

[11] To my knowledge, the term 'sufficientarianism' was first used by Richard Arneson, "Why Justice Requires Transfers to Offset Income and Wealth Inequalities," *Social Philosophy & Policy* 19 (1) (2002): 172–200, but the basic idea is due to Harry Frankfurt, "Equality as a Moral Ideal," *Ethics* 98 (1) (1987): 21–43. However, the debate is still in flux and so far no elaborated account has been published. For a helpful overview and critique of the sufficiency perspective, see Paula Casal, "Why sufficiency is not enough," *Ethics* 117 (2007): 296–326, and, in relation to health care, Madison Powers & Ruth Faden, *Social Justice: The Moral Foundations of Public Health and Health Policy* (Oxford: Oxford U.P., 2006).

[12] Norman Daniels, *Just Health Care* (Cambridge: Cambridge U.P., 1985). Anita Silvers poses an interesting critique of Daniels's basic idea, that a medical 'normalisation' always implies a restitution of opportunities, in "A Fatal Attraction to Normalizing: Treating Disabilities as Deviations from 'Species-Typical' Functioning," in *Enhancing Human Traits*, ed. Erik Parens (Washington: Georgetown U.P., 1998), pp. 95–123.

[13] Daniels, *Just Health Care*, p. 28.

[14] John Rawls, *A Theory of Justice* (Oxford: Oxford U.P., 1971), p. 74. By using this expression I seem to imply that disease is a phenomenon caused by natural events and is not due to the responsibility of individuals. This is of course not true in every single case. It is therefore no surprise that the (alleged) responsibility for disease has become an important criterion for a possible forfeiture of entitlement to medical resources.

[15] Cf. Boorse, "On the Distinction Between Disease and Illness," p. 61.

[16] "Health is a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity." If we would base publicly funded health care on this definition we would have created a legal right to happiness. For a penetrating critique of the WHO-definition see Daniel Callahan, "The WHO Definition of 'Health'," *Hastings Center Studies* 1, no. 3 (1973): 77–87.

[17] For a similar account, which is applied to the British NHS, see Roger Crisp, "Treatment According to Need," in *Justice and Health Care*, eds. Rosamond Rhodes et al. (Oxford: Oxford U.P. 2002), pp. 134–143.

[18] More would need to be said about the logical order of naturalism and normativism, and the relation of the concepts of disease and illness (cf. Thomas Schramme, "A qualified defence of a naturalist theory of health," *Medicine, Health Care and Philosophy* 10 (2007): 11–17).

[19] Cf. Daniel Callahan, "Symbols, Rationality, and Justice: Rationing Health Care," *American Journal of Law and Medicine* 18, nos. 1–2 (1992): 1–13; Norman Daniels, "Justice, Health, and Healthcare," *American Journal of Bioethics* 1 (2001): 2–16.

[20] I should like to thank Steve Edwards and Hugh Upton for helpful comments and suggestions.

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