CHAPTER III

CENTRAL HEALTH CARE AS A SPECIAL SOCIAL GOOD IN THE FACE OF FINITE RESOURCES

Central Health Care is a Special Social Good

From a Kantian point of view one can argue that together with the basic liberties and the level of resources of the least well-off socio-economic groups, those functions of health care which protect or restore moral agency are the most important social good. As such they should be insulated against trade-offs with other social goods such as the economic goals of a society. In different ways, the basic liberties, basic welfare, and the central forms of health care all protect those capabilities that are constitutive of our moral agency. Therefore, they should be the primary focus for constructing just institutions in society. Otherwise we have to live with institutions that do not embody universalizable principles and mutual respect as moral agents.

The basic liberties, basic welfare, and the central functions of health care do have a long tradition of being insulated against other considerations such as improving average welfare. This intuitively compelling insulation is

very difficult to accommodate within utilitarian or communitarian theories of justice.[43] In such theories, rights are either reduced to their instrumental value, for maximizing the welfare of society, or seen as fulfilling a particular society's ideal of the good. In contrast, we often intuitively think that these rights have an important non-instrumental and non-contextual value.[44] My suggestion here is that such insulation is rooted in the immediate and direct threat that the violation of such rights implies for an individual's moral agency. The functions of the basic liberties and welfare entitlements, as well as those functions of health care that protect our morally most significant capabilities, are in that respect similar.

Suppose we do grant that these social goods are morally special because they protect our status as moral agents. This does not imply that the social goods that are less central, are not morally important. For example, consider resources beyond the minimum level such as a maximally unconstrained freedom of speech, or an entitlement to the most extensive potentially beneficial education. The absence of any of these social goods does not reduce someone to being less than a full moral agent. Still they do contribute to capabilities in a way that extends the range of ideals of the good one could

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43 Daniels (1985)

44 Scheffler (1988); Lyons (1994)

enjoy. Thus, capabilities cannot be regarded as a non-continuous step-function. Moral agency, in contrast, is to be understood as a step function, in a sense. At a certain level of capabilities, a person becomes able to pursue the ideals of the good that are typical of its society. This threshold level is somewhat different from society to society because, for example, it takes different life-expectancies in different societies to pursue the ideals of the good typical for it. Any threshold we define as the goal at which protecting moral agency should be targeted will, therefore, be somewhat arbitrary, and achievements above that goal are also always morally important.

To say that some forms of health care are not part of the central functions of health care means that not all forms of health care are a special social good. Likewise, not all income is a special social good, but minimum income is. And the basic liberties are special, whereas maximally extensive liberties cannot plausibly be regarded as more important than minimum health care or income.

This ranking of social goods does have important implications for justice in health care. First, it is normally not acceptable to spend so much on the non-central health care that the resources of the worst-off socio-

economic groups fall below the level which is necessary for them to pursue typical ideals of the good in society. Thus, basic welfare support is more important than some forms of health care. This is a key argument for avoiding having health care become an entitlement which takes up all of our resources. To spend money on the peripheral functions of health care, at the expense of neglecting the welfare of the poor, is like improving the socio-economic status of the better-off at the expense of the central health care of those who are in need of it.

We should, therefore, neither see health care as an unrestricted social good we can use in order to maximize utility in society, nor as an unrestricted means toward the fulfillment of the ideals of the good that the majority in society pursues. The central functions of health care should rather be seen as a necessary component of any just society that can afford to provide them, no matter what specific ideals of the good are pursued by the majority.

However, recognizing that the central functions of health care are a special social good does not imply that an individual has an unlimited entitlement to health care in order to preserve their moral agency. This would imply that such a person is prepared to reduce others to merely being the means to achieve their ends. It could imply, for example,

that someone would sacrifice the external means of the basic capabilities of others in order to save their own internal means. Such an intention is not compatible with respecting others as moral agents.

It is, therefore, crucial to provide an interpretation of what it could mean to require others to make substantial sacrifices for saving one's own moral agency without thereby reducing them to being the means toward our ends. On a societal level, it must be possible to limit, in a principled way, the costs we have to shoulder in order to be able to say that we have discharged the obligation of respecting all citizens as moral agents through making the central functions of health care available to all citizens. This is a difficult task since, as I have argued in the first chapter, the moral agency of some cannot be saved regardless of how much we as a society would decide to spend on health care.

The Bottomless Pit Objection

The most serious objection against insulating the morally central functions of health care from being traded against other social goods is indeed that this might require us to spend almost unlimited resources on health care. This

would make our lives long and safe but impoverished.[45] How can we prevent health care from becoming, to use Daniels' term, a *"bottomless pit"*,[46] while at the same time recognizing that any just society must make some sacrifices to protect the moral agency of its citizens? How can the ideal of justice with respect to the central functions of health care meet this constraint of feasibility?

Before I address the bottomless pit objection for health care directly, I want to note that a similar objection can be raised against the widely supported insulation of the basic liberties from such trade-offs. The state is commonly assumed to be under an obligation to protect the basic liberties of people. This is acknowledged even by libertarians who want to reduce the role of the state to that of a "nightwatchman".[47] But how much should the state spend for meeting this obligation? It is clear, for example, that with more law enforcement or national defense spending we could protect the basic liberties of some individuals better than we do now.

It is possible that in the future spending on internal and external security could become more expensive than health care at least in some societies. Because of increased threats

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45 Buchanan (1983); Dworkin (1993)

46 Daniels (1981)

47 Nozick (1974)

from wars, terrorism or civil unrest, potentially useful expenditures could increase limitlessly. Thus, the bottomless pit objection does not seem to me to be a problem specific to health care.

For our time, however, the bottomless pit objection is clearly more relevant to the central functions of health care than to the basic liberties or welfare. There already is an almost unlimited potential for spending money on health care to avoid the premature loss of moral agency through health care. But going from this fact to a bottomless pit claim depends on the following specific unspoken assumption: If we have a moral obligation, we are under this obligation until we have done everything we can to fulfill it. I think that this assumption can be challenged on grounds of impartiality. My suggestion is that we have the potential to agree on an interpretation on what it means to respect others as moral agents that also specifies the limits on our obligations. Moreover, these limits do not have to lead back to the trade-offs between saving lives and more peripheral social goods which, I argued, are objectionable.

Limits on an individual's obligations to provide others with health care are here analyzed under the assumption that the individual is living a reasonable life in a just society. This implies, for example, that the limited life-expectancy

or health of those whom we should support are not the result of some external factors that we could object to, such as the exploitation by others, or the willful self-inflicted destruction of health. In such a situation, our duty to invest into their health as part of respecting them as moral agents can be diminished. An individual who is living in a just society, meeting the undiminished maximum claims by those who stand to lose their moral agency, can also not be expected to sacrifice her own moral agency to save that of another person. This is so because there cannot be an impartial justification for the claim that she should regard her own moral agency as less important than that of another person. The person, who without the first person making such a sacrifice, has to die cannot make an impartial Kantian argument that she should be given whatever is required for her to remain a moral agent, since she also has to respect the potential giver as a moral agent.

On reflection, this Kantian interpretation of impartiality seems highly plausible. Contrast it with a utilitarian interpretation of impartiality. For a utilitarian, such a sacrifice may be morally required in certain circumstances. For example, suppose the potential recipient is a great contributor to society's utility, whereas the potential sacrificer contributes very little. Yet most people find such a conclusion repugnant.

The Kantian explanation for this intuitive judgement is that our interest in the survival of others is neither to insure survival per se nor to achieve utility maximization, but to allow everyone the pursuit of ideals of the good. To sacrifice one person's capabilities to pursue such ideals in order to save those capabilities in another person is to fail to respect the former as a moral agent and to reduce them to the means of providing something for someone else.

This limitation is subject itself to reasonable qualifications. The second person could perhaps require the first to make sacrifices that temporarily reduced them below that level of income or resources needed to pursue various ideals of the good. Similarly, I believe we plausibly can infringe on a person's basic liberty in some slight way to save another person's life, contrary to what Kant appears to have argued about such cases. But the basic argument clearly rules out long or permanent severe deprivations. For example, if someone, through making a large sacrifice would be permanently so impoverished that he could not hope to ever establish a family, to raise and educate his children, or to pursue any other commonly accepted ideal of the good, he does not appear to be under an obligation to make such a sacrifice even in cases where it would save another person's life.

This may at first appear as an unjustifiable

restriction on the maximum sacrifice a person may be required to make to save another person's life. But since the reason we have to sustain the life of others is to sustain their moral agency, no individual can justify a demand for a sacrifice that would put significant and permanent external limits on someone else's moral agency in order to have the internal limitations on their own moral agency removed. This, again, would imply that the moral agency of the sacrificer is not adequately respected. On the other hand, a sacrifice up to the point where moral agency becomes impaired does appear justified. In any just society, one has an entitlement to the amount of income equal to the threshold level which is adequate, given that such an entitlement can be provided for everyone, but not automatically to more than that if sacrifices are needed to meet categorical obligations we have towards others.

An additional factor that needs to be considered here is the effectiveness of potential sacrifices. I have so far implicitly assumed that one person could, through their sacrifice, restore another person who is in need back to full moral agency. The sacrifice could, however, be extremely ineffective, restoring the other person only to a fraction of typical moral agency by allowing only a couple of weeks of additional survival, for example.

From an impartial perspective, the effectiveness of a sacrifice does seem to have moral significance. It would not be defensible to require at least a very large sacrifice for very little gain. For example, we could not reduce the level of resources of a socio-economic group by 50 percent of its original level-- all the way to the minimum threshold for several decades-- in order to allow a single person to function as a moral agent for an additional day. The point is that moral agency gets its importance from its relationship to the pursuit of ideals of the good. It is not a clearly defined mode of human functioning which is either achieved or not, although there is some threshold level involved since it requires adequate functioning for an adequate life-expectancy, which again depends on the life-plans typical for a society. An additional day in a typical life does not allow for a larger set of life-plans. Thus, the posited huge sacrifice does not really add any significant capabilities to the recipient's life.

What a morally significant gain in capabilities is depends on the specific features of a society and cannot be specified in advance for all just societies. For example, in a society in which most ideals of the good are limited to young people, where aging is dreaded and the old see little meaning in life, sacrifices by older people, as well as gains by older people, may be impartially less morally significant

than similar gains or losses in younger people.

Not all the societies that focus on the young would, of course, impartially have to be considered just. If aging is considered to be meaningless or dreaded, this may have produced pattern of discrimination and neglect of older people. From a Kantian perspective, it would be important to know whether the old people actually did have an opportunity to develop ideals of the good that included a meaningful old age. If this were not the case, the resulting distribution of ideals of the good among various ages would not be a morally privileged starting point for deliberating what kind of sacrifices and gains in survival or resources are impartially justifiable.

To give another example, suppose the majority in a society, for religious reasons, favoured survival into old age and an ascetic life-style. An oppressed minority, however, preferred ideals of the good that favored higher investments in education and consumption. In such circumstances, discounting sacrifices of those who are younger, and highly valuing even small gains in survival for the old, may not be impartially justifiable. For this would mean that the relatively powerless minority could not realize its own ideals of the good through culture and politics.

From this discussion we can synthesize the following parameters that should influence how much an individual can be expected to sacrifice in order to save the moral agency of others in any just society:

1. The distribution of ideals of the good pursued in a society and how this came about.

2. The life-expectancy which is generally accepted as necessary for pursuing these ideals.

3. The minimum level of resources needed to pursue some of these ideals in the absence of internal limits on basic capabilities.

4. The current and future level of resources of potential sacrificers.

5. The effectiveness of the sacrifice, including how many other persons have to make a sacrifice of the same magnitude in order to help one other person.

The maximum justifiable sacrifice in any just society is then defined as that sacrifice which would reduce the level of resources of the sacrificer from its current level to the

minimum acceptable level. This does, on the level of society, give a first principled answer to the bottomless pit-objection. The point is that even if we could potentially spend an unlimited amount to save the moral agency of a single person, in any just society a person does not have an unlimited claim. The claim comes to a halt when the sacrifices made by society reduces the level of resources of at least one other person below the minimum level needed to maintain moral agency.

This analysis thus also implies that, in a just society, those who are threatened by premature death cannot require the sacrifice of the moral agency of even a single individual to save their own. To proceed otherwise would lead us into a trade-off among moral agency of various persons, where one person is sacrificed to save others. To take moral agency seriously and not to make others the means to our ends means that such trade-offs are not permissible. Thus, regardless of the number of those whose moral agency is threatened by death or severe disability, we do have a limit for how much any one individual can appropriately be required to sacrifice to provide even the central functions of health care to others.

I will now turn to the economic context in which the maximum sacrifices that an individual can be impartially

expected to endure and derive the implications of the obligations of individuals to contribute to the central health care of others for the total budget. A just society is characterized, among other things, by a fair distribution of resources, a political process and public culture that allow all groups in society to express and advance their ideals of the good, and a public awareness of the legitimacy of existing institutions. A fair distribution of income implies that the worst-off socio-economic groups have available at least that level of resources which is needed to choose and pursue a reasonable range of the ideals of the good in that society, including full political participation. Note that I do not here assume that the distribution of income also has to fulfill Rawls' difference principle, i.e. that the distribution of income should be such that it raises (in Pareto-improvement steps) the income level of the socio-economically worst-off to the highest possible level.

If there were no differences in internal limitations on the basic capabilities, further redistributions of income would, in a just society, not be justified. But since there are such differences, we are under an obligation to sacrifice part of our fair share of income. For those who are close to or at the minimum level of income needed to have an adequate range of life-plans, no further sacrifices can be demanded. But even for those who are better off there are limits on the

potentially justifiable sacrifices such that they might not even be under an obligation to reduce themselves to the minimum level.

To the extent that the higher share of income of those who have it, can be considered just, it must have an impartial justification. The most important such justification is that such inequalities in income in any existing just society benefit the socio-economically worst-off group.[48] This is so because of the efficiency gains for the economy which are made possible through the incentive effects of the possibility of a higher than average income. If the better-off would consistently have to reduce themselves to the minimum adequate income level to help the worst-off, this would impair the absolute capabilities and ultimately the status as moral agents of the worst-off, in a way that overshadowed any gain to them that this sacrifice produced.

This implies that the better-off cannot be under an obligation to always reduce themselves to the minimum income level, since such a principle would imply a lack of concern for the status as moral agents of the worst-off. Still, they are clearly under an obligation to make substantial sacrifices if by doing so those who depend on these sacrifices can become full moral agents. It appears that they are under an

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48 Rawls (1971)

obligation to make that sacrifice which would reduce their income to the level where doing any more would have a negative impact on efficiency that in turn would reduce the worst-off below the level of adequate income.

The claim made here is not that the better-off are under an obligation to not sacrifice slightly more than the amount just described. Indeed, it might be virtuous for them to do just that, since their sacrifice might not have a negative impact on the status of the worst-off when it is made voluntarily. The claim is rather that a greater sacrifice cannot be demanded of them, since this, if generalized as a principle, by definition would reduce the worst-off to being less than moral agents.

If the better-off would voluntarily sacrifce a lot more than what they are obliged to sacrifice, they might actually put the worst-off at risk. This could be so because of macro-economic reasons, such as the need for consumption of goods not related to health care in order to make those investments that allow the economy to grow or, at least, to remain productive.

I also do not think that the institutionalization of justice in health care should rely on individuals going through these considerations, and then making the appropriate

sacrifice. All I argue is that this justification of the determination of who should sacrifice how much for saving others is compelling. If this is the case, institutions may be designed that enforce such sacrifices and can be considered as legitimate.

My analysis in a sense extends Rawls' difference principle in a world in which there are large differences in health status. It implies that there are claims for funding health care that limit everyone's income. As a result, when there are large health care needs, the income of the socio-economically worst-off should not be much more than adequate and that of the better-off should not be higher than what is needed for incentive reasons to maintain the worst-off at the adequate level. This is the only way we can take seriously our obligation to help those who are threatened by premature death and disability and, at the same time, not sacrifice anyone inappropriately. The need to take into account the negative impact on the worst-off of less unequal distribution of income answers the bottomless pit objection.

My analysis does require that the income differences between the better-off and the worst-off should be minimized and that the socio-economically worst-off group should not do much better than what is needed for them to have an adequate range of life-plans available. This is so that there are as

many resources as possible available to help the really worst-off, namely those with short life-spans and severe disabilities. It is of interest to observe that even if one rejects Rawls' difference principle in the absence of such differences in health status, taking these differences seriously from a Kantian point of view moves one toward accepting a distribution of income which is quite Rawlsian. However, now the focus is on maximizing the prospects of those with inadequate health rather than the prospects of the socio-economically worst-off. The socio-economically worst-off, however, provide an anchor for total spending on health care, since they cannot be deprived of income below what they require to remain full moral agents.

I will now consider a possible objection to my analysis, namely that my proposal cannot be impartially justified because it would not be accepted from behind a veil of ignorance. I explained that I did not use a veil of ignorance to develop my proposal because such a veil would either be too thick; not allowing us enough information on the distribution and consequences of disease and the costs of their care, or too thin; not justifying the choices that may result from its use as impartially just.

To support this latter claim I want to consider a theory

of just health care offered by Ronald Dworkin.[49] In it, he tries to solve the bottomless pit objection through using a thin veil of ignorance, and as a result his solution differs substantially from mine. This in turn helps us see why a thin veil really does no useful philosophical work.

Dworkin rejects the kind of special status for any form of health care that I proposed for the central functions of health care. He argues that the total budget for, and the distribution of health care resources, are fair if everyone gets at least the amount of health insurance that would be chosen by a representative individual having a fair income share, complete knowledge about the current state of medical care (including the cost-effectiveness of the available procedures and the incidence and prevalence of all diseases), but lacking any knowledge of their own genetic dispositions. The representative chooser is then asked how much of their resources and for what kind of health care services she would spend, using the values and ideals of the good that they currently hold.

This approach, which was called the "*prudential allocation approach*" by Brock, attempts to construct impartial fairness from prudential considerations. It leads us to impartiality through blinding the representative

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49 Dworkin (1993)

choosers about their identity.[50] It differs from traditional Kantian ethics among other things in that it takes prudence as the starting point to construct social justice, although it does not regard prudence as a substitute for justice. The same method of reasoning was used before by Daniels in order to ascertain a just distribution of health care resources between different age groups.[51]

Behind Dworkin's veil, the choosers have to make a choice that is prudential given the comprehensive ideals of the good they accept. Thus, Dworkin does not specify the concerns he expects people to have when they decide on the amount and type of insurance to purchase. In fact, such a proposal would yield quite different insurance packages for different people, in different societies, even with the same amounts of resources being available. This is so because what it is prudent to do would, at least partly, depend on what ideals of the good are accepted. Moreover, as I argued above, not all of the resulting budgets and distributions would be fair, as demonstrated in the example of the age-discriminating society.

I am in general skeptical about the success of approaches that try to construct impartiality from prudence

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50 Brock (1986)

51 Daniels (1985), (1988)

or rational self-interest. First, to model moral motivations through a non-moral motivation is theoretically unnecessary since moral motivation is universally available to all of those who can be moved at all by moral concerns. There is no compelling philosophical argument available that could by necessity morally motivate an amoralist[52] and reference to explicitly moral rather than self-interested reasons may better motivate most individuals to act morally.[53] Secondly, such an argumentative strategy seems to be misleading, as was pointed out by Scanlon and Barry.[54] A prudential choice, made not knowing one's identity, may not carry moral weight as a heuristic metaphor for constructing social justice. We may afterall plausibly ask ourselves why we should be morally bound by what we would have chosen <u>for us</u> if we had less information about ourselves than we actually do now.

But these methodological points are not my only concerns. Suppose a determinate prudential solution is possible, and that every citizen has an insurance package which it would have been prudent for them to buy from an average income, having no knowledge about their own risks. Even then we would have a group of people who are still threatened by premature death and disability. Some of them

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52 Scanlon (1982); Nagel (1991); Williams (1985)

53 Nagel (1991)

54 Scanlon (1982); Barry (1989)

will need services against which they have not taken out insurance, for example because they have very rare or unknown diseases. Or they may need services that are relatively expensive and insurance would not have appeared prudent.

In such a situation, everyone has a fair share of income and some health insurance. But there is still the group of those who, through further sacrifices of others, could be spared their loss of moral agency. We are again faced with the possibility that we could further reduce the number of those who lose their status as moral agents yet we are not prepared to make further sacrifices that would not put anyone else's moral agency at risk. If we take our obligation to respect others as moral agents seriously, I would argue, we need to make these sacrifices up to that point where the worst-off are reduced to the minimally acceptable income level.

As a matter of fact, the sacrifices we might be demanded to make include giving up some of the insurance we would have taken out from behind the veil of ignorance. We might have prudently taken out generous life-prolonging care for older age, but now we recognize that the opportunity costs of having such protection is to allow others to die who have not had any chance to fulfill their life-plans. To say that they

would not have taken out insurance before against the conditions that now shorten their life now, does not diminish the obligation we have when we encounter them as fellow moral agents whom we could save.

From a Kantian point of view, this result should not be surprising. It is inconsistent to will that everyone should have the kind of insurance that would prudently have been chosen having an average income when, at the same time, we know that this insurance will not always rescue us from the loss of any functioning as a moral agent. For such a situation we would will the help of others. The prudential allocation principle, thus, does not appear to pass the test provided by the interpretation of the categorical imperative I offered, in which rational agency is a matter of having the minimum capabilities to pursue typical ideals of the good in a society. Dworkin's solution to the bottomless pit objection is essentially an attempt to make health insurance part of a fair distribution of income, without in any way taking account of the special status of the central functions of health care.

The insulation of health care from the distribution of income is also an important principle of Daniels' theory of just health care which has influenced my proposal in many ways. Daniels regards health care as an entitlement every

individual should have regardless of their share of income in order to ascertain equality of opportunity. Opportunity is broadly construed by Daniels and like capabilities focuses on the life-plans people can choose and execute. However, Daniels does not commit himself explicitly to Rawls' reasons for establishing why equality of opportunity is morally important. He only claims that his account of justice in health care should be appealing to any general theory of justice that acknowledges a principle of equality of opportunity.

The central difference between this way of distributing health care and my own proposal is that I tried to offer an argument why everyone should have an adequate amount of capabilities rather than an equal amount of opportunities to pursue life-plans from a Kantian point of view. Kant's ethics does not support the idea that everyone should have an equal opportunity of pursuing life-plans since we can respect others as moral agents without making large sacrifices to broaden their choices beyond an adequate range. There is also no need to refer to the notion of *"species typical functioning"* Daniels uses in order to determine our obligations to provide others with health care. If others do have an adequate range of ideals of the good available, why should we be under an obligation to provide them with health care that additionally restores them to species typical

functioning?

To take just one example, imagine that a society has managed to make a broad range of life-plans available to those who are physically moderately disabled, and thereby not able to function as is typical for our species. Suppose further that their disability could never be fully rectified, but could be slightly improved at enormous costs. Why should we be under an obligation to make these investments, in particular if these resources could be needed to secure the income level of the worst-off socio-economic group in society at a level that allows them to have a full range of life-plans available?

A further difference between Daniels' theory and my suggestion is how we address the bottomless pit objection. Daniels seems to be suggesting that the bottomless pit objection can be avoided if we allow the political process to determine a total budget for health care, taking seriously that it needs to be sustainable in the long run. I try to go further and argue at what level the budget should be sustainable and what our primary concern should be for limiting it to that level.

In the next chapter, I will try to be more specific about how we should limit the total budget and how we should

distribute it by spelling out some of the consequences of my approach for evaluating justice in the health care systems in the U.S. and in Germany.