

UNE REVUE MULTIDISCIPLINAIRE SUR LES ENJEUX NORMATIFS  
DES POLITIQUES PUBLIQUES ET DES PRATIQUES SOCIALES.

# Les ateliers de l'éthique The Ethics Forum

A MULTIDISCIPLINARY JOURNAL ON THE NORMATIVE  
CHALLENGES OF PUBLIC POLICIES AND SOCIAL PRACTICES.

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La revue est financée par le Conseil de recherches en sciences humaines (CRSH)  
et administrée par le Centre de recherche en éthique (CRE)

The journal is funded by the Social Sciences and Humanities Research Council (SSHRC)  
and administered by the Center for Research on Ethics (CRE)



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# THE ETHICS OF BURDEN SHARING: WHEN CANADA TALKS ABOUT FAIRNESS, BUT ACTUALLY COUNTS BENEFITS

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## ABSTRACT:

This paper aims to rethink the problem of NATO burden sharing along ethical lines. It argues that the ethics of burden sharing reveals the tensions between utility of contribution and fairness of distribution. Inspired by Jarrod Hayes and Patrick James's theory-as-thought method and using the traditions of normative ethics, this interpretive research looks at how the issues of sharing and contributing were discursively framed by its practitioners during NATO's first decade. Focusing on one of the largest founding members, Canada, the paper finds incoherence between the predominantly consequentialist discourse of government authorities with respect to Canada's contributions and those authorities' discourse on allied sharing in NATO, shaped by obligations and communitarian ethics. Consequently, this presence of different ethical logics points to a split discourse on NATO burden sharing in Canada. The paper sheds light on the normative roots of the burden-sharing problem and demonstrates the relevance of theoretical pluralism and eclectic methodology for foreign-policy analysis.

## RÉSUMÉ :

Cet article vise à repenser le problème du partage de fardeau au sein de l'OTAN dans son horizon éthique. Il démontre que l'éthique du partage de fardeau dévoile des tensions entre l'utilité de contribution et l'équité de répartition. Inspirée par la méthode « théorie-comme-pensée » de Jarrod Hayes et Patrick James, et en s'inscrivant dans les traditions de l'éthique normative, cette recherche interprétative se penche sur la manière dont les problèmes de partage et de contribution ont été cadrés dans le discours de ses praticiens durant la première décennie de l'OTAN. En privilégiant un de ses plus larges membres originaux, le Canada, cet article repère une incohérence à la fois entre le discours des autorités canadiennes principalement conséquentialiste, pour ce qui a trait aux contributions canadiennes elles-mêmes, et un discours communautaire axé plutôt sur les obligations collectives dans le cas des enjeux de répartition de coûts entre les alliés. Cette présence de différentes logiques éthiques montre un « split discourse » sur le partage de fardeau au Canada. Finalement, ce texte met en lumière la racine normative du problème du partage de fardeau otanien et démontre la pertinence du pluralisme théorique et une méthodologie éclectique dans l'analyse de politique étrangère.

## INTRODUCTION

Ethics and morality are not necessarily the first thing that comes to mind regarding military cooperation. Yet, in the North Atlantic Treaty Organization (NATO), allies follow the principle of *costs lie where they fall*, which invites each of them to exercise ethical judgments as to whether they should contribute, which of the right forms of contribution they should choose, and how much they should contribute relative to the efforts made by fellow allies. This rather vague arrangement about the division of costs incurred by the common burden of collective defence has fuelled NATO's most protracted collective action problem, commonly referred to by the expression *burden sharing*.

In contrast to deductive rationalist approaches that dominate the past and contemporary burden-sharing scholarship, my approach builds on the interpretive and ethical turns in social sciences (Yanow and Schwartz-Shea 2006; Vilmer and Chung 2013). Positioned at the crossroads of politics, history, and ethics, and armed with interpretive-qualitative methodology, this paper reconstructs the ethical dimension of the Canadian burden-sharing discourse during the liberal government of Louis St. Laurent (1948–57). To shift the attention towards the ethical elements of burden sharing in NATO, this paper uses interpretation as its research strategy and analytical tools that blend International Relations (IR) theory with the traditions of normative ethics on a conceptual level.

This paper argues that the ethics of burden sharing reveals the tensions between *utility* of contribution and *fairness* of distribution. The findings indicate that the simultaneous presence of different ethics resulted in a split discourse on NATO burden sharing in Canada. Consequentialist ethics shaping the Canadian discourse on specific contributions proved incoherent with the discourse, informed by the ethics of obligations and communitarian ethics, of Canadian authorities on allied sharing in NATO. This paper comes to the conclusion that, rather than pursuing a free-riding strategy or simply calculating its own benefits, Canada has developed a split discourse—in which several ethical logics shape the way in which national authorities approach the issues of contributing and sharing—thus turning burden sharing into a long-lasting problem in NATO.

The Canadian perspective on burden sharing is particularly compelling in this period of NATO's formative years. Canada's involvement in the creation of NATO—its first peacetime alliance—meant a U-turn in Canadian foreign and defence policy. While ranking fourth on the international great power scale in the aftermath of the Second World War (Létourneau 1992, p. 53), it chose the path of becoming a middle power (Chapnick 1999). This did not stop it from launching a mutual aid programme free of charge to its Western European allies, the only one next to the United States' military assistance. Finally, yet importantly, Canada faced a peculiar security dilemma. Given its superpower southern neighbour, Canada had to balance its security and economic concerns on two continents. This turbulent period formed a liberal-realist generation of Canadian statesmen (Haglund and Roussel 2004, p. 57–60). In short, these multiple crucial

policy choices, together with the availability of detailed historical records, make the in-depth interpretive analysis of Canadian contribution strategies particularly rich on contrasting a range of possible ethical considerations related to NATO burden sharing.

In order to help understand the ethics of burden sharing in NATO, the paper first situates and presents the methodological framework to explain how the insights of normative ethics can inform an interpretive research strategy on allied contributions and sharing. Adapting the theory-as-thought method originally developed by Hayes and James (2014), the paper then develops an interpretive codebook of four ethics, constructed as a synthesis of three IR theories (realism, liberalism, and constructivism) with three grand families of normative ethical theory (deontological, consequentialist, and relational). The second part sifts through ethical elements in the Canadian discourse on allied sharing, as recorded in the archival documents of the Canadian government in Library and Archives Canada (LAC), and analyzes specific discursive instances when Canadian authorities discussed concrete contributions to NATO. Part three contrasts and compares ethical patterns of this Canadian discourse on burden sharing. The paper concludes on the implications for the future research on multinational military cooperation and makes the case for pluralist theorizing in the IR and foreign-policy analysis.

### **BURDEN SHARING: MORE UNDERSTANDING, LESS THEORIZING**

The problem of allied contributions in NATO—of why members decide to contribute to a military alliance—has been studied from several theoretical angles within the alliance-management literature. Arguably, the burden-sharing scholarship remains dominated by studies based on the alliance security dilemma (e.g., von Hlatky 2013), economics of alliances based on public-goods theories (e.g., Sandler and Shimizu 2014), or domestic and alliance-level institutional structures (e.g., Weitsman 2013; Auerswald and Saideman 2014). The studies provide rather narrow positivist, hypothetical-deductive, and mostly static accounts of burden sharing (Zyla 2016, p. 12).

Yet, in the past decade, several scholars have recognized that more diverse research on burden sharing is necessary. For instance, Ringsmose believes that a qualitative approach could “take public goods theory examinations of NATO one step further” (2016, p. 219). Becker (2017) calls for an enhanced dialogue between qualitative and quantitative studies on burden-sharing measurements. Given the contested nature of the burden-sharing concept, this literature would also benefit from further conceptual work on this politically loaded problem (Foucault and Mérand 2012, p. 424). Equally importantly, Webber observes that NATO has not been “the subject of much normative theorising” (2016, p. 11).

Interpretive and sociological approaches are particularly apt to study “intersubjective meanings and the role of social forces, norms, beliefs, and values” in states’ burden-sharing behaviour (Zyla 2016, p. 5). The most significant examples of these approaches can be found in the recent literature: Zyla (2015)

studies a burden-sharing norm of external responsibility, Kitchen (2010) explains states' participation in NATO's out-of-area operations by referring to a norm of responsibility, and Mérand and Rayroux (2016) conceptualize burden sharing as an anchoring practice, while Flockhart sees behind the burden-sharing problem a practice of "constructive ambiguity" (2016, p. 156). Lastly, in his study of the EU approach to the refugee problem, Thielemann (2003) develops an especially useful analytical model for studying the burden-sharing problem that contrasts the norm-based logic with the cost-benefit logic of burden-sharing behaviour, and distinguishes between motivations and patterns.

This paper analyzes the burden-sharing problem from an ontological and epistemological perspective that differs from the dominant positivist research on allied contributions and burden sharing. In interpreting Canadian contribution strategies, I regard burden sharing as a process, rather than an outcome, and propose an alternative use of scientific theories to analyze the "why contribute?" problem. Instead of factoring in various systemic and domestic variables, I look at how the traditions of normative ethics, blended in IR theory, shaped the discourse of national practitioners at the beginnings of NATO: Canadian elected officials, bureaucrats, and senior military staff under the liberal government of Louis St. Laurent (1948-57). I do not look for objective reasons why a state should contribute to alliances; rather, I explore what national actors themselves put forward as being a "right thing to do" in terms of military cooperation. Representing a specific case of NATO burden sharing, this paper should not be looked upon to provide a comprehensive study in Canada's history.<sup>1</sup>

## **ETHICS ENTERS INTERPRETIVE RESEARCH STRATEGY**

*Ethics is not a choice to do good when the overwhelming temptation—or the easier option—is to do evil; it is, rather, a competing set of perspectives about what it is to do good, and about what that good might be.* (Burke et al. 2014, p. 8–9)

This historical and interpretive analysis explores ethical elements of the burden-sharing problem. It rests on two important premises with respect to ethics. First, there is no ethically neutral action or "ethic-free zone" (Booth 2011, p. 475). Even in politics no action is void of ethical considerations since decision makers, bound by legitimacy concerns, act according to some conception of a right course of action (Burke et al. 2014, p. 9; Vilmer 2015, p. 177–178). Second, IR is a domain of moral choice. Every IR theory has a normative dimension, and these IR "moral codes" are not different from those that exist in domestic politics or on the individual level (Hoffmann 1988, p. 29).

To reconstruct this normative dimension of burden sharing, the paper uses a theory-as-thought method, originally introduced by Hayes and James (2014). Based on the assumption that IR theories represent different modes of thinking about the world, the theory-as-thought method puts forward the idea that policy makers think and make sense of world affairs in terms of theoretical logics

(Hayes and James 2014, p. 401). Theory-as-thought conceives IR theories as socially constructed systems of meanings and relations in narratives and discourses. These modes of thinking are intersubjective structures enabling actors to understand the world. The method’s central analytical tools are discursive markers and inductive extraction that indicate the presence of particular theoretical logic (*ibid.*, p. 406, 427). They roughly correspond to key concepts of the chosen theories. Since discursive markers are integral part of the studied texts, rather than abstract terms externally imposed by the researcher, tracing theoretical logics within actors’ discourse requires a certain degree of analytical flexibility.

Given this paper’s objective to analyze Canadian contribution strategies through the lenses of ethics, the theory-as-thought method is here accordingly adapted by narrowing the range of discursive markers. I rely on the conceptual apparatus drawn from the traditions of normative ethics,<sup>2</sup> which are further situated in three IR theories. The resulting four ethical ideal-types create together a single interpretive grid (see table 1). This codebook of the four ethical traditions does not pretend to embrace the complexities within and among various ethical and IR schools, as it represents only one of possible ways of simplifying the centuries of moral philosophy. Its role is to systemize ethical elements in the Canadian burden-sharing debates.<sup>3</sup>

**TABLE 1. INTERPRETIVE GRID**

<i>IR Theory</i> <i>Ethical Tradition</i>	Realism	Liberalism	Constructivism
Rule-Oriented (Deontology)	Ethics of obligations		
Consequence-Oriented (Consequentialism)	Ethics of Prudence	Utilitarian ethics	
Relational			Communitarian ethics

Having outlined the interpretive research strategy, this paper approaches the burden-sharing problem differently from the positivist studies. Instead of using the precepts of existing applied ethics developed within the IR research agenda<sup>4</sup>, this paper reconstructs the ethics of burden sharing by identifying the broad traditions of normative ethics in practitioners’ discourse. Situating them within the IR theories then facilitates the grasp of ethical elements in the burden-sharing discourse of Canadian authorities and improves our understanding of how the issues of contributing and sharing were framed in normative terms.



The adapted theory-as-thought method establishes, first, which ethics shaped the Canadian discourse on the issue of allied sharing in NATO, and second, how Canadian authorities talked about Canada's sharing with respect to concrete contributions to NATO. The paper then compares the patterns of ethical logics framing both issues of sharing and contributing as part of the Canadian discourse on burden sharing. The following paragraphs are dedicated to an overview of central prescriptions for action and justice of the four ethics. The different IR theories and ethical traditions constitute, respectively, the columns and rows of the interpretive grid and serve as a basis for discursive markers.

### Ethics of obligations

According to deontology, or the rule-oriented ethical tradition, the right action depends on and is constrained by an interpretation of duties (rules, obligations) and authority (Smith 1992, p. 215). The authority can be divine, but most deontological approaches emphasize the centrality of reason (Kantianism) or agreement (contractarianism). According to the Kantian tradition, an actor is motivated by duty rather than by achieving interests, and his or her moral motives overrule consequences. Contractarians, another branch of deontological ethics, stipulate that only in basing international reciprocity and social relations on the concept of social contract can international cooperation become a matter of moral duty, not charity (Sandel 2014, p. 142). Regardless of empirical facts or probability, the a priori defined moral duty justifies actions, not vice versa (Donaldson 1992, p. 136, 142). An overriding moral duty is to make (perpetual) peace possible (Smith 1992, p. 209).

The liberal IR tradition, characterized by individualism, egalitarianism, universalism, and meliorism, embraces both deontological and consequentialist ethical thought (Williams 2009, p. 29). Although the motivations behind these two ethics are different, when it comes to practical ends, they often converge; in order to phase out negative impacts of international anarchy, states themselves should agree to limit their sovereignty and create international organizations and law, and maintain international commerce.

According to this ethics of obligations, states should provide contributions through their rationalization of the North Atlantic Treaty constitution. This should result in free riding being considered an unethical action and in members adhering to a moral egalitarianism that aims at universal (political) equality of actors. As to the sharing problem, the Kantian tradition offers only procedural prescriptions for justice in the form of impartial application of international law. In the Rawlsian "justice as fairness" tradition, burden sharing should be procedural and distributive at the same time, where inequalities in sharing are not necessarily problematic insofar as they benefit the least advantaged.

### Utilitarian ethics

Consequentialist ethical approaches emphasize the results of actions, rather than duties or intentions, as the benchmark of morality. Utilitarianism is the most

widespread consequentialist theory. It stands on two basic premises. First, in contrast to a Kantian duty, happiness (well-being, welfare, common good, or benefit) is considered the only intrinsically good thing. Second, consequences are the only relevant factor in deciding whether any action or practice is right or wrong. Utilitarian ethics implies that the principle of (collective) utility—the greatest happiness for the greatest number—should guide states' contributions to NATO. Both Benthamite and Millian versions of utilitarianism, even if they propose more substantive conception of ethical action, remain too vague when it comes to international burden sharing. According to its central axiom, burden sharing is just when it maximizes the common good (collective defence). However, it is only implicit about the assumption that these benefits should not be concentrated in a small number of states but rather spread evenly across the members of the group. Utilitarianism is therefore often supplemented by other principles, such as equality (Ellis 1992, p. 168).

### Ethics of prudence

A quite standard realist denial of the morality in IR is connected with the realist core principles of action being determined by a conflictual anarchic international system and/or by human nature, the radical separation of domestic and international realms, and the primacy of self-interest over any moral principle. In short, this radical position advances that there is no room left for ethics in international politics. Yet, although most IR realists do not overtly acknowledge any ethical concerns, the moderate variant of realism can be best understood as “a cautionary ethic of political prudence” (Donnelly 2005, p. 150), where moralism is seen as a distortion and an impediment to effective foreign policy.

The ethics of prudence is a variant of Weber's ethics of responsibility, where prudence is a function of the statesperson's responsibility for his or her own population/country and is characterized by the dilemma of dirty hands (Warner 1991). Ethical action is thus guided by the imperative of national interest, whose defence has an important normative value for realists (Forde 1992, p. 79). National contributions to alliances should therefore have positive consequences for the country's security. States above all contribute in order to increase national gains from military cooperation. However, even moderate realists are pessimistic about the possibility of international justice. The absence of coercion makes justice either unavailable in the IR sphere or only limited and contingent on the interests of the most powerful (Brown 1997, p. 276). The ethics of prudence implies that great powers instrumentalize allied sharing to their own advantage and power projection.

### Communitarian ethics

Contemporary ethicists have added relational ethics to the classical families of normative ethics (e.g., Burke 2007; Shapcott 2010). Addressing problems of power and vulnerability, relational ethics emphasizes the interdependence of all humans,

rather than take a moral individual separately as a basis of ethical theorizing. Relational ethical approaches claim to propose an alternative to deontology and consequentialism by centring on responsibilities to and for those with whom actors choose to enter into relation (Altman and Wellman 2009, p. 131; Burke et al. 2014, p. 11). The constructivist IR school focuses on the role of norms and identities in respect to actors' behaviour. It puts emphasis on intersubjective realities and operates with social facts. In spite of having an inherently normative research agenda, constructivism has found it problematic to advance some prescriptions for what should count as an ethical action. Nevertheless, there are two recent developments of constructivist ethical thought: the ethics of humility and communitarian ethics. Since it is not clear whether the ethics of humility is a distinctive ethics at all (Hoffmann 2009, Price 2008), I use the second conception and place it within the family of relational ethics.

Popularized especially in the works by Emmanuel Adler on the communitarian turn in IR normative and analytical theory, communitarian ethics introduces a concept of "communities of practice" and describes social mechanisms that could facilitate the emergence of "normatively better" communities. Often presented in opposition to cosmopolitanism, communitarianism is certainly not a novel ethical theory. What its many versions have in common is that they highlight the moral significance of communities, where "the common good or community interest ... is greater than individual goods and interests" (Morrice 2000, p. 237). Although constructivist communitarian ethics does not elaborate on the hierarchy of interests or goods, it considers "community and individual interests as ontologically complementary" (Adler 2005, p. 13). The constructivist version of communitarianism stresses the important role of the social construction of knowledge in the development of collective normative understandings as a source of moral action and justice (Adler 2005, p. 3, 11, 27). It is particularly useful for clarifying where communities and commitments, including solidarity and we-feeling, to these communities came from. However, these constructivist communities are not limited to national sovereign borders. Communitarian ethics therefore calls for shared moral expectations and cultural understanding, which may in turn provide some substance to relational ethics' premises of responsibility to and for the others.<sup>5</sup> According to this ethics, states' contributions to alliances are reflections of responsibility to their like-minded allies, and allied sharing becomes an expression of Atlantic community building.

### **CANADA CONTRIBUTES TO NATO (1948-1957)**

No specific military commitments were discussed in the Canadian cabinet prior to signing the North Atlantic Treaty on April 4, 1949. However, over the summer of 1949, the government started to contemplate how Canada could materialize its political pledge. The Chiefs of Staff Committee cautiously considered improvements to Canada's military strength for national defence purposes, if war should break out. Ottawa mandarins first supposed that NATO members would optimize or even decrease defence costs by pooling their resources.<sup>6</sup> With the adoption of the NATO Balanced Collective (later, Integrated) Forces concept in the midst of the Korean War, Canada's defence programme started to develop in relation to the total

capabilities of the entire group of NATO nations.<sup>7</sup> During this early Cold War period, Canada became one of the leading contributors to the Alliance.

The strategic narrative on NATO in the early 1950s was uncontested at the elite level. The Canadian government helped create the Atlantic alliance with a clear objective: to build collective defence to deter potential aggressors (avoid war), and to strengthen the Atlantic community (reinforce peace). The attitudes towards NATO were generally positive across the political spectrum, agreeing on its importance for both Canadian and international security, and on the perception of the Soviet threat. No disputes arose over the basic policy of Canadian involvement in NATO during St. Laurent's premiership (Byers 1967, p. 4, 18).

This paper is not, however, interested in general long-term objectives with respect to the Alliance.<sup>8</sup> I focus on what came next once NATO's military strategy of collective territorial defence and deterrence was established. The analysis of Canadian burden-sharing discourse aims to clarify why Ottawa contributed to NATO, by looking at ethical elements behind concrete defence measures. The empirical section first explores the discourse of Canadian authorities on allied sharing in NATO. Then it looks at the specific instances in the discourse related to Canada's contributions: provision of military equipment and services to the European allies, deployment of Canadian aerial and ground troops to Western Europe, and continental defence of North America. I do not evaluate the actual impact of contributions on the overall NATO defence. Rather, I explore the "good reasons" that national authorities evoked in their private and public discussions to help them rationalize Canada's participation at NATO.

### Allied sharing in NATO: Distributing costs of collective defence

This section looks at how Canadian authorities framed the issue of sharing with the fellow allies. It is important to note that they neither publicly nor privately tried to evade their commitments to NATO. At times the Canadian government attempted to delay or compensate one type of contribution with another, such as by providing military equipment instead of deploying troops. Yet they never questioned their obligation to share the NATO burden. Free riding on other allies—deliberately avoiding or diminishing one's share of the common burden—was not considered acceptable behaviour in Ottawa.

Three ethics in the Canadian discourse shaped this basic but central point in the approach to the burden-sharing problem. First, from the utilitarian viewpoint, the cost-benefit calculation favours sharing due to a more efficient utilization of national resources for the common cause, which otherwise could not be attained. In several of his public speeches, the foreign secretary, Pearson, explicitly ruled out free riding because "peace could not be achieved by leaving the job of securing it to others."<sup>9</sup> Second, in accordance with the ethics of obligations and the communitarian ethics, the international danger "demands a unity of sacrifice by all free nations in the common cause of peace."<sup>10</sup> Pearson publicly urged the NATO countries less exposed to the risks of war to actively demonstrate solidarity with those who would

have to make the “ramparts of sacrifices” to resist the ground attack.<sup>11</sup> Similarly, his under-secretary, Heeney, observed that “no national government was willing to shift to other shoulders, even if it could, the responsibility for its own security.”<sup>12</sup> The necessity to share in terms of relational ethics was unequivocal: “the Atlantic Community” could not persist “without some form of burden-sharing.”<sup>13</sup>

NATO eventually launched a series of burden-sharing studies at the beginning of the 1950s, which were supposed to determine an equitable distribution of defence costs among the allies. Proposals took various forms, such as statistical formulas or arrangements for transfers of equipment. The studies resulted in the institutionalization of the NATO Annual Review in 1952. In this multilateral procedure, the allies exchanged information on their military capabilities and defence programmes and identified the ways in which to improve NATO’s overall strength without resorting to some rigid distributive mechanism.

Canadian authorities conceived the sharing problem in terms of fairness. Instead of determining allies’ shares in relation to the benefits received, they framed the equitable distribution of costs in NATO in terms of each country’s idiosyncratic characteristics and by analogy with domestic distributive justice among Canadian provinces. The Canadian discourse on allied sharing was therefore dominated by the ethics of obligations and further shaped by the communitarian ethics.

In the House of Commons, in June 1950, Minister of National Defence Claxton defined Canada’s “fair contribution towards collective security” in accordance to Canadian resources, needs, capacities, and responsibilities.<sup>14</sup> The Canadian officials alluded to principles of proportionality, especially in speeches to the American public. For the Department of External Affairs (DEA), it was perfectly normal for the US to pay more than anyone else in the Alliance: “The Americans should not complain if they have to pay the price of empire, nor should they expect us [the Canadians] to pay that price with them.”<sup>15</sup> At the same time, the minister of trade and commerce tried to dismiss any doubt that Canada was not doing enough despite the unequal—but fair—cost distribution: “We do not expect the United States to carry our burdens, even though it has twelve times the population and eighteen times the productive strength. [...] We expect to carry a fair share of the sacrifices and costs of collective defence. On a per capita basis we shall probably carry more than many of our allies.”<sup>16</sup> In other words, national contributions should reflect not merely the overall size of national income, but, most importantly, the national income per capita, required for a decent living standard.

On the contrary, in the case of NATO common budgets, the only departure from the NATO principle of “let the costs lie where they fall,”<sup>17</sup> the Canadian government acknowledged that the US had already borne a substantial contribution to European defence strength.<sup>18</sup> Consequently, Secretary to the Cabinet Robertson, seconded by the deputy minister of national defence, thought that Canada should agree to a formula modified in the US favour, since “the US were paying such a high proportion of the real cost of rearming the alliance.”<sup>19</sup> Ottawa accepted to pay more than pure national-income proportion, since this scheme would be *fairer* to the US.

When turning to the European allies, Heeney acknowledged that in addition to these principles of proportionality, there was also the obligation to help less well-off allies. The DEA's Economic Division recognized that relatively richer North American members had the ability and capacity to assist the European allies struggling with economic problems, and, again, the unequal contributions to NATO defence could be justified "in order that the common burden may be shared more equitably."<sup>20</sup>

Another way to incorporate fairness into their burden-sharing discourse was the analogy with contributions of Canadian provinces to the federal budget, where proportionality reflected their per capita income. Well before the whole Alliance embarked on painful burden-sharing exercises, Acting Under-Secretary Reid sketched out a proposal for an equitable distribution of defence efforts based on "principles of pooling of resources, of risks and of control over policy." He thought that the percentage of defence spending should be linked to the aggregate national incomes of all NATO members and that this amount should be then allocated according to the strength of the respective national income of each.<sup>21</sup> Although other members in the DEA were sceptical, for Reid the problem resembled that of "measuring the comparative burdens of national expenditures, which persons of different income groups within a country bear."<sup>22</sup>

The Canadian authorities searched for the criteria that would have made the cost sharing in NATO more equitable. Their fairness discourse on allied sharing lacked the utilitarian element of expenditures-benefits correspondence. Contrary to the predictions of most economist and realist studies on burden sharing, Canada, and the allies in general, had been actively attempting to arrive at some form of distributive justice instead of dodging their shares of NATO defence burden. In contrast to this discourse on sharing, shaped by the ethics of obligations and communitarian ethics, the ethical logic in the Canadian debates on specific contributions refocused on consequences.

### Mutual aid programme

By the end of 1949, the Canadian government decided to launch a form of contribution that Canada "can reasonably be expected to contribute in the most effective way" to the mutual benefit to both Canada and the allies in Europe.<sup>23</sup> By September 1950 it had started providing its own facilities to train aircrew from NATO members, and transferring them some of its military equipment.<sup>24</sup> Together as a Mutual Aid Programme (MAP), these contributions of services and equipment, free of charge, were meant not only to rehearse the Canadian reputation as an "arsenal of democracy,"<sup>25</sup> but also to yield numerous benefits to both Canada and NATO.

First, spending public funds on military production was supposed to help the Canadian economy and maintain a high level of employment. The Canadian high commissioner in London, Wilgress, explained that the MAP funds, in addition to meeting European deficiencies, should "enable us to cut the coat of our aid to suit the cloth of our economy."<sup>26</sup>

Second, from the military viewpoint, the MAP should serve the dual purpose of developing and maintaining the productive capacity, especially in the aviation industry, to meet the needs of the Canadian Forces, and of furnishing strategically important equipment to NATO allies. This was the “useful ‘pump priming’ function,” as described by Secretary to Cabinet Robertson, where “a modest element of self-interest was permissible.”<sup>27</sup> Although Canada had no legal means to control the destiny of military material once it left the Canadian territory, it reserved a “moral right” to know how the transferred equipment was put to use. Especially for the military authorities, it was important that, regardless of the country destination, the MAP should strengthen overall NATO defence.<sup>28</sup>

Third, the MAP was to generate positive political consequences. Although the government was able to make a contribution at a relatively small cost (some \$300 million annually), which was highly valued by the allies,<sup>29</sup> Canadian authorities used the MAP to avoid sending troops overseas and later to compensate for its small manpower contribution to NATO forces in Europe. Canadian offers were tabled in NATO agencies who then recommended the allocations based on allied strategic needs. Some Canadian officials, however, later complained that Canada was not getting enough credit for its efforts. As reported by Chairman of the Chiefs of Staff General Foulkes, due to this multilateral allocation procedure, it was the NATO Standing Group, not Canada, that enjoyed more visibility, and the recipient countries were sometimes not aware of the equipment’s origin. Ottawa desired more publicity so that Canada could make proper political gains from its contribution.<sup>30</sup>

Given the prospect of political gains, all equipment and services under the MAP were free of charge to European allies, except for transportation costs. Ottawa refused any reciprocal mutual aid. Wilgress explained that if Canada were to seek counter benefits, the MAP “would have to be substantially larger in order to get the same political results.”<sup>31</sup> Deputy Minister of National Defence Drury explicitly ruled out making a profit on any country, as he did not consider it politically advantageous for Canada.<sup>32</sup> The only actor who consistently opposed free Canadian aid was the Bank of Canada, and, to a lesser extent, the Department of Defence Production, which wanted the government to put more emphasis on the sale of equipment, instead of having the military assistance put a direct burden on the Canadian economy. Several public speeches eventually started to frame the issue with the new slogan “trade not aid” in order to encourage economic activity on the both sides of the Atlantic.<sup>33</sup>

The last benefit of the programme, as identified by the Canadian authorities, concerned the Canadian military procurement in the US. This introduces a prudential element into a largely utilitarian discourse with respect to the MAP. Ottawa used its mutual aid to strike a deal with the US on the reciprocal military procurement between these two countries. It convinced the US that Canada’s inability to start its MAP for European partners was because much of the equipment, which the government intended to produce in Canada, included an important US dollar

content. At that time, Canada faced a challenging balance-of-payment problem with respect to the American dollar and the Buy American Act, which barred military purchases for the US forces in Canada.

Given the ongoing Canadian conversion programme of equipment from the British to the American type, General Foulkes was, as usual, more straightforward in his statement that “if the US authorities were interested in encouraging the Canadian Armed Forces to standardise on American equipment, they would have to make it possible for us to buy the equipment.”<sup>34</sup> Prime Minister St. Laurent was more moderate as he presented the deal with the US as beneficial to NATO in general, since it implied more efficient utilization of the allied resources for producing defence equipment. Having revived the spirit of the 1941 Hyde Park Declaration, the US government agreed to reciprocal military purchases in Canada in May 1950.<sup>35</sup>

The Canadian discourse with respect to its mutual aid contribution to NATO was shaped largely by utilitarian ethics, while tainted with the ethics of prudence as the Canadian government used the MAP to improve its bargaining position with the US in the matter of military procurement. Overall, exchanges among the government’s departments (Defence, External Affairs, Finance, Trade and Commerce, Defence Production) suggest that the consequentialist logic played the central role in how Ottawa should bring about and execute the MAP, converging political, economic, and military benefits.

### Canadian forces in Europe

Although Canada withdrew its soldiers from Europe in 1947, it sent them back four years later as its contribution to the NATO Integrated Forces. Throughout the initial period of NATO’s military build-up, the Canadian government firmly held the line that the provision of equipment to Europe would be its most effective contribution to the collective defence strength. Yet, in October 1951, Parliament approved sending to Europe one brigade group and an air division of eleven fighter squadrons.<sup>36</sup> The Twenty-Seventh Canadian Infantry Brigade landed in Western Germany on December 23, 1951 (Maloney 1997, p. 21). Which ethics shaped the Canadian discourse on the redeployment of armed forces overseas?

Troop deployment to Europe was a great nuisance to the Canadian government. The minister of defence acknowledged that although “participation by the Canadian army will show more emphatically than any amount of equipment . . . that we stand together with our allies,” at the same time he added that “material considerations alone might suggest that there might be greater military value in spending the same amount on equipment for forces already on the spot rather than on Canadian ground forces.”<sup>37</sup> The financial factor did not play a minor role—the Canadian defence policy at that time did not contain plans for maintaining an expeditionary force of ground troops. External Affairs’ Head of Economic Division Plumtre confirmed that keeping “any considerable force in Europe would be in a military sense expensive and wasteful of men and resources,” though he noted the pressure of public



opinion at home and in the US on Canada to increase its forces in being.<sup>38</sup> Wrong, the Canadian ambassador in Washington, explained to US Secretary of State Acheson that the Canadian deployment would “be unwise and unprofitable.”<sup>39</sup> As it turned out, Canadian forces stationed in Europe were indeed the most expensive item on the national defence budget.

Ottawa definitively leant towards the deployment option when General Foulkes together with the deputy minister of national defence concluded that “stationing more troops in Western Europe was the only effective deterrent and that forces in Canada would not serve the same purpose.”<sup>40</sup> In December 1950, Pearson and Claxton in their memorandum advised the cabinet that “there is no alternative to defending North America in Europe.”<sup>41</sup> Doubts, however, never disappeared. General Foulkes reminded the government of the limited military value of the Canadian brigade in Europe, since Germany had been contributing to the Integrated Force since 1952 and, more importantly, “this [Canadian] brigade and its dependent costs do not in any way increase the military position of NATO.”<sup>42</sup>

The Canadian authorities believed that this contribution would have only narrow military utility. Nevertheless, utilitarian cost-benefit calculations shaping their discourse identified some benefits. Considering the US pressures and allies’ expectations of future Canadian contribution, by deploying forces to Europe the Canadian officials hoped to enhance Canada’s reputation as a responsible and committed ally.<sup>43</sup> For example, they let the NATO Supreme Commander choose the location of the deployed troops instead of deciding unilaterally<sup>44</sup> and the Canadian government paid for these brigade forces stationed in Germany.<sup>45</sup> Yet it remains puzzling why the government helped its allies in a way that the Canadian elites themselves did not consider at all as the best means to maximize NATO strength.

Public speeches made by Canadian officials suggest an ethics different from utilitarianism, or consequentialism in general. Here the Canadian discourse was shaped by the communitarian ethics and ethics of obligations, since they framed the question of troop deployment as “necessary for the protection of the Atlantic community,” and as contributing to “a better understanding between our two [Canadian and German] peoples.”<sup>46</sup> This discourse did not expect Canada’s contribution to maximize anything, but rather pointed to the appreciation of the value of the Atlantic community and interdependence between Europe and North America. This communitarian posture put Canada in relation with the European nations to whom the government felt responsibility for their common destiny, as it was “the solemn obligations which bind us [Canadians] to our friends there [in Europe].”<sup>47</sup> This discourse on “solemn obligations” and responsibility to “friends” was absent in the case of the Canadian mutual aid. In a similar vein, one memo that attracted attention in Ottawa in 1954 proposed to include some European units in the North American continental defence under a new NATO command structure in Canada (to be called SACNAM). It meant to decrease the sense of European dependence and inferiority to the US while making NATO “more of an affair between equal partners.” According to this memo, Canada would sacrifice part of its sovereignty to improve ties between the NATO allies in North America and in Europe.

In short, although forces in Western Europe did not represent Canada’s major strate-

gic military contribution, Ottawa made this commitment despite the heavy burden it would place on the national budget. The government's decision reflected, on the one hand, the utilitarian ethics in terms of nonmaterial political gains, but, on the other hand, the communitarian ethics combined with the ethics of obligations played an important role in how the Canadian authorities further framed the issue in terms of its great symbolic value. This communitarian discourse will be more evident in a parallel discussion on the continental North American air defence. The heavy expenditures earmarked for the construction and operation of radar lines forced the Canadian government to decrease its MAP, but not the number of Canadian troops in Europe.<sup>48</sup>

### Continental air defence

In the first half of the 1950s, Washington came up with ambitious projects of radar chains—most of them on the Canadian territory—to improve the continental air defence of North America. Although the Canadian government knew very well that the radars did not qualify as NATO common projects, it equalled this early warning system with the Canadian contribution to European defence for two reasons. First, since the radar chains increased the strength of North American defence, which is a part of the NATO area, they contributed to overall NATO strength.<sup>49</sup> Second, the government emphasized the sharing and pooling element, which was central in the NATO military build-up and which had always been encouraged in Canada.<sup>50</sup> Over time, there were three lines of radar stations built on the Canadian territory, with Canada involved in each of them quite differently. The ethics shaping the discourse on Canadian participation in this continental radar system could be characterized as prudential utilitarianism. Although sovereignty and the country's reputation were Ottawa's overriding concerns, financial feasibility and military efficiency informed the Canadian discourse to a significant extent.

As to the first radar chain, the Pinetree Line, approved by the Canadian Cabinet in February 1951, the two governments quickly arrived at a cost-sharing formula, according to which the US shared two thirds and Canada one third of all costs. The question of economic impact on the Canadian defence budget was not pronounced in this case.<sup>51</sup> The Cabinet Defence Committee, however, made sure that the US administration presented the project as a joint enterprise and measure of self-defence, not as American mutual aid to Canada.<sup>52</sup>

The conjoint negotiations of the next two chains, the McGill Fence (or the Mid-Canada Line) and the Distant Early Warning (DEW) Line, were far from being as smooth as the first one. Especially the issue of Canadian sovereignty re-emerged when the DEA's Defence Liaison Division complained about Canada not being consulted sufficiently ahead on the development of US plans for radars in the Canadian Arctic.<sup>53</sup> MacKay noted that the Defence Department and the Department of Finance were busier "assuming their responsibilities for operations abroad [...] rather than protecting such intangibles as sovereignty or autonomy at home."<sup>54</sup> Wilgress concurred that judgments made by the Canadian government "were governed largely by financial considerations."<sup>55</sup> The Canadian government approved in principle the construction and operation of the McGill Fence as a

Canada-funded project in November 1953. After long deliberations, in November 1954 the Cabinet Defence Committee agreed to the DEW Line construction as a joint project, with Canada's responsibility confined to the operation and maintenance.

The Mid-Canada Line is usually presented as a Canadian tactic to preserve its reputation at home and to dilute criticism of the US taking control over Canada (Lajeunesse 2007, p. 56). However, several Canadian officials simply doubted both financial feasibility and military efficiency of the DEW Line project. Especially the Canadian military were persuaded that the McGill Fence was more reasonable than the DEW Line. The acting chief of the air staff pointed out that from a strictly technical point of view, the DEW Line would be of little value without sea wings, which the US had undertaken at its expense, whereas the Mid-Canada Line was less challenging to build and would be immediately able to provide a warning earlier than the Pinetree Line.<sup>56</sup> Since feasibility of the DEW Line was too contingent on US action and Canadian authorities did not know how authentic the US estimates of construction costs were, Ottawa avoided specifying its contribution to this "crash programme."<sup>57</sup>

Private discussions in Ottawa suggest that the financial aspect turned out to be decisive.<sup>58</sup> Not forgetting the dilemma of dividing its resources between continental defence and its commitments to Western Europe, in October 1953 Claxton suggested Canada should use a "cost avoidance strategy" (Jockel 1987, p. 83). Coupled with the doubts regarding the military feasibility of the DEW Line, Ottawa decided to fully pay for the Mid-Canada Line even though it knew this would affect Canada's room for manoeuvre in the DEW Line project. This lower cost option would keep Canada's "self-respect without having to put out too great an expenditure of materials, manpower, and money" and in such a way that the Canadian economy would get the maximum benefit from this contribution.<sup>59</sup> Although Canada did not participate but in a final phase of the DEW Line development, it was crucially important for Ottawa to signal joint responsibility for the DEW Line and to present it publicly as one element of a larger continental defence project.<sup>60</sup>

In sum, prudential utilitarianism shaped Canadian discourse in the case of radar lines. The government's decision to assume the costs of the Mid-Canada Line was predominantly made on utilitarian grounds of financial and military efficiency and in accordance with its cost-minimizing preferences, while the DEW Line project was informed by the prudential considerations with regards the country's reputation.

Canadian officials played the NATO card to do some political damage control regarding the perceived loss of sovereignty. Eventually, the role of the ethics of prudence in the Canadian discourse diminished since Ottawa preferred allowing more US troops to Canada over reducing Canadian forces in Europe. Even though Foulkes proposed to cut down the Canadian air force in Europe, Pearson made sure they did not decrease.<sup>61</sup> Rather, Ottawa chose to reduce its MAP by two thirds in November 1955, so that the value of the Canadian presence in Europe would not shrink.<sup>62</sup>

## SPLIT DISCOURSE: INCOHERENT OR INCOMPATIBLE ETHICS?

Having looked at the ethical elements in the Canadian discourse on NATO burden-sharing, this article, through the interpretive analysis of how Canadian authorities discursively framed the issues of sharing and contributing, makes two principal observations (see table 2). The first relates to the co-occurrence of several ethical logics in the Canadian burden-sharing discourse. The second sheds light on how these “ethical codes” differed in relation to the topic discussed.

Two broad tendencies characterize the presence of ethical logics in the Canadian discourse. On the one hand, the co-occurrence of the ethics of utility and the ethics of prudence, as in the case of the mutual aid programme or the construction of the radar lines, points to a practical convergence into the consequentialist type of ethics. On the other hand, the archival evidence indicates the combined presence of the ethics of obligations and communitarian ethics. Canada’s principled action with respect to the Washington Treaty stems from the ethics of obligations, which emphasizes rules, and communitarian ethics further shaped Canadian officials’ discourse in terms of relational responsibility to the European allies. A case in point is the justification for the overseas deployment of the Canadian forces—namely, that Canada has an obligation to share the burden of the Atlantic community and to protect it.

**TABLE 2. THE ETHICS OF BURDEN SHARING: THE CANADIAN CASE**

Ethics Topic	Ethics of prudence	Utilitarian ethics	Ethics of obligations	Communitarian ethics
Mutual aid program	×	×		
Canadian troops in Europe			×	×
Radar lines in North America	×	×		
Allied sharing			×	×

As to the different ethics shaping the Canadian discourse in relation to the concrete topic, this is where the normative contours of the burden-sharing problem start to emerge. Canadian authorities framed the issue of contributing to NATO by employing largely consequential types of ethics: prudential and utilitarian. In contrast, the issue of allied sharing was largely shaped in the Canadian discourse by both deontological and relational ethics, appealing to rules, obligations, and responsibility.

On the whole, Canadian authorities had a pretty clear idea about how Canada's share in NATO should look. Their discourse on allied sharing had a deontological background. These principles for equitably dividing the costs of collective defence according to some notion of fairness were supposed to go beyond utility seeking, otherwise characteristic for the ethics shaping the Canadian discourse in the case of specific contributions to NATO.

The problem with this split discourse is that utilitarian rationality does not create a mindset apt for anything but benefit-maximizing behaviour. According to its plain prescriptions, a utilitarian discourse on allied sharing would base the cost distribution upon the benefits received from this collective action. Alternatively, a utilitarian could also justify individual shares in accordance with strategic utility—for example, in the sense that the alliance is as strong as its weakest member. However, this kind of utilitarian discourse was absent when Canadian authorities talked about the issue of dividing collective defence efforts. Instead of utility, Canadian authorities framed sharing in terms of fairness. Due to the limits of utilitarianism, the ethical logic behind contributions could not generate additional criteria should fairness require them.

## CONCLUSION

How can an ethical perspective contribute to our understanding of NATO burden sharing? At the very least, the available evidence suggests that there are normative roots to the burden-sharing problem. According to the historical interpretive analysis of Canadian archival documents, the ethics of burden sharing in NATO can be characterized as tensions between utility of contribution and fairness of distribution.

This split discourse means that the same set of actors (Canadian politicians, bureaucrats, and military) in the same institutional setting (the government and its committees) employed a burden-sharing discourse that was shaped by multiple ethics, depending on whether these actors were talking about the cost distribution in NATO or discussing specific Canadian contributions. Although utilitarian ethics shaped how concretely Canada was going to share in the burden, the very issue of sharing was framed in terms of equitable cost distribution. The utilitarian ethics under these circumstances could not make burden-sharing discourse more intelligible, since it generally operates within a logic based on efficiency, not fairness.

In light of these findings, this paper suggests several theoretical and empirical implications with respect to the burden-sharing dynamics in NATO, interdisciplinary theoretical pluralism, and applied ethics. Following the renewed academic interest in studying ethical questions in IR and in overcoming theoretical boundaries, the interpretive grid used in this paper combined three IR theories with three traditions of normative ethics. It put forward the claim that none of these theories alone could properly seize how Canadian leaders approached NATO burden sharing. While liberal and constructivist ethics

informed the Canadian discourse on sharing of defence cost (fairness of distribution), the liberal utilitarian ethics, occasionally together with realist prudence, shaped the discourse on what Canada should actually spend money on (utility of contribution). The simultaneous presence of all three IR theories in the Canadian discourse can then be depicted by the terms of cautiousness and sovereignty concerns (realism), principled action and benefits from cooperation (liberalism), and responsibility to and for the community of Atlantic nations (constructivism). This theoretical pluralism made it possible to embrace the complexity of multinational cooperation in NATO and to identify the split discourse as the possible normative root of the burden-sharing problem.

The interpretive analysis further points to the relevance of using normative ethics to address the burden-sharing problem. In contrast to most realist and economic theories of alliances, the paper found that free-riding in an alliance voluntarily created by like-minded sovereign states is not considered acceptable behaviour by those same member countries. Canada did not contribute to purely seek private benefits or to strengthen only its own defence. The contributions were meant to enhance the collective enterprise, to produce benefits for itself *and* the allies at the same time. Moreover, the Canadian discourse reflected some notion of justice and responsibility to the others. Despite the sovereignty concerns about the control over the national budget, the realist ethics of prudence did not prevent Canadian authorities from framing the issue of sharing in terms of fairness. With reference to Thielemann's analytical model, NATO burden-sharing poses that many challenges because it combines norm-based (deontological and relational) motives with cost-benefit (consequential) patterns of states' behaviour. Further research on how ethical considerations help actors choose the right contribution strategy over others should improve our conceptual understanding of military cooperation.

The St. Laurent government represents a rather hard case for NATO burden sharing. Despite the absence of parliamentary opposition against the policy of Canada's active participation in NATO, even this pro-NATO government developed a split discourse shaped by incoherent ethical logics. Furthermore, internal differences emerged between the departments driven by the ethics of prudence and utilitarian ethics (Finance, Trade and Commerce, Defence) on the one hand, and the actors using a discourse more centred around obligations and communitarian arguments (Department of External Affairs, Prime Minister's Office) on the other hand. The 2016 announcement of "responsible conviction"<sup>63</sup> to guide Canadian foreign policy confirms to some extent that international politics is just too complex to follow one simple *code of ethical conduct*.

In sum, this interpretive research with an ethical twist provides further insights into the relational burden-sharing dynamics beyond the quantitative realms of public goods theory. In adding a normative layer to the collective-action problem in NATO, this study suggests that there is one ethics proper to sharing and other ethics to contributions. In short, individual action that pursues practical gains, rather than fairness, can undermine the desirable fair distribution of costs. To overcome this ethical impasse, NATO committees, in discussing allied

burden-sharing efforts, might have to put emphasis on more tangible benefits of contributing, not only obligations, to share the common burden equitably. This would create more compelling incentives for individual allies to commit their national resources for the defence of others and produce greater, and fairer, burden sharing in NATO.

## ACKNOWLEDGEMENTS

I am grateful to my PhD supervisor Frédéric Mérand, my graduate colleagues at the Centre de recherche en éthique, and the editors of *Les Ateliers de l'éthique/The Ethics Forum* for their valuable comments on earlier drafts of the manuscript.

## NOTES

- <sup>1</sup> For a historical account of Canada in this period, see, for example, works by John Holmes, James Eayrs, or Norman Hillmer.
- <sup>2</sup> The contemporary ethicists divide normative ethics into four grand traditions: deontology, consequentialism, the virtue ethics, and the relational ethics (Sandel 2010; Burke et al. 2014, p. 11). Virtue approaches give priority to moral character and personal qualities in judging moral behaviour. However, they are almost never represented in any IR work. Making the case for this ethics in the IR realm neither corresponds to the objective of this paper nor falls within its scope. For a notable exception, see Gaskarth (2011).
- <sup>3</sup> The decision to include normative ethics as an analytical tool stems from a recent call for more dialogue between descriptive and normative ethics (Sandberg 2015). On the one hand, greater understanding of normative ethics can lead to more accurate descriptions of moral attitudes in social activities. On the other hand, empirical investigation can put normative ethics into perspective, generate new concepts, and give credibility to existing ones.
- <sup>4</sup> For more details, see IR ethics handbooks edited by Hayden (2009), Reus-Smit and Snidal (2010), Bell (2010), or Moellendorf and Widdows (2015).
- <sup>5</sup> Since security communities, or communities of cooperative-security practices, depend on shared moral expectations of self-restraint, Adler indirectly suggests that spreading the norms of self-restraint could constitute the much-sought constructivist prescription for ethical action (Adler 2008, Adler and Greve 2009). Adler's approach contrasts with that of liberal constructivists, who build on the Kantian tradition and focus on liberal democratic security communities; see Williams (2001).
- <sup>6</sup> LAC, LSL/224/E4-26 Reid to Pearson, October 26, 1948.
- <sup>7</sup> LAC, DEA/4526/50030-T-40/1 Defence Liaison Memo, August 30, 1950.
- <sup>8</sup> Among others, Roussel (1998) already demonstrated the Kantian liberal-constructivist logic behind the Canadian activism in the creation of NATO.
- <sup>9</sup> Pearson, 3 March 1953. *Speeches & Statements*, 53/11.
- <sup>10</sup> LAC, DEA/4526/50030-T-40/1 White Paper on Canadian Defence Policy, August 23, 1950.
- <sup>11</sup> Pearson, June 5, 1950. *Speeches & Statements*, 50/22.
- <sup>12</sup> Heeney, March 19, 1951. *Speeches & Statements*, 51/11.
- <sup>13</sup> LAC, DEA/4499/50030-K-40/2 Memo for the Panel, November (n.d.), 1950.
- <sup>14</sup> LAC, DEA/4526/50030-T-40/1 Claxton speech, June 26, 1950.
- <sup>15</sup> LAC, MG26L/235 Memo for the Prime Minister, February 9, 1949.
- <sup>16</sup> Howe, February 27, 1951. *Speeches & Statements*, 51/7.
- <sup>17</sup> LAC, DEA/4499/50030-K-40/2 Department of Finance to Deutsch, February 5, 1951.
- <sup>18</sup> LAC, DEA/4499/50030-K-40/3 SSEA to High Commissioner of Canada in London, February 17, 1951.
- <sup>19</sup> LAC, DND/20707/2-2-30/3 19th Panel meeting, April 10, 1951.
- <sup>20</sup> LAC, DEA/4788/50096-40/1 Plumptre to Pearson and Cabinet, November 17, 1950.
- <sup>21</sup> LAC, MG26L/224/E4-26 Reid to Pearson, October 26, 1948.
- <sup>22</sup> LAC, DEA/4526/50030-T-40/1 Reid to Heeney, September 5, 1950.
- <sup>23</sup> Pearson in the House of Commons, November 16, 1949. Documents on Canadian External Relations (DCER), volume 16, p. 890.
- <sup>24</sup> Extract from Cabinet Conclusions, Ottawa, December 21-22, 1949. DCER, volume 15, p. 733-734.



- <sup>25</sup> During the Second World War, Canada used only 30 percent of its war production for itself. LAC, DEA/50030-K-40/4498/1 Memo by Department of Trade and Commerce, February 27, 1950.
- <sup>26</sup> LAC, DEA/50030-K-40/4498/1 Wilgress to Pearson, December 12, 1949.
- <sup>27</sup> LAC, DND/20707/2-2-30/2 16th Panel meeting, January 18–19, 1951.
- <sup>28</sup> LAC, DND/20708/CSC 2-2-30/4 34th Panel meeting, June 15, 1954.
- <sup>29</sup> LAC, DEA/4526/50030-T-40/3 MacKay to Pearson, August 25, 1952.
- <sup>30</sup> LAC, DND/20708/CSC 2-2-30/4 36th Panel meeting, November 19, 1954.
- <sup>31</sup> LAC, DEA/4501/50030-L-40 Ritchie to Defence Liaison Division, February 25, 1950.
- <sup>32</sup> LAC, DND/20707/2-2-30/2 Memo, April 6, 1951.
- <sup>33</sup> St. Laurent, May 8, 1953. *Speeches & Statements*, 53/21.
- <sup>34</sup> LAC, DEA/50030-K-40/4498/1 1st Meeting of Mutual Aid Working Group, July 12, 1950. However, Ottawa kept the funds for the replacement programme for its own forces separate from the reciprocal procurement with the US.
- <sup>35</sup> LAC, DEA/50030-K-40/4498/1 Defence Liaison to Reid, July 26, 1950.
- <sup>36</sup> LAC, DEA/4526/50030-T-40/2 Memo for Pearson, March 19, 1952.
- <sup>37</sup> Claxton's speech in the House of Commons, February 5, 1951.
- <sup>38</sup> LAC, DEA/4526/50030-T-40/1 Plumpre to Prime Minister, September 22, 1950.
- <sup>39</sup> LAC, DEA/452450030-S-40/1 Canadian Ambassador in Washington to SSEA, September 8–9, 1950.
- <sup>40</sup> LAC, DEA/4499/50030-K-40/2 13th Panel meeting, October 2–3, 1950.
- <sup>41</sup> LAC, DEA/4499/50030-K-40/2 Claxton and Pearson to the Cabinet, December 28, 1950.
- <sup>42</sup> LAC, DEA/4499/50030-K-40/3 Memo by General Foulkes, November 23, 1955.
- <sup>43</sup> Some Canadian officials argued that the manpower contribution could have an impact on restoring the European morale, which was certainly important if NATO wanted its military strategy to succeed. However, this limited military utility of Canada's manpower contribution could not outweigh the heavy cost of the deployment.
- <sup>44</sup> There was no consensus in the Military Staff Committee on this issue.
- <sup>45</sup> LAC, DEA/4499/50030-K-40/3 Memo for the Cabinet Defence Committee, April (n.d.), 1951. Canadian forces in Europe used facilities of other NATO countries through the pooling of infrastructure, though. LAC, DND/20708/CSC 2-2-30/4 Pearson to the head of Post, Bonn, May (n.d.), 1956.
- <sup>46</sup> St. Laurent, February 10, 1954. *Speeches & Statements*, 54/8.
- <sup>47</sup> Heeney, March 19, 1954. *Speeches & Statements*, 54/20.
- <sup>48</sup> LAC, DEA/4903/50115-P-40/3 Memo by Southam, April 30, 1954. This project was never realized.
- <sup>49</sup> Extract from Cabinet conclusions, January 22, 1953. DCER volume 19, p. 1052.
- <sup>50</sup> Wrong to Under-Secretary, July 26, 1951. DCER, volume 17, p. 1271–72.
- <sup>51</sup> LAC, DEA/4499/50030-K-40/2 Extension of the Canadian Defence System, January 17, 1951.
- <sup>52</sup> Reid to Pearson, July 20, 1951. DCER, volume 17, p. 1269. Claxton even suggested that Canada should build this line on its own. Although Pearson was sympathetic, Reid and Wrong disapproved.
- <sup>53</sup> Memo by MacKay, November 22, 1952. DCER, volume 18, p. 1118.
- <sup>54</sup> LAC, DEA/4526/50030-T-40/2 MacKay to Under-Secretary, July 9, 1952.
- <sup>55</sup> LAC, DEA/4526/50030-T-40/2 Wilgress to Pearson, July 15, 1952.
- <sup>56</sup> Cabinet Defence Committee meeting, June 25, 1954. DCER, volume 20, p. 997.
- <sup>57</sup> Cabinet Defence Committee meeting, November 12, 1954. DCER, volume 20, p. 1043.
- <sup>58</sup> The central point of disagreement was the decision to approve in principle the DEW Line and the favouring of one of the two lines in terms of costs. DEA officials had expressed to Pearson, Foulkes, and Bryce (Department of Finance) their misgivings that Canada's freedom on determining the extent of participation in the DEW Line would be limited if Canada was to construct the Mid-Canada Line alone.
- <sup>59</sup> Defence Minister to Prime Minister, October 21, 1953. DCER, volume 19, p. 1092.

- <sup>60</sup> MacKay to Pearson, December 2, 1954. DCER, volume 20, p. 1055.
- <sup>61</sup> LAC, DEA/4886/50115-J-40/5 NATO Delegation to Under-Secretary, December 15, 1953.
- <sup>62</sup> LAC, DND/20709/2-2-34/1 Draft of Statement on Canadian mutual aid, December 3, 1954.
- <sup>63</sup> Stéphane Dion, March 29, 2016. Available from: <http://www.macleans.ca/politics/ottawa/stephane-dion-how-ethics-inspires-liberal-foreign-policy/> (Accessed December 1, 2016).

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## DOSSIER

### INTRODUCTION TO THE SPECIAL ISSUE “EQUALITY, HEALTH, AND HEALTH POLICY”

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#### INTRODUCTION

The field of bioethics has secured a voice for philosophers when it comes to many of the ethical questions that arise in medical contexts, such as those about end-of-life care and consent to medical research. Philosophers have also begun to move beyond the medical context to consider broader questions about health policy and the distribution of health outcomes within populations, often using the lens of political philosophy to shed light on questions arising in this context. The label “population-level bioethics” (Wikler and Brock, 2007) that is sometimes applied to this area of inquiry explicitly makes the link between the field of bioethics and research concerned with issues around health arising at the level of populations.

This growing literature addresses questions around health and health policy that are philosophically interesting and challenging but also high on political agendas across the world. Perhaps most prominently, Daniels’s (2008) seminal book *Just Health* explicitly engaged with the growing empirical literature on health inequalities and on the connection between social factors and health outcomes (the “social determinants of health”), opening up a rich and ongoing debate about justice and equality in health. The debate has also addressed possible justifications for universal healthcare and the conditions under which access to specific healthcare services may be denied; questions about whether there is a “right to health” and what this might entail; and questions about how to distribute resources between the young and the old, to those with different kinds of conditions, and to those facing different disadvantages.

In addition to concerns arising within specific political communities, there has also been recognition of the importance of global justice for questions around health. For example, how should we respond to the migration of healthcare professionals from low-income to wealthier countries, which puts significant pressure on already strained healthcare systems? How should resources for global health be allocated, and how are we to assess the influence of private donors on such decisions? What is to be done about global threats to public health, such as highly contagious diseases that quickly spread across national borders?

This special issue contributes to these ongoing debates by bringing together several papers that consider questions of justice, equality, and fairness as they arise in the context of healthcare, health policy, and population health. The papers in this special issue address a range of issues arising within healthcare systems, in relation to the arguments supporting individuals' access to healthcare and with respect to how we think about health inequalities.

The contributions by Ben Davies and Ben Saunders are concerned with the fair allocation of health-related goods. Three principles have emerged as the main contenders in the philosophical debate about distributive justice: egalitarian, prioritarian, and sufficientarian approaches. These approaches have also been considered for the distribution of healthcare resources. Davies's paper defends a sufficientarian position. But his paper also considers a question that has received significantly less attention in the literature: the timescale over which concerns of justice in health apply. While it may seem natural to think that concerns of justice apply to people's aggregate outcomes over their lifetimes, it is not clear that this leaves us with an adequate response to variations that may occur within a person's life, leaving the person healthy and well off in some periods and suffering in others. Davies's paper argues that lifetime views must be supplemented with what he calls "momentary sufficientarianism": justice demands that we care about particular moments in people's lives and about whether or not they have "enough" in each particular moment. In particular, on the kind of sufficientarian view Davies endorses, claims to benefits are discontinuously stronger when they would take people above the sufficiency threshold or prevent them from falling below it. Importantly, Davies sees requirements of momentary sufficientarianism as supplementing, rather than replacing, other distributive principles, such as lifetime egalitarianism: neither principle on its own can fully capture what matters for the distribution of health-related goods. Rather, decisions about distributing health-related goods should reflect considerations of both momentary sufficientarianism and lifetime egalitarianism.

Saunders's paper addresses the question of how scarce resources—in particular, vaccines—can be distributed fairly among those who need them when there is not enough for everyone. While, in a sense, the fairest outcome might be one in which *no one* receives the vaccine, this approach has obvious disadvantages. Lotteries have struck many philosophers as a fair way of proceeding in such cases: the state (or whoever is in charge of distributing the vaccine) can show equal concern and respect for individuals by seeking to equalize people's chances—their chances of receiving the vaccine, for example, or their chances of survival. While different types of lotteries have been proposed, the underlying idea is that what makes such lotteries compelling is that they *equalize* the relevant chances. Saunders, however, argues that equal concern and respect for individuals need not require lotteries that equalize chances. Rather, under certain circumstances, equal concern for citizens can be consistent with, or even require, *unequal* chances. This, Saunders argues, is the case where some citizens' being saved (or not) affects the likelihood of *other* people's being saved. Saunders's prime example is that of citizens who, if saved, will help produce more vaccines



and thereby increase everyone's chances of survival, but he notes that the argument would also apply in the case of citizens who, if not treated, are likely to infect more people than others. Saunders makes the case for giving people unequal chances (of surviving, of receiving the vaccine, etc.) in these cases. In fact, he argues, there is even a case for simply giving the vaccine to the person who will go on to produce more vaccine or who will go on to infect others, instead of running a lottery. This is because doing so increases *everyone's* chances of survival. While this may not sound particularly fair, considering how unequal people's chances of receiving the vaccine have become on this approach, Saunders argues that it is consistent with the requirement of equal concern and respect: just as distributing vaccines via a lottery is preferable to not giving the vaccine to anyone even though this leads to unequal outcomes, refusing to increase everyone's chances of survival because this makes people's chances unequal is to make a fetish of equality.

Johannes Kniess's and Brian Berkey's contributions are concerned with the role of states and societies in providing the conditions and resources that allow individuals to avoid poor health outcomes. The question of individual responsibility for health has loomed large in the health-justice debate, not least because the empirical evidence suggests that a significant proportion of the social inequalities in health that we find in high-income countries is the result of differences in health-related behaviours, such as smoking and physical activity. Kniess's paper in this issue offers a critique of the luck egalitarian approach to this question, before proposing that we shift our focus from individual to social responsibility for health. Luck egalitarians are typically associated with the view that when individuals are responsible for poor health outcomes they face, they should bear the costs associated with those outcomes rather than have their treatment covered. However, what precisely this might require and how much responsibility this approach would allocate to individuals in the real world are far from clear. In order to spell out what is involved when we call people "responsible" for certain health outcomes, some luck egalitarians have relied on the idea of "reasonable avoidability": not all health risks are reasonably avoidable and individuals should be held responsible if and only if the poor outcomes they face could reasonably have been avoided. Kniess explores possible interpretations of the notion of reasonable avoidability and argues that none of them provides a determinate answer to the question at hand. The underlying problem, Kniess suggests, is that the luck egalitarian approach misunderstands the place of responsibility within a theory of distributive justice. Drawing on a Rawlsian understanding, he argues that before we answer what health risks we can reasonably expect individuals to avoid, we must have an understanding of what *societies* owe *individuals*. In particular, we need to know what societies owe their citizens when it comes to the background conditions that shape the health behaviours that individuals adopt. The answer Kniess offers to this question is that the state needs to provide a "fair package" of primary goods, among which are the social bases of health. Only when individuals make their health-related choices against a background in which these packages of goods are provided to citizens, can questions about citizens' responsibilities for their health get off the ground.

Kniess's paper contributes to the debate about luck egalitarian responses to the Rawlsian understanding of justice in health developed by Daniels and others. In the broader philosophical debate about the value of equality, the distributive approach assumed by luck egalitarians has come under criticism from advocates of relational equality. While many critics have worried that luck egalitarians would find it difficult to justify assistance for those who face disastrous outcomes—including health outcomes—because of choices they have made, others have called into question the basic assumption underlying the luck-egalitarian approach: that equality is essentially about the fair distribution of *something*, be it resources or well-being. Philosophers such as Elizabeth Anderson (1999) and Samuel Scheffler (2003) have defended conceptions of equality that centre not on questions about the fairness of distributions, but on the relations between individuals. Equality, from the relational perspective, requires that people regard and treat each other as equals.

Relational egalitarians typically see themselves as part of a political tradition that advocates a strong welfare state that guarantees people's entitlements to things such as healthcare, education, and social services (e.g., McTernan et al., 2016)—rather than a state that leaves the provision of these services to the market (see, for example, Fourie's 2016 discussion about the problems associated with private health insurance)—so as to ensure that people stand in egalitarian relationships to one another. However, as Berkey explains in his contribution to this issue, it is not clear how far relational theories can take us in justifying state-funded healthcare. The precise contours of the kind of healthcare coverage and provision that can be justified by the requirements of relational equality may be less demanding than we might expect. Relational egalitarians, Berkey argues, do not have a good explanation for why people are entitled to socially provided healthcare. A particularly challenging example for relational egalitarians is the pain associated with many medical conditions. Given that (at least mild and moderate) pain does not undermine people's status as social and political equals, how can relational egalitarians justify treatment for painful conditions? While the goal of relational equality seems intuitively compelling, we need more argument to understand what kinds of health policy it can, and cannot, justify, and whether it might, as Berkey suggests in his paper, need to be supplemented with a distributive principle in order to justify the social provision of healthcare.

The final contribution, by Carina Fourie, shifts the focus from questions about health inequality to the question of *how we conceive of* such inequalities. Her paper focuses on the models used in the empirical literature on health inequalities, particularly in relation to the effects of different forms of oppression, such as racism and sexism, on people's health outcomes. While it may seem unequivocally positive that researchers are calling attention to, and improving our understanding of, the pathways through which oppression can impact individuals' health outcomes, Fourie highlights the risks associated with what she calls the "discrimination-emotion-health model" on which much of this research relies.

This model seeks to capture the effects of oppression on individuals via the impact of oppression on emotional states. For example, oppression may create psychological distress, which in turn can increase the risk of physiological and psychological impairment.

While Fourie emphasizes the importance of identifying how, precisely, individuals' health outcomes are shaped by oppression and injustice, she also highlights that the models used to capture the relationships among oppression, emotional states, and health outcomes can actually *reinforce* the phenomena they are investigating. For example, the descriptions offered by the model may inadvertently strengthen stereotypes about marginalized groups or denormalize their emotional responses to the oppression they experience. The models used to capture the impact of oppression on health, Fourie argues, are not sufficiently sensitive to the political dimension of emotions. She concludes by outlining a number of ways in which health researchers can respond to this problem.

While the contributions in this special issue address a wide range of different issues, both theoretical and practical, around equality, health, and health policy, I would like to conclude by highlighting a number of connections among the papers. First, it is interesting that despite the different questions Davies and Berkey address in their papers, pain plays a role in both their arguments. Davies argues that decisions about allocating pain relief need to reflect both lifetime egalitarian and momentary sufficientarian perspectives. Berkey argues that it is not obvious what arguments relational egalitarians can provide for the social provision of care that can address pain. Pain and discomfort are central to the experience of many health conditions and, arguably, a central reason for wanting to address these conditions. However, despite the fact that pain is such a crucial aspect of ill health, it has received surprisingly little attention in the literature on equality and justice health; instead, much of the focus has been on the opportunities that poor health can foreclose for people. Davies's and Berkey's papers suggest that accommodating pain within theories of justice in health is less straightforward than we might have anticipated and suggests that more work needs to be done to make the theories and arguments developed in the literature appropriately responsive to pain.

Second, the papers reflect, in different ways, the larger debate between distributive and relational approaches to equality that I mentioned earlier. Berkey's paper, which explicitly considers what these two approaches might have to contribute to a justification of socially provided healthcare, and Fourie's contribution, which evaluates, from a relational perspective, the models used to capture empirically the effects of oppression on health outcomes, do so explicitly. But in Davies's and Saunders's papers, too, the two perspectives play a role. Davies considers the role of relational concerns in the debate about the temporal dimension of equality in health. Relational goods, he suggests, seem to lend themselves to the momentary view he is proposing, whereas the lifetime view appears more congenial if we are adopting a distributive perspective. Saunders, in describing what a fair distribution of scarce resources (such as vaccines) would

require, starts from question of what it means for distributions to reflect equal concern and respect for individuals—this is consistent with how some relational egalitarians have suggested we approach distributions (see Schemmel, 2011). At the same time, the question of fairness in *outcomes* (as opposed to chances) still plays an important role in Saunders’s analysis. Whereas much of the literature has painted a rather adversarial picture of the relationship between relational and distributive conceptions of equality, the contributions to this special issue suggest that we can draw on both perspectives to make progress on questions about equality and fairness in health.

Finally, the question of who is responsible for ensuring individuals’ health and for fairly dividing healthcare resources has played an important role in the debate. While individuals’ responsibilities—for not becoming ill and for not using more than their “fair share” of health-related resources—have played an important role in the debate, some authors have sought to attenuate the focus on individual responsibility by arguing for greater responsibilities of the state and the healthcare system (as in Davies’s, Berkey’s and Saunders’s papers), as well as society more broadly understood (as in Kniess’s contribution). Fourie’s paper in this special issue calls attention to a group whose responsibilities have received much less, if any, attention in the debate: researchers investigating the social factors that lead to unequal health outcomes. Unless this work is built on a recognition of the political dimension of the phenomena it investigates, it threatens to contribute to the inequalities it examines.

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# HEALTH(CARE) AND THE TEMPORAL SUBJECT

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## ABSTRACT:

Many assume that theories of distributive justice must obviously take people's lifetimes, and only their lifetimes, as the relevant period across which we distribute. Although the question of the temporal subject has risen in prominence, it is still relatively underdeveloped, particularly in the sphere of health and healthcare. This paper defends a particular view, "momentary sufficientarianism," as being an important element of healthcare justice. At the heart of the argument is a commitment to pluralism about justice, where theorizing about just principles demands paying attention to the role particular goods play in our lives. This means that different approaches to the temporal subject—as well as other relevant issues—may be appropriate for different goods, including different goods within healthcare. In particular, the paper discusses two central goods targeted by healthcare: life-saving and pain relief. The view is offered as complementary to, rather than competitive with, lifetime approaches. As such, the paper finishes by considering how a pluralist approach, which engages both with people's lives as a whole and with their states at particular moments, can reconcile the potentially competing claims in healthcare that emerge from these two perspectives.

## RÉSUMÉ :

Plusieurs présument qu'il est clair que les théories de justice distributive doivent prendre la durée de vie des gens comme seule et unique période de distribution pertinente. Même si la question du sujet temporel a gagné en importance, elle demeure relativement sous-exploitée, et ce, particulièrement dans le domaine de la santé et des soins de santé. Cet article présente une conception particulière, le « suffisantisme momentané », comme une composante importante de la justice en santé. Cet argument se centre sur un engagement pluraliste en matière de justice, qui implique que toute théorisation de principes justes doit prendre en compte le rôle que jouent des biens particuliers dans nos vies. Cela signifie que différentes approches du sujet temporel - ainsi que d'autres enjeux pertinents - peuvent convenir à différents biens, y compris des biens dans le domaine de la santé. Plus précisément, l'article traite de deux biens principaux qui visent les soins de santé : l'aide vitale et le soulagement de la douleur. Cette conception s'articule en complémentarité avec les approches de la durée de vie, plutôt qu'en compétition avec elles. Dans cette optique, l'article examine pour finir comment une approche pluraliste, qui concerne à la fois la vie des gens dans sa totalité ainsi que leur condition à des moments précis, peut arriver à concilier les thèses émergeant de ces deux perspectives sur les soins de santé qui, autrement, entreraient potentiellement en conflit.

## 1. THREE QUESTIONS OF HEALTHCARE JUSTICE

According to Dennis McKerlie (1989; 1992; 2001; 2013), discussions of egalitarian justice have mainly engaged with two central issues, at the expense of a third of equal importance. The first issue is the currency of justice: which good or goods we should distribute in an egalitarian way. The second issue is the distributive pattern; within egalitarian thought, this typically concerns whether to aim for strict equality (egalitarianism), to prioritize the worst off (prioritarianism), or to make sure people have “enough” (sufficientarianism).

The neglected issue is the “temporal subject” of justice—that is, *when* or *over what timescale(s)* justice applies. It has risen in prominence since McKerlie (1989) framed it in this way, though it is still overshadowed by questions of currency and pattern. And, although the topic has been the subject of important work in healthcare justice specifically (e.g., Daniels, 1988, 2008; Jecker, 2013, 2018), it has received considerably less attention than the other two in this area. Yet a full theory of justice in healthcare must have something to say about the temporal subject because it has significant implications for the allocation of resources.

The main aim of this paper is to advocate a specific stance on the temporal subject with respect to healthcare. That answer is that justice demands a concern with particular moments in people’s lives, which is sufficientarian. This is “momentary sufficientarianism.” I make the initial case for a momentary view in section 2. This view is related to McKerlie’s own advocacy of a principle of justice applied to different “segments” of people’s lives, but differs in that he aims to provide an account of justice’s temporal structure and pattern from a purely welfarist perspective. My view is that different approaches to the pattern and temporal subject may be warranted depending on our choice of currency, and that there is no one currency that commands the undivided attention of justice. This means that the case for any particular answer to the questions of pattern and temporal subject demands attention to the nature of the good being distributed.<sup>1</sup> This is true even within a single sphere of concern: while section 3 makes the case for adopting a momentary view with respect to some central aims of healthcare, healthcare has multiple aims, and they may suggest different answers to the temporal question. Section 3 also considers two versions of an objection to my argument: that the intuitions elicited by the cases on which McKerlie relies can be explained without appealing to time-relative distributive principles.

Section 4 then adds the question of *pattern* to this momentary view of healthcare and makes the case for momentary sufficientarianism. This is a second point of departure from McKerlie (2013), who rejects sufficientarianism with almost no discussion,<sup>2</sup> instead advocating prioritarianism as a time-relative principle.

Section 5 extends this discussion by considering a comparison between two important goods that healthcare aims at—life-extension and pain relief—and which seem to offer different perspectives on the temporal subject even within

healthcare. Initially, pain relief seems naturally to suit a momentary principle, while life-extension appears to be best considered from the lifetime view. I suggest, however, that neither of these claims is as straightforward as it seems.

Finally, section 6 considers the relationship between lifetime and momentary views in the context of healthcare rationing. Unless we adopt one view exclusively, we need to know how to decide between them. I suggest that some ways of combining the two—lexical priority and a “tie-break” system—unreasonably relegate one principle to insignificance and argue that the best way to accommodate both kinds of claim is a macro approach to healthcare spending, rather than an attempt to micromanage individual patient claims.

## 2. THE TEMPORAL SUBJECT

We can often find injustice when we look at how people’s lives go overall. That some live privileged lives while others barely manage to get by is unjust. McKerlie’s important observation (e.g., 2013, p. 6–7) is that we should also be troubled by distributions when we look at periods shorter than entire lives. He imagines a city block whose young citizens enjoy a high standard of living, but whose elderly residents are crammed into substandard retirement homes, isolated and neglected. If today’s elderly enjoyed a similar high standard of living when they were young, and today’s youth will themselves be consigned to poverty and exclusion when they are old, the city block achieves lifetime equality of welfare, opportunity, and resources. We can add, given the context of this paper, that the youth of this block have strong priority in terms of healthcare access. While older patients are entitled to some healthcare, services that target older patients and the conditions that affect them are a low spending priority, and the fairly minor complaints of younger patients are given priority over more serious issues for the elderly. In this case, we also have lifetime equality with respect to healthcare *access*, and one that aims at equality in health.

Such a distribution also passes lifetime priority and sufficiency tests. Since nobody’s life is worse than anyone else’s, we cannot advocate improving the elderly’s lives because they are absolutely worse off. Similarly, since everyone has the same quality of life, either everyone will have a sufficiently good life or nobody will. If the latter is true, then we have reason to improve everyone’s life, so that each one reaches sufficiency. But, according to a pure lifetime view, we have no stronger reason to target that improvement at the worse period of life, old age, rather than at the already high-quality period of youth. Both will lead to a better life overall.<sup>3</sup>

McKerlie claims that the unequal city block is clearly unjust because it neglects those who are worse off at particular times. As we’ll see, this has been challenged on several fronts. We can, however, make the case for a time-relative principle from a weaker claim. This claim is that, in some cases, people’s time-relative situations can give them claims on our prioritizing them, even if that reason is



ultimately overridden by stronger claims from elsewhere. All that matters is that the time-relative claim is not reducible to something else, such as a lifetime claim.

Imagine a choice between two people whose lives are entirely synchronous, both living for eighty years. Call the respective halves of these lives  $T_1$  and  $T_2$ , and assume that health is measured by something like the Quality-Adjusted Life Years (QALY) score (e.g., Williams, 1997; 2004). The QALY measure represents perfect health with a score of 1, death with 0, and various health conditions with decimal scores to represent how bad they are compared to these two extremes. Each potential added year is weighted according to the health conditions it contains. So, we can compare prognoses for patients that differ in both length and quality.

Adali suffers from a chronic condition that gives her extremely poor health (0.2 QALYs per year) for the first forty years of her life, but on her fortieth birthday is given a treatment that significantly alleviates her situation, giving her good health (0.8 QALYs per year). Bilal enjoys full health (1 QALY per year) for the first forty years of his life, but at forty suffers an accident that leaves him in extreme ill health (0.1 QALYs per year) for the second half of his life. We can represent our lifetime situation as follows, with the numbers representing total QALY scores over each forty-year period:

	$T_1$ (0-40)	$T_2$ (41-80)	Whole life (additive)	Whole life (average qalys/year)
Adali	8	32	40	0.5
Bilal	40	4	44	0.55

In lifetime terms, there is an inequality in Bilal’s favour; his lifetime QALY score is 44 (or 0.55 per year, depending how we measure lifetime QALYs), and Adali’s is 40 (0.5 per year). Similarly, Adali’s life is overall worse than Bilal’s, and so she is the stronger candidate for lifetime priority. Finally, although we haven’t specified the sufficiency threshold, it’s clear that if Bilal’s life is below it, so too is Adali’s, and even more so.

However, at the beginning of  $T_2$ , we can reasonably predict several things. First, without intervention there will be a large inequality in Adali’s favour. Second, over the next forty years, Bilal will be much worse off than Adali in absolute terms.

If lifetime equality were all that mattered, we would have reason, perversely, to make Bilal’s situation *worse*. Of course, almost all egalitarians would deny that this is what we ought to do. Temkin (2000, p. 155), for instance, would say that,

while there would be something good about Bilal's situation getting worse (since it would equalize things at the lifetime level), this is overridden by other moral principles. Nonetheless, all three lifetime views imply that, if we can offer treatment to only one of these two, we ought to choose Adali.

More importantly for my argument, however, they imply that there is *no reason at all* to prefer Bilal. People may have different intuitions about what we should do in this case. But all I require is the following claim: Bilal has some claim to priority over Adali, based on what his life will be like in  $T_2$ . This is important, because this claim cannot be based on lifetime considerations, which point exclusively in Adali's favour. As such, I suggest, we must recognize that there are distinctive distributive claims based on people's situations at particular times.

The purpose of this section has been to motivate the need for a time-relative principle. Sections 3 and 4 say something more specific: First, the relevant period of time is the moment. Second, in the context of healthcare, the relevant principle should be sufficientarian. To motivate these claims, I argue in section 3 that different principles may be appropriate for different kinds of good, and that this depends in part on how that good features in our lives. I also consider two objections to my Adali-and-Bilal case, which both claim that we can explain the relevant intuitions without invoking time-relative claims. Section 4 makes the case for adopting a sufficientarian momentary view in healthcare.

### 3. THE TEMPORAL SUBJECT IN HEALTH(CARE)

According to some of its opponents, the time-relative view has an intuitive hill to climb, because the lifetime view is the only intuitively plausible timeframe for distributive justice. Bidadanure (2016, p. 245) calls the lifetime the "*par excellence* time unit of distributive fairness," citing in support Lippert-Rasmussen (2015, p. 156) and Wagland (2012), and offers four reasons for thinking so. Though not all are addressed in this section, I mention them all, since Bidadanure sets out the intuitive challenge facing time-relative views especially clearly.

Firstly, the lifetime view explains why maximization of utility is acceptable within a person's life, but not across lives (the "separateness of persons" thesis). I address this "prudence problem" when I consider Daniels's prudential account, in section 3.2.

Secondly, there is a potential problem with arbitrariness in choosing the relevant sublifetime time frame (the "arbitrariness problem"). I address this in section 4.2.

The third reason, related to the first reason, is that the complete-lives view allows us to accommodate the idea of responsibility and compensation. That I am doing badly at one point in my life can be less objectionable if that is the result of choices I took earlier or if I am compensated at some other point in my life. This, the "responsibility problem," is addressed in section 4.4.

Finally, the lifetime view corresponds to “a widespread metaphysical view” about persons, which is that the same person occupies an entire life. The rest of this section considers this “metaphysical problem.”

We can think of the lifetime and time-relative principles as coming from two distinct, independent perspectives on social goods. From the inside, human lives embody both a lifetime and a momentary perspective, and certain goods matter to us from both. For most of us, it is impossible to think of ourselves coherently except as temporally extended across our lives. We make projects and plans, care about access to goods now because of their future implications, make sacrifices for later gains, and accept benefits knowing they’ll require sacrifice later. This is the lifetime view.

Some goods seem to be most naturally considered from this perspective (though perhaps constrained by momentary considerations, too, as we will see below). For instance, Daniels (1988, p. 41) suggests that it is not problematic if a society has its young people start out less wealthy and then accumulate wealth, so long as all generations go through the same process. Similarly, it seems acceptable if, *on average*, young people have readier access to education than older people—though that does not preclude the right of older people to access education if they need it.

But we are also temporally embedded beings. We care about certain things quite apart from how they contribute to our *lives*, but simply because of how they feel or matter to us now. This is the momentary view. My current pain does make my life worse. But I care about it primarily because of how it feels now. Similarly, some debilitating forms of ill health matter because they make the sufferer’s life worse. Ill health at one time may therefore call out, particularly if it is severe, for compensation at another. But my ill health also matters to me because of the way it feels as it occurs, because of the way it limits my ability to be and do various things (see Nussbaum, 1992; Sen, 2009), and because of the way it limits my capacity to create and take advantage of opportunities that matter to me right now. Since many of these experiences and opportunities are neither fully interchangeable with others nor capable of being recreated at another time, my ill health can also generate distinctive claims to be treated *at particular times*. While compensation might be welcome, compensation often cannot make up for what I lost while suffering ill health.

This suggests that the temporal subject cannot be entirely disentangled from currency, because different currencies may naturally imply different temporal views. Many of those who have discussed the temporal subject have adopted a specific currency before offering their arguments. For instance, McKerlie (2013) adopts a welfarist view, and Daniels (2007) is concerned with having a “normal” level of opportunity for one’s age. My focus is on health as a currency of justice. But it is worth reiterating two points explicitly. First, I will not assume that health is *the* currency of justice, because I do not suppose that there is single, irreducible currency. Second, I do not assume that there is one single answer to the temporal

question even when we focus solely on healthcare. This is because, even when healthcare is intrinsically valuable, it may be valuable in a pluralistic way; there is no obvious reason for us to assume that the intrinsic value of pain relief is the same as the intrinsic value of life extension. But both constitute healthcare.

### 3.1 Relational goods

Another set of goods that matter from a momentary perspective relate to social standing. Relational egalitarians argue that the egalitarian perspective must include, as well as (Wolff, 1998) or perhaps even instead of (Anderson, 1999) distributive concerns, a focus on our ability to relate to one another as equals, which includes a concern with oppression, exploitation, shame, and respect. These are all goods that can be affected by health and access to healthcare, and which also arise in a momentary sense. McKerlie (1989, p. 479) imagines another case, where two groups swap social standings throughout their lives, with one group occupying an exploitative, domineering position over the other, which is then reversed.

While there is a sense in which this society equalizes social standing over its citizens' lives, there are deep social inequalities during both periods. Being somebody's social equal is not something that comes out in the wash, considered on balance over the course of a lifetime. One reason for this is that social standing is in part about our relationships and interactions with others. To say that people interact on an equal basis is not to say that they interact on an unequal basis, but while taking turns on top.

Some of our concern with moments in the distribution of other goods, such as healthcare, may well relate to this relational concern, as Bidanure (2016) argues. She suggests that our intuitive reaction to McKerlie's unequal-city-block example can be explained by appealing to *relational* equality. On this view, momentary distributive inequalities in health and healthcare access do not matter in themselves, but matter because they contribute to, or constitute, *relational* inequalities. For instance, Bidanure (*ibid.*, p. 246) suggests that one problem with the city block is "not that there is a timeslice inequality in distribution as such, but rather that relationships of inequality may pertain at all times."

Bidanure is concerned here with rejecting a time-relative *egalitarian* view, understood in the narrow, comparative sense. Since my view, as outlined in section 4, is that the momentary principle should be *sufficientarian*, I am not in direct conflict with her central proposal. But her view does raise the prospect of a more general sceptical view, that any intuitions that seem to suggest specifically momentary distributive concerns can be explained by nondistributive considerations.

Kasper Lippert-Rasmussen (2015, p. 155-156) notes that, in describing his unequal-city-block case, McKerlie says that the elderly residents lack "dignity," and compares their situation to a racial injustice, which is clearly not only a *distributive* problem (see also Segall, 2016, p. 87). So, even if these cases raise valid concern, that concern may be directed towards nondistributive issues.

It is certainly right to suggest that one reason to object to a momentary distribution in healthcare rests on its implications for other forms of justice, and indeed issues beyond justice. But these other areas do not matter only because of their relationship with relational inequalities. As Daniels (1981, p. 146; 2007, p. 18) suggests, a central reason to place special emphasis on health is its implications for opportunity. Momentary inadequacy in health may thus also have a serious effect on opportunity.

But we should also care about (at least some) momentary allocations in healthcare not only for the sake of their implications for *further* issues (such as relational inequalities), but also for their own sake. As I suggest in section 4.1, one reason for this is that some cases of the relevant good—healthcare need—matter irreducibly from a momentary perspective. But we can offer an initial, different motivation here. One potential issue with an appeal to relational equality is its capacity to explain why certain distributions exemplify relationships of inequality, while others do not. Relational egalitarians are, says Bidanure (2016, p. 236), concerned with “oppressive relationships such as exploitation, domination, or exclusion.” On the relational view, a distribution is unjust only if it constitutes or otherwise contributes to such a relationship.

Similarly, Lipper-Rasmussen notes that McKerlie’s imagined elderly lack dignity. But to frame a distribution as constitutively exploitative, dignity denying or (unjustly) exclusive, we must have a sense of why the relevant good matters in a particular way. For instance, Bidanure (*ibid*, p. 246) suggests that McKerlie’s unequal city block may be relationally problematic because elderly citizens are “segregated,” which, along with different levels of affluence, “easily become[s] associated with unequal status and unequal levels of respect.” But why should it be that markedly different levels of affluence, for instance, are often associated with disrespect for some? It is because one’s level of affluence *matters* for the quality of one’s existence that it can imply disrespect.

Similarly, one reason that having (avoidably) insufficient access to healthcare may be demeaning and suggest a level of disrespect—even if it is balanced out at another time—is because it is wrong *for its own sake*. That the society of which you are a member has allowed you to fall into severely ill health is something that it is reasonable to feel aggrieved and disrespected over, because of the fundamental value that health has. It is bad in itself to be in severe pain, or to suffer from significantly restricted mobility, or to be bedridden. That is why some levels of disparate healthcare access constitute disrespect.

Further, even if one thinks that a nondistributive explanation can be found for the intuitive force of the unequal city block, the same is not so obviously true for my narrower healthcare example. For one thing, the linguistic cues highlighted by Lipper-Rasmussen with respect to the unequal city block are absent here. All I appeal to is the fact that various points of Bilal’s future will be very bad indeed.

Lippert-Rasmussen assumes that, unless advocates of the momentary view can come up with an example for which *no* alternative explanation can be found,

then we should not adopt the momentary view. In part, this is based on the claim that the momentary view is deeply unintuitive, so we should accept it only if it explains a case for which no other explanation is available.

This rests on two further claims. First, the momentary view is *prima facie* implausible, since it faces the four challenges mentioned by Bidanure. Second, it holds no intrinsic attraction, so its only support is its ability to explain cases that no other view can. But, as I will argue, the four challenges Bidanure mentions can be overcome. Furthermore, the momentary view does have intrinsic plausibility if understood correctly. For, if it is understood as a sufficientarian view, and simply as a claim about grounding claims that are nondecisive, then it amounts to the following: that we have *some distributive reason* to want to prioritize Bilal over Adali, and that this is grounded in his poor future prospects.

Of course, one might worry that Bilal's poor health will have various effects that we should care about for nondistributive reasons. But this is not the fundamental reason to care about his poor health. Rather, our fundamental reason for concern is simply that his future will be very bad. The claim that there should be a momentary principle of justice is grounded, in this case, only on the thought that there is a distinctive claim grounded in how a person will fare at a particular moment, or during a collection of moments. So, while I accept that alternative explanations must be considered, I am not sure it is reasonable to expect that advocates of the time-relative view find cases where we can completely discount alternative, nondistributive explanations of our intuitions.

### 3.2 Prudence

A different alternative explanation is that we can explain the intuitions raised by cases like McKerlie's and mine from within a solely lifetime framework. A central example of this approach is Norman Daniels's prudential lifespan account (PLA) (e.g., 2013). Briefly, Daniels suggests that, since we all occupy multiple age groups during our lives, intergenerational justice should be based on what one would prudentially choose from behind a Rawlsian veil of ignorance, with various morally irrelevant facts about oneself obscured. Such deliberators might well suffer reduced healthcare in old age for increased access while younger, in order to increase the chance of them *making* it to old age. Crucially, while Daniels's deliberators have their actual age hidden from them, he stipulates (2008, p. 475) that allocators "must assume they will live through each part of the life, accepting any tradeoffs they make."

One might therefore worry, as McKerlie (1989) and Jecker (2013) do, that this will lead us to tolerate not only inequality but extreme hardship in old age. Citizens who must reason as if they will start life from birth, with a limited amount of resources to spend on healthcare, would allocate (almost) nothing to some levels of old age, since they are less likely to reach that stage of life. In addition, Lazenby (2011) and Davies (2018) suggest that the requirement that

citizens live through all stages of life, and start at the beginning, unavoidably obscures important issues, such as that of individuals who suffer from incurable life-shortening illnesses.

Defending Daniels, Bidanure (2013, p. 26) rejects such charges as focusing on only one part of the PLA. In addition, she says, the account also stipulates that “it would be imprudent to discount one stage of our life span by denying our younger or older self sufficient resources to live decently.” As such, the intuitions elicited by McKerlie-style cases are accommodated by adopting a lifetime principle based in prudence as well as in equality.

However, while this may redeem Daniels’s account, it can do so only by incorporating a time-relative sufficientarian principle. It is worth noting that, later in her discussion, Bidanure suggests not that avoiding hardship would be imprudent, but rather that “it would not be *fair* to deny the elderly the necessary resources to live decently” (my emphasis). This difference is important, and the second formulation is more plausible. As Daniels has since noted (2008), it is actually quite difficult to stipulate a single view of prudence—even from behind a veil of ignorance—that will rule out some individuals seeing hardship during some periods as worth enduring to maximize lifetime welfare. Indeed, some may even see it as worthwhile to endure aged hardship even if it does not maximize lifetime well-being, because they simply prioritize their youth to a considerable extent. So, an appeal to hypothetical prudence is incomplete.

#### 4. THE PATTERN OF MOMENTARY JUSTICE

If people may have momentary claims to healthcare, to what distributive pattern do these claims relate? Recall that there are three broad answers we might give to this question: egalitarian, sufficientarian, and prioritarian. In the context of a momentary principle for health, these ideas might turn out in something like the following way:

**Egalitarian:** People have a claim to the healthcare they need to be just as healthy as the healthiest members of their society *at all times*.

**Prioritarian:** People’s claims to healthcare become stronger, the worse their health is at a particular time.

**Sufficientarian:** People’s claims to healthcare are discontinuously<sup>4</sup> stronger whenever they fall below some threshold of health.

Deciding among these principles requires a further specification of the idea of momentary egalitarianism, which will offer a further reason for adopting a momentary view, rather than a more general “sublifetime segments” view. The next two sections advocate momentary sufficientarianism. This is the view that justice gives people discontinuously stronger claims to benefits when those benefits would either *prevent* them from not having enough (in terms of health)

at a particular moment, or *rescue* them from not having enough. The argument is that the moment is the only nonarbitrary alternative to the lifetime, and that a concern with moments is best understood as a concern with sufficiency, at least with respect to some goods that are central aims of healthcare.

#### 4.1 Arbitrariness and equality

I have argued that some justice-relevant goods are best understood as implying a distinct concern with moments. A common criticism of the call for a time-relative principle of justice is the arbitrariness problem: to find a nonarbitrary time frame, aside from a lifetime, that grounds concerns of justice. These ideas combine to give an argument for some goods being governed by momentary sufficiency.

A concern with periods of time shorter than a life could mean a concern with *all* time periods shorter than a life. In the case of Adali and Bilal, the sublifetime inequities I identified were over a period of forty years. This leads us to a problem. In the original example, I assumed that both Adali's and Bilal's health statuses would be uniform throughout each period.

But it is more realistic to assume that their health will fluctuate *within* those periods. Although Adali does better across  $T_2$  than Bilal, perhaps this is because she does much better during the final twenty years of life, but a little worse during years 41 to 60. Once we identify this possibility, more emerge: since we can continuously subdivide time periods, there is always the possibility of further distributive issues.

The arbitrariness problem is the challenge to find a nonarbitrary length of time, shorter than the lifetime, to which to apply a time-relative distributive principle. In my view, following McKerlie, the only nonarbitrary option is that the relevant periods are moments, since no intrasegment inequities can occur. For McKerlie, this raises a fundamental problem for time-relative egalitarianism (cf. McKerlie, 2013, p. 84-85), since a demand for strict equality at every moment seems excessive. For instance, some healthcare treatments themselves negatively affect our health in an unavoidable way. An operation to avoid cancer may cause additional, less serious, health issues. Similarly, an intervention that relieves long-term pain may nonetheless cause pain for a shorter period. If two people undergo similar such interventions, momentary egalitarianism tells us that we must, as a matter of justice, schedule those operations so that the two individuals suffer their unavoidable reduction in health at the same time; otherwise, there will be an avoidable inequity at various moments between those two. But this seems unnecessarily fussy.

It is worth acknowledging that, just as I argued that currency may affect the temporal subject, not all goods are equally vulnerable to this fussiness concern. For instance, the relational goods discussed in the previous section may be such that, as Axelsen and Nielsen (2015) argue, only equality can count as enough in



these contexts. Since the basic demand of social standing is to be treated as an equal, it does not seem arbitrary to demand that people are treated *as equals* in terms of their social standing; since, as I have argued, this cannot be understood in a lifetime balancing-out sense, that implies that momentary equality is not an unreasonable demand in terms of social standing.

But this kind of thinking does not apply to healthcare; as Schramme (2007, p. 126) says, “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.” So, the fussiness complaint against momentary egalitarianism stands.

As McKerlie suggests (2013, p. 105-106), this implausibility does not affect prioritarianism, because it is only derivatively comparative. Hence, small changes in one person’s behaviour or situation need not have meddlesome implications for others. We can have stronger reasons to help those who are worse off at any particular moment, without having to coordinate collective behaviour. Although he does not consider it, similar logic applies to sufficientarianism: that one person does not have enough at a particular moment can be understood without reference to anyone around that person.

Opponents of a momentary principle might insist that, even if momentary sufficientarianism does not demand scheduling, a focus on moments is still overly precise. Consider S, who is very well off for her whole life except for one moment, when she suffers a moment of intense agony. Opponents might object that we have no reason to benefit S during this one moment, given how good her life has been otherwise; S’s suffering is simply too minor to be concerned about. Yet on my view, S’s claims to benefits are stronger with respect to that moment. To respond to this claim, I think it will help to locate the view I am advocating within a family of related views.

Before doing that, in the next section, I will offer one argument in favour of sufficientarianism rather than prioritarianism being our momentary principle with regard to healthcare—a further such argument comes in section 4.4, with my discussion of the responsibility objection. Schramme’s argument explains why we want a noncomparative view. To see it should be sufficientarian, note that, as well as being noncomparative, many healthcare needs are *satiabile* from a momentary perspective. When you suffer severe pain, we can give you pain relief; your claim to pain relief is based on the fact that it will relieve the pain. There comes a point at which this claim is sated. This may be because the pain is gone, because it is no longer severe, or because the pain is such that further pain relief will do no good.

As Shields (2012, p. 35-36) argues, when it comes to satiable claims, “those who have not secured enough can call on the weight of more and therefore a different profile of reasons than those who have secured enough.” This requires that the basis of the claim be noninstrumental and weighty. Insofar as seriously poor health—including severe pain—is intrinsically bad, and the source of a

weighty claim, then, this supports a sufficientarian approach. The sufficientarian threshold represents the point at which claimants can call upon a discontinuously weighty set of reasons to benefit them: reasons that are based on their not having enough.

Shields does not outline his view in terms of either a time-relative principle or healthcare. But his reasoning clearly applies to both. Satiability is typically a time-relative concept: many needs are satiable in a temporary sense, but not in an ongoing sense. And I have demonstrated how satiability relates to claims to healthcare.

#### 4.2 Momentary sufficientarianism: What it is and is not

I will now explain how momentary sufficientarianism differs from some other nearby alternatives. That a concern for sufficiency should aim at particular times is not a new idea. For instance, Jecker (2013, p. 10) says that a healthcare principle that looks only at lifetimes will “miss the unique features of caring for the chronically disabled,” and proposes that an allocation is just if it “maintains basic functioning and capabilities at a sufficient level”; although she does not specify the precise nature of the temporal subject, it is clearly shorter than the lifetime. Similarly, Gosseries (2011) considers a “continuous sufficiency” view, which places considerable restrictions on the forms of compensation allowed between different points in a person’s life. Gosseries does not commit to a full picture of what sets these restrictions, but seems to endorse a view based on the idea of human dignity. One important point of difference is that Gosseries explicitly claims that such a sufficientarian view “would not be concerned about the ability of people to meet their basic needs every second.” This reflects the concern raised at the end of the previous section, that such a concern would be excessive.

In my view, momentary sufficientarianism *is* concerned about people falling below the threshold set by sufficiency, even for just a moment. To be sure, if we can predict that it really will be *just* a moment, then we may not be *greatly* concerned. All theories of justice may lead to a theoretical concern with apparently somewhat trivial matters: for instance, a strict lifetime egalitarian view will care whether two people have nearly identical lives, which are extremely happy, but one of them has a single moment of feeling a little down. Momentary sufficientarianism can explain why we should care more about longer periods of insufficiency for at least one reason: a longer period comprises more moments than a shorter period. So, it does not imply that we should be indifferent between someone suffering a single moment of insufficiency and someone suffering a year of insufficiency.

This leads to two potential points of misunderstanding. First, as with many related views, momentary sufficientarianism sees injustice (as opposed to tragedy or a cause for regret) only in *avoidable* deviations from our pattern. This again serves to make the requirement that we care about every moment less demanding, and so more plausible.

Second, momentary sufficientarianism does not claim that people are entitled to *compensation* for every moment of their lives spent below the sufficiency threshold. The fact that someone drops, or will drop, below the threshold in a particular moment is the grounds for their having a strong claim on the rest of us to avoid or end that situation. It doesn't mean they are entitled to compensation.

The person who experiences agony for a moment thus has a claim to *having their pain relieved*. If it is a genuine moment of agony, it seems odd to deny that we have a significant reason to prevent it. But, as with Bilal, the relevant reasons are defeasible; that S has a *stronger* claim at that time does not mean we must do everything it takes to help her. There may be practical constraints that mean we typically ignore such brief agonies. In addition, as I discuss in section 6, the claims that derive from momentary insufficiency might be outweighed in some cases by the claims that derive from other principles, such as a lifetime egalitarian principle.

Since our reasons are defeasible, a rejection of momentary sufficientarianism is committed to saying that, if we can foresee S suffering terribly for just a moment, we have *no distributive reason* to prevent it. Contrary to Lippert-Rasmussen and Bidadanure, it seems to me that it is a *rejection* of such a view that requires strong justification. As McKerlie (2013, p. 82) says, suffering is morally serious, even if it lasts only for a moment. If it is also something we could prevent or relieve, then that is something others may demand of us.

### 4.3 The sufficiency threshold

In characterizing sufficientarianism, I adopted a view based on Liam Shields's: the sufficiency threshold marks a point at which distributive claims become discontinuously weaker. The main issue that Shields's sufficientarianism faces is how to define the threshold nonarbitrarily. His answer to this shows why momentary sufficientarianism is an appropriate principle in the case of health. Shields argues that the key concept underlying the sufficientarian ethos is the idea of satiability. As he puts it, if someone is in pain, or needs treatment for an infection, there is a level of resources that will complete that task. That person may have further claims to a different benefit, but must appeal to a "different profile of reasons" (2012, p. 113) to make that claim.

The idea of satiability seems most obviously applicable to resources. One might worry that sufficientarianism looks plausible only because we can set the threshold for resources by appealing to a different pattern, such as priority, for some more fundamental good, such as health: people have "enough" resources if their holdings enable them each to satisfy their prioritarian claims to healthcare. But satiability can also apply to health itself. Health is itself valuable because of its relationship to well-being. As Ram-Tiktin (2012, p. 341-342) argues, we can identify key thresholds within the range of health statuses a person might have on the grounds of their contribution to personal flourishing.

Such a view can also make room for a plurality of thresholds, each of which instantiates a discontinuous weighting for priority of claims. For instance, Ram-Tiktin suggests a lowest threshold of *personhood*, below which “human lives are not possible, either because the person dies or loses some fundamental capabilities basic to human life, such as the ability to perceive or communicate (even by eye or finger movement) when, for example, a person falls into a coma” (*ibid.*, p. 343; see also Huseby, 2009).

To some extent, this idea bases sufficientarian health thresholds on their *instrumental* contribution to a further idea of flourishing or opportunity. This is enough to show that sufficientarian reasoning has a role to play in allocations of justice, since a central part of the value of health is its instrumental value. But, at least in some cases, we can also talk about *intrinsic* thresholds related directly to health. For one thing, health is not only instrumental to human flourishing but is on some views partly constitutive of it (e.g., Nussbaum 2006; Chisholm, 2011, p. 189) or of some related idea such as well-being. Insofar as Ram-Tiktin’s health thresholds are constitutive rather than instrumental, we thus have a more fundamental role for momentary sufficientarianism.

For a more specific example, consider again the idea of pain relief. A basic reason that many forms of healthcare are valuable is their contribution to pain relief. Pain may not seem an obvious candidate for sufficientarian justice, because it can obviously be increased and decreased incrementally, and so invites a common complaint towards sufficientarian views: how can two people whose conditions are almost identical be—by virtue of falling just above and just below the sufficiency threshold—seen as radically different by a theory of justice?

Frankfurt’s (1987) discussion of resourcist sufficientarianism is grounded in the *reasonable attitudes* that people take towards their holdings. For instance, Frankfurt discusses the idea of contentment. Contentment does not mean that one’s position cannot be improved, but that improvement is a possibility about which one is not particularly concerned. On Frankfurt’s view, people no longer have claims of justice when they are content with what they have. But, while contentment may work as an upper threshold, it surely cannot operate as a lower threshold; it would be overly demanding to say that the only point at which our claims of justice become distinctively strong is when we feel discontent. Rather, one option for a lower threshold is the notion of tolerability.

Toleration is an attitude taken towards one’s situation. It is neither merely a psychological state that contributes to welfare, like happiness, nor an external description of a particular level of welfare. It is true that finding a situation intolerable may cause additional distress, and hence lead to further declines in welfare or barriers to flourishing. But finding something intolerable is not the distress itself. Frankfurt discusses contentment in similar terms, saying that to be content need not imply that one would not be happier with more, but that one feels no sense of urgency to acquire more. Similarly, finding your situation tolerable—or intolerable—is a kind of attitude. Frankfurt applies this idea of

attitudes solely to resources, but it is also applicable to other goods, including one's level of pain or one's opportunities. At the margins, a small increase in pain can move a person from being in pain they can just about bear to unbearable pain. In relation to opportunity, the notion of tolerability can occupy a midpoint between the fairly demanding notion of flourishing and the fairly minimal idea of personhood. Health, and healthcare, can therefore be the subject of momentary sufficientarian claims on these bases.

#### 4.4 Responsibility

The final of Bidanure's challenges is the responsibility problem, which also includes a concern with compensation. On the face of it, momentary views seem excessively willing to ignore the *history* of distribution (e.g., Bou-Habib, 2011, p. 291; Bidanure, 2016, p. 244-245). If Chris prefers to spend his money at the cinema every night, and Jenny saves hers, what right has Chris to complain if he is badly off at the end of the month? Perhaps it is also unfair to provide healthcare to people who are unhealthy because of their own poor choices. Relatedly, people often willingly tolerate hardship for the promise of benefits later. If they autonomously chose hardship, why is that unjust?

On the other hand, it can seem overly harsh—in Bou-Habib's terms, overly willing to tolerate hardship—if we simply refuse healthcare to all who bear some level of responsibility for their condition (see Fleurbaey, 1995). This is exacerbated by the fact that the same level of responsibility can, through sheer bad luck, result in significantly different outcomes depending on one's luck, such that isolating the degree to which one is responsible for one's situation is extremely difficult to determine (Wikler, 2002).

Momentary egalitarians and prioritarrians seem bound either to ride roughshod over people's free choices—whether wise or foolish—thereby ignoring responsibility and prudence, or to reject freely chosen hardships as grounding stronger claims of justice, even if those hardships are extreme. To adapt Fleurbaey's (1995, p. 40) phrase to a different context, “if you freely and deliberately make the slightest mistake that can put you in a very hazardous situation, a society complying with [these brands of egalitarianism or prioritarianism] will quietly let you die.”

The momentary sufficientarian, however, can mark a threshold below which *even freely chosen hardships* must be corrected. For the sake of explanation, assume tolerability grounds the relevant threshold. If someone is poorer than others due to a spending spree on concert tickets, and hence suffers some level of ill health, this need not be a concern of sufficientarian justice. But, if someone has, as in Fleurbaey's example (*ibid*, p. 40), gone motorbiking without a helmet and suffered a life-threatening crash, sufficientarians can insist that her position below the relevant threshold means that her responsibility is immaterial to her claim (see Gosseries, 2011, p. 474 for discussion related to this point).

This ability to accommodate both responsibility and hardship in a principled way is a distinct advantage of momentary sufficientarianism over both pure lifetime views and other momentary views.

This strength is compatible with a range of views on responsibility. One might take different views on hardship that occurs through foolish mistakes, and hardship that comes about through careful planning. Perhaps it is excessively harsh to punish people with extreme hardship for making a foolish mistake, but fair to expect people to endure the hardship they carefully planned into their lives. So long as one wants to make a distinction for some forms of responsibility, momentary sufficientarianism is the best placed to do so.

## 5. MOMENTARY JUSTICE IN HEALTHCARE: LIFE EXTENSION AND PAIN RELIEF

My argument thus far has been that momentary sufficientarianism is an important principle in the context of many health-related goods. This section addresses the application of this idea to two key aims of healthcare: saving people's lives and relieving their pain.

If lifetimes alone matter, we have reason to significantly target healthcare spending in particular directions—namely, towards conditions that affect children (Lazenby, 2011) and those who will suffer worse lives overall because of bad luck or social injustice (Overall, 2009). This is particularly true for life-threatening conditions; someone who dies in childhood, or after many years of deprivation, is irredeemably badly off in a lifetime sense, both absolutely and comparatively with others. But this will also apply to many cases where someone's predicted recovery will only partially compensate that person's earlier deprivation. If, on the other hand, moments matter as well, this will affect the priority, and perhaps the direction, of this targeting.

It is important to note that when we speak of targeting, we are not necessarily restricting ourselves to choices between individual patients. Many philosophical discussions of healthcare justice focus (perhaps even fixate) on choices such as that between Adali and Bilal. These choices are relatively straightforward and make it easier to tease out features of problems and proposed solutions; they have philosophical value. But it is rare for rationing decisions to be made at this level. The UK's National Institute for Health and Care Excellence (NICE) is one example. NICE's methodology for calculating cost effectiveness involves identifying the *average* improvement in the health status of individuals receiving the intervention, "over and above any other gains they might receive" (Rumbold et al., 2017, p. 112). A distributive view of healthcare must say something about choices broader than those between individual patients.

As I discuss in section 6, the targeting of spending also applies at this macro level. For instance, a strategy that prioritized the healthcare of children might set less demanding cost-effectiveness thresholds, or actively increase spending per

capita, for conditions that predominantly affect children. It might also devote greater funding to research into childhood diseases, and to centres that care predominantly or exclusively for children. Finally, it might simply take being below a particular age as an additional factor in deciding treatment priority in nonemergency cases.

Life extension is an issue where lifetime impulses are keenly felt. Many people argue on egalitarian grounds that in allocating life-extending resources, we must prioritize younger over older patients (e.g., Battin, 1987; Kappel and Sandøe 1992, 1994; Callahan 1995; Hardwig 1997; Lazenby, 2011). This sentiment is also common among the general public, many of whom prefer to some degree to give a shorter amount of additional life to a younger patient than a longer time to an older patient (see, e.g., Cropper et al., 1994; Nord et al. 1996; Johanneson and Johansson 1997; Nord 1999, p. 57–61). Many justifications of this view are explicitly egalitarian, appealing amongst other ideas to the fact that older patients, by definition, have had more life than younger patients. Others are more apparently sufficientarian, but where the notion of sufficiency is applied at the lifetime level. For instance, the “fair innings” argument (Harris 1985, p. 91) suggests that it is legitimate to make the saving of older people’s lives a lower priority not because they have had more life than the young, but because they have had a sufficient amount of time alive.

I claimed in section 3 that whether we apply a momentary principle, a lifetime principle, or both, depends in part on the kind of perspective the relevant good is valued from. Whereas some goods, such as equal social standing, seem constitutively bound to a momentary perspective, others are more naturally viewed from the lifetime perspective. It may seem that support for age-based rationing is backed up by this, because the idea of extending someone’s life is surely a concept that makes sense only from an extended point of view; the very concept of extending cannot be made sense of only at one moment.

Contrast that with pain. It may seem equally obvious that pain matters only in the moment. While it is not exactly constitutive of pain that we think of it from the perspective of the moment it is occurring, pain is a harm whose badness is very much of the moment; I want pain relief not because it makes my life better, but because it hurts *right now*.

However, this apparent simplicity is open to challenge. Consider first the suggestion that pain should be considered solely from a momentary perspective. We *could* allocate pain relief from a lifetime perspective. Some people have relatively pain-free lives, even though they would benefit from pain relief at particular times; others suffer pain more frequently throughout their lives. A lifetime view of pain would take the *cumulative* pain people have felt across their lives, and prioritize access to pain relief for those with the worst lifetime-pain score. A purely lifetime view would not further consider the current pain someone is in, except insofar as it contributes to that person’s lifetime pain score. We could, at least in principle, get the result that someone who is currently in mild pain is prioritized over someone who is currently in agony because the former has suffered more lifetime pain.

While a purely lifetime view of pain may thus seem implausible, the idea that there is some injustice in the fact that people have radically different lifetime experiences of pain—and that this inequality is often clustered with inequalities in other areas—is surely not. In a context where pain relief is scarce (or where cuts in pain relief might serve to secure other fundamental goods), those who advocate the lifetime principle in some cases need to explain why we should not also take this approach for pain relief.

We can also challenge the idea that interventions that prolong someone's life can be meaningfully viewed only from the lifetime perspective. It is certainly true that when we consider these interventions as life extensions (which they surely are), we are taking on a lifetime perspective. And that suggests that there is some truth to the egalitarian complaint outlined above. If we control for quality, older individuals clearly have *had* more of a foundational good (life) than younger patients.

But, to make a point related to Harris's (2004, p. 528), life extension is also *life-saving*. When we save people's lives, we are not only giving them more of a good that they have been accumulating; we are also maintaining their access to a good that is of foundational value *at particular times*, in a way that is not merely reducible to its cumulative value. It is foundational because being alive is a prerequisite for enjoying all other goods, including those that make sense primarily from a momentary perspective. Even if we cannot understand human lives except as an interrelated whole, this does not mean that such a perspective fully encapsulates the way in which we care about having more life. Having our lives saved is also valuable to us because it allows us to enjoy relationships and projects (and simply being alive) at moments.

So, while there is something to be said for the idea that life extension is naturally viewed from the lifetime perspective, and pain relief from the momentary perspective, the motivation for adopting the corresponding principle is available for each. This raises a final question. If the momentary theorist does not abandon the lifetime view, but only supplements it, how do these principles fit together in the context of healthcare?

## 6. THE RELATIONSHIP BETWEEN MOMENTARY AND LIFETIME PRINCIPLES

There are several ways the claims of lifetime and momentary egalitarian principles might be jointly assessed. One option is for claims of one kind to take lexical priority over claims of the other. But, depending on what kind of pattern the lifetime principle takes, this might mean that we end up entirely ignoring momentary claims. For instance, if lifetime claims are lexically prior and egalitarian, this would imply that we cannot meet any momentary claims until we have achieved lifetime equality. If we had achieved lifetime equality, on the other hand, we could not meet them if that would violate lifetime equality. But



this would mean we could never meet any momentary claims; for once we had achieved lifetime equality, any nonderivative momentary claims would upset that equality.

Conversely, a view that gave lexical priority to momentary claims would also have some problematic implications. What lifetime views get right is the thought that there is a problem of justice in assessing claims to certain kinds of goods from a purely momentary perspective. For instance, a lifetime view can explain why, if we are faced with a patient of eighty, and a patient of eight, each of whom will die without treatment, it misses something important to see both as having the same kind of claim. A view that saw momentary claims as lexically prior would, I take it, say that if we cannot treat both patients, we should simply choose at random. This is because such a view would say that until all momentary claims have been met, we cannot even consider lifetime claims. This differentiates it from a tie-breaker view, outlined below.

A more plausible, though incomplete, suggestion is that each principle may act as a tie breaker in cases where claims from the other principle are equally weighted. In a microallocation healthcare decision between individual patients, this would mean that we treat reasons to prioritize a particular individual as additive. If two patients are equally badly off in a momentary sense—for instance, if they will both die without treatment—then we look to the strength of their lifetime claims.<sup>5</sup> This will effectively mean preferring younger patients and those who have had worse lives overall, just as we would if we ignored momentary claims entirely. But it would rule out, for instance, a policy of allocating pain relief automatically to the patient who has had the greatest lifetime burden of pain; this is because two such patients may not be in the same momentary position. In other words, this idea seems largely in line with the common-sense combination of age-based rationing for life-extending treatments and a predominantly momentary focus for treatments such as pain relief. One worry, however, is that it will not provide sufficient protection against insufficiency for the elderly, giving rise to problems similar to those that affect an appeal to prudence, discussed in section 3.2.

A final possibility, then, is to treat the two kinds of claim as distinct, and not fully commensurable, on the grounds of my earlier argument: that they represent two distinct kinds of perspective that are, for most people, not reducible to one another. One option is to *weight* chances to be selected for treatment according to both lifetime and momentary claims; this allows some role for lifetime egalitarianism, but also recognizes the importance of momentary sufficiency by giving all those with a particular level of momentary claim a chance to benefit.

The thought behind this is that if people have equal claims, they should receive an equal chance of being selected; a move to unequal, but still important claims should thus prompt us not to act as if one person's claim has been eliminated entirely, as appealing to tie breakers would, but to move to unequal chances. For instance, if flipping a fair coin would in principle be a fair way to decide between

two patients with equal claims—giving them a fifty-fifty chance—then, for two patients with equal momentary claims, but unequal lifetime claims, we would move to a weighted lottery that gave both patients some weight due to their momentary claims, but greater weight to one patient proportional to the greater strength of his or her lifetime claim.<sup>6</sup>

Of course, there are practical issues of efficiency in running a weighted lottery every time a patient conflict arises for indivisible resources, particularly in emergency situations. It is more feasible to allocate greater weight for patients on the basis of lifetime priority for treatments that are allocated by waiting lists as one of a number of features that determine priority. However, there are still problems with applying weighting to such microallocations even in these more congenial circumstances. For instance, such a scheme seems likely to place excessive epistemic and bureaucratic demand on institutions in assessing entire lifetimes of welfare or opportunity for individuals. And as Wolff (1998) points out, egalitarian policies that depend on considerable amounts of personal information about the quality of individual lives might—despite those policies’ good intentions—exacerbate social stigma. Quizzing patients on intimate details of their lives, or even categorizing them as having had bad lives, may be humiliating and degrading even if it is not intended as such. But just as we should be reluctant to abandon momentary claims simply because of practical obstacles, it would also be wrong to focus *only* on such claims because we are worried about the potential invasiveness of trying to determine people’s lifetime claims.

If we cannot determine lifetime claims reasonably at the microlevel, due to a combination of practical constraints and competing normative concerns, an alternative way to include a concern for lifetime priority is in weighted *macro*allocations among different groups. When we are deciding how to allocate funds across the entirety of our healthcare budget, giving some weight to proportionality suggests that we ought to give what might otherwise appear to be a disproportionate level of resources (considered simply in terms of the number of people affected or in terms of the total health burden) to conditions that predominantly affect the lifetime worse off, or to target funding at health initiatives for groups who tend to be less well off in lifetime terms, or in geographic areas containing those groups. This allows some considerable role for lifetime egalitarian claims, without those claims “swamping” the role of momentary sufficiency (as an absolute tie break would), and without explicitly picking out particular individuals for lower priority. The cost, of course, is some level of inaccuracy; some individuals picked out in this macroallocation will not be the worst off. But where accuracy competes with intrusiveness and efficiency, trade-offs are inevitable one way or the other.

Even if some microallocations (such as additional criteria for waiting lists) could be framed to avoid this problem, a focus on macroallocations seems at least a plausible minimal role for lifetime priority. Treatments that will predominantly benefit the best off in lifetime terms are a lower research and funding priority than they would be if considered solely on the basis of the number of lives saved,

QALYs added to a population, or some other consideration of efficiency. But this does not mean that we should entirely ignore or defund treatments that address momentary claims of the lifetime best off. For they still have considerable claims to those treatments on momentary grounds. In other words, the perspective of momentary justice shows us what is wrong with the claim that we should abandon life-extending treatments for patients above a certain age; it also shows us why egalitarian reasoning does not lead us towards an absolute preference for the worse off in lifetime terms.

## CONCLUSION

As the idea of egalitarianism in healthcare grows more popular in both government policy and social demand, it is vital that we clearly delimit what exactly we mean by “equality.” If we focus only on lifetimes, the language of equality has significant potential to be used to deprive some people of access to fundamental forms of healthcare. At the very least, proponents of equality in healthcare must justify *some* position on the temporal subject, even if it is to reject anything beyond the pure lifetime view. I have suggested that, for some central goods at which healthcare aims, the most plausible position will incorporate momentary sufficientarianism, and will do so in a way that does not allow it to be overshadowed—either in principle or in practice—by lifetime egalitarianism. We cannot ignore momentary claims because they represent a distinctive and irreducible aspect of how we view our lives from within. This does not preclude the importance of lifetime egalitarianism, but should instead complement it.

## NOTES

<sup>1</sup> See also Walzer (1984). Walzer claims that the correct distribution of a particular good is relative to its “social meaning”. My claim is consistent with this, but broader, since I merely argue that distributions should be relative to the *value* of some good, and the role it plays in our lives. That may be socially constructed, but it may not be. In addition, following Gutmann (1995), I do not endorse Walzer’s claim that the principles which regulate different goods are purely internal to that good; as Gutmann says (1995, p. 99) “many relevant moral considerations cut across distributive spheres”.

<sup>2</sup> See Davies, 2015.

<sup>3</sup> The obvious exception to this is for those people who have irreversibly left youth behind. If their lives will be insufficient without intervention, that intervention must be targeted at their old age.

<sup>4</sup> This follows Shields’s (2016, p. 30) contemporary understanding of sufficientarianism as being concerned with what he calls “the shift thesis”: the idea that passing the sufficiency threshold results in a “shift” in the weight of our reasons to confer benefits.

<sup>5</sup> E.g., Casal (2007, p. 321).

<sup>6</sup> This proposal is inspired by Timmerman’s (2004) solution for the parallel problem of whether to save the largest number of people.

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# EQUALITY IN THE ALLOCATION OF SCARCE VACCINES

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## ABSTRACT:

In the event of a pandemic, demand for vaccines may exceed supply. One proposal for allocating vaccines is to use a lottery, to give all citizens an equal chance, either of getting the vaccine (McLachlan) or of surviving (Peterson). However, insistence on strict equality can result in seriously suboptimal outcomes. I argue that the requirement to treat all citizens impartially need not be interpreted to require equal chances, particularly where citizens are differently situated. Assuming that we want to save lives, we should also seek to use vaccine efficiently, so far as this is compatible with equality. Thus, in allocating vaccine, we may want to be sensitive to (i) different levels of need and/or (ii) effects on vaccine production. While such policies may result in unequal chances, they may even improve everyone's chances. In such cases, the resultant inequality is not a violation of impartiality, but a consequence of considering each person's claim seriously.

## RÉSUMÉ :

Dans le cas d'une pandémie, il est possible que la demande pour des vaccins excède l'offre. Une proposition concernant la distribution des vaccins est d'employer une loterie, afin de donner à tous les citoyens une chance égale soit de recevoir le vaccin (McLachlan) soit de survivre (Peterson). Toutefois, l'accent mis sur une stricte égalité peut produire des résultats gravement sous-optimaux. Je soutiens que l'exigence de traiter tous les citoyens de manière impartiale ne doit pas forcément être interprétée comme une exigence d'égalité des chances, particulièrement en ce qui concerne des citoyens qui sont dans des situations différentes. En supposant que nous voulons sauver des vies, nous devrions également viser à employer les vaccins de manière efficiente, dans la mesure où cela demeure compatible avec l'enjeu d'égalité. Ainsi, notre distribution du vaccin devrait tenir compte de (i) différents degrés de besoin et/ou (ii) des effets sur la production du vaccin. Bien que de telles politiques risquent de conduire à une inégalité des chances, elles peuvent néanmoins améliorer les chances de tous. Dans de tels cas, l'inégalité qui en résulte ne va pas à l'encontre de l'impératif d'impartialité, mais découle plutôt d'une considération sérieuse de la demande de chacun.

Questions about equality in healthcare provision are particularly urgent when we consider an emergency situation, such as an influenza pandemic. In such an event, demand for vaccines would exceed supply, at least in the short term. While it has been suggested that the state's primary responsibility should be to reduce the need for rationing (Wynia 2006, p. 6), this is not always possible. We cannot predict what diseases, or strains of diseases, will break out in pandemics and we cannot stockpile vaccines for all possible eventualities. This raises questions as to how the limited vaccine stock should be distributed consistently with the state showing equal concern and respect for all of its citizens.<sup>1</sup>

There are many possible principles for allocating scarce vaccines (Verweij 2009). One common response in pandemic planning is to draw up a hierarchy of priority groups. There is some debate as to whom is appropriately given priority. Many such plans aim to maximize the numbers of lives saved. However, other priority orderings are possible. For instance, it can be argued that it makes more sense to target the young, rather than the old, as this would save more life years (Emanuel and Wertheimer 2006). Others reject most forms of maximizing, arguing that such priority lists fail to show equal concern for everyone. Two authors in particular have argued that, in the event of vaccine shortages, the state should allocate vaccine through some form of lottery (Peterson 2008; McLachlan 2012). I will not attempt to address the fundamental question of what makes a lottery fair, which has been debated extensively elsewhere (Broome 1991; Sher 1980; Stone 2007; Saunders 2008; Vong 2015). For present purposes, I simply assume that a lottery is sometimes a fair way to distribute resources, such as doses of vaccine, when there is not enough for everyone. However, "use a lottery" is not itself a complete answer, but opens further questions as to how the lottery should be conducted.

Martin Peterson (2008) argues, on consequentialist grounds, for a lottery giving different people different chances of receiving a dose of vaccine in order to equalize their chances of survival. Thus, those who would be at greater risk of dying without any intervention are given a greater chance of getting the vaccine, so that their chances of dying are the same as everyone else's (or as close as possible to it). In contrast, Hugh McLachlan (2012, 2015) defends an equal-chance lottery on nonconsequentialist grounds, arguing that this satisfies the state's duty to treat all citizens impartially.<sup>2</sup> Though they concern themselves with different goods (respectively, chances of surviving and chances of getting an effective dose of vaccine) and base their arguments in different moral frameworks (prioritarian consequentialism and nonconsequentialist impartiality), both authors suggest that all citizens deserve an equal chance of receiving the good in question.<sup>3</sup> Both appear to assume that the state's giving equal or impartial consideration to all citizens requires giving them equal chances of something. In Peterson's case, this is more complicated, since he justifies equal chances on the basis that this brings about the best overall consequence. However, it appears that his "chance-prioritarianism" can be understood as an attempt to show equal concern for all individuals, since each individual's chances matter equally (for a given chance).

I agree that the state ought to show equal or impartial concern for all of its citizens. My argument here is that this equal consideration need not lead to giving them equal chances, either of surviving or of getting an effective dose of vaccine. Sometimes we may distribute vaccine (or chances of getting it) such that some people end up with a greater chance than others. This need not be due to objectionable partiality towards some particular group, for it need make no reference to categories such as age, race, or sex.

I consider two examples, each of which presents a plausible case for distributing chances unequally. First, there are cases where some individuals need more vaccine than others. In such cases, we might face a choice between treating one person who needs more of the vaccine or two others who need less.<sup>4</sup> To give everyone an equal chance, by tossing a coin, does not obviously give due consideration to each person involved. It has been argued elsewhere that, if we consider each person's claim equally, then the two should have a greater chance than the one (Kamm, 1985). The requirements of equal consideration in such cases are contested, though. Hence, I introduce a second case, where giving one person a greater chance of getting the vaccine increases everyone's chances of survival. (The particular example is one where prioritizing someone working in the pharmaceutical industry can increase vaccine production.) Giving this person priority is unfair, for the one has no special claim to better prospects than anyone else. Nonetheless, if it does not harm—and actually increases—everyone else's prospects, then it seems like good policy. This can be justified in a way similar to the difference principle (Rawls 1999), which is itself intended to reflect equal concern for all while recognizing that there is nothing to be said for making everyone worse off (Parfit 1997).

While Peterson and McLachlan may be right to reject a policy seeking to maximize the number of lives saved, on the grounds that this will be unfair to some, it does not follow that we should give everyone equal chances. Impartial consideration is compatible with taking efficiency into account, even if the results are contrary to strict equality.<sup>5</sup>

## EQUAL CHANCES AND UNEQUAL NEED

McLachlan argues that the state has a special duty of care towards public health-care providers, who undertake risks at its behest, which justifies giving them priority. But, with this exception, he suggests that other citizens should be given equal chances of receiving an effective dose of vaccine: "If there is not sufficient vaccine to give all other citizens equally an effective dose, the state should give them all an equal chance of receiving an effective dose... This would be the just thing to do because the state has a duty to treat each and all of its citizens impartially and they have a corresponding right to such impartial treatment" (McLachlan 2012, p. 318). This duty of impartiality, he claims, acts as a constraint on state policy and may prevent it from maximizing the number of lives saved. However, it is not obvious that impartiality always requires equal chances, particularly when individuals are differently situated.<sup>6</sup>

Consider a small-scale example that may illustrate this point. Suppose that Alpha is very sick and needs 100 mL of vaccine, while Beta and Gamma have been exposed to the virus but are not yet sick and need only 50 mL of vaccine each as a prophylactic. Suppose further that, as it happens, there is exactly 100 mL of vaccine available. This would be enough to cure either Alpha alone or both of Beta and Gamma. Assume that giving 50 mL to Alpha will produce no benefit whatsoever; it is simply not an effective dose for her. How should one distribute the vaccine in such circumstances?

Though he does not discuss such cases, McLachlan (2012, p. 318) proposes “the random selection of names.” That is, we could put the three names into a hat and draw one out to decide who gets the vaccine, thereby giving everyone a one-in-three chance of getting an effective dose. However, note that if either Beta or Gamma is drawn, there is still enough vaccine left to treat the other. Thus, it would be possible to treat both Beta and Gamma, should either one’s name be drawn, but this means that they each effectively have twice the chance of Alpha.

#### Option 1

Name drawn	Probability	Outcome
Alpha	1/3	Alpha is treated. No vaccine left over.
Beta	1/3	Beta is treated. Leftover vaccine used to treat Gamma too.
Gamma	1/3	Gamma is treated. Leftover vaccine used to treat Beta too.

If the aim is to give all citizens an equal chance of getting the vaccine, in the name of impartiality, then this policy is no good.

One possible solution is to say that any leftover vaccine should be wasted. If Beta is selected by the lottery, then Beta—and Beta alone—should be vaccinated. Though there is also enough vaccine left over for Gamma, it would be unfair to vaccinate her too, for she was in the lottery and lost.

#### Option 2

Name drawn	Probability	Outcome
Alpha	1/3	Alpha is treated. No vaccine left over.
Beta	1/3	Beta is treated. Leftover vaccine is wasted.
Gamma	1/3	Gamma is treated. Leftover vaccine is wasted.

However, the idea that impartiality requires wasting potentially life-saving vaccine seems counterintuitive. The state has a duty to protect all of its citizens. Impartiality matters where it cannot protect all and must therefore choose which citizens to vaccinate, but it would be perverse if it were to discard vaccine simply because it cannot vaccinate everyone. If that were the preferred option, then,

presumably, there would be no need for a lottery to begin with; the state might simply discard all of its vaccine and vaccinate nobody. This might be the fairest solution (Broome 1991, p. 95; cf. Lazenby 2014, p. 335–336), since it guarantees that all citizens get nothing. However, our rejection of this solution shows that we care not only about equality but also about the saving of lives (Piller 2017, p. 215).<sup>7</sup> Thankfully, there is another possibility. Once it is realized that Beta and Gamma can be treated together, they could be given a single lottery ticket. Thus, we can increase everyone’s chance of getting vaccinated (from 33 percent to 50 percent) and avoid waste at the same time.

### Option 3

Name drawn	Probability	Outcome
Alpha	1/2	Alpha is treated. No vaccine left over.
Beta and Gamma	1/2	Beta and Gamma are treated. No vaccine left over.

This proposal gives everyone the greatest equal chance of vaccination (Hirose 2007). While Beta and Gamma had a greater chance under option 1, this came at the expense of inequality, in the form of a much lower chance for Alpha. Note also that, while this particular example concerns only a two-against-one conflict, the same logic would apply in more extreme cases. For instance, suppose Alpha needed 500 mL of the vaccine, while ten other people each needed 50 mL. Again, giving everyone the greatest equal chance of receiving an effective dose of the vaccine would mean, in effect, tossing a coin between Alpha and the other ten.

It is not clear what Peterson’s recommendation would be here. First, it depends on how much priority was assigned to the worse off.<sup>8</sup> Option 1 gives Alpha only a one-in-three chance of survival, whereas Beta and Gamma each have a two-in-three chance of survival, because both of them can be rescued together. Option 3 would increase Alpha’s chances, from one in three to one in two, but both Beta and Gamma would see their chances fall, from two in three to one in two. Prioritarianism tells us that more weight, or value, should be given to the prospects of the worse off (Alpha). Thus, if the choice were simply between Alpha and Beta, prioritarianism would recommend reducing Beta’s chances of survival in order to increase Alpha’s (up to the point at which Alpha is as well off as Beta). However, whether it is worth reducing the chances of two people (Beta and Gamma) by one in six in order to increase Alpha’s chances by one in six depends on how much priority Alpha is given. If we give only very weak priority to Alpha, then her gain may not be enough to outweigh the gain to Beta and Gamma. Second, it is unclear whether (priority-weighted) chances are the only good to be considered in Peterson’s consequentialist framework, or whether they must be balanced against conventional utility when the best overall consequences are being determined. If the latter, this would be a further reason to favour policies saving more people.

Given the indeterminacy of Peterson's proposal in such cases, the immediate discussion will focus primarily on McLachlan (though some of the later discussion is relevant to Peterson too). McLachlan does not explicitly discuss cases such as these, where there are differing levels of need. It is possible that he might consider need a relevant difference between individuals, thereby justifying differential chances. However, if this were so, then it might be justifiable to aim at maximizing the number of lives saved, and McLachlan clearly rejects this. He explicitly accepts that impartial treatment of all citizens might result in worse outcomes (2012, p. 317). Thus, it seems likely that he would favour option 3 over either option 1 (which gives some better chances than others) or option 2 (which, by being wasteful, is worse for everyone).

If this is McLachlan's position, this is interesting, since this has not been a popular solution to the analogous "numbers problem" posed by John Taurek (1977), in which a rescuer must choose between saving one person or two others. While consequentialists take the solution to be obvious (save the greater number), most nonconsequentialists who have considered this problem also think that numbers matter in some way. Some have sought to argue for a policy of saving the greater number on nonconsequentialist grounds (Scanlon 1998, p. 229–241; Hirose 2004), while others have advocated weighted lotteries that give larger groups a greater chance of rescue (Timmermann 2004; Saunders 2009). There are some who defend positions close to this, though few, if any, hold that groups of unequal sizes must be given equal chances. Taurek (1977, p. 306) suggests that, when faced with a choice between saving one person or five others, then, other things being equal, he would give each an equal chance by tossing a coin. However, he does not argue that this is obligatory; since he thinks it permissible to save either group, it could be that he considers the situation to be like that facing Buridan's ass. Other authors argue that tossing a coin is better than a weighted lottery (Hirose 2007; Huseby 2011), but they generally think that saving the greater number is better still (Hirose 2004; Huseby 2012). Broome (1998) argues that tossing a coin between groups of different sizes may be fair, because it gives everyone an equal chance of survival, but denies that this is what must be done all things considered, since sometimes (in his view) the extra value of saving more lives, without a lottery, outweighs the unfairness of doing so. Hence, if this is McLachlan's position, it is not a popular one, even among nonconsequentialists.

While I cannot review all of the now-extensive literature on this "numbers problem" here, it should be noted that the various solutions proposed can be (and often are) defended as alternative interpretations of equal or impartial concern for all involved. For instance, Frances Kamm (1985) and Jens Timmermann (2004) have each defended proposals analogous to option 1 here. Though this proposal does mean that some will have a greater chance of being saved than others, it can be seen as giving each an equal "baseline chance" (Kamm 1985, p. 185). Circumstances may be such that, after Beta has been picked, it is still possible to save Gamma, but this does not necessarily justify depriving Gamma of her own independent chance. Scanlon (1998, p. 232) claims that Gamma could

reasonably reject any procedure for vaccine allocation that effectively ignores her presence by treating the choice between Alpha on the one hand and Beta and Gamma on the other the same as a choice simply between Alpha and Beta.<sup>9</sup>

To settle on the best account of impartial treatment in such cases is beyond the scope of the present article. My aim is simply to point out that the requirements of impartiality are hotly contested. Moreover, one cannot simply assume that impartial treatment will result in people getting equal chances of vaccination (as McLachlan does) or equal chances of survival (as Peterson does). We might arrive at unequal chances without showing any partiality for particular individuals.

### FURTHER OPTIONS

Continue to assume that we have 100 mL of vaccine, all of which Alpha needs, but which is also enough to treat both Beta and Gamma. Since there is enough for Beta and Gamma, there is at least a *prima facie* case for treating this as two 50 mL doses of vaccine, though it happens that Alpha needs a double dose. It is not obvious that Alpha's chances of getting a double dose should be equal to Beta's chances of getting one dose. We might, instead, implement a two-stage procedure.

#### Option 4

Allocate the first dose by lottery, giving each person a one-in-three chance of receiving it. Then allocate the second dose by lottery, between those still in need. This means that if either Beta or Gamma won the first lottery, they would no longer be in need and the second lottery would be fifty-fifty between the remaining two. However, if Alpha won the first lottery, she would still be in need, so the second lottery would also give each of the three a one-in-three chance to receive the second dose.

Alpha will survive only if she wins both lotteries, so her chance of survival is one in nine. Beta and Gamma are symmetrically situated, and each have an eleven-in-eighteen chance of survival.<sup>10</sup> In this case, the chances of Beta surviving are over five times greater than the chances of Alpha surviving, even though they each were given an equal chance to get each dose of drug that they needed.

One oddity of this policy is that it might give Alpha the second dose of the drug, even when she did not win the first, even though this is (by hypothesis) useless to her. Thus, this policy is wasteful, by which I mean not simply that it does not maximize the number of lives saved, but that it may give one (and only one) dose of vaccine to Alpha, though this will do no good. To illustrate this, suppose that Gamma wins the first dose. In this case, we may think that there is no point in holding a second lottery. Though Alpha and Beta are both still needy, the remaining dose is no use to Alpha, though it would save Beta. Hence, we might prefer a policy that avoids this waste, which I call option 5.

### Option 5

Allocate the first dose by lottery, giving each person a one-in-three chance of receiving it. If Alpha wins the first dose, then allocate the second dose by lottery, giving each person a one-in-three chance of receiving it. However, if Beta wins the first lottery, give the second dose to Gamma, since it is no use to Alpha. And, conversely, if Gamma wins the first lottery, give the second dose to Beta.

Again, Alpha gets the two doses needed only if she wins both lotteries, which is a one-in-nine chance. Here, however, Beta and Gamma have even better prospects, since there is no danger of wasting the second dose. Their chances of survival are now seven in nine, since Beta will certainly be saved either if she wins the first lottery (one in three) *or* if Gamma wins the first lottery (one in three) *or* if Alpha wins the first lottery but she (Beta) wins the second lottery (one in nine).

Compared to option 4, this option is what economists term a “Pareto improvement.” It is no worse for anyone—Alpha’s chances of survival are not reduced—but this option improves the prospects of both Beta and Gamma. It does this by eliminating the chance of wastefully giving the second dose to Alpha in cases where she did not win the first dose (this does not make Alpha worse off, in terms of health outcomes). Note, however, that this is not simply a maximizing strategy; while Beta and Gamma each enjoy a greater chance of survival than Alpha, they are not automatically saved. Furthermore, option 5 still involves some risk of the *first* dose being wasted, since Alpha may win that but not the second. Since this is still wasteful, we might prefer a policy that avoids this too.

### Option 6

Allocate the first dose by lottery, giving each person a one-in-three chance of receiving it. If Beta wins the first dose, then give the second to Gamma, and vice versa. So far, this is the same as option 5, but, if Alpha wins the first dose, then give her the second dose too, in order to avoid waste. (This is option 1 from the previous section.)

Here, Alpha has a one-in-three chance of survival, whereas Beta and Gamma each have a two-in-three chance of survival (because if either of them wins the first lottery, then, in effect, they both win). This is better for everyone than option 4 is; however, for Beta and Gamma it is worse than option 5. Even though it is more efficient, by reducing any chance of waste, their chances of survival are reduced from seven in nine to six in nine. However, this loss is necessary in order to improve Alpha’s chances of survival. Furthermore, Beta and Gamma are still twice as likely to survive as Alpha is. This itself might be thought objectionably unfair. There is, however, another policy option that gives all three an equal chance of survival.



## Option 7

Since giving the first dose to Beta will mean giving the second to Gamma, and vice versa, they can effectively “share” chances (cf. Hirose 2007, p. 50). Thus, allocate both doses together, giving a 50 percent chance to Alpha and a 50 percent chance to Beta and Gamma. (This is option 3 from the previous section.)

This way, everyone has a 50 percent chance of survival (or of receiving an effective dose of vaccine). Furthermore, no vaccine is ever wasted, unlike in options 4 and 5. However, this option is inefficient when judged on the expected consequences, for the expected number of lives *lost* is 1.5, and it can also be argued that it is unfair to Gamma, since her presence makes no difference to the procedure (Scanlon 1998, p. 232).

This is not an exhaustive list of options. Two others worth mentioning are (i) a policy that aims to maximize the total number of lives saved by giving the vaccine to Beta and Gamma without a lottery and (ii) a policy that gives the drug to no one, which would be perfectly equal but highly inefficient. Since these can be taken to represent opposing ideals—one giving absolute priority to efficiency over equality, and the other absolute priority to equality over efficiency—they are useful options to consider. I label the maximizing policy option 8 and the policy of leaving everyone to die option 9.

These six policies, along with their consequences, can be summarized as follows. For ease of comparison, I have expressed each person’s chance of survival in eighteenths, even though some fractions could be simplified (e.g., six eighteenths to one third).

### COMPARISON OF OPTIONS 4 THROUGH 9

Policy	A’s chance	B’s chance	C’s chance	Inequality?	Wasteful? (Probability)	Expected deaths
Option 4	2/18	11/18	11/18	Y	Y (5/9)	1.67
Option 5	2/18	14/18	14/18	Y	Y (2/9)	1.33
Option 6	6/18	12/18	12/18	Y	N	1.33
Option 7	9/18	9/18	9/18	N	N	1.5
Option 8	0/18	18/18	18/18	Y	N	1
Option 9	0/18	0/18	0/18	N	Y (1)	3

If our *only* concern were fairness or equality, then we might choose option 9, though it is highly suboptimal (everyone dies). Assuming that we wish to save lives, we should seek an option that saves as many lives as possible consistent with impartial treatment. McLachlan (2012, p. 318) agrees with this, though he thinks impartial treatment precludes option 8. As we saw in the previous section,

McLachlan might endorse what is here option 7, since this gives each person the greatest chance of receiving an effective dose of vaccine compatible with everyone else receiving the same chance. However, while this is egalitarian and does not involve gratuitous waste, it also involves more expected deaths than either option 5 or option 6. Thus, if our aim is indeed to save as many lives as we can, consistent with impartial treatment, we ought to consider whether either of these options is consistent with impartiality.

I think a case could be made that option 5 reflects impartial concern for all, since it gives each person who can potentially benefit from a dose of vaccine an equal chance of receiving that dose. (Thus, Alpha gets a chance of receiving the first dose, but no chance of receiving the second if she did not get the first, as then she can no longer benefit.) However, Alpha might object that requiring her to compete for each dose separately results in her having a *much* lower chance of getting the vaccine that she needs than either Beta or Gamma. Holding separate lotteries might be said to exacerbate her initial misfortune in needing more.

It is not clear whether the same objection can be made to option 6 though. Here, the first dose is allocated via an equal-chance lottery, then the second dose allocated in whatever way avoids waste (which means it goes to Alpha if she won the first lottery, but not to her if she did not). To be sure, her chances of getting an effective dose are lower than the chances of Beta and Gamma doing so, but it could be argued that this reflects their lesser need, rather than partiality in the system.<sup>11</sup> While Alpha's disadvantage could be mitigated, by the adoption of option 7, we have already seen that this option could be criticized for failing to show proper concern for Gamma (Scanlon 1998, p. 232). Though a weighted lottery has the effect that some are more likely to survive than others, it can also be seen as showing impartial concern for each individual.

I do not propose to settle, here, the best interpretation of impartiality. My argument, thus far, is merely that this is more complex and contested than McLachlan's references to equal chances would have us believe. Indeed, showing impartial (or equal) concern for everyone does not necessarily require giving them equal chances of anything. It may be that equal concern leads to unequal outcomes. We might read McLachlan's proposal to prioritize healthcare workers as a tacit admission of this point, though it is not clear to me whether he takes this to be compatible with impartial treatment or a justifiable departure from impartiality. In any event, there are other cases where it seems we might want to depart from strict equality or impartiality. An obvious example is where an unequal distribution would make everyone better off.

## IMPARTIALITY AND FECUNDITY

In the previous section, I posited a natural inequality (in need) and illustrated how this may result in reasonable disagreement about the requirements of equal consideration. In this section, I wish to consider a different complexity—a case where bestowing the vaccine on one person increases the chances that others

can benefit. I call this fecundity, since one benefit produces further benefits. For example, suppose that Alpha is involved in the pharmaceutical industry in the manufacture of vaccines. If Alpha receives an effective dose of vaccine, then the supply of vaccine will be increased. In such circumstances, it may be reasonable to give Alpha a greater chance of getting some of the initial vaccine, because doing so need not reduce—and may increase—everyone else’s chance of getting the vaccine.

Suppose we have ten individuals, labelled Alpha through Kappa, and two doses of vaccine. With no relevant differences among individuals, it would seem reasonable to allocate the vaccine randomly, giving an equal chance (20 percent) to each individual. But what if Alpha works in the manufacture of vaccine? Let us suppose that if she receives one of the two initial doses, whether as a result of a lottery or not, then she can produce two further doses, which can be randomly allocated among the remaining individuals. Should this alter our distribution and, if so, how?

### Option 10

One option is to say that Alpha should not enjoy any special privilege as a result of her occupation. She is no more likely to be exposed to infection than anyone else, so Peterson’s proposal that those at greater risk should have greater chances of getting the vaccine, in order to equalize their chances of survival, does not apply. Similarly, McLachlan’s suggestion that the state must protect those health-care workers who assume risk in their occupation does not apply. Thus, it may seem that Alpha should not enjoy any greater chance of receiving the vaccine than anyone else, even though giving her a greater chance could result in more lives saved. This option looks, at first sight, as though it would treat others unfairly.

However, first appearances are deceptive here. Suppose that one refuses to give Alpha any special privilege and runs the lottery as before, giving each individual a 20 percent chance of survival. In this case, Alpha has a 20 percent chance of survival, but the others actually have a greater chance of survival. Since the other nine individuals are identically situated, it will suffice to consider only Beta. Beta, like Alpha, has a 20 percent chance of receiving one of the two initial doses of vaccine. However, Beta also has an additional chance of being saved because, if Beta does not receive one of the initial doses, but Alpha does, then Beta might receive one of the two additional doses that Alpha will produce.

There is an 80 percent chance that Beta will not get one of the initial doses. In two ninths of those cases, where Beta does not get a dose, Alpha does.<sup>12</sup> There is an almost 18 percent (sixteen-in-ninety) chance that Alpha will get a dose and not Beta. In these cases, there will then be two extra doses and eight people still in need. So, in these cases, Beta will now have a one-in-four (25 percent) chance of getting one of these extra doses. That means that Beta enjoys an extra four-in-ninety chance of survival. Therefore, her overall chances of survival are

twenty-two in ninety, which is higher than Alpha's eighteen-in-ninety chances because, self-evidently, Alpha can never be the one to benefit from her producing the extra vaccine.

This seems unfair. While each individual receives the same 20 percent chance of getting one of the *initial* vaccine doses, Beta has a greater chance of receiving a vaccine dose than Alpha, because Beta gets a second chance to benefit if Alpha survives. Refusing to give Alpha any extra chance not only reduces the overall good that can be done, but also consigns her to a lower chance of survival than anyone else. Even if our aim is merely to give everyone an equal chance of receiving an effective dose of vaccine, we might seek to “compensate” Alpha for this, by giving her a higher chance of getting one of the initial doses. Doing this has two benefits. First, we can give Alpha the same chances of survival as everyone else. Second, by making it more likely that Alpha survives—and hence more likely that the two additional doses of vaccine are produced—we make it more likely that more lives are saved.

### Option 11

Alpha is given a 25 percent chance of receiving one of the two initial doses of vaccine. The other nine have their chances of receiving one of these doses reduced accordingly (to 19.44 percent). However, while Beta has a lesser chance of getting one of the *initial* doses, she is more likely to benefit from a second chance, because it is more likely that Alpha will survive. In fact, Beta's overall chances of survival also come to 25 percent, the same as Alpha.<sup>13</sup>

This option rectifies the inequality in option 10 by increasing Alpha's chances of getting one of the initial vaccine doses. Further, because this also increases the probability that Alpha can produce additional vaccine, it actually increases everyone's chances of survival. True, Beta's chances are not increased to the same extent as Alpha's. Beta sees an increase only from 24 percent to 25 percent, while Alpha's chances increase from 20 percent to 25 percent. But this is because Beta already enjoyed a greater chance than Alpha in option 10 (24 percent as opposed to 20 percent), which is precisely what seemed unfair about it. Option 11 redresses this inequality without making Beta and the others worse off. Presumably, then, all ten individuals involved would prefer option 11 to option 10, since it increases their chances of survival.

I assume that both Peterson and McLachlan would prefer option 11 to option 10. Whether we are concerned with equalizing individuals' chances of survival or their chances of getting an effective dose (which, given my simplifying assumptions, amount to the same thing here), option 11 results in equal chances. The lesson, however, is that we might have to weight the lottery, giving some more chance than others of winning the lottery, in order to equalize everyone's chances of getting the vaccine. We cannot simply assume that an equiprobable lottery gives each person the same chance of receiving the vaccine when the outcome of the lottery also influences how much vaccine is available.

However, while option 11 is an improvement on option 10, it is not the best that we can do from the point of view of efficiency. Since giving one dose to Alpha will result in two additional doses, more than replacing what was used, it is possible to increase everyone's chances still further.

### Option 12

Give the first dose to Alpha, without a lottery. Allocate the other of the initial doses, and the two extra doses produced by Alpha, by lottery, giving each of the other nine individuals an equal chance. Allocating three doses between nine people means that each has a one-in-three (33.33 percent) chance of receiving a dose of vaccine.

If we do this, then there is a further Pareto improvement: everyone's chances of survival are increased. However, once again, Alpha enjoys a larger share of the benefit than the other nine. The result is that we depart from the equality of option 11. In this case, Alpha receives the vaccine for certain, which makes her much more likely to benefit than anyone else. The fact that Alpha's survival is instrumentally useful does not give her any greater claim to the vaccine, though. Thus, while it may be rational for all involved to consent to Alpha receiving one of the initial doses, it is nonetheless unfair (Broome 1991). It is an unfairness that we should almost certainly tolerate, since it increases everyone's chances of receiving the vaccine, so to insist on equality would represent a particularly harsh form of levelling down (Parfit 1997, p. 211). If we are prepared to compromise equality for the sake of efficiency by allocating the vaccine by lottery in the first place, rather than giving it to no one, then we ought also to prioritize efficiency here.

In fact, Peterson seems clearly committed to this conclusion, since he rejects equality as a moral ideal, on the grounds that it may require levelling down, and instead endorses a form of prioritarianism (2008, p. 324–325). According to prioritarianism, a benefit of given magnitude produces more moral value when given to someone who is worse off than someone who is better off. This diminishing marginal value of benefits favours an equal distribution of benefit where the total amount of benefit is fixed and benefits can be reallocated without cost. For example, the prioritarian will think a world where everybody has \$10 better than a world where half have \$5 and half have \$15, because giving \$5 to the poorer people produces more moral value than is lost when it is taken from the rich. However, the prioritarian denies that there is any gain to be had by making the rich poorer. If we were unable to make the poor any better off, but we could reduce everyone to having \$5, then those who value equality as such seem committed to thinking that this would be in one respect good, since it would be more equal (Parfit 1997, p. 210–211). The prioritarian, in contrast, thinks that this would be an unmitigated loss.<sup>14</sup> Though we are presently concerned with distributing (chances of getting) a vaccine, rather than money, the same is true here. There is simply nothing to be gained from making the better off (Alpha) worse off, if we cannot thereby improve the lot of the worse off.

McLachlan's attitude is harder to predict. On the one hand, McLachlan is clearly committed to the value of equality, even when it results in more deaths (McLachlan 2015, p. 193). On the other hand, his case for giving everyone equal chances is that the state ought to treat its citizens "the same in relevant respects *unless there are relevant reasons for treating them differently*" (McLachlan 2012, p. 317, emphasis added). When he introduces priority for frontline healthcare workers, he refers to there being "at least one relevant reason for treating some citizens differently" (McLachlan 2012, p. 318)—namely, the fact that their occupation puts them in danger. This reason does not extend to those whose work involves production of vaccines who, I assume, are at no greater risk of infection than anyone else. Nonetheless, it is possible that the case I am considering, in which giving Alpha priority benefits everyone else, represents another relevant reason to depart from equal chances. Further, he suggests that, "if all rational people could be expected to favour a particular policy [this] might be an indication that a policy is impartial" (McLachlan 2015, p. 194), though he suggests that this may be neither necessary nor sufficient to establish impartiality.

I would suggest that, if we find ourselves in these circumstances, we ought to favour option 12. If we take the perspective of those involved, then what they care about is maximizing their own chances of survival. They ought not to care what chances others have, except insofar as those chances affect their own chances. (Indeed, if anything, they ought to welcome more others surviving along with them.) It would not help Beta to reduce Alpha's chances of survival if this did not increase Beta's chances, and this is true *a fortiori* where Beta's chances are actually lessened. To reduce everyone's chances for the sake of equality would be to make a fetish of equality. The only reason to care about equality is that we are distributing a good, hence people should prefer inequality if it means more of that good for all.

This situation is similar to Rawls's famous original position (Rawls 1999, p. 15–19). Here, Rawls assumes that parties are concerned only with their absolute position and not with how they stand relative to others. Thus, he proposes that they would reject strict egalitarianism in favour of the difference principle, which permits inequalities that benefit all (*ibid*, p. 65–73).<sup>15</sup> Rawls intends the difference principle to apply to the basic structure of society and only to certain goods (*ibid*, p. 6–10). Nonetheless, my proposal is an application of similar reasoning to the problem at hand. That is, I suggest that vaccine ought to be distributed equally unless an unequal distribution benefits everyone. This policy satisfies the requirement to treat everyone impartially. It explains why we should prefer allocating effective doses of vaccine by lottery to giving everyone an equal but ineffective share of the vaccine. And it also tells us that if prioritizing Alpha improves everyone's chances of survival, this is what we should do.

Note that, while I have focused on what might be termed a "positive" case—where there is a reason to prioritize Alpha because she can produce more vaccine and thereby increase the number of people vaccinated—there is also a parallel

“negative” case for prioritization, where leaving someone unvaccinated would increase danger to others. Some groups may be more likely to spread infection than others. For example, the homeless—because they are more likely to move around—may increase risk to others (Buccieri and Gaetz 2013, p. 189–190). Suppose we have five individuals, each of whom has an equal chance of being one of three who will be infected, but we have only one dose of vaccine. Allocating that vaccine by lottery gives each person a 20 percent chance of protection and a 48 percent chance of being infected without vaccination. But now change our assumptions. Suppose that if we were to give the vaccine to Delta, a homeless person, the spread of disease would be reduced and only two people would be infected. The other four would be denied the vaccine, but their chances of infection would be reduced to 40 percent.<sup>16</sup> Again, it would be rational for all to agree to this prioritization, since everyone’s chances of avoiding infection would be increased. To be sure, Delta may seem a less “worthy” candidate for prioritization than Alpha, because Delta exposes others to risk, rather than providing protection. The homeless, like many other at-risk groups, are stigmatized, and this may affect public attitudes towards such prioritization (Kaposy and Bandrauk 2012). However, statistically, the cases are equivalent. More people will contract infection if Alpha (in the first example) or Delta (in the second example) is not vaccinated. The case for prioritizing them has nothing to do with their moral worth or desert, but simply with the fact that giving them the vaccine improves everyone else’s chances.

The lesson, I suggest, is that equal consideration of everyone does not necessarily mean giving everyone equal chances. As pointed out above, giving everyone equal chances is compatible with giving everyone zero chance, but this would be equal neglect, rather than equal concern. If we are to show not only equal but also *maximal* concern for each person, then we ought to favour increasing each person’s chances of survival, whenever it is possible to do so consistent with similar concern for others.

It might be worried that this would inevitably lead to a form of consequentialism according to which we ought to show equal concern and respect for all by maximizing the number of lives saved (other things being equal).<sup>17</sup> This is not so. I believe that consequentialism is best understood as offering another interpretation of impartial concern for all. However, consequentialists focus on the good of all as a collective, rather than on the good of each.<sup>18</sup> Thus, they ignore the separateness of persons (cf. Rawls 1999, p. 23–24). If one focuses only on maximizing total prospects of survival, then it makes no difference whether we increase Alpha’s chances or Beta’s. The impartial consequentialist is indifferent between giving them each a 50 percent chance, on the one hand, and giving Alpha a 100 percent chance and Beta no chance at all, on the other. Moreover, consequentialists would prefer a world in which Alpha has a 90 percent chance and Beta a 20 percent chance, since it increases the overall good. However, the distribution of chances does matter to the individuals concerned. If Beta’s chances are reduced from 50 percent to 20 percent, it is no compensation to her that Alpha enjoys a greater increase, from 50 percent to 90 percent.

Thus, Beta may have reasonable grounds to reject a principle that treats this simply as an improvement. Perhaps there is a point at which Beta ought to accept a loss because what others have at stake is greater. For example, maybe Beta should accept her chances being reduced from 50 percent to 49 percent if we can thereby increase Alpha's chances from 50 percent to 99 percent. But Beta is not required to be perfectly indifferent between her own chance to receive the vaccine and Alpha's. Hence, we might reject consequentialism as failing to show due concern for each person.

A rejection of consequentialism should not, however, be confused with a rejection of efficiency. The difference between consequentialists and nonconsequentialists is a difference about *why* particular choices are right or wrong (McLachlan 2015, p. 193). In very many cases, they agree about what is right or wrong. Thus, we should not assume that any policy aiming to maximize the number of lives saved is necessarily consequentialist and reject it for that reason. Peterson (2008) demonstrates that not all consequentialists will favour maximizing the number of lives saved. Conversely, some nonconsequentialists may favour a policy that seeks to maximize the number of lives saved (Scanlon 1998). As long as everyone stands to benefit from the adoption of this policy, even if not necessarily benefiting equally, it may be that this is what would follow from a nonconsequentialist approach to morality, such as Scanlonian contractualism.

## CONCLUSION

I do not offer a complete policy recommendation for allocating vaccines. My point is merely that the proposal to give "equal chances" to everyone is not as simple or as appealing as it first appears. Any policy will have to be sensitive to differences, in need and productive capacity, between people. Otherwise, what initially looks like equal chances might turn out to give some people a much greater chance of survival than others. However, once these considerations are admitted as relevant, we face a question as to how they ought to be balanced against equality. I have tentatively suggested that we ought to prefer unequal situations when everyone is better off. To privilege a strictly equal allocation here, by passing up opportunities for Pareto improvements, is to engage in leveling down. Thus, while I believe that policymakers should show equal concern for all citizens, I suggest that this may permit, or even require, departures from equality in the distribution of (chances of getting) vaccine.



## NOTES

- <sup>1</sup> I confine myself to a case of a single state allocating doses of vaccine amongst its citizens (or residents). Given that a pandemic is likely to cross state boundaries, there are further questions about whether the state is justified in prioritizing its own citizens at all or whether it may be required to distribute vaccines to foreigners. I do not address these matters here, although I think there may sometimes be a case for giving vaccines to noncitizens/nonresidents.
- <sup>2</sup> More precisely, McLachlan (2012, p. 318) suggests that the state should first of all prioritize public healthcare workers, and then give everyone else an equal chance of receiving an effective dose of the vaccine. It is not clear whether he intends this to extend to nonprofessional workers who support healthcare provision (see Draper et al. 2010). In any case, I set aside this qualification and focus only on the lottery stage.
- <sup>3</sup> McLachlan (2015, p. 192–193) remarks, “The point is not to distribute the vaccine (or anything else) impartially or equally but to treat citizens justly. Citizens have a moral right to be treated impartially that corresponds to the moral duty of the agents of the state to treat them impartially.” This sounds more hospitable to the claims made in this paper but, at least in his 2012 paper, he gave the impression that impartial treatment requires equal chances.
- <sup>4</sup> Note that “needy” here refers only to how much vaccine each needs; they are no worse off in terms of the potential harms that they face, for they each will die if they do not get the vaccine that they need.
- <sup>5</sup> My position is that the state owes citizens something like equal consideration or treatment as equals, but this need not require giving them equal amounts of anything, be it vaccine, chances of vaccine, etc. I believe this point is relatively familiar in discussions of distributive justice—besides Rawls (1999), see also Anderson (1999), Dworkin (2000), and Scheffler (2003). Thus, the novelty of the present paper lies not in making this general point, but in applying it to the allocation of vaccines and thereby challenging the assumption, common to Peterson and McLachlan, that citizens must be given equal chances of something.
- <sup>6</sup> One might also make a stronger claim: that equal chances are not even *compatible* with impartiality, since using a lottery leads to unequal outcomes. Even though a lottery is fair in some sense, it generates outcome unfairness.
- <sup>7</sup> Some, such as Hooker (2005, p. 340–341) and Saunders (2010, p. 45–49), suggest that fairness consists not simply in equal or proportionate satisfaction, but in greatest equal or proportionate satisfaction. On such a view, wasting vaccine is not merely suboptimal, but also unfair. On Broome’s view, it is bad all things considered, because suboptimal, but not unfair.
- <sup>8</sup> Peterson does not elaborate on the degree of priority to be given to the worse off. He argues (2008, p. 325) that prioritarianism requires equalizing chances, but this is only so in “zero-sum” contexts, where we can take some chance from one person and give it (the same amount) to another. It is not true where numbers are unequal (2008, p. 327), as in cases like the present one, where reducing Alpha’s chances in favour of Beta and Gamma produces a higher overall total.
- <sup>9</sup> Though, for objections to Scanlon’s argument, see Lang (2005, p. 330) and Saunders (2009).
- <sup>10</sup> This is the sum of (i) their chance of winning the first lottery (1/3), plus (ii) their chance of winning a second lottery when Alpha wins the first (1/9), plus (iii) their chance of winning a second lottery when the other of them wins the first (1/6). These can be converted into chances out of 18 as follows:  $6/18 + 2/18 + 3/18$ , which sums to  $11/18$ .
- <sup>11</sup> The mere fact that Alpha has a lower chance of getting an effective dose does not show objectionable partiality. Suppose there were only 80 mL available. In this case, presumably we should toss a coin between Beta and Gamma, giving Alpha no chance (as to give her the vaccine would be wasteful). Here, Alpha would have no chance at all of getting an effective dose of

vaccine, but this is because of her greater need, rather than because the allocation is partial. A similar argument might be made on behalf of option 6. Alpha's lesser chance is the result of her greater need, not partiality.

- <sup>12</sup> There are ninety possibilities in all ( $1/10 \times 1/9$ ). Each individual has an  $18/90$  chance of getting one dose, made up of the  $9/90$  chance of being drawn in the first lottery and the  $9/90$  chance of being drawn in the second. However, of the 18 cases in which Beta gets a dose, 2 also involve Alpha getting the other dose. Thus, the chance of Alpha getting a dose and Beta not is  $16/90$ .
- <sup>13</sup> Consider 144 possibilities. Alpha gets an initial dose in 36 out of 144 cases. Of the 108 out of 144 in which Alpha does *not* get one of the initial doses, Beta will get a dose in 24 of them (2 out of 9). Meanwhile, of the 36 where Alpha does get an initial dose, Beta gets the other initial dose in four of them (1 out of 9). These sum to give Beta a  $28/144$  (or 19.44 percent) chance of receiving an initial dose. Now consider the 32 cases where Alpha gets an initial dose, but Beta does not. In eight of these (one in four), Beta will get one of the extra doses. Thus, Beta's overall chances of survival increase from  $28/144$  to  $36/144$ , or 25 percent.
- <sup>14</sup> Matters are trickier where redistribution involves some loss. For instance, if we can go from \$5 and \$15 to \$8 and \$10. Here, taking \$5 off the rich produces only a \$3 gain for the poor and some loss (perhaps because higher taxes are a disincentive). Whether this is an all-things-considered moral improvement depends on how much priority is given to the worst off. Some prioritarrians may favour this, while others may not.
- <sup>15</sup> In canonical formulations, Rawls focuses on benefits to the worst off, but if the comparator is perfect equality, then we can benefit the worst off only by benefiting everyone. Rawls (1999, p. 72) also introduces a "lexical" interpretation of the difference principle, according to which we should allow Paretian benefits to the better off. If we follow this line, then we should accept a policy that increases the chances of some, provided that it does not diminish anyone else's chances. I thank an anonymous referee for pushing me on this point.
- <sup>16</sup> Note that I am focusing on the chance of survival, rather than on the chance of receiving a dose of vaccine. McLachlan (2012, p. 318) argues that the state should concern itself with distributing vaccine, rather than chances of survival. However, this is criticized by Wardrope (2012), and McLachlan (2015, p. 192-193) seems to partly concede the point that vaccine is not an end in itself.
- <sup>17</sup> The "consequentialism" that I am concerned with here is the traditional sort concerned with maximizing a sum of individual goods (e.g., welfare). There are other forms of consequentialism, such as Peterson's, that focus on other values.
- <sup>18</sup> This is the mode of reasoning apparently underpinning the UK government's 2007 *Responding to Pandemic Influenza: The Ethical Framework for Policy and Planning*, which McLachlan (2012, p. 317) opposes.

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# RELATIONAL EGALITARIANISM AND THE GROUNDS OF ENTITLEMENTS TO HEALTHCARE

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## **ABSTRACT:**

In recent years, a number of philosophers have argued that much theorizing about the value of equality, and about justice more generally, has focused unduly on distributive issues and neglected the importance of egalitarian social relationships. As a result, relational egalitarian views, according to which the value of egalitarian social relations provides the grounds of the commitment that we ought to have to equality, have gained prominence as alternatives to more fundamentally distributive accounts of the basis of egalitarianism, and of justice-based entitlements. In this paper, I will suggest that reflecting on the kind of explanation of a certain class of our justice-based entitlements that relational egalitarian considerations can offer raises doubts about the project, endorsed by at least some relational egalitarians, of attempting to ground all entitlements of justice in the value of egalitarian social relationships. I will use the entitlement to healthcare provision as my central example. The central claim that I will defend is that even if relational egalitarian accounts can avoid implausible implications regarding the extension of justice-based entitlements to health care, it is more difficult to see how they can avoid what seem to me to be implausible explanations of why individuals have the justice-based entitlements that they do. To the extent that I am correct that relational egalitarian views are committed to offering implausible explanations of the grounds of justice-based entitlements to healthcare, this seems to me to provide at least some support for a more fundamentally distributive approach to thinking about justice in healthcare provision.

## **RÉSUMÉ :**

Au cours des dernières années, certains philosophes ont avancé qu'une grande part de la théorisation sur la valeur de l'égalité, et la justice de façon plus générale, s'est concentrée de manière excessive sur des enjeux distributifs et a, par là même, négligé l'importance des relations sociales égalitaires. Par conséquent, les approches relationnelles de l'égalité, selon lesquelles la valeur des relations sociales égalitaires constitue le socle de l'engagement qui doit être pris envers l'égalité, ont pris du terrain en tant qu'alternatives à des explications plus fondamentalement distributives de la base de l'égalitarisme et de l'admissibilité fondée sur la justice. Dans cet article, je propose qu'en réfléchissant au type d'explication d'une certaine catégorie de droits fondés sur la justice que peuvent offrir des considérations liées à l'égalitarisme relationnel, on peut remettre en doute le projet, auquel souscrivent certains partisans de l'égalitarisme relationnel, de baser tous les droits fondés en justice sur la valeur des relations sociales égalitaires. Comme exemple principal, je prendrai le droit à l'accès aux soins de santé. Je défendrai l'argument central suivant : même si les explications relationnelles de l'égalitarisme peuvent éviter des implications peu plausibles quant à l'extension de droits fondés sur la justice aux soins de santé, elles peuvent toutefois plus difficilement éviter ce qui me semble être des explications invraisemblables des raisons pour lesquelles les individus possèderaient de tels droits. S'il est bien vrai que les conceptions de l'égalitarisme relationnel sont contraintes à offrir des explications invraisemblables du fondement en justice des droits aux soins de santé, il me semble que cela offre au moins un certain soutien à une approche plus fondamentalement distributive pour penser les enjeux de justice dans l'accès aux soins de santé.

## INTRODUCTION

In recent years, a number of philosophers have argued that much theorizing about the value of equality, and about justice more generally, has focused unduly on distributive issues and neglected the importance of egalitarian social relationships.<sup>1</sup> The distributive theorists that these “relational egalitarians” criticize typically begin from an account of the currency of justice (for example, welfare, resources, primary social goods, or capabilities), and proceed to articulate principles to govern the distribution of that currency (for example, equal distribution, priority for the worse off, equal opportunity, or sufficiency).<sup>2</sup> Egalitarian distributive theorists typically hold that equal distribution of the currency of justice is a baseline that can be deviated from only given a sufficient justification.<sup>3</sup> For my purposes in this paper, the most important feature of distributive views is that they explain individuals’ entitlements to particular resources and socially provided services, at least in part, in terms of more general entitlements to shares in the currency of justice. And since entitlements to shares in whatever currency a theorist favours are, on distributive views, themselves grounded in whatever more general interests of individuals are thought to support that currency over alternatives, distributive views ultimately ground at least some entitlements to resources and socially provided services in the justice-relevant interests that those resources or services might promote.

Relational egalitarians claim that distributive theorists have failed to appreciate the role that an ideal of egalitarian social relationships should play in an appropriate conception of the value of equality. Though some who embrace this criticism of prominent distributive approaches do not view relational egalitarianism as a competitor to distributive views,<sup>4</sup> many of the most prominent relational egalitarians do see their approach as an alternative to such views, rather than as a complement to them.<sup>5</sup> My focus in this paper is on relational egalitarian views conceived of as competitors to distributive approaches to equality and justice; none of my arguments applies against the view that distributive approaches should be complemented by a concern for relational equality.<sup>6</sup> For ease of presentation, I will, in the remainder of the paper, use the label “relational egalitarianism” to refer only to views that constitute alternatives to distributive approaches, and “relational egalitarians” to refer only to proponents of such views.

Relational-egalitarian views that constitute alternatives to distributive approaches hold that the fundamental value that grounds entitlements of justice is egalitarian social relationships, rather than the kinds of interests that might be taken to support one view about the currency of justice over others. On these relational egalitarian views, entitlements of justice, including distributive entitlements, should be understood as grounded, in some way or other, in the value of egalitarian social relations. For relational egalitarians, then, it is ultimately the value of egalitarian social relationships that explains why individuals have whatever particular entitlements of justice that they do, including entitlements to a share of society’s resources, to opportunities, and to the provision of services such as healthcare.

My aim in this paper is to suggest that reflecting on the kind of explanation that relational egalitarians are committed to offering of a certain class of our justice-based entitlements raises doubts about the relational egalitarian project of attempting to ground all entitlements of justice in the value of egalitarian social relationships, rather than allowing that at least some such entitlements might be grounded in the kinds of values underlying distributive approaches. I will use the entitlement to healthcare provision as my central example, since I think that this case highlights the challenge facing relational egalitarians in a particularly striking way.<sup>7</sup> The central claim that I will defend is that even if relational egalitarian views can avoid implausible implications regarding the *extension* of justice-based entitlements to healthcare, it is more difficult to see how they can avoid what seem to me to be implausible *explanations* of why individuals have the justice-based entitlements that they do. To put this point another way, I will argue that, even if relational egalitarians can give a plausible answer to the question “Who is entitled to what, when it comes to the social provision of healthcare?,” it is less clear that they can offer an equally plausible answer to the question “Why are individuals entitled to the socially provided health care that they are?” To the extent that I am correct that relational egalitarian views are committed to offering implausible explanations of the grounds of justice-based entitlements to healthcare, this seems to me to provide at least some support for a more fundamentally distributive approach to thinking about justice in healthcare provision, since plausible distributive approaches are consistent with quite intuitive explanations of the grounds of justice-based entitlements to healthcare. More generally, the success of my challenge to relational egalitarian explanations of justice-based entitlements to health care would suggest that relational egalitarians will struggle to provide plausible explanations for a number of other widely endorsed entitlements of justice.

The force of the concerns that I will raise for relational egalitarian approaches to justice in healthcare provision, however, do not by themselves generate support for any particular more fundamentally distributive theory. The success of my argument, then, will not necessarily lead us in the direction of what has, in recent years, been the main competitor to relational egalitarianism, both in discussions of health and healthcare justice, and in discussions of egalitarian justice more generally—namely, luck egalitarianism.<sup>8</sup> Luck egalitarianism offers a distinctive type of answer to the question of why individuals are entitled to the socially provided healthcare that they are. That answer is, roughly, that such care is necessary to remedy inequalities in health that are the result of brute luck, rather than the result of option luck, or, in other words, the result of choices for which individuals can be held responsible. And although I am inclined to think that this luck egalitarian answer is at least more plausible than what relational egalitarians can offer, I do not think that it is necessarily the most plausible answer available.<sup>9</sup> I hope, then, that reflecting on the question about the grounds of entitlements of justice in healthcare that I will focus on in this paper can help to lead egalitarian discussions of health and healthcare justice in new directions. I will not, however, attempt to pursue any of those directions here.

I will proceed in the remainder of the paper as follows. In section 1, I will describe the key features of relational egalitarianism, drawing primarily on Elizabeth Anderson's development of the view. In particular, I will highlight the kind of explanations that relational egalitarians are committed to offering for justice-based entitlements to resources, opportunities, and service provision. In section 2, I will examine the explanations available to relational egalitarians for entitlements to healthcare provision, and argue that, at least in certain kinds of cases, these explanations seem unsatisfying. The difficulty of providing satisfying explanations for entitlements to healthcare provision within a relational egalitarian framework, I will suggest, provides some reason to favour a more fundamentally distributive approach to justice in health and healthcare provision. I will conclude, in section 3, by briefly highlighting the limits of the argument developed in section 2, and by suggesting how it might inform our thinking about the divide between relational and distributive approaches to justice going forward.

## 1. RELATIONAL EGALITARIANISM

While some views that can be described as versions of relational egalitarianism claim only that the value of *equality* is best understood in relational egalitarian terms, and allow that *justice* may be an entirely distinct value that can at times compete with equality, my concern in this paper is relational egalitarian approaches that aim to offer alternatives to distributive approaches to justice.<sup>10</sup> Relational egalitarianism, insofar as it constitutes an alternative to such distributive approaches, is both a view about how the value of equality is best understood, and a view about the basis of entitlements of justice, including distributive entitlements. Relational egalitarian views, then, constitute a type of egalitarian view about justice that can be contrasted with the type represented by the distributive views that relational egalitarians have aimed to challenge.

Several prominent relational egalitarians clearly conceive of their views as offering alternatives to distributive approaches to justice, in addition to offering an account of the value of equality. Anderson, for example, explicitly contrasts the view that she develops with luck egalitarian approaches to justice. She says that, contrary to what is implied by luck egalitarianism, on her relational egalitarian view, “the proper negative aim of egalitarian justice is not to eliminate the impact of brute luck from human affairs, but to end oppression” (1999, p. 288). Elsewhere, she makes it clear that, on her view, it is relational egalitarian principles that explain when inequality in the distribution of “non-relational goods” is and is not unjust.<sup>11</sup> She says, for example, that while “luck egalitarians claim that inequality is unjust when it is *accidental*... [,] relational egalitarians claim that inequality is unjust when it *disadvantages* people: when it reflects, embodies, or causes inequality of authority, status, or standing” (2010, p. 1-2, italics in original).<sup>12</sup>

Samuel Scheffler endorses a slightly weaker view than Anderson's about the connection between relational equality and the requirements of distributive justice. On his view, the content of principles of distributive justice is explained



by a range of values, including, but not limited to, equality as understood in relational terms (2015, p. 42). Like Anderson, however, he insists that relational egalitarianism is “a genuine alternative to the distributive view” of egalitarian justice, as opposed to a version of such a view (2015, p. 23). He adds that “if we accept the relational view, this will affect the way we think about the content of distributive justice” (*ibid*). Specifically, the relational approach that Scheffler favours “asks what the broader [relational] ideal of equality implies about distributive questions” (*ibid*). Like Anderson, then, Scheffler believes that relational egalitarianism will play an important role at least in explaining a range of distributive entitlements, and that the explanations offered for such entitlements by distributive views should be rejected.<sup>13</sup>

Christian Schemmel is, among self-described relational egalitarians, perhaps the most explicit about understanding relational egalitarianism as a view about justice, in addition to a view about how we should understand the value of equality. Relational egalitarianism, he says, “is a view about social justice” (2011, p. 366). He notes that “it is unclear what social justice as relational equality demands in distributive terms” (*ibid*, p. 365), and aims to argue that “a relational egalitarian conception of social justice yields powerful intrinsic and instrumental reasons of justice to care about distributive inequality in socially produced goods – despite its according center stage to just social relationships and not to the distribution of goods per se” (*ibid*). On Schemmel’s view, then, the requirements of distributive justice are explained by the requirements of just social relationships, which are, on the relational egalitarian view of justice that he endorses, the fundamental justice-relevant value.<sup>14</sup>

It is clear, then, that at least some prominent relational egalitarians hold that the value of egalitarian social relationships provides the ground-level explanation for entitlements of justice, including distributive entitlements. This should not be surprising, since relational egalitarianism was developed by its early proponents as an alternative to distributive approaches to equality and justice, and in particular to luck egalitarianism.<sup>15</sup> Before I move on to consider the kinds of explanations that can be given in relational-egalitarian terms for entitlements of justice to socially provided healthcare, it is worth highlighting some further key features of relational egalitarian views. This will serve as additional background for thinking about the distributive implications of relational egalitarianism, and the kinds of explanations that can be offered within the relational egalitarian framework for distributive entitlements.

According to Anderson, a central, minimal aim of relational egalitarianism is to eliminate relations of oppression, including domination, exploitation, and marginalization (1999, p. 313; see also Schemmel 2011, p. 366). Opposing these hierarchical relations, relational egalitarians “seek a social order in which persons stand in relations of equality” (Anderson 1999, p. 313; see also Anderson 2012, p. 40 and Scheffler 2015, p. 21-23). Achieving relational equality, according to Anderson, requires eliminating at least three types of hierarchy, which are “typically based on ascriptive group identities such as race, ethnicity,

caste, class, gender, religion, language, citizenship status, marital status, age, and sexuality” (2012, p. 42). The first are “hierarchies of domination or command,” in which some are “subject to the arbitrary, unaccountable authority of social superiors and thereby made powerless” (2012, p. 42-43). The second are “hierarchies of esteem,” in which “those occupying inferior positions are stigmatized – subject to publicly authoritative stereotypes that represent them as proper objects of dishonor, contempt, disgust, fear, or hatred on the basis of their group identities” (2012, p. 43; see also Schemmel 2011, p. 380-385). And the third are “hierarchies of standing,” in which the interests of those favoured are “given special weight in the deliberations of others and in the normal (habitual, unconscious, often automatic) operation of social institutions” (2012, p. 43; see also Scheffler 2015, p. 35, 37-38 and Schemmel 2012).

In virtue of their concern to eliminate these forms of hierarchy, relational egalitarians are committed to democratic norms according to which everyone is entitled to participate in open discussion as part of a project of collective self-determination, and everyone’s claim to be heard and treated with equal respect is to be acknowledged. Relational egalitarians, then, are committed to a requirement of political equality (Anderson 2012, p. 46-47; Scheffler 2015, p. 37). Standing in relations of political equality requires that all citizens have the capabilities that are necessary to function as equal citizens in a democratic state (Anderson 1999, p. 316). The value of relations of political equality, then, will ground entitlements of justice to whatever is necessary for citizens to function as equals in a democratic state, such as a sufficient level of socially provided education.

Anderson’s view is not, however, concerned only with the way in which the various types of hierarchy described might undermine political equality. Equal political rights, along with social provision of all of the necessary conditions for individuals to exercise those rights, are, at least in principle, consistent with private relations of domination and exploitation. But Anderson takes these inegalitarian private relations to be unjust as well, and so holds that the capabilities necessary to avoid private oppression must be socially provided. More generally, she accepts a broad view of social equality, according to which individuals must be capable of relating to each other as equals not only within the political arena, but also in civil society more broadly, including in market transactions and in the range of activities that constitute the broader social life of a society.<sup>16</sup>

There is, I think, quite a bit that is appealing about Anderson’s characterization of her view and about the claim that egalitarian social relationships are a fundamental concern of justice. And the view does seem to be able to incorporate a wide range of the entitlements to resources, services, and opportunities that egalitarians of all types are typically committed to endorsing. For example, having the capability to function as an equal citizen clearly requires having access to adequate food, clothing, and shelter, as well as sufficient education. It also plausibly requires, as Anderson points out (1999, p. 317), effective access to medical

care. The ideal of social equality seems clearly capable of grounding entitlements to a sufficient income, to equal opportunity in the pursuit of desirable careers, and to a wide range of familiar social and political rights.

The unique feature of relational egalitarianism that is important for my purposes in this paper is not the content of the entitlements that it entails (though these will differ from the entitlements entailed by at least some alternative egalitarian views), but rather the fact that these entitlements are taken to be grounded in the more fundamental value of egalitarian social relationships. Here is how Anderson puts this point with respect to the distribution of resources: “Certain patterns in the distribution of goods may be instrumental to securing [egalitarian social] relationships, follow from them, or even be constitutive of them. But [relational] egalitarians are fundamentally concerned with the relationships within which goods are distributed” (1999, p. 313-314; see also Scheffler 2003, p. 23 and Schemmel 2011, p. 365).<sup>17</sup> In other words, on relational egalitarian views, any distributive entitlements of justice that individuals have must be explained by their status as a means to egalitarian social relationships, as a necessary consequence of egalitarian social relationships, or as an essential feature of egalitarian relationships themselves. More generally, entitlements of justice must be explained in terms of the value of egalitarian social relationships.<sup>18</sup> Egalitarian social relationships are, then, something of a master value within relational egalitarian views. Individuals’ fundamental entitlement of justice is to be capable of standing in egalitarian relations with all of their fellow citizens; and they are derivatively entitled to anything that is a necessary means to, a necessary consequence of, or a constitutive element of such relations.

It is clear that distributive entitlements will sometimes be necessary means to egalitarian social relationships. For example, access to adequate education is surely a necessary condition of becoming capable of functioning as an equal citizen in a democratic society. It also seems at least plausible that certain distributive entitlements might follow as a consequence of the fact that citizens in fact stand in egalitarian social relationships. For example, if a society’s economic structure is designed in a way that fosters fair equality of opportunity<sup>19</sup> and the egalitarian social relations that can plausibly be thought to be encouraged in conditions in which individuals engage in economic activity on fair terms, it seems plausible that the distributive outcomes of voluntary transactions generate entitlements of justice.<sup>20</sup>

It is at least somewhat less clear what it might mean for a distributive pattern or set of entitlements to be constitutive of egalitarian social relationships. One approach to developing this possibility, which will be relevant to the discussion of entitlements to healthcare provision, is to claim that social provision of certain goods or services is an essential expression, via social institutions, of citizens’ equal status.<sup>21</sup> The central idea behind this approach is that part of what it is to stand in egalitarian relationships with one’s fellow citizens is to live under shared institutions whose policies properly express the equal status of all. If it can then be argued that, in the absence of policies ensuring the provision of certain goods

or services to all, the relevant institutions could not possibly be taken to properly express the equal status of all citizens, then we could conclude that those policies are a necessary condition of egalitarian social relations, not because they are a necessary means of bringing about some other state of affairs that is important from the perspective of relational equality, but instead because they constitute the only available way of expressing the equal status of all in policy.

## 2. RELATIONAL EGALITARIANISM AND ENTITLEMENTS TO HEALTHCARE

What do the central features of relational egalitarian views noted in the previous section imply about justice-based entitlements to healthcare? One thing that they imply is that, on a relational egalitarian view, the content of individuals' entitlements to healthcare will depend on what, in the way of healthcare, is necessary to ensure that they are capable of standing in egalitarian social relations to their fellow citizens. In addition, the explanation of why individuals are entitled to what they are, and why they are not entitled to other things, will be that the things to which they are entitled are necessary to ensure that they are capable of standing in egalitarian social relations to their fellow citizens, while the lack of other things from which they might benefit is at least consistent with the development and maintenance of egalitarian social relations.<sup>22</sup>

One possible concern about a relational egalitarian account of entitlements to healthcare is that it will not be able to account for all of the entitlements that we intuitively think people have as a matter of justice. In other words, we might worry that relational egalitarianism has implausible implications regarding the *extension* of entitlements to healthcare. We might worry about this because there seem to be cases in which we think that people are entitled to socially provided healthcare, but in which it is at best unclear whether the care to which we think they are entitled can plausibly be understood as necessary to the development or maintenance of egalitarian relationships, constitutive of such relationships, or an essential expression, via health policy, of citizens' equal status. Consider the following case:

Valerie suffers from condition X, which flares up occasionally. When it flares up, it makes it quite painful for Valerie to walk more than a short distance. Nonetheless, she remains capable of getting anywhere that she wants to go, and the condition does not prevent her from performing any essential tasks at her job. No one treats her any differently as a result of her condition, and having it in no way undermines the bases of her self-respect. Still, her life would be significantly better if she were able to avoid the pain that the condition causes.

In order to see why relational egalitarianism might face a problem regarding cases like Valerie's, it will be helpful to consider, first, what we should say if it turns out that her condition is entirely untreatable. Would we think that she simply could not stand to her fellow citizens in an egalitarian relationship of the kind that Anderson and other relational egalitarians have in mind? Surely this

cannot be the case. Those with untreatable chronic pain, and many other untreatable conditions, are clearly capable of standing in egalitarian relations to their fellow citizens. It would, I think, be an obviously unacceptable implication of a conception of the egalitarian relationships that ground entitlements of justice if it turned out that Valerie, or, for example, someone with an untreatable physical disability requiring the use of a wheelchair to get around, simply cannot stand in the sort of relations to her (or his) fellow citizens that ground entitlements of justice.

Now consider what a relational egalitarian can say about Valerie's entitlement to socially provided treatment for condition X in a case in which such treatment is available. I assume that relational egalitarians will want to hold that, at least as long as the treatment is not extremely expensive, and as long as there are not many more urgent justice-relevant concerns that need to be addressed and ought to take priority, Valerie will be entitled to socially provided treatment. But if her pain is not a barrier to her ability to stand in egalitarian relations to her fellow citizens when it is untreatable, then at least certain ways of accounting for her entitlement to treatment are not going to be available to the relational egalitarian. Specifically, it cannot be claimed that alleviating pain of the kind that she experiences is necessary for the development or maintenance of egalitarian social relations between those who suffer from that kind of pain and their fellow citizens. After all, the pain is not itself a barrier to such relations, as we saw from considering the case in which it is untreatable.

This may not seem like a significant problem, since, as I noted earlier, relational egalitarians can claim, of some entitlements of justice, that social provision is an essential expression, via social institutions, of citizens' equal status. And it may seem quite plausible to say that providing treatment for pain like Valerie's, when it is available, is such an essential expression. Failure to provide it, we might think, would amount to the community expressing that she has an inferior status within society, since viewing her as an equal would seem to require the sort of concern about her pain that would generate social provision of available treatment.

This seems to me to be the kind of explanation that a relational egalitarian will likely have to offer for entitlements to treatment in cases like Valerie's,<sup>23</sup> which I assume they will generally want to endorse. But I think that there are reasons to be concerned about explanations of this kind. One reason for concern is that it is far from clear that the appeal to the need for policy to express the equal status of citizens is distinctive of relational egalitarianism.<sup>24</sup> This, of course, does not provide any reason to reject a relational egalitarian approach. It does, however, prevent relational egalitarians from appealing to the fact that their view allows for this kind of explanation in order to provide support for their approach as against alternatives. A second reason for concern is that it is not clear that the appeal to the need for policy to express the equal status of citizens avoids implicit commitment to claims that, it seems to me, relational egalitarians are committed to rejecting, and which are endorsed by proponents of more fundamentally distributive approaches.

First, a wide variety of egalitarian views, including luck egalitarian views, hold that policy must reflect and express the equal status of citizens. Of course, there is disagreement about exactly which policies properly do this, since there is also disagreement about which fundamental values must inform policy if it is to have the appropriate expressive content. What is supposed to be distinctive about relational egalitarianism is that it holds that the value of egalitarian social relationships, not other values, must ground policy in order to properly reflect and express citizens' equal status. In order to be a distinctive view, relational egalitarianism requires an independent account of the content and requirements of egalitarian social relationships, which can then serve as a criterion for assessing candidate entitlements of justice. On such a view, in order for something to be an entitlement of justice, it must be necessary for the promotion or maintenance of egalitarian relationships as defined by the relevant view, or else constitutive of such relationships. If something is neither necessary as a means to nor constitutive of egalitarian social relations, then it is difficult to see how proponents of the view that such relations are the fundamental value that grounds entitlements of justice can claim that providing that thing is necessary to express citizens' equal status. In the absence of an argument that appeals to an independent account of the content of egalitarian social relations for the claim that providing treatment for Valerie's pain is either necessary as a means to or constitutive of such relations, then, it seems ad hoc for a relational egalitarian to claim that the provision of treatment is a necessary expression of her equal status.<sup>25</sup>

Since her condition is not itself a barrier to egalitarian social relations (as was shown by considering the case in which it is untreatable), the explanation of why the claim that providing treatment is an essential expression of her equal status is true cannot be that providing the treatment is a necessary means to bringing about, or is constitutive of, the conditions for egalitarian social relations. Instead, if it is true that providing treatment for her condition is the only way that the community can properly express her equal status, the explanation for this would seem to be that alleviating her pain matters in itself, in a way that is relevant to justice—that is, it matters even though the presence of the pain is not itself a barrier to egalitarian social relations between her and her fellow citizens. But this is something that, it seems to me, a relational egalitarian cannot say. What is supposed to be distinctive of relational egalitarianism is that it holds that our fundamental justice-relevant interest is in egalitarian social relationships with our fellow citizens, and that any other justice-relevant interest that we have is derivative of that fundamental interest. On this view, to the extent that we have a justice-relevant interest in, say, the alleviation of pain, which grounds entitlements to things like medical care, this has to be explained, ultimately, in terms of our fundamental justice-relevant interest in egalitarian social relationships. Where an interest that people have is not connected in the right way to their interest in egalitarian social relations, relational egalitarians have to accept that it is not a justice-relevant interest that can ground justice-based entitlements. And trying to avoid this implication, where it seems intuitively implausible, by claiming that providing for the interest is an essential expression of a person's equal status, seems objectionably ad hoc.<sup>26</sup>

Note that more explicitly distributive views seem to be able to handle cases like Valerie's quite a bit more easily. Many such views accept that avoidance of pain is itself a fundamental justice-relevant interest,<sup>27</sup> while others accept that our justice-based entitlements to resources and services are themselves explained by our broader interests, including the interest in avoiding pain.<sup>28</sup>

I suspect that the best response on behalf of relational egalitarianism is to argue that if the community were to fail to provide available treatment for Valerie's condition, this would in fact undermine what could otherwise be egalitarian social relations between her and her fellow citizens. This could not be because her condition itself makes egalitarian relations impossible, but must instead be because the community's failure to provide relief when it could have done so will necessarily affect the way in which Valerie can relate to her fellow citizens. In particular, the thought is that the community's refusal to provide available treatment would make it impossible for her to engage with her fellow citizens on terms of equality, perhaps because the community's chosen policy cannot be plausibly interpreted other than as an indication that she is viewed as having inferior status.

On the one hand, it seems to me plausible that the community's failure to provide available treatment to Valerie would, at least in some circumstances, undermine what could otherwise be egalitarian social relations between her and her fellow citizens. Because of this, it seems true that relational egalitarians can plausibly insist that their view is consistent with the intuition that she is entitled, as a matter of justice, to socially provided treatment. It is, however, difficult to see how the ground-level explanation of her entitlement could lie in the value of egalitarian social relations, as it must for a relational egalitarian. This is because when we ask why it is that failure to provide treatment would undermine the possibility of egalitarian social relations, the answer cannot be that the condition itself is incompatible with egalitarian relations. Instead, it seems to be the failure to alleviate avoidable pain that makes it the case that, in the absence of socially provided treatment, egalitarian social relations would be undermined. We take it that Valerie would be justified in thinking that the community is not treating her as it should, that she is being denied something to which she is entitled as a matter of justice. And it is the fact that she would be justified in objecting to the policy, on independent grounds, that explains why the policy would undermine the possibility of egalitarian social relations. If we did not think that there are good independent grounds for objecting to the policy, then we would not have any reason for thinking that it would undermine egalitarian social relations. Therefore, the fact that the policy would undermine egalitarian social relations cannot explain why Valerie would be justified in objecting to it. Instead, the order of explanation goes the other way. But relational egalitarians cannot accept what seems to be the right direction of explanation here. It seems to be the case that Valerie's independent interest in pain avoidance explains why she would be justified in objecting to a policy that does not include socially provided treatment for her condition, and the fact that she would be justified in objecting to the policy explains why the policy would undermine the possibility of egalitarian

social relations between her and her fellow citizens. But this line of explanation attributes to Valerie a fundamental justice-relevant interest in pain avoidance, and that seems to be something that relational egalitarians are committed to rejecting.

There is a closely related and, I think, simpler point that we can see in light of the line of reasoning that I have developed. It now seems that there is a way in which the relational egalitarian can get what will seem, at least in many cases, to be the correct answer about Valerie's entitlement to treatment for her painful condition. It does seem true that the community's failure to provide treatment would, in the absence of conditions that would justify this failure, undermine the possibility of egalitarian social relations between her and her fellow citizens. So, relational egalitarianism can, it seems, avoid extension problems in cases like Valerie's. It can, that is, give what appear to be the correct answers to questions about who is entitled to what in the way of healthcare. I suspect that this will be true in at least most cases, so that relational egalitarian views will not face any significant problems regarding the extension of entitlements to healthcare. But in cases like Valerie's, the explanation that relational egalitarians must give of why individuals are entitled to the healthcare that they are seems difficult to accept. If we ask why Valerie is entitled as a matter of justice to treatment for her condition, the right explanation seems to be that she has an important interest in the avoidance of pain that the community is obligated to take seriously when making health policy. That is a straightforward and, it seems to me, intuitively compelling answer to the question. The relational egalitarian, on the other hand, must say that she is entitled to treatment because the failure to provide it would, in some way or other, undermine egalitarian social relations. I have acknowledged that when it is true that a person is entitled to treatment, but not provided with it, this is likely to undermine egalitarian social relations. But it simply does not seem as though this fact can constitute the ground-level explanation of why someone like Valerie is entitled to treatment for her condition. To see why, imagine that we are asked whether we think that she is entitled to treatment, and aim to answer this question in a way that is consistent with a commitment to relational egalitarianism. It would appear that what we would have to say is something like the following:

Well, of course the condition is quite painful, but what we really need to know in order to determine whether she is entitled to treatment is whether failing to provide it would undermine egalitarian social relations. If it would, then she is entitled to the treatment. Otherwise, justice does not require that it be provided.

It may be true that, barring unusual conditions, every failure to treat a treatable painful condition would undermine egalitarian social relations. If this is the case, then relational egalitarianism will not have any particular problems getting the right extension when it comes to healthcare policy. But its explanations of why it is that people are entitled to the treatment that they are strike me as difficult to accept, and certainly less intuitive than the alternative of referring directly to the sort of justice-relevant interest in pain avoidance that more fundamentally distributive views can allow that we have.<sup>29</sup>



### 3. CONCLUSION: RELATIONAL AND DISTRIBUTIVE APPROACHES TO JUSTICE

The fact that relational egalitarian views face the kind of difficulty that I have highlighted when it comes to providing plausible explanations of justice-based entitlements to healthcare seems to me to constitute a significant challenge to the relational egalitarian project of grounding entitlements of justice in the value of egalitarian social relationships. Nevertheless, I do not take the argument that I have offered in this paper to amount to anything like a decisive case against relational egalitarian approaches to justice, or a vindication of a more fundamentally distributive approach. What I have offered is a characterization of a challenge for relational egalitarianism that, it seems to me, has not been fully appreciated in discussions of the view thus far. I take myself, then, to have presented relational egalitarians with a plausible line of objection to their view, which an adequate defence of the view must address.

One response that a relational egalitarian might offer to my challenge is to acknowledge that the explanations of entitlements to healthcare that are available on the relational egalitarian approach are indeed counterintuitive, but to claim that we nonetheless ought to accept them, since the more fundamentally distributive approaches that are consistent with more intuitively plausible explanations face even more significant objections.<sup>30</sup> I accept that this is a possibility worth taking seriously, although I am at least cautiously optimistic about the prospects of developing an approach that avoids commitment to the kinds of explanations of entitlements to services such as healthcare provision that I have criticized, while also accommodating what seems to me to be the central valuable insight that relational egalitarian views have brought to recent discussions of justice, namely that individuals have a fundamental justice-relevant interest in standing in egalitarian social relations to their fellow citizens.

One way of attempting to develop such a view is to include egalitarian social relations within a pluralist account of the currency of justice.<sup>31</sup> Although this approach has been suggested by some luck egalitarians (Lippert-Rasmussen 2015b), I suspect that it may be at least somewhat easier to develop within views that include distributive principles that are inconsistent with luck egalitarianism than within views that include central luck egalitarian commitments. For example, the luck egalitarian commitment to permitting distributive inequalities that are the result of choices for which individuals can be held responsible appears to put at least some pressure on a view to permit distributive inequalities that might threaten egalitarian social relations. More generally, the fact that people find themselves on the disadvantaged side of inequalitarian relations with some of their fellow citizens can, in principle, be the result of choices for which they can be held responsible.<sup>32</sup> There appears, then, to be at least some difficulty facing those luck egalitarians who might attempt to incorporate egalitarian social relations directly into the currency of justice and to combine that account of the currency of justice with a luck egalitarian distributive principle.

Consider, alternatively, the relative ease with which it appears possible to combine a pluralist account of the currency of justice that includes egalitarian social relations with, for example, a sufficientarian distributive principle. If we hold that justice requires that everyone be provided with a sufficient share of the elements that make up a pluralist account of the currency of justice, it seems open to us to hold that, with respect to social relations, sufficiency requires equality. We can, on this type of view, also hold that sufficiency with respect to goods and services such as income and healthcare requires that all citizens be provided, insofar as this is possible, with, for example, a share of these goods that allows them to live a pleasant, rich, and satisfying life.<sup>33</sup> And since pain avoidance is clearly a constitutive feature of the values that, on this type of view, ground the entitlement to a sufficient share of goods and services, Valerie's entitlement to treatment for her condition can be explained in a way that is much more intuitively plausible than the explanations available on relational egalitarian views.<sup>34</sup>

It is unclear to me what the best version of a view of this general type might look like, and also unclear whether such a view can ultimately be defended. I cannot pursue the matter further here, but must leave it for future work. What I do hope to have accomplished in this paper is to have provided some reasons for those who are attracted to relational egalitarian approaches to justice to take seriously the possibility that at least some entitlements of justice must be grounded in values other than egalitarian social relationships. If I have succeeded in this aim, then the project of developing a view that takes both egalitarian social relationships and basic interests such as pain avoidance as fundamental justice-relevant interests should become more appealing than it has appeared to be thus far. This would, it seems to me, be a positive development within debates about the fundamental values that ground requirements and entitlements of justice.

## ACKNOWLEDGEMENTS

I am grateful to two anonymous reviewers for helpful written comments and to audience members at the 2017 Eastern Division Meeting of the American Philosophical Association. For helpful discussion, I thank Carina Fourie, Paul Kelleher, Rekha Nath, Christian Schemmel, Liam Shields, and Kristin Voigt.

## NOTES

- <sup>1</sup> The seminal contribution is Anderson (1999); see also Anderson (2010 and 2012) and Scheffler (2003, 2005, and 2015).
- <sup>2</sup> Important discussions within the distributive framework include Dworkin (1981a and 1981b) and Cohen (1989).
- <sup>3</sup> Both luck egalitarian views (e.g., Cohen 1989) and Rawlsian views (e.g., Rawls 1999) share this feature.
- <sup>4</sup> See, for example, Wolff and De-Shalit (2007), Fourie (2012), and Lippert-Rasmussen (2012, 2015a, and 2015b).
- <sup>5</sup> See, for example, Anderson (1999, 2010, and 2012), Scheffler (2003, 2005, and 2015), and Schemmel (2011 and 2012).
- <sup>6</sup> Indeed, I am inclined to think that this view is correct.
- <sup>7</sup> For sympathetic discussion of relational egalitarian approaches to health and health care justice, see Voigt and Wester (2015) and Kelleher (2016).
- <sup>8</sup> For recent discussion of the relationship between luck egalitarianism and relational egalitarianism (or democratic egalitarianism, as it is sometimes called) see Anderson (2010) and Lippert-Rasmussen (2012, 2015a, and 2015b). With regard to health and healthcare, see Kelleher (2016, p. 89-94). For a defence of a luck-egalitarian approach to justice in health and healthcare provision, see Segall (2010).
- <sup>9</sup> Once again, some who endorse the criticism that prominent distributive approaches are problematic because they have neglected the value of egalitarian social relations do not reject distributive accounts entirely, and so hold that the right kind of commitment to the value of relational equality is not necessarily incompatible with at least some distributive approaches, potentially including luck egalitarian approaches. The contrast that I suggest between luck egalitarian and relational egalitarian answers to the question of why individuals are entitled to the socially provided healthcare that they are applies only to relational egalitarian views that constitute competitors to distributive approaches such as luck egalitarianism.
- <sup>10</sup> I am grateful to an anonymous reviewer for prompting me to clarify this. Views that include a relational egalitarian component that is treated as separable from, and potentially in competition with, justice can be found in Cohen (2009) and Mason (2012).
- <sup>11</sup> Presumably Anderson uses the phrase “non-relational goods” to refer to the various kinds of goods that distributive theorists might think constitute part of the proper currency of justice.
- <sup>12</sup> Further evidence that Anderson conceives of her relational egalitarian view as, at least in part, a view about justice, and about distributive justice in particular, can be found in her claim that “relational egalitarians identify justice with a virtue of agents (including institutions). It is a disposition to treat individuals in accordance with principles that express, embody, and sustain relations of social equality. Distributions of socially allocated goods are just if they are the result of everyone acting in accordance with such principles” (Anderson 2010, p. 2; see also Anderson 2012, p. 44).
- <sup>13</sup> It is a bit difficult to state precisely to what extent my argument in this paper constitutes a challenge to Scheffler’s overall view, since he does not specify which values, apart from relational equality, can contribute to explaining distributive entitlements. It seems to me, however, that Scheffler’s insistence that the relational egalitarian view that he endorses constitutes a genuine alternative to distributive views puts at least some pressure on him to

reject the kinds of explanations of entitlements to socially provided healthcare that I will argue seem most plausible.

- <sup>14</sup> See also Schemmel's remarks about the justice-relevance of relational egalitarian considerations in his 2012 contribution (p. 124-125, 128-129, 131, 133-134).
- <sup>15</sup> This fact about the development of relational egalitarianism is noted by Schemmel (2011, p. 389). It is most explicit in Anderson (1999 and 2010) and Scheffler (2003 and 2005).
- <sup>16</sup> Anderson discusses what she views as the problematically inegalitarian relationships that exist in contemporary workplaces between superiors and subordinates in her 2017 contribution.
- <sup>17</sup> Kasper Lippert-Rasmussen describes relational egalitarianism's concern for distributive matters in a somewhat narrower way. Relational egalitarians, he says, "contend that distribution matters *only* instrumentally in virtue of its impact on social relations and the degree to which these are suitably egalitarian" (2012, p. 118). This description seems to me unduly narrow, since Anderson's claim that some distributive requirements might be constitutive of egalitarian social relations seems at least plausible. I am grateful to an anonymous reviewer for helping me to clarify the relationship between Anderson's and Lippert-Rasmussen's descriptions of relational egalitarianism's concern for distributive issues.
- <sup>18</sup> Schemmel's (2011) argument that range constraints on distributive inequality are required as a matter of justice clearly proceeds on the assumption that this claim is correct.
- <sup>19</sup> For the ideal of fair equality of opportunity, see Rawls (1999, p. 73-78).
- <sup>20</sup> It is important that, for relational egalitarians, the conditions in which individuals engage in economic transactions must actually realize egalitarian social relationships in order for the distributive outcomes of voluntary transactions to generate robust entitlements of justice. This requirement will, on at least many views of what egalitarian social relationships consist in and require, rule out entitlements being generated in all of the cases in which, for example, right libertarians will take them to be generated.
- <sup>21</sup> For an argument that takes this form, but which focuses on range constraints on distributive inequality, rather than on entitlements to socially provided healthcare, see Schemmel (2011, p. 371-375).
- <sup>22</sup> Voigt and Wester describe the implications of relational egalitarianism for entitlements to healthcare in this way (2015, p. 211), and they note that both Anderson (1999, p. 317) and Scheffler (2003, p. 23) suggest this as well.
- <sup>23</sup> For discussion, see Voigt and Wester (2015, p. 212-214).
- <sup>24</sup> As an anonymous reviewer helpfully points out, it seems consistent with Ronald Dworkin's view that coercive institutions must express equal concern, via policy, for those subject to their authority (2000, p. 1).
- <sup>25</sup> In some circumstances, relational egalitarians (and others) might plausibly deny that Valerie is entitled to treatment for her pain, and so accept that there is no argument that can, or needs to, be made to the effect that providing it is an essential expression, via social institutions, of her equal status. This would plausibly be true in cases in which society faces a shortage of resources and there are more urgent priorities that must be addressed first, or perhaps in cases in which the treatment is, for reasons that cannot be justly remedied by society's institutions, extremely costly. It might also be true in cases in which society has chosen to prioritize providing a variety of other goods and services to Valerie and people like her, and has reasonably left treatment for her particular condition off the list of socially provided services. I am assuming, however, that relational egalitarians will, in at least some cases, want to insist that Valerie is entitled to socially provided treatment, and I am considering what kinds of explanations they can offer for this entitlement in those cases. I am grateful to an anonymous reviewer for prompting me to clarify this.
- <sup>26</sup> Relational egalitarians might claim that the explanation of Valerie's entitlement to treatment for her pain is that relating as equals within a political community requires that everyone's interests, or at least their justice-relevant interests, are equally taken into account in decisions made on behalf the community (see Scheffler 2015, p. 35 and 38). While this claim is

plausible, for reasons that are given in the remainder of this section, I believe that the structure of the explanation that it allows relational egalitarians to provide for entitlements to socially provided healthcare is less plausible than alternative explanatory structures available on distributive views. I am grateful to an anonymous reviewer for prompting me to consider this type of explanation.

- <sup>27</sup> All welfarist views clearly have this implication, regardless of their position on the appropriate distributive principles, as do all positions that take welfare to be among the components of the correct currency of justice. For a view of the latter type, see Cohen (1989). At least some distributive views, however, may face greater difficulty offering quite as simple and intuitive an explanation of Valerie's entitlement to socially provided treatment. It seems to me that this provides at least some reason to favour views that include welfare as part of the currency of justice, though I cannot defend that claim here.
- <sup>28</sup> Consider, for example, a view on which resources are accepted as the currency of justice because of concerns about the implications of views that include welfare as part of the currency in cases involving expensive tastes (Dworkin 1981a, p. 228-240). Proponents of such a view might plausibly hold that a central part of the explanation of our resourceist entitlements is that the resources to which we are entitled will typically serve as means to promote various interests that we have, including, potentially, the interest in avoiding pain.
- <sup>29</sup> A large issue that arises for views that accept the kind of explanation of entitlements to socially provided healthcare that I claim is plausible is whether they can justify limiting the entitlements to members of a particular political community. Relational egalitarians might claim that it is an advantage of their approach that it can more easily justify this limitation, since it is plausible and widely accepted that the demands of social equality apply only within, and not across, political communities. I obviously cannot address this issue in any detail, but it seems to me that there are two reasons to doubt that relational egalitarians can claim a clear advantage over distributive views here. The first is that there are no obvious grounds for thinking that distributive theorists cannot consistently hold that an individual's interest in pain avoidance grounds entitlements of justice only within their particular community. And the second is that it is not obvious that there are compelling grounds on which relational egalitarians can deny that the value of egalitarian social relations can ground entitlements, and therefore obligations, of justice that apply across the boundaries of political communities.
- <sup>30</sup> The idea here is that we should judge competing theoretical positions according to a standard of relative plausibility and, at least provisionally, accept the one, of the sufficiently plausible alternatives, that is most plausible in comparison with the others. This will, at least in many cases, commit us to accepting views that we acknowledge face potentially significant objections, simply because all of the available views face at least some significant objections. For an argument that adopts this notion of relative plausibility as its standard, see Murphy (2000).
- <sup>31</sup> Lippert-Rasmussen (2015b) develops a view of this kind, on which he includes social standing in the currency of justice within a luck egalitarian framework. G. A. Cohen (2009) suggests that an ideal of "community," which bears strong resemblances to what relational egalitarians typically have in mind when referring to egalitarian social relations, might constitute a set of background conditions within which principles of luck egalitarian distributive justice should operate. Cohen's view does not, strictly speaking, build egalitarian social relations into the currency of justice, as he understands it. A view that incorporates Cohen's set of normative commitments could, however, be described in those terms.
- <sup>32</sup> Of course, in the actual world, inequalitarian social relations overwhelmingly do not derive from choices for which those on the disadvantaged side can be held responsible.
- <sup>33</sup> This is, of course, a rather imprecise criterion. It is, however, sufficient for my merely illustrative purposes here. Anderson (1999) suggests that relational egalitarianism might be best interpreted as implying a sufficientarian distributive requirement; for criticism see Schemmel (2011).

<sup>34</sup> As an anonymous reviewer points out, it may be that, on some sufficientarian views, Valerie will not be entitled to socially provided treatment for her condition. If we think that the correct view of justice should imply that she is, at least in some cases (e.g., those in which it is not too expensive), entitled to treatment, then we should reject those sufficientarian views. The important point for my purposes is that sufficientarian views that do imply that she is entitled to socially provided treatment can provide what seems to be a quite plausible explanation of her entitlement.

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# A SOCIAL DIVISION OF RESPONSIBILITY FOR HEALTH

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## ABSTRACT:

When is it fair that some people are less healthy than others due to their own individual choices and preferences? In this paper, I explore two alternative answers. The first is a luck-egalitarian account that holds people responsible for choices that society could have reasonably expected them to avoid. I argue that this account is indeterminate and go on to sketch an alternative proposal based on Rawls's idea of a "social division of responsibility." This latter approach connects the notion of responsibility for health to the social conditions under which health-related behaviour is developed.

## RÉSUMÉ :

Dans quelles circonstances est-il juste que certaines personnes soient en moins bonne santé que d'autres à cause de leurs propres choix et préférences individuels ? Dans cet article, j'examine deux avenues de réponse. La première est une explication en termes d'égalitarisme de la chance qui tient les gens responsables des choix que, selon une attente raisonnable de la société, ils auraient dû éviter. Je défends que cette explication est peu concluante. Par la suite, j'esquisse une autre proposition qui s'appuie sur l'idée rawlsienne d'une « division sociale de la responsabilité ». Cette seconde approche rattache la responsabilité de la santé aux conditions sociales dans lesquelles les comportements liés à la santé se développent.

## INTRODUCTION

The topic of personal responsibility for health tends to elicit two different kinds of reactions. On the one hand, we like to see ourselves as masters of our own fates. When we exercise too little or drink too much or fail to follow our doctors' advice, it's only natural to think that we must assume responsibility for ending up with worse health and longevity than others who have been more prudent. From this point of view, choices and preferences appear to justify (or at least excuse) inequalities. On the other hand, many of us believe that large social inequalities in health should be eliminated or at least reduced. Think of the city of Glasgow, for example, where average life expectancy in some neighbourhoods trails that of others by decades (Marmot, 2007, p. 1153). Even people who find nothing objectionable about large inequalities in income or wealth are often shocked by these forms of inequality in health, regardless of whether these came about by differences in health-related behaviour (cf. Daniels, 2008, p. 29). Hence our two intuitions may sometimes stand in conflict, prompting us to ask the following general question: *when are health inequalities that result from individual choices or preferences fair?*

Now, it is important not to overstate the causal impact of behavioural patterns on inequalities in health. In his famous Whitehall studies, for example, Michael Marmot (2004, p. 45) calculated that “aspects of lifestyle account for less than a third of the social gradient in mortality.”<sup>1</sup> And yet lifestyle diseases—such as smoking- and obesity-related conditions—do constitute a major source of premature mortality and avoidable morbidity. It is also widely thought that they harbour the biggest potential for improvements in population health (e.g., Schroeder, 2007). As a result, the notion of personal responsibility is increasingly invoked by health authorities to encourage healthier lifestyles. A recent trend in health-care policy, for example, is to create reforms that delineate the kinds of behaviour that health-care recipients ought to avoid, and which in some cases even make access to certain medical services conditional upon compliance (Schmidt, 2007; Daniels, 2011).

If personal responsibility has been in the minds of policymakers, the same can be said of political theorists. Indeed, much of the literature on justice and equality in the last three decades has revolved around this elusive concept. Many observers have interpreted this surge of interest as a reaction to John Rawls's theory, which, though hugely influential, hardly discusses the topic (e.g., Kymlicka, 2002, ch. 3). As is well known, the difference principle instructs us to improve the position of the worst off, seemingly without regard to their own role in ending up among the least advantaged. Under the influence of Ronald Dworkin's pioneering writings, however, many came to think that a theory of justice must somehow hold individuals accountable for the outcomes of their own choices and preferences. The general position of those who have put the idea of responsibility at the heart of their egalitarian theories of justice has come to be known as luck egalitarianism.

In this paper, I aim to answer the question regarding the fairness of health inequalities caused by individual choices and preferences by contrasting Rawlsian and luck-egalitarian views of responsibility. I am here primarily interested in *substantive* responsibility, which I take to be the propriety of a given benefit or burden falling on an agent. To be responsible for one's health-related behaviour in this sense means that one cannot complain about the outcomes of said behaviour. In the first part of the paper, I focus on a recent version of luck egalitarianism, developed, among others, by Shlomi Segall, which suggests that people are responsible for those imprudent health-related choices that we could have reasonably expected them to avoid. I argue against this intuitive yet misleading way of thinking about personal responsibility. My issue is not so much with the idea that a choice or preference is inequality excusing when an individual could have reasonably avoided it, but rather with the specification of our "reasonable expectations." Here, I claim we must appeal to more fundamental notions of justice than luck egalitarians have hitherto provided.

In a second step, then, I aim to say something more positive about the place of responsibility in distributive justice. By drawing on Rawls's idea of a "social division of responsibility," I argue that we cannot know when people are responsible for the outcomes of their health-related behaviour until we examine the social conditions under which they develop preferences and make choices. If people make imprudent health choices against a background of distributive unfairness, their choices do not excuse their worsened health and longevity. This may be seen as a reversal of the intuitive view on the relationship between justice and responsibility: we do not establish which inequalities are fair by looking at what people are responsible for, as luck egalitarianism suggests, but instead define the role of personal responsibility through a theory of what justice requires.

## LUCK-EGALITARIAN JUSTICE IN HEALTH

Luck egalitarianism is a relatively recent view in the history of political thought, and, as such, its formulation has provoked significant disagreement. At its core, however, luck egalitarianism is held together by the belief that we should not be worse off than others through no fault or choice of our own. Other things being equal, we should not bear substantive responsibility for being disadvantaged by what Dworkin (1981) calls "bad brute luck." For instance, it would be unfair to enjoy worse health and longevity than others due to an incurable genetic illness. It wouldn't be unfair, however, if our worse health status were due to our own choices and preferences.

A key question is how to specify and separate these ideas; that is, how to locate the appropriate cut between chance and choice. It is increasingly recognized that luck egalitarianism must move beyond a crude or "inflated" view, according to which justice requires that we bear any disadvantage that arises from our choices (Stemplowska, 2013). More recent and sophisticated versions of the theory emphasize that choices must be made against some background of adequate

opportunities in order for the resulting disadvantage to be just. In this context, an important development in the literature is the appeal to a “reasonable avoidability” criterion (e.g., Arneson, 1997; Vallentyne, 2002; Sandbu, 2004; Elford, 2012). The general idea here is that people should be responsible only for the outcomes of choices they could have reasonably avoided. There are, of course, different ways of understanding this idea, and in this paper I will explore three possible interpretations. But I shall focus primarily on the account developed by Shlomi Segall (2009; 2012), which I take to be the most clearly articulated version of the reasonable-avoidability criterion. It is, furthermore, an account developed explicitly as a theory of justice in health and therefore the most comprehensive luck-egalitarian treatment of the subject to date.

Segall’s (2009, p. 20) proposal is to interpret brute luck as “the outcome of actions (including omissions) that it would have been unreasonable to expect the agent to avoid (or not to avoid, in the case of omissions).” Expectations are here understood in a normative sense: self-inflicted health deficits are only unfair, on this view, if society could have reasonably (that is, rightly) expected the agent to act more prudently. This is an advance over simpler versions of luck egalitarianism that simply hold people substantively responsible for choices they could have avoided or for outcomes they could have foreseen. For example, imagine residents of California who could, at considerable cost to themselves, move to a different state to avoid the risk of earthquakes. Because it would be unreasonable to expect these Californians to move, Segall argues that we should not hold them substantively responsible for any health-related consequences were an earthquake to occur.

A particularly attractive feature of this account is that it does not ask whether it is reasonable for an *individual* to avoid a choice, but whether *society* could reasonably expect that individual to avoid it. For example, take the nurses who enlist to care for Ebola patients during a public-health crisis. From an individual point of view, the nurses would be substantively responsible were they to accidentally contract the disease, since they could have reasonably avoided this health-threatening line of work. From a societal perspective, however, it might be unreasonable to hold the nurses individually responsible for the choice to enlist. After all, they might be simply helping to fulfil society’s collective duty of assistance to the needy, for which nurses should not be penalized. To my mind, this is an important and underappreciated feature of the theory. It exemplifies a growing awareness among luck egalitarians about the necessity of thinking about substantive responsibility against a background of societal rights and duties (e.g., Stemplowska, 2009; Eyal, 2006).

But the example also hints at the necessity of providing an account of what precisely those rights and duties are. The nurses’ choice may not be reasonably avoidable if they were helping to discharge societal obligations of justice; but perhaps we would consider it reasonably avoidable were it supererogatory. In the latter case, they would be substantively responsible for the ensuing health risks, no matter how praiseworthy their behaviour. In short, to know which inequali-

ties in health are just, we need to know what kind of health-related behaviour we can reasonably expect people to avoid. But to know that, in turn, it seems that we require a background theory of what we owe to one another as a matter of right. Perhaps surprisingly, Segall (2009, p. 21) disagrees:

The luck egalitarian need not provide any further independent criteria by which to judge what sort of conduct individuals ought to bear on their own. She simply states that her aim is to level inequalities that result from such [not reasonably avoidable] conduct, *whatever conduct precisely that might be*.

Although Segall admits that this renders his reasonable-avoidability criterion ambiguous and indeterminate, he argues that this “ambiguity could also be a source of strength. The strength of the ‘reasonable avoidability’ criterion is that it can give due consideration to the changing circumstances of each case” (2009, p. 22). Hence, we decide what is reasonable on a case-by-case basis. He provides several examples of the following ilk: it might be reasonable to expect people camping on the slope of an active volcano to move elsewhere to avoid being endangered, but it would be unreasonable to expect the same of residents of California, who run a similar risk by living on a geological fault line. It might be reasonable to expect a woman with high risks of serious childbirth complications to avoid pregnancy, but it would be unreasonable to expect the same of a healthy woman. China’s one-child policy might be reasonable under “extreme” circumstances, but not under “normal” ones. And so on (Segall, 2009, p. 21-22).

These examples reveal what we might call an *intuitivist* approach. By this I mean an approach characterized by two features: an appeal to common-sense morality and the eschewal of general principles to define what ought to count as reasonably avoidable. The intuitivist proposes to settle questions of substantive responsibility by consulting our intuitions on a case-by-case basis. But there are at least two obvious dangers here. For one thing, our intuitions on different cases may pull us in opposite directions. Just think of the moralistic, and often lopsided, expectations that so permeate our contemporary political discourse on responsibility for health. Overeating or drug taking, for example, are commonly seen as avoidable and therefore inequality excusing, whereas daredevilry in sports is seldom seen in the same light (cf. Wikler, 2004, p. 129). Of course, an intuitivist may on proper reflection reject these inconsistencies. But in the absence of a principled way to define what sort of behaviour we can reasonably expect of one another, the theory runs the risk of replicating them. Worse still, our intuitions on *individual* cases may not be very clear. For, to adequately judge whether a person could have avoided a choice, we need to know more about that person’s circumstances, the set of options that the person faced, their relative costs, and so on.

The intuitivist approach does little to identify and assign responsibility in light of structural factors that make compliance with some prudential standard easy for some, but hard for others. As is well documented in the empirical literature,

the prevalence of behavioural risk factors follows a social gradient, with healthy lifestyles becoming more common as one climbs up the socioeconomic ladder (Marmot, 2004; Wilkinson, 1996). Social epidemiologists have distinguished at least three major ways in which the social environment can influence individual behaviours: by shaping norms and enforcing patterns of social control, by providing the opportunities and resources to engage in certain behaviours, and by reducing or producing stress for which certain behaviours can be coping strategies (cf. Berkman and Kawachi, 2014, p. 8).

Take the influence of norms. Through longitudinal studies, researchers have been able to observe that behavioural patterns are passed on through the family, culture, and social class from an early age on (Lynch, Kaplan, and Salonen, 1997). A striking example of the role of environmental opportunities is the phenomenon of “food deserts” in impoverished American city-centres, where it is significantly more difficult to avoid an unhealthy diet because fresh produce is not as available and affordable as it is in better-off neighbourhoods (Beulac, Kristjansson, and Cummins, 2009). Examples of other resources that have been shown to have a causal impact on health-related behaviour are education, information, and knowledge, which, again, are unequally distributed in society (de Walque, 2007; Mirowsky and Ross, 2003). Finally, consider health-threatening behaviours that are associated with the relief of stress. Smoking among low-income women, for instance, has been identified as a resource to cope with material pressures and responsibilities to care for others (Graham, 1993). These examples are not exhaustive, and we may not yet fully understand all mechanisms linking social background conditions to lifestyle choices. Nevertheless, there is little doubt that individuals do not make choices in a vacuum.<sup>2</sup>

It is hardly surprising, then, that “poor people behave poorly,” as a much-cited study puts it (Lynch, Kaplan, and Salonen, 1997). The relevant normative question is whether these background factors can make a person less substantively responsible for his or her poor health choices—that is, whether we could reasonably expect a person to avoid them. When a given obstacle to a healthy lifestyle is obviously a matter of bad brute luck, the answer will surely be positive. But what if the answer is less clear? For example, how poor must a person’s educational opportunities have been for society to judge that that person could not have reasonably avoided adopting an unhealthy diet? The answer is not obvious, and it doesn’t help that Segall’s theory suggests a binary attribution of responsibility, according to which certain choices and preferences are either reasonably avoidable or not (cf. Knight, 2011, p. 79).

Part of the problem is epistemic in nature: we may not fully know or understand the structural impediments facing a person who is trying to conform to a given prudential standard. But even more troubling is the normative uncertainty inherent in the intuitivist approach. Since only *unfair* disadvantages should influence our societal expectations such that an imprudent choice doesn’t render the resulting inequality in health just, we need to know which disadvantages are unfair. Segall, of course, argues that a disadvantage is unfair when it is the result of an

individual choice that was not reasonably avoidable. But, at this point, it becomes evident that the argument is circular unless we can appeal to independent criteria to define reasonable avoidability.

So, let me now turn to a second interpretation of reasonable avoidability, one that might provide such independent criteria. A plausible way to specify the reasonable-avoidability criterion is to define some form of decent minimum to describe the conditions under which people's choices can be considered inequality excusing. Martin Sandbu (2004, p. 297), for instance, has suggested that there is "a level of social, economic, and cultural inclusion to which we think every person in the society is entitled. Such entitlement concerns, if we accept them, give us reasons to put a lower bound on what prospects it is reasonable to demand that people turn down only at their own risk." Similarly, Gideon Elford (2012, p. 450) argues that a person's options are unreasonable when they entail "consequences that are incompatible with a decent standard of living." And even Segall himself has suggested, in later writings (2012, p. 330), that it is unreasonable to expect agents to avoid actions that they have a "vital interest" in exercising. However precisely it is fleshed out, a decent minimum would allow us to identify cases where it would be unreasonable to hold people responsible for their imprudent health choices in virtue of the options they faced. Take, for instance, the issue of food deserts and food poverty. We cannot fault somebody for choosing an unhealthy diet if the cost of nutritious food were so high that it would rule out the satisfaction of other basic needs. In other words, people should not have to choose between buying fresh vegetables and paying the gas bills.

This way of interpreting the reasonable-avoidability criterion is appealing, and superior to the intuitivist approach. But it also raises a further question about the precise content of the decent minimum. Clearly, there is much disagreement about what people are entitled to as a matter of justice, and the approaches mentioned above fail to specify what exactly these entitlements are or what standard of living we should take as a baseline. This amounts to a recognition that luck egalitarianism still requires a fully fledged "auxiliary theory of when prospects are reasonable" (Sandbu, 2004, p. 296). So, rather than providing a theory of responsibility and justice in health, the reasonable-avoidability criterion still *presupposes* a theory of justice to guide us in cases where it is not intuitively clear whether a choice or preference was reasonably avoidable.

Furthermore, the decent minimum approach raises a question about inequalities in health caused by behaviour exercised against a backdrop of adequate but unequal opportunities. Imagine that a person has faced relatively poor opportunities to exercise—say, because that person lives in a neighbourhood with few parks and recreational facilities—but that his or her options are nonetheless just above some specified threshold. It would seem unfair, other things being equal, if, as a result, that person's health status were lower than that of people in better-off neighbourhoods (and, we could add, incompatible with the luck-egalitarian idea of neutralizing the effects of bad brute luck). Hence the decent minimum approach seems at best an imperfect way to define our reasonable expectations.

At this point, someone might object that it is not necessary to provide a full normative account of the appropriate conditions for choice. For a third way to interpret the reasonable-avoidability criterion is to define our expectations in an *epistemic* way. Instead of developing a theory of the social conditions under which it is sufficiently fair to hold people responsible for their health-related behaviour, we may simply judge people according to certain conventional standards. In other words, we could reasonably expect people to act at least as prudently as others who are in similar circumstances. This, at any rate, is a possibility that has been put forward by John Roemer (1993) as a “pragmatic theory of responsibility for the egalitarian planner.” His suggestion is to group people together in terms of shared socioeconomic and genetic characteristics, thus identifying different “types.” People are then assigned different “degrees of responsibility” depending on the extent to which their health-related behaviour departs from the typical behaviour of their respective type. For instance, a chain-smoking male steelworker might have a degree of responsibility for developing lung cancer comparable to that of a female college professor who smokes only occasionally. If the college professor smoked the same amount as the steelworker, however, she would be displaying behaviour that is rather uncommon for her type. From this we’d be encouraged to suppose that she has had a greater degree of choice and therefore should be taken to bear more substantive responsibility for developing cancer than the steelworker (Roemer, 1993, p. 151).

One immediate difficulty with this proposal lies in the determination of relevant types, for this already presupposes a judgment about what factors undermine responsibility. More factors entail ever more fine-grained types. Taken to the extreme, the theory may arrive at groups of one, making any assignment of responsibility impossible. But even if we assume some satisfactory way of dividing people into types, it is implausible that our responsibility for some imprudent behaviour would depend on the statistical distribution of said behaviour. To return to Roemer’s own example, we might in part explain the statistical inequalities in smoking rates between the sexes by reference to unjust gender norms: traditionally, a social stigma was attached to women smoking in public. If fewer women smoke because they are denied a liberty that men can take for granted, then a female college professor who smokes as much as her male colleagues is punished, in Roemer’s account, for disregarding unjust social conventions. But this cannot be right. Whether we are substantively responsible for our actions should not depend on unjust social conventions.

Now, to be fair, Roemer’s proposal is best understood as a rough guide to policy-making, and as such it might prove useful in many instances. Yet ultimately it cannot replace a normative theory about the sorts of prudential standards we should set as a society. In order to specify the ambiguous notion of a reasonable expectation, we still need to appeal to more fundamental notions of justice than any of the approaches we have thus far considered have provided.



## A SOCIAL DIVISION OF RESPONSIBILITY

Luck egalitarianism, I mentioned at the outset, has often been portrayed as a reaction to the purportedly inadequate discussion of responsibility in Rawls's work. Although *A Theory of Justice* contains sophisticated arguments against desert as a distributive principle, it is true that its positive claims about the proper place of individual responsibility seem underdeveloped. Nevertheless, it would be wrong to infer from this that it has nothing useful to contribute or, for that matter, that luck egalitarians have simply taken Rawls's underdeveloped ideas to their logical conclusion. In this section I want to explore the Rawlsian notion of a social division of responsibility and apply it to our question about health inequalities caused by individual choices or preferences. As I hope to show, the model is not only plausible and coherent in itself. It can also be used to address the question that the reasonable-avoidability approach left unanswered—namely, the question about what sort of health-related conduct society can reasonably expect individuals to avoid.

As is well known, Rawls's project is that of specifying principles of justice to regulate a system of social cooperation among free and equal people from one generation to the next. Justice and injustice, on this view, are features of social institutions—the basic structure of society—rather than judgments about distributive states of affairs as such. In essence, the social system is just when the basic structure regulates the distribution of benefits and burdens of social cooperation in ways that could be justified to all members. For Rawls, this is both measured by and achieved through the distribution of so-called *primary social goods*: all-purpose resources such as liberties, opportunities, and income. Provided a fair distribution of these goods, Rawls says, justice obtains.

But even with a fair distribution of a good like income, say, people can differ in their abilities to satisfy their preferences or to achieve welfare. Imagine, to take Rawls's example (1999, p. 369), that one person is content with a diet of milk, bread, and beans, while another cannot do without expensive wines and exotic dishes. Let's further assume that the latter never chose his or her sophisticated preferences, but rather was raised to have them, and could not change them even if he or she wanted to. If we deny this person is therefore entitled to more resources—as Rawls does—then the use of primary goods appears to render some people worse off through no fault or choice of their own, as it doesn't compensate for the bad brute luck of having unchosen expensive tastes. Here, the theory stands in contradiction with the intuitions that motivate luck egalitarianism. But in response to those who take issue with this outcome, Rawls argues that the viability of a fair system of social cooperation relies on the capability of its members to take responsibility for their ends. As he puts it, his conception of justice

includes what we may call “a social division of responsibility”: society, citizens as a collective body, accepts responsibility for maintaining the equal basic liberties and fair equality of opportunity, and for providing a fair share of the primary goods for all within this framework;

while citizens (as individuals) and associations accept responsibility for revising and adjusting their ends and aspirations in view of the all-purpose means they can expect, given their present and foreseeable situation. This division of responsibility relies on the capacity of persons to assume responsibility for their ends and to moderate the claims they make on their social institutions in accordance with the use of primary goods. Citizens' claim to liberties, opportunities and all-purpose means are made secure from the unreasonable demands of others (Rawls, 1999, p. 371).

These remarks require some unpicking. It is not immediately obvious, for instance, in what way people can take responsibility for their ends and preferences, or whether Rawls is advancing metaphysical claims about the control we exert over our choices. It is also not entirely clear what makes a demand "unreasonable." Before I turn to these questions, however, let me lay out the general structure of this social division of responsibility as it applies to the domain of health. The first thing to note is that society's responsibility to ensure the justice of the system is logically prior to the individual's, for the latter is meant to adapt to the former. Indeed, what society owes the individual can be established independently. As already mentioned, justice demands a fair package of primary goods, including liberties, opportunities, and resources like income and wealth.

It would not betray the spirit of the theory, I believe, if we added to this package a claim to what we might call "the social bases of health."<sup>3</sup> Although Rawls himself saw health as a natural good, one that is primarily determined by genetic factors, there is now little doubt that social arrangements take centre stage in shaping the level and distribution of health and longevity among members of a society. The "social determinants of health"—factors such as education, housing, income, social status, and workplace conditions—profoundly affect our opportunities to live a healthy life, far outweighing the role of genetic factors (e.g., Marmot and Wilkinson, 2005). These determinants, as I understand them, are features of the basic structure or of the situation of individuals in relation to it. Hence, much like with the distribution of the other primary goods, justice demands a fair arrangement of the social conditions that set the background to our health-related choices. Although it would go beyond the scope of this paper to discuss what precisely a fair distribution of the social bases of health would look like—for instance, whether it required equality among social positions or rather allowed inequalities along the lines of the difference principle—I shall take it for granted that Rawls's theory could be expanded in this way to make judgments about unjust social inequalities in health.<sup>4</sup>

Against this backdrop, we can now specify what kind of health-related conduct society can reasonably expect its members to avoid. We cannot reasonably expect those who have been dealt a bad hand to adopt the healthy lifestyles of those who have been more fortunate, since taking these choices to be inequality excusing would ignore and thereby entrench the underlying influence of an unjust basic structure. Yet provided someone has been given a fair share of

primary goods—including the social bases of health—the way that individual makes use of them in pursuing goals and ambitions becomes his or her responsibility. If someone chooses a health-threatening lifestyle in a just society, that choice may be inequality excusing. In short, the model suggests that health inequalities are unfair when they stem from individual health-related conduct that is developed under conditions of social disadvantage, defined in terms of scarcity of primary goods. The same is not true of those inequalities that result from individual choices and preferences that go beyond what is owed to all as a matter of justice. Here, we rightly expect individuals to bear responsibility for their actions.<sup>5</sup>

Rawls writes that the social division of responsibility presupposes an ability on the part of the individual to adapt and adjust his or her ends in light of the share of primary goods that individual can reasonably expect. On the face of it, it may seem implausible to stipulate such an ability. Imagine, for example, a person who is among the better-off members of society, but who is born with a risk-loving nature and therefore chooses to engage in dangerous sports. Someone else, equally well off with regard to the initial share of primary goods, develops an addiction to cigarettes as a child and cannot kick the habit. If these individuals do not exert direct control over their health-related conduct (that is, if they cannot adapt their preferences), is it really plausible to hold them responsible for it? If not, should we agree with the luck egalitarian in considering their poorer health and longevity unjust? To understand what is at stake here, it will be useful to introduce a distinction between two different senses of responsibility. Thus far we have considered personal responsibility primarily as *substantive* responsibility: the idea that people can be held liable for the outcomes of their choices in a way that affects the justice of distributions of benefits and burdens. But as T. M. Scanlon has argued, this sense of responsibility can be contrasted with a different sense, which he calls responsibility as *attributability*. Here, responsibility means that “some action can be attributed to an agent in the way that is required in order for it to be a basis for moral appraisal” (Scanlon, 1998, p. 248).

It would be inappropriate, in the example I just gave, to blame the two individuals for their health-threatening conduct. Since their preferences are outside their control (*ex hypothesi*), these cannot be attributed to them as a moral judgment of their character. However, this sense of responsibility does not necessarily entail a judgment of substantive responsibility, and this is where Rawls’s view is so easily misunderstood. In assuming the capacity to revise and regulate their ends, Rawls is not suggesting that those with “expensive tastes” are responsible in the attributive sense for their preferences (much less is he advancing a metaphysical claim about freedom of the will). Instead he is proposing a conception of the person that is “at least implicitly accepted as an ideal underlying the public principles of justice” (Rawls, 1999, p. 370). In other words, Rawls is claiming that a conception of the person that includes the ability to revise and adjust one’s ends would be accepted by the members of a fair social system that endures over time. To ensure the fairness of the basic structure and to protect individual shares

of primary goods from unreasonable demands, members would agree to a system in which they can be held substantively responsible for their choices and preferences, even if these cannot be attributed to them (cf. Blake and Risse, 2008, p. 181-186).

Compare this view to Segall's. Intuitivism, we said, appeals to common-sense morality, which tends to conflate both senses of responsibility. When people are blamed (or praised) for voluntary choices, it is commonly assumed that they ought to bear the resulting burdens (or benefits), whatever those may be. From this point of view, it looks intuitively unfair that people could be worse off with regard to their health due to factors for which they cannot be blamed, as in the examples of the well-off smoker and the risk taker. But note how this intuition is driven by common-sense morality and a focus on particular cases. When we step back to consider the theory as whole, the Rawlsian notion of responsibility is nevertheless plausible and coherent. For if what we owe to each other is to be factored into our judgments of substantive responsibility—as Segall and other luck egalitarians recognize in principle—then it is not enough to know whether we can attribute people's choices to them. We must also know what effects the assignment of substantive responsibility has on the justice of the social system as a whole.<sup>6</sup>

Having sketched the idea of a social division of responsibility for health, I now turn to two more practical objections. Health inequalities caused by differences in individual behaviour can be fair, I argued, only when that conduct is developed under fair conditions, as measured by the distribution of the social bases of health and other primary goods. Taken to its conclusion, this argument suggests that where there is no justice, there is also no (substantive) responsibility. The disadvantaged in an unjust society are therefore let off the hook, so to speak, no matter what they do or don't do to look after their health. Yet this will strike many people as implausible, for even under the most unfavourable circumstances, we commonly think that individuals bear at least *some* responsibility for their choices and preferences.

This objection arises because we haven't said much yet about the practical application of the theory to realistic circumstances. Rawls introduces the social division of responsibility as a model within what he calls "ideal theory," which assumes favourable conditions and full compliance to the principles of justice. But what shall we make of it in societies like the ones we live in, societies that are not ideally just? The objection in the preceding paragraph assumes an implausible dichotomy, according to which people are either fully responsible for the outcomes of their choices and preferences or, on the contrary, bear no substantive responsibility at all. However, these two extremes are plausible, if at all, only under conditions of perfect justice or radical injustice, respectively. Most societies fall somewhere in between these extremes. Hence, in a more plausible application of the model to realistic circumstances, we would make judgments of substantive responsibility that are scalar in character. That is, we might want to assign "degrees of responsibility," to borrow Roemer's phrase, accord-

ing to the distributive fairness of the backdrop to our health-related choices. I take this view to be well aligned with our considered judgments: the appeal of distributive outcomes that reflect people's manifested choices generally declines as the injustice of society increases, in the same way that we are less inclined to accept the results of a game, the more we have reason to believe that the rules have systematically disadvantaged its losers.

Consider, finally, a different practical objection to the model I have just sketched. I suggested that our degree of substantive responsibility should reflect the distributive fairness of the conditions under which we make our health-related choices. But this seems to have a counter-intuitive implication: the more disadvantaged a particular person is, the less appropriate it seems for the state (or some other relevant agent) to appeal to that person's responsibility for his or her own health-related behaviour. For to appeal to someone's responsibility seems to imply that that person bears responsibility in the first place. If this is correct, however, then one might think that governments should have nothing to say about the poor health choices of their citizens, and in particular those of the worst off, who often display the most harmful patterns of health-related conduct.

Given that lifestyle diseases are increasingly a leading cause of death in many parts of the world, this objection would have far-reaching implications. It seemingly suggests a limited role for public health approaches to encourage behaviour change. However, the objection moves too quickly. There is a relevant difference between holding a person responsible—either in the substantive way or the attributive way identified by Scanlon—and appealing to that person's responsibility—for instance, as part of a public health campaign. In this latter sense, responsibility can be understood merely as causal involvement, as a recognition of the fact that there are choices a person could make to help bring about a given outcome. Public health initiatives that discourage smoking or heavy drinking, for example, may appeal to people's casual ability to change their behaviour, without thereby necessarily blaming them or making them bear the costs should they fail to do so (cf. Waller, 2005, p. 180; Wikler, 2004, p. 131; Daniels, 2011, p. 275).

What is more, public health efforts aimed at lifestyle diseases are arguably even part of what justice requires by way of a fair distribution of the social bases of health. As Norman Daniels (2011, p. 277) has pointed out, for example, efforts to curb smoking are set against a historical background in which governments subsidized tobacco production, failed to regulate advertisement by tobacco companies, and so on. We may see this as a societal failure to create fair conditions under which individuals form their health-related conduct. Now, to be sure, there are limits to what governments may do to encourage or discourage health-related choices and preferences. For one thing, not all behaviour-change campaigns are successful, and there is a real risk that individuals come to overestimate their own abilities to change their lifestyles. This can lead to disappointment and frustration, or, even worse, stigmatization by others, with ultimately detrimental effects on individual health (cf. Wikler, 2004, p. 131).

There are also obvious worries about autonomy and paternalism. But none of this rules out the use of appeals to personal responsibility as a policy tool, nor the idea that these can be separated from discussions of substantive responsibility, which have been the primary focus of this paper.

## CONCLUSION

Let me conclude by contrasting, in a more general spirit, the two different ways of thinking about responsibility for health that this paper has discussed. We began by considering a conception of justice that revolves around the idea of personal responsibility. For luck egalitarians, inequalities among individuals are fair when they track choices and preferences that those individuals are responsible for, in the relevant sense. But what sense is that? For Shlomi Segall and others, inequalities in health are fair when they are the result of choices and preferences that society could have reasonably expected the individuals in question to avoid. This proposal is not implausible, but it raises a further question—namely, what sort of health-related conduct society can reasonably expect from individuals. In its inability to provide a principled way to settle this latter question, the reasonable-avoidability approach theory reflects a basic problem in much of our intuitive thinking about responsibility.

The problem might be put as follows. According to the old adage, justice consists in “giving each person his or her due.” But this phrase allows for at least two different interpretations. The first, which luck egalitarians embrace, is that justice in the distribution of health can be established if we keep track of what each person is substantively responsible for. The idea is intuitively plausible: by looking at what individuals are due—what benefits and burdens are rightly theirs to bear, given the choices they have made—we arrive at judgments about the fairness of distributive states of affairs. But, of course, knowing what individuals are responsible for is no simple matter. With regard to people’s health-related behaviour, we know that unequal socioeconomic positions influence our choice-making and choice-following abilities. We shouldn’t hold people responsible for their poor health choices if these are made under conditions that are *unfair*—that is, if people have a right to better conditions for choice. If this is correct, however, asking what we can reasonably expect from people is not a way to determine what is fair—rather, we must know what fairness requires to know what we can reasonably expect from people.

And so, the idea of a social division of responsibility reverses the relationship between responsibility and justice implicit in luck egalitarianism, and centres on the justice of the social arrangements under which we make choices and develop preferences. From this point of view, giving each person “his or her due” means providing a fair package of primary goods, including, as I have argued, the social bases of health. If we are to assign substantive responsibility in a way that takes into account people’s rights and duties, then we must establish what society owes individuals first.

Naturally, there is still a place for personal responsibility within this way of thinking about justice. If people have been given their fair opportunities to be healthy, but nonetheless act or develop preferences such that they are rendered worse off than they could have been, it is not unreasonable to treat them as substantively responsible for their situation. And furthermore, even when some have *not* had their fair opportunities to be healthy—as is often the case in our non-ideal societies—there might be reasons to invoke the idea of personal responsibility as an acknowledgement of their causal powers to improve their own health. Asking individuals to take charge of their lives can be seen, in a very pragmatic way, as a means to improve population health. In this way, the idea that people are authors of their own fates may be reconciled with the thought that it is not always fair to expect them to bear the burdens of their imprudent choices.

## ACKNOWLEDGMENT

I thank Norman Daniels, Cécile Fabre, Jessyca Hutchens, Dan Iley-Williamson, David Miller, audiences at Warwick and Manchester, as well as two anonymous reviewers for *Les Ateliers de l'éthique*.

## NOTES

- <sup>1</sup> In other words, when we control for behavioural risk factors, we still observe major inequalities in health, which suggests that the same choices can lead to different outcomes for different people.
- <sup>2</sup> There are two main challenges in establishing a causal relationship between social-background factors and health behaviours: reverse causation (“Do disadvantaged people choose poor health behaviours or does poor health behaviour lead to social disadvantage?”) and confounding (“Do disadvantaged people smoke because smoking and disadvantage are both determined by a third factor, such as intelligence?”). It is hard to deny that some part of the association is due to these factors. However, a multitude of studies—including the ones mentioned above—have managed to control for these effects by employing methods such as natural experiments and longitudinal designs. Thus, in a seminal early survey of the field, Link and Phelan (1995, p. 83) conclude: “While medical sociologists and social epidemiologists have not denied the possibility that illness affects social conditions ... [,] they have, at the same time, demonstrated a substantial causal role for social conditions as causes of illness.”
- <sup>3</sup> The analogy here is with another Rawlsian primary good: the social bases of self-respect. Self-respect cannot be (re-)distributed directly, but the basic structure influences individual holdings through the distribution of other goods—namely, equal basic liberties, fair equality of opportunity, etc. Something similar applies to health: we can aim at a fair social distribution of health only by ensuring that other important goods are distributed fairly.
- <sup>4</sup> It may be useful to contrast the approach sketched here with the most prominent theory of justice in health, Norman Daniels’s (2008). Although Daniels also embeds his account within Rawls’s theory and, furthermore, defends similar views with regard to personal responsibility (Daniels, 2011), his approach differs in some respects. Rather than treating the social bases of health directly as a primary good, Daniels argues that good health is a precondition for the realization of Rawls’s principle of fair equality of opportunity. Due to the structure and the lexical priority of the equality-of-opportunity principle, his view seems to require equal opportunities for health and to rule out societal trade-offs between health and other goods governed by the difference principle, such as income or wealth. My view here is more modest in this regard, in that it allows for the possibility that a just society may not offer strictly equal opportunities to be healthy—for example, if that implied considerable losses in other primary goods. The precise weighting of the different elements of an index of primary goods is of course an open question within Rawls’s theory, and I shall say nothing about it here.
- <sup>5</sup> Note that this still requires spelling out what it would mean for someone to bear that responsibility. Our account need not imply the harsh conclusion that we owe *nothing* to those who are responsible for their imprudent health-related behaviour. It may still be the case, for example, that we owe them access to a minimally decent level of health care, but that they bear the burden of their choices and preferences in some other way.
- <sup>6</sup> At this point, a luck egalitarian might object that justice obtains not when a social system can be justified to its members, but rather when the effects of bad brute luck are eliminated. I have not provided an independent argument for thinking that the latter view of justice is incorrect, nor, indeed, that the former is correct. Rather, I have sought to show that Rawls’s theory includes a conception of responsibility that is plausible and coherent. It is not an objection to it that it cannot accommodate elements of a conception of justice that is foreign to it, even if these resonate with some aspects of common-sense morality. Moreover, the model that I have sketched can help specify the reasonable-avoidability criterion, which in turn is one of the more sophisticated proposals to define substantive responsibility in the luck-egalitarian literature.



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# DISCRIMINATION, EMOTION, AND HEALTH INEQUITIES

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## ABSTRACT:

In this paper I argue that certain ways in which the relationship among discrimination, emotions and health is presented can undermine equity. I identify a model of this relationship - the discrimination-emotion-health model - and claim that while the model is important for understanding the detrimental impact that discrimination and oppression can have on emotions and health, certain implications of the model are troubling. I identify six critiques of the model, and show that equity could be undermined, for example, when stereotypes of the oppressed are reinforced and the experiences of the privileged are normalized. I then assess the implications of my analysis of the model and its critique for a framework of health equity, demonstrating what such a framework would need to look like in order for it to best represent discrimination as a psychosocial determinant of health.

## RÉSUMÉ :

Dans cet article, je soutiendrai que certaines façons de présenter le rapport entre la discrimination, les émotions, et la santé peuvent miner l'équité. Je présente un modèle de ce rapport - le modèle discrimination-émotion santé - et avance que même si ce modèle est important afin de comprendre l'impact négatif que peuvent avoir la discrimination et l'oppression sur les émotions et la santé, certaines implications du modèle sont troublantes. Je présente six critiques du modèle, et montre que l'équité peut être affectée lorsque, par exemple, il renforce les stéréotypes concernant les opprimés et normalise les expériences des privilégiés. J'évalue ensuite les implications de ma propre analyse du modèle et de sa critique en vue de l'articulation d'un cadre de l'équité en santé, en démontrant la forme que devrait prendre un tel cadre afin de représenter de la meilleure façon possible la discrimination en tant que déterminant psychosocial de la santé.

Social epidemiology, medical sociology, and other social sciences are systematically identifying and mapping out the specific causal pathways that demonstrate what oppressed people feel and know as lived experience—that violations of respect, in forms such as discrimination, are bad for one’s health. In the US, for example, much research has been conducted on how racial discrimination against people of colour impacts negatively on their health. Included is research that demonstrates evidence for psychosocial determinants of health—not only does discrimination function to skew access to resources such as healthcare and opportunities for healthy living, but it also creates stress and negative emotional states such as psychological distress, which can in and of themselves be manifestations of ill-health (e.g., in the form of psychological ill-health), or which can increase the risk of physiological disease and impairment, or both. A model of the way in which discrimination can affect emotions and in turn health can be called the discrimination-emotion-health model.

Identifying the causal pathways for specific health outcomes provides essential information to better understand the bad consequences of what is already a manifest injustice—wrongful discrimination—as well as to intervene to improve health outcomes. In this paper, however, I identify an unrecognized and troubling problem: that certain ways in which the relationship among discrimination, emotion, and health is presented actually reinforce inequities—for example, by reinforcing stereotypes, by prescribing how the disadvantaged should feel and behave, and by presenting the emotional life of the privileged as “normal.”

In the first and second sections of the paper, I identify the discrimination-emotion-health model and its implications. This model appears to underlie much public-health literature on discrimination as a psychosocial determinant of health but is not made explicit. In the third section I argue that an appreciation of the political dimensions of emotions indicates that the model can have troubling implications. I will provide a critique focusing on six concerns: the *reinforcement*, *agency*, *respectability*, *dissidence*, *fragility of privilege*, and *object of emotions* critiques. In the final section, I will demonstrate how this political critique helps us to develop the features required of a theory of health equity in order for it to best represent discrimination as a psychosocial determinant of health. I highlight six implications of the critique for theories of health equity, including the recognition that health policies have expressive value, and that oppressive systems can damage the privileged, as well as the oppressed. Thinking about the model and its critique according to such a theory will provide health policymakers and practitioners with a nuanced way of thinking about the role of emotions in health disparities, which can help with the development of suitable policies and guidance for health equity.

## 1. THE STRESS-EMOTION-HEALTH MODEL

Over the last few decades, social epidemiological and medical research have accumulated evidence for the causal connections between numerous social determinants of health and health disparities (e.g., Marmot et al., 1978; Marmot and

Wilkinson, 1999; Marmot, 2005; LaVeist and Isaac, 2012; Berkman et al., 2014). Social determinants of health, “conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks,” include factors such as discrimination and socioeconomic conditions (Office of Disease Prevention and Health Promotion; see also Marmot and Wilkinson 1999; LaVeist and Isaac, 2012; Berkman et al., 2014). Two of the primary categories of social determinants of health are material and psychosocial (Wilkinson, 1997; Marmot and Wilkinson, 2001).

Material social determinants of health can be described as the resources available to individuals and communities (e.g., healthcare, nutrition, and housing). Psychosocial determinants affect the individual psychologically, and this in turn impacts on health. The impact on health includes psychological health, which may seem obvious, and also *physiological* health (measured in terms of an increased risk of mortality from cardiovascular disease, for example). Claims that are made that *relative* position in a social hierarchy affects health, for example, are often claims about psychosocial determinants of health. It is not (only) the actual material circumstances that are impacting health, but (also) something related to how the situation makes the individuals think and feel about their social position that has this impact. Note that the same determinant can be both material and psychosocial—for example, experiencing homelessness can have a material impact (e.g., one is exposed to cold weather) and a psychosocial impact (e.g., one is anxious about experiencing homelessness and all that it entails).

Research is honing in on the various and complex ways in which social determinants impact the body (e.g., Adler and Newman, 2002; Berkman et al., 2014; Goosby et al., 2018). One of the proposed causal pathways for psychosocial determinants of health is via emotions. Research indicates that the experience of “negative emotions”<sup>1</sup> (e.g., psychological distress) can exacerbate poor health outcomes or increase the likelihood that certain poor health outcomes will develop (Kubzansky et al., 2014). For example, anxiety (Roest and et al., 2010) and anger and hostility (Chida and Steptoe, 2009) have been associated with an increased incidence of coronary heart disease. Furthermore, positive emotions appear to have positive, protective effects on health (Kubzansky et al., 2014, p. 324). It is not only one’s experience and expression of negative or positive emotions that is at play, but also, and perhaps primarily, the overarching mechanisms by which emotions are regulated. Being able to monitor and manage emotions has an influence on health—a lack of emotional self-regulation appears to contribute to poor health outcomes, while strong self-regulation appears to protect health (Kubzansky et al., 2014, p. 324–325; 337–338).

Emotions and their regulation can affect both healthy and unhealthy populations. They can influence the onset of certain diseases in healthy populations as well as exacerbate current diseases or increase the likelihood of additional diseases developing in unhealthy populations. Depression and anxiety have, for

example, been identified as increasing the risk of the *onset* of coronary heart disease (Kubzansky et al., 2014, p. 335–336).<sup>2</sup> While there is a lack of evidence to indicate that emotions are related to the onset of cancers, there is evidence to indicate that psychological distress plays a role in the further development of cancer after its onset (Kubzansky et al., 2014, p. 342).

While genes and individual behaviours are likely to affect emotions and their impact on health, social epidemiology emphasizes the significant role that social factors play in patterning negative emotions, positive emotions, and emotional self-regulation. Numerous social stressors and combinations of those stressors influence emotions and their regulation. A model used to delineate the causal chain linking social stressors, emotions, and health, as described in this section, where stress influences emotion and its regulation, can be called the *stress-emotion-health model* (Kubzansky et al., 2014, p. 326–327). Childhood trauma is a major stressor that impacts emotion—children who experience traumatic relationships with significant adults are at high risk of emotional dysregulation (Villalta et al., 2018). Discrimination and perceived discrimination are also stressors that can influence emotion and its regulation (Zilioli et al., 2017).<sup>3</sup>

Before we explore discrimination in more detail, consider, as illustration, how the stress-emotion-health model could be seen to manifest in the lived experience of the socially disadvantaged. Here is how Darren McGarvey (BBC, 2017), a rapper and social commentator from Glasgow, who grew up in what he refers to as “the lower class,” describes his first realization of how class differences in the UK manifest:

It was... when I took my first trip across to the affluent side of Glasgow where I really got insight. The first thing I noticed was how calm it was... And my first thought ... was, “all right, this is how people dress when they aren’t afraid they are going to be stabbed.” And for me that was a sort of real epiphany because I thought, okay, people here have more money but actually what they really have over me is an advantage, as they have an emotional reserve. They have an ability to absorb stress. They have this in-built resilience which I don’t have because I am constantly in a state of fight or flight.

Notice a couple of particularly interesting and insightful points. First, not only does it seem that being disadvantaged means you are likely to be exposed to more social stressors than someone who is advantaged, you also, McGarvey claims, have less effective coping mechanisms—“they have an ability to absorb stress.” This sounds similar to what the stress-emotion-health model would refer to as the importance of emotional self-regulation. Second, consider how he rejects the idea that the best way in which to describe his disadvantage is with reference to resources, such as his lack of income and wealth, although clearly these are disadvantages; rather, a primary disadvantage is related to emotions and, in turn, to its impact on health (e.g., being constantly in a physiological state of fight or flight).

There are different ways of understanding McGarvey's claims, however, and, in fact, his claims foreshadow some of the concerns I raise in section three. Consider that there may be an important difference between having "an ability to absorb stress," which sounds like it could overlap with emotional self-regulation, and having "an emotional reserve" because you are not exposed to a lot of stressors in the first place.<sup>4</sup> It is possible that those who are advantaged have both; however, in section three I will explore claims that, at least under certain circumstances, the advantaged break down easily in the face of stress precisely because they are not used to experiencing it and have not developed abilities to cope with it.

## 2. DISCRIMINATION, EMOTION, AND HEALTH

Discrimination, such as racial discrimination or discrimination on the basis of sexuality, has been identified as a significant social determinant of health (Krieger, 2014, 1999). It can have a material or psychosocial influence, or both. Discrimination (e.g., in the form of residential segregation) can influence where people live, leading people to live in areas with poor infrastructure, much pollution, exposure to environmental toxins, food deserts, a lack of safe spaces for exercise, and low-quality healthcare facilities. In this way, discrimination is a cause of *material* determinants of health and of exposure to toxic environments. However, responses to discrimination, such as psychological distress, mean that it can also be a psychosocial determinant of health. Here the stress-emotion-health model becomes significant—the specific stress involved is discrimination.

Consider racial discrimination as an example. Exposure to the stressors of everyday racism and microaggressions can make so-called negative emotions more likely to occur. In turn, these emotions, as we have seen, are linked to negative health outcomes. This includes mental ill-health—for example, an anxiety disorder (Levine and et al., 2014) or depressive symptoms (Nadal et al., 2014). Distress can also lead to or impact on poor health beyond constituting mental ill-health—for example, chronic worry about racial discrimination could be one of the factors that explains Black-White disparities in preterm birth (Braveman et al., 2017). While a majority of research on the impact of discrimination on health in the US has been done on racial discrimination, there is also evidence that other forms of discrimination (e.g., those based on sexuality, gender, age, religion, class, disability, and immigrant status) have similar effects on health. There is only limited research, however, on some of these forms of discrimination, such as age and disability, or on combinations of them (Krieger, 2014, p. 61–67, 81–105).

When the stress is discrimination, I will call the stress-emotion-health model *the discrimination-emotion-health model*. While this model is seldom explicit in the public health literature something like this model often underlies research on the influence of discrimination on emotions and health.<sup>5</sup>

### 3. THE POLITICAL CRITIQUE OF THE DISCRIMINATION-EMOTION-HEALTH MODEL

The stress-emotion-health model, and more particularly the discrimination-emotion-health model (from here on I will refer to the latter as “the model”), can clearly be significant in helping to develop our knowledge about population health and health inequity. Furthermore, the model often dovetails with humanities literature emphasizing the internalization of oppression and its psychological and emotional burdens,<sup>6</sup> by demonstrating some of the likely biological and psychological pathways that connect disadvantage and the risk of poor health outcomes. In this section of the paper, however, I will argue that, seen in isolation from a broader social context, and particularly in light of critical theory and political philosophy on race, class, gender, and the emotions, the model has possible implications that raise some concerns.

Criticisms of aspects related to the model are not unusual—for example, methodological concerns have been raised about measuring emotions primarily through self-report assessments (Kubzansky et al., 2014, p. 330–331), and concerns have also been expressed about how epidemiological research on discrimination and health disparities primarily focuses on interpersonal discrimination, rather than on structural discrimination (Krieger, 2014). The critique I formulate here is different, however, although at times it overlaps with some of the ongoing criticisms; in the final section of this paper, I will discuss how the criticism related to the neglect of structural discrimination is relevant to my critique.

The model could be taken to have the following implications: First, it takes as given that there are negative and positive emotions and it is fairly clear which are which. Second, it understands the relationship among social stressors, emotions, and health as following this pattern: On the one hand, the disadvantaged, due to their disadvantage, have an increased likelihood of experiencing negative emotions and a decreased likelihood of experiencing positive emotions. They are also at risk of emotional dysregulation. On the other hand, then, it follows that at least relatively, the privileged, due to their privilege, have a decreased likelihood of experiencing negative emotions, an increased likelihood of experiencing positive emotions, and an enhanced ability to regulate their emotions. For the disadvantaged the risk of negative emotional states and dysregulation can exacerbate, or increase, the likelihood of the incidence of ill-health, while the privileged receive relatively greater protection from these risks.<sup>7</sup> I am not saying that researchers, practitioners, or health policymakers who implicitly assume such a model are necessarily committed to these implications—my claim is rather that these implications could follow from the model, and, more specifically, as I discuss in this section, where they do, they raise often-unrecognized and troubling concerns.

Before we investigate the critique, I will make four clarifications or qualifications about my claims. First, I consider “discrimination” and “oppression”;



second, *which* oppressions; third, the use of *political* in “political critique”; and, last, theories of emotions.

While I am assessing the *discrimination*-emotion-health model I will often refer to “oppression” and to “oppressed people.” Social groups on whom this epidemiological research tends to focus are often not only discriminated against, but also oppressed. Discrimination can be understood as differential treatment, and *wrongful* discrimination then would be wrongful differential treatment (Hellman, 2011). Not hiring someone for a job because they are black is wrongful *racial* discrimination.

While wrongful discrimination is problematic in and of itself, and while it often overlaps with oppression, discrimination does not fully represent oppression. Concerns with how women and people of colour are unfairly disadvantaged in society are often concerns of more than discrimination but also of gender and racial oppression, respectively. Oppression also includes violence and exploitation, for example (Young, 1990; Cudd, 2006), and neither of these are well represented as discrimination, or as merely discrimination.<sup>8</sup> Exploitation committed against certain social groups is not primarily wrongful because it is wrongful *differential* treatment even though it is indeed wrongful differential treatment; it is because it is *exploitation* that it is wrongful—the treatment itself is morally wrong whether or not it is differential, although it becomes a concern of structural group oppression when one group (e.g., immigrants; people of colour) is more likely to suffer exploitation than another (citizens; white people) (see Haslanger, 2012, p. 311–338 on structural group oppression). Even if the epidemiological literature with which I am concerned is mainly focused on discrimination, in this critique I will refer to oppression as well, in an effort to recognize that often the discrimination being identified is part of systematic oppression. Moreover, analysis of the literature on oppression has necessitated this critique—it is when we assess the relationship between oppression and emotions that aspects of the critique become apparent. There is more to be said about the importance of considering oppression, but I will discuss this in the final section of this paper; preliminarily, I have explained my use of terms, foreshadowing my discussion of the implications of the critique later on.

Second, I will focus primarily, but not exclusively, on three forms of discrimination and oppression—racial, gender, and class based, as well as intersections of these. This does not mean that my claims about oppression, emotion, and health necessarily lack application to other axes of oppression, such as disability and sexuality; rather, much of the relevant literature that seems to apply well to my critique tends to centre around socially constructed race, gender, and class, although it may also apply further. I consider the particular oppressions I discuss to be *examples* of the categories of critique rather than fully representative of them. I do, however, also recognize that particular oppressions and intersections of those oppressions have unique histories and features. The particular point I aim to make in this paper is not, however, about one particular form of oppression but about oppression more generally—it would be fruitful, however, to

explore these critiques according to each particular axis of oppression, and their intersections, to consider how applicable they are and where distinctions may lie.

Third, let me note why I refer to this as a *political* critique. I take political here to emphasize the relationship between the state and its residents (the people living within its territories, no matter their legal status). My use of this term is pragmatic—not all of the aspects of the critique below seem necessarily directly related to this relationship. However, by using the term “political” I want to emphasize that while discrimination and oppression can occur outside of relationships between the state and its residents, the kinds of discrimination and oppression that, as things stand, should cause us most concern morally, and which require the most urgent action, are systematic forms of group oppression. These oppressions, while they exist in everyday and interpersonal relationships, are very much a feature of the state, its agencies, its laws, its policies, and its communications.

A final clarification concerns philosophical theories of emotions. I take no direct stand in this piece on what kind of theory of emotions should be endorsed—this would be beyond the scope of this paper. However, it is worthwhile to acknowledge that some of the claims I make preclude certain theories of emotions and assume others. For example, my claims preclude physiological and sensation theories of emotions, where these claim that “emotion is considered primarily or exclusively a ‘feeling’” (Calhoun and Solomon 1984, p. 9). They also preclude the notion that emotions are exclusively inner, private feelings, and that they are exclusively or primarily instinctive, rather than (also) learned (Calhoun and Solomon 1984, p. 14, 33). Instead, my claims assume that emotions have a cognitive basis (e.g., Nussbaum 2003) and that they are strongly socially shaped (e.g., Ahmed, 2015).

#### a. The Reinforcement Critique

We should be concerned if the discrimination-emotion-health model is used in such a way that problematic stereotypes of oppressed people and problematic connotations of certain emotions are reinforced. First, the stereotyping of social groups often includes stereotypes about their emotional states and their emotional regulation. Across numerous cultures, women have often been characterized as being “emotional” (Jaggar, 1989; Ahmed, 2015, p. 168–172, 195; Niedenthal and Ric, 2017, p. 247–271), which implies that they have an inability to control their emotional responses—for example, in being prone to crying. Black women, more specifically, are often depicted as angry (Moreton-Robinson, 2003, p. 70; Lorde, 2007 [1984], p. 124–133, 145–175). Working-class men in the UK are also often depicted as angry and hostile (Nayak, 2006, p. 823; Wollaston, 2018). The model could be interpreted as validating these stereotypes, encouraging the idea that, yes, people who are socially disadvantaged are indeed more likely to experience negative emotions or to struggle with emotional self-regulation. The model provides a more sympathetic account of the relationships between emotions and social groups than models that claim that these

emotions are determined by innate characteristics—it is precisely *because* of social injustice that members of certain groups are likely to experience these problems with affective states; however, the problem remains that the model could be described in a way that endorses the stereotypes.

Second, we should also be concerned if the model not only reinforced stereotypes about oppressed people, but also reinforced problematic connotations of emotions and of emotional self-regulation. Consider that the model may take for granted what is a “negative” or “positive” emotion. Being emotional, crying, openly showing distress, and being angry are not only often associated with being a woman or with being a black woman, but they are also often associated with something negative, something that you are doing *wrong*. The discrimination-emotion-health model seems to reinforce ideas that these are indeed negative emotions, by directly labelling them as such and by emphasizing the health costs associated with them. I am not claiming that we have no reason to be concerned about the possible consequences of certain affective states associated with anger and anxiety. However, it is important to emphasize that notions of what are positive or negative emotions are not politically neutral, and which emotions should be encouraged and which discouraged is already imbued with social value. Particularly of concern is that these values are often likely to reflect the values or perceived characteristics of the privileged—for example, it is the stereotypically feminine mode of emotional being to be distressed or to be lacking in control over emotions that is considered negative. Analyses of oppression and emotion can question and complexify this—these emotions are appropriate (Srinivasan, 2017) and can, at least in certain ways, be “positive.” Consider, for example, Audre Lorde on the productivity of anger in the face of oppression (Lorde, 2007) and Darren McGarvey on the justifiability of anger as a norm among the working class in the UK (McGarvey, 2017). Here the stereotypes about the oppressed and their tendencies to certain negative emotions are in fact embraced—yes, many African-American women are angry and, yes, so are working class men in the UK, but they are angry because that is the appropriate, and even productive, reaction to the injustices they suffer.

Endorsing the discrimination-emotion-health model needn’t commit one to reinforcing troubling stereotypes, nor to the problems highlighted by the remaining critiques; however, it’s important to recognize that there is a danger of this happening when one is endorsing the model, and that when one is discussing, researching, or acting on the literature on discrimination and health, that one take care to avoid the dangers associated with these critiques.

### b. The Agency Critique

One could use the model to encourage social control over oppressed groups, even if unintentionally, thus interfering with their behaviour and undermining their agency. The model’s users could be seen to promote certain attitudes and behaviours associated with emotions, for example, encouraging the avoidance of negative emotions, thus seeming to prescribe how oppressed people should

feel and how they should be regulating their emotions. This can be called a problem of agency because it implies that the disadvantaged have a diminished capacity for intentional action—at least in terms of the experience and expression of emotions and of the regulation of these—and for this reason, their behaviour needs to be externally influenced so that they are able to act healthfully.

Of course, public policies often intend to influence, even dictate, behaviour (e.g., requiring seatbelt usage). The concern here is not, however, that the behaviour of the population as a whole is being influenced; rather, the concern is related to inequity between or among social groups. When the focus is on how discrimination influences emotion and health, the control that it might imply over behaviour is specifically related to the behaviour of oppressed people—they are the ones, according to the model, suffering a greater risk of health problems due to the experience of negative affective states and emotional dysregulation, as well as to the lack of protection that positive states would provide them. Not only is the model in danger of justifying control of oppressed groups, it also seems to normalize the behaviour of the privileged—it is they who seemingly experience healthy, normal emotional states—and pathologizes the behaviour of the oppressed. The analogy with seatbelt regulations, for example, would seem more relevant if the disadvantaged were the only group who were encouraged to wear seatbelts. A further point to consider is that emotions and emotional regulation are somewhat morally different from behaviours such as seatbelt usage. Which emotional states we experience and how we express and regulate those emotions can be a part of our identity in a way that wearing seatbelts appears not to be. Thus, this is a concern not merely about interfering with our independence as agents, but interfering with our identities. Public health efforts that aim to help individuals regulate their emotions might be not only ignoring that those emotions are apt and justifiable, but also undermining individuals' identities, trying to make them into different, albeit, healthier people.<sup>9</sup>

In fact, the causal picture that the model could put forward may be flawed in a further way that does not take the relationship between agents' identities and emotion into account. Here let's return to an example of class. Using the work of Raymond Williams and Annette Kuhn as her references, Beverley Skeggs (1997) claims that when it comes to the relationship between class and emotions such as anxiety, it is not merely that being working class *causes* anxiety but that class is *constituted* by certain emotions. Class is, among other things, a “structure of feeling,” and being working class means that “doubt, anxiety and fear inform the production of subjectivity” (Skeggs, 1997, p. 6). How should we understand this? What is significant here is that individuals shouldn't be seen (merely) as agents who encounter the world and then whose subjectivity and identity are influenced by the world via emotions; rather, who that agent is and how that agent's identity has been shaped from the start is already impacted, among other ways, emotionally, by how the agent is “classed.”<sup>10</sup> Emotions and disadvantage are then deeply entrenched in a person's socially determined identity and in how that identity shapes that person's subjectivity.

This can have implications for how we try to resolve the problems caused by social stressors—when we think of a pathway from stress to emotion to health it seems as if intervention at the point between stress and emotion (for example, providing enhanced access to mindfulness training) might be particularly fruitful. However, when we emphasize that the agent’s identity has already been partially constituted by expectations of emotions associated with social grouping, then trying to intervene to stop ongoing stressors influencing emotion becomes a less appropriate approach. This does not mean that such interventions should not be implemented—they may well need to be—however, as I discuss in the final section of the paper, they are often second-best solutions to what are major structural injustices. Ideally, it is the structural injustices rather than primarily problems of an individual’s health that need to be addressed, and focusing on the individual’s health can interfere with that individual’s agency and identity, even though it may improve health.

It seems, however, that by describing class in this way we might be making the problem of agency even worse—the implication is not only that oppression can influence behaviour, but also that what it means to be oppressed is constituted partially by particular emotional expectations. Does this critique not have even more troubling consequences for the free agency of the oppressed than the possible implications of the model do? This, however, would miss an important part of the critique. The claim is not that the emotional lives of *only* those who are disadvantaged—e.g., the working classes—are partially constituted by social structure. Rather, class is, among other things, a structure of feeling, and that means all classes, including the privileged (the upper and middle classes). Which feelings, however, depends on which class. In other words, while the discrimination-emotion-health model could be assumed to imply that the privileged have an increased likelihood of experiencing healthy emotions and strong emotional self-regulation, whereas the disadvantaged have an increased likelihood of experiencing unhealthy emotions and poor emotional self-regulation, as if the privileged are unfettered and their behaviour is “normal,” the claim here is that everyone’s emotional life is shaped by privilege and disadvantage. The ways in which the emotions and subjectivity of the privileged are shaped is not necessarily “normal,” even if in many ways it represents or entrenches their privilege. The last two critiques—*fragility of privilege* and *object of emotions*—will explore this point in more detail.

### c. The Respectability Critique

A third concern is that the model may unintentionally support respectability politics. Marginalized peoples are often expected to act in a so-called respectable way, which can require them to disassociate themselves from the values and practices of their own communities and cultures and to act according to the norms of the privileged. Besides reinforcing problematic notions of what it means to be a citizen, this could be self-defeating, as the model may then be encouraging frustration, anger, and distress, for example, at having to maintain respectability, and these are some of the very emotional states that, it purports, can negatively impact health.

Critical theories of class as well as race express concern that the exemplar of a citizen demands particular attitudes and behaviours (Young 1990; Skeggs, 1997; Cooper, 2017). Not only do these demands encourage people to act in ways that may not suit their particular personalities, but these attitudes and behaviours are often those typically associated with privilege. The ways in which the privileged tend to act in a particular society are the basis for the norms to which everyone else is subject in order, for example, to be respected, to be taken seriously, and to garner valuable social opportunities, such as jobs and education. These can be called *norms of respectability*.

Consider, for example, the behaviours, attitudes, and preferences that are often associated with being highly educated and well-to-do in the US—these will differ at least somewhat from one community to the other, but among them are likely to be expectations about emotional states and their regulation, including expectations about being able to control the expression of emotions, particularly any strong emotions. Here the respectability critique expresses a concern independent of the agency critique; it is not only that the agency of the disadvantaged is undermined, but also that *how* they are expected to behave—respectably—is independently troubling.

The first concern from the respectability critique is that the discrimination-emotion-health model can be seen to encourage the oppressed to act respectably—that is, to adopt the particular norms of respectability determined by dominant values. The second concern is that this emphasis on being respectable may in fact create the problem that it seems that the model would want us to rally against—consider that the pressure to act respectably could generate frustration and anxiety, as well as the suppression of emotions, thus seemingly creating greater risks to health. Indeed, there is growing evidence that the need to act respectably has health costs for African-Americans (Lee and Hicken, 2016).<sup>11</sup>

#### d. The Dissidence Critique

As the agency and respectability critiques claim, the model may be used to prescribe feelings and behaviours to the disadvantaged. An overlapping yet independent concern is that the model can be used to encourage them to behave in particular ways in the face of *injustice* when health becomes prioritized over other values. Indeed, even more specifically, it appears that the model can be used to shape their responses to the discrimination with which it is concerned. If the advice that follows from the model is that negative emotions such as anger should be avoided and that high-intensity emotion should be controlled in the name of health, for example, then it may sound as if the model encourages passivity in the face of injustice and brands anger and the motivation to protest as pathological. Dissidence, except in its most subdued forms, may be undermined.

One could argue in response to this concern that by indicating how emotions are linked to health outcomes, the model could be used to provide important

guidance on how best to pursue dissidence and protest. The advice that might follow from the model could emphasize that there are healthier and unhealthier responses to injustice, and that in the face of injustice, while dissidence may be necessary, one would do best to regulate one's emotions and to avoid negative emotions, thus protesting and resisting injustice in a calm (and healthy) manner.

While the burdens of dissidence against injustice, which include emotional and health burdens, should be recognized and further researched,<sup>12</sup> this response to the dissidence critique is not ideal. First, it still seems subject to both the agency and respectability critiques—the model appears to be prescribing what dissidents should feel and express if health is overly prioritized, and it does so in ways that seem to reinforce notions of respectability. The anger of dissidents, for example, and especially the anger of women of colour, is often used as an excuse by dominant groups not to listen to the claims made by oppressed groups (Lorde, 2007; Cherry, 2018). The model could be seen to provide a scientific and paternalistic basis for the privileged to continue to ignore dissidence that is expressed with anger or other intense emotions—“calm down, it's not healthy for *you* to express your claims in this way.” I am not implying that the disadvantaged would be wrong to take the potential health consequences of intense emotions into account, nor for epidemiologists to warn about the links between emotions and health—rather, I want to point to the pitfalls associated with expressing the relationship among discrimination, emotions, and health in an overly simplistic way that would neglect the concerns I express in this section.

Second, this response remains vulnerable to the dissidence critique itself when we consider certain understandings of dissidence—that is, when we think of emotions *as* dissidence. Sara Ahmed (2015) argues, for example, that it is not that oppression is likely to spur emotions such as anger and fear, which in turn can encourage dissent or which can be expressed as part of resistance to oppression, but indeed, the actual experience and expression of these emotions *is* resistance. She argues that challenging unjust social norms means adopting a new emotional response to those norms, and it is that emotional response that partially constitutes one's resistance (Ahmed, 2015, p. 144–190, 196). What I am emphasizing here is that separating out emotions and ill-health from dissidence—thus, for example, trying to promote calm, healthy dissidence—can be problematized when we consider that dissidence can require the experience of certain so-called negative emotions, and thus the dissidence critique of the model (the claim that this model could be used to discourage dissidence) can apply to even a modified version of the model's implications.

#### e. Fragility of Privilege Critique

The model's potential implications may also neglect the ways in which privilege can make one particularly vulnerable to negative emotions. Here we can refer to the “fragility of privilege critique” relying on what Robin DiAngelo (2011; 2018) has influentially termed “white fragility.” DiAngelo argues that white people in the US suffer a kind of fragility “in which even a minimum amount of racial

stress becomes intolerable, triggering a range of defensive moves” (2011, p. 57). Among these defensive reactions, DiAngelo identifies the expression of emotions such as anger, fear, and guilt. An example of a situation that might trigger these defensive moves is when a person of colour describes the US as still severely hampered by racial oppression.

DiAngelo implies that white people thus have—in the terms familiar to the discrimination-emotion-health model—a reduced capacity for emotional self-regulation and a tendency towards negative emotions that *stem from their privilege*. This disrupts the idea that it is being oppressed that will increase the likelihood of negative emotions or troubling emotional traits. DiAngelo also argues not only that white people are lacking, at least under certain circumstances, in what she refers to as “psychosocial stamina” (p. 56), but also that people who are oppressed do have this kind of stamina.

DiAngelo is referring to a specific axis of oppression—racial oppression—and within a specific context, the US. We can see, however, that this kind of identification of privilege with fragility has also been identified in some other contexts of oppression. For example, think of some feminists’ claims about the vulnerabilities of masculinity within patriarchy. Among the harms to *men* in patriarchal societies are those related to stress and emotions. The pressure to live up to expectations of masculinity, such as the expectation to be the primary provider for a family and to be strong and in control, which includes being very much in control of emotions, for example, has been identified as leading to “repressing... emotions, failing to develop emotionally” (Jaggar, 1989) and even promoting violence (Miles, 1992). Public health research also indicates that women may cope better with stress because they tend to employ better coping strategies such as seeking social support (see, e.g., Williams 2003); one of the reasons that this may be the case is related to gendered norms—for example, the norm that men are relatively discouraged from seeking support from others. One can say, then, that men in patriarchy are often likely to be emotionally impaired, despite their overall privilege.

A noteworthy corollary of the notion that privilege can make one fragile is that moving from a position of disadvantage to one of advantage also implies vulnerability. Consider, for example, the way in which Lynsey Hanley (2017) describes moving from the UK working class, in which she was born and raised, to the middle class: “I am... one of ‘the uprooted and anxious’: at once socially mobile and psychologically stuck, or at least divided, somewhere in between our place of origin and the place we must inhabit in order to ‘get on’” (p. xiv). Social mobility, she claims, comes with its own emotional problems. When Hanley became more class privileged, she did not also become emotionally privileged, despite the typical association of being of higher class and being less likely to suffer (at least certain) negative emotions. Note that she is not claiming that her social mobility caused anxiety because, as someone who started off as working class, she does not have the tools to regulate her emotions, tools which someone



who started off privileged might be more likely to have, according to our model. Her claim is that in order to be middle class, one has to disassociate one's self from one's working-class values and background, and this causes anxiety; thus, this risk of anxiety becomes a necessary part of climbing the class ladder. According to Hanley, then, social immobility in the form of working-class people remaining working class does psychological and emotional damage (p.xii) as one might expect, considering the discrimination-emotion-health model, *but so does social mobility*, a more surprising claim.

By including Hanley's claims, we can say that the fragility critique means that *being* privileged can be associated with emotional problems, and so can *becoming* privileged. One should not then assume—as the discrimination-emotion-health model might be taken to imply—that disadvantage should necessarily be associated with an increased likelihood of emotional problems, and privilege with healthy emotions.

#### f. Object of Emotion Critique

A final concern is the idea that the person for whom or the thing for which we should feel emotion is already imbued with social and political value. Here I am thinking of claims, such as those expressed by Judith Butler (2006) and Sara Ahmed (2015), that emotions are often *the products* of social norms that aim to uphold or create power relationships. In this sense, the objects of emotions—e.g., the people for whom one should feel emotions—are socially determined and reflect which lives are valued and which are not. According to this critique, then, the privileged often exclude the disadvantaged as the objects of emotions like grief and compassion.

Consider, for example, the journalist Seymour M. Hersh's reaction to the charge sheet brought against one of the US soldiers responsible for the My Lai massacre during the Vietnam War, which asserted that he was being charged with the premeditated murder of 109 "Oriental" human beings: "Did the Army mean to suggest that one 'Oriental' life was somewhat worth less than that of a white American? It was an ugly adjective" (Hersh 2018, p. 57). The object of emotion critique claims that the use of the word "Oriental" marks out the victims of the massacre as undeserving of the same emotional response as (white) Americans should have for the murder of (white) Americans. One need not turn to the 1960s for relevant examples—when heads of state, here Donald Trump and David Cameron respectively, describe migrants as "rapists" (Jacobs, 2018) and use the collective noun "swarms" to refer to them (BBC, 2015). Among other effects, they indicate that migrants don't deserve to be objects of emotions such as compassion, love, pity, and grief; the objects of emotions such as these are human beings, implied in this case to be limited to citizens. While migrants are denied status as objects of these emotions, indicating that their lives have less value, this kind of language seems to also encourage particular emotions towards them—e.g., while compassion and grief may be denied them, hatred, outrage, and fear seem appropriate when we are dealing with "rapists" and "swarms."

This can be termed a critique of the discrimination-emotion-stress model because it complexifies the idea that if privilege does have an influence on emotion, then it is likely to advantage the privileged. As this critique and the previous one—the fragility of privilege critique—indicate that there is potential for privilege to *impair* the emotional lives of the privileged. In the case of the object of emotion critique, the privileged appear more likely to have a restricted and troubling emotional range towards the oppressed and disadvantaged. Thus, the privileged do not have so-called normal or healthy emotions in this respect; they have an impaired emotional range. This insight—that the privileged aren't necessarily emotionally privileged—is one of the significant implications of the political critique that I explore in the next and final section of this paper.

#### 4. IMPLICATIONS OF THE POLITICAL CRITIQUE FOR HEALTH EQUITY

In the previous section I highlighted six critiques of potential implications of the discrimination-emotion-health model. I want to emphasize that my claim is not that the model is wrong—indeed, I believe it provides a highly significant perspective on the relationship among discrimination, emotions, and health. However, I am claiming that, seen in isolation, it provides a very partial picture of these relationships and that the implications of this partial picture can be troubling. The primary aims of this paper were to identify the often-implicit model and its possible implications, and to highlight my critique—accomplished in sections 1–2 and 3, respectively. In this final section, I explore what we can learn from the critique in order to represent the relationship among discrimination, emotion, and health more fully. Particularly, the political critique has implications for how we should understand health equity/inequity. While much of the analysis in this section is (necessarily) theoretical, there are likely to be significant implications for practice—for example, for epidemiologists in conducting research, for public health practitioners in developing guidance for individuals and communities, and for health policymakers.

I will highlight six implications of my critique for an understanding of how a framework of health equity/inequity should be specified and I will demonstrate how positioning our understanding of the relationships among discrimination, emotion, and health within such a framework will help us to avoid troubling implications of the model.

First, health inequity needs to be understood as part of a wider and pluralist notion of social injustice.<sup>13</sup> In this particular case, the inequities associated with relationships of discrimination, emotion, and health are best understood in the context of social injustice more generally and not merely as issues of health inequity. By a pluralist notion of social justice, I refer to a specific kind of pluralism, dimension pluralism—that is, pluralism in the dimensions of an individual's well-being or capabilities that are relevant to equity.<sup>14</sup> According to dimension pluralism, when we aim to determine what is equitable we need to consider each of these dimensions, which could include being healthy, being

respected and having self-respect, and being autonomous.<sup>15</sup> Health is seen as only one of a number of significant morally valuable dimensions in an individual's life, not as the only value or as necessarily the most important value. We can see how this is related to the political critique of the discrimination-emotion-health model by considering as an example the dissidence critique. Where this critique seems particularly relevant is in cases where we use the model combined with *health exceptionalism*, which means that health is treated as the only or the most important dimension. When we do so, we promote the idea that an individual's health should be prioritized above all else, including the individual's dissidence in the face of injustice. A dimension-pluralist notion of justice, however, helps us to recognize that health is only one value, so we are more likely to recognize that promoting the best health outcome could undermine other values, such as an individual's attempts to act autonomously and with self-respect by protesting injustice.<sup>16</sup>

Second, recognizing the significance of the model and of the critique necessitates consideration of second-order injustices. Second-order injustices occur due to another injustice (the first-order injustice). A concern that could be expressed about my argument is that taking both the model's possible implications and their critique into account might result in inconsistency. For example, if we take both health and self-respect into account, this could interfere with the provision of coherent guidance as to which should be promoted, because each is morally significant. Speaking about anger that is both apt *and* counterproductive, Amia Srinivasan (2017, p. 134) puts it this way: "We want to say both at once, and yet that will be to offer practically incoherent advice." However, rather than this being a problem with my argument, it is actually an important consideration that should be accommodated by a framework of health equity. It is not that there is only an initial injustice—discrimination—which in turn can have unjust consequences in the form of health inequity, but rather that discrimination can also often lead to second-order injustices in terms of the conflict an individual has to face in being forced to choose between two significant dimensions. It is another *injustice*, rather than merely a moral conflict, when it is the disadvantaged, those who are already suffering the first-order injustice, who then, in light of this injustice, must face a further burden—making a choice between independent, morally significant values.<sup>17</sup> Using Srinivasan's analysis of anger, we can refer to this kind of second-order injustice, where it is related to apt emotional responses, as an *affective injustice*: "It forces people, through no fault of their own, into profoundly difficult normative conflicts—an invidious choice between improving one's lot and justified rage" (p. 136).

Frameworks of health equity that can thus incorporate a notion of second-order affective injustice may do a better job of representing the relationships among discrimination, emotion, and health. Such a framework indicates that even when emotions and health are not negatively affected by discrimination, a significant and inequitable loss may still have occurred, such as when individuals have sacrificed their autonomy and self-respect in order to behave more healthfully.

Third, by investigating the relationship of discrimination, emotion, and health within a wider context of social injustice, we can see that greater weight should be put on *structural oppression* in population and public health, with an emphasis here on both the “structural” and the “oppression.” As I mentioned at the beginning of section 3, a central criticism of the epidemiological literature on discrimination is that it neglects structural discrimination. As Nancy Krieger (2014) explains, much research focuses on *interpersonal discrimination*, which refers to “encounters between individuals in which one person acts in an adversely discriminatory way toward another person” (p. 63). In contrast, there is limited research on *structural discrimination*, which refers to “discrimination enacted by institutions (e.g., laws or rules that impose adverse discrimination, by design, such as legalized racial discrimination, or in effect, such as the racialized impact of the New York Police Department’s ‘stop-and-frisk’ policy”...) (*ibid*). While I agree with Krieger’s concern, research should focus more on structural *oppression*, and not merely discrimination. As I mentioned in section 3, discrimination does not seem to capture oppression fully, and thus the various disadvantages associated with racial and other forms of injustice, such as exploitation and violence, would not be fully captured either, even if structural discrimination were taken into account.

Consider, for example, that it is by recognizing the structural nature of oppression that the reinforcement and respectability critiques become apparent. These critiques emphasize that emotions and emotional self-regulation are already imbued with social meaning, and, more specifically, that they are imbued with the meaning of systematic power relationships reflected in structures such as social norms (and not merely in instances of individual behaviours or particular policies). The oppressed are stereotyped as being a certain way emotionally (e.g., having a lack of emotional control or a tendency to express certain kinds of emotions), and that way is seen to be supposedly negative, while the stereotypes of the emotional ways of the privileged are considered to be “positive,” and the oppressed are encouraged to be more like the privileged. Furthermore, an overemphasis on the *interpersonal* appears to focus our attention so much on individuals and their behaviours that it may seem that solutions to problems associated with discrimination, emotion, and health should primarily occur at an individual level as well; for example, that healthcare professionals should be encouraging individuals to develop tools of emotional self-regulation and to experience or express fewer negative emotions. An emphasis on the structural helps to show that ultimately structural solutions are required.

The fourth point, following on from this, is that health-focused interventions, while they may be necessary, are likely to be second-best solutions to the inequities associated with the model. The primary normative concern with social determinants of health, such as discrimination, is that they are not issues of health per se but rather issues of social injustice, and solutions to them should primarily be approached as such (Preda and Voigt, 2015). Racial or class discrimination (and oppression) are the normative problems, *whether or not* they lead to health problems. In other words, the health inequities that may be associated

with discrimination are inequitable consequences of what is already an inequity—the wrongful discrimination itself. Ideally, the primary solution to these inequities is reducing or eliminating discrimination, as opposed to trying to solve the emotional and health concerns associated with them. This does not mean that we—as policymakers and public health or healthcare practitioners and ethicists—should not *also* be concerned about the health inequities themselves, and we may need to address them. But when we do so, we should recognize that we are providing second-best solutions—in other words, we are aiming to make the situation more equitable for the disadvantaged, but we are not thereby fully solving the problem.<sup>18</sup> Furthermore, what a good second-best solution is should be informed by the wider context of social injustice. Consider again the dissidence critique: if we did not take this critique into account, the discrimination-emotion-health model could be seen to imply that individuals should necessarily forego dissidence to promote better health. Ironically, however, we would then be giving them advice that may undermine one of the few means available to them to try to change an unjust system, such as through protest and civil disobedience.

Fifth, health policies, programmes, and guidance and the discourse surrounding them have expressive value that can influence how equitable they are. This means that the equity of a policy should be assessed not only according to its direct impact on health and healthcare, for example, but also according to the message that that policy expresses (for ease, I will refer in the following only to “policy” but my claims are not limited to policies—public health programmes and the guidance given by health agencies, for example, can also be expressive). In considering whether or not the policy should be pursued, what it expresses should be taken into account, and, more particularly, what it expresses in terms of the respect it shows for the disadvantaged is significant (Anderson, 1999; Voigt, 2018). Part of the concern the political critique is highlighting is expressive. It is asking us to consider what the model’s implications may be expressing about the oppressed—is it, for example, problematically implying that the emotions and emotional self-regulation of the privileged tend to be normal, while those of the oppressed tend to be pathological and require change so that they resemble those of the privileged?

As an example of how this might apply, consider an explanation that may be provided to justify an increase in mental-health resources in a deprived urban area where African-Americans are a majority. If the model is used as a justification for this reform, expressive problems could follow—for example, according to the reinforcement and agency critiques, this justification can reinforce stereotypes about the disadvantaged being prone to a lack of emotional self-regulation and to pathological behaviour. Furthermore, this justification appears to be conveying a message to the community that the actual primary injustice they are suffering—racial oppression—will not be addressed, but only its consequences will be. In this case, there are reasons to use a justification that conveys a more respectful message—for example, by referring to redressing the likely

healthcare resource deprivation and specifically the lack of mental-health resources in these areas as the central reason for the policy.

Last, when considering health inequity within the context of social injustice, we need to consider the influence of injustice on both the privileged and the disadvantaged. The fragility of privilege and object of emotion critiques especially demonstrate that emotional impairment can be associated with privilege in an unjust society. This fits in well with thinking about *structural* oppression—the entire social system, including its social norms and major political and economic institutions, reflects and maintains injustices, influencing and shaping everyone within it. The privileged, while mostly benefitted by the system, are not somehow outside of it; they too are shaped by it, and that shaping is not always positive and, indeed, can be damaging in different ways, including emotionally. Policy and guidance that promote the idea that only the emotional states and traits of the oppressed are influenced by injustice, and that the privileged are seemingly autonomous and emotionally “normal” are likely to pathologize and stereotype the oppressed. While I emphasize this point here in relation to health inequity and the discrimination-emotion-health model, I think it requires greater attention even within the wider literature on social injustice and oppression. Much more work needs to be done to unpack how the privileged are damaged by the oppression that, in many but not all ways, privileges them.<sup>19</sup>

## CONCLUSION

The discrimination-emotion-health model helps to capture a significant part of the way in which social stressors like discrimination can influence emotion and health. In this paper, however, I have identified six aspects of a political critique of the potential implications of the model that demonstrate how they can reinforce injustices, including health inequities and the disrespectful social norms and stereotypes underlying discrimination. To improve the health of populations and communities equitably in light of the psychosocial influence of discrimination and oppression on health, both the model and the critique need to be considered. We need to understand this psychosocial influence within a framework of health equity/inequity, which emphasizes the following: health should be understood within a pluralist theory of social injustice; the relationships among discrimination, emotions, and health lead to second-order injustices; structural oppression, not merely interpersonal discrimination, is a major factor in the social determination of emotions and their regulation; health-focused solutions to the problems created by social injustice to emotion and health are often second-best solutions; health policies and guidance have expressive value; and the emotional states and expectations of the privileged are also shaped by oppression.

## ACKNOWLEDGEMENTS

Many thanks are due to participants at the “Phil Lunch” presentation series at the Department of Philosophy, University of Washington, and those at the colloquium of the Department of Philosophy, University of Victoria, for questions and comments on the paper. I also much appreciate the detailed feedback I received from Erika Blacksher, Sara Goering, Anjum Hajat, and Kristin Voigt; their constructive comments have helped enormously in improving this paper.

## NOTES

- <sup>1</sup> Preliminarily, a negative emotion is one where its experience is usually considered undesirable by the individual experiencing it, while a positive emotion is one that is usually considered desirable. In section 3 of this paper, I raise concern about what is often an unquestioned presumption in the epidemiological research about which are negative and which are positive emotions.
- <sup>2</sup> Depression and anxiety, although at times described in the epidemiological literature as “negative emotions” (Kubzansky et al., 2014, p. 330), are not merely emotions. In the psychological literature they are also considered to reflect “complex constellations of chronic elevations of maladaptive cognitions and behaviors” (Kubzansky et al., 2014, p. 330). When I refer to research focused on depression and anxiety, this can be understood as taking an interest in the emotional states with which they are often associated, although I recognize that they are not merely, or even at times necessarily, represented by emotional states. Underlying this discussion are important philosophical questions about emotions, beyond the scope of this paper to address—e.g., what counts as an emotion and thus which are emotions (Calhoun and Solomon 1984, p. 23–26).
- <sup>3</sup> Health, of course, can influence emotions, and could also be a basis for discrimination so the causal relationship can function in different directions. This paper, however, is focused on discrimination as a stressor and thus as a social determinant of health. The name of the model—stress-emotion-health—indicates the direction of the causality on which we are focused.
- <sup>4</sup> I thank Kristin Voigt for pushing me to clarify this point.
- <sup>5</sup> Consider, for example, how abstracting a model from research on discrimination as a psychosocial determinant of health (usefully summarized by Krieger 2014) combined with research on the influence of social stressors on emotions and health (usefully summarized by Kubzansky et al. 2014) is likely to result in the discrimination-emotion-health model.
- <sup>6</sup> For a classic account of the internalization of oppression, see Frantz Fanon (2008 [1952]). For more recent work, see, for example, Ann Cudd (2006) on the psychological mechanisms of oppression and Nora Berenstain (2016) on epistemic exploitation and its emotional burdens.
- <sup>7</sup> The privileged can also be referred to as the advantaged or the dominant group. The disadvantaged and the privileged are those disadvantaged or privileged by social injustice—e.g., as represented by inequities in the distribution of social goods or by social-relational inequalities—in a particular society. This can occur along a number of axes often represented by membership in a social group. So, for example, merely being a man in many societies will mean that you experience some privilege as a man, even if you are often disadvantaged according to other axes—e.g., class, sexuality, and race. A particular individual then could be disadvantaged when our focus is on one axis (e.g., race), but that same individual could be privileged according to another axis (e.g., class), and whether or not that individual should be considered disadvantaged or privileged will depend on which form of discrimination or oppression we are focused on. It is worthwhile to acknowledge here that people who experience multiple disadvantages are uniquely disadvantaged in ways that cannot be represented by “adding up” the disadvantages of the single axes along which they are disadvantaged—e.g., black women are disadvantaged not merely as black and as women but also as black women specifically (see, for example, Crenshaw, 1989).

- <sup>8</sup> The relationship between oppression and discrimination is itself often not explored enough in the humanities literature, with some theorists, for example, even downplaying or ignoring discrimination in their analyses of oppression (Young, 1990). While the relationship requires greater theoretical exploration, I take it here that oppression and discrimination are not identical, and each is significant. I also take it that discrimination is often one of the constituent parts of oppression, but that oppression is not necessary for wrongful discrimination to occur. For example, it is reasonable to claim that it is pro tanto wrongful discrimination when a landlord in Seattle refuses to rent an apartment to anyone who has recently moved there from California, for the reason that she dislikes Californians, but that does not mean that Californians are oppressed in the process.
- <sup>9</sup> I thank Sara Goering for helping me to formulate this point.
- <sup>10</sup> See also Sara Ahmed's (2015) theory of the sociality of emotions. She claims that "emotions create the very effect of the surfaces and boundaries that allow us to distinguish an inside and outside in the first place ... the 'I' and the 'we' are shaped by, and even take the shape of, contact with others" (Ahmed, 2015, p. 10).
- <sup>11</sup> Lee and Hicken consider the health costs of "vigilance" as a manifestation of respectability and do not focus on emotions per se; however, it seems reasonable to claim that vigilance is often related to the suppression of emotions such as anger and could increase the likelihood of experiencing emotions such as psychological distress. In fact, one of the primary results of their study is that vigilant behaviours are associated, in a dose-response fashion, with depressive symptoms (Lee and Hicken, 2016, p. 433–435), and thus we can understand their research as partially measuring stress, emotion, and health, where vigilance is the stress (the proximal stress; the cause of this stress is racial oppression), and where the emotion and health aspects are combined in the measurement of depressive symptoms. Vigilance was measured via self-assessment according to the frequency of the following experiences: trying "to prepare for possible insults from other people before leaving home," feeling "that you always have to be very careful about your appearance to get good service or avoid being harassed," trying "to avoid certain social situations and places," and watching "what you say and how you say it" (Lee and Hicken, 2016, p. 429).
- <sup>12</sup> Political resistance is burdensome in many ways – e.g. taking time away from pursuing other opportunities, demanding emotional and psychological effort, running the risk of arrest and violence, and creating moral dilemmas. See, for example, Lisa Tessman (2005, p. 107–131) on the burdens of political virtue, especially the traits one requires to be a hardened dissident.
- <sup>13</sup> See, for example, Fabienne Peter (2006) and Madison Powers and Ruth Faden (2006) for their particular arguments to justify the same claim—that health inequity needs to be seen within a framework of social injustice.
- <sup>14</sup> A theory can be pluralist in numerous ways—consider, for example, the distinction between a dimension-pluralist theory of social justice and a pattern-pluralist theory of social justice (Fourie, 2016, p. 191–192).
- <sup>15</sup> Examples of dimension-pluralist theories would be Martha Nussbaum's capabilities approach (2000) and Powers and Faden's well-being approach (Powers and Faden, 2006).
- <sup>16</sup> Admittedly, there are significant philosophical challenges here. Should some of the dimensions be prioritized over others, at least in certain circumstances? If we want to design just policies, how do we adjudicate between conflicts? The only stand I take on these issues in this paper is that health should not *necessarily* be prioritized over other values. However, a more comprehensive theory of health equity and social justice would have to provide much more detail on this topic; see, for example, the debates about the priorities of social goods in the political philosophy literature (Nussbaum 2000, p. 81–86).
- <sup>17</sup> See also Killmister (2015) on the "double binds" created by oppression, which often force the oppressed "to either make trade-offs *within* autonomy or make trade-offs *between* autonomy and another core personal value. Agents under oppression are thus faced with a particularly tragic dilemma" (p. 162).



- <sup>18</sup> While we need, and should indeed aim for, a radical restructuring of unjust societies in order to achieve justice, particular norms, policies, and institutions can be more or less just, and where we can make them more just, even though we cannot change the system in entirety, *pro tanto*, we should do so. Consider, for example, Amartya Sen's (2009, p. 1–27, 87–112) claims that we require comparative justice, and not (or not only) transcendental justice. A comparative framework means that we can compare policies or institutions in terms of how just they are, and advance justice by choosing the more just alternative; on the other hand, transcendental justice requires that we identify and pursue perfect or ideal justice. My claims about second-best solutions can be seen to be aiming for something like comparative justice (although admittedly they don't map precisely onto Sen's framework).
- <sup>19</sup> There is significant work that has been done on this—however, it remains underdeveloped. Work in critical race and feminist theory on epistemologies of ignorance, for example, demonstrates how the oppressed are epistemologically privileged, while the privileged are ignorant (e.g., Alcoff, 2007; Mills, 2007). Notice that, on the one hand, this can be said to demonstrate an impairment of privilege and yet, on the other, it serves an important purpose in keeping the privileged in positions of power by helping them, for example, to maintain the myth that their privilege is deserved. See also, for example, Fourie (2012) on the ways in which social-relational inequalities damage the privileged.

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