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# EQUALITY, HEALTH, AND HEALTH POLICY INTRODUCTION

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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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