Health, Risk, and Justice

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Abstract

While citizens in a liberal democracy are generally expected to see to their basic needs out of their own income, health needs are an exception. Most rich liberal democracies provide their citizens with health care or health care insurance in kind. Many people find this special treatment for health care appealing, but political philosophers and bioethicists have struggled to justify it. Most theorists hold that it is justified by the moral importance of health, but this approach has many flaws, not least of which is the fact that access to personal health care services is in fact a relatively inconsequential determinant of population health.

This dissertation offers a new justification for health care entitlements. Health needs are not more important than other basic needs, morally speaking, but they are more unpredictable. I argue that health care entitlements are best justified in terms of risk management rather than health equalization or health promotion. Citizens ought to have insurance against health risks to provide stability in their future expectations and thus to protect their capacities to form, revise, and pursue a rational plan of life. The failure of private markets to deliver adequate access to health care insurance provides a rationale for state involvement in the delivery of health care.

This approach provides tidy answers to some pressing problems in macro-level bioethics, but it has implications for political philosophy as well. One of the most important functions of
the modern state is to provide citizens with security against various risks, including health risks, and yet this function is conspicuously absent from John Rawls's influential theory of justice. My dissertation begins the work of integrating security from risk into a liberal-egalitarian theory of justice.
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Most wealthy liberal democracies organize the provision of health care through insurance systems. In some places, like Canada, this takes the form of a single-payer health insurance system, where the government provides all citizens with comprehensive health care insurance, but most medical care is delivered privately. More common is for governments to deliver health care through a mixture of public and private insurance arrangements, as is the case in the United States, France, and Germany. In these countries, as in Canada, most doctors practice privately, but are compensated from insurance pools that are either run directly by the state or carefully regulated by it. In this respect, Britain's various National Health Services and Norway's Regional Health Authorities are outliers in the developed world; Britain and Norway offer truly socialized medicine, where most health care is delivered by doctors employed directly by the state.

The fact that most rich countries deliver health care via insurance systems has consequences for the ways that access to health care is distributed.\(^1\) What these countries provide their citizens in the first instance is not health or even health care, but rather indemnity against certain health risks. If a citizen gets sick and finds herself in need of medical care, her insurer will pick up the tab—if not the whole tab, then a specified portion thereof—and this is

\(^1\)While I will sometimes speak loosely of the delivery or distribution of health care, properly speaking what health care systems in liberal democracies distribute is access to care. As I explain later in §1.2.3, a free society cannot actually distribute health care, since a free society cannot force citizens to submit to care that they do not want.
true regardless of how well off or badly off that citizen might otherwise be. While health care insurance does pay for most medically necessary health care, it does not provide everything a person may need to become or remain healthy; health care insurance does not pay for nutrition or education, for example, even if a citizen cannot afford these things herself and even though these things are at least as significant to health outcomes as medical care. Further, health care insurance does not pay for voluntary or elective procedures, nor does it compensate those with untreated medical conditions for their ill health. These particular distributive patterns are characteristic of insurance as a delivery mechanism. (It is also worth pointing out that, despite their different payment models, Britain and Norway also distribute health care in these specific ways; one can interpret their socialized medicine as a kind of national Health Maintenance Organization or “HMO,” providing indemnity against certain health risks through managed care rather than by compensating physicians on a fee-for-service basis, while still not providing for all of a person's health needs or wants.)

When attempting to justify health care entitlements, however, political philosophers and bioethicists have tended to suppose that the insurance logic we see in the health care systems of most developed countries is merely a surface logic. Below the surface, these theorists have sought a deeper, egalitarian logic for state involvement in the delivery of health care or health care insurance. The aim of state involvement in the health care sector on this egalitarian picture is not in the first instance to protect citizens against health risks but rather to equalize health outcomes, either for its own sake or perhaps as a means to equalizing some further value like opportunity or welfare.²

If these egalitarian theorists' aims were to radically revise existing health care delivery practices, then they could not have chosen a better strategy. For one thing, recent research into the social determinants of health shows that equalizing access to personal health care services is not a particularly effective means to equalizing health outcomes. Things like education, income, and socioeconomic status have a far greater impact on population health disparities (the so-called “social gradient in health”). In an influential article, Gopal Sreenivasan has drawn out the far-reaching implications of these findings for egalitarians. Sreenivasan argues that a society committed to equalizing health outcomes would do well to dismantle its national health care system entirely and devote its total health budget to ameliorating the social determinants of health instead—in other words, devote its entire health budget to things like education and poverty-alleviation instead of personal health care services. This, Sreenivasan argues, would do more to bring citizens up to their fair shares of health than running a national health care system. The same problem obtains for those egalitarian views that see health care as a means to equalizing some further value like opportunity. The connection between health care access and opportunity cannot be any stronger than the connection between health care access and health

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(that is, unless health care access affects opportunity in some other way than through its effect on health; it is difficult to imagine what way that might be, though).  

Even if these startling conclusions from the social determinants of health are overstated, a health care system constructed along egalitarian lines would still be radically different from one organized as an insurance scheme. For instance, if our aim is to promote equality in health outcomes, it is difficult to see why the health care system does not provide things like nutrition and education in addition to (if not instead of) health care, given how important these things are to good health, or why the health care system does not compensate people with untreatable health conditions, given the inequality that obtains between them and the healthy. From an egalitarian point of view, it is also difficult to see why health care should be distributed so as to meet medical needs per se rather than so as to promote equality in health or opportunity or indeed in whatever it is that the health care system is supposed to equalize. In these and other ways, grounding health care entitlements in egalitarian principles pushes us far away from the health care system we have now. 

Notwithstanding these considerations, most egalitarian theorists of health care justice do not see themselves as advocating for a substantial revision of existing practices. To be sure, most urge that existing health care systems ought to be made more comprehensive and more equitable, but by and large thinkers like Norman Daniels want to preserve the basic structure of health care delivery as we know it in the developed world. For one thing, pace Sreenivasan, they

5 Ibid.

6 We do of course compensate the victims of severe disability via disability insurance, but these payments are not compensation for ill health per se, and not all those who suffer untreatable health conditions qualify for payments under disability insurance.
want the health care system to continue to exist and to continue to deliver personal health care services. For another, they want the health care system to continue to deliver those services according to medical need and independently of ability to pay, but not to deliver other health needs like food, education, or income. One aim of this dissertation is to show that this structure of health care delivery is not readily derived from egalitarian premises. Taking the arguments of Daniels et al. seriously pushes us toward a radical transformation of the health care system.

Some hold that health care provision is better justified on sufficientarian rather than egalitarian grounds. There is a widely recognized obligation of justice to ensure citizens can meet their basic needs, including basic health needs, and this might be thought a better strategy for justifying the provision of health care in wealthy liberal democracies. I do not specifically address this view in this dissertation, but offhand it seems less promising than the egalitarian strategy for justifying the structure of health care delivery as we know it. Much depends on how the idea of a “basic” or “sufficient” level of care is defined, of course, but a sufficientarian view will have trouble explaining why developed countries provide health care for rich citizens as well as poor ones, since rich citizens can secure a basic level of care for themselves without state assistance. A sufficientarian view will also have trouble justifying the provision of health care for the elderly; it is hard to see expensive, chronic care for the aged as meeting a “basic” need, given that such care goes beyond what is needed to live a minimally decent human life. Indeed, a sufficientarian view will have a hard time justifying the provision of almost any exotic or

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7 Daniels, *Just Health*, 42-43.

8 Ibid., 60-61.

expensive medical intervention, unless the idea of a “basic” need is understood very generously. For these reasons, and despite its weaknesses, I take the egalitarian picture to be the more promising strategy for justifying the structure of health care provision we see in the developed world.

0.1 A Different Way Forward

In light of these problems with the egalitarian argument for health care provision, I argue that those who would defend the basic structure of health care delivery as we know it would do well to seek a different normative foundation for it. The primary aim of this dissertation is to provide such a foundation. This foundation takes the form of a defence of the “surface logic” of the health care systems we find throughout most of the developed world. I aim to show that there are compelling reasons to distribute health care through insurance mechanisms, not as a means for equalizing health or opportunity but in order to reduce individuals' exposure to health risks as such.

Individuals confront a great deal of uncertainty surrounding their health needs. Most people do not know if, when, or how they will get sick, or how much it will cost when they do. Reducing this uncertainty by making sure people have access to health care insurance is beneficial in itself, and in a variety of different ways. In what follows, I focus primarily on the ways that insurance protects and enhances people's ability to form, revise, and pursue a rational plan of life. Because uncertainty interferes with people's abilities to make effective plans for the future, providing health care insurance protects and enhances people's capacities for rational
self-determination. This is of great significance on a liberal-egalitarian theory of justice, according to which respect for persons requires that we protect these capacities for each citizen.

The benefits of insurance are significant on practically any political measure of well-being. Insurance makes citizens more secure in the enjoyment of their fair share of social resources, and thus insurance is important for those who take resources as the appropriate currency of political justice. Moreover, because people are typically risk-averse, health care insurance generally increases people's welfare. And providing access to health care insurance can make people more secure in the enjoyment of their basic functionings or capabilities.\(^{10}\) In all of these ways, making sure people have security against health risks in the form of health care insurance is of great value in itself, apart from the benefits of making sure people have access to health care. Whether a theory of distributive justice works in the space of resources, welfare, or capabilities, that theory will have good reason to carve out a place for insurance, including health care insurance.

Of course, to show that health care insurance is beneficial in these ways is not enough to justify state involvement in its delivery. For that, it is necessary to appeal to the failures of private markets in delivering access to health insurance. Private markets in health care insurance consistently fail for reasons that have long been familiar to economists.\(^{11}\) The upshot of these failures is that individuals are often unable to obtain health care insurance through private markets, and where they can they pay a substantial premium for it. The state can and should


intervene to correct these market failures, either through careful regulation of the insurance sector or by providing health care insurance or health care directly, in order to secure the full benefits of pooling health risks.

Grounding health care entitlements in risk management rather than health equalization or health promotion circumvents the problems posed by the social determinants of health literature. Whatever the merits of dismantling a society’s health care system from a health-equalization or health-promotion point of view, it would represent a massive unpooling of risk and for that reason alone would be disadvantageous. Moreover, my account has the advantage of providing a justification for those appealing aspects of existing health care delivery systems that follow the logic of insurance rather than equality. This includes indemnifying individuals against certain health risks but not against ill health per se, distributing health care according to medical need and independent of ability to pay, and paying for medically necessary health care but not paying for other health needs or for elective care. These popular and appealing features of existing health care systems fit naturally within an insurance framework.

This is not to say that existing health care systems are worth defending root and branch. Most if not all existing systems have troubling problems of inequity and inefficiency that ought to be corrected. I will try to show that my account has the resources to criticize these inequities and inefficiencies (and also the resources to distinguish the two). But the basic normative logic of health care delivery, if it is to be defended at all, is best defended under the rubric of risk management rather than health equalization.
0.2 Aims and Limitations

This project has three main goals. The first is to provide the best possible reconstruction of the normative logic of the welfare state in advanced liberal democracies. I aim to show that situating health care justice within an insurance framework provides a better justification for the appealing aspects of existing health care delivery practices than the rival egalitarian picture, while still leaving space to criticize existing practices on grounds of inequity and inefficiency. I will argue that taking seriously the rival egalitarian picture would entail a fairly radical transformation of the health care sector.

The second goal of this dissertation is to show how this insurance framework fits naturally within a liberal-egalitarian theory of distributive justice, with particular emphasis on John Rawls's theory of justice as fairness. By connecting my account of justice in health care to Rawls's general theory of justice, I show how Rawls's theory can be extended to cover health care in a more perspicuous way than rival accounts. This extension is significant not only because it extends Rawls's theory of justice to health care, an important end in itself, but also because it strengthens Rawls's account of well-being by incorporating protection from risk into his theory of primary goods. One of the most important functions of the modern state is to provide citizens with protection from various risks, including not only health risks but also risks of unemployment, disability, and poverty in old age, and yet this function is conspicuously absent from Rawls's theory of distributive justice. This dissertation fills that gap.

Although I will take pains to show how my account of justice in health care fits naturally within a liberal-egalitarian account of distributive justice like Rawls's, I nonetheless develop my
account to be “free-standing” with respect to Rawls's theory or indeed any particular theory of distributive justice. In other words, while my account can be endorsed from within a Rawlsian theory of justice, it does not presuppose a Rawlsian theory of justice. This leads to the third goal of the project. Insurance is beneficial in a variety of ways, as noted earlier (§0.1.1), and so the account of justice in health care I develop here has affinities with a variety of different theories of justice and their respective accounts of well-being. Utilitarians and welfare-egalitarians will find my account appealing insofar as insurance typically raises people's welfare. Capability theorists will find it appealing insofar as insurance secures people's capabilities or functionings. The account of justice in health care I develop here is fit to serve as a sort of module, one that can be plugged into nearly any general theory of distributive justice. Thus nearly any theorist who endorses the basic structure of health care delivery as we know it can endorse the broad outlines of the theory of health care justice presented here.

The account I offer here is limited in several ways. I aim to articulate the normative logic of health care provision in wealthy liberal democracies. I do not intend my account as a theory of justice in health care for the developing world. The developing world raises special problems of justice in health that are not necessarily well treated under the rubric of insurance. For example, given the relative inefficiency of personal health care services for improving population health, it is perhaps more appropriate for developing countries to prioritize the improvement of basic public health services like nutrition and sanitation over the delivery of personal health care services. At any rate, I do not intend my account to cover these cases.
Following on that, I am interested in the justification for the delivery of personal health care services. My account is not intended to provide a justification for the delivery of basic public health measures like sanitation and vaccinations, in the developed world or elsewhere. This is not to say that such measures are insignificant; in fact, by all accounts, such measures are far more significant to health outcomes at a population level than personal health care services are. But the justification for the provision of these public health measures will be different from the one I provide here for guaranteeing access to personal health care services. I believe public health measures are best justified under a public goods framework: being non-rivalrous and non-excludeable, public health goods will be undersupplied on a private market. Efficiency gains can be realized when the state intervenes to ensure an optimal supply of these goods. But it is not my purpose to argue that claim here.

0.3 Outline of Dissertation

I begin in Chapter 1 by setting out the broad outlines of a general liberal-egalitarian theory of justice, with special attention to Rawls's theory of justice as fairness. I also motivate the intuition that a general theory of justice is incomplete without a special account of justice in health care, and I sketch in broad strokes the form such a theory should take. Chiefly, I argue that such a theory should justify distributing access to health care according to medical need and in isolation from other social goods like income and wealth. Chapter 1 concludes by explaining

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certain obstacles to such a theory, including principally the liberal aversion to paternalism in the
distribution of social resources.

Chapter 2 discusses existing attempts to develop a liberal-egalitarian theory of justice in health care. I focus primarily on the work of Norman Daniels, whose theory of justice in health care is the most influential and developed of existing theories, but I also discuss the views of Ronald Green, Deborah Satz, and John Rawls. I argue that each of these attempts fails to satisfy the desiderata for a theory of justice in health care developed in Chapter 1: they fail to justify distributing health care according to medical need and in isolation from other social goods. While these theories differ in important ways, ultimately in each case it is their egalitarian starting point that is their undoing. The logic of health care delivery as we know it is not the logic of equality.

Chapter 3 puts forward my account of justice in health care, according to which justice requires that citizens have access to insurance against health risks. I begin by sketching an account of risk and risk-aversion, and I argue that, among other things, exposure to risk poses significant obstacles to individual rational self-determination. I argue that this exposes a significant lacuna in Rawls's theory of justice, to be filled later (in Chapter 5). I develop a simple model of an insurance scheme in order to show how risk-pooling reduces individuals' exposure to risk and thus helps to protect people's capacities for self-determination. I explain why and how private markets in health insurance fail, thus providing a rationale for government intervention in the health insurance sector. Chapter 3 concludes by contrasting my account with Ronald Dworkin's influential “hypothetical insurance” account of justice in health care.
In Chapter 4, I explain how the account of justice in health care developed in Chapter 3 can justify distributing access to care according to medical need and in isolation from other social goods. I also show how my account can provide intuitive answers to some vexing problems in political bioethics—answers that cannot easily be derived from egalitarian premises, but fit naturally within an insurance framework. My account explains why justice requires that individuals have access to medically necessary treatment for disease and disability but not access to biomedical enhancement, and it shows why justice requires that the elderly, too, receive access to medical care. In each case I contrast my view with Norman Daniels's egalitarian account of justice in health care, arguing that Daniels's theory cannot yield the same intuitive results, notwithstanding Daniels's own arguments to the contrary.

I conclude in Chapter 5 by showing how my account of justice in health care can be integrated into Rawls's influential theory of justice. I show how security from risk can be integrated into Rawls's theory of primary goods by situating it under the existing primary good of income and wealth. Concerning the distribution of this good, I argue that ideally individuals should be allowed maximal flexibility to select the level of protection best suited to their own tastes and preferences. In reality, however, the problem of adverse selection may make such fine-grained, market-based solutions impracticable. Thus as a second-best solution, I provide an argument for the democratic determination of the appropriate level of protection in the basic insurance package guaranteed to all, and I argue that individuals should be allowed to purchase supplementary insurance beyond that level where this does not interfere with the effective operation of the basic tier of insurance. Finally, I address the financing of insurance, arguing that Rawlsian justice does not require that individuals pay the differential expected costs of their
health needs where such differences are due to natural inequalities, but may require that individuals pay the expected costs of chosen health risks.
Chapter 1: Desiderata

Most well-to-do liberal democracies distribute health care differently from other goods, even other basic needs. When it comes to food, clothing, shelter, and so on, citizens in a liberal society are generally expected to see to their needs out of their own income, and those without the means to do so receive assistance in the form of cash transfers. Health care is special. Most liberal democracies provide their citizens with health care or health care insurance in kind, either directly or through privately-held insurance companies that are regulated like public utilities. Citizens are not typically expected to see to most of their health care needs out-of-pocket, regardless of how well-off they might be. Instead, if they get sick and need medical care, the state (or a carefully regulated private insurer) picks up the tab, at least for some basic level of care.¹

Two features of this familiar distributive pattern for health care are worth picking out. First, the distribution of health care is largely if not completely isolated from the distribution of other social goods, particularly that of income and wealth. The amount of health care a person

¹This is not true of all medical needs, of course. Dental care and prescription drugs are not provided in most liberal democracies. Presumably the reason for this is because dental care and prescription drugs have not been until recently a significant part of health care costs. But prescription drug costs, for example, are growing rapidly. In Canada between 1998 and 2007, spending on prescription drugs outside of hospital grew by 238%, an average annual growth rate of 10.1%. There may now therefore be strong reason for liberal democracies to begin including prescription drugs in their health care or health care insurance plans. The account of justice in health care I develop here could readily be extended to cover these cases. Canadian Institute for Health Information, *Drivers of Prescription Drug Spending in Canada* (Ottawa, Ontario: CIHI, 2012), http://www.cihi.ca/cihi-ext-portal/pdf/internet/drug_spend_drivers_en (accessed 13 June 2014), iii.
receives does not typically affect, nor is it affected by, the contents of the rest of her bundle of social resources. Second, health care is typically distributed according to medical need rather than, say, ability to pay. Citizens receive medically necessary treatment for disease and disability as their condition dictates, but they do not usually receive elective procedures, regardless of how much they may want them or how much they might benefit from them (although in most cases citizens are free to purchase elective procedures from their own share of resources if they wish).

The central aim of this dissertation is to provide a theory of justice in health care that justifies distributing health care in these two specific ways: in isolation from other goods and on the basis of medical need. I will also show how this theory of justice in health care fits naturally within a general liberal-egalitarian theory of distributive justice.

This chapter lays the groundwork for my account of health care justice. I begin in §1.1 by setting out the general form of a liberal-egalitarian theory of justice, with special attention to John Rawls's theory of justice as fairness. §1.2 motivates the intuition that such a theory is incomplete without a special theory of justice in health care, and sketches in broad strokes the form that such a special theory should take. §1.3 discusses a pair of significant obstacles to such a theory posed by other liberal commitments, including principally the justifiable liberal aversion to paternalism in the distribution of social resources.

1.1 Rawls's Liberal Egalitarianism

The moral core of liberalism is the idea that persons are free and equal. Persons are free in the sense that no one is antecedently bound to any particular personal, moral, or religious
authority; each person is free to decide for herself the kind of life most worth leading. Persons are equal in the sense that no one's life matters more, morally speaking, than any other; no one's interests are seen as intrinsically deserving of greater consideration than any other's. For liberals, the problem of political justice is the problem of determining the most reasonable terms of political association for persons so conceived.

A problem immediately arises. Free societies under modern conditions are marked by intractable disagreement about questions of ultimate value.\textsuperscript{2} Citizens in a democratic society affirm a variety of different and incommensurable but nonetheless reasonable conceptions of the good, a “conception of the good” meaning a conception of what is valuable in human life, a more or less determinate system of final ends.\textsuperscript{3} To attempt to organize political life around any one of these particular conceptions, whether religious or secular, would be inconsistent with the freedom and equality of persons. The state cannot legitimately force free and equal citizens to live publicly according to principles that they might reasonably deny privately.

If any solution to the problem of political justice can be consistent with the freedom and equality of persons so understood, it must be one that allows individuals broad scope to lead their lives as they see fit and provides them with a fair share of the means necessary to do so successfully. It must be one that gives each citizen a fair chance to pursue her own conception of the good, consistent with the like freedom of others.\textsuperscript{4} A liberal conception of justice must have


\textsuperscript{3}Ibid., 19.

this form, because any other would (in effect if not in intent) privilege certain ways of life or conceptions of the good over others. To do this would be to fail to respect the freedom and equality of persons, forcing citizens to live according to principles they could not reasonably be expected to endorse.\(^5\)

A liberal solution to the problem of political justice cannot therefore be derived from any particular religious or moral view. Instead, it should be independent of these views, so far as possible; it should be a “political” conception of justice in Rawls's sense, a moral conception worked up from certain fundamental ideals implicit in the political culture of a democratic society. It should be capable of serving as a “module” that can fit into and be supported by a variety of different reasonable moral and religious doctrines.\(^6\)

Further, a liberal view must be limited in scope to what Rawls calls the basic structure of society: a society's major political, social, and economic institutions as they fit together into a unified system of cooperation.\(^7\) A fully general conception of justice, one that applied to all areas of human life, would not leave individuals sufficient moral space to pursue their own particular projects. Restricting the application of principles of justice to society's major institutions leaves individuals broad scope within those institutions to live in the ways that seem best to them.\(^8\) As Rawls puts it, the role of institutions belonging to the basic structure is to secure “background

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\(^6\) Ibid., 11.

\(^7\) Ibid.

\(^8\) Ibid., 268.
justice,” that is, fair background conditions within which the actions of individuals and associations take place.\textsuperscript{9,10}

1.1.1 Society as a Fair System of Cooperation

The fundamental idea of Rawls's conception of justice is the idea of society as a fair system of cooperation over time.\textsuperscript{11} The idea of social cooperation is well-suited to the “political” nature of Rawls's project because cooperation is possible even among people who disagree about final ends or questions of ultimate value. Cooperative arrangements are mutually beneficial; they make participants better off by their own lights relative to a baseline of non-cooperation. Individuals enter cooperative arrangements voluntarily, for the sake of their own advantage.

While social cooperation makes everyone better off, people are not indifferent as to how the benefits of cooperation are distributed.\textsuperscript{12} Principles of justice are needed to specify the terms of cooperation, that is, to determine the appropriate division of the benefits and burdens of social cooperation. Rawls's preferred principles of justice are complex, but the intuitive idea has already been expressed: because participants in cooperation are conceived as free and equal, social cooperation should be arranged to give each person a fair chance to pursue her conception

\textsuperscript{9}Ibid., 266.
\textsuperscript{11}Rawls, \textit{Political Liberalism}, 15.
of the good, consistent with the like freedom of others. In Rawls's case, this is understood to mean that each person is owed a robust set of individual liberties and opportunities, together with a share of the material benefits of cooperation—income and wealth—that is no smaller than any share needs to be, as resources for the pursuit of her ends.

If the stock of social goods were fixed, then the way to guarantee that no share is smaller than any share needs to be would be to insist upon a strictly equal division. But the stock of goods is not fixed, because social cooperation is not a zero-sum game. Thus there may be circumstances where an unequal division of the benefits of cooperation can work to everyone's advantage—for example, it may be that material incentives for productive labour can grow the social product by more than the cost of the incentives themselves, thereby making more goods available for all.\(^{13}\)

In its general form, then, Rawls's conception of justice requires that “[a]ll social values—liberty and opportunity, income and wealth, and the social bases of self-respect—are to be distributed equally unless an unequal distribution of any, or all, of these values is to everyone's advantage.”\(^{14}\) Rawls's general conception of justice requires an equal distribution except where an unequal distribution improves the situation of all; “[i]njustice,” Rawls says, “is simply inequalities that are not to the benefit of all.”\(^{15}\) Rawls's view can thus be understood as the conjunction of a principle of equality with a principle of efficiency.

\(^{13}\)Rawls, *Theory of Justice*, 68.

\(^{14}\)Ibid., 54.

\(^{15}\)Ibid.
A distribution is efficient in the sense of Pareto-optimal when it is impossible to change it so as to make someone better off without making at least one other person worse off. Although the Pareto principle is commonly presented as a value-neutral economic principle, it reflects an important moral ideal. Violations of the Pareto principle occur when one person is worse off in ways that do not benefit anyone else; in other words, inefficient arrangements involve gratuitous suffering. The Pareto principle requires that we eliminate this gratuitous suffering.\(^6\)

Rawls's special conception of justice is somewhat more complicated than his general conception, in that it makes more fine-grained distinctions in the required distributive patterns for different social goods, but the intuitive idea is the same. While Rawls's general conception of justice allows in principle that citizens may countenance the restriction of basic rights and liberties for the sake of greater economic advantages, his special conception forbids these kinds of trade-offs. Rawls intends his special conception to apply once a society reaches a level of economic development such that it is possible for everyone to enjoy the full establishment of certain basic rights and liberties. The idea is that once a society attains a certain level of development, persons who conceive of themselves as free and equal would no longer be willing to sacrifice their liberties merely for the sake of more income and wealth. These liberties are far too central to a person's status as free and equal to be sacrificed for financial gain.\(^7\)

Rawls's special conception of justice consists of two principles, with the first lexically prior to the second, and the first part of the second lexically prior to the second part:


\(^7\)Rawls, *Theory of Justice*, 55 and 475.
a. Each person has an equal claim to a fully adequate scheme of equal basic rights and liberties, which scheme is compatible with the same scheme for all; and in this scheme the equal political liberties, and only those liberties, are to be guaranteed their fair value.

b. Social and economic inequalities are to satisfy two conditions: first, they are to be attached to positions and offices open to all under conditions of fair equality of opportunity; and second, they are to be to the greatest benefit of the least advantaged members of society.\(^\text{18}\)

To say that the first principle is “lexically prior” to the second is to say that it is not acceptable to sacrifice the rights and liberties guaranteed under the first principle for the sake of greater social and economic advantages, the distribution of which falls under the second principle. The same relation holds between the first and second parts of the second principle.

1.1.2 The Political Conception of the Person

The idea of social cooperation includes a certain conception of persons as participants in cooperation. To be participants in cooperation, persons must have certain capacities. In particular, each must have a capacity for a conception of the good, which conception she is trying to advance through cooperation, as well as a capacity for a sense of justice, a capacity to understand and abide by fair terms of cooperation. His being a liberal theory of justice, Rawls conceives of persons as free and equal just in the sense that each person is understood to possess

these capacities at least to the minimum degree required to be fully cooperating members of society over a complete life. Rawls's idealizing assumption that persons are “normal and fully cooperating members of society over a complete life” has important implications for health care; I return to this point in §1.2.)

Importantly, persons are free not just in the sense that each possesses a determinate conception of the good, a system of final ends, that she is free to advance through cooperation. Persons are free in the deeper sense that each has the capacity for a conception of the good and is capable of revising her particular conception of the good over time on reasonable grounds. This is not to say that citizens themselves, in their private lives, must view themselves as “free” in the sense of being able to stand apart from their particular ends and devotions. But from a political point of view, persons are not identified with or bound to their ends at any particular moment; they are free to change them over time on reasonable grounds.

The importance Rawls attaches to protecting the exercise of these capacities explains a number of important features of his view. It explains, for example, the priority of the first principle of justice, which protects the basic liberties, over the second principle, which regulates social and economic inequalities. These basic liberties are understood as essential conditions for the development and exercise of person's moral powers, their capacities for a conception of the good and for a sense of justice. A person concerned only to advance his particular conception

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19 Rawls, Political Liberalism, 18-21.
21 Rawls, Political Liberalism, 30.
22 Ibid., 293.
of the good as he presently conceives it might be willing to trade away certain liberties for the sake of other means more immediately useful to him. Because Rawls ranks citizen's interests in protecting these capacities higher than their interest in pursuing their present advantage, such trade-offs are forbidden. This is a consequence of Rawls's political conception of the person rather than of his idiosyncratic view of the place of conceptions of the good in a theory of political justice.

1.1.3 Primary Goods

Another important feature of Rawls's theory is that it takes the justice of a society to be a function of how that society distributes certain primary goods—general, all-purpose means to the pursuit of citizens' ends. Rawls specifies the primary goods in a list:

a. basic rights and liberties, also given by a list;

b. freedom of movement and free choice of occupation against a background of diverse opportunities;

c. powers and prerogatives of offices and positions of responsibility in the political and economic institutions of the basic structure;

d. income and wealth; and finally,

e. the social bases of self-respect.\(^\text{23}\)

\(^{23}\)Ibid., 181; Rawls, *Theory of Justice*, 54.
These primary goods are meant to serve as an account of a person's good—his rational advantage—appropriate for the purposes of assessing the justice of institutions and adjudicating competing claims on social resources. Using these “all-purpose means” for assessing individual advantage is appropriate for purposes of political justice because citizens in a modern democratic society disagree about ends. A liberal state cannot promote an individual's good in the sense of preference satisfaction or human perfection any more than it can promote an individual's good in the sense of his ultimate salvation. Because citizens do not agree about final ends, it is natural that they would take the problem of justice to be a problem of dividing up the means. Rawls's view is therefore a version of “equality of resources.”

Because liberalism begins with the idea that citizens are free to decide questions of ultimate value for themselves, there is a presumption in favour of specifying these primary goods as generally and fungibly as possible. This allows individuals to tailor the precise content of their particular bundle of resources to their own particular needs and wants. An account of individual advantage that made fine-grained determinations of citizen's needs and distributed social resources accordingly—giving each person a certain amount of bread, milk, fine wine, button-down shirts, and so on—would inevitably privilege certain ways of life over others. It is preferable therefore to focus on the distribution of “all-purpose means” like rights and liberties, opportunities, and income and wealth, and then allow citizens to use those resources to acquire the particular goods most suited to their own plan of life.

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24 Rawls, *Political Liberalism*, 179-80

As Rawls takes pains to point out, using primary goods as the metric of advantage for purposes of distributive justice implies that people are, in a certain sense, responsible for their ends. Of course, persons are not responsible for their ends in the sense that their ends are fully under their control, or in the sense that their ends are freely chosen.\textsuperscript{26} Rather, persons are responsible for their ends in the sense that each person's success or failure in achieving any of their ends is a matter of indifference from the point of view of social justice.\textsuperscript{27} Equality of resources implies that individuals are capable of taking responsibility for their ends and adjusting them in light of the share of social resources they can expect over the course of their lives.\textsuperscript{28}

For this reason, Rawls notes that his account of primary goods implies what he calls a “social division of responsibility:”

[S]ociety, 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.\textsuperscript{29}


\textsuperscript{27} Rawls, \textit{Theory of Justice}, 80-81; Rawls, \textit{Political Liberalism}, 187-188.


\textsuperscript{29} Rawls, \textit{Political Liberalism}, 189.
The idea is that once a fair distribution of resources has been achieved, as measured in primary goods, we do not then look further into the level of satisfaction that each person derives from her share. Instead, it is the responsibility of each person to make what she will of her fair share of social resources. Equality of resources aims to equalize inputs, so to speak, rather than outputs.

1.1.4 The Original Position and Justification

The final feature of Rawls's theory of justice that I will mention is that principles of justice are conceived as agreed to by those engaged in social cooperation. To model this agreement, Rawls introduces the idea of the original position. The original position is a “device of representation,” a hypothetical choice situation that is supposed to model all of the considerations we think relevant to reasoning about justice.30

In the original position, persons conceived as free and equal are imagined deliberating about the problem of justice from behind a “veil of ignorance,” which conceals from them all knowledge of the particular features of their person—their sex, race, age, and their particular conception of the good, to name a few. This serves to prevent anyone from tailoring principles of justice to benefit them; the fact that someone occupies a particular social position, Rawls says, is not in itself a good reason to accept principles of justice that favour those in that position.31 Thus parties in the original position are given only enough information (and information of the right kind) to enable them to reach an agreement. They are imagined as wanting, above all, to protect their two moral powers, their capacities for a conception of the

30 Ibid., 24.
31 Ibid.
good and for a sense of justice, but also as wanting to advance the particular conception of the good they happen to have, whatever it turns out to be. They are imagined as preferring a larger rather than a smaller share of primary goods to do this.\textsuperscript{32}

Rawls argues that when the original position is imagined in this way, the parties there would agree upon his two principles of justice stated above. I will not repeat his argument here.\textsuperscript{33} The essential idea is one that has already been stated: always preferring a larger to a smaller share of social resources (and not being moved by envy), parties in the original position would agree upon an equal division of all social resources unless an unequal division would work to everyone's advantage.

The original position is designed to model the choice of principles of justice as a matter of pure procedural justice. Because the choice situation of the original position is fair, any agreement reached in it is also fair. But here it is important to remember the role of the original position as a model, a device of representation. If you and I endorse Rawls's two principles of justice, it is not merely because they are agreed to by imaginary persons in a hypothetical choice situation; it is rather because we affirm that the original position models the appropriate circumstances and restrictions on reasons for thinking about questions of justice, and thus we recognize that the principles that would be selected there are fair and "supported by the best reasons."\textsuperscript{34}

\textsuperscript{32}Ibid.

\textsuperscript{33}See Rawls, \textit{Theory of Justice}, Chapter 3 for the full argument from the original position to Rawls's two principles of justice.

\textsuperscript{34}Rawls, \textit{Political Liberalism}, 26.
The role of the original position, then, is to give an uncluttered view of the problem of justice, and to serve as a means of “public reflection and self-clarification.” The ultimate test of principles of justice is not from the point of view of the original position but from the point of view of you and me. For Rawls, justification depends upon what he calls “reflective equilibrium.” A political conception of justice is in a state of reflective equilibrium when it “accords with our considered convictions, at all levels of generality, on due reflection.” We arrive at a state of reflective equilibrium by working back and forth between our considered judgements about particular cases and the more general principles brought to bear to explain them. The original position is meant to serve as a mediating device in this process, helping us to organize and establish coherence among our many convictions about justice.

In sum, liberal egalitarianism is the approach to political justice according to which respect for persons as free and equal requires that we protect each person's moral powers, their capacities to form, revise and pursue a conception of the good and for a sense of justice. It is liberal insofar as it protects a broad range of individual liberties and opportunities and guarantees citizens adequate means to make use of these. It is egalitarian insofar as it limits the range of acceptable social and economic inequalities. In the case of Rawls's theory, this includes

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35 Ibid.
36 Ibid., 8.
37 Ibid., 26.
protecting fair equality of opportunity and permitting only those social and economic
inequalities that are to the greatest benefit of the least advantaged members of society.\textsuperscript{38}

\section*{1.2 On the Need for a Distinct Account of Justice in Health Care}

Rawls's general theory of justice takes no special account of variations among
individuals caused by disease, disability, and premature death. This is by design; Rawls brackets
the problems posed by these variations in order to get a clearer view of what he calls the
“fundamental question of political justice,” that question being, “what is the most appropriate
conception of justice for specifying the terms of social cooperation between citizens regarded as
free and equal, and as normal and fully cooperating members of society over a complete life?”\textsuperscript{39}
Rawls himself points out that his theory is incomplete without an account of justice in health
care.\textsuperscript{40} His hope is that once a suitable answer to the fundamental question has been worked out,
that answer can be extended in appropriate ways to provide for the contingencies of accident and
illness. The problem of justice in health care, along with other problems like our duties to future
generations and the duties of justice between societies or peoples, falls under what Rawls calls
“problems of extension.”\textsuperscript{41}

\begin{flushleft}
\textsuperscript{38}Ibid., 7.
\textsuperscript{39}Ibid., 20.
\textsuperscript{40}Ibid., 21; Rawls, \textit{Justice as Fairness}, 170f.
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The assumption that citizens are “normal and fully cooperating members of society over a complete life”—the assumption, in other words, that no one gets sick—is one of many simplifying and idealizing assumptions that Rawls makes in working out his theory of justice. It is not my aim to defend all of these assumptions here. It does not seem unreasonable to abstract from certain problematic features of the human condition to get a clearer picture of fundamental questions, provided that those features can be properly accounted for later. The proof will be in the pudding.

My aim in this section is to motivate a certain picture of what a “proper accounting” for the problems of disease and disability would look like on a liberal-egalitarian view, before turning in Chapter 2 to consider and reject several recent attempts to provide such an account, and then putting forward my own account in Chapter 3.

Broadly speaking, there are two questions that a theory of justice in health care must answer. The first concerns the kinds of health care services that should be generally available to citizens as a matter of justice, given that no society can afford to provide all possible care. The second set concerns the principles or mechanisms by which those health care services should be distributed to individual citizens. An answer to the first question would specify which health care services are owed to citizens as part of a basic health care package, while an answer to the second would specify the conditions whereby access to those services is equitable or just.

42 Strictly speaking, the particular idealizing assumption under consideration here is distinct from what Rawls calls “ideal theory” proper. In ideal theory, we assume that everyone strictly complies with principles of justice. Ideal theory considers what a perfectly just society might be like. Rawls's hope is that an ideal theory of justice can provide guidance in non-ideal situations, to identify both the goals of reform and also which injustices are more urgent to correct. The assumption that citizens do not suffer disease and disability is different from the assumption that citizens do not violate the demands of justice. The problem of justice in health care is not in general a complication that arises because citizens do not fully comply with principles of justice. Rawls, Justice as Fairness, 12.
While the first question is arguably both more important and more difficult to answer, the second has received far more attention in the philosophical literature. I follow that convention here, discussing primarily the desiderata for just or equitable access to whatever health care services are deemed “basic” or “essential.” There are a few remarks about determining the content of a basic health care package in §1.2.5, but I leave a sustained discussion of that topic for Chapter 5 (§5.2).

### 1.2.1 The Problem of Expensive Needs

From a liberal-egalitarian perspective, perhaps the most natural approach to justice in health care would be to treat health care in a way that is continuous with other basic needs and leave its distribution up to the market. Given a fair share of income and wealth, individuals could purchase the health care or health care insurance most appropriate for them by their own lights. Such an approach would take no special account of health care or health need. Instead, like other basic needs, health care would be distributed to individuals according to their desire to consume and willingness to pay, and a just distribution of health care resources would be whatever distribution results from the health care choices of individuals in the marketplace.

This approach has some merit. It allows individuals to decide for themselves what share of their own resources should go to meeting health needs and what share should be devoted to other purposes, rather than making those decisions on their behalf. And it promotes efficiency of a sort, in that it does not result in the “oversupply” of health care services to those who do not want them. More generally, assuming a fair initial distribution of social resources, it is not immediately clear what basis there would be for objecting to the distribution that results.
Notwithstanding these advantages, most liberal theorists reject this approach, arguing that health care poses special problems of distributive justice. The chief reason has to do with the problem of expensive and unequal health needs. The problem is not simply that health needs are expensive. In a society where everyone had the same expensive health needs and no one could afford to meet them, even given an equal or maximum-minimum distribution of wealth, this would not be an injustice per se; the problem would be that such a society is simply too poor. But health needs are also unequally distributed in the population. In the United States in 2008, for example, just five percent of patients accounted for nearly 50% of all health care spending, while the top one percent alone accounted for over 20% of all spending. At the other end of the distribution, half of the population consumed practically no health care at all, accounting for only three percent of all spending. The distribution is even more skewed in Ontario, where in 2007 just one percent of the population accounted for 34% of all public health care spending, while half of the population accounted for just one percent of spending. This suggests that, even in the wealthiest society, a theory of justice that treats health care continuously with other basic needs would leave many citizens unable to afford the care they need. Many more might have sufficient means to meet their health care needs, but with little left over for other purposes. This seems intuitively unjust, and is perhaps the strongest motivation

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behind the desire for a distinct account of justice in health care, one that justifies treating health care differently from other basic needs.

For the liberal who is also an egalitarian, however, there is a second problem, and it cuts in the other direction. An egalitarian might be forced to prioritize transfers to a poor but healthy person over a wealthy sick one, even if the wealthy sick person could not afford the medical treatment she needs, as a way of promoting equality overall. While it is no doubt unjust for the health care system to discriminate against the poor on grounds of inability to pay, it also seems unjust to discriminate against the rich on the grounds that they have a large-enough share of other social resources already. It does not seem appropriate to ignore health needs in the name of promoting equality in the distribution of wealth.

1.2.2 Is Health Care Special?

These two considerations speak to the need for a distinct account of justice in health care, one that justifies treating health care as “special” vis-à-vis other social goods. To say that health care is special is to say that it should be distributed more equally than other social goods, particularly income and wealth. In its weakest form, the specialness thesis might be interpreted to require simply that no one should be denied basic or essential health care due to inability to pay. But this seems too weak, as it is consistent with some being left very badly off indeed after meeting their expensive health needs. For instance, a person with $50,000 in savings and exactly


47Daniels, *Just Health Care*, 18; Segall, “Is Health Care (Still) Special?,” 342.
$50,000 in health needs will not be denied care due to *inability* to pay, and thus the specialness thesis in its weakest form is satisfied, but it seems unfair that this person's savings should be entirely wiped out because of her expensive health needs.

For this reason, some political philosophers and bioethicists argue that health care should be treated as “special” in the strongest possible sense, to wit, that health care should be distributed *in isolation* from other social goods, particularly income and wealth.\(^{48}\) In its strongest form, the specialness thesis requires that the amount of health care a person receives should not affect, nor should it be affected by, the contents of the rest of her bundle of social resources. Isolating the distribution of health care from the distribution of other social goods embodies many people's strongly-held intuition that no one should be made worse off (or better off) relative to others due to expensive health needs, needs for which individuals are not usually responsible.\(^{49}\) It also has the benefit of ruling out discrimination against both poor and rich in the distribution of health care.

While the weakest version of the specialness thesis is too weak, the strongest version may be too strong. It is not obviously unjust if individuals have to pay *something* towards their health needs, perhaps in the form of modest co-pays or deductibles at the point of use, provided at least that these forms of co-insurance do not impose an undue burden on the poor. Indeed, the use of co-pays may lead to a more efficient health care system overall, by disincentivizing the

\(^{48}\) This definition of “specialness” comes from Shlomi Segall, “Is Health Care (Still) Special?,” 344.

\(^{49}\) Where individuals *are* responsible for their expensive health needs, perhaps by choosing to engage in risky behaviours like smoking, there is fairly broad agreement that it is fair for individuals to bear some of those costs. But this does not mean that those individuals ought to be refused medical care or left to pay for it themselves; instead, it is better to assess the costs of these risky behaviours ex ante, for example by tacking additional taxes onto the sale of cigarettes. I address this issue in §5.3. On the issue of responsibility for health, see Daniels, *Just Health*, 155-157; for a different perspective, see Segall, *Health, Luck, and Justice*, particularly Chapters 3 and 4.
overconsumption of care. Between the weakest and strongest version of the specialness thesis, a variety of middle-ground views are possible. Each of these might require that the distribution of health care be in some way *partitioned*, so to speak, but not necessarily *isolated*, from the distribution of other social goods.

In this chapter and the next, I take for granted that justice requires treating health care as special in some sense, that is, that health care should be distributed more equally than other social goods. I also take for granted that the weakest form of the specialness thesis, which demands only that no one be denied basic care due to inability to pay, is simply too weak. I will generally speak of the specialness thesis in its strongest form, as requiring the *isolation* of health care distribution from the distribution of other goods. In large part this is because the strongest version at least has the virtue of being precise. But the arguments I raise will also apply (sometimes with greater strength, sometimes with weaker strength) to middle-ground, *partitioning* versions of the specialness thesis. After setting out my positive view in Chapter 3, I will return to the specialness thesis in Chapter 4 (§4.1), to vindicate these assumptions through a more thorough justification for treating health care as special, as well as to provide a more precise interpretation of the specialness thesis.

### 1.2.3 Health Care as a Separate Sphere

Endorsing the specialness thesis (in any form) introduces the idea of a health care system specifically as an object of justice. The specialness thesis in effect forbids us from treating health care continuously with other social resources under a general theory of distributive justice. Once we see health care as something that cannot be distributed according to the same
general principles governing the distribution of other social resources, we are forced to confront questions about how health care ought to be distributed instead.

The specialness thesis forces us to ask these questions, but the specialness thesis alone is not sufficient to answer them. This is because the specialness thesis is a negative thesis; it requires only that the distribution of health care should not affect (nor be affected by) the distribution of other goods like income and wealth. It does not say anything positive about how health care should actually be distributed to individuals. For that, we need to supplement the specialness thesis with some positive distributive principle or principles.

Properly speaking, positive principles of health care distribution should govern the distribution of health care access rather than that of health care itself. Although I have been speaking loosely of justice in the distribution of health care, a liberal society cannot actually distribute health care. This is because a free society cannot force persons to submit to care they do not want. The idea of access to a good implies the opportunity to make use of that good if one wishes. Focusing on access to care accommodates individual differences in preferences for health-care use against a just background distribution of opportunity to obtain care.

How then should access to health care be distributed? Access according to what? Given the privileged place of individual choice on a liberal view, one obvious answer would be to distribute access according to individual choice alone, that is, to give individuals whatever health care they happen to want. There are obvious flaws with this approach, however, having to do with the lack of specialized knowledge most people have with respect to medical science. Individuals do not typically know what health care they need, so distributing access to health
care according to choice alone would lead to the inefficient and often pointless consumption of care. Such wastefulness is especially egregious when it comes to medical care, which unlike other basic needs is objectively scarce even in rich societies.

A second possibility would be to distribute access to care according to desert or social utility, that is, to give priority in treatment to those of exemplary moral character, or perhaps those who have contributed or those who can be expected to contribute a great deal to society. But outside of certain very specific situations like immediate post-disaster triage, where it is perhaps appropriate to prioritize care for rescue workers for the sake of saving as many lives as possible, principles of distribution like these are hard to justify. A political conception of justice cannot distribute goods like health care according to moral desert, because reasonable comprehensive moral views will disagree about what it is to be morally deserving. On the other hand, while the idea of distributing health care according to expected future contributions can at least be given a neutral foundation in terms of advantage, refusing health care to some for the sake of delivering greater benefits to others or to society at large amounts to a fairly straightforward failure to take seriously the distinction between persons. Persons who conceive of themselves as free and equal would not agree to such a principle.

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52 Segall, Is Health Care (Still) Special?, 345.

53 Rawls, Justice as Fairness, 73.

Because of the problems with distributing health care according to these non-health considerations, many hold that access to health care should be distributed according to medical need alone, and patients should have access to the care that is reasonable and appropriate for their particular medical condition. Following Michael Walzer, Shlomi Segall calls this the “separate sphere” view of medicine. The separate sphere view is so-called because it holds that access to medical care should be distributed according to principles that are local or internal to the sphere of medicine. If the aim of medicine is to promote health, and health is construed as the absence of disease, then the “separate sphere” view amounts to the view that health care should be distributed according to medical need rather than non-medical criteria like moral desert or social utility.

1.2.4 Distribution According to Medical Need

Medical need is standardly defined by reference to a particular pathology or disease: a medically necessary intervention is one that is reasonable and effective for the prevention, diagnosis, treatment, or amelioration of disease, injury, or disability. (For the sake of concision I will often speak of necessary care simply as care that is “effective for the treatment of disease or disability.”) I leave aside here the controversial issue of defining disease or pathology; I follow Norman Daniels in relying on Christopher Boorse's position that pathology is any interference

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57 Segall, “Is Health Care (Still) Special?,” 345.
with normal species functioning, but nothing I will say hangs on that. Medical need has to do with the appropriateness of a particular intervention to a particular case or type of case.

To say that access to health care should be distributed according to medical need is to impose at least two distinct requirements on the distribution of access to care. First, as we have already seen, the idea of distributing health care access according to medical need limits the kinds of considerations that are relevant in allocating care. Distribution according to medical need rules out making access to care contingent on ability to pay, of course, but it also rules out distributing access according to considerations of a person's overall (non-medical) neediness, merit, usefulness, or desert. It requires that the amount of care a person receives depends on her medical condition alone, and not on her life outside the examination room.

Second, and perhaps more controversially, the idea that health care should be distributed according to medical need limits our obligations of justice in health care to interventions that effectively treat disease or disability. Thus it rules out care that is merely cosmetic, elective, or experimental. To say that care should be distributed according to medical need is to say that we do not owe patients elective and experimental care, at least not as a matter of basic justice, regardless of how much such care may benefit the patient or how much the patient may want it. In this way, an intervention's being medically necessary serves as a usually necessary condition for its being owed to people as a matter of justice. (I say “usually necessary” because there are some exceptions. Contraception and non-therapeutic abortion services, for example, are not

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“medically necessary” in this sense—pregnancy is not a disease—but many people believe access to these services should be included in a basic health care package.60)

That health care ought to be distributed according to medical need is appealing. Bernard Williams went so far as to call it a “necessary truth.”61 Whether or not it is a necessary truth, it has many advantages. Distributing care according to medical need requires doctors to serve as gatekeepers to the health care system, making sure that people do not receive unnecessary care and thus avoiding the excesses of distributing care according to choice alone.62 In this way it also preserves the distinct role of doctors as professionals bound by duties of care rather than mere technicians providing any services the consumer requests.63 Distributing care according to medical need also embodies a certain ideal of equality, insofar as it requires that persons with equal medical need should receive equal care (or at least equal chances of obtaining care) regardless of their overall moral worth or social usefulness. Many people are strongly attached to the idea that decisions about their medical care should be made between them and their doctors, and they recoil at the suggestion that care should be distributed according to bureaucratic determinations of desert or social usefulness.

60Daniels, Just Health, 41


62Of course, in societies where physicians are compensated on a fee-for-service basis, physicians also face strong financial incentives to over-treat patients, placing them in a complicated ethical position.

1.2.5 Limitations of the Concept of Medical Need

I indicated earlier that a theory of justice in health care should answer two general questions: what kinds of health care services should be offered, and how should those services be distributed to individuals? It might be tempting to think that the idea of distributing care according to medical need can answer both of these questions in a single stroke: not only should care be distributed to individuals according to medical need, but individuals should be offered all those health care services that meet a medical need. Medical need would then serve as a (usually) necessary and (always) sufficient condition for receiving care.

As appealing as this thought may be at first blush, in fact the concept of medical need cannot play the role of sufficient condition for receiving medical care. This is because the idea of “need” in play here—being an effective treatment for disease or disability, as opposed to a merely elective procedure—is far too broad. Providing all beneficial medical treatments would turn health care into a “bottomless pit” that would bankrupt even the wealthiest society. We have to balance the importance of meeting health needs against other social priorities.\(^6\)

For example, consider the case of Avastin, a cancer drug. Avastin extends the life of colorectal cancer patients by an average of four months, but half of patients enjoy no benefit whatsoever, and the drug has many serious adverse effects ranging from gastrointestinal problems to severe hemorrhage. In Canada, a course of Avastin costs about $50,000 per patient. Currently only three Canadian provinces offer the drug as part of their provincial insurance plans, but cancer advocacy groups are pushing for more provinces to cover it. According to one

estimate, providing Avastin to all Canadians who need it would cost about four billion dollars annually, a sum equal to nearly 2% of all health care expenditure in Canada in 2011.\(^{65,66}\) And Avastin is but one in a growing list of new, astronomically expensive drugs.

Avastin certainly meets a medical need in the sense I've described: it is a treatment for a disease, and one that is effective in the sense that it yields on average an extra 4 months of life. For many, Avastin is a “need” in an even stronger sense, to wit, that without it they will die sooner rather than later. But it is at least an open question whether every Canadian who would benefit from Avastin is owed this costly and cost-ineffective drug as a matter of justice. The fact that something meets a “medical need” is not a sufficient condition for its being owed to citizens as a matter of justice.

It might be tempting to think that the concept of medical need can provide an objective, scientific standard of what we owe to one another by way of medical care, but in fact it cannot play that role. Medical need is a medical concept, not a moral one. We cannot offload difficult questions about what we owe to one another onto medical science. The concept of medical need can tell us when a particular person would benefit from a particular treatment, but it cannot tell us which treatments or classes of treatments belong in the package of health care services guaranteed to all.\(^{67}\) Ideally a theory of justice in health care should give some guidance in how to

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\(^{67}\) Allen Buchanan et al., *From Chance to Choice* (New York: Cambridge University Press, 2000), 120.
answer that question, but a theory of justice cannot simply defer to the judgement of the medical community in these matters.

1.3 Obstacles to a Liberal-Egalitarian Account of Justice in Health Care

In the previous section, I tried to provide some intuitive support for the idea that health care access should be distributed, first, more equally than other social goods, and second, according to medical need. These distributive principles have, I think, a certain intuitive plausibility to them. Certainly most theorists have attempted to defend something like them. But to defend them from within a liberal theory of justice, one immediately confronts a couple of significant obstacles. These are, first, liberals’ general opposition to paternalism in the distribution of social resources, and second, the aversion of some liberal theorists, Rawls most notably, to viewing the redress of natural inequalities as a requirement of justice.

1.3.1 Against Paternalism

As mentioned above, perhaps the strongest motivation for giving a distinct account of health care justice is the problem of expensive and unequal medical needs. But the mere fact of inequality in medical needs is not sufficient to justify the direct provision of health care or health care insurance to citizens by the state. This is because of liberalism's strong presumption against paternalism in the distribution of social resources. If the problem is simply that health needs are

68Walzer, Spheres of Justice, 86-91; Williams, “What Is the Point of Equality?,” 106-107; Daniels, Just Health, 149-155; Buchanan et al., From Chance to Choice, 121-124.
unequal, the preferred liberal solution should be to give sick people money. If there is a reason for giving the sick health care services in kind rather than cash, it should be something stronger than the paternalistic concern that the sick will not actually spend their money on the health care they need.

One reason for liberals' anti-paternalism has to do with efficiency. Providing goods in kind will often make people worse off than they could be with a more fungible form of transfer, like cash, which they could use to purchase something they might rather have. But there is also an argument against paternalism from equality. This is because providing goods in-kind rather than cash will inevitably privilege certain conceptions of the good over others. A hedonist committed to the principles “live fast” and “die young” might be better off with the cash equivalent of his health care needs to spend on a sports car or an exotic vacation. A social order that provides him with only health care will leave him disadvantaged in the pursuit of his conception of the good relative to others whose life plans favour more staid pursuits. It appears that such a social order fails to treat the hedonist as an equal. This is not to say that the hedonist is owed a cheque instead of health care; it is only to point out that, if he is not owed a cheque, he is owed an argument that explains why.

Here the contrast with education is instructive. Like health care, primary and secondary education is usually distributed in kind to citizens by the state; it is not a need that citizens are normally expected to meet out of their own fair shares of income and wealth. Theorists like Norman Daniels stress the continuity between education and health care in their accounts of

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health care justice. But one major reason that there is nothing objectionable about distributing primary and secondary education to citizens in kind is that primary and secondary education are typically distributed to children. It is appropriate for the state to behave paternalistically towards children, providing them with the appropriate means to develop their moral powers and grow into free and equal citizens instead of giving them cash transfers with which to satisfy their immediate desires. These considerations may well extend to young adults, providing a possible rationale for targeted subsidies for post-secondary education. But surely this kind of argument is not readily extended to full-grown citizens conceived as free and equal. Being a free and equal citizen means being entitled to decide for yourself what is in your own best interests, rather than having such decisions made on your behalf by well-meaning fellow citizens. This suggests at least one major discontinuity between the argument for the public provision of education and the argument for the public provision of health care: the former can be unobjectionably paternalistic in a way that the latter cannot (unless, of course, we are talking about the public provision of health care for children).

1.3.2 On Natural Inequalities

The second obstacle to a liberal theory of justice in health care is that health inequalities are “natural” inequalities, and many liberals follow Rawls in denying that natural inequalities require redress as a matter of justice. As Rawls puts it, natural inequalities in themselves are neither just nor unjust. On Rawls's view, this is because the scope of justice is limited to the

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[70] Daniels, Just Health, 60-61.


fair division of the benefits and burdens of social cooperation. Justice requires that “morally
arbitrary” differences in endowment not determine the distribution of the cooperative surplus
(except perhaps in cases where this works to everyone's advantage, as in the incentives
argument), but it does not require that all inequalities of condition be corrected. In particular, it
does not require that the cooperative surplus be distributed in such a way as to precisely offset
any undeserved natural inequalities.73

If we want a theory of justice to be “political” in Rawls's sense, confining the scope of
justice to the benefits of cooperation is important. Justice as mutual advantage can be given a
justification that is freestanding with respect to any particular conception of the good in a way
that the principle of redress—the principle that undeserved inequalities call for redress—cannot.
Justice as mutual advantage can be freestanding because the notion of “advantage” at work there
is simply a placeholder for the particular conception of the good affirmed by each citizen.
Moreover, the constraints that Rawls's theory imposes on each person's pursuit of their good can
be justified by the principle of reciprocity, which is itself a thin moral concept.74

Once we start to extend the scope of justice beyond the division of the cooperative
surplus to the redress of natural inequality, we need to appeal to more robust and controversial
moral principles. For example, the notion of “desert” at play in “undeserved inequalities” is

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73 As Rawls himself notes, the difference principle does “give some weight” to considerations of redress. The
difference principle directs us to maximize the long-term expectations of the least advantaged. This may require, for
instance, that a larger share of social resources be spent on the education of the less talented. Such special
education, however, would not be a form of compensation to the less talented for their misfortune, nor an attempt to
correct undeserved disadvantage, but rather a way of enhancing the prospects of the least advantaged overall.

74 Joseph Heath, “Political Egalitarianism,” 511f.
itself extremely controversial.\textsuperscript{75} To ask people to accept constraints on the pursuit of their advantage in the name of fair play is by no means an easy sell, but it is far easier than asking people to accept real sacrifices to their own interests merely so that those who are worse off may have more. Indeed, if justice requires the redress of natural inequalities, most people will stand to lose simply by participating in social cooperation at all; if we assign lexical priority to the interests of the person or persons most disadvantaged by natural inequalities, a society could spend its entire GDP trying to raise that person's expectations to the point of the next least advantaged person.

Recent research into the social determinants of health has led some philosophers to argue that health inequalities are not natural inequalities after all. This research shows significant correlation between socioeconomic status and health outcomes, suggesting that health may be a social good rather than a natural good.\textsuperscript{76} If health is in fact a social good, then a Rawlsian can and should hold that it (or its determinants) should be distributed fairly. One problem with this claim is that, even if socioeconomic status is an independent risk factor for many serious diseases (as opposed to a mere indicator of other underlying risk factors, like behavioural differences among social classes), it is clearly not the only risk factor. No one is suggesting, for instance, that socioeconomic status is the only cause of cardiovascular disease or lung cancer, even if it is a contributing factor. And this is to say nothing of the many serious diseases that are purely genetic or otherwise natural. It would be unsatisfying if a theory of justice in health care held that we have a duty to redress socially-caused health inequalities but not natural ones, or

\textsuperscript{75}Ibid., 488f.

\textsuperscript{76}Daniels, \textit{Just Health}, 58.
worse, that we have a duty to redress that portion of health inequalities traceable to social
causes, but not the rest.

1.4 Conclusion

In this chapter I have sketched the broad outlines of Rawls's general liberal-egalitarian
theory of justice, according to which respect for persons as free and equal requires that we
protect each person's capacity to form, revise, and pursue a conception of the good. I have
argued that Rawls's general theory is incomplete without a special theory of justice in health
care. Such a theory should justify distributing health care in isolation from other social goods
and on the basis of medical need. The next chapter examines existing attempts to justify
distributing health care in these ways from liberal-egalitarian premises.
Chapter 2: Problems of Extension

In Chapter 1, I argued that a liberal-egalitarian account of justice in health care ought to be able to justify distributing access to health care according to two distinct but related principles. First, such an account ought to be able to justify treating health care as “special,” that is, distributing health care access largely (if not entirely) in isolation from other social goods, particularly income and wealth. Second, such an account should be able to justify distributing health care access according to medical need. Justifying the distribution of health care access according to these two principles (or something very close to them) is essential to defending the normative logic of the health care delivery systems we see throughout the developed world.

These two principles are related in that distributing health care access according to medical need (alone) entails distributing health care in isolation from other social goods; that is, distribution according to need entails treating health care as special. The converse is not true, however; treating health care as special in this sense is consistent with distributing health care access according to any principle or set of principles, so long as the distribution of health care access does not touch or depend upon the distribution of other social goods. Thus treating health care as special need not entail distributing health care according to medical need.¹

In this chapter, I look at existing attempts to provide a liberal-egalitarian theory of justice in health care, and I argue that none of them is able to justify distributing health care according to these two principles. Their failure stems from the fact that all of these theories attempt to provide an egalitarian foundation for health care justice. Despite appearances, the two principles just identified are not readily susceptible of an egalitarian foundation. Or so I will argue.

I begin in §2.1 by considering what I call “the moral importance of health” view, according to which the moral importance of health explains our obligations of justice in health care. I pay particular attention to Norman Daniels's influential account of justice in health care, which locates the moral importance of health in its contribution to opportunity, but I also present my argument against the moral importance of health view in general form. In §2.2 I discuss Rawls's own remarks about health care. §2.3 considers and rejects Ronald Green's argument that health care should be treated as a primary good in its own right. §2.4 considers Deborah Satz's recent attempt to justify the state provision of health care by appeal to the egalitarian failings of private markets in health care.

2.1 Norman Daniels and the Moral Importance of Health View

In Chapter 1, I pointed out that liberals have good reason to eschew paternalism in the distribution of social resources (§1.3.1). The mere fact that a person would benefit from receiving a particular good like health care is not a good reason for insisting that social institutions should distribute that good to her directly. It is usually better to provide individuals
with fungible resources like income and wealth, which they may then use to purchase the goods they want, whether what they want is health care or something more frivolous. If there is a reason for distributing health care or health care insurance to citizens in kind rather than simply giving citizens money, that reason should be something other than the worry that citizens won't actually use their money to purchase the health care they need.

A non-paternalistic rationale for the in-kind provision of health care services might appeal to the idea that meeting people's needs, including their health needs, is somehow more important or more urgent, morally speaking, than merely satisfying people's preferences. If that is right, then even if a person with expensive medical needs might prefer to have the cash equivalent of his health care costs to put toward some other purpose, society's obligation may be limited to providing him with health care. T.M. Scanlon expresses a view like this in “Preference and Urgency:” “The fact that someone would be willing to forego a decent diet in order to build a monument to his god does not mean that his claim on others for aid in his project has the same strength as a claim for aid in obtaining enough to eat (even assuming that the sacrifices required of others would be the same).” On a view like this, it is the objective importance of meeting health needs that explains society's obligation to provide health care, independent of the subjective importance that people may attach to having their health needs met.

Considerations like this motivate what I call the moral importance of health view, or “the MIH view” for short. The idea behind the MIH view is that health's moral importance explains

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why we treat health care as special, that is, why we distribute health care in isolation from other social goods. The MIH view holds that health care is important because health is important, and health in turn is important either intrinsically or because of the contribution that health makes to some further value or values.

The MIH view is very much the dominant liberal-egalitarian approach to justice in health care. My aim in this section is to show that in fact the MIH view cannot give a satisfactory justification for treating health care as special in the relevant sense. Because distributing health care access according to medical need alone entails treating health care as special in that sense, any view that cannot justify treating health care as special cannot justify distributing access to care according to need alone.

One problem with the MIH view is that it is not easily reconciled with the liberal commitment to neutrality among conceptions of the good. It is difficult to give an account of “basic” or “urgent” needs that won't presuppose or privilege some particular conception of the good, one that some citizens may reasonably reject. If we want a conception of justice to be “political” in the Rawlsian sense—formulated independently of any particular comprehensive moral view and capable of serving as the object of an overlapping consensus—then we may think that the MIH view is doomed from the start. But that is not my objection to the MIH view.

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My objection is that no account of the moral importance of health can justify treating health care as special. This is because, for whatever value or combination of values put forward to explain the moral importance of health, not all health care services will promote that value, and not all of the things that promote that value will be health care services. There is no value or combination of values that has the property of being promoted by all and only health care services. Health care is not *sui generis*, morally speaking, and yet that is what would be required to justify treating health care as special on the MIH view. Although in this section I am primarily concerned with liberal-egalitarian applications of the MIH view, this objection applies with equal force to any view according to which health care should be treated as special because of the moral importance of health.

I devote the bulk of this section to a discussion of the work of Norman Daniels, whose account of justice in health care is the most sophisticated and influential exemplar of the MIH view. I explain Daniels's view in §2.1.1 and argue that it cannot justify treating health care as special in §2.1.2. §2.1.3-4 consider and reject some possible modifications to Daniels's view. §2.1.5 generalizes my argument against Daniels, to show that no account of the moral importance of health can yield an account of justice in health care that justifies treating health care as “special.”

### 2.1.1 Daniels's Account of Justice in Health Care

Norman Daniels's account of justice in health care is unquestionably the most influential on offer. Although Daniels's position has evolved over the years, the basic structure of his argument remains essentially unchanged from 1981’s “Health Care Needs and Distributive
Justice” through 2008's *Just Health*.\(^6\) Daniels's argument for a right to health care consists of two main premises:

(1') Since meeting health needs promotes health (or normal functioning), and since health helps to protect opportunity, then meeting health needs protects opportunity. (2') Since Rawls's justice as fairness requires protecting opportunity, as do other important approaches to distributive justice, then several recent accounts of justice give special importance to meeting health needs.\(^7\)

In these two premises we see the basic outline of the MIH view: meeting health needs is important because it promotes health, and health is important because it protects opportunity. It is the value of opportunity that ultimately explains the importance we attach to meeting people's health needs. Because liberal theories of justice like John Rawls's require that we protect citizens' opportunities, these theories can be understood to attach “special importance” to meeting health needs.

Daniels uses the prime symbol in the argument quoted above to indicate that his argument has been revised since its earlier formulation in his 1985 *Just Health Care*. In *Just Health Care*, Daniels put “health care” in place of “meeting health needs.” This revision is meant to emphasize that “health needs” should be understood broadly to include all factors that affect population health, and not merely personal health care services narrowly construed. As

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\(^7\)Daniels, *Just Health*, 30; cf. Daniels, *Just Health Care*, 45.
Daniels himself says, however, this is merely a shift in emphasis, and does not reflect any profound change in his underlying view. My concern here is to show that Daniels's view cannot justify treating personal health care services as special in the relevant sense, and I leave aside any complications that arise from the broader scope of Daniels's project. That caveat aside, I now take up each of the two steps in Daniels's argument in turn.

The first step in Daniels's argument is to develop an account of health and health needs that shows the conceptual connection between health and opportunity. Daniels argues that health is of special moral importance because pathology (the absence of health) reduces the range of opportunities available to individuals to construct their life plans or conceptions of the good. Daniels does not deny that health is also important for other reasons, but for him it is people's fundamental interest in maintaining a normal range of opportunities to form and pursue life plans that explains why we attach special importance to meeting health needs.

Daniels follows Christopher Boorse's functional analysis of health. Health is normal functioning, and its opposite, pathology, is “any deviation from the natural functional organization of a typical member of a species.” This account makes health needs objectively ascribable; the line between normal functioning and pathology can be drawn using the publicly acceptable methods of science, and the goods and services necessary to maintain or restore

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8 For a discussion of some of these complications, see Shlomi Segall, “Is Health Care (Still) Special?”
9 Daniels, Just Health, 35.
health can be identified in the same way.\textsuperscript{11} This functional account of health is readily connected to Daniels's normative account of the moral importance of health. Departures from normal functioning reduce the range of opportunities open to a person, the range of things available for that person to do or to be. Thus the importance we attach to protecting our shares of the opportunity range explains the importance we attach to meeting health needs.\textsuperscript{12}

Still, the bare idea of normal species-typical functioning isn't sufficient to develop a full account of health needs. It does not on its own tell us which departures from normal functioning are most morally significant, and thus it does not tell us how to prioritize scarce health-care resources. For this, Daniels introduces the idea of the “normal opportunity range:” the normal opportunity range is the set of life plans that reasonable persons are likely to set for themselves in a given society.\textsuperscript{13} Such a range will be relative to the technological and economic development of a particular society, as well as to certain facts about its cultural and political life. For example, as Daniels notes, “dyslexia might be less important to treat in a generally illiterate society than in a highly literate one.”\textsuperscript{14}

For Daniels, meeting health needs means protecting individuals' shares of the normal opportunity range. This point cuts in two directions. On the one hand, it means that meeting health needs does not require levelling all differences between individuals. Instead, Daniels argues that we must protect for individuals that portion of the normal opportunity range that

\textsuperscript{11} Daniels, \textit{Just Health}, 42-3.

\textsuperscript{12} Ibid., 44.

\textsuperscript{13} Ibid., 43.

\textsuperscript{14} Ibid., 45.
their natural talents and skills would give them access to, if it were not for the influence of disease and disability.\textsuperscript{15} On the other hand, because we assess the impact of disease and disability by reference to the normal opportunity range rather than the range of opportunities that particular individuals have actually chosen to cultivate or pursue, we abstract from the effects of individuals' particular life plans or conceptions of the good on their opportunities. So, for example, while arthritis may be a more severe impairment to the effective opportunities of a manual labourer than to those of a knowledge worker, the impairment to their share of the normal opportunity range is the same and so their health needs are understood to be equal.\textsuperscript{16}

The second step in Daniels's argument is to connect his account of the moral importance of health with a theory of distributive justice. Because Daniels locates the moral importance of health in its effect on opportunity, he argues that any theory of justice which requires us to protect people's opportunities can therefore be understood to require that we meet people's health needs. Although Daniels aims to be ecumenical in his approach—he seems to think that his account of justice in health care can be in some sense “free-standing,” that is, able to be endorsed from within any theory of justice that requires us to protect opportunity—he focuses (as I do) primarily on Rawls's theory of justice as fairness.

As we saw in chapter 1, Rawls holds that the justice of a society is a function of how that society distributes certain “primary goods,” general all-purpose means to the pursuit of a person's ends. Opportunities are counted among these primary goods, and Rawls's second

\textsuperscript{15} Ibid., 44-5.

\textsuperscript{16} Ibid., 45-6.
principle of justice requires that opportunities be distributed such that all citizens enjoy what Rawls calls “fair equality of opportunity.” 17 Fair equality of opportunity requires not merely that offices and positions should be formally open to all comers, but also that everyone should have a fair chance to attain them. Roughly, it requires that people with similar levels of talent and ambition should enjoy similar life prospects. It is via Rawls's fair equality of opportunity principle (“FEOP”) that Daniels aims to connect his opportunity-based account of the moral importance of health with Rawls's general theory of justice. Opportunity remains the primary good on Daniels's view, but meeting citizens' health needs is understood to be an important component of protecting fair equality of opportunity.

Daniels argues that including health care institutions among those institutions that protect fair equality of opportunity is consistent with the spirit of Rawls's argument for that principle. Rawls's argument for fair equality of opportunity turns on the idea that if differential rewards attach to different jobs and offices, then everyone should have a fair chance to attain those jobs and offices and the associated rewards. It would be unfair to allow the morally arbitrary effects of the social lottery to determine individuals' life prospects. But insofar as we have reason to try to counter the disadvantages in opportunity produced by the social lottery, Daniels argues, we have reason to counter the disadvantages caused by ill health as well, because ill health is also morally arbitrary. “Just as we must use resources to counter the opportunity advantages that some get in the social lottery,” Daniels writes, “we must also use resources to counter the disadvantages induced by pathology.” 18

18 Daniels, Just Health, 57-8.
In the same way that Daniels's account of health needs accommodates normal variation in talents and skills between individuals, Rawls's FEOP does not require that we attempt to level all differences in natural talent. The FEOP requires that individuals with roughly equal levels of talent and skill should enjoy roughly equal life chances.19 (The meritocratic tendencies of the FEOP are mitigated somewhat by Rawls's difference principle, which requires that social and economic inequalities work to the greatest benefit of the least advantaged.) The FEOP requires that we take steps to ameliorate special disadvantages that result from injustice, such as inequalities in access to education due to race or social class, but we do not attempt to correct or compensate for differences in natural talents. This connection to equality of opportunity explains, according to Daniels, the greater importance we attach to providing medically necessary treatment for disease and disability over the biomedical enhancement of below-average but non-pathological traits.20 (I return to this particular issue in §4.2.1.)

In order to integrate his account of justice in health care into Rawls's theory, Daniels finds that he must make one important modification to Rawls's view. When Rawls speaks of fair equality of opportunity, he intends it in a very restricted sense: fair equality of opportunity obtains when all citizens have a fair chance to compete for jobs and offices and the rewards attached to them.21 If the role of institutions that meet health needs is to protect equality of opportunity in this restricted sense, many important health care services will not be covered on Daniels's view. Infertility is Daniels's favourite example: although infertility is a departure from normal functioning that restricts a person's opportunities broadly construed, in most societies

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20 Daniels, *Just Health*, 149-155.
infertility does not interfere with individuals' access to jobs and the rewards attached to them. Thus Daniels argues that we should replace Rawls's more restricted sense of opportunity, opportunity to compete for jobs and offices, with Daniels's own more expansive notion of opportunity, opportunity to pursue life plans more generally.

With this change to Rawls's theory, Daniels's basic argument for a right to health care is complete. Meeting health needs is of special moral importance because doing so protects health, or normal functioning, and health is important because of its contribution to opportunity. Because Rawls's theory requires that we protect fair equality of opportunity, Daniels argues that Rawls's theory can be understood to require that we meet citizens' health needs, including their needs for personal health care services.

### 2.1.2 Daniels's View Cannot Justify Treating Health Care as Special

Daniels's account has attracted considerable critical attention over the years; I will not rehash these criticisms here. For my purposes, it suffices to point out that Daniels's view clearly exemplifies the two problems I identified earlier with the MIH view: not all health care services promote equality of opportunity, and not all things that promote equality of opportunity are health care services. Thus Daniels's view cannot justify treating health care (and health care alone) as special. (Again, because distributing health care according to medical need entails

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treating health care as special, it follows that Daniels's view cannot justify distributing health care according to medical need, either. I will not develop this point here, but see §4.2.1-2.) This is a problem for Daniels's view, not only because treating health care as special is important and appealing, as I argued in §1.2.2, but also because Daniels himself clearly wants to justify treating health care as special in this way.24

To take the first problem first, many important health care services cannot plausibly be said to promote equality of opportunity. Many simply relieve pain, prolong life, or facilitate a dignified death.25 This is especially important given that a huge portion of health care spending in the developed world goes toward the elderly, particularly those in the last few months of their lives.26 Opportunity is a prospective notion, and thus whatever else we may wish to say about individuals in the last few months of life, their major opportunities, their major life plans, are all behind them. This is so unless we are prepared to stretch the meaning of the word “opportunity”

24Daniels, Just Health, 17-21.


beyond all recognition. Providing health care in these kinds of cases will look positively mysterious on a view like Daniels's.27

Daniels does nibble at this particular bullet, but he doesn't bite it quite as unreservedly as his view would seem to require. Daniels argues that we have reason to limit health care spending on those over the age of 75.28 On Daniels's “Prudential Lifespan” account, the problem of intergenerational equity should be viewed, not as a matter of redistributing health care resources from young to old, but in terms of a single prudent individual's decision about how to allocate his own access to health care over a complete life. According to Daniels, prudent persons would reserve some of their fair share of health care resources for later in life, but they would do so in the knowledge that, due to the normal ageing process, years of life after a certain threshold become less valuable to the agent than years of life before that point. In other words, a prudent person would care more about guaranteeing himself access to important medical services in youth and middle age than he would in his more advanced years, and thus he would reserve only a limited portion of his share of health care resources for those advanced years.

The prudent planner account has considerable merit, but it is in tension with the rest of Daniels's view. A prudent planner might wish to save some of her health care resources for her declining years, but in doing so she would not be saving exclusively to protect her share of opportunities.29 Or put another way, if a prudent planner were to save exclusively to protect her

27I am not the first to make this point, of course. See Shlomi Segall, “Is Health Care (Still) Special?,” 347-349, as well as Segall, Health, Luck, and Justice, 33.

28Norman Daniels, Am I my Parents’ Keeper? (New York: Oxford University Press, 1988), 90-91. Daniels appears to relax this view somewhat in Just Health, emphasizing the importance of the democratic process in allocating health care resources, but the essentials of his view seem to me unchanged. Daniels, Just Health, 177-181.

own opportunities, she would not appear to have any *extra* reason to reserve some of her share of health care services for when she is aged. If the prudent planner account solves the problem of health care for the elderly, it does so only by introducing non-opportunity considerations into the distribution of health care. But this means, on Daniels's view, distributing health care for reasons other than reasons of justice. As Shlomi Segall argues, if the aim of just health care on Daniels's view is to promote fair equality of opportunity, that implies, not that society should devote *fewer* health care resources to the elderly as a matter of justice, but that society should devote *none.* 30 Citizens should use their own resources for this purpose, if they wish. 31

While the problem that not all health care services promote equality of opportunity is especially acute when it comes to health care for the elderly, it is in fact a perfectly general problem with Daniels's view. There are plenty of examples of health care services for the non-elderly that do not promote equality of opportunity as Daniels understands it. Treatment to relieve a nagging cough or an annoying pain that does not interfere with a person's ability to pursue her life plans, for example, would not appear to serve fair equality of opportunity. All such treatments would be unjustified on Daniels's view, at least as a matter of basic justice. 32

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31 It might be suggested that I am being unfair to Daniels when I suppose that the purpose of health care for the elderly is to protect the opportunities of the elderly when they are elderly. One opportunity that working-age people typically care about is the opportunity to plan for their future health needs when they *become* elderly, and it might be thought that it is the importance of protecting this opportunity (rather than in addition to the importance of protecting the prospective opportunities of the aged) that explains our obligations of justice in health care to the elderly. See §4.3 for a full discussion of this possible view, but broadly speaking the problem with this view for Daniels is that individuals *already* have the opportunity to plan for their health needs when they are aged. There is nothing to prevent citizens from saving money to meet their future health needs at any time. The problem is only that such saving is likely to be ineffective due to the huge variation we see in health needs across persons, but this problem (it seems to me) is irrelevant from the point of view of *equality* of opportunity. Equality of opportunity is satisfied whether everyone's opportunities to save for their future health needs are equally good or equally bad.

32 Although see Stern, “Opportunity and Health Care,” 346-349, for a dissenting view.
It might be suggested that Daniels could get around this problem by stipulating that everyone has among their life plans the plan to live a long and pain-free life. This would have the agreeable effect of explaining why we provide treatment to the elderly, as well as in other cases where pathology does not seriously interfere with a person's opportunities to pursue her (other) life plans. But this tack is not open to Daniels for a few reasons. One is that it is false that everyone wants to live a long and pain-free life. A second is that Rawls's opportunity principle requires that we protect equality of opportunity, and equality of opportunity is satisfied if everyone has the same chance of leading a long and pain-free life, regardless of whether that chance is equally good or equally bad. A third and related reason, brought up by Segall, is that Rawls's opportunity principle is meant to protect equality of opportunity among those with roughly equal levels of natural talent and ambition; Rawls's FEOP is, in other words, a principle of fair competition. Living a long and pain-free life is not a competitive endeavour. How far others succeed in leading a long and pain-free life does not affect my ability to do so, and so Rawls's opportunity principle simply does not come into play here.

Indeed, life plans in general are not competitive endeavours. Life plans are not like offices and positions, out there in the world waiting for individuals to sort themselves into. Instead, life plans are fundamentally individual. I cannot simply “take up,” much less compete for, your life plan, although I may modify my own plan on the basis of what I like or dislike in yours. It is unclear what sense can be made of Rawlsian fair equality of opportunity to compete for life plans in general, and thus it is unclear how Daniels's view can justify health care

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34 Segall, Health, Luck, and Justice, 35.
entitlements with respect to these sorts of plans. Thus I conclude that not all important health care services promote equality of opportunity in the relevant sense.

From the other side, not all of the things that promote equality of opportunity are health care services. Daniels's argument would seem to commit him to the view that all goods that promote equality of opportunity, or at least all goods that promote it to the same degree that health care services do, ought to be distributed in isolation from income and wealth. At first blush, this may seem a welcome implication; many non-health determinants of opportunity, such as primary and secondary education, should be treated as special in this way. But in fact to justify treating most health care services as special, including those that have a relatively insignificant impact on opportunity, consistency will force Daniels to extend “special” treatment to any other goods that have a comparably (in)significant effect, ranging far beyond what most liberals think should be socially provided. This is especially true on Daniels's broader understanding of opportunity. If a liberal society must protect not just equality of opportunity to compete for jobs and offices, as Rawls would have it, but equality of opportunity to pursue any reasonable life plan whatsoever, then it would seem that we have a case for treating practically any good as special: education and health care, to be sure, but also housing, cars, smartphones, computers, and indeed anything a person might need for any possible purpose.

Daniels considers whether his broader notion of opportunity is problematic in this way in *Just Health*:

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Suppose that supplying a computer to everyone who cannot afford one would do more to remove individual impairments to the normal opportunity range than supplying certain health-care services to those who need them. Does the fair equality of opportunity approach commit us to supply computers instead of or in addition to medical treatments?^{36}

After noting that the problem of connecting equality of opportunity to any specific goods like education or health care is not specific to his view, Daniels responds that his approach “rests on the specific calculation that institutions meeting health needs quite generally have a central impact on individual shares of the normal opportunity range and should therefore be governed directly by [Rawls's] opportunity principle.”^{37} This response is incomplete, to say the least. The question is not whether health care has a “central impact” on opportunity, but whether health care's impact is more central than that of any number of other factors.

The idea that health care's contribution to equality of opportunity is greater than the contribution of other factors like computers is plausible if we focus on care for the most debilitating forms of disease and disability. Someone who is immobilized, unconscious, or dying has few (if any) effective opportunities to pursue her life plans, whatever they may be. If anything can help protect people's opportunities in cases like these, it is medical care. But most cases are not like this. The fact that some health care services have this kind of crucial role in protecting opportunity is not a reason to treat all health care services as special. This may be an

\textsuperscript{36}Ibid., 59.

\textsuperscript{37}Ibid., 59-60.
argument for getting the bed-ridden out of bed before providing the disadvantaged with a computer, but it is not necessarily an argument for treating sore throats or skin rashes before providing that computer. Daniels has not given an argument for treating health care as special; he has given an argument for treating the determinants of opportunity as special, and the determinants of opportunity extend well beyond health care.

The two objections I have raised against Daniels's view combine to present a sort of dilemma. The more expansive Daniels makes his notion of “opportunity” in order to respond to the first objection, the more vulnerable he becomes to the second, and vice versa. If Daniels is worried that some important health care services are not justified on a narrow account of opportunity, he might move to a more expansive definition, but in doing so he is also bound to capture more non-health care services in his net. On the other hand, narrowing the definition so as to include fewer non-health care services means that fewer health care services will be justified, too, thus making himself more vulnerable to the first.

In fact, we have already seen this dynamic at work in Daniels's view. As mentioned earlier, Rawls's FEOP applies to opportunities in a very narrow sense: opportunities to compete for jobs and offices. Daniels finds that he needs to broaden Rawls's opportunity principle to apply to opportunities to pursue all “life plans,” not just careers. This is because many important health care services do not affect our opportunities to compete for jobs, but they are important nonetheless; infertility treatment, for example, or any form of health care for those beyond
working age. But as we have seen, broadening the notion of opportunity in this way also lets in many more things that are not health care services. If we're concerned to protect equality of opportunity to do effectively anything, to pursue any life plan whatsoever, then there is little reason to think that health care will have any distinctive role to play; it will be but one of many factors that determine a person's share of opportunities.

### 2.1.3 Health Needs and Opportunity Needs

My argument against Daniels turns on the teleological structure of his view. Because Daniels's view makes health care instrumental to equality of opportunity, his view does not require that we provide health care in cases where health care does not contribute to equality of opportunity. By the same token, if it requires that we provide health care in cases where the contribution of health care to equality of opportunity is weak, then sheer consistency entails that we are also required to provide other goods whose impact on equality of opportunity is comparably weak.

Daniels might urge that I have mischaracterized the structure of his argument. Daniels appears to think that once we see the significance of health needs in general for opportunity, we have a reason to meet all needs of that kind, without being obliged to appeal directly to the opportunity principle to decide the merits of meeting each specific kind of health need. Daniels may think that the moral importance of health justifies meeting any need that is functionally connected to health, even those whose actual significance for equality of opportunity is relatively weak. Contrariwise, the moral importance of health does not justify meeting those

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38 Ibid., 59-60.
needs that are not functionally connected to health, even if those needs are in fact more significant to equality of opportunity than certain health care services. The idea seems to be that the moral importance of health justifies treating health care not just as special but as a sort of “separate sphere,” such that resources allocated to that sphere get distributed according to the sphere's own inner logic (i.e., to promote health) rather than by appeal to the opportunity principle directly.

This may well be Daniels's view, but I do not find it tenable. The main problem with this view is that it entails that a society should not deploy its limited opportunity resources in the most effective way, that is, in the way that would do the most to bring about fair equality of opportunity. Instead, according to this view, a society should aim to meet certain kinds of opportunity needs, such as health needs, and it should aim to do this without regard to how effectively meeting particular needs of those kinds actually brings about fair equality of opportunity vis-à-vis alternative uses of the same resources.

The problem with this position is not merely that it is unwise to allocate opportunity resources so inefficiently. The deeper problem for Daniels is that this allocation cannot possibly be justified by the principle of fair equality of opportunity alone. If the FEOP requires anything, it requires that we bring about fair equality of opportunity as far as we possibly can. If we are prevented from pursuing fair equality of opportunity in the most effective way by, say, an overriding obligation to meet certain health needs despite their insignificance for equality of opportunity, that constraint must derive its moral force from something other than the FEOP. But

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39 I am grateful to Shlomi Segall for suggesting this interpretation of Daniels in private correspondence.

40 The term “separate sphere” comes from Walzer, *Spheres of Justice*, 88-89; see also Segall, “Is Heath Care (Still) Special?,” 344. See back to §1.2.3-4 for a discussion of the “separate sphere” view of medicine.
if that is right, then Daniels cannot hold this position without abandoning the core of his account of justice in health care, which locates our obligation to meet health needs under a principle mandating fair equality of opportunity.

Another way of putting the point is this. The idea under consideration is that once we see the moral importance of health in its contribution to equality of opportunity, we have a justification for meeting all needs of the health kind without having to appeal directly to the opportunity principle to decide the merits of meeting each particular health need (or each particular kind of health need). And yet while there is no doubt a sense in which all health needs are “of a kind,” surely they are not all of the right kind for Daniels's purposes. There are health needs and then there are health needs, health needs that are significant for opportunity and those that are not. Only health needs that are significant for opportunity can matter from the point of view of the FEOP. Other health needs might matter for other reasons, but Daniels cannot appeal to those non-opportunity reasons without significantly altering his view.41

Consider the analogy with education: classes in Pilates or wine tasting are, in some sense, “of a kind” with education that prepares citizens for jobs and careers. But that does not suffice to show that access to Pilates and wine tasting classes is required under the FEOP. To spend our limited opportunity resources on such frivolous programs merely because such programs are of the education “kind” would be irresponsible. It cannot possibly be a requirement of the FEOP that we forgo more effective opportunity-equalizing measures for the sake of these programs. The same goes for health care. If there is a reason to meet those health

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needs that do not contribute to opportunity, that reason must come from something other than the FEOP.

My argument here does not depend on the thought that we should be act-utilitarians about opportunity, deciding the merits of each particular intervention for each particular citizen by a direct calculation of the opportunity costs and benefits. Practical considerations and reasons of fairness require that at some point we resort to general principles and policies, even where applying those principles in a particular case would not be optimific from an opportunity-equalizing point of view. My point here is only that these principles and policies ought to make more fine-grained distinctions among opportunity needs than simply “health needs” and “education needs.” Of course we should not ask whether a knee replacement for Jones would do more to equalize opportunity than an adult literacy course for Smith, but at the margin we ought to ask whether, say, providing knee replacements in general would equalize opportunity to a greater or lesser degree than offering adult literacy courses in general.

2.1.4 A Possible Modification to Daniels's View

A possible modification to Daniels's view is suggested by the following passage, where Daniels stresses the continuity between education, which falls uncontroversially under the fair equality of opportunity principle, and Daniels's own account of health care:

Both are strategically important contributors to fair equality of opportunity (in both the narrow and broad senses of opportunity). Both address needs that are not equally distributed. Various social factors, such as race,
class, and family background, may produce special learning needs; so too may natural factors, such as learning disabilities.

To the extent that education aims at providing fair equality of opportunity, it must address these special needs. Thus, educational needs, like health-care needs, differ from other basic needs, such as food and clothing, which are more equally distributed. The combination of their unequal distribution and their great importance for opportunity distinguishes these needs from those basic needs we can expect people to purchase from their fair income shares, like food and shelter.

This comparison suggests that Rawls's argument about the importance of public education for fair equality of opportunity is readily broadened to include health care. Any justification for the one extends to the other. Making that argument helps preserve a central line of argument in justice as fairness.  

On the account suggested here, it is not merely the moral importance of health needs but also the fact of their unequal distribution that explains why we treat health care as “special.” Although Daniels rarely expresses his view in these terms, this may well represent his considered view. Regardless, I discuss it as a possible view that might fare better against the objections raised in the previous section.

42Daniels, Just Health, 60-61. I mentioned in §1.3.1 an important discontinuity between education and health care, namely, that public education is typically distributed to children.
This revised view does nothing to answer my first objection. It does not provide any new justification for providing health care services that do not protect equality of opportunity. But it might be thought to offer some help in responding to the second objection. Although many factors other than health care contribute to opportunity, only health and education needs are distributed in dramatically unequal ways over the population. This may explain why we treat only health care and education as special, while we expect people to meet the more equally-distributed opportunity needs out of their own fair shares of income and wealth.

Despite these appearances, I do not believe this strategy provides an effective argument for meeting health needs. The reason is that the rationale for meeting special educational needs that Daniels appeals to in the quoted section above is simply not available under Rawls's FEOP; thus a fortiori it cannot be extended to health care.

As I have said, Rawlsian fair equality of opportunity obtains when individuals of roughly equal natural talent and ambition enjoy roughly equal life prospects. Fair equality of opportunity says nothing about how the life prospects of individuals with different levels of natural talent should compare. Insofar as there is a rationale for meeting special educational needs in Rawls's theory, it would fall under the difference principle, not the opportunity principle. The point of such interventions would be to raise the long term prospects of the least advantaged, not to equalize opportunity between those with special needs and those without. This is what Rawls means when he says that the difference principle “gives some weight” to

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considerations of redress. The fact that health needs are unequally distributed does not give us any additional reason to meet those needs under Rawls's FEOP.

Put another way, Rawls's FEOP requires that we correct disadvantages due to the “social lottery,” such as disadvantages due to sex, race, or social class; it does not require that we redress disadvantages due to the natural lottery, such as different levels of natural talent and skill. Rawls's account of fair equality of opportunity has a strong deontological flavour; he holds that society is required to correct socially-caused disadvantages but not to redress natural inequalities, inequalities for which no one is responsible. Special health needs, like special educational needs, would be a result of the “natural” lottery, and so Rawls's FEOP is silent on them.

Daniels frequently appeals to recent research into the social determinants of health to undermine the claim that health needs are a product of the natural lottery. Because factors like sex, race, educational attainment, and socioeconomic status are highly correlated with mortality and morbidity, Daniels argues, health is not such a natural good after all. Thus Daniels argues that our obligations to meet special health needs can be located under the opportunity principle.

As I argued in §1.3.2, the trouble with this claim is that, even if we grant that a great deal of the inequalities we see in health status are social rather than natural, it is clear that not all such differences are. A great many differences in health status are merely genetic or otherwise natural, while others are caused by behavioural choices like diet, exercise, smoking, and the like.

Furthermore, even differences in health status that can be partly explained by differences in

44 Lawrence Stern, “Opportunity and Health Care,” 343-345; Rawls, Theory of Justice, 86.
45 Norman Daniels, Just Health, 58.
socioeconomic status are not wholly explained by them. It would be unsatisfying if an account of justice in health care required us to treat disease and disability when due to social causes but not when due to other causes, or even to treat that portion of disease and disability traceable to social causes but not that portion due to other factors.

In this section, I have considered the suggestion that it is not the moral importance of health alone but that combined with the fact of the unequal distribution of health needs that justifies treating health care as special. I think this view fails to justify treating health care as special for two reasons. First, it does nothing to answer my first objection, the objection that not all health care services promote opportunity. Second, the fact that health care needs are unequally distributed does not provide an adequate justification for meeting health needs under Rawls's FEOP. This is because Rawls's FEOP does not aim to correct for differences due to the natural lottery or differences due to individual choices.

2.1.5 Generalization of the Argument Against Daniels

Like most liberal accounts of justice in health care, Norman Daniels's account aims to justify treating health care as “special,” that is, distributing health care resources in isolation from other social goods. Daniels argues that the special moral importance of health for opportunity justifies treating health care as special. I have argued that Daniels's view fails to justify treating health care as special for two reasons: not all health care services promote equality of opportunity, and not all of the things that promote equality of opportunity are health care services. At best, Daniels's view can justify treating the things that promote equality of opportunity for
opportunity as special. Some health care services will fit that bill, but many will not. And many of the things that fit that bill will be things other than health care services.

I have discussed Daniels's account at length because his is the most developed account of justice in health care on offer, in the liberal tradition or elsewhere. But I think that the objections I have raised against Daniels's view would apply with equal force to any attempt to justify treating health care as special by grounding health care entitlements in the moral importance of health. For any value or values put forward to explain the moral importance of health, there will always be some health care services that do not promote those values, and some things that promote that value that are not health care services. Thus we will not have a justification for treating health care and health care alone as special.

One exception might be health itself. Someone might suggest that health itself, or perhaps equality in health, is of intrinsic moral importance, and this explains the importance we attach to meeting health needs. But even here, there is enough space between health and health care to run my argument. Not all important health care services promote health. Palliative care and other end-of-life health care services are prime examples. But more importantly, not all of the things that promote health are health care services. Indeed, a health care system that was designed to promote health would look quite different from the health care system we have now. At any plausible margin, a health care system designed to promote health should devote more resources to basic public health measures like sanitation, vaccinations, and nutrition, as well as things like education and income support at the expense of traditional health care services. This is because the former have proven much more effective at promoting health than the latter. As Dan Brock explains:
But health care's impact on both health and health inequalities is quite limited; for example, medical care is estimated to account for only about one fifth of the life expectancy gains in the twentieth century. More important, inequalities in health among individuals and groups that are within human and social control are not primarily the result of inequalities in access to or use of care... The crucial point is that differences in the incidence of illness and injury from social causes swamp the effects on health of differences in access to and use of medical care to treat that illness and injury.\(^{46}\)

For these reasons, even a view that locates the moral importance of health in health itself would not justify treating health care as special.\(^{47}\)

In general, to say that health care is distributively special because of the contribution that health care makes to some further value or values is to make the justification of health care's specialness in some sense teleological. In Daniels's case, health care is instrumental to the equalization of some value (opportunity), but similar problems would obtain for a view that saw health care as instrumental to the promotion of some value. It is an empirical question whether a particular health care service helps to promote or equalize the value in question. It is a further question whether health care services are the only things, or even the most significant things,  


\(^{47}\)As I noted in the Introduction, Sreenivasan goes so far as to argue that a society committed to equalizing health would do well to dismantle its health care system entirely and instead devote its entire health budget to alleviating the social determinants of health instead. Gopal Sreenivasan, “Health Care and Equality of Opportunity,” *Hastings Center Report* 37.2 (2007): 27.
that promote or equalize the value in question. My claim is that there is no value or combination of values that happens to be most effectively promoted or equalized by treating health care as special, i.e., by distributing all health care services in isolation from other social goods. Insofar as we seek a justification for providing health care, the moral importance of health is a poor place to start.

### 2.2 John Rawls: Health Needs and the Social Minimum

Rawls's own remarks about health care situate health care under the difference principle, and more specifically under institutions charged with providing the social minimum. For simplicity, Rawls supposes that the citizens' total expectations of income and wealth are comprised of competitively-determined wages plus transfers. Rawls refers to these transfers as the social minimum. On his view, the social minimum is to be set at that point where the total expectations of the least advantaged (wages plus transfers) are maximized—so, for example, at the point where further taxation to grow the minimum would impede economic activity to the point that the total prospects of the least advantaged would start to decline.\(^{48}\)

In developing his account of justice in health care, Rawls claims that the provision of medical care can be included as part of this social minimum. “Within the guidelines of the difference principle, provisions can be made for covering these needs [i.e., medical needs] up to the point where further provision would lower the expectations of the least advantaged.”\(^{49}\)


Rawls emphasizes, the same expectations of care ex ante are compatible with different benefits received ex post, depending on differences in need.

The purpose of medical care on Rawls's view is not merely to supplement the income of the least advantaged, but to meet the needs of citizens as free and equal. Medical care is provided to sustain individuals as normal and fully cooperating members of society over a complete life. As Rawls notes, this provides a framework for setting health care priorities. Health care that restores persons to good health and enables them to resume their role as participants in social cooperation would be of very great importance indeed, while at the other extreme, cosmetic medicine would not appear to be important at all. This view also provides a framework for balancing the importance of meeting medical needs against the importance of meeting the other needs of individuals as citizens, according to Rawls.\(^{50}\)

There appear to be two discrete ideas at work in Rawls's account. The first is a straightforward application of the moral importance of health ("MIH") view rejected in the previous section. On Rawls's account, health is morally important because health is requisite for being a normal and fully cooperating member of society over a complete life; health care is important because it is instrumental to that end. In this way, Rawls's view instantiates the two problems identified above: not all health care services sustain citizens as normal and fully cooperating members of society over a complete life, and not all of the things that so sustain citizens are health care services. Like Daniels, Rawls's view is particularly vulnerable when it

\(^{50}\)Ibid., 174
comes to justifying health care for the elderly, who are typically no longer engaged in social cooperation in any robust sense. Even on a loose interpretation of what counts as “social cooperation”—even if social cooperation means simply participating in civic and family life and not necessarily engaging in productive economic activity—palliative and other end-of-life care would be ruled out completely.

In respect of the elderly, Rawls emphasizes the importance of viewing claims for medical care in the same way that we view all claims on the social product, that is, from the point of view of a single person who is to live through all phases of life. Like Daniels's “prudential lifespan” account discussed in §2.1.2, however, this does not seem to me to solve the problem. If a single person living through all phases of life were to reserve some of her health care resources for palliative and other end-of-life care, she would not be deploying her health care resources solely for the sake of sustaining herself as a normal and fully cooperating member of society over a complete life; she would be introducing additional considerations into the distribution of health care. At the very least, Rawls owes an account of what those reasons might be and how they can be made to fit within his broader theory of distributive justice.

A second idea at work in Rawls's account is suggested by the following remark, quoted earlier: “Within the guidelines of the difference principle, provisions can be made for covering [medical needs] up to the point where further provision would lower the expectations of the least advantaged.” At first blush, this claim makes no sense. For suppose that the maximum possible

51 Ibid.
52 Ibid., 173
expected value for the social minimum is found to be $50,000. Whether the social minimum is then parsed into $45,000 in cash transfers and a health care package with an expected value of $5,000, or $5,000 in cash and $45,000 in expected health care, the total expectations of the least advanced, as measured in the primary good of income and wealth, would be the same. (Their expected utility might be quite different, of course, but this is irrelevant on a Rawlsian view.) It seems Rawls must have something else in mind.

Rawls may be appealing to the fact that spending on health care is not necessarily zero-sum. To see why, imagine a society with no health care system at all. In such a society, persons who found themselves sick or disabled would have to drop out of the workforce, either permanently or until they recovered on their own. This could be a considerable drag on economic growth. There may be some level of health spending such that the benefits to total productivity would exceed the cost, or in other words, some level of health spending that would cause the social product to grow by more than the amount spent on medical care. In that way, health care may raise the expectations of everyone, including the least advantaged. Determining how generous the health care minimum should be would then be a matter of finding that point where the marginal dollar of health care spending yields exactly a dollar of extra economic activity—in other words, that point where the benefits to economic growth of further spending on health care no longer outweigh the costs.

I have no objection to this argument, so far as it goes. If there is a level of health care provision that literally pays for itself in this way, then a society would be irrational to refuse to provide it. But a health care system structured in this way would be very different from the system we have now. For one thing, the level of provision this argument justifies would be
extremely stingy. This is especially true when we consider that the productivity of members of the least advantaged group is likely to be quite low, and thus the level of health care provision that “pays for itself” in those cases is also likely to be quite low. For another, just like the argument above, this argument provides no justification at all for treating the elderly, who are typically no longer actively engaged in productive labour. Treating them would not grow the social product at all. Moreover, there would appear to be no justification on this view for distributing health care according to medical need. On this view, we ought to distribute health care resources where they will do the most to enhance productivity and thus increase the expectations of the least advantaged. In some situations that might entail meeting medical needs, but in other cases it might mean distributing therapies to enhance the functioning of those who are otherwise healthy but not as productive as they might be.

2.3 Ronald Green: Health Care as a Primary Good

Given the problems that confront any attempt to justify the provision of health care by appeal to the contribution that health care makes to some further value, we might decide instead to focus on the value health care resources have as a general, all-purpose means. Unlike Daniels and other exemplars of the moral importance of health view, such an account would remain neutral on the question of what health care is “for,” thus avoiding the problems with the MIH view canvassed in the previous two sections. We can conceive of health care resources as means that individuals would want at their disposal, regardless of the particular ends that health care can be used to promote.
This is the strategy pursued by Ronald Green in his 1976 essay, “Health Care and Justice in Contract Theory Perspective.” Green argues that it is reasonable to treat health care as a primary good, as it fits with the definition of primary goods Rawls gives in *Theory of Justice* as things that any rational person would want, whatever else she wants. It is also worth noting that, while Green's article was published long before Rawls's "political" turn, health care could also be argued to fit Rawls's later definition of primary goods as “things citizens need as free and equal persons”). Health and well-being are at least as central to a person's ability to pursue a conception of the good as basic liberties like freedom of speech or freedom of conscience, according to Green; health care should therefore be included in the list. Once we add health care to the list of primary goods, we need only work out what principle or principles are appropriate for its distribution in order to yield an account of justice in health care. On Rawls's view this means considering how parties in his original position would choose to distribute health care.

The chief problem with Green's view is well-documented. He faces a dilemma. Either he must hold that parties in the original position would insist upon a principle of maximum equal or maximum-minimum access to health care, or he must hold that parties would limit access to health care to make room for other social goods like income and wealth. If he chooses the former, he turns health care into a “bottomless pit” that would consume all of the resources of even the wealthiest society. If he opts for the latter, he finds himself mired in the index...

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problem; he must develop a metric for comparing and trading-off health care resources against other resources like income and wealth. Who is better off, the rich sick person or the poor healthy one?56

The index problem is of course a perfectly general problem for egalitarian theories of justice like Rawls's, and it is present regardless of what we may say about health care. But adding more primary goods to the list complicates the index problem considerably.57 By way of contrast, when Rawls considers adding leisure to the list of primary goods, he suggests that a fair daily share of leisure could be “twenty-four hours less a standard working day,” with a standard working day stipulated as equivalent to the expectations of income and wealth for the least advantaged.58 This provides a natural way of trading off income against leisure. A similar strategy is not available for health care, and there would not appear to be an obvious way of reconciling expectations of health care with expectations of income.

For what it's worth, Green himself seems to be aware of this dilemma. He flirts with the first horn, maximum equal access to health care, before settling on the second. Green appears to favour limiting access to health care to make room for other social goods.59 Most commentators have taken this dilemma to be sufficient reason to reject Green's approach.60

56 Arrow, “Some Ordinalist-Utilitarian Notes,” 254; Daniels, Just Health, 56.
57 Daniels, Just Health, 57, 57n.
58 Rawls, Political Liberalism, 181n.
59 Green, “Health Care and Justice,” 119-121.
60 Daniels, Just Health, 56-57; Denier, Efficiency, Justice, and Care, 125-127.
All that being said, I would like to comment on the prospects of Green's approach for justifying a health care system that treats health care as special and distributes health care according to medical need. Even if we are prepared to bite the bullet and take on a more complicated version of the index problem, Green's view cannot justify a health care system like ours.

The reason is this. Green himself is never terribly clear about whether the primary good at stake on his view should be health itself or health care. He vacillates between the two, perhaps because he assumes that the two are necessarily connected. As we have already seen (§2.1.5), this assumption is unwarranted. Either way that Green goes in disambiguating his view, he runs into problems.

If we add health to the list of primary goods, we are back to the moral importance of health view and the objections I raised to it earlier. We do not have a justification for treating health care as special, because not all health care services promote health, and not all of the things that promote health are health care services. Moreover, if health is a primary good, then maximizing the expectations of the least advantaged could be disastrous for society as a whole; a society could spend its entire GDP on its sickest citizen, in a vain attempt to bring her level of health up to that of the next sickest person.

On the other hand, if we add health care to the list of primary goods, we may have a justification for treating health care as special, but this creates a new problem. Meeting medical needs is only one of the possible purposes for which health care services can be deployed. If we treat health care as a means that can be used for any possible purpose, separating it from the
promotion of health or the treatment of disease, we no longer have a justification for limiting access to care according to medical need. Why would we suppose that parties in the original position would agree to a principle of justice that distributes health care according to medical need? Offhand, it is not clear why they would agree to defer to the judgement of doctors in these matters. This is especially true when we consider the many beneficial forms of biomedical enhancement that parties in the original position might want to guarantee themselves access to. Thus I conclude that adding health care to the list of primary goods will not yield a justification for a health care system that treats health care as special and distributes care on the basis of medical need.

2.4 Deborah Satz: Why Health Care Should Not Be for Sale

Deborah Satz has recently offered an egalitarian argument for the state provision of health care that differs in important ways from the arguments considered so far. While Daniels, Rawls, and Green offer positive arguments to the effect that justice requires a certain distribution of access to medical care, Satz offers negative arguments meant to show that the distribution of health care ought not be left to the free market. Because we have strong egalitarian reasons not to distribute health care by the market, Satz argues, its distribution ought to be determined or regulated by the state.

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Satz is not the first to put forward this kind of argument, but her argument differs from other arguments of this kind in interesting and important ways. Egalitarians like Michael Walzer and Elizabeth Anderson have argued that some markets ought to be blocked or regulated due to certain substantive social or moral features of the goods being traded. In *Spheres of Justice*, Walzer argues that it is part of the social meaning of certain goods that they should not be distributed according to ability to pay; it is part of the “social meaning” of medical care, for example, that it ought to be distributed according to medical need.62 Elizabeth Anderson has argued that is is part of our “best understandings” of certain goods that they should not be treated as market commodities.63

Satz endorses the standard liberal objections to these types of arguments. First, the “social meaning” or “best understanding” of certain goods is contested in modern societies; a conception of justice that is political in Rawls's sense ought to remain neutral on the question of how individuals ought to value certain goods. Second, and just as important, there is no necessary connection between the moral or social meaning of some good and the use of the market as a mechanism for distributing that good. As Satz points out, a religious person can buy a Bible without believing that its market price expresses its true worth.64

In identifying certain markets as objectionable or “noxious,” then, Satz focuses on certain general or formal features of those markets rather than on substantive features of the goods being exchanged. She identifies four such features. Some markets produce harmful

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outcomes for participants or third parties, as when a person is unable to meet her basic needs or when the entire stock of a valuable resource is consumed. Other markets can be harmful for society as a whole by undermining the equal standing of persons, as when markets in child labour undermine the development of capacities for civic participation or when markets in votes undermine the democratic process. Other markets feature asymmetric or weak information or agency, as when one or both parties lack full information about the likely effects of their interaction or when someone has to make decisions on behalf of another. And still others reflect extreme vulnerabilities, as when certain goods are urgently needed and there is only a small supply or a small number of suppliers.65

When a market exhibits one or more of these features, Satz argues, we have a pro tanto reason to block or regulate it. Whether we should in fact do so depends, in her view, on the consequences of the market mechanism vis-à-vis the consequences of alternative policies. The mere fact that a market is noxious is not sufficient to motivate intervention, because the consequences of intervention may turn out to be worse than the moral failure of the market in the first place.

Satz clearly believes that unregulated markets in health care are noxious on some or perhaps all of the grounds listed above. But it does not seem to me that Satz's arguments provide an egalitarian justification for distributing health care access in the ways I have isolated, that is, in isolation from other goods and on the basis of medical need. Most of the problems Satz identifies in noxious markets do not support that conclusion, and those problems that do support that conclusion are not really egalitarian problems.

65 Ibid., 94-98.
Most of the moral failings Satz identifies appear to be problems, not with markets themselves, but with the background inequalities from which people enter certain markets. For instance, we may say that a market for food is noxious when some people are unable to afford enough to eat, but that problem is readily solved by redistributing income and wealth. The harm that such a market generates is a consequence of the unequal distribution of wealth rather than anything intrinsic to the operation of markets for food.

A similar point can be made about markets for scarce and urgently needed goods. For example, Alvin Roth has demonstrated that while people are generally repulsed at the thought of human organs being sold for cash, they do not tend to have a similar reaction to the idea of such organs being traded.\textsuperscript{66} If a person is willing to donate a kidney to a family member in need but cannot do so due to incompatibility, the two of them might seek out a similarly situated pair, where each donor is compatible with the other's recipient; the two pairs might then simply swap kidneys. People do not tend to object to that kind of “paired exchange.” But if two may swap, why not three or four or indeed indefinitely many? This pushes us toward a barter economy in kidneys, and one that could potentially save many lives. It is perhaps crude to call this an efficiency gain, but that is precisely what it is.

It would seem that the only morally significant difference between a cash market for kidneys and a barter market is that the barter market necessarily neutralizes any background inequalities between participants. A cash market in kidneys allows people to leverage their social and economic advantages into advantage in access to kidneys, but in a barter market, where the only thing that can buy a kidney is another kidney, the playing field is levelled. This makes it

seem like objections to markets in kidneys are really objections to the background inequalities at play, rather than to anything intrinsically immoral—let alone inegalitarian—in the trading of kidneys.67

Finally, Satz argues that the operation of certain markets can be harmful to society as a whole by undermining the equal standing of persons in society. This claim could be interpreted in a couple of ways when applied to health care. If the problem is simply that equal standing is undermined when some people are unable to afford the care that they need, then (to repeat myself) that problem could be solved through through the redistribution of wealth rather than through intervening in or blocking markets for health care. If something stronger is meant—if for example Satz means to suggest that equal standing is undermined when people exhibit differential willingness (as opposed to ability) to pay for necessary care, and that this is why health care must be distributed by the state rather than left to the market—then it is difficult to see how Satz could make such an argument without appealing to the substantive moral importance of health or health care. It is not a failure of markets per se that people sometimes fail to purchase what would be best for them.68

The other features of noxious markets that Satz identifies appear to be ordinary cases of non-moral market failure. Asymmetric information, monopoly/monopsony power, and principal-agent problems certainly pose problems for markets, but this is hardly a uniquely egalitarian insight. The case for intervening in these markets is strong on efficiency grounds. I do not see what extra reason for intervention is given by egalitarian concerns. As I will argue in the next


68I return to the issue of equal standing in §5.2.4.
chapter, markets for health care insurance are certainly “noxious,” but not for egalitarian reasons. If the problem were merely that health needs are unequal, that problem would be best addressed through the redistribution of wealth. But that is not the only problem. Markets in health care insurance fail for reasons that can be traced to uncertainty, not inequality, and this (I will argue) is what justifies state intervention.

In conclusion, I have argued that the specifically egalitarian objections that Satz raises against certain kinds of markets are best understood as objections to the unequal positions from which individuals enter those markets. These problems are more efficiently solved by addressing those background inequalities directly, rather than by blocking or regulating specific markets. On the other hand, where Satz identifies real market failures, these failures do not appear to be specifically egalitarian in nature. These may give us good reasons to intervene in certain markets, but those reasons are not readily traced back to inequality.

2.5 Conclusion

I have canvassed several attempts to develop a liberal-egalitarian account of justice in health care, and I have tried to show that none of them provides a justification for a health care system that distributes health care in isolation from other goods and on the basis of need. In each case, the failure stems from the theory's egalitarian starting point. Daniels tries to show that health care is important for realizing fair equality of opportunity, but in fact access to health care is not an effective tool for equalizing anything at all (other than access to health care, of course). Rawls argues that health care can raise the expectations of the least advantaged, but the level of
health care provision that actually increases the social product is likely to be quite stingy. Green argues that health care is a valuable all-purpose means that citizens are owed an equal share of, but by viewing health care as a means he is unable to justify distributing access to care on the basis of medical need; after all, treating disease and disability is only one purpose for which health care may be used. Satz tries to motivate intervention in health care markets on the grounds of those markets' egalitarian failings, but the problems she identifies are either egalitarian failings extrinsic to markets or market failings that have nothing to do with egalitarianism. These conclusions suggest that the prospects for justifying health care entitlements on egalitarian grounds are poor, and we would do well to look elsewhere for a justification.
Chapter 3: Risk and Risk-Pooling

In chapter 2, I argued that existing liberal-egalitarian accounts of justice in health care fail to justify distributing health care in isolation from other goods and on the basis of medical need. In each case I traced this failure to their egalitarian starting points. My aim in this chapter is to put forward a different justification for health care entitlements, one that can better justify why liberal democracies distribute health care in those specific ways. My account begins from the observation that almost every well-to-do liberal democracy on earth articulates health care rights under the rubric of social insurance rather than through the direct provision of medical care. Moreover, those liberal democracies that do provide medical care directly still distribute care by and large according to the logic of insurance; what they provide is indemnity against certain health risks through managed care rather than guaranteeing their citizens everything they may need to become or remain healthy. To my mind, these facts should be interpreted not merely as an historical accident, but also as reflecting part of the the deep structure of liberal political morality.

Liberalism begins with the idea that respect for persons requires that we protect each person's capacity to form, revise, and pursue a particular plan of life. This entails, among other things, that each person is owed a fair share of the rights, opportunities, and other social resources necessary for the effective exercise of that capacity. When it comes to fair shares,
though, what matters is not only the resources that people can count on, but also how reliably they can count on them. At some margins, at least, people's capacities for self-determination are better served by a more secure bundle of resources than by a larger bundle. I would suggest that this is why nearly all existing liberal democracies provide their citizens with various forms of social insurance: health insurance, of course, but also insurance against sudden unemployment, against outliving one's savings (i.e., old-age pensions), against disability, against various kinds of natural disaster, and so on. They provide these insurance policies because of the threat that risk poses to the capacity for self-determination, and because of the weaknesses of private markets in delivering access to these kinds of insurance products. My focus here is health care insurance, but the arguments I raise could be extended to justify other forms of social insurance as well.

In this chapter, I develop this account of justice in health care, showing how health insurance is beneficial and why the state needs to be involved in the delivery of health care insurance. This sets the stage for the next two chapters, where I show how health care insurance justifies the distribution of health care in isolation from other social goods and on the basis of need (Chapter 4) and how health care insurance can be integrated into a broader liberal-egalitarian theory of distributive justice (Chapter 5).

I begin in the next section (§3.1) with a brief account of the nature of risk and the significance of risk to a person's capacity for self-determination. In §3.2, I develop a simple model of an insurance scheme to show how insurance can be beneficial to an agent. §3.3 explains why private markets in health insurance fail and thus provides an argument for state
involvement in the health care sector. §3.4 explains how the account given here differs from Ronald Dworkin's “hypothetical insurance” account of health care justice.

3.1 Risk and the Capacity for Self-Determination

As we have seen, wealthy liberal democracies treat health care differently from other basic needs. While citizens are generally expected to see to their basic needs out of their own income (perhaps supplemented by cash transfers), rich societies typically distribute health care according to need and in isolation from other goods. To justify this differential treatment, it is necessary to isolate what makes health care different from these other basic needs.

It is perhaps natural to think that the great moral importance of health justifies this differential treatment, but it is implausible that health care is *more* important, morally speaking, than other basic needs like food, clothing and shelter. If the moral importance of health is sufficient to justify the distribution of health care according to medical need, surely the moral importance of shelter suffices to justify the distribution of housing according to shelter need, the moral importance of nutrition suffices to justify the distribution of food according to nutritional need, and so on. It may be that health care is but the first step on the road to a socialist utopia where all goods are distributed on the basis of need. Far more likely, however, there is another factor that explains why health care is properly treated differently from these other basic needs.

Another salient difference between health care and other basic needs is the fact that health needs are unequally distributed in the population. I mentioned in §1.2.1 that in Ontario
just one percent of patients accounted for 34% of health care system costs in 2007, while fully half of the population consumed practically no health care at all.¹ But as I argued in §1.3.1, if this inequality in health needs were the only problem, this would not suffice to motivate the distribution of health care according to need. If inequality is the problem, redistribution of wealth recommends itself as the optimal solution. Society could simply transfer cash to the sick and let them purchase the care they need, or indeed put the money to another use if they so choose. If we are moved by paternalistic concerns that the sick may not actually spend their money on health care, society might instead provide them with a voucher that could only be used for health care.

But the unequal distribution of health needs is not the only problem. In addition to being unequally distributed, health needs are also subject to great uncertainty. In the normal case, it is difficult to say ex ante where a particular individual will fall in the distribution of health needs over her whole life, or for that matter when particular health needs will emerge within her life. Needs for food, clothing, shelter, and the like are all quite predictable, so it is reasonable to expect people to see to those needs from their fair income shares. If certain people have particularly expensive needs in one or more of these areas—if a handicapped person, for instance, needs a home that is outfitted for accessibility in certain costly ways—that problem is readily solved by giving people money. But because of uncertainty, health needs are more difficult to plan for; individuals do not know how much to save for their health needs and when, and states do not know how much to transfer.

3.1.1 Risk and Uncertainty

This uncertainty about future health needs is properly called “risk” once we begin to estimate the likelihood that certain health needs will emerge and to weigh their costs. Risk always obtains in a context of uncertainty; we do not speak of risk when we know for certain that some event will or will not occur. But risk is a special kind of uncertainty, uncertainty that has been brought to mind and subjected to some kind of accounting, however rough-and-ready. Risks are statements about the future made in probabilistic terms; uncertainty in the strict sense obtains when probabilities have not been or cannot be assigned.\(^2\) As John Adams puts it, “if you don’t know for sure what will happen, but you know the odds, that’s risk, and if you don’t even know the odds, that’s uncertainty.”\(^3\)

As finite rational beings, making plans for the future involves dealing with risk in this sense. The future, being in the future, is unknown to us. Having even rough knowledge of the background probabilities of various events can be very helpful in planning for the future. With this knowledge agents may take steps to avoid certain risks altogether, or to mitigate the harms that may result from them. Failing that, an agent may at least prepare for the arrival of certain risks.\(^4\)

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That said, there are limits to what these risk management strategies can accomplish. This is particularly true when it comes to health risks. An agent may avoid certain risks (by abstaining from smoking or alpine skiing, for example), or adopt a general fitness regime to mitigate any harms stemming from disease or disability. But many health risks are impossible to avoid, or impossible to avoid except at unacceptable personal cost. Many health risks are simply genetic, or can be avoided only by shunning all contact with other human beings and the natural world. For these types of risks, the only thing an agent can reasonably be expected to do is to prepare for the possibility of their arrival. Above all, this means putting aside some money to see to any unexpected health needs.

But how much to save? Knowing the background prevalence of various forms of disease and disability does not necessarily tell a person very much about whether and when a particular disease will strike her. Knowing the average cost of treating various forms of disease and disability does not necessarily tell a person very much about what such treatment will cost her.\(^5\) The huge variance we see in health care consumption in the rich world suggests that any particular level of health savings is almost certain to be either too much or too little. One person's expensive health needs may exhaust her savings, leaving her unable to afford necessary care, while another may scrimp and save for a lifetime, never to encounter any costly health needs at all.

\(^5\)To take one example, a 2012 study found that the cost of an appendectomy in California in 2009 ranged from just over $1,500 to over $185,000, depending on where it was performed. Renee Y. Hsia et al., “Health Care as a “Market Good”? Appendicitis as a Case Study,” *Archives of Internal Medicine* 172.10 (2012).
3.1.2 Why Risk Matters

Risk has significance for political philosophy, particularly on a liberal view. Liberals hold that respect for persons as free and equal requires that we protect each person's capacity to form, revise, and pursue a rational plan of life. Liberals recognize that in order for a person to form and pursue a plan of life effectively, she must have resources at her disposal.\(^6\) Liberals go wrong, however, insofar as they suppose that what matters is only the resources an agent can expect. What matters is also how reliable or how secure those expectations are.

The connection between an agent's having resources under her control and her capacity to set and pursue various ends runs deeper than is often appreciated. It is not only that, in order to achieve any of her ends in particular, an agent must have the necessary means (although that is true). More than that, what ends it is reasonable for a person to set for herself in the first place depends upon the resources she can count on. A person cannot craft a rational plan of life in a vacuum. What it makes sense for a person to aim to do or to be depends crucially on the resources she can expect.

For this reason, a person whose personal and external resources are subject to great risk will find it difficult to form, revise, and pursue a rational plan of life. Jonathan Wolff and Avner de Shalit call this phenomenon “planning blight.”\(^7\) For example, a person whose employment or housing is insecure may find it difficult to plan in other areas of his life. He may forgo important personal projects like marriage or education while waiting for his situation to become more


\(^7\) Wolf and de Shalit, *Disadvantage*, 69.
secure. Indeed, this may be a rational response to great uncertainty. In extreme cases, though, planning blight may spread beyond what is rational; if everything seems beyond a person's control, he may find it difficult to plan for any area of his life, even when failure to plan may make his situation worse. Wolff and de Shalit call this more extreme case of planning blight “paralysis of the will.”

Despite the significant threat that risk poses to our capacities for self-determination, liberals have tended to ignore risk in their accounts of distributive justice. Rawls's theory of justice, for example, directs us to maximize the lifetime expectations of income and wealth going to members of the least advantaged group. But on the most natural interpretation of the word “expectations,” lifetime expectations are a mean, an average, and a mean can conceal great variation. The lifetime expectations of members of a particular social group do not tell us how many people within that group actually realize those expectations over their whole lives, or how many exceed or fall short of those expectations and by how much. Nor do lifetime expectations tell us how actual returns are spread over the whole life of a single person within that group—for example, whether income is variable or steady, or whether wealth is secure or risky. These sorts of facts about people's lives cannot be read off the mean lifetime income of their social group, yet these facts are extremely important to people's abilities to form, revise, and pursue a conception of the good.

For this reason, liberals should care not only about the expected value of a person's bundle of resources, the mean; they should also care about the variance. Variance is a measure of how “spread out” a set of numbers is, that is, how far numbers in the set lie from the mean. The

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farther numbers diverge from the mean, the greater the variance. For example, the set of numbers $[1, 8, 18]$ has the same mean (9) as the set $[8,9,10]$, yet the variance of the first set is much greater. This is because numbers in the first set are not so tightly clustered around the mean. If we think of these sets of numbers as representing the payoff structures of possible gambles, and we suppose that each outcome within the set is equally likely, then the expected value of the gamble is given by the mean, while we can think of the variance as a measure of how risky each gamble is.

Because the variance is independent of the mean, maximizing the expected value of a gamble does not necessarily do anything to reduce one's exposure to risk per se. For that reason, Rawls's difference principle is consistent with some members of the least advantaged group winding up quite badly off indeed, even as the expectations of members of that group are maximized. Even among those individuals who meet or exceed their expected share of income and wealth over a complete life, some may enjoy a steady or steadily rising income while others may find their income highly volatile from year to year or from season to season, perhaps due to sickness, sporadic employment, or temporary disability. Still others may fail to achieve their lifetime expectations of income and wealth altogether, due to long-term sickness, disability, or other forms of bad luck. None of these outcomes for individuals is inconsistent in itself with their ex ante expectations being maximized. Indeed, none of these outcomes is inconsistent with those expectations being indefinitely high in an absolute sense. Thus the difference principle alone does not guarantee security from risk.
For these reasons, a liberal society, one concerned to protect each citizen's capacity to form, revise, and pursue a rational plan of life, should aim to make the expectations of the least advantaged—indeed, the expectations of all citizens—not only larger but also more secure.

### 3.1.3 Risk and Loss

Not all liberal political philosophers ignore risk altogether. But when they do talk about risk, they tend to conflate the desirability of providing security from risk per se with the desirability of correcting or compensating for certain bad outcomes, the bad outcomes that those risks are risks of. This is particularly clear in Ronald Dworkin's account of equality of resources.\(^9\)

Dworkin speaks of insurance as analogous to gambling. In gambling, a small bet buys the chance of a big gain, while in insurance a small bet buys indemnity against a big loss.\(^10\) If insurance is like gambling, it is natural to think that someone who buys insurance against a loss that never occurs simply made a bad bet; he spent resources that would have better been spent elsewhere.\(^11\) In this way, Dworkin suggests that insurance is beneficial only when it pays out.

Looking at the matter ex post, Dworkin is surely right that someone who purchased security from a risk that never materialized might think that he would have been better off spending those resources on something else. But to look at the matter ex post is to remove the

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\(^10\) Dworkin, *Sovereign Virtue*, 95.

\(^11\) Ibid., 77.
very uncertainty that makes insurance beneficial. No doubt one reason why individuals purchase insurance is because they do not wish to suffer the consequences that follow if and when certain risks materialize. But another reason, arguably just as important, is to relieve themselves of the uncertainty of bearing those risks alone.

In a world where individuals bear their health risks alone, a responsible person will have to plan for the possibility of needing medical care. This means setting some money aside—in the modern world, a great deal of money—to pay for such care. If this person also has to bear the risks of unemployment alone, she should put aside still more in case her illness prevents her from working for a time (or for that matter in case she loses her job for some other reason). She should save still more to prepare for the possibility that she finds herself temporarily or permanently disabled. Doing all of this is itself very costly, even if this person never actually finds herself sick, unemployed, or disabled. Putting aside all of that money would be a considerable drag on a person's ability to carry out any of her other life projects, even in the happy event that she never needed to tap into her rainy-day fund. A person could spend her entire working life struggling to amass the kind of wealth needed to give herself a measure of security against these risks, with few resources left over to do anything else, and that even under the best of circumstances. If one of these risks were to come to pass before she had saved enough to meet it, her life prospects could be permanently altered for the worse.

For these reasons, I am arguing that a liberal theory of justice, one which aims to protect each person's capacity to form, revise, and pursue a certain rational plan of life, should aim to protect individuals against risk per se rather than simply alleviating the bad consequences should those risks ripen into loss. Being sick jeopardizes a person's ability to execute a rational plan of
life, to be sure, and is for that reason undesirable. But bearing the risk of illness alone is in itself costly, even for the healthy. Reducing that risk *qua* risk is a great help to a person's capacity for effective self-determination. Liberal societies can do this by making sure people have access to insurance policies.

### 3.2 Risk-Pooling as a Source of Cooperative Benefits

As we just saw, political philosophers like Dworkin sometimes represent insurance as a special case of gambling. On this picture, when you buy insurance, you are betting that an unlikely but disastrous event will occur; your insurance company is betting that it will not.\(^{12}\) Some kinds of insurance work like this, but chiefly those forms of insurance that deal with unusual and hard-to-quantify risks, as when Lloyd's of London underwrites a policy for Keith Richard's hands or Céline Dion's vocal cords.\(^{13}\) Most insurance schemes operate by pooling large numbers of similar risks together. In this way they reduce everyone's exposure to risk, rather than simply transferring risk from one person to another.

This is possible because of a phenomenon that statisticians refer to as the “law of large numbers:” increasing the number of trials of an experiment causes the average result to converge on the expected value.\(^ {14}\) For example, a fair coin flip has a 50% probability of coming up “heads,” but we know that flipping it ten times is quite unlikely to yield exactly five heads

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\(^{14}\)Ian Hacking, *An Introduction to Probability and Inductive Logic* (New York: Cambridge University Press, 2001), 189f.
(p=.24). However, we also know that, as we increase the number of coin tosses, the frequency of heads we observe will tend to converge on 50%. (If you flip it 1,000 times, your chances of getting between 49-51% heads are about two in three; to get between 48-52% heads, your chances are about nine in ten). In other words, increasing the number of trials induces statistical stability. This “large numbers” effect is the chief mechanism through which insurance schemes are able to produce benefits for their members. It enables individuals to swap a gamble with an expected value of x for the certainty or near-certainty of x (less, of course, the costs of administering the scheme).

We can see how this is possible with the help of a simplified example. Imagine a merchant who owns a small ship that she uses to take her goods to market overseas. Suppose that on any given journey there is a 20% chance that the ship will sink, and suppose that a lost ship will cost her $100,000. The expected cost of this risk is then $20,000 (20% of $100,000), but as things stand she will not actually lose $20,000. Instead, either the accident will occur and she will lose $100,000, or it will not occur and she will lose nothing. Suppose that our merchant is very risk-averse; she would gladly accept a guaranteed loss of $20,000 (or even a bit more) to escape the risk of losing $100,000. In this way, we might imagine, she can better plan for the future of her business.

She can't achieve this on her own. But suppose she meets 99 other merchants who face identical (though, we shall suppose, independent) risks. The 100 of them might agree to pool

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their risks of shipwreck and hold any potential losses in common. Should they do this, each of them swaps her 20% chance of a $100,000 loss for the gamble represented in Table 1 (next page) and graphed in Figure 1 (below).

Table 1 represents the probability-weighted payoffs under a scheme where each of the merchants assumes liability for an equal share (i.e., 1/100th) of the total losses of the pool. Although 100 is not a particularly large number, we can already see the law of large numbers at work. If the chances of any one ship sinking are 20%, then out of 100 ships we should expect approximately twenty of them to sink, and that is precisely what we see. The most likely outcomes are those clustered around the mean of 20 ships sinking, entailing a $20,000 loss for each member. The farther an outcome lies from that result, the less likely it is to occur, such that for more than 35 of the ships to sink would be very nearly mathematically impossible.
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<th>Loss to each person</th>
<th>Probability</th>
<th>Expected Value</th>
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With more members in the pool, the range of realistically possible losses narrows even further. Figure 2 (below) shows the probability distribution over 1,000 trials graphed on top of the distribution over 100 trials. The trend should be quite clear: as more members are added to the pool, the average result tends to converge on the expected value, squeezing the likely outcomes toward the mean. With 1,000 members in the pool, each can be over 99% confident of losses between 15 and 25 thousand dollars.

In practical terms, the impact of this arrangement is that each member swaps the small chance of a big loss for the near-certainty of a small loss. What they achieve in mathematical terms is a substantial reduction in the variance of their future expectations. The expected value of the risk does not change: the gamble represented in table 1 has an expected cost of $20,000, just like the 20% chance of a $100,000 shipwreck with which our merchants began. (Again, in reality, the gamble will have an expected cost of somewhat more than $20,000; this is due to transaction costs.) But thanks to the law of large numbers, the subjective risk is reduced.
considerably. Everyone can be confident of losses around $20,000, and utterly certain of avoiding anything like the $100,000 cost of bearing a single shipwreck alone.

### 3.2.1 Insurance and Equality

A risk-pooling arrangement like this does not eliminate or even reduce the risk of shipwreck; it simply redistributes the losses over the whole pool. Still, it would be a mistake to suppose that its primary purpose is redistributive. By its very nature, any insurance arrangement involves ex post redistribution from lucky to unlucky, from those who do not suffer the insured loss to those who do. But people do not join an arrangement like this to compensate the unlucky for their misfortune. They join an arrangement like this to reduce their own exposure to risk.\(^{16}\)

The logic of risk-pooling is therefore more appropriately described in terms of solidarity rather than equality. By committing to share each other's fate in certain ways, each member of the risk pool can advance her own interests more effectively. In that sense it is a cooperative endeavour. Of course, risk-pooling may have an egalitarian element if premiums are structured progressively, but this is distinct from the logic of risk-pooling per se. For example, if the merchants in our shipwreck pool offered insurance to some of their poorer members on more favourable terms—if in other words the wealthier merchants cross-subsidized the premiums of poorer ones—this would introduce a properly egalitarian dimension to the scheme. But this egalitarian dimension is separable from the main purpose of the scheme, which is to reduce everyone's exposure to risk.

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\(^{16}\)Joseph Heath, “Reasonable Restrictions on Underwriting,” 131.
Ronald Dworkin's treatment of insurance in *Sovereign Virtue* tends to obscure this point because of Dworkin's broader luck-egalitarian commitments. Dworkin holds that equality requires that people be compensated for bad brute luck. Because Dworkin supposes that the purpose of insurance is to compensate people for bad luck, he sometimes appears to suggest that insurance as such promotes equality. But in fact if Dworkin's insurance markets serve an egalitarian function, it is only because he insists that insurance should be priced in an egalitarian way—that is, it is only because Dworkin insists that the price of insurance should not reflect unchosen differences in risk. Even on Dworkin's view, it is not actually insurance that promotes equality, but rather the cross-subsidization of those with expensive unchosen risks by those without.\(^\text{17}\) (I discuss this issue in more detail in §3.4 below.)

### 3.2.2 Risk-Pooling Is a *Sui Generis* Source of Cooperative Benefits

If risk-pooling is a form of social cooperation, it is worth being clear on how it differs from other, more familiar forms of cooperation. It is common, for example, to conflate the gains that come from pooling risk with the gains that come from trading risk, but their logic is quite different.\(^\text{18}\) If two individuals have different levels of risk-aversion, it may be possible for each to benefit by trading risks between them. The less risk-averse individual may be willing to assume some of the other's risk in exchange for compensation. This is what Lloyd's of London does when it insures one-of-a-kind risks like those to the inimitable Ms. Dion's voice. Risk-

\(^\text{17}\) See Dworkin, *Sovereign Virtue*, 73f.

aversion is after all a kind of preference, and different preferences make mutually beneficial exchanges possible.

Risk-pooling differs from risk trading in two important ways. First, the benefits of risk-pooling do not depend on the assumption of different preferences for risk. The benefits come, not from transferring risk from the more risk-averse to the less, but by taking advantage of the reduction in variance produced by the large numbers effect. Because of this, risk-pooling, unlike risk trading, can generate cooperative gains even among individuals with identical levels of risk-aversion. 19

Second, unlike risk trading, risk-pooling is structurally neutral with respect to the magnitude of the loss. As Dworkin observes, trading risk is a lot like gambling; the person who assumes the risk is essentially betting that the loss will not occur, and she benefits only when she “wins” the bet. 20 But if trading risk is like gambling, then high-risk persons are like racehorses with no chance of winning. 21 The payment must be quite large for anyone to take the bet, and once the odds get bad enough, no one will bet on them at all. Risk-pooling, by contrast, does not depend on the assumption that members of the pool are “low risk.” Indeed, in the example above, we assumed a 20% chance of the ship sinking, already very bad odds indeed, but the model would work in the same way with even greater chances of loss.

If risk-pooling is not a case of gain from trade, neither is it a straightforward economy of scale. It is true that risk-pooling depends upon the law of large numbers, and thus a larger pool is

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20 Dworkin, Sovereign Virtue, 95.
21 Heath, “Reasonable Restrictions on Underwriting,” 146.
more effective at reducing uncertainty. However, unlike economies of scale, it is not that adding extra bodies to the risk pool increases output per se, as when adding an extra worker at harvest time increases the amount of crops that can be brought in before the frost. In a risk-pooling arrangement, the benefit of more bodies comes from increasing the sample size and thus reducing the variance in the distribution.

3.2.3 The Benefits of Pooling Health Risks

The model of shipwreck insurance developed in the previous sections is very simple compared to a modern health insurance plan. I have been supposing that everyone faces discrete, identical risks, that everyone's precise level of risk is known to everyone else, that these risks are completely independent both of one other and of human action, and so on. A modern health insurance plan is exponentially more complicated. Still, I believe this simple model has great explanatory power.

This model shows how, by pooling their health risks with sufficiently many (and sufficiently similar) others, individuals can “lock in” the ex ante expected value of their health care costs, despite significant differences in need that may emerge ex post. This provides stability in their future expectations of resources, and in that way it protects and enhances each person's ability to form, revise, and pursue a rational plan of life. Each person can pursue their conception of the good more effectively, secure in the knowledge that their health needs will not overwhelm their ability to pursue other projects (or for that matter their ability to obtain necessary medical care). This is one reason why liberals should care about making sure each

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person has access to health care insurance. (Although I will not pursue this here, similar points could be made about the benefits of insurance when it comes to other significant risks to a person's internal and external resources, such as the risk of unemployment, disability, or abnormally long life.)

Health care insurance is a boon to people's capacities for self-determination, but it is beneficial in other ways as well. For one thing, most people are risk-averse; given the choice between a gamble with an uncertain payoff and a gamble with a lower but more certain payoff, most people prefer the more certain payoff. Because people typically prefer not to bear significant risks, insurance typically enhances people's welfare. For that reason, a theory of justice that works in the space of welfare rather than resources will also have reason to care about providing security from health risks through health care insurance.

Moreover, as Wolff and de Shalit have shown, exposure to risk has serious implications for a person's capabilities or functionings. This is not only because risk, when it materializes, can jeopardize people's functionings, although that is true. In addition, the risk of illness itself can be a threat to people's functionings. People are sometimes forced to forgo certain valuable activities to avoid or mitigate certain risks, or indeed to put one functioning at risk in order to secure another against risk. For example, a person with expensive health needs might have to choose between paying his mortgage and paying his medical bills. For these reasons capability theorists, too, have reason to care about security from risk.23

23 Wolff and de Shalit, Disadvantage, Chapter 3, especially pp. 72-73.
Thus although my primary aim here is to show that insurance against health risks is significant on a liberal-egalitarian view which takes resources as the currency of egalitarian justice, I believe that the benefits of health care insurance have an important role to play in most current theories of distributive justice. Moreover, as I will show in the next chapter, the logic of health care insurance provides a better justification for distributing health care access in isolation from other goods and on the basis of medical need than do rival accounts of health care justice. Insofar as partisans of any theory of justice endorse that particular distributive pattern for health care, they have an additional reason to make room in their theories for health care insurance.

Before turning to that argument, however, there are two remaining issues to take up in this chapter. In the next section (§3.3), I sketch an argument as to why health care insurance should be universal (or nearly so). Then, in §3.4, I contrast my account of the nature and benefits of insurance with Dworkin's influential use of hypothetical insurance in his theory of equality of resources.

### 3.3 Justifying Universal Health Care

Insurance is beneficial because it reduces people's exposure to risk, providing stability in their future expectations. This is of interest to liberal theorists because, among other things, it protects people's ability to make effective plans for the future. But to show that insurance is beneficial in this way does not yet explain why certain kinds of insurance should be mandatory; it does not yet provide an argument for social insurance.
In general, liberals should favour allowing individuals to decide for themselves the balance of risk and security that is appropriate for them, by purchasing the insurance products they want on the market according to their own level of risk-aversion. But for certain kinds of insurance products, including health insurance, this is not always possible. Private markets in health care insurance consistently fail for reasons that have long been familiar to economists. The principal reason has to do with the unequal distribution of health risks, which generates problems of adverse selection.

In the example of shipwreck insurance developed above, I assumed that every member of the insurance pool faces identical risks. In the real world of health risks, this is obviously not the case. In a perfect market under symmetric information, insurance companies will respond to different levels of risk with price differentiation, charging higher premiums to those who expose the pool to higher levels of risk. For instance, if one of the merchants in the pool above had two ships, or a ship that was twice as likely to sink, she would be charged twice as much. This seems only fair, given that the magnitude of the risk she brings to the pool is twice as large. But when it comes to health risks, insurance companies do not usually have full knowledge of their customers' levels of risk, and such perfect price differentiation is impossible. This leads to problems of adverse selection.

Adverse selection occurs when individuals who face different levels of risk are able to obtain insurance at the same price. When that happens, those who face higher levels of risk will be more inclined to buy insurance than those who face lower levels of risk; at any given price,

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insurance is simply a more attractive deal for higher-risk individuals. Over time, this “adverse selection” of risks increases the per capita liabilities of the insurance pool, which in turn drives up the price of insurance. As the price of insurance rises, more good risks may begin to drop out of the pool and “self-insure,” causing per capita liabilities and thus premiums to rise even further. In this way, the bad risks drive out the good. In the end, this may lead to the dreaded “insurance policy death spiral:” premiums drift ever upward, to the point where the pool finally prices itself out of existence. The pool may try to prevent this dynamic from taking hold by engaging in more careful underwriting practices, but these too are costly and raise the price of insurance for everyone.

Thus the problem of adverse selection is not that high-risk individuals are unable to obtain insurance; the problem is rather that they are too easily able to obtain insurance, at prices that do not accurately reflect the level of risk they bring to the pool. Insurance companies may respond to adverse selection with more aggressive screening practices, in an attempt to shut these bad risks out of the insurance pool altogether, but this is a response to the problem of adverse selection rather than an example of it. In the first instance, adverse selection is a problem for low-risk persons. It is they who are unable to obtain insurance at reasonable prices.

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27 One benchmark estimates that marketing and underwriting practices account for nearly two-thirds of overhead costs in a typical private health insurance plan. Insurance overhead in the United States, where private health insurance has a larger role than in other developed countries, totalled $47 billion dollars in 1999, or nearly $260 per capita. Canada's single-payer insurance system, which effectively eliminates marketing and overhead, spent $311 million on overhead that year, or only $47 per capita, in PPP-adjusted 1999 US dollars. See Steffie Woolhandler, Terry Campbell, and David U. Himmelstein, “Costs of Health Care Administration in the United States and Canada,” New England Journal of Medicine 349 (2003).
because of the difficulty insurance companies face in distinguishing them from high-risk individuals.

Adverse selection is a perfectly general problem for insurance markets, but it is endemic in markets for health care insurance. This is because practical and legal barriers often prevent insurers from making accurate determinations of a person's risk level and then pricing insurance plans accordingly. It is not as easy to conceal your home's risk of fire from an insurance underwriter as it might be to conceal your own risk of heart disease, and of course there are good privacy-related reasons for this. But the consequence is that adverse selection runs amok in the individual health insurance marketplace, leaving many people unable to obtain health insurance.28

At bottom, adverse selection is a kind of collective action problem. It is individually rational for each person to seek insurance on the best possible terms, but when high-risk persons obtain insurance at low-risk prices they unleash a dynamic that can undermine the entire scheme, making it difficult or impossible to secure the full cooperative benefits of pooling risk. The most effective solution to this problem is to force the good risks back into the insurance pool, that is, to force everyone to carry health insurance. This prevents the dynamic of adverse selection from taking hold. This can be achieved by having the government itself act as insurer, as in Canada, or by forcing citizens to purchase health insurance on the private market, as in the U.S. under the Affordable Care Act. Having the state provide medical care directly, as under Britain's National Health Service, can also be seen as a way of pooling health risks.

The importance of securing the benefits of risk-pooling against the problem of adverse selection points toward a non-paternalistic rationale for universal coverage. The problem of adverse selection means that the alternative to mandatory health insurance is that health insurance will not be available at all to large segments of the population, and where it is available it will be on very unfavourable terms. In other words, the alternative to forcing all citizens to carry health insurance is often leaving many citizens to go without health insurance. In this way a large cooperative benefit would go unrealized.

To be clear, I give this account of the problem of adverse selection merely to describe a problem with private health insurance markets. I am not here endorsing the idea that health insurance premiums should be “actuarially fair,” that is, priced to reflect each individual’s precise level of risk. I will return in Chapter 5 (§5.3) to the complicated question of how insurance plans should be priced in a just society. My account here is intended only to establish that leaving health insurance to private markets is not a viable solution to the problem of justice in health care, even on a liberal view, because of the problem of adverse selection.

### 3.4 Dworkin's Hypothetical Insurance Markets

Dworkin's account of justice in health care is very similar to the account developed here. Dworkin argues that there would be no special problem of justice in health care if individuals were able to purchase health care insurance from a position of equality. If resources in our society were equally distributed, if no one had any knowledge of their own or others’ specific level of health risks, and if everyone had full information about the prevalence of various
diseases and their effects, then justice would be served by whatever insurance packages individuals purchased (or declined to purchase) in the marketplace. Unfortunately, the stated conditions do not obtain, nor could they; even if an egalitarian distribution of resources were achieved, it would still be the case that knowledge of differences in health risks would distort insurance markets in unfair ways before individuals ever had the opportunity to purchase insurance. Yet Dworkin argues that we may nevertheless implement a hypothetical insurance scheme that mimics the insurance choices people would have made from a position of equality. We can use information about the average person's aversion to various health risks to determine the level of insurance that the average person would have purchased against these risks, and then implement a mandatory tax-and-transfer scheme to provide that level of insurance for all.29

Dworkin presents this proposal as a special application of a more general moral principle according to which individuals should bear the costs their choices impose on others, but should not bear the costs of their unchosen circumstances. For Dworkin, the fact that most inequalities in health risk are unchosen means it would be wrong for individuals to bear the differential costs of these; someone should not be made worse off relative to others merely because of a genetic predisposition to some costly disease. On the other hand, because health insurance is something that people would have chosen if they had had the opportunity to insure against health risks from a position of equality, it is reasonable to treat people as if they had so chosen, and force them to bear the costs of that choice.

One problem with this argument is that, whatever reasons we may have to want people to bear the costs of their choices, these reasons do not apply to mandatory choices. If I choose to eat an apple, there is one less apple for others to eat. This makes everyone else worse off, and in that way it imposes a kind of externality. Introducing a market for apples aligns private and social costs, so that for every apple I consume, I must forgo something else of equivalent value to others; in this way the externality is internalized. These considerations, however, do not apply to mandatory choices. If we institute a law requiring everyone to consume an apple a day, tacking on the provision that each person must also pay for her apple would not be a roundabout way of forcing people to bear the costs of their choices. It would be a way of forcing people to bear the costs of the choices of others. The same point applies to mandatory health insurance.

Another problem with forcing everyone to carry the same health insurance plan is that it does not allow people to choose the level of security best suited to their own tastes and ambitions. Allowing people to tailor their bundle of resources to their own preferences is another of the virtues of markets, a virtue that Dworkin endorses when it comes to other kinds of resources. Dworkin rejects the market solution when it comes to health care insurance, however, and he does so on egalitarian grounds. Dworkin appears to think that if we make the purchase of health care insurance optional, then the healthy, knowing that they are healthy,

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30 Dworkin argues that the reason individuals must bear the costs of their choices has to do with equality, not efficiency. On this point he is mistaken. If you want the apple more than I do, there may be an unrealized exchange between us; perhaps I would rather have your orange, and you would rather my apple. If I eat the apple anyway, and you eat the orange, I may be showing a lack of concern for your interests, but you show the same lack of concern for mine. In this way our situations are perfectly symmetrical. Our decisions to eat apple and orange respectively are therefore not inegalitarian; they are merely inefficient. On this point see Joseph Heath, “Dworkin's Auction,” Politics, Philosophy & Economics 3.3 (2004): 16-17.


32 Dworkin, Sovereign Virtue, 147f.
would simply decline to purchase insurance, thus shirking their egalitarian obligation to compensate the sick for their bad luck. But this conflates the egalitarian reasons we may have to compensate those with expensive health needs with the efficiency-promoting reasons that speak in favour of pooling health risks. Dworkin conflates the two because in his scheme the compensation of the sick comes in through the pricing structure of insurance. Dworkin holds that the healthy and the sick should pay the same premiums, in that way causing the healthy to cross-subsidize the insurance plans of the sick. Setting up the scheme that way means that for the healthy to decline to purchase insurance is also a way for them to decline to compensate those with expensive health needs for their undeserved misfortune. But this is not essential to risk-pooling; it is a contingent feature of Dworkin's particular way of setting up his hypothetical insurance markets.

We can see this clearly by looking at the example of shipwreck insurance developed earlier (§3.2). In that example, we supposed that everyone faced identical risks, but now let us imagine that some merchants own ships that are more likely to sink—say, they have a 25% chance of sinking rather than 20%. The expected value of the loss that these high-risk merchants bring to the pool is then $5,000 greater—25% percent of $100,000, or $25,000—than that of those facing the original, $20,000 expected loss. It is natural that the insurance scheme would respond to this differential level of risk with differential pricing, charging the high-risk merchants $5,000 more for their insurance than those who face the original, lower risk. This idea is known as “actuarial fairness:” an insurance plan is actuarially fair when the premium paid is equal to the expected loss.

But suppose that for whatever reason we decide that this higher risk is due to no fault of these merchants' own, and therefore that these high-risk merchants should not be made worse off because of it. One way of redressing this inequality—Dworkin's preferred way of doing so—would be to mandate that all merchants should pay the same insurance premium, regardless of their individual level of risk. The low-risk merchants would then pay a premium somewhat higher than the expected value of their loss (how much higher would depend, of course, on the precise ratio of high- to low-risk merchants in the pool), with the additional premium going to subsidize the insurance of the high-risk merchants. The high-risk merchants would pay a premium somewhat lower than the expected value of their loss, the difference being made up by the low-risk merchants who are now paying more.

If we set out to compensate the high-risk merchants for their undeserved misfortune in this particular way, then it is true that for any of the low-risk merchants to decline to purchase insurance for themselves is also to decline to compensate their high-risk peers for the misfortune of having a ship that is particularly disposed to sink. Again, this is because part of the price of insurance to the low-risk is a subsidy to those with higher risk. If the scheme is set up in this way, one might then see an egalitarian reason to force everyone to purchase insurance; doing so prevents anyone from shirking their egalitarian duty.

But nothing compels us to set up the scheme in this way. Instead of compensating the high-risk merchants through the pricing of insurance, we could instead simply implement a tax and transfer program to compensate those merchants for their greater risk directly, independent of the operation of the insurance scheme. We could simply transfer to each of them an extra $5,000 from the other merchants, $5,000 being the difference between their expected loss and
that of the low-risk merchants. This would nullify the inequality up front. We could then allow high- and low-risk merchants alike to purchase (or decline) shipwreck insurance at actuarially fair rates.

Setting up the scheme this way would effectively separate the egalitarian aim of compensating undeserved misfortune from the efficiency-promoting aim of pooling risk. We would not then have any egalitarian reason to force those who do not wish to purchase insurance to purchase it anyway. This would lead to a more efficient outcome than forcing some people to purchase insurance they may not want, and it would achieve the same egalitarian goal.

A similar option is available for health care insurance. Instead of forcing everyone to purchase health insurance at the same price, as Dworkin proposes, we could simply transfer to each person the expected cost of their future health needs up front. Then, in theory, everyone could proceed to purchase or decline insurance as they saw fit, according to their own tastes and ambitions, at actuarially fair rates. Even if all the healthy individuals declined to purchase health insurance, nothing would stop the sick from taking advantage of the law of large numbers by pooling health risks among themselves, thus reducing their own exposure to uncertainty. As noted above, risk-pooling is structurally neutral with respect to the magnitude of the loss; its efficacy does not depend upon the cooperation of low-risk persons.

So what is wrong with this new proposal? Why not simply give people the cash value of their expected health costs, thus nullifying the impact of brute luck on people's expected health needs directly, and then allow people to purchase (or decline) health insurance on the market? For Dworkin, the problem with this solution is that some people might decline to purchase
health insurance and then find themselves very badly off indeed when they get sick. Dworkin mentions two reasons for resisting this possibility and instead making the purchase of insurance mandatory. The first appeals to the fact that the costs of declining health care insurance are not always borne by the uninsured alone; their employers or dependents may suffer as well. Dworkin likens this to an externality and argues that it should be internalized.\textsuperscript{34} The second reason is straightforwardly paternalistic: “a decent society strives to protect people against major mistakes they are very likely to regret, like not fitting and wearing seatbelts, and not providing for emergency medical care.”\textsuperscript{35}

Dworkin's first reason is, I think, best set aside. If my employer would prefer that I not run risks with my health, that is her choice, not mine. By Dworkin's own reasoning, she should bear the cost of that choice, not I. My dependents might have a stronger claim than my employer that I carry health insurance, but not everyone has dependents. Anyway, parents are typically legally permitted to be irresponsible toward their children in all kinds of ways; it is not clear why society should draw the line at parents declining health insurance for themselves (even if their may be good paternalistic reasons why parents may not decline health insurance for their children).

Regarding Dworkin's second argument, I have already given reasons why liberals should resist paternalism in the distribution of social resources (§1.3.1). Dworkin himself appears to endorse these reasons in other contexts.\textsuperscript{36} I do not believe it is necessary to resort to this kind of

\textsuperscript{34}Ibid., 114.

\textsuperscript{35}Ibid., 114-115.

\textsuperscript{36}Dworkin, \textit{Sovereign Virtue}, 147f.
straightforwardly paternalistic reasoning, given that there is a non-paternalistic rationale available for forcing individuals to carry health care insurance. That reason is one that I have already given: adverse selection. Forcing citizens to carry health care insurance is necessary to secure the full cooperative benefits of risk-pooling.

If we simply gave people the cash value of their expected health needs and left them to purchase insurance on the free market, the basic dynamics driving adverse selection would still be present. It would still be the case that estimations of individuals' levels of health risk would be imperfect, and individuals would still be likely to know more about their level of health risk than either their insurer or the egalitarian planner. At any given price, sick individuals would still be more disposed to purchase health insurance than healthy individuals. This dynamic would be strengthened if individuals could opt to purchase insurance at any time, since many people would be disposed to wait until they got sick to shop for health insurance. (The alternative, locking individuals out of insurance markets forever once they declined insurance, or even locking them out for a specified period of time, would be unreasonably punitive.) The upshot of all of this would be that many individuals would end up paying far more for health care insurance than their level of risk would indicate, and some might be not be able to obtain insurance at all.

3.4.1 Insurance and Equality, Again

More generally, insurance plays two distinct roles in Dworkin's theory. On the one hand, Dworkin uses hypothetical insurance to set the appropriate level of redistribution for bad brute luck that has already materialized. If a person is born with a costly health condition (or a genetic
predisposition to such), or a disability, or a below-average level of natural talent, Dworkin argues that it is reasonable to compensate that person as if he had insured against such a condition at the level that the average person would have, if insurance had been available from a position of equality. Such insurance is necessarily hypothetical because it is impossible to insure against something that has already happened. Indeed, such insurance is not actually insurance, since the element of uncertainty that makes insurance beneficial is not present. Dworkin's hypothetical insurance is in fact simply a heuristic for setting rates of redistribution. Equality demands some level of compensation for the victims of bad brute luck, and Dworkin argues that hypothetical insurance is the best way of determining how much compensation is owed—hypothetical insurance most exhibits equal concern and respect for lucky and unlucky alike.

But there is also an element of actual insurance present in Dworkin's account of justice in health care. We might use hypothetical insurance to determine what compensation is owed for the bad luck of being born with expensive health risks, but individuals are still apt to want security against those risks going forward. Even someone born with a genetic predisposition to some costly disease will face uncertainty surrounding his future health needs. He may know that he is more likely to develop cancer or heart disease than the average person, but he still does not know whether or when it will strike or how much it will cost when it does. Pooling risks with others can reduce this uncertainty, and that is beneficial in itself in a variety of ways that have nothing to do with equality (§3.2.3). It is true that actual insurance sometimes makes outcomes more equal ex post, but this is not the primary aim of insurance; this is a happy consequence of the reduction in uncertainty that is the function of insurance.
Dworkin's account of justice in health care combines hypothetical and actual insurance in ways that are perhaps better kept separate. The question of what level of compensation is owed to someone born with expensive health risks (or expensive health needs) is separate from the question of what level of security against health risks that person is apt to want going forward. Dworkin's approach answers the two questions in a single stroke, but nothing is gained by doing so. In fact this approach tends to obscure the difference between risk-aversion and inequality-aversion.

The problem with leaving individuals to bear health risks alone is not that it is inegalitarian; the problem is that it is inefficient. If equality requires that everyone receive the same level of security against certain health risks, it is not clear why providing everyone no security would be any more or less egalitarian than providing everyone average security or even maximal security. Security against risk can be equalized at any level. But in fact, equality does not require that everyone have the same level of security against risk, or indeed that everyone have any security against risk, as Dworkin himself acknowledges at one point.\textsuperscript{37} Pooling risks with others makes everyone (or nearly everyone) better off, and is for that reason desirable. Insurance promotes efficiency, not equality.

\subsection*{3.5 Conclusion}

In this chapter, I have argued that health care entitlements should be grounded, not in the moral importance of health, but rather in the importance of providing security against health

\textsuperscript{37}Ibid., 77 and 312-13; Dworkin, “Justice in the Distribution of Health Care,” 889.
risks. Guaranteeing citizens access to health insurance has the agreeable consequence of making sure that no one goes without needed medical care, but I have argued that this is not its primary purpose. Instead, its primary purpose is to protect a person's bundle of social resources against risk, thus enabling that person to plan for the future more effectively.

My proposal may seem somewhat counterintuitive given that the standard liberal view holds that the order of explanation goes the other way. The standard liberal view holds that we have an obligation of justice to meet health needs. On that view, it follows from our obligation to meet health needs that individuals are relieved of bearing their health risks alone, but relieving individuals of these risks *qua* risks is not the main purpose of the health care system. Instead, on the standard view, health risks are socialized as a somewhat accidental consequence of socializing health *losses*.

I am arguing that this position is exactly backwards: the reason we meet citizens' health needs is primarily to reduce individuals' exposure to risk. On my view, health losses are socialized primarily as a means to the socialization of health risks.

There is nothing in the nature of health needs to distinguish them, morally speaking, from other basic needs. As I argued in §2.1, any attempt to articulate what is important about health needs will inevitably fail to capture some health needs and will include many non-health needs. There is nothing in the moral nature of health needs to explain why we are required in justice to meet them but not other basic needs. What distinguishes health needs from other needs is in their nature as risks. The risk of needing health care is very costly for a person to bear alone, and not just in the sense that, if a health risk should grow into a health loss, a person
would find herself very badly off. Bearing health risks alone is *in itself* costly to a person's ability to plan for the future, even in the happy event that no health risks ever materialize. A person's ability to form, revise, and pursue a plan of life effectively is greatly enhanced by pooling these risks with others to provide stability in people's future expectations.
Chapter 4: Applications

In the previous chapter, I argued that health care entitlements are best justified in terms of the importance of providing citizens with security against health risks. The failures of private markets in delivering adequate access to health care insurance provide a rationale for forcing citizens to carry health care insurance. In this chapter, I exhibit some of the benefits of this approach, showing how it can justify certain popular features of health care systems in advanced liberal democracies, features that have proven difficult to justify on rival views. Most significantly, I show that insurance provides a tidy justification for distributing health care access (mostly) in isolation from other social goods and (mostly) on the basis of medical need. I will argue that this particular distributive pattern is tightly connected to the function of health insurance, which is to reduce people's subjective uncertainty surrounding their health needs.

I begin in §4.1 by showing how insurance justifies distributing health care in isolation from other goods. In §4.2 I show that distributing care according to medical need, including providing medically necessary treatment but not enhancement, fits naturally within an insurance framework. By way of contrast, I argue that it is difficult to justify distributing care according to medical need from egalitarian premises. §4.3 concludes by showing how insurance can justify health care for the elderly.
4.1 What Makes Health Care Special?

There is widespread (though not unanimous) agreement among liberals that health care should be treated as “special,” that is, that health care resources ought to be distributed more equally than—perhaps in isolation from—other social goods, particularly income and wealth (§1.2.2). The distribution of health care should not be left entirely to the vagaries of the market, but neither should health care be used as a tool to promote a more general equality of condition.

Although the intuition that health care should be treated as special is strong, I argued in Chapter 2 that the predominant liberal account of justice in health care cannot justify treating health care as “special” in this way. The predominant liberal account of justice in health care grounds health care rights in the moral importance of health. On the moral importance of health view (or “the MIH view,” for short), health care is important because health is important, and health is important because of the contribution that health makes to some further value or values. I argued that this picture cannot justify treating health care as “special” because health care is not morally *sui generis*. Whatever value or values explains the moral importance of health, not all health care services will promote that value, and not all of the things that promote that value will be health care services. Thus the MIH view cannot justify distributing all and only health care services in isolation from other social goods.

The risk-pooling model can explain why health care is “special” in a straightforward way. Looking at the operation of the shipwreck insurance scheme described earlier in §3.2, someone might suggest that its logic shows that the merchants in the insurance pool believe that meeting people’s shipping needs is “special.” They certainly treat shipping needs in accordance
with the requirements of specialness. No one in the pool is expected to meet their shipwreck needs out-of-pocket. If one of the merchants loses her ship, the pool compensates her for the loss. This is true whether she happens to be a very wealthy merchant who could easily afford to replace the ship herself, or a poor trader who could never afford such an expense on her own. In this way, the pool distributes shipwreck funds in isolation from other goods.

But the reason that the insurance pool treats shipping needs as special in this way is simply that it is an insurance pool against shipwrecks. Shipping needs are special for shipping insurance arrangements in the same way that housing needs are special for home insurers and health needs are special for health insurers. Compensating someone for an insured loss is just what insurance does. We need not appeal to the “moral importance of shipping” to explain this. The purpose of the arrangement is to reduce individuals' exposure to uncertainty surrounding their shipping needs. If the pool did not compensate individuals in accordance with their shipwreck losses, it would not serve that function.

The question of why health care should be treated as “special” on my view, then, has a two-step answer. If the question is why health care should be distributed in isolation from other goods, the answer is because citizens should have health care insurance. If the question is why citizens should have health care insurance, the answer is to provide them with greater security in the enjoyment of their basket of social resources and thus to protect their capacities to form and execute a rational plan of life.

Once we grant that individuals should be insured against health risks, we have a justification for treating health care as “special” in the relevant sense. We don't need to appeal to
the moral importance of health to explain health insurance any more than we need to appeal to the “moral importance of employment” to explain unemployment insurance, or the “moral importance of being able-bodied” to explain disability insurance. Bearing the risk of losing your job unexpectedly, of being unable to work due to disability, or of losing your nest-egg due to unexpected medical bills are all real obstacles to a person's ability to form and pursue a certain plan of life effectively. Because private markets do not provide adequate access to insurance against these risks, the state is justified in intervening to correct these market failures.

4.1.1 How Special is Health Care?

I pointed out in §1.2.2 that the thesis that health care is special can be interpreted in a variety of different ways. In its most general form, to say that health care is special is to say that access to health care should be distributed more equally than other social goods. But how much more equally? In its weakest form, the specialness thesis might be interpreted to require only that no one be denied care due to inability to pay. In its strongest form, which I have tended to favour, the specialness thesis might be interpreted to require that the distribution of health care be completely isolated from the distribution of other social goods—that no one be made better or worse off at all due to their health care needs. And there are indefinitely many possible middle-ground positions, where the specialness thesis might be understood to require something stronger than merely that no one be denied care due to inability to pay but weaker than the complete isolation of the distribution of health care from that of other goods; on a middle-ground view, the specialness thesis might be interpreted to require that the distribution of health
care be partitioned, so to speak, but not fully isolated, from the distribution of other goods. We are now in a position to specify a bit more precisely what treating health care as special requires.

On the egalitarian picture of health care justice, the strongest, isolating interpretation of the specialness thesis is hard to resist. If meeting citizens’ health needs is a requirement of equality, then asking citizens to pay a portion of their own health care costs would seem like a straightforward failure on the part of society to fulfill its egalitarian obligations. And yet it does not seem obviously unjust if citizens are asked to pay something towards their own health care needs, at least assuming a fair distribution of other social resources, such that so asking does not impose an undue burden on the poor.

The risk-pooling model of health care justice provides a principled reason for deviating from the strongest, isolating interpretation of the specialness thesis. That reason is the phenomenon of moral hazard. Moral hazard occurs because an individual who has fully or partially insured against a certain loss now has reduced incentive to avoid that loss. If the loss in question is at all subject to human control, this means that the reduced subjective uncertainty that insurance provides can be accompanied by an increase in the objective probability of the loss. This has the structure of a straightforward collective action problem. It is in the nature of pooling risk that each person becomes liable for only a small fraction of his own health care costs. For that reason, each person has little incentive to eschew unnecessary care for himself; the bulk of the cost will be borne by the other members of the pool. But if every person reasons in that way, then the liabilities of the pool grow and everyone winds up paying much more for their health care insurance.

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Attaching small co-pays or deductibles to the use of medical care is an effective way of limiting moral hazard. The effect of a co-pay or deductible is to “unpool” a certain amount of an individual's health risks, so that more than just a tiny fraction of a person's health care costs are borne by the individual herself. This can provide the necessary incentives for individuals to refrain from consuming unnecessary or low-benefit health care, while still providing the requisite degree of security against bank-breaking health risks. This may make the overall health care system work more efficiently. But again, this is assuming a just (or nearly just) distribution of other social resources, so that these co-pays and deductibles do not impose an undue burden on the poor and prevent them from accessing necessary care.²

At the same time, my account can also explain why the weakest version of the specialness thesis is too weak. If the specialness thesis is understood to require only that no one be denied care due to inability to pay, individuals would still be exposed to potentially catastrophic risk. As I pointed out in §1.2.2, someone with $50,000 in savings and exactly $50,000 in health care needs would not be denied care due to inability to pay, and so the weakest version of the specialness thesis is satisfied, but she would still see her savings wiped out by her expensive health needs. The risk of losing one's nest-egg due to expensive health needs may not be as serious as the risk of being unable to afford necessary care altogether, but it is still a grave threat to a person's capacity for rational self-determination. Thus a just society should ensure its citizens have access to security against that threat.

²Of course, even in a less-than-fully just society, it is always possible to introduce targeted programs to help the poor meet their health care co-pays, while still taking advantage of the efficiency benefits of unpooling some of the health risks of the well-to-do.
4.1.2 Neither Too Narrow nor Too Broad

I would like to point out here that my account will not be open to the same objections that I raised against Norman Daniels and the MIH view in §2.1.2. The problem with the MIH view, I argued, was that no account of the moral importance of health will extend over all and only health care services. For any value put forward to explain the moral importance of health, some important health care services will not promote that value, and many things that promote that value will not be health care services. Thus the MIH view cannot justify treating health care as “special.” It might be suggested that my account will fall before the very same objection. It is not true that every health need constitutes a “risk” in the relevant sense, and not all things that are “risks” in the relevant sense are health needs. I address these two problems in turn.

Regarding the first objection, it is true that not all health needs constitute “risks” properly understood. Routine health care, for example, certainly poses a problem for my account. There is no uncertainty surrounding whether someone needs a physical every few years. This is not a risk; it is a fact, and thus insurance isn't really appropriate for these kinds of needs. This is a bullet that I am prepared to bite. I do not think it is a grave injustice if people have to pay for routine health care out of pocket, or (what is essentially the same thing) if health insurance attaches a small deductible. The vast majority of health spending is due to non-routine care, and it is the expensive, bank-breaking treatments that raise the most troubling problems of justice.³ These are the expenses that most threaten a person's ability to plan for the future effectively.

It may be possible to cobble together efficiency-based arguments as to why insurance should cover routine care, or at least a portion of it. For example, large insurers are often able to bargain for better prices than individuals. Also, if people have “already” paid for their check-up, they may be more likely to use it, which may help keep overall health costs down by allowing doctors to catch serious conditions early, when they are less costly to treat. These will not be reasons of justice, but the end result will be the same. If these arguments fail—if these potential benefits of paying for routine care do not outweigh the costs of moral hazard—then I do not see a non-paternalistic rationale for covering routine doctor visits. At that point, leaving citizens to pay for routine care themselves does not seem to me to raise serious problems of justice (even if it may cause some to forgo potentially beneficial care).

From the other side, it is also true that not all risks are health risks, but I don't see this as a serious threat to my account, either. While there are many risks that threaten a person's ability to make future plans and for which insurance is generally unavailable on private markets, there are also many forms of social insurance: unemployment, disability, old-age, and so on. My account could be extended to these cases as well. Insofar as each of these is a form of insurance,

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4. A 2004 study examined the paradoxical fact that American states with higher levels of Medicare spending tend to enjoy lower quality of care. The authors claim that this is because states with higher levels of Medicare spending also have a higher ratio of specialists to general practitioners. Primary care is both cheaper and more effective than tertiary care. Katherine Baicker and Amitabh Chandra, “Medicare Spending, the Physician Workforce, and Beneficiaries' Quality of Care,” *Health Affairs* online (April 2004), [http://content.healthaffairs.org/content/early/2004/04/07/hlthaff.w4.184.full.pdf](http://content.healthaffairs.org/content/early/2004/04/07/hlthaff.w4.184.full.pdf) (accessed 19 Sept. 2013). See also Barbara Starfield, Leiyu Shi, and James Macinko, “Contribution of Primary Care to Health Systems and Health,” *The Milbank Quarterly* 83.3 (2005).

5. Perhaps the most influential study of this issue was conducted by Rand from 1974-1982. The Rand experiment randomly assigned individuals to insurance plans with different levels of cost-sharing (deductibles). Not surprisingly, the study found that cost-sharing reduced consumption of both unnecessary and necessary care. The study found no significant positive effect of free care on most measures of health, although those with certain specific health conditions did benefit from free care, with this effect being largest among the poor. Robert H. Brook et al., *The Effects of Coinsurance on the Health of Adults: Results from the Rand Health Insurance Experiment* (Santa Monica: Rand, 1984), [http://www.rand.org/content/dam/rand/pubs/reports/2006/R3055.pdf](http://www.rand.org/content/dam/rand/pubs/reports/2006/R3055.pdf) (accessed 30 Oct. 2013).
each will treat their respective risks as “special” in their own way—each insured loss, if and when it materializes, will be compensated in isolation from the rest of people's income and wealth. I take it to be a virtue of my account that it can explain why health care is properly treated as distributively “special” without having to take on the dubious claim that health care is somehow morally unique.

4.2 On Distribution According to Medical Need

Distributing health care according to medical need is a special case of treating health care as special; distribution according to need (alone) entails treating health care as special, but not vice versa. Thus I would also like to show the tight connection between insurance and distribution according to medical need. Distributing care according to medical need fits naturally within an insurance framework. Because the point of a health care insurance scheme is to reduce individuals' exposure to uncertainty surrounding their medical needs, it is natural that such a scheme would distribute access to care according to medical need. Paying for unnecessary care would generate massive problems of moral hazard, while refusing to pay for necessary care would not provide much in the way of security against health risks. Or so I will argue in §4.2.4.

Before making that argument, however, I will argue (in §4.2.1-4.2.3) that egalitarian approaches to health care justice like Norman Daniels's cannot justify distributing care according to medical need. Of course, it follows trivially from the fact that these approaches cannot justify treating health care as special that they cannot justify distributing care according to medical need alone, because distributing care according to medical need alone entails treating
health care as special. But in fact the problem is more serious than that. The problem is that these theories have no principled place for the idea of medical need at all. This finding is especially significant since the notion that distributing health care access according to medical need is the egalitarian position on health care justice is ubiquitous.⁶

The reason egalitarian theories like Daniels's have no place for the concept of medical need is because these theories treat health care as merely instrumental to an ideal of equality that is specified independently of health care. But if health care is merely instrumental to equality, it's hard to see a principled reason for distributing health care in any way other than so as to promote equality overall. Distributing health care according to medical need describes a very specific pattern of distribution, as we shall soon see. It is implausible to think that distributing health care in this very specific way will prove to be an optimal means—or even a particularly effective means—of promoting equality in some broader sense, like equality of opportunity, or resources, or welfare. On a view like this, it is hard to see why the concept of medical need should have any special significance at all.⁷

Before turning to that argument, it is worth recalling what it means to say that access to health care should be distributed according to medical need. We saw in §1.2.4 that the concept of medical need refers to the appropriateness of a particular medical intervention to the


⁷To be fair, If health care insurance attaches a small deductible or co-pay, as I argued it might in §4.1.1, then on my view as well it follows trivially that health care access will not be distributed according to medical need alone, but instead according to medical need together with citizens' willingness to pay their deductibles. But still on my view medical need will have a very significant role to play. I return to this point in §4.2.4.
treatment of a particular condition. A medically necessary intervention is one that is reasonable and effective for the prevention, diagnosis, treatment, or amelioration of disease, injury, or disability. For the sake of brevity I will speak of medically necessary care as care that is “effective for the treatment of disease or disability.”

Distributing care according to medical need imposes two distinct requirements on the health care system. First, to say that care should be distributed according to medical need limits the kinds of care that society is obliged to provide. It means that society owes care that is effective for the treatment of disease or disability, but not elective or experimental care, regardless of how much the patient may benefit from such care or how much the patient may want it. Second, to say that care should be distributed according to medical need limits the kinds of considerations that are relevant to decisions about care. It means that whatever health care services are offered as part of the basic health care package should be distributed according to medical considerations alone, and not by facts about a person's life outside the examination room, such as her ability to pay, her overall neediness or well-being, or her moral desert or social usefulness.

That being said, it is also worth recalling that distributing access to care according to medical need does not mean that medical need is a sufficient condition for treatment. Providing any and all effective treatments for disease and disability would bankrupt even the wealthiest society (§1.2.5). Medical need provides a way of distributing access to whatever health care services are offered as part of the basic health care package, but medical need alone does not tell us which services should be included in that package. Additional considerations, like the long-
term sustainability of the health care system and the importance of other (non-health care) values must be brought to bear.

### 4.2.1 Daniels on Treatment and Enhancement

To take the first requirement first: distributing care according to medical need means that we owe care that is effective for the treatment of disease or disability, but not elective or experimental care. But treating disease or disability is not the only purpose for which medical care may be used. Let us call interventions that do not treat disease or disability but instead enhance normal—i.e., non-pathological—traits, “enhancements.” Enhancements include not only cosmetic surgery, but also the stuff of science fiction, such as genetic interventions that enhance intelligence, perception, and other traits beyond normal human functioning. It is controversial whether enhancements are owed as a matter of justice, but among liberal egalitarians there is fairly broad agreement that citizens are owed medically necessary treatments but not enhancements, at least as a matter of basic justice.\(^8\)

But if health care is viewed as merely instrumental to an ideal of equality specified independently of health care, there would appear to be no principled reason to privilege treatments over enhancements. If an inequality exists and can be rectified through biomedical intervention, why should it matter whether the cause of that inequality is some kind of pathology or simply bad luck in the genetic lottery? From the point of view of equality, the distinction

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between treatments and enhancements would appear to be arbitrary, and so it is not clear why it should be accorded any significance in the distribution of health care resources.

This problem can be clearly seen in Norman Daniels's account of health care justice. Daniels locates the special moral importance of health in its significance for opportunity, and he locates our obligation to meet citizens' health needs under a more general obligation to protect fair equality of opportunity. The trouble for Daniels is that there is no morally significant difference between an impairment to opportunity caused by disease or disability and one caused by below-average but non-pathological functioning. Thus there would appear to be no good reason to privilege treatment over enhancement on Daniels's view.

An example might sharpen the problem. Imagine two children, Billy and Johnny, both of whom have a projected adult height of 160cm (5'3). The only difference between them is that Billy's short stature is caused by a deficiency of human growth hormone, a disease, whereas Johnny's is not. Providing synthetic growth hormone to Billy and Johnny can increase both their adult heights. Because of Billy's growth hormone deficiency, providing synthetic growth hormone in his case would count as a treatment, as meeting a medical need, whereas providing it in Johnny's case would count as the “enhancement” of a non-pathological trait. Height is a major determinant of opportunity in our “heightest” society, so someone concerned to protect equality of opportunity should presumably want to provide HGH in both cases. The difference between shortness due to disease and shortness due to simple heredity is arbitrary from the point of view

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9 In developing my critique of Daniels's view, I draw both from his own work in Just Health and from his collaboration with Buchanan et al. in From Chance to Choice. In the introduction to that latter work, it is stated that Daniels is the primary author of the relevant chapter of that volume (Chapter 4, pp. 104-155), so I believe it is fair to attribute those arguments to Daniels. Buchanan et al., From Chance to Choice, xiii.
of equality of opportunity. Thus if we are concerned to protect equality of opportunity between Billy and Johnny, it seems indefensible to provide HGH in the one case but not the other.¹⁰

Daniels offers what he calls a “limited” defence of the treatment-enhancement distinction. Daniels does not deny that in certain special cases justice may require biomedical enhancement (although presumably not in Johnny's).¹¹ But he insists that the “primary rationale” for meeting health needs appeals to the importance of providing necessary treatment of disease and disability. “Other reasons may broaden societal obligations,” Daniels concedes, “but the primary justification gives us the core.”¹²

Daniels observes that Rawls's principle of fair equality of opportunity does not require leveling all differences among individuals; it requires only that people with roughly equal levels of talent should enjoy roughly equal life chances.¹³ Extending this idea to health care, Daniels argues that equality requires that we maintain individuals as normal competitors for advantages, but not necessarily equal competitors. People's shares of opportunity will still be determined to a large extent by the natural distribution of talent and skill, although this will be lessened somewhat by the operation of the lexically posterior difference principle. A just distribution of health care protects people's portion of the normal opportunity range from the influence of pathology, but does not eliminate all individual differences in native endowment.¹⁴

¹⁰I adopt this example from Buchanan et al., From Chance to Choice, 115.

¹¹Buchanan et al., From Chance to Choice, 140-1; Daniels, Just Health, 152-154.

¹²Buchanan et al., From Chance to Choice, 121.


¹⁴Daniels, Just Health, 44-5.
Daniels calls this the “normal function” model of health care. Daniels's primary positive argument for this model is to claim that it makes for better public policy. He points out that whether a particular condition is pathological or not can generally be easily determined using the objective, publicly verifiable methods of medical science, whereas it is less clear how to determine whether a particular person's capability set constitutes an opportunity deficit. Moreover, all developed countries agree on the importance of providing treatment, but few on the importance of enhancement. In the U.S., Daniels claims, there is considerable public support for the idea that citizens are owed medically necessary treatment, but less support for the idea that they are owed biomedical enhancement. In fact, Daniels points out, offering enhancement might undermine support for just health care generally, if people perceive that others are unfairly gaming the system to receive unnecessary medical care at public expense.  

In the end, Daniels himself admits that the treatment-enhancement distinction is both morally and metaphysically arbitrary. Arguably it is the job of the moral philosopher to try to move public opinion against arbitrary moral distinctions rather than acquiescing in them. This makes Daniels's conception of health care justice “political in the wrong way,” to appropriate a phrase from Rawls.  

There is a clear tension between explaining the moral significance of health care in terms of opportunity, and then treating equal limitations on opportunities differently, as in the example

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15 Ibid., 151-155; Buchanan et al., From Chance to Choice, 141-144.
16 Daniels, Just Health, 155.
of Billy and Johnny. Indeed, if Daniels's defence of the treatment-enhancement distinction works, it should lead us to ask how much work is actually being done by equality of opportunity in explaining what we owe to each other by way of health care. If we can remove two equally significant impediments to opportunity through medical intervention, and there is broad agreement that we owe the intervention that counts as a “treatment” but not the one that counts as an “enhancement,” on what basis should we conclude that *equality of opportunity* is what explains our agreement?

### 4.2.2 Daniels on Distributing Care According to Medical Considerations Alone

The second role the idea of medical need plays in the distribution of health care is to restrict the kinds of considerations we can appeal to in distributing access to medical care. Distributing care according to medical need means that people's care should depend on their medical condition alone, not on non-medical considerations like ability to pay or moral desert. This restriction also seems arbitrary from the point of view of equality. If our aim is to promote equality overall, we would be more effective in pursuit of this goal by distributing health care according to considerations of a person's overall level of need, that is, prioritizing care for the least well-off according to our chosen *equalisandum*.

This problem, too, can be seen clearly in Daniels's account of justice in health care. There is no reason to think that medical need will be a reliable proxy for opportunity need. For example, the poor typically enjoy fewer (or worse) opportunities than the rich. If we are

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concerned to protect equality of opportunity between rich and poor, it would seem that we should try to make it the case that the poor receive better access to health care than the rich. This would introduce non-medical considerations into the distribution of care, but it would also bring the overall shares of opportunity enjoyed by rich and poor closer to equality.\textsuperscript{19} Thus it would appear that equality of opportunity requires it.

Strangely, Daniels gives no argument at all for the claim that protecting equality of opportunity requires distributing access to health care according to medical need rather than access according to opportunity need. He may be assuming that because access to health care is a determinant of opportunity, protecting equality of opportunity requires something like equal access to health care, where equal access to health care is understood to mean equal access among those with equal medical need. But this is a sort of fallacy of division. It does not follow from the fact that the whole must have a certain property that therefore each of the parts must have that property. It does not follow from the fact that people should enjoy equality of opportunity overall that they should therefore enjoy equal shares of each of the particular determinants of opportunity.

To illustrate, suppose there are four major determinants of opportunity. It is true that one way of equalizing opportunity overall would be to equalize people's shares of each of its four major determinants, thus (perhaps) summing to equal shares overall (I will question this momentarily). But that is not the only way of ensuring everyone an equal share of opportunity overall, since it would be possible to equalize total opportunities in indefinitely many other ways. In other words, this would not mean that distributing care according to medical need is

required, but only that it is permissible, and indeed permissible only if the other determinants of opportunity are equalized as well.

But the other determinants of opportunity will never be equal. With respect to some determinants of opportunity, it is simply impossible or immoral to guarantee everyone equal shares. Early childhood upbringing, for instance, is a major determinant of future opportunity, but it is not possible to equalize childhoods across persons (or if it is possible, perhaps through the communal raising of children as in Plato's *Republic*, doing so would require unjust interference with the rights of parents).\(^{20}\) This is to say nothing of the unequal distribution of wealth in a liberal society, which also significantly affects people's opportunities. Since some determinants of opportunity must always be unequal, equalizing people's total opportunity shares will arguably always require some offsetting—i.e., will always require giving people unequal shares of some of the other determinants of opportunity, like perhaps health care.

A deeper problem with the line of reasoning I'm imputing to Daniels is that, even if it were not impossible or immoral to equalize all determinants of opportunity, it is not necessarily the case that giving everyone equal shares of each of the major determinants of equality of opportunity would sum to equality of opportunity overall. The relationship between equality of opportunity and its determinants might be more complicated than that. In the same way that a set of transactions that are individually fair may add up to an overall distribution that is not,\(^{21}\)


equalizing each of the specific determinants of opportunity may not yield an overall distribution of opportunity that exhibits equality.

One way this might happen is through what is known as “Simpson's paradox,” where a trend that appears in individual sets of data reverses when the data are aggregated. To see how Simpson's paradox can upset our intuitions about equality, let us suppose that equality of opportunity requires that we supply resources to meet citizens' opportunity needs in equal proportion. For simplicity, let us suppose there are only two kinds of opportunity needs: health needs and education needs. Suppose that person A has minor health needs but expensive education needs, whereas person B finds herself in just the opposite situation. It is then possible to treat both of them equally in the realms of health and education taken separately, while treating them unequally in the aggregate (Table 2).

<table>
<thead>
<tr>
<th></th>
<th>Person 1 (opportunity resources supplied/opportunity resources needed)</th>
<th>Person 2 (opportunity resources supplied/opportunity resources needed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health needs</td>
<td>70/100 = 70%</td>
<td>210/300 = 70%</td>
</tr>
<tr>
<td>Education needs</td>
<td>165/300 = 55%</td>
<td>55/100 = 55%</td>
</tr>
<tr>
<td>Total needs</td>
<td>235/400 = 59%</td>
<td>265/400 = 66%</td>
</tr>
</tbody>
</table>

What drives the paradox here is the fact that the denominators are different; in this example, because A and B have different absolute levels of need in different areas, giving them proportionally equal treatment in those different areas does not in fact add up to proportionally

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22 This is not Daniels's conception of equality of opportunity, of course (and I will return to that point momentarily). Indeed, this is perhaps not a terribly plausible conception of equality of opportunity at all. But I believe it will suffice to make a certain general point.
equal treatment overall. This paradox could emerge on any account of equality whereby equal
treatment is understood proportionally rather than absolutely.

The purpose of the example in Table 2 is only to show that we cannot assume that
treating people equally in a variety of specific domains will add up to equality in the aggregate.
This is a fallacy of composition; just because each of the parts has a certain property, it does not
follow that the whole will have that property as well. Just because each of the determinants of
opportunity are equalized, it does not follow that opportunity will be equalized overall. At the
very least, the burden of proof is on those egalitarians who urge equal treatment in a variety of
specific domains to show positively that such treatment will add up to equality overall; this
cannot be assumed.

Of course, Daniels's conception of fair equality of opportunity is not proportional.
Daniels has a conception of fair equality of opportunity according to which protecting equality
of opportunity requires that we remove *impediments* to opportunity.\(^{23}\) We treat citizens equally
on his view when we remove all of their opportunity impediments, or if that is not possible due
to resource constraints, when we remove those impediments that we can given a fair democratic
procedure for limit-setting.\(^ {24}\) For Daniels, it is as if we are all going to compete in a race, but
some are disadvantaged because of lack of adequate training and others due to sprained ankles.
If we remove these impediments, or failing that if we remove those impediments that we can
(subject to a fair democratic procedure), then it is fair that the outcome of the race be determined

\(^ {23}\) For Daniels's reading of Rawls's FEO, see *Just Health*, 51f.

\(^ {24}\) For Daniels's account of a reasonable democratic procedure for setting limits on health care, see his *Just Health*,
117f.
by the natural distribution of talents and skills. (The distribution of the spoils of the race will be
mitigated by the difference principle, of course, at least on a Rawlsian view.)

Daniels's account can still be vulnerable to something similar to Simpson's paradox, however, because of the fact of resource constraints. For example, a fair procedure for limit-setting might dictate that treatment for a certain condition should not be included in the basic health care package on grounds of cost-ineffectiveness, but that condition may disproportionately affect members of a certain sex or of a certain ethnic or racial group. For that matter, the condition may interact with other disadvantages in complicated ways, so that some individuals or groups are more burdened than others by lack of treatment. More generally, any decision to limit health care access due to resource constraints will disproportionately burden the poor, since the rich can usually obtain such treatment from their own considerable resources (assuming this is permissible). In these ways, treating people equally in the domain of medical care, meaning distributing basic care according to medical need, may not contribute to equality of opportunity overall; at least, the burden is on Daniels to prove that it will.

To summarize, equality of opportunity requires that citizens' total shares of opportunity be equal, but says nothing about how those shares should be constituted; it does not require that citizens enjoy equal shares of each of the particular determinants of opportunity, such as medical care. It may permit giving citizens equal shares of each of the particular determinants, but even then, we cannot assume that giving citizens equal shares of health care, education, and so on will sum to equality of opportunity overall. Thus it is hard to see the distribution of health care according to medical need as having any particular significance to equality of opportunity.
4.2.3 Is Distributing Care According to Medical Need Intrinsic to Equality?

The problems I've identified in Daniels's view are going to be present on any view that sees health care as merely instrumental to the promotion of equality. This is because, first, whether an inequality is due to pathology or simply due to bad luck in the genetic lottery is arbitrary from the point of view of equality; thus there is no egalitarian reason to privilege treatment over enhancement in the distribution of medical care. And second, medical considerations are not of any intrinsic significance from the point of view of equality, so there is no egalitarian reason to think that medical considerations alone should govern the distribution of medical care. Egalitarians should favour distributing medical care so as to promote equality overall, however that is best understood, and not necessarily so as to meet people's medical needs. Thus egalitarianism is much less congenial to the idea of distributing health care according to medical need than people have supposed.

It might be suggested that my argument errs in supposing that the distribution of health care according to medical need is merely instrumental to the promotion of an ideal of equality specified independently from health care. It might be argued that the distribution of health care according to medical need is intrinsic to or constitutive of equality, in the way that equal voting rights, say, are not merely a means to the promotion of equality but a constitutive part.

I would start by saying that it's not clear that a society is inegalitarian just in virtue of violating either of the requirements of distribution according to medical need that I've isolated. Would it be intrinsically inegalitarian for a society to introduce non-health considerations into
the distribution of medical care? Arguably, it depends on what those considerations are. Distributing medical care according to race or religious belief is obviously inegalitarian, but distributing care to promote the welfare of the least advantaged is not obviously so. Would it be intrinsically inegalitarian for a society to provide enhancements as well as treatments? It would depend on the kinds of enhancements and their distributive consequences, I think, but that is just to say that it would not be intrinsically inegalitarian. Thus I do not see why a society should be inegalitarian just to the extent that it fails to fulfill one or both of the requirements of distribution according to medical need, and thus I do not see how distribution according to medical need could be seen as constitutive of equality.

I suspect that part of the appeal of the idea that it is constitutive of equality that we distribute health care according to medical need derives from conflating that idea with the nearby one that it is a constitutive part of equality that people's medical needs—or at least people's basic medical needs—are met. But these two are not the same thing. I have already given one reason why they are not, namely, because the concept of “medical need” is not a moral concept but a medical one. The principle that “health care should be distributed according to medical need” does not require that we provide everything that meets a medical need, nor indeed does it tell us which medical needs in particular we are required to meet as a matter of justice.

But here's another problem: Suppose we grant that people's basic medical needs should be met, and that this is a constitutive element of equality. There is still the question of how to get from there to the idea that health care, even basic health care, should be distributed according to medical need rather than, say, according to ability to pay. This is a further step in the argument.
The idea that people's basic medical needs should be met is an egalitarian moral principle, whereas distribution according to medical need is an institutional requirement. The former describes a general moral ideal, whereas the latter imposes a very specific pattern of distribution on social institutions. In the normal case, embracing the moral principle that people's needs should be met does not move us to the further conclusion that social institutions must distribute the relevant goods on the basis of need alone.

For example, the egalitarian moral principle that people's basic nutritional needs should be met does not by itself get us to the institutional requirement that food should be distributed according to nutritional need. The fact that we have an egalitarian obligation to meet people's nutritional needs does not entail that grocery stores do wrong when they distribute food according to ability to pay. If we are worried that some people will not have enough money to meet their nutritional needs, that problem is readily solved by giving people money. Transferring money rather than providing goods in kind is not only more efficient; it is also more egalitarian. This is because providing goods in kind will inevitably privilege certain conceptions of the good over others.  

We are happy to leave the distribution of food, housing, and shelter to the market, notwithstanding the general egalitarian principle that people's needs in these areas should be met. If the egalitarian moral principle that people's basic needs for food, clothing, and shelter should be met does not by itself get us to the institutional requirement that these goods should be distributed according to need, it doesn't get us there with health needs, either. Granting the force

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of the egalitarian moral principle that people's needs should be met, we still must ask why we only want to institutionalize that moral principle when it comes to health care. What is different? This is a further step in the argument, and it is this step—the step from “people should be able to meet their basic health needs” to “health care should be distributed according to need”—that lacks a specifically egalitarian justification (although it is not without justification altogether).

### 4.2.4 Medical Need and Health Care Insurance

As we have already seen, the difference between health needs and other basic needs is not that they are more important, morally speaking, nor even that they are more unequally distributed; the difference is that health needs are more uncertain. This is what makes insurance beneficial. And (I will argue) it is natural that health care insurance would distribute health care according to medical need as an important part of reducing people's uncertainty surrounding their future health needs. Indeed, it is worth nothing that the legal doctrine of “medical necessity” emerges from insurance law. It did not originate as a medical concept. The phrase “medical necessity” began appearing in private insurance contracts in the U.S. in the 1960s as a way of controlling costs, by refusing to pay for “unnecessary” care.²⁶

It is easy to see why the idea of medical need would play a prominent role in insurance law. Risk pools would need some way of determining which claims should be compensated from the common pool. They could not simply take members' claims of need at face value, for

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fear of encouraging the over-consumption of health care services and thus raising everyone's premiums. As we have seen, this latter phenomenon is known as “moral hazard.”

As explained above (§4.1.1), moral hazard occurs because an individual who has insured against a certain loss now has less incentive to avoid that loss. Where the loss is subject to human control, this means that insurance against that loss can provoke an increase in the objective probability of the loss.\textsuperscript{27} Providing care only in cases where such care meets a medical need is a natural way of limiting moral hazard. (As we have already seen, so is the use of co-pays and deductibles to “unpool” risk.) By paying for care only in cases where such care is reasonable and effective in the judgement of the medical community, the total liabilities of the pool are limited, but limited in a way that does not undermine the purpose of the pool, which is after all to reduce uncertainty surround health needs. It is for this reason that the insurance pool would insist on paying only for care that meets a medical need.

This explains why we prioritize treatment over enhancement in the provision of medical care. From an egalitarian point of view, the priority of treatment over enhancement is puzzling because the line between inequalities due to medical need and inequalities due to other factors is morally arbitrary. The egalitarian must explain why she refuses to fall back on her more fundamental ideal of equality in deciding how to distribute access to care, rather than resting on this arbitrary distinction. From an insurance point of view, however, there is no idea more fundamental than medical need to fall back on. The purpose of the scheme is to reduce people's uncertainty with respect to their medical needs, and so the concept of medical need is the natural place to draw the line in distributing access to care.

\textsuperscript{27} Heath, “Benefits of Cooperation,” 332.
Oddly, Daniels himself invokes the concept of moral hazard in his own defence of the treatment-enhancement distinction. He appears to think that, if we do not draw the line at meeting medical need, we will have little choice but to take individuals' own assessments of their opportunity needs at face value. This is a strange argument for Daniels to make; if there is no objective way of determining when an individual's opportunities are impaired, that would seem to be a major problem for Daniels's account of justice in health care in general.

The concept of moral hazard, so out of place on Daniels's view, fits naturally with mine. To the extent that individuals' desires for enhancement are subject to their own control while their medical needs are not, there are good reasons for insurance to cover only the latter. Moral hazard is a kind of collective action problem that can undermine the viability of the insurance system as a whole, making it harder for citizens to secure the full cooperative benefits of pooling health risks. Preventing moral hazard by providing care only when such care is medically necessary helps to realize these benefits in a way that is consistent with the system's function of reducing citizens' uncertainty surrounding their medical needs. Looking at the matter from the point of view of the insurer (or from the point of view of the insurance pool considered as a whole, if you like), medical need is an obvious way of limiting access to health care to ensure the sustainability of the health care system.

Looked at from the other side, from the point of view of individual members of the pool, medical need also plays an important role. People buy health care insurance to reduce their exposure to uncertainty when it comes to their future medical needs. An insurer allocating care according to non-medical criteria would not reduce that uncertainty; arguably it would only

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28 Buchanan et al., From Chance to Choice, 143; Daniels, Just Health, 153-4.
increase it. For this reason, members of the pool would insist that their insurer stick to medical criteria rather than considerations of overall neediness or desert in determining what care to pay for.

Consider a non-health example: suppose you were in a car accident, and your automobile insurer insisted on an investigation to determine whether you truly “needed” their assistance before they would pay for repairs—not just whether your car needed repairs, as it obviously does, but whether you were needy or deserving of their help in some absolute sense. The problem is not just that this would be galling (although it would be galling; you paid the premiums, after all). The problem is that an insurance policy like this would not do much to reduce a person's uncertainty surrounding her automotive needs. Instead, it would simply replace one kind of uncertainty with another; it would replace uncertainty about one's automotive needs with uncertainty about how sympathetic or needy one will be found in the eyes of their insurance company.

From an egalitarian point of view, this restriction, too, is puzzling. If our aim is to promote equality, why not distribute care in order to make people more equal overall, rather than simply to meet people's medical needs? To ignore considerations of overall opportunity, well-being, or advantage in the name of promoting equality in overall opportunity, well-being, or advantage is unwise, bordering on self-defeating. But if the purpose of health care insurance is to reduce people's uncertainty regarding their future medical needs, then the restriction seems more plausible. Bringing non-medical considerations into the distribution of care would considerably reduce the value of insurance to citizens. Indeed, it would undermine the very function of insurance for them.
Thus distributing care according to medical need fits with health care insurance in two directions. From the point of view of the pool as a whole, refusing to pay for unnecessary care limits moral hazard and serves to keep liabilities (and thus premiums) down, ensuring the sustainability of the scheme and thus protecting a substantial source of cooperative benefits. From the point of view of individual members of the pool, distributing care according to medical criteria alone is an important part of reducing their uncertainty surrounding their medical needs. Distributing access to care according to medical need is not, therefore, a response to egalitarian concerns; it is a response to the uncertainty surrounding health needs.²⁹

I noted earlier that if considerations of moral hazard speak in favour of attaching deductibles or co-pays to the use of health care services, then my account (like Daniels's) would not justify distributing access to health care according to medical need alone; instead, it would justify distributing access to care according to medical need together with willingness to pay that deductible. This is true, but the idea of medical need will still have a very central role to play in distributing health care access on my view. Medical need will still determine the circumstances under which health insurance pays for some portion of a person's health care, or at least the circumstances under which health insurance pays for some portion of those health care services.

²⁹I have been emphasizing the importance of distributing care according to medical need for reducing uncertainty. At the same time, as I noted in §1.2, the concept of medical need is put forward as an answer to the question of how access to care should be distributed, for whatever care is included as part of the basic or universal health care package, but not as an answer to the question of what care should be included in that basic package. It may be worth pointing out that the answer to this second question—what care should be included in the basic health care package?—may also contribute to uncertainty. That is, citizens will also face uncertainty regarding whether, when they get sick, treatment for their particular condition will be covered by their insurance plan. This kind of residual uncertainty is ineliminable, of course, except in a post-scarcity world. I can only say, first, that the total uncertainty that individuals face regarding their health needs will be less with insurance, even when insurance places limits on care, than without insurance. Second, since treatments that are not covered by insurance are likely to be high-cost and low-benefit, most citizens would be unable to access such care even without insurance. Thus insurance does better at reducing uncertainty in most cases and probably does no worse in others, except perhaps in very unusual cases.
included in the basic health care package, even if health care insurance does not foot the entire bill for those services. That is, health insurance will pay for those services (or for a portion of those services) whenever they meet a medical need. This contrasts sharply with Daniels's view, where (I have argued) the concept of medical need should have no significant role to play at all. On Daniels's view, health care, like all opportunity resources, should be distributed so as to meet opportunity needs, not medical needs, and the connection between those two kinds of needs is tenuous at best.

### 4.2.5 Note on Treatment and Enhancement

One caveat on treatment and enhancement before concluding this section: the chance of being born with a below-average level of normal functioning, whether along some particular dimension or overall, is not a risk that someone can insure against in the real world. This is because in the real world there is no uncertainty surrounding that particular problem, or at least there is no uncertainty by the time a person is of age to purchase insurance against it. For example, Johnny in the example above (§4.2.1) could not insure against being extremely short in a heightist society, because before he comes of age his height can be predicted with great precision. But Ronald Dworkin has shown that we could implement a hypothetical insurance scheme that would compensate people as if they had insured against such bad luck at the rate that the average person would have from a position of equality. This might be taken to show that the distinction between treatment and enhancement is not of any great significance, even on a view like mine that takes security from health risks to be the primary function of health care provision.
Two comments about this possibility are in order. First, as I argued in §3.4.1, Dworkin's hypothetical insurance is not actually insurance, since the uncertainty that makes insurance beneficial is not present. Hypothetical insurance is simply a heuristic for determining the appropriate rates of compensation for various forms of bad brute luck. Hypothetical insurance really is a response to egalitarian concerns rather than to the inefficiencies that result when individuals bear health risks alone. Thus even if we make out a hypothetical insurance argument for entitlements to certain forms of biomedical enhancement, this will be a fundamentally different kind of argument from the argument that speaks in favour of pooling health risks. (Indeed, even if we decide that individuals should be compensated for bad brute luck of this kind, nothing compels us to use hypothetical insurance to set the appropriate rates of compensation.)

There may in fact be good reason to think that some enhancements are owed as a matter of justice, but I think it is a virtue of my account that it keeps the reasons we may have for providing these enhancements separate from the reasons we have for providing medically necessary health care. For one thing, enhancements are far more controversial than treatments; it would be strange if both were at bottom a response to the same egalitarian concerns. More generally, if individuals are owed some compensation for the misfortune of being born with a below-average level of functioning, whether along some particular dimension or overall, this would seem to be a clear case where it is preferable to provide such compensation in cash rather than through enhancements provided in kind. In addition to the ordinary equality- and efficiency-based reasons we always have to favour redistributing wealth over redistributing specific goods, here there is the additional problem that offering enhancements but not their cash
equivalent might place undue pressure on some citizens to submit to an intervention that will alter their person in significant ways. That does not seem consistent with treating citizens as free and equal persons.

Second, even employing Dworkinian hypothetical insurance, we can still make out an argument for why *most* forms of enhancement should not be socially provided. Dworkin himself gives the reason: due to transaction costs, the price of insurance always exceeds its mathematical value. For this reason, it simply isn't rational to insure against relatively common and only mildly undesirable occurrences. For example, half the population is of below-average height. This means that insurance against this possibility would pay out just as often as not; such insurance would therefore be very costly relative to the benefit. The average person wouldn't expect to benefit by buying insurance on those terms.

That said, when it comes to the risk of being not just below the average height but a couple of *standard deviations* below average, the odds start to become more favourable and insurance begins to seem more reasonable. If the costs of being short in a heightist world are significant, then insurance starts to seem more reasonable the shorter a person is projected to be. Given what we know about the disadvantages faced by the very short, it is not unreasonable to think that Johnny might have wanted to insure against the possibility of an expected adult height of 5’3, even if not against an expected adult height of 5’6 or 5’7.

To sum up, despite their superficial similarity, the hypothetical insurance argument for compensating undeserved inequality is actually fundamentally different from the actual insurance argument for providing medically necessary treatment for disease and disability. The
former is an argument from equality, the latter from efficiency. Moreover, even if we accept the hypothetical insurance argument for access to biomedical enhancement, such an argument would only extend to very great deviations from the normal range. Insurance against the chance of being only slightly below average in height or intelligence or what have you would not be appealing ex ante; most people would expect to do worse by purchasing such insurance.

4.3 On Care for the Elderly

I would also like to show that my account provides a plausible account of our health care obligations toward the elderly. I argued in §2.1.2 that Daniels's account of justice in health care could not yield a justification for providing health care for the elderly. This is because Daniels grounds our obligation to meet health needs in a principle requiring that we protect fair equality of opportunity, and the elderly as a group do not have opportunities in the relevant sense. It might be suggested that my account also struggles to explain our obligations toward the elderly, but for different reasons. As we age, it becomes almost certain that we will eventually need some form of expensive health care. If expensive health needs are a near-certainty for the elderly, how is it possible to insure against them?

This ignores the fact that, while it is certain or nearly certain that all of us will face expensive health needs as we age, none of us is certain of exactly how expensive our health needs will be. For this reason, insurance can still be beneficial. People will want to start saving during their working years for the care they will one day almost inevitably need, but no one knows exactly how much to save. One person may find that she needs a small fortune to manage
a variety of chronic conditions over many years, while another may die suddenly (and cheaply) at the age of 65. The huge variance in health care consumption, even among the elderly, means that any level of individual health savings is apt to be too much or too little.

When individuals pool their health savings and health risks with others, however, things look different. This is thanks to the law of large numbers: over sufficiently many trials, the average result tends to converge on the expected value. Even though we may not be able to predict any particular individual's health care costs with great precision, we can easily predict what the average person will need. Pooling health savings and health risks with others makes it possible for each person to simply save the average amount and still be confident that it will be sufficient to meet her health needs in her golden years.

Here it is worth recalling that the structure of risk-pooling is neutral with respect to the magnitude or likelihood of the expected loss. The benefits of risk-pooling come from the reduction of uncertainty thanks to the law of large numbers; they do not depend upon the assumption that people are “good risks” or that accidents will not happen. Thus there is nothing in the nature of risk-pooling to prevent high-risk individuals like the elderly from taking advantage of these benefits.

On the view I am putting forward here, then, our obligations of justice in health care toward the elderly are to be viewed, not as a matter of redistributing resources from those who are presently young to those who are presently old, but as a way of helping individuals plan and save for their own health needs over a complete life. This would yield a two-step justification for care for the elderly. The justification for helping citizens gain access to health insurance (and
thus helping them pool their health savings) is to enhance citizens' ability to form, revise, and pursue a rational plan of life. The justification for meeting the health needs of the elderly has a different form: it is because they have paid their insurance premiums throughout their working life and thus have established a reasonable expectation of receiving care.

This argument is very similar to Daniels's prudential lifespan account of our health care obligations to the elderly. Daniels observes that the problem of intergenerational equity can be viewed as a problem of allocating health care resources over the life of a single individual. A prudent person would reserve some of their fair share of health care resources for later in life, Daniels argues, but would do so in the knowledge that life-years after a certain point become less valuable than life-years before that point, due to the normal ageing process. Because most citizens will pass through all phases of life, there is not necessarily anything inegalitarian about providing care for the elderly in this way.\textsuperscript{30}

As I argued in §2.1.2, the only problem with this account is that it does not fit neatly with Daniels's main argument for meeting citizens' health needs. If the prudential lifespan account solves the problem of health care for the elderly, it does so only by introducing non-opportunity considerations into the distribution of health care. This is a problem for Daniels, who locates our obligations of justice in health care under institutions charged with protecting fair equality of opportunity. But this is not a problem for my view. The justification I offer for meeting the health needs of the elderly is continuous with the justification for meeting the health needs of all

\textsuperscript{30}Norman Daniels, \textit{Am I my Parents' Keeper?} (New York: Oxford University Press, 1988), 90-91; Daniels, \textit{Just Health}, 177-181.
citizens: to reduce their uncertainty regarding their future medical needs and thus to protect and enhance their capacities to form, revise, and pursue a rational plan of life.

4.3.1 A Deeper Problem?

It might be suggested that care for the elderly poses a more serious problem for my view. I have argued that citizens should have access to health care insurance to protect their bundle of social resources against risk and thus ultimately to protect their capacities to form, revise, and pursue a rational plan of life. In the same way that Daniels's view falters because the elderly do not have opportunities in the relevant sense, it might be suggested that my view falters because the elderly are generally past the point of forming, revising, and pursuing a plan of life.

This is to look at the matter from the wrong direction. Whether or not the elderly are in the business of forming, revising, and pursuing a plan of life (and it is not obvious that they are not), it is uncontroversial that working-age people are. For most working-age people, one important part of their plan of life will be a plan for meeting their health needs when they are aged. By making it possible for citizens to pool their health savings with others, the state can help citizens form and execute this plan more effectively.

Is this strategy available to Daniels? It might be suggested that one “opportunity” people want to have is the opportunity to save for their health needs when they are aged, and in this way Daniels can take advantage of the very same argument made here. The problem for Daniels is that his view is based in the importance of protecting equality of opportunity, and equality of opportunity is satisfied whether everyone's opportunities are equally good or equally bad. It is
always possible for people to save for their health needs, whether they are saving individually or pooling their savings with others. It is true that, thanks to the law of large numbers, pooled savings are more effective when it comes to saving for uncertain needs like health needs, but I do not see that equality of opportunity per se requires that we equalize opportunity at a high level rather than a low level. This seems to me to be a separate concern, and Daniels would need to appeal to something other than equality to address it.

4.4 Conclusion

In this chapter, I have shown that an account of justice in health care that takes security from risk to be fundamental provides a tidy justification for distributing health care according to medical need and in isolation from other goods. It also provides, I think, an appealing defence of the treatment-enhancement distinction and a workable framework for our obligations of justice in health care toward the elderly.

The pattern of distribution of health care defended here—distribution according to medical need and in isolation from other social goods—is one that provides citizens with indemnity against health risks; it is not a pattern that provides citizens with everything they may need to become or remain healthy. In that respect it is puzzling that philosophers have attempted to defend this pattern by appeal to the moral importance of health. A health care system committed to promoting or equalizing health ought to follow a very different pattern. Insofar as this pattern is appealing, its appeal derives from the benefits of providing citizens with security against risk.
Chapter 5: Benefits and Burdens

I have argued that health care entitlements are best justified in terms of the benefits of providing citizens with security against health risks through health care insurance. Health insurance provides stability in citizen's future expectations, and thus protects and enhances each person's capacity to form, revise, and pursue a rational plan of life. One benefit of this approach, as shown in the previous chapter, is that it provides a tidy justification for distributing health care in isolation from other goods and according to medical need.

The aim of this chapter is to address the problems of distributive justice raised by health care insurance from within a general liberal-egalitarian theory of justice. Broadly speaking, that means specifying how the benefits and burdens of health care insurance should be distributed: how comprehensive should health care insurance be, and how should it be priced to citizens? I focus primarily on John Rawls's theory of justice as fairness, but many of the considerations I raise will apply to other liberal theories as well. I will argue that an ideally just society should strive to allow citizens maximal flexibility in allocating their fair share of income and wealth between cash and insurance policies. This means erring on the side of less comprehensive insurance, at least when it comes to the minimum insurance package, and allowing the more risk-averse to “top up” by purchasing supplemental insurance. In the real world, however,
practical considerations may give legislators good reason to insist upon more generous health care insurance than would be appropriate in an ideally just society.

I begin in §5.1 by situating insurance within Rawls's account of primary goods. I argue that insurance should be situated under the existing primary good of income and wealth rather than treated as a primary good in its own right. §5.2 considers the distribution of the benefits of insurance, particularly health insurance. This section considers how generous the basic health insurance policy ought to be, as well as whether citizens should be allowed to purchase health care or health care insurance beyond what is included in the basic package. §5.3 considers how the burdens of insurance should be shared, that is, how insurance should be priced to citizens who face different levels of health risks, whether by nature or by choice.

5.1 Incorporating Security from Risk into the List of Primary Goods

The first step in integrating security from risk into a Rawlsian theory of justice is to situate it within Rawls's account of well-being. Rawls employs an index of primary goods for the purposes of establishing a public metric of well-being (§1.1.3). These primary goods are general, all-purpose means for the pursuit of citizens' ends. They include basic civil and political liberties, a range of diverse opportunities, the powers and prerogatives of office, income and wealth, and the social bases of self-respect.¹

The most obvious way of integrating security from risk into Rawls's account of primary goods would be to simply add it to the list. There is some precedent for this, as Rawls himself considers adding leisure and freedom from pain to the list.\(^2\) I resist this strategy, for both direct and indirect reasons.

To take the indirect reasons first, adding security from risk to the list would necessitate major revisions to Rawls's theory of justice in at least three ways. First, decisions about the appropriate pattern of distribution for each of the primary goods are made in the original position, but parties in the original position lack the relevant information to make determinations about what kinds of insurance policies would be appropriate for them. The veil of ignorance conceals from them any knowledge of particular facts about their society, such as its level of technological advancement or material wealth. Parties in the original position also lack information about the kinds of risks that are prevalent in their society or how much it would cost to provide protection against these risk at different levels.\(^3\) Surely actuarial data concerning the likely costs of different kinds of insurance policies are relevant to judgements about how much insurance is appropriate. Moreover, people tend to become more risk-averse as they become wealthier, and this seems perfectly reasonable; in a less affluent society it may be rational to tolerate higher levels of personal risk for the prospect of greater reward, whereas in a wealthier society those kinds of trade-offs might be less appealing. To yield reasonable results, Rawls's “veil of ignorance” would have to be made significantly thinner.

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Second, even if parties in the original position had the information they would need, they would not be able to make effective use of it. Parties in the original position are imagined as always preferring more primary goods to fewer. In this way, the original position effectively forces the choice of “maximum equal” or “maximum-minimum” distributions of all primary goods. Even if the veil of ignorance were lifted enough to allow in information about the prevalence of various risks and their costs, parties in the original position would still be compelled by their own imagined motivations to insure themselves to the hilt. This would effectively turn health care (and other forms of insurance) into a “bottomless pit” that would consume all social resources. Or if it would not, it is unclear on what basis parties in the original position would weigh security from risk against other social resources like income and wealth. The psychology of the parties in the original position would have to be made much richer (and more controversial) to yield a determinate yet reasonable answer.

This raises a third and final indirect problem: adding security from risk to the list of primary goods would complicate the index problem considerably. An index of primary goods is necessary on Rawls’s theory to assess relative levels of well-being and to identify the least advantaged members of society. Rawls had hoped to avoid the index problem, or at least minimize it, by taking income and wealth as proxies for the whole list. This simplifying assumption becomes untenable once we add insurance to the list of primary goods, since insurance must be traded off directly against income and wealth. Who is better off, the rich

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4 Ibid., 123.

person with no security or the secure person with little income and wealth? In all these ways, treating security from risk as a primary good in its own right would complicate Rawls's theory of justice considerably.

There are also more direct reasons to resist adding security from risk to the list. It is difficult to see security from risk as fundamentally different from the existing primary good of income and wealth, and one should not multiply primary goods needlessly. While it is true that security of the person against the risk of violence and coercion is not readily reduced to income and wealth, security against those kinds of risks is already provided under the basic liberties. And anyway, physical security is very different from the kind of security that insurance provides. Insurance in the first instance protects citizens' pocketbooks, not their persons.

Rawls himself emphasizes that wealth should not be identified with money. Rather, wealth includes any exchangeable means that a person has under her control for the pursuit of her ends. To illustrate, he gives the example of faculty members, who typically have some control over their university's resources for the purposes of carrying out their research, or members of a congregation who may have some say in how church property is used. Insurance policies, having an exchange value and being something citizens may use for their purposes, fall under this description as well.

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That said, the connection between insurance and wealth is not simply that insurance policies are a *form* of wealth, although they are. Insurance is a sort of complement to citizens' (other) income and wealth, serving as it does to make citizens' wealth more secure going forward. Rawls argues that we should aim to maximize the expectations of income and wealth going to the least advantaged social group, but as I argued in §3.1.2, the magnitude of citizens' expectations is only part of the story. We also have reason to reduce the variance in citizens' expectations, and insurance accomplishes this.

For all these reasons, I think it is better to co-opt Daniels's strategy and situate insurance under the existing primary good of income and wealth. Recall that Daniels argues that institutions that meet citizens' health needs belong under institutions that protect fair equality of opportunity; opportunity remains the primary good, on Daniels's view, but meeting health needs is understood (by him) as a particularly important part of protecting equality of opportunity.\(^8\) A similar strategy is available here. Because insurance works in the space of income and wealth, it is not necessary to introduce a new primary good. Instead, insurance can be understood as a component of each citizen's fair share of income and wealth.

### 5.1.1 The Four-Stage Sequence

Rawls holds that the primary goods are not fully specified by considerations available in the original position. Instead, he imagines a four-stage sequence, of which the original position is but the first stage. In the original position, parties deliberate behind a “thick” veil of ignorance, one that obscures knowledge of all particular facts about persons and their society. At

\(^8\)Norman Daniels, *Just Health* (New York: Cambridge University Press, 2008), 57.
each subsequent stage, the veil of ignorance is gradually lifted, so that parties have the necessary information to work out the requirements of justice in full detail. Each stage is supposed to represent an appropriate point of view for answering certain questions of justice, subject to the constraints agreed upon at earlier stages.\footnote{Rawls, \textit{Theory of Justice}, 172.}

The four-stage sequence proceeds in the following way. In the original position, parties agree to the general form of the two principles of justice, as well as the priority of the basic liberties, behind a thick veil of ignorance. At the second stage, the “constitutional convention,” parties specify the constitutional powers of government and elaborate the basic rights of citizens. At the second stage, they are allowed the benefit of some knowledge of general facts about their society, such as its level of economic development, political culture, and so on. The third stage is the legislative stage. There, parties assess the justice of particular social and economic policies, knowing all the facts about their society but still not knowing any particular facts about themselves. The priority of the constitutional convention over the legislative stage reflects the priority of the first principle (which secures basic liberties) over the second (which regulates social and economic inequalities). The final stage is the adjudicative stage, the application of rules to particular cases; at this point everyone has complete access to all the facts.\footnote{Ibid., 171-176.}

Working out the details of social insurance clearly belongs at the legislative stage. As a matter of social and economic policy it fits there. Moreover, without full knowledge of the facts about their society—for example, the incidence of particular forms of disease and disability, the
available treatments, and their costs—judgements about the appropriate levels of insurance
coverage could not be made.

5.1.2 Insurance and Pure Procedural Justice

The business of the legislative stage is to design a social system that meets the
requirements of distributive justice. Rawls's theory of justice relies on pure procedural justice to
deal with the contingencies of particular situations. The idea is to design a system of social and
economic institutions—a market system together with the background institutions of, e.g.,
taxation and transfer—such that the resulting distribution is just, however it turns out.\textsuperscript{11} These
background institutions are designed to protect what Rawls calls “background justice,” that is, to
correct social and economic processes in the direction of equality so that the whole social
system works to the greatest advantage of the least well-off.\textsuperscript{12} Within these institutions,
individuals are free to order their lives as they see fit, drawing up their plans in light of the
foreseeable effects of just institutions. In this way, the maintenance of a just distribution does not
require constant interference with individuals' lives, instead leaving them broad scope to pursue
their particular conceptions of the good as just institutions allow.\textsuperscript{13}

Among the institutions necessary to preserve background justice is a branch of
government Rawls calls the “transfer branch.” The role of the transfer branch is to provide the

\textsuperscript{11}Ibid., 75-76 and 242-43.


\textsuperscript{13}Rawls, \textit{Political Liberalism}, 268; Rawls, \textit{Justice as Fairness}, 51.
“social minimum,” Rawls's preferred term for income support. The social minimum is to be set at that point where the total expectations of the least advantaged (wages plus transfers) are maximized. The problem with allowing total income to be determined by the market, Rawls argues, is that the market gives no consideration to claims of need and a decent standard of living. “From the standpoint of the legislative stage,” Rawls argues, “it is rational to insure oneself and one's descendants against these contingencies of the market. Indeed, the difference principle presumably requires this.” Rawls notes that using taxation and transfer to bolster the living standards of the least advantaged is likely to be more effective than trying to accomplish this through minimum wage standards and other labour market regulations. Given a suitable minimum provided by the transfer branch, the rest of total income can be settled by the price system.

The same considerations that lead parties at the legislative stage to introduce a transfer branch should also lead them to set up an insurance branch. If they are going to rely on pure procedural justice to determine citizens' distributive shares, then there is a strong case for making sure citizens have access to insurance to protect them against significant and unexpected shocks to their income and wealth. If it is rational to insure oneself against the contingencies of the market, as Rawls claims, then it is rational to insureself against the contingencies of the market, and perhaps to insure oneself against other contingencies like unexpected health needs as well.

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15 Ibid., 252.
16 Ibid., 244-45.
17 Ibid.
The social minimum could be thought of as a form of insurance, although it's worth noting that Rawls does not intend the social minimum to serve as an unconditional basic income. In his later work, Rawls specifically distances himself from that view, making it clear that he intends the social minimum to be contingent upon work. If that is right, then citizens' access to insurance policies that protect their income in the event of loss of work (unemployment) or loss of ability to work (disability) would be seen as especially significant by legislators. Providing access to this kind of stability for citizens' expectations would ensure people are able to meet their basic needs if they find themselves temporarily or permanently unemployed, and in general would help them plan for the future more effectively.

But even an unconditional social minimum is not a perfect substitute for insurance. For one thing, even in the wealthiest society, the social minimum will not be sufficient to meet unexpected and expensive health needs or needs related to a costly disability. More subtly, even if the social minimum is generous enough to guarantee everyone a minimally decent life, most people in a just society will choose to work and thus will come to depend upon an income that is considerably higher than what the social minimum provides. In that case there may still be a role for insurance in protecting people against sudden drops in income, even if their income does not fall to a level that is very low in any absolute sense. (Of course, the extent to which this is true will depend upon how generous the social minimum is.) Thus regardless of whether the social minimum is conditional or unconditional, access to insurance would still be seen as beneficial by legislators.

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5.2 The Benefits of Insurance

It is clear that parties at the legislative stage will have good reason to make sure that various kinds of insurance policies are available to citizens generally. How would they decide what kinds of insurance should be offered, and how generous these policies should be? It is tempting to think that legislators would approach this problem by asking what kinds of insurance policies citizens need as free and equal persons, or perhaps in the way that Dworkin proposes in *Sovereign Virtue*, by asking what kinds of insurance policies the average or typical person would want under certain idealizing conditions. After answering this question to their own satisfaction, legislators would then craft and distribute such insurance policies directly to citizens.19 The problem with this approach is that it is not clear that there is a single answer to the question of what insurance policies citizens need or want, the correct answer for each person depending on that person's own preferences and ambitions.

Not everyone has the same attitudes toward risk. Some people might prefer to run risks that the typical person would regard as unacceptable, while others might regard an average level of insurance as providing insufficient protection against the vagaries of human life. This is not merely a theoretical point. Insurance is not free, even in an egalitarian utopia. Pooling risks with others carries certain costs; it means that citizens will have fewer non-insurance resources left over with which to pursue their other projects and ambitions.

For these reasons, and in general, legislators should aim to ensure that citizens have access to various kinds of insurance policies rather than making insurance decisions on citizens' behalf. By making sure there are robust and competitive markets in various kinds of insurance products, legislators can enable citizens to tailor their insurance portfolios to their own tastes and ambitions, making their particular expectations as secure (or insecure) as they wish. Most private insurance markets work quite well, or at least well enough that citizens can insure their homes and other valuables, indeed even their lives, for themselves. In general, if a person can afford a certain loss, then she can afford insurance to cover the risk of that loss. If we are worried that some people will not be able to afford adequate insurance, that problem can be solved through the transfer branch, by giving people money.

In principle, these considerations apply to health insurance and other forms of social insurance as well. The problem, as we have seen, is that health insurance markets are particularly prone to problems of adverse selection. At any given price, those who are most likely to need insurance are precisely those most likely to purchase it, undermining the sustainability of the insurance scheme. This is certainly true of markets for health care insurance, and one can easily see how this dynamic would take hold in markets for unemployment and disability insurance as well.21

Probably a significant reason why markets in home and auto insurance do not face significant problems of adverse selection is because people are typically required to purchase


these forms of insurance, either by law or by the bank that issues their mortgage. This means that consumers are not self-selecting on the basis of risk. Forcing the “good risks” to stay in the risk pool prevents the dynamic of adverse selection from taking hold. Of course, the reasons for forcing people to carry these kinds of insurance are not in the first instance related to adverse selection. Driving a car exposes others to significant risks of injury or property damage, and it is appropriate that drivers bear the costs of these risks; that is simply an instance of forcing people to bear the costs of their choices. If a person's home is offered as collateral on a loan, it is reasonable for the issuer of the loan to demand some security on that collateral. If the purchase of these forms of insurance were truly voluntary, we might see adverse selection take hold in markets for these kinds of insurance as well.

The other-regarding reasons we have to force citizens to insure their cars and (usually) their homes are not available in the case of health insurance and other forms of social insurance, as these generally benefit only the policy holder directly. But that does not mean we must resort to paternalism, forcing citizens to carry insurance for their own good. Adverse selection provides a sufficient reason for forcing citizens to carry certain forms of social insurance. The vast majority of citizens will want access to these kinds of insurance products. If their purchase were left optional, many would be unable to obtain these kinds of insurance products at all, and many more would be unable to obtain them at anything approaching a fair price. Forcing people to carry certain kinds of insurance, including health insurance, is essential to securing the full cooperative benefits of risk-pooling.

Some citizens may genuinely prefer not to pool certain risks, including health risks, with others, and they may object that it is unfair to force them to do so merely for the sake of
securing certain cooperative benefits that they themselves do not regard as advantageous. In reply, it might be tempting to appeal to the paternalistic or perfectionist reasons we may have to refuse to allow citizens to bear certain risks alone. Such appeal is, I believe, unnecessary.

The situations of those who would prefer not to pool certain risks and of those who would so prefer are, in one respect at least, perfectly symmetrical; neither group can realize their preferred distribution of risk without also imposing it on the other, at least to some extent. It might be thought that in cases like these we should err on the side of liberty and refrain from forcing citizens to pool risks at all, but I do not see why this should be so.

In general, Rawls does not treat the economic liberties as basic liberties. The right to own and use personal property is counted as a basic liberty, of course, because in order for a person to set and pursue ends she must have means under her control. For that reason, the freedom to own personal property is necessary for the development and exercise of the two moral powers, and thus cannot be overridden by considerations of the public good. But more robust economic liberties, like the right to private property in the means of production (or on the other hand the right to participate in the democratic control of the means of production, which means are socially owned), are not counted as basic liberties, not being essential in Rawls's view to the development and exercise of the two moral powers. Thus Rawls holds that the specification of these kinds of property rights belongs properly at the legislative stage, where considerations of social circumstances and historical traditions can be brought to bear.

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23 Ibid., 298.
Following this line of reasoning, it is hard to see the right to bear health risks alone (or what is the same thing, the right to decline health care insurance) as something essential to the development and exercise of the two moral powers. If anything, the opposite is probably true. Thus it is hard to see why that right should be immune from considerations of the public good.

For any sufficiently large cooperative scheme, there is always a nearby scheme where some particular person would do better. It is impossible to maximize with respect to every social position, let alone every single individual, at once. What is essential on a Rawlsian view is that we design our cooperative scheme such that the least advantaged do better than the least advantaged under any alternative scheme. I will argue that the least advantaged are likely to do better under a cooperative scheme that includes the mandatory pooling of certain risks, including health risks, than under one that does not. Securing the benefits of risk-pooling is a legitimate aim of social and economic policy, and it is reasonable to restrict some non-basic liberties to achieve this. Of course, those restrictions should be no greater than what is necessary to achieve the desired end, and this consideration will be significant going forward.

In what follows, then, I will not appeal to the paternalistic or perfectionist reasons we may have to force citizens to carry certain kinds of insurance policies. I believe it is possible to derive a justification for universal access to an adequate set of social insurance policies, including health care insurance, without appeal to those sorts of reasons, but simply by appeal to the need to correct a significant market failure. Those who are willing to rely on paternalistic or perfectionist considerations may have the resources to argue for more generous mandatory insurance policies, if they find that my minimal assumptions do not justify sufficient protection against risk. That said, I think it is significant that it is possible to derive a justification for
universal access to a decent minimum of health care insurance (and other forms of social insurance as well) without appeal to these more controversial moral principles.

The main argument of the rest of this section will proceed in three stages. In the next section, I consider what kinds of risks legislators should guarantee all citizens insurance against. In §5.2.2, I focus on health care insurance, outlining the kinds of considerations that should guide legislators in determining how comprehensive such insurance should be. In §5.2.3, I argue that the least advantaged will do better under a system of social cooperation that includes health insurance of this kind than under a system without. The main argument of this section complete, the last two sections consider some more specific questions of institutional design. §5.2.4 argues that a so-called “two-tiered” health care system, where all citizens have access to a basic health care or health care insurance package and some citizens have the option of purchasing additional coverage above that basic tier, is not necessarily unjust. §5.2.5 considers whether justice requires any particular institutional form for the provision of health care or health care insurance, for example, whether health care insurance should be public or private.

5.2.1 Which Risks Must Citizens Be Insured Against?

The problem of adverse selection means that legislators cannot simply leave all forms of insurance to the market. They will instead have to identify certain risks that everyone should be insured against, and take steps to make sure that all citizens have access to insurance against them, including if necessary forcing citizens to carry insurance.
I've already named four risks that most liberal democracies insure their citizens against: health, disability, unemployment, and poverty in old age. These risks have two important features in common, besides the fact of being prone to problems of adverse selection when pooled voluntarily. Most obviously, they are risks that everyone faces in virtue of being a human being (or, in the case of unemployment insurance, in virtue of being a human being in a free society with a market economy). They are not risks that are assumed only by some. Second, they are risks that can seriously set back a person's ability to form, revise, and pursue a rational plan of life. They do this primarily by posing significant threats to the stability and security of a person's income and wealth. Reducing these risks can thus protect and enhance all citizens' abilities to form, revise, and pursue a rational plan of life.

I would suggest that a liberal society has good reason to ensure that all of these insurance products are available to citizens, even if it is necessary to force all citizens to purchase them. However, I will not pursue the entirety of that claim further. My focus in the remainder of this chapter will be on health care insurance. But the arguments I will raise with respect to health care insurance, suitably revised, could be applied to these other forms of social insurance as well.

5.2.2 How Generous Should Health Care Insurance Be?

If legislators are to force citizens to purchase a certain minimum level of health care insurance, they will have to make some determination of how generous that minimum should be. Despite the fact of adverse selection, it may still be possible for legislators to set up health insurance markets that leave individuals some scope to tailor their particular insurance plan to
their own level of risk-aversion. For instance, under the 2010 Patient Protection and Affordable Care Act (“PPACA”) in the United States, citizens have the option of choosing among plans that are expected to meet 60, 70, 80, or 90 percent of a person's health care costs, the remainder in each case being paid out-of-pocket by the insured. People under the age of thirty and those with special financial hardships also have the option of purchasing a catastrophic plan, which covers only essential care at high deductibles.  

Some analysts worry that adverse selection will undermine this feature of the PPACA, with high-risk individuals gravitating towards plans with less cost-sharing and young and healthy persons opting for more. This has the potential to create a sort of adverse selection “death spiral,” where the high-value plans become unaffordable due to their sickly risk pools, and eventually only the lowest-value plans survive. The PPACA has some mechanisms in place to prevent this from happening, including the use of risk-adjustment and reinsurance (where essentially the healthier risk pools subsidize the sicker ones), but it is an open question whether these will succeed. If they do, then from a liberal point of view this solution to the problem of health care justice would be preferable to a one-size-fits-all approach, where everyone is provided the same level of health care insurance regardless of their particular level of risk aversion.

Even if it is possible (and sustainable) to present citizens with a range of health care insurance options as under the PPACA, legislators will still have to make some determinations

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24Patient Protection and Affordable Care Act, U.S. Code 42 (2010), §18022.

regarding how generous the minimum health care insurance package should be. Legislators will still have to set a floor, a basic level of provision that all plans must meet. If it is not possible to offer citizens a range of plans from which to choose over the long run, which is not unlikely, then legislators will have the more difficult task of determining what level of basic coverage is appropriate for all citizens. In either case, on a Rawlsian view, their deliberations should be guided by how best to realize citizens' two moral powers, that is, their capacities to form, revise, and pursue a conception of the good and their capacities for a sense of justice.  

How then to set the minimum level of coverage? For the moment, let us assume that all citizens have the same expected health costs over a complete life. (In assuming this, of course, I abstract from the very conditions that generate the problem of adverse selection, but doing this will give us a clearer grasp of the basic trade-offs; I will consider what happens when we relax that assumption in §5.3.) Because the distribution of income and wealth falls under the difference principle, legislators can focus their attention on the least advantaged group. Imagine a society that is otherwise fully just by Rawlsian lights, that is, where the expectations of the least advantaged are maximized. If the expectations of the least advantaged are already maximized, then by hypothesis it is not possible to transfer further resources from the well-off in order to provide the poor with more comprehensive insurance. In that case, the operative trade-off will be between more comprehensive health care insurance for the least advantaged and a larger share of (other) income and wealth for the very same. That is, the legislators' choice

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concerns only how to allocate the expectations of the least advantaged between cash and insurance policies, and not how to raise their expectations further.

In this highly idealized scenario, legislators should aim to set the minimum level of coverage just at that point where the costs of devoting more of the resources of the least advantaged to health care would outweigh the benefits, where the costs and benefits are measured in terms of their effects on the effective exercise of the two moral powers on the part of members of the least advantaged group. Every dollar devoted to health care insurance is a dollar that the least advantaged will not have available for other projects, and thus there comes a point where more generous health care insurance will do more harm than good to citizens' capacities to form, revise, and pursue a rational plan of life. Where that point is, exactly, is obviously a matter of judgement; as I have emphasized, there would not appear to be a single rational answer to the appropriate way to trade-off larger expectations of resources against more secure expectations of resources. Indeed, the optimal trade-off will be different in each individual's case, depending as it does on each person's own tastes, ambitions, and of course risk-aversion.

If citizens are offered the choice between a range of coverage levels, this speaks in favour of setting the minimum level of coverage rather low, since citizens can always opt for a more comprehensive plan if they wish. But even if the minimum level should be “rather low,” there is reason to think that it should nonetheless be sufficient to provide everyone with a decent minimum of care. For one thing, there would be little point in forcing citizens to purchase health

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28 Of course, if there is flexibility in choice of plan, then a person who chooses a plan with a higher expected value should forgo a corresponding amount of income and wealth, so that their total expectations (wages plus cash transfers plus insurance) stay the same. Otherwise they would be shifting the costs of their insurance choices onto others. And indeed, if plans were not priced in this way, no one would choose a low-value plan in the first place.
care insurance if that insurance did not provide them with a reasonable amount of security against health risks. More subtly, if the minimum level of coverage did not guarantee a decent minimum of care, then practically no one but the young and healthy would be content with it. This could generate significant problems of adverse selection for plans above the minimum, undermining the very choice-sensitivity that made this approach appealing to begin with.

If legislators are instead designing a single basic plan that all citizens must carry, then there is good reason to think that the basic plan should be more generous than when they are simply setting a floor. Legislators would still have reason to eschew what Dworkin calls a “rescue policy,” a plan that guarantees citizens any necessary treatment regardless of cost.29 Such a plan would leave citizens with few—indeed, perhaps not any—resources left over to pursue their own projects; everyone would expect to do worse with a policy like that. Legislators should aim instead to establish a level of coverage that would be to the greatest benefit of the least advantaged in forming, revising, and pursuing a rational plan of life.

These considerations notwithstanding, there are clearly a variety of possible just health care insurance arrangements, and it is the business of legislators to choose the one that best fits with the interests of their citizens and the political culture of their particular society. At some point our ability to make precise philosophical discriminations runs out and we are entitled to plead practical considerations, as Rawls says in another context.30 Of course, wherever the minimum level of coverage is set (or if there is only one level of coverage, then however generous that level is), there will always be some citizens who would prefer that it had been set

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29 Dworkin, *Sovereign Virtue*, 313.

somewhere else. This problem is inevitable, but if it is an injustice it is a lesser injustice than eschewing the provision of health care insurance altogether.

The problem of setting a single level (or floor) of provision is a perfectly general problem for publicly-provided goods. It is unlikely for instance that there is a precise level of police protection that is required as a matter of justice; there is probably a range of permissible options. Whatever point within that range legislators choose, there will inevitably be some who would have preferred a different point—some who would have preferred less security and a bit more money in their pocket, and others who would have preferred just the opposite. Again, where it is possible for people to “top up” their personal level of provision out of their own resources—for example, by hiring their own private security force (if this is not unjust) or by purchasing more generous health care insurance out-of-pocket—this speaks in favour of erring on the side of less coverage rather than more. This gives citizens broader scope to tailor their particular bundle of resources to their own interests and ambitions.\(^{31}\)

Everything I have said in this section has been assuming a highly idealized scenario where the expectations of the least advantaged are already maximized. In that world, the relevant trade-off is between more generous health care insurance for the least advantaged and a higher expectation of income and wealth for the very same. In the real world, however, the trade-offs look very different. No society on earth comes close to truly maximizing the expectations of their least advantaged citizens. Moreover, in the real world, citizens are generally more supportive of redistributive programs targeted at meeting specific needs than

they are of programs that simply give money to poor people.\textsuperscript{32} Given these practical constraints, there may be good reasons in the real world to make the basic health care insurance plan more generous than it would be in an ideal world, and then use the tax system to subsidize the insurance choices of the poor. Indeed, if the choice is between more insurance for the poor and allowing the well-off to keep a larger share of their pre-tax income, this choice is an easy one by egalitarian lights. But I would emphasize that, while this might be a politically expedient way of raising the expectations of the least advantaged beyond what would be possible through the direct redistribution of wealth, this is still a second-best solution rather than an ideally just arrangement. The optimal solution would be to simply give the least advantaged more money.

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5.2.3 \hfill The Least Advantaged Do Better

Having outlined the kinds of considerations that should guide Rawlsian legislators in designing health care insurance policies, I conclude my main argument for health care insurance by showing in this section that the least advantaged will do better under a system of social cooperation that includes such insurance than under one that does not. I have already argued that the least advantaged will do better—indeed, all citizens will do better—in the sense that they will be better able to plan for the future and thus better able to develop and exercise their moral powers, particularly their capacities to form, revise, and pursue a conception of the good, thanks to the reduction in uncertainty that insurance provides (Chapter 3). In this section, I focus more narrowly on how the least advantaged will fare in terms of their expectations of primary goods.

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In a less than fully just society, which is to say in every actual society on earth, it seems clear that the least advantaged will do better with insurance. The reason has already been given: in the real world, people are generally more supportive of redistributive programs targeted at meeting specific needs than they are of programs that simply give money to poor people. This means that by implementing a health care or health care insurance system and then subsidizing the insurance choices of the poor, it is possible to do more redistribution toward the least advantaged than would be feasible without such a system. Of course, this is not a benefit of insurance per se; on this picture, the health care system is simply a tool for carrying out redistribution that in a more perfect world would be done directly. But in the real world, motivating citizens to support redistribution politically is arguably the most important step toward promoting equality, so this is not an insignificant benefit.

Moreover, if we hold that health insurance should not be priced to reflect unchosen differences in health risks, as I will argue that we should in §5.3.3, then in the world we live in the least advantaged will stand to benefit disproportionately from health insurance compared to other social groups. This is because persons of low socioeconomic status suffer significantly higher rates of mortality and morbidity than those of higher status. For that reason, pooling health risks across socioeconomic lines will result in a significant transfer of resources from rich to poor. For example, a recent study of the distributional effects of Canada’s health care system found that the health care system spends roughly 1.15 times as much on members of the poorest income quintile over their whole lives, on average, than on those in the wealthiest quintile ($237,470 versus $205,670 in 2011 Canadian Dollars), even after adjusting for the fact that the
wealthy tend to live longer than the poor.\textsuperscript{33} This is despite the fact that Canada's single-payer health care system offers the same defined benefits to rich and poor alike. This, too, is not intrinsic to the operation of insurance; this also assumes that the insurance system will be used to carry out redistribution, but this I think is a reasonable assumption (see §3.3).

That being said, things look different in a fully just society. As we have seen, the price of an insurance policy will always exceed its mathematical value, due to the costs of administering the scheme. Thus in a fully just society, where it is impossible to raise the expectations of the least advantaged further and so the full cost of insurance for the least advantaged must be borne by the least advantaged themselves, the least advantaged will necessarily pay somewhat more for insurance than they receive back in expected benefits. In other words, replacing some of their expectations of (non-insurance) income and wealth with insurance policies would actually slightly lower their expectations, in clear violation of the difference principle, even as those expectations are made more secure.

Here I think it is appropriate to be more careful in singling out who, exactly, belongs to the “least advantaged” group. From the standpoint of the original position, with its thick veil of ignorance, it makes sense to paint in broad strokes. For that reason, Rawls suggests that we may think of the position of the typical unskilled worker as representative of the least advantaged group, or perhaps instead all those making less than half the median income.\textsuperscript{34} At the legislative stage, with more detailed information available, we may wish to draw finer distinctions. We may


\textsuperscript{34}Rawls, \textit{Theory of Justice}, 84.
wish to focus not just on the typical unskilled worker, but on the typical unskilled worker who is also most disfavoured by nature or chance. Although the average unskilled worker can expect to fare ever-so-slightly less well (in terms of income and wealth) with insurance than without, this will not be true of the unlucky unskilled worker, i.e., the unskilled worker who turns out to be frequently sick. Her expectations will be raised considerably. Rawls himself suggests something like this understanding of the least advantaged when he defines that group intuitively as “those who are least favored by each of the three main kinds of contingencies:” family and class origin, native talent, and fortune or luck. He singles out the position of the unskilled worker after pleading “practical considerations”.

These are all ways in which the foreseeable effect of a universal health insurance system in a Rawlsian society will be to improve the situation of the least advantaged, which is to say, all ways in which a universal health insurance system will tend to promote equality. But I would emphasize that these are not in the first instance the purpose of the universal health insurance system. I argued in Chapter 3 that the purpose of insurance is to reduce uncertainty, not to promote equality. This is the primary benefit of insurance for the least advantaged (and indeed for all citizens); by reducing the uncertainty surrounding citizen's future health needs, insurance makes everyone (or nearly everyone) better off.

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35 I am not speaking here of the unskilled worker who has unusually high expected health needs ex ante. I am thinking of the unskilled worker whose actual health needs ex post exceed her expected needs ex ante. She will do better—possibly much better—with insurance than without, even without assuming any incidental redistribution carried out through the insurance scheme. Of course, we cannot say ex ante who in particular will fall into the class of “unlucky unskilled worker”—who in particular will have health needs ex post which exceed their expected needs ex ante—but we can say that the class will not be empty, and that whoever winds up in that class will do better with insurance than without.

36 Ibid., 83-84.
It is necessary to show that insurance enhances the prospects of the least advantaged (or at least doesn't worsen them) in order to show that it is consistent with the strictures of Rawlsian justice. But if our only aim, or even our primary aim, in designing a health care system was to promote equality, universal insurance would be a poor choice of mechanism for achieving it. Indeed, most of the ways in which insurance actually raises the expectations of the least advantaged depend upon the assumption that the insurance system will also be used for redistributive purposes as well—a reasonable assumption, on a Rawlsian view, but not essential to the logic of insurance.

It is common to many publicly-provided goods that they are intended primarily to realize efficiencies but also useful for promoting equality. Public roads and sewers, for example, benefit the poor more than the rich, to say nothing of the disproportionate amount the rich contribute to build them. In this way, roads and sewers contribute to equality, but it would be difficult to argue that building them is justified primarily by egalitarian considerations. Given the massive cost of such projects, equality per se would have been far better served by simply passing that money out to the least advantaged members of society. We build these things to make people better off, not to make people more equal. Because on a Rawlsian view efficiency is understood to be part of justice, it can readily handle these kinds of cases; justice requires not only that we equalize but that we equalize at a high level of advantage rather than a lower level.

5.2.4 On Two-Tiered Health Care

From what I have said so far, it should be clear that I see nothing intrinsically unjust about a so-called “two-tiered” health care system, where there is a basic minimum of health care
insurance provided to all but citizens have the option of purchasing additional health care or health care insurance beyond that on the private market.

People do tend to have strong egalitarian intuitions that the rich should not enjoy better access to health care than the poor. The standard response to this claim, of course, is to point out that the rich enjoy better access to *everything* than the poor; it is unclear why differential access to health care is any more unjust than differential access to education, housing, transportation, and so on. I hope that shifting the focus to risk management helps to defuse some of these concerns. People do not tend to object when some people voluntarily assume greater risk than others. I do not see that the choice to decline more generous health care insurance for the sake of more money is any different from the choice to assume a risky occupation for the sake of the same.

This problem recalls the so-called *Titanic* problem. Thomas Schelling claims that the *Titanic* was equipped with adequate lifeboats only for first-class passengers, while passengers in steerage were expected to go down with the ship.\(^{37}\) The price of a seat in a lifeboat was supposedly included in the price of a first-class ticket, and those in steerage paid less in part because their ticket did not include that safety net. Schelling indicates that most people find this inequality in risk-bearing unacceptable, at least among those who are “in the same boat,” so to speak:

\(^{37}\)Thomas Schelling, *Choice and Consequence* (Cambridge, Massachusetts: Harvard University Press, 1984), 116. It might be worth noting that Schelling's account of what happened aboard the *Titanic* is probably false. As it happened, women and children were given first priority in access to lifeboats, and men were expected to go down with the ship. This is reflected in the fact that women in steerage had higher survival rates than any group of male passengers, even those in first-class. This is pointed out by Joseph Heath in his “Review of Deborah Satz's *Why Some Things Should Not Be for Sale,*” *Erasmus Journal of Philosophy and Economics* 4.1 (2011): 105; see also Robert Allen Butler, *Unsinkable* (New York: Stackpole Books, 1998), 105-06.
Those who want to risk their lives at sea and cannot afford a safe ship should perhaps not be denied the opportunity to entrust themselves to a cheaper ship without lifeboats; but if some people cannot afford the price of passage with lifeboats, and some people can, they should not travel on the same ship.\textsuperscript{38}

The situation I'm advocating for health care insurance is very similar to the position Schelling attributes to passengers aboard the \textit{Titanic}. I have argued that those who are more risk-averse can pay a higher premium and be secured against a greater share of their health risks, while those who prefer to skimp on health insurance are free to do so. The cost of denying more comprehensive health care insurance, however, is the possibility of finding oneself in need of unaffordable health care and being abandoned to go down with the ship. Is this inequality unjust?

I am inclined to think that our objections to the situation aboard the \textit{Titanic} are primarily objections to the considerable background inequalities involved. The problem is not in the first instance that passengers in steerage were allowed to gamble with their lives in this way, but rather that they were sufficiently badly-off that such a gamble seemed appealing to them in the first place. (The misinformation passengers faced also appears objectionable; the \textit{Titanic} was supposed to be “unsinkable,” after all, and so perhaps passengers lacked adequate appreciation of the risks they were assuming.)\textsuperscript{39} If everyone aboard the \textit{Titanic} had been equally well-off \textit{ex ante} and adequately informed of the relevant risks, it is hard to see what would have been wrong


\textsuperscript{39}Satz, \textit{Why Some Things Should Not Be for Sale}, 86.
with an arrangement where some chose a riskier voyage for the sake of keeping more of their share of social resources for other purposes. People are allowed to take on risk in other areas of their lives for the sake of financial gain; no one thinks it objectionable that policemen or firemen risk their lives in the line of duty, for example, as long as their pay reflects this. And indeed, people are permitted to take considerable risks for the sake of mere enjoyment, as in sky-diving and mountain climbing.

Deborah Satz has recently argued that the situation aboard the Titanic is objectionable because it undermines the relation of equality among passengers. It gives some passengers the power of life and death over others, allowing them (for example) to push a third-class passenger out of the lifeboat and into the water if doing so is necessary to secure a place for a first-class passenger who is (supposedly) entitled to a seat. Satz argues that this power undermines or contradicts relations of equal citizenship. Differential protection against health risks might be thought to provoke a similar problem. If a person chooses less generous health care insurance than his fellow citizens, this gives his fellow citizens the power to “push him out of the lifeboat,” so to speak, leaving him to suffer (and perhaps die) from his uninsured health needs. (Or less dramatically, if moral, professional, or legal duties of rescue prevent physicians from denying emergency care, some citizens still have the power to allow others to fall into poverty or even bankruptcy because of expensive medical bills.)

We must be careful to formulate this objection carefully. Satz's objection is not simply that some people may have very expensive health needs for which society might then deny them care; this will be a problem on any account of justice in health care, as no society can afford to

provide all necessary health care. The objection is to the fact that some people will be treated differently with respect to the very same health needs. Those who purchased more comprehensive coverage will have their health needs met, while society may decline care to those who opted for a less generous plan. The objection, in other words, is not to “pushing people out of the lifeboat” per se, but to pushing some people out of the lifeboat but not others. It is this, Satz urges, that offends relationships of equal citizenship.

Satz is a bit unclear on whether relationships of equal citizenship require strict equality with respect to risk or merely a “floor,” a decent minimum of protection against risk, for all.41 If her view requires strict equality, then her view will be vulnerable to the levelling-down objection, promoting equality by worsening the lot of the better off. This would be like suggesting that the situation aboard the Titanic would be improved if no one had access to a lifeboat. This might be an improvement from the point of view of equality, but it would hardly be for the best, all things considered.

With respect to health insurance, at any conceivable level of security against health risks, there will always be some—the extremely health-conscious or risk-averse—who would prefer more. To prevent these people from purchasing additional health care out of their own resources would impose a very serious loss upon them, and to no clear benefit to anyone else. It would seem that we would need very weighty reasons to prevent them from doing so. There may of course be good reasons to prevent people from making private health care arrangements that undermine the basic tier of insurance, as I discuss momentarily, but it is hard to see a case for

41Ibid., 106. At the top of the page she suggests that relationships of subordination and servitude can be rectified by providing a “floor of of position, a (literal?) safety net,” but in the next two paragraphs she shifts to speak of the “equal provision of certain specific goods.”
denying citizens the right to purchase additional health care when doing so makes no one else worse off.

On the other hand, if Satz's relations of equal citizenship require merely a “floor,” a decent minimum of security for all, then I do not see this as an objection to my account. I have already argued that legislators will have to set up a floor of coverage in order to prevent problems of adverse selection, even if some may then purchase more comprehensive insurance above the floor. I argued in §5.2.2 that there is good reason to think that this floor will need to be generous enough to provide everyone with a decent minimum of care. If it did not, it would have little value to citizens and would probably not suffice to upset the dynamic of adverse selection for coverage above the basic tier, generating significant deadweight loss of its own.

As I said in §5.2, I think that all of these conclusions can be established without appealing to the paternalistic or perfectionist reasons we may have to prevent citizens from running certain kinds of risks, or for that matter the reasons we may have for refusing to abandon citizens to their fate when they choose to run certain risks and those risks turn out badly for them. Those who are moved by those sorts of considerations may have additional reasons to insist upon a higher level of coverage for all rather than a basic floor of provision from which citizens may “top up.” In an ideally just society, as I have noted, the cost of this will be a smaller share of other resources for the least advantaged to put towards their other projects, but some may find that an acceptable price to pay for greater equality in risk-bearing. As I have said, I think it is nonetheless significant that we can provide a justification for a decent minimum of health care without appealing to these more controversial moral ideals.
When setting up a two-tiered health care system, there are certain practical concerns that legislators should be aware of, particularly in a society marked by significant inequalities. For one, there is good reason to favour a policy where the rich have the option of “topping up” their basic health care insurance, but not the option of “opting out.” If the rich abandon the basic insurance plan and obtain all of their insurance through an alternative system, they will no longer have any incentive to make sure that the basic plan is adequate; indeed, they will have good reason to try to squeeze the minimum plan as much as possible to keep their own taxes down. Moreover, allowing people to opt out may generate a “cream skimming” problem, where the healthiest people (who tend also to be the wealthiest) buy health care on the private market, leaving only the sickest to the basic system, in this way making the basic tier a victim of adverse selection. The supplemental tier should not be allowed to undermine the operation of the basic tier, either financially or politically.42

There may also be concerns about equity of access to supplemental insurance. In wealthy liberal democracies with “two-tiered” systems, many people receive supplementary insurance through their place of work. This is often due to preferential tax treatment, but it is also because a workplace forms a natural risk pool, rather than one self-selected on the basis of risk. Those who wish to purchase supplemental insurance on an individual basis can for that reason expect to pay significantly more, again because the market for individual insurance will be prone to serious problems of adverse selection. For this reason, those with well-paying jobs with

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generous benefit packages may enjoy superior access to supplemental insurance, out of proportion even to the superior access their greater wealth allows. This may be an additional injustice that legislators should seek to correct through various avenues like risk adjustment.

These practical considerations aside, there would appear to be nothing intrinsically unjust about a two-tiered system. If designed properly, it may improve the situation of many while worsening the situation of none—allowing the more risk-averse to purchase more security without lessening the security of anyone in the basic tier. And indeed to prevent people from voluntarily contracting with others to pool risk or to purchase health care services beyond what is provided to all would be a significant interference with liberty, one that would require a very strong moral justification.43

5.2.5 On Institutional Forms

Nothing I've said here compels the choice of any particular institutional arrangement for the administration of health care insurance, for example, public single-payer insurance or private insurers or a mixture of public and private. Legislators may wish to set up their own health insurance program under the transfer branch, or they may prefer to regulate the private insurance market instead, or to pursue a combination of the two. Indeed, legislators may even choose to build hospitals and hire doctors to meet citizens' health needs directly. This can be seen as an indirect way of pooling health risks and thus of providing a kind of health care insurance—a sort of national managed care or Health Maintenance Organization (“HMO”). Which of these

43The Supreme Court of Canada wrestles with some of these questions in Chaoulli v. Quebec (Attorney General), 2005 SCC 35, Deschamps J.
options is preferable will depend in no small part on the public political culture of a given society. The essential thing is that the whole arrangement work to the greatest benefit of the least advantaged, so that their total expectations (wages plus transfers plus insurance) are maximized.

The efficiency argument for a single-payer system or indeed for socialized medicine would appear to be strong. A system of private insurers entails redundant administration, marketing, and underwriting costs, all of which are unnecessary from a certain point of view. A single insurer also has the ability to negotiate better prices with health care suppliers, keeping overall costs down, whereas a patchwork of smaller insurers will not enjoy that monopsony power. Moreover, by the nature of risk-pooling, a larger risk pool is more effective at reducing uncertainty. It is not clear that the benefits of robust competition in the insurance sector would outweigh these significant gains that a single insurer could realize.

Of course, these same sorts of considerations might lead legislators to think that they should forgo the administration of insurance altogether and simply hire doctors directly. But there may be more benefit from competition among health care providers than there is from competition among insurers. If health care providers are private entrepreneurs, they have reason to adopt new technologies and business practices to control costs and provide more effective service, whereas these incentives are not necessarily present with national managed care. At

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any rate, these are empirical questions, and ones that legislators should weigh carefully in
deciding the best arrangement for their society.

It is also worth noting that there is nothing in the nature of single-payer or socialized
medicine that precludes offering different levels of cost-sharing to different citizens. It might be
thought that the chief virtue of private health care insurance is that it allows individuals to
choose among different plans depending on their own level of risk-aversion, but in principle a
public system could do the same. It would appear that the choice between public and private
administration of health care insurance would depend primarily on considerations of efficiency,
and perhaps also on the political culture of a particular society. Public systems may be more
suited to solidaristic societies and private systems to societies with a more individualistic
culture, for example.

5.3 How Should Health Care Insurance Be Priced?

So far in this chapter, I have argued that Rawlsian legislators would have good reason to
make sure that citizens have access to insurance policies to cover risks, including health risks,
that pose significant threats to a person's ability to form, revise, and pursue a rational plan of
life. I have argued that it is not unjust to force citizens to purchase insurance against these risks
if it is necessary for the functioning of the insurance scheme as a whole. In defining minimum
health insurance benefits, legislators should do their best to maximize the ability of the least
advantaged to effectively exercise their two moral powers, including the power to form, revise,
and pursue a conception of the good.
It remains to be considered how health insurance should be priced. In the previous sections, I assumed that all individuals face the same expected health needs ex ante. In that case, there is no special problem about how insurance should be priced. Holding constant that the expectations of the least advantage are maximized, everyone should simply pay the expected value of their health insurance plan. In the case of a less-than-fully-just society, on the other hand, we would have extra reason to provide special subsidies to the poor, as a way of raising their expectations overall. The essential point is that the price of insurance should work in conjunction with the rest of the price system and with other social institutions to maximize the expectations of the least advantaged.

In the real world, however, individuals do not all face the same expected health care costs. Some people can expect to have more expensive health needs over their lives, due either to a genetic or otherwise natural predisposition to some costly disease or to behavioural choices that impose significant health risks. We must ask whether it is fair if the price of insurance varies with these ex ante differences in expected cost.

5.3.1 Actuarial Fairness

Think back to the example of an insurance pool for shipwrecks developed in §3.2. There, each person expected to pay a premium that was equal to the expected value of her loss—the 20% chance of a $100,000 shipwreck has an expected cost of $20,000, and the cost to each member of the insurance pool converged over many trials on $20,000. (I set aside here the costs of administering the scheme). An insurance scheme is *actuarially fair* when the premium paid is
equal to the individual's expected loss; in other words, an actuarially fair insurance plan has an expected net payout of zero.

Suppose now that someone proposed to join the risk pool with a ship that was twice as likely to sink, or perhaps with a ship that cost twice as much to replace. This person exposes the pool to a loss with an expected value of $40,000. It seems fair—not only actuarially fair, but fair *simpliciter*—that she should pay a correspondingly higher rate; i.e., her premium should be set at $40,000 rather than $20,000. Otherwise she would be shifting the cost of her greater expected loss onto the other members of the pool. Applied to health risks, this line of reasoning pushes us toward the conclusion that each person should pay the true expected cost of their health care. Those who have higher expected health costs, whether by choice or by nature, should pay correspondingly higher premiums.

### 5.3.2 On Chosen Risks

When it comes to voluntarily chosen behaviours that lead to great health risks, the theoretical argument for internalizing those costs is impeccable. It is unfair that someone should be able to shift the costs of their chosen behaviours onto others, and charging equal premiums between those with risky and non-risky lifestyles would entail just that. It is also possible that providing citizens with insurance against health risks will lead citizens to engage in more risky behaviours than they otherwise would, generating problems of moral hazard and raising the costs of insurance beyond where it would otherwise be; charging differential premiums based on

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47 Heath, “Reasonable Restrictions on Underwriting,” 132.
differences in chosen risks can prevent this from happening. Thus both fairness and efficiency speak in favour of charging higher premiums to those who engage in risky behaviours.

In practice, however, there are limits to how far this can succeed with respect to health care insurance. For one thing, when it comes to most differences in behaviour, the costs of assessing and pricing them would not be worth the benefit. For example, a hermit probably faces marginally lower risk of communicable disease or accident than a socialite, but the costs of monitoring these kinds of individual behaviours for the sake of underwriting insurance policies would be so expensive that probably no one could expect to come out a winner. (This is to say nothing of the serious privacy concerns such monitoring would raise.)

For that reason, it is probably preferable to attach costs to especially risky behaviors at the point of use, rather than trying to do risk-adjustment through the insurance system. Adding a health tax to each pack of cigarettes or each ski pass would be less costly and less intrusive than monitoring each individual's behaviour, and the funds could be used to support the health care system as a whole. Of course, if legislators start down this road, it is important that they apply such taxes fairly and consistently. Often these kinds of taxation are driven by quasi-moralistic objections to certain behaviours (or indeed by sheer paternalism) rather than an impartial assessment of the costs those behaviours impose on the health care system. For example, the conceit that smokers impose greater costs on the health care system is almost certainly false. In the long run, smokers probably save the health care system money by dying sooner than non-
An impartial assessment of the expected health costs of certain behaviours might well offend the citizenry.

5.3.3 On Natural Inequalities in Risk

Things look somewhat different when it comes to natural differences in health risks. Neither of the considerations that speak in favour of differential pricing for chosen risks speaks in favour of differential pricing for natural risks. Charging more to people born with expensive health risks would not prevent moral hazard, since by definition these differences are beyond human control. And while there are good reasons grounded in fairness and efficiency for making people bear the costs of their choices, natural inequalities are not chosen.

That said, it does not follow from the fact that individuals are not responsible for their natural health inequalities that therefore society is responsible. It may be simply that no one is responsible, and that these losses (or these risks) should simply lie where they fall. A Rawlsian view might seem to compel this position, since Rawls argues that natural inequalities per se do not call for redress (§1.3.2). To charge equal premiums to people with different levels of natural health risks is to force the healthy to subsidize the sick, and in this way it might be thought to violate the requirements of Rawlsian justice.

In this respect it is important to remember that while Rawls's view does not require the redress of natural inequalities, it does require that the social system neutralize the effects of

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natural inequalities on the distribution of the cooperative surplus. This is significant because risk-pooling itself is a form of social cooperation. This brings natural health inequalities within the scope of social cooperation, and so these inequalities, too, should not influence the distribution of the cooperative surplus.

To be clear, Rawls's view does not require that each transaction considered in isolation, such as the purchase of insurance, should conform to principles of justice. What Rawls's view requires is that the whole social system work to the greatest benefit of the least advantaged. Viewed in that light, the relevant question is whether a social system that charges actuarially fair premiums would be of greater benefit to the least advantaged on the whole than a system that charges individuals the same premium to all, regardless of their expected health care costs.\(^4\) (A health insurance scheme that charges the same price to all, without medical underwriting, is said to practice “community rating.”) We do not need to concern ourselves with the intrinsic fairness (or unfairness) of redressing natural inequalities.

Offhand, it seems unlikely that an actuarially fair pricing scheme would be more advantageous to the least advantaged than a scheme that charges the same rate to all. For one thing, as we have already seen, the efficiency considerations that speak in favour of differential pricing for chosen risks do not speak in favour of differential pricing for unchosen risks. For another, medical underwriting practices are expensive. One benchmark estimated that underwriting practices in the United States in 1999 (i.e., prior to the PPACA, when medical

\(^{49}\)In Daniels's article on Insurability and the HIV epidemic, he argues against actuarial fairness on the grounds that Rawls's view prohibits people from profiting from their natural endowments. Strictly speaking this is wrong; Rawls's view prohibits people from profiting from their natural endowments in ways that do not redound to the benefit of all. Norman Daniels, “Insurability and the HIV Epidemic: Ethical Issues in Underwriting,” *Milbank Quarterly* 68.4 (1990): 506.
underwriting was more common) cost Americans about $260 per capita, compared to only $47 per capita in Canada, in PPP-adjusted 1999 dollars.\(^{50}\) This is a significant cost, and without any clear social benefit, let alone any clear benefit to the least advantaged. Finally, the least advantaged tend to have more expensive health needs than those in higher income brackets; thus actuarially fair premiums would arguably disproportionately burden the least well-off rather than working to their advantage.\(^{51}\) It is true that community rating exacerbates problems of adverse selection, but that problem has already been solved by making health care insurance mandatory.

This is not to say that there is no justification for charging differential health premiums, but these justifications will not turn on different levels of natural health risk. For example, the PPACA allows insurance providers to charge different rates to customers in different age brackets. This does not seem unjust, insofar as these differences would affect all citizens equally over the course of a complete life. Moreover, since on average older people are wealthier than younger people, this pricing scheme is arguably more equitable than charging individuals the same premiums over their whole lives.

\subsection*{5.3.4 What About the Very Sick?}

There are of course limits to how far this argument regarding natural inequalities can be pushed. Some people are born with disease or disability so severe that they are unable to be participants in social cooperation at all, either because they lack the moral capacities for a

\begin{thebibliography}{9}
\bibitem{50}See Steffie Woolhandler et al, “Costs of Health Care Administration in the United States and Canada,” 768.
\bibitem{51}Canadian Institute for Health Information, \textit{Lifetime Distributional Effects of Publicly Financed Health Care in Canada}, 8.
\end{thebibliography}
conception of the good and a sense of justice or because they lack the physical capacities to engage in social life.

We might say that these persons can participate in social cooperation in a limited sense, by (for example) refraining from violating the basic liberties of others or even by pooling (or acquiescing in the pooling) of their health risks with others. This would provide a rationale for allowing them to share in the benefits of social cooperation, including enjoying access to health care insurance (and thus health care). I think this strategy should be resisted, however, and not only because it rests on a false premise. If a society assigns lexical priority to the interests of persons least well-off in this sense, it could end up spending its entire GDP on that one group (or indeed on just one person).

It is appropriate instead to plead beneficence for these kinds of cases. A decent society should provide the seriously ill and persons with severe disabilities a decent life, including access to health care, not because it would be unfair to refuse but because it would be inhumane.

Once we have a national health care system in place, it can be used to promote a variety of worthwhile ends. It can be used to realize public goods, as when the system is used to distribute vaccinations or disseminate education about good health practices. It can be used to promote equality, by transferring resources from rich to poor. And it can be used to care for those who cannot care for themselves. But the reason for setting up such a system in the first instance is to protect citizens against risk.
5.4 Conclusion

In this chapter, I have argued that security from risk should be included under Rawls's primary good of income and wealth, serving as it does to make citizens' expectations of income and wealth more secure. In a liberal society, legislators should strive to give citizens maximum flexibility to tailor their individual insurance portfolios to their own particular tastes and ambitions, but the problem of adverse selection makes this impossible with respect to many significant risks that citizens face, including health risks. Thus I have argued that legislators have reason to make the purchase of health care insurance mandatory, and they should design the basic health care package with an eye toward the development and exercise of the moral powers of members of the least advantaged group. Finally, I have argued that there is nothing intrinsically unjust about forcing citizens to pay the costs of chosen health risks, but that insurance policies should not be priced to reflect unchosen differences in risk.
Chapter 6: Conclusion

The central aim of this dissertation has been to show that uncertainty, not inequality, drives the central problems of justice in health care. Inequality is significant, of course; if individuals did not have unequal expected health needs over their lives, there would be no problem of adverse selection in private insurance markets and thus there would be no market failure. But what generates the problem of adverse selection is not merely that different people have different expected health needs; it is rather that there is no way for insurers—indeed, no way for anyone—to know with certainty what a particular person's health needs will be.

In the absence of uncertainty, there would be no special problem of justice in health care. There might be grounds for redistribution, i.e., grounds for compensating those with expensive health needs in the form of cash transfers or, if we are moved by the worry that those individuals might not spend their money properly, in the form of vouchers that can only be redeemed for health care. But there would be no need for anything like the level of state involvement in the health care sector that we see throughout the developed world. There would be no need for states to run a national health care or health care insurance system, no need to ensure that access to health care is distributed according to medical need, and no need to worry that access to care is distributed in isolation from other social goods. In the absence of uncertainty, health care could be treated like any other basic need. Or at least so I have argued.
Rather than summarize those arguments here, in closing I would like to consider the implications for my account if this uncertainty regarding health needs were eliminated. As we learn more about the human genome and about the other causal factors underlying various diseases, it is not initially implausible to think that someday soon the genetic “veil of ignorance,” so to speak, will be lifted, and it will be possible to predict with great accuracy a person's future health needs. If the uncertainty that has so far been distinctive of health needs is removed, would this render my account of justice in health care obsolete?

I believe this objection is mistaken in assuming that the only uncertainty surrounding health needs is uncertainty regarding whether a person will get sick. Uncertainty in health care obtains along a number of dimensions, and it seems to me unlikely that this will change in the near future.

First, even restricting ourselves to that form of uncertainty in health care that has to do with whether a person will get sick, it is far from clear that this uncertainty can be completely eliminated. It is true that some forms of disease and disability are genetically determined, but in many cases what genes provide is a mere predisposition to a certain disease. These predispositions may interact with behavioural or environmental factors in ways that are themselves difficult or impossible to predict. This is to say nothing of communicable diseases; previously unknown viruses like HIV can emerge suddenly and, one presumes, unpredictably, and this on top of the uncertainty surrounding whether one will contract a familiar but nonetheless costly infection. And of course some very costly health needs arise from accidents that are impossible to predict, like falling down a flight of stairs.
In addition to the uncertainty surrounding whether one will get sick, there is also a considerable amount of uncertainty surrounding what it might cost when one does. Partly this is due to special features of the market for medical care, like the absence of overt price competition, the uncertainty on the part of the patient surrounding the quality of the service, and the considerable price discrimination that obtains wherever prices are not fixed or negotiated by a single purchaser.¹ This means that prices for the very same service can vary widely from case to case. A 2012 study found, for example, that the cost of an appendectomy in California in 2009 ranged from just over $1,500 to over $185,000, depending on where it was performed.² Significantly, this study considered only uncomplicated cases of appendicitis, with patients between 18 and 59 years old, in hospital for fewer than four days, and who received routine discharges to home; thus the study bracketed the additional uncertainty about cost that follows on the risk of complications.

But the risk of complications is enormous, and introduces even more uncertainty into the cost of care. How much it may cost to treat a particular condition will depend in large measure on what other conditions the patient suffers from and how these interact over the course of treatment. On top of that, of course, other complications may arise during the course of treatment, like opportunistic infections or other unexpected problems. A recent article in the New York Review of Books gives a first-person account of some of these uncertainties. It tells the story of Arnold Relman, a physician in his nineties, who fell down the stairs at home and broke his neck. The fractured vertebrae were but part of the story; due to some combination of his


²Renee Y. Hsia et al., “Health Care as a “Market Good”? Appendicitis as a Case Study,” Archives of Internal Medicine 172.10 (2012).
advanced age, his many chronic health problems, and the severity of his fall, Relman required (among other things) an emergency tracheotomy to insert a breathing tube, CPR leading to several cracked ribs, multiple catheterizations of various sorts, and a feeding tube. At the end of the day, Relman's insurer was billed a total of just over $400,000 for his stays in two different hospitals. Of that princely sum, his insurer ultimately paid $332,000; Relman himself paid but a few hundred dollars in co-payments. Given Relman's advanced age, it is perhaps not surprising that a major accident like this would lead to serious complications, but it is hard to see how these particular complications, and the treatments and costs they made necessary, could have been known in advance.

In health care there is also uncertainty on the part of the patient regarding the quality of the service. Patients do not typically know enough about medical science to know what kind of care they need, or the likely effects of such care on their health and welfare. I already mentioned that this kind of uncertainty can contribute to uncertainty about the cost of medical care, but it also affects the health care system in other ways not previously touched on in this dissertation. It probably explains, for instance, why the state takes such an active interest in the training and licensing of physicians. It probably also explain the important role that professional organizations like the Canadian Medical Association play in establishing codes of ethics and the appearance (if not the fact) of a concern on the part of the physician for the patient's welfare over her own self-interest. These considerations have little to do with insurance per se, but they


are nonetheless important ways that uncertainty leads to state involvement in the health care sector.

Finally, another significant element of uncertainty in health care is uncertainty about whether a treatment will be available at all. If I knew today, for example, that I was certain to develop a fatal and presently untreatable condition, even this would not eliminate the uncertainty I face surrounding my future health needs. A treatment may be developed in my lifetime; this stroke of good luck may save my life, but it may also cause my expected health care costs to skyrocket.

It is worth digressing for a moment to point out that a theory of justice in health care that takes the reduction of uncertainty to be the central aim of the health care system can readily explain why a society ought to invest in the research and development of new and better therapies. It is not immediately clear that the rival egalitarian picture can do so. If the central problem of justice in health care is taken to be the problem of equalizing access to medical care, conditions for which there are no treatment are in some sense the least troubling of all; it is guaranteed from the start that access to care will be equal in those cases. Of course, it is possible for egalitarians to supplement their theory with additional principles to address these concerns, but this would appear to be somewhat ad hoc.

In all these ways, then, I would suggest that uncertainty surrounding people's future medical needs is unlikely to be eliminated anytime soon, even assuming that the uncertainty surrounding individuals' genetic predispositions is eliminated. For that reason, I expect that insurance will continue to be beneficial for citizens.
What is less clear is whether these other forms of uncertainty that I have glossed are sufficient to generate the problem of adverse selection. If we assume that uncertainty surrounding people's genetic endowments is eliminated, the remaining forms of uncertainty I have identified—uncertainty surrounding accident and communicable disease, surrounding the potential for complications, the costs of care, and the availability of treatment—all seem likely to be fairly evenly distributed over the population. Thus even though individuals will continue to face significant uncertainty surrounding their actual health care costs ex post, there may be little uncertainty surrounding an individual's true expected health costs ex ante. If that is right, then my rationale for mandatory insurance falls apart. There would be no market failure to correct, and thus no non-paternalistic reason to force citizens to purchase health care insurance.

I am not yet prepared to concede this. Even assuming full knowledge of individuals' genetic endowments, environmental and behavioural factors are likely to influence individuals' expected health needs in ways that are not likely to be evenly distributed throughout the population, leading to uncertainty about a person's true expected health needs. Moreover, there may be good privacy-related reasons why information about individuals' genetic endowments should not be made available to governments or insurance underwriters.

In 2008 in the United States, for instance, George W. Bush signed the Genetic Information Nondiscrimination Act, which prohibits employers and health insurers from discriminating on the basis of genetic information.\(^5\) In part, the act was motivated by concerns that individuals would refrain from undergoing medically beneficial genetic testing for fear that

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\(^5\) Genetic Information and Nondiscrimination Act, U.S. Code 42 (2008), §2000ff et seq.
it would be used against them in the insurance marketplace. But even bracketing such concerns, one can easily imagine other reasons why such information should be kept private, being so central to a person's sense of self.

That being said, let us indulge the hypothetical and suppose that genetic testing eliminates all of the uncertainty regarding individuals' true expected health needs over their whole lives. There may still be at least two non-paternalistic reason to force citizens to carry health care insurance. It is likely that in a world where the purchase of health care insurance is optional, many citizens will be inclined to wait until they become or are soon to become sick to shop for insurance. This may undermine the sustainability of the insurance system, by making the risk pool much sicker on average than the population at large. This may make it difficult for healthy but risk-averse individuals to obtain health care insurance. How far this is true will depend not just upon how accurately we can predict each particular person's expected health needs in general, but how accurately we can predict such needs at the exact moment when they enter the insurance market.

A second reason has already been mentioned. Insurance underwriting practices are very expensive. While it may be possible to predict each person's expected health needs accurately and then price insurance plans accordingly, thereby solving the problem of adverse selection, to do so would require a considerable investment of resources, at least under present conditions. It may be that in the future genetic testing becomes not only much more accurate but also much cheaper, but that is a further step in the argument. It may well be that the costs of performing all

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of these tests outweigh the benefits, and all things considered it is more advantageous for society at large and from the point of view of the least-advantaged to force citizens to purchase health insurance rather than to devote so many resources to underwriting. It is not clear that the value to citizens of the economic liberty to decline health care insurance would outweigh the costs of that liberty.

Thus there may be additional reasons to force citizens to carry health insurance even if the uncertainty surrounding future medical needs is eliminated. If these arguments fail, then it may be necessary to revisit the paternalistic or perfectionist reasons we may have to force citizens to carry health insurance. Again, even in a world where the genetic “veil of ignorance” is lifted, individuals will still face a great deal of uncertainty surrounding their own health needs over a complete life, and so insurance will still be a great benefit to citizens. It is only the non-paternalistic rationale for mandatory insurance that is undermined by this eventuality. If and when this eventuality comes to pass, at that point we may wish to revisit the more controversial paternalistic and perfectionist arguments for mandatory insurance. But that point has not yet come.

In this dissertation, I have argued that the appealing pattern of health care delivery we see in the rich world, which includes distributing access to health care according to medical need and in isolation from other goods, paying for medically necessary health care but not for all of a person's health needs, and providing medically necessary treatment but not biomedical enhancement, is best justified by the importance of providing citizens with insurance against health risks rather than the desirability of equalizing health outcomes. Insofar as theorists of health care justice find this pattern appealing, they would do well to make room in their theories
for health care insurance. I have argued further that the importance of securing the significant cooperative benefits that come from pooling health risks against the dynamic of adverse selection provides a sufficient non-paternalistic rationale for making the purchase of a decent minimum of health care insurance mandatory. Dispensing with that latter argument, however, does not undermine my claim that the pattern of health care distribution we see in the developed world is a pattern of indemnity, not equality.


Baicker, Katherine and Amitabh Chandra. “Medicare Spending, the Physician Workforce, and Beneficiaries' Quality of Care.” *Health Affairs* online (April 2004). Accessed 19 September 2013. 


