

Equality of Opportunity versus Sufficiency of Capabilities in Healthcare

Efrat Ram-Tiktin^{1*}

¹ Department of Philosophy, Bar-Ilan University, Ramat-Gan, Israel

* Efrat Ram-Tiktin, E-mail: Efrat.Ram-Tiktin@biu.ac.il

Abstract

This paper compares three accounts of distributive justice in health and, more specifically, healthcare. I discuss two accounts—Norman Daniels’ fair equality of opportunity for health and Shlomi Segall’s luck-prioritarian equity in health—and contrast them with a sufficientarian account based on sufficiency of capabilities. The discussion highlights some important theoretical differences and similarities among the three accounts. The focus, however, is on the practical implications of each account in three hypothetical cases: synthesized growth hormone for short children, forms of compensation for paraplegics, and reconstructive breast surgery versus cosmetic breast enhancement. My aim is to show that by replacing egalitarian concerns with sufficiency and by focusing on capabilities (rather than opportunities), it is possible to provide a more reasonable and justifiable account of justice in healthcare.

Keywords

fair equality of opportunity, luck-prioritarianism, sufficientarianism, capability, healthcare

1. Introduction

1.1 Three Possible Alternatives to Outcome Equality in Health

When should inequality in health be considered unjust (Note 1)? In the broadest sense, it is *always* unjust when individuals have different levels of health and accordingly we should strive to achieve *outcome equality in health*. Such a position is not only subject to the well-known objections of “leveling down” (Note 2) and the “bottomless pit” (Note 3), but in general will produce demands that are impossible to meet.

According to more practical positions, not all health disparities should be considered unjust, but rather only those that are the outcome of unequal opportunity in health. The advocates of such positions must then define the threshold conditions that satisfy this criterion. Norman Daniels (2008) views health as a fundamental condition that allows an individual to pursue her life plans. The more an individual is burdened by illness, disability, or lack of function, the more limited will be her ability to achieve her goals. The health status of an individual is affected by multiple factors, such as genetic disposition, environmental factors (access to clean air, water, food, etc.), and social-cultural norms that may lead to

the adoption of risky or unhealthy behavior. Daniels contends that the only cases that should be considered violations of equal opportunity in health are those that stem from social arrangements affecting those factors. Therefore, if two individuals have different levels of health and the sole reason is their genetic profiles (and assuming these profiles have not been affected by a social policy such as the unequal distribution of genetic enhancement), then those differences should not give rise to claims of injustice. In section 3, I will explain Daniels' view on this matter more thoroughly.

Luck-prioritarians adopt a broader definition of the threshold conditions for equal opportunity in health. Shlomi Segall (2010), for example, claims that unequal opportunity in health is not simply manifested in certain social circumstances, but is also the result of genetic profiles. The realm of justice, according to luck-prioritarians, includes all instances in which brute luck negatively affects an individual's state of affairs (Note 4). Since an individual's genetic disposition is a matter of brute luck, a theory of justice in health must address genetic disparities and provide compensation for those disadvantaged by factors beyond their control. However, when differences in health status are matters of option luck, they should not be regarded as matters of injustice in health (Note 5).

These two alternative approaches to outcome equality in health avoid the unreasonable demands of outcome equality by opting for the more moderate demand of equal opportunity. I wish to present a third alternative according to which the scope of justice in healthcare is narrower and includes only instances in which individuals lack a sufficient level of health. In contrast to the two alternative versions of equality of opportunity in health, differences in the level of health between two individuals that are the result of social arrangements or genetic variations will only be considered unjust if at least one of the individuals is beneath a defined sufficient level of health.

In this paper, I will not attempt to provide a justification for the doctrine of sufficiency; rather, I will postulate a specific concept of justice in healthcare, namely, *sufficiency of basic human functional capabilities* (henceforth, sufficiency of capabilities or SOC). Using three hypothetical cases, my goal will be to show that SOC is able to provide more plausible criteria for determining: (a) which cases ought to be regarded as matters of injustice in healthcare, and (b) what kind of compensation should be offered.

Since SOC is less familiar than the rival accounts, I will devote the following section to elucidating it. In section 3, I will critically discuss Daniels' fair equality of opportunity account and counter it using SOC. In section 4, I will describe Segall's luck-prioritarian account and how it overcomes some of the disadvantages of Daniels' account and will claim that SOC provides a better method for evaluating health equity.

2. A Brief Introduction to SOC

In this section, the notion of SOC will be presented in order to show that efforts to address injustice in the distribution of healthcare can be more precisely targeted if: a) the objective is to achieve sufficiency rather than equality of opportunity or luck-prioritarian distribution, and b) focus is placed on capabilities rather than opportunities. The details of this theory and the arguments in its support have already been presented elsewhere (Note 6) and therefore I present only highlights of SOC in order to contrast it with the other two accounts. In order to explain why I chose the notion of capabilities and embrace the main features of Sen-Nussbaum's capability account, the following three points will be made: First, I contend that a theory of justice is about providing individuals with positive freedoms and that this objective would be better served by focusing on capabilities rather than opportunities. Second, I will show why the notion of capabilities is intuitive in the discussion of justice in healthcare. Finally, I will present an argument that justice in healthcare can be attained if we aim for sufficiency of capabilities rather than equality. At the end of the section, I will present a general prescription for delineating the sufficiency threshold.

Sen and Nussbaum's capability approach focuses on human life, i.e., on the multiple possible combinations of functioning that we are able to achieve (Note 7). Therefore, unlike theories that focus on resources as the currency of justice, the capability approach concentrates not on the "means of living" but on the "*actual opportunities of living*" (Note 8). It stresses the central role of freedom in individuals' lives and the ability not only to choose freely but also to *act* freely in order to pursue life plans. As Nussbaum (1988, 1992) claims, choice is not only pure spontaneity, and human flourishing is not possible without material and social conditions. Therefore, in order to guarantee individual autonomy, attention cannot be limited only to negative autonomy (i.e., the conditions and requirements of not interfering with others' autonomy) and positive autonomy must be guaranteed as well. In other words, one must provide the material conditions and develop the capabilities that allow individuals to pursue their life plans. An individual's set of capabilities determines her ability to realize chosen goals and ambitions in life. The more capabilities an individual possesses, and the more developed they are, the greater will be her ability to pursue life plans and live a dignified and flourishing life.

In a sense, an individual's capabilities reflect her opportunities, though the two are not identical. As Sen (2009) explains, we need to distinguish between two understandings of the opportunity aspect of freedom: one which focuses on the actual state of affairs the individual ends up with, and another which has a broader scope and focuses not only on what the individual actually has achieved (the opportunities she exploited) but also on the *manner* in which it was achieved. For example, how many options did she have to choose from? Was her choice a reflection of an authentic decision, not dictated by others? How active was she in realizing her opportunities (Note 9)? The notion of capability focuses on the broader opportunity aspect of freedom, and, according to my understanding of the Sen-Nussbaum account, it emphasizes the importance of the deliberate and active embracement of an

opportunity and the effort the individual invests toward its realization.

I wish to suggest that capabilities constitute a more precise currency than opportunities. In Section 3 and 4, I will demonstrate why this is so, and present problematic features of the concept of “opportunity”. However, for now I will simply provide a general outline. As Cohen claimed: “your opportunities are the same whether you are strong and clever or weak and stupid: if you are weak and stupid, you may not use them well—but that implies that you have them” (1989, pp. 916-917). On the other hand, I would add that if we focus on capabilities, then we are referring to what individuals *de-facto* are able to do and to the extent that their ability allows them to do it.

Besides the theoretical advantages of the Sen-Nussbaum account discussed above, which support my position that capabilities should be the currency of justice, I think that in discussing justice in health and more specifically in healthcare, to focus on capabilities is quite intuitive. However, a careful distinction needs to first be made between health and healthcare. Health is a broader notion and includes multiple factors affecting our health, such as genetics, education, work environment, road safety, access to clean water, air and food, and proper medical care (Note 10). In other words, the term “health” includes a large number of variables that differ in nature from one another. Healthcare, on the other hand, relates only to medical interventions such as cure, prevention, rehabilitation, and so forth. Health relates to the operation of various state institutions, among them those that allocate healthcare. Therefore, the sphere of health deals with many sub-issues of justice, one of them being the just distribution of healthcare. I wish to stress that SOC addresses the issue of just distribution of healthcare alone, not the allocation of the multiple variables affecting human health.

Conceptually, health resides on two levels: physiological and social-cultural-political (Note 11). On the physiological level, the concept of health is value-free, i.e., normatively neutral, and can be defined as *the presence of a normal species structure and/or function relevant to the individual reference group (sex and age)*. On the social-cultural-political level, the concept of health is value-laden and consists of normative judgments. It can be defined as *an expression of physiological and psychological capabilities that advance the goals of individuals in their social environment*. As summarized in these definitions, a state of health can be viewed as normal species function or, simply put, capabilities. Therefore, the primary goods of healthcare are basic human functional capabilities. These can be divided into nine key systems: thinking and emotions, senses, circulation, respiration, digestion and metabolism, movement and balance, immunity and excretion, fertility, and hormonal control. The purpose of this classification is to distinguish between capability systems that are responsible for different functions. Though it is an artificial classification, and there are interactions and mutual influences between each system, such as, for example, between circulation and respiration, it suits my purpose, which is to differentiate between capabilities that address different functional aims (Note 12). Contrary to other contributors to the capability approach, I present here a specific list of concrete capabilities that are the currency of justice in healthcare. Nussbaum’s theory of justice encompasses the

various components of life and goes well beyond just health. Therefore, her list of ten central human capabilities is too broad to form the basis of a theory of distributive justice in healthcare and cannot provide specific guidance for the health policy planner. Sridhar Venkatapuram (2011) develops Sen and Nussbaum's capability approach. He describes the capability of being healthy as an individual's ability to exercise a cluster of basic capabilities and functions at a level that constitutes a life worthy of human dignity, as it is perceived in the modern world. The capability to be healthy, according to Venkatapuram, is a meta-capability, i.e., the capability to achieve or exercise Nussbaum's ten central human capabilities. As a meta-capability, it relates to various factors that affect human health, such as genetics, possible exposure to external pathogens, social-material circumstances and norms, etc. Despite his important contribution to the literature on health justice and the capability approach, Venkatapuram's account is too general and too broad to provide guidance for the policy planner whose specific task is to arrive at a just distribution of healthcare among various groups of individuals with various types of malfunctions and levels of health. My intention in the following sections is to show that by using a specific list of basic human functional capabilities as the currency of justice we can more accurately identify the *kind* of cases for which a claim of injustice in healthcare can be made. In addition, this list will serve as a better guide in determining what *form* of compensation should be taken.

After discussing briefly why a theory of justice is required in order to guarantee positive freedom, and why this can be done better by focusing on capabilities, I want to present an argument that such a theory should strive for sufficiency rather than equality of capabilities or equality of opportunity in health. First, equality has no intrinsic value in health or in healthcare. The fact that two individuals have the same level of physical capability or function is not important in itself. However, it may have a derivative value, which is dependent on whether their capability or function level broadens or narrows their positive freedom, or in other words, what their capability level allows or restrict them from doing. Second, even if equality or equality of opportunity has extrinsic value and an instrumental value in health (or in healthcare), we still need to determine when inequality on the descriptive level (the different positions of two individuals along an axis of some functional capability) is accompanied by a negative normative evaluation that gives rise to legitimate claims of injustice. In other words, if the descriptive difference also implies that one of the two individuals is normatively worse off (health-wise) than the other, justice requires that she be compensated. In view of some of Harry Frankfurt's (1988) concerns about sufficiency, I claim that only when an individual is beneath the sufficiency threshold of some functional capability can we point to a *qualitative* disadvantage in her state of affairs that gives rise to justified claims of injustice. Being beneath a sufficiency threshold means that the individual to some extent lacks a functional capability, a situation that limits her positive freedom.

On the other hand, if someone (call her A) is above the sufficiency threshold, she has at least the minimal physical ability to exercise her positive freedom. That would be true even if there is another person (call him B) who is located well above A in terms of that capability. Thus, although B may be in

perfect physical condition, while A is not, A is nonetheless above the threshold. The quantitative difference between them does not in itself indicate that there is a qualitative difference in their ability to live a decent life. It is true that B might have a better life (or will reach a higher level of achievement) than A, and in that regard A is worse off than B; but, as long as A is above the threshold, she doesn't suffer from any disadvantage that limits her positive freedom in a way that justifies a legitimate claim of injustice. Providing A with compensation for being worse off than B is not a matter of justice (Note 13).

The key task is to define the sufficiency threshold that represents a qualitative dividing line between the better-offs and the worse-offs, where the latter have a legitimate claim of injustice. In order to decide whether someone lacks a basic capability or has an impaired capability that negatively affects her ability to live a good life, there are two questions to be asked: First, is the person's capability within the normal range of values for her reference group? Second, does the deviation from normal values create a burden on the individual in exercising her positive freedom and fulfilling her life plans? The sufficiency threshold is determined at the point where a lack of capability negatively affects the individual's ability to exercise her positive freedom and reach her goals.

To illustrate, consider the threshold level for fertility in males. Normal levels of sperm cells in adult males are in the range of 20-150 million per ml. Males with less than the lower bound are considered to have decreased fertility. Those values take on a negative normative meaning if fertility in males is valued in a given society. In other words, the threshold level of sperm cell count is 20 million per ml and only males below that level can present claims of injustice. This does not mean that we should force treatment on every man located beneath the threshold, but rather that treatment should be provided to those whose life plan includes the wish to have offspring (Note 14). By compensating or treating a male with low fertility, we enhance his positive freedom and provide him with one of the necessary biological conditions to fulfill his goals.

Thus, according to SOC, cases of injustice in healthcare do not exist simply as the result of different levels of basic human functional capabilities, but rather when positive freedom is narrowed in a substantial way, thus placing individuals below the sufficiency threshold. Legitimate claims of injustice can be presented only by those who are located (or might possibly fall to) beneath the sufficiency threshold. Once an individual's health is insufficient, there is moral value in providing compensation in order to raise her to at least the threshold level. Our objective should be to provide treatment (or compensation when there are no treatment options) to the worse-offs and to elevate them to the threshold level. More specifically, justice in healthcare is about providing the basic human functional capabilities needed for every person to exercise their positive freedom and to fulfill their life plans. It is worth emphasizing that when an individual is deciding on her life plan and goals, she ought to consider her given set of capabilities and, if she feels that one or more of them is deficient, she needs to also decide whether it is justifiable to demand that society provide her with treatment or compensate her for

the shortfall (Note 15).

In the next section, I will compare SOC to the fair equality of opportunity and luck-prioritarian accounts of justice in healthcare (Note 16).

3. Daniels' Fair Equality of Opportunity in Health

According to Daniels (2008), inequality in health is unjust whenever individuals with similar genetic dispositions do not enjoy Fair Equality of Opportunity (FEO) in health. My dispute with Daniels' position rests on our different responses to the following two questions: (1) Should the currency of justice in health be capabilities or opportunities? (2) Which is the just pattern of distribution: sufficiency or FEO?

Daniels elaborates on Rawls's principle of *justice as fairness* as it applies to health. He views health as strategically important in an individual's pursuit of her life plans. The absence of health "reduce[s] the range of exercisable opportunities from which individuals may construct their 'plans of life' or 'conception of the good'" (p. 35). According to Daniels (who is influenced by Christopher Boorse's bio-statistical view), "health is the absence of pathology", and pathology should be understood as "departure from normal [human] functioning" (p. 37).

When viewed as normal human functioning, health is related to an individual's "normal opportunity range", which is a socially relative notion. The normal opportunity range is "the array of life plans reasonable persons are likely to develop for themselves" (p. 43) and is influenced by a society's history, level of wealth, technology, etc. Given the connection between health and life's opportunities, Daniels applies Rawls' second principle, i.e., FEO, to the allocation of healthcare.

As Daniels himself points out, Rawls's principle is much narrower, focusing on the allocation of offices and jobs (Note 17). Accordingly, positive steps ought to be taken to broaden the career opportunities of those disadvantaged by social factors and family backgrounds. Daniels' attempt to apply that principle to health leads to a notion of the normal opportunity range that is both broader and vaguer. It is more difficult to determine what kind of health deficits negatively affect an individual's normal opportunity range than it is to determine what factors interfere with FEO in the case of employment. For example, should we view short stature, dyslexia, infertility, unwanted pregnancy, or hirsuteness as narrowing one's opportunity range? And if we do, why should such conditions be regarded as health deficits?

As indicated by the discussion so far, the objective of Daniels' FEO is not very different from that of SOC (Note 18). Both strive to guarantee the ability of an individual to execute her life plans. Daniels uses the terminology of health needs, normal opportunity range, and FEO, whereas I use the terminology of basic human functional capabilities that are required for normal human functioning. Although the general objectives of the two approaches are quite similar, there are important theoretical and practical differences, which stem from our different understandings of the currency of justice and the pattern of distribution.

Using three hypothetical cases, I will demonstrate that the two accounts lead to different conclusions as to whether or not they are examples of injustice and how they should be addressed. Daniels' account is simultaneously too narrow and too broad. It is narrow insofar as it defines "health" as the absence of pathology and therefore overlooks some instances of injustice. It is too broad since the use of FEO relative to SOC runs the risk of judging certain cases to be examples of injustice when in fact they are not.

To see how Daniels' account may sometimes be too narrow, consider the case of short-statured children. FEO directs us to provide equal opportunity in healthcare if the individuals being considered have genetically similar dispositions and if they suffer some health deficit. Children that are short because of low growth hormone secretion suffer from a health deficit and hence have a legitimate claim to treatment with synthesized growth hormone. In contrast, short children who are the offspring of short parents and are expected to be of similarly low height in adulthood, do not suffer from a health deficit, however, and although they may face fewer opportunities because of their height, they are not entitled to public funding for treatment with synthesized growth hormone (Note 19).

According to SOC, both groups of children are equally entitled to publicly funded treatment with growth hormones and Daniels' account does not lead to the correct outcome. Before presenting the rationale for this claim, it is worth mentioning that this example highlights an additional theoretical problem with Daniels' account, in that FEO does not object to inequalities that are the result of the "natural lottery", that is, of different genetic dispositions. In this case, Daniels's replacement of Rawls' "talents and skills" with "genetic disposition" misses Rawls' intention. According to Rawls, jobs and careers should be open to people of equal talent, even if by making them so we cause some leveling down. Such an unattractive outcome is justified by the fact that equal opportunity for jobs protects the self-esteem of individuals and the respect we owe them. Similarly, in healthcare, we can say that guaranteeing FEO for individuals with genetically similar dispositions protects their self-esteem. However, that policy does not protect the self-esteem of those with different genetic dispositions, and it is hard to think of any morally relevant reason for such discrimination. While equality of opportunity for genetically similar individuals makes sense in the allocation of jobs (since an individual's skill set has to fit the job requirements), that is not the case in the allocation of healthcare and ultimately we arrive at unjust outcomes. In distributing healthcare, individuals' entitlement to public funding should be determined according to their functional disadvantages rather than their genetic disposition (which is a matter of brute luck).

According to SOC, health is defined more broadly and includes normative judgments. It relates to the individual's ability to advance her goals in her particular social environment. Both groups in the example (i.e., children with low secretion of growth hormone and offspring of short parents), are located beneath the sufficiency threshold (at least in some societies). They have fewer capabilities to advance their goals in their social environment, and hence both have a legitimate claim to treatment. In

other words, the reason *why* they are beneath the sufficiency threshold is not relevant in determining their entitlement to medical care.

Thus, my criticism of Daniels' account is that it overlooks some cases as instances of injustice. This is due to two reasons: First, his narrow definition of a health deficiency as a pathology does not allow for the fact that sometimes individuals do not have a pathology and yet experience social disadvantage because of their physical properties. If Daniels viewed health in terms of basic human functional capabilities, his account would not ignore the short-statured offspring's disadvantage. The second reason is that he applies the FEO principle rather than sufficientarianism as the pattern of distribution. The FEO principle disregards different genetic dispositions that are relevant to an individual's health as evoking possible justified claims of injustice. The notion of sufficiency does not suffer from this shortcoming since sufficiency is not concerned with *why* someone has impaired capability or lack of opportunity; it only separates those who lack basic human functional capabilities (and have legitimate claims of injustice) from those who do not.

As previously stated, Daniels's account is also too broad. Since he uses the notion of "normal opportunity range" instead of "sufficiency of capabilities" (or even "capabilities" alone), his account could lead to wrongful compensations. Consider, for example, a paraplegic (Note 20). She certainly suffers from a health deficit, and therefore the FEO principle would direct us to provide her with an expensive wheelchair. Let's say, however, that she is a talented musician and claims that her "normal opportunity range" would be improved much more if we gave her an equally expensive Stradivarius instead of the wheelchair. She supports her request by claiming that music is the most important thing in her life. If Daniels is persuaded that providing her with a violin would improve her normal opportunity range, he should grant her request. The problem with Daniels' account, therefore, is the use of the vague and subjective notion of a "normal opportunity range". If, for the paraplegic, playing fine music on the best instrument is more important than anything else, Daniels has to provide her with the Stradivarius, which seems counter-intuitive. We are led to the wrong conclusion because the account uses a broad and vague currency of justice (opportunity) rather than basic human functional capabilities. According to SOC, justice in healthcare is about providing individuals with the basic capabilities required for normal human functioning within their social environment and mobility is part of normal human functioning. It is important to stress that we would not force the paraplegic to make use of her wheelchair should she choose to stay home and play the violin. In other words, we would not infringe on her autonomy. Not granting her request would not violate her autonomy, and would be consistent with justice in healthcare (i.e., providing basic human functional capabilities rather than satisfying personal preferences).

In order to emphasize the shortcomings that stem from focusing on the notion of FEO rather than SOC, consider a third hypothetical case of two women who I will call Annette and Betty. Annette has had a mastectomy and now wishes to have reconstructive breast surgery. Betty feels that she has the "wrong"

breast size and wishes to have cosmetic breast enhancement that will “correct” the situation. According to Daniels, we have an obligation to include only reconstructive breast surgery in healthcare schemes but not cosmetic breast enhancement. The reason is that reconstructive breast surgery is a form of treatment addressing a healthcare need resulting from illness, whereas cosmetic breast enhancement is a way of benefiting people according to their own expensive tastes (Note 21). Betty could rightfully claim, however, that we are treating her unjustly if we refuse to pay for her surgery while we allow the paraplegic to trade her wheelchair for a Stradivarius. Since the benefit derived from the Stradivarius does not address a healthcare need but rather a desire to promote the paraplegic’s opportunity range, how can we consistently refuse to provide Betty with something that she feels would improve her opportunity range?

If we could describe the opportunity range we wish to address more accurately—that is, in terms of SOC—we would not run into the problem of expensive tastes. In these two hypothetical cases, the “sufficiency” and “capabilities” terminology has two advantages: First, it enables us to provide a precise defense of public funding of reconstructive breast surgery. Daniels explains why reconstructive breast surgery ought to be included in the healthcare scheme, though his reasoning is imprecise. According to Daniels, reconstructive breast surgery is a form of treatment that addresses a functional deficit; however, according to his own understanding of health and justice in health, this is simply incorrect. The treatment of the pathology (breast cancer) is the operation that *amputated* the breast. The breast reconstruction does not compensate a *functional* deficit, because the surgery would not restore the woman’s functional ability to breastfeed. It might benefit the woman’s self-esteem, and that is certainly a worthy goal, but Daniels’s narrow understanding of health does not include those kinds of individual disadvantages (recall our conclusions regarding the provision of growth hormone). Hence, Daniels cannot use this as justification for including reconstructive breast surgery in his healthcare scheme. He would be correct to describe reconstructive breast surgery as a treatment for a functional deficit only if he were willing to accept a broader definition of health—like the one I suggested in the previous section—that includes normative judgments regarding the effect of different physiological and psychological conditions on an individual’s ability to advance her goals in a particular social environment. In short, according to SOC, reconstructive breast surgery ought to be publicly funded because losing a breast locates an individual beneath the threshold.

The second advantage of using the terminology of “sufficiency” and “capabilities” is the ability to explain why, as a matter of justice, the paraplegic’s request should not be granted and why we are not required to include cosmetic breast enhancement in our healthcare schemes. According to SOC, we are obligated to treat or compensate for a physiological or psychological lack of capabilities that narrows an individual’s abilities to advance her goals. To the paraplegic, we would say that our obligation is to compensate her for the inability to walk (rather than to guarantee her “normal opportunity range”). To Betty we would say that if her breast size is not causing any health problems (such as back pains due to

very large breasts or serious emotional distress due to her appearance), then she is above the sufficiency threshold and hence not entitled to public funding. As long as Betty's dissatisfaction with her appearance does not affect her ability to appear in public or, in other words, does not locate her beneath the sufficiency threshold, she is not entitled to funded surgery.

In order to further clarify the distinction between cases that are a matter of justice in healthcare and those that are not, imagine the following scenario: Assume that in a given society, women with small breasts have difficulties getting dates (and consequently in getting married) or getting good, high-paying jobs (similar to the situation of short men). Under such circumstances, having small breasts would be a matter of justice in healthcare because the physical property itself acquires negative normative meaning in a given social environment, rather than being just a subjective preference that should be regarded as an expensive taste. Of course, a more worthy policy (morality-wise) would be to change the social norm and eliminate the stigma regarding breast size. But if that is not feasible, we ought to regard a request to change breast size as a legitimate claim.

One might accept this distinction but at the same time point to its potential disturbing outcomes. For example, assume there are two individuals, Dan and Erik, with equally crooked noses in a given society where the shape of one's nose does not determine life outcomes but does affect one's sense of self-esteem. Assume that Dan seriously injures his (already crooked) nose in an accident. Can Erik rightfully complain that we are treating him unjustly if, as part of the treatment of Dan's injury, we give Dan a completely normal nose for free? I think not. Dan experienced a misfortune that led to an injured nose. It would seem that *if* we could straighten his nose *while* treating the injury, we ought to do so (assuming that he wants his nose fixed). Even though his wish is an expression of his expensive tastes, it is not expensive under *those* circumstances, because there is no additional cost to the procedure (Note 22). We expect that people learn to live with their natural properties as long as those properties do not decrease their capabilities below the threshold. I will return to this at the end of the next section.

4. Segall's Luck-Prioritarian Equity in Health

As stated in the previous section, my dispute with Daniels' account relates to two criteria: the currency of justice and the pattern of distribution. They also will serve to differentiate Segall's (2010) account from my own. Before doing so, however, it is worth highlighting the differences between the accounts of Segall and Daniel.

According to Segall's luck-egalitarian stance (which, as I will explain shortly, he abandons in favor of a luck-prioritarian stance), it is unjust for individuals to be worse off than others through no fault or choice of their own. One can immediately see the advantage of Segall's position over Daniels' FEO principle in that it does not neglect differences in genetic dispositions. It would be unreasonable to expect people to avoid bad brute luck. Segall emphasizes that an "unreasonable expectation" is not an epistemic expectation but a normative one. Outcomes that are the result of bad brute luck are ones that

society cannot expect the individual to avoid. Thus, the burden of proof is on the society, not the individual (Note 23).

In applying this approach to health, Segall formulates the following principle: “*Equality of opportunity for health*: It is unfair for an individual to end up less healthy than another if she invested at least as much effort in looking after her health” (p. 99). This principle is compatible with Segall’s moral intuition regarding personal responsibility (Note 24). Society can reasonably expect individuals to avoid dangerous habits such as smoking. Thus, if there are two unhealthy individuals, one due to bad brute luck and the other due to reckless behavior, only the former has a legitimate claim to equal opportunity in healthcare.

As Segall rightly points out, this principle has another important advantage over Daniels’ FEO principle. Recall that one of the difficulties with the FEO principle is that it allows leveling down. This unattractive outcome can be justified when we apply the principle to jobs (as in the case of Rawls’ theory) but not to health. Segall explains that if we could provide some public medical intervention (such as vaccination) to everyone and even though everyone would benefit from it, those who were better off (health-wise) prior to the intervention would benefit far more than those who were worse off (given the multiple factors affecting our health). Such an outcome would increase the health inequality between the better-offs and the worse-offs. In order to prevent such an outcome, we would have to avoid providing the better-offs with the publically funded medical intervention or, in other words, we would have to level them down (Note 25).

In order to avoid the leveling-down objection to the luck-egalitarian account, Segall abandons the egalitarian sentiment in favor of what has become known as a “close cousin” of egalitarianism, namely, Parfit’s (1995) priority view. Segall justifies this shift by showing that equality has only a negligible instrumental value in health. In the case of income inequality, egalitarians can claim that leveling down leads to desirable and justified outcomes. Income equality, according to egalitarians, can strengthen society’s sense of community and solidarity, preserve people’s sense of self-esteem, and so on. Segall is right in claiming that the same kind of outcomes cannot come from leveling down in health. The fact that others are brought down to a lower level does not contribute to society’s sense of community or to anyone’s self-esteem. Therefore, Segall concludes, “So whereas income inequality (and, to some extent, inequality in access to health *care*) has a strong instrumental disvalue, health inequality does not appear to have an equivalent disvalue” (2010, p. 115). By ridding himself of the more demanding requirement of egalitarianism and by endorsing the prioritarian stance, Segall can maintain the position that justice requires prioritizing the health of the worse-off. Accordingly, he proposes the following principle: Prioritizing the opportunity for health of the worse off: Fairness requires assigning priority to improving the health of an individual if she has invested more rather than less effort in looking after her health, and of any two individuals who have invested equal amounts of effort, giving priority to those who are worse off (health-wise) (p. 119).

Despite this assertion, Segall treats healthcare as a “normatively nonexcludable” good (pp. 78-79). In other words, although society has the ability to deny people healthcare, it does not do so because that would be morally wrong. The moral obligation to provide medical care to everyone, even to the non-prudent patient, is not due to that person’s identity (citizen or non-citizen, friend or enemy, etc.), but rather due to society’s spatial obligations toward those within its political boundaries.

Segall’s principle is vulnerable to four challenges: (1) How do we determine who is worse off? (2) How do we determine who has invested more effort in maintaining a healthy lifestyle? (3) Should the number of beneficiaries be taken into account? (4) Under what circumstances is it justifiable to hold someone accountable for not maintaining a healthy lifestyle? I will not discuss these issues here (Note 26). Rather, I will focus on the two criteria mentioned above, starting with the pattern of distribution.

Segall writes, “[W]e must not allow basic needs, including medical needs, to go unmet” (p. 68), and adds that, “[T]his is a moral requirement that is external, and prior (in the sense of being more fundamental), to the one of egalitarian distributive justice” (p. 69). Viewing healthcare in this way introduces a sufficientarian distribution into Segall’s luck-prioritarian account. Thus, he writes explicitly that: “...by supplementing the requirement...of meeting basic needs we are thereby adding a layer of sufficientarian distribution...” (p. 69). Despite this statement, he presents his account as luck-prioritarian (and not luck-sufficientarian). Furthermore, he presents several arguments against sufficientarian distribution. Here I will relate to only one of them, i.e., that sufficiency is not enough, which was previously made by Paula Casal (Note 27).

The argument claims that sufficientarian distributions care too little, and by guaranteeing a socially relative notion of sufficiency, they allow inequalities above the sufficiency threshold. I have no dispute with Casal and Segall on this point. Indeed, sufficientarian distributions do allow inequalities above the sufficiency threshold because they do not find such inequalities to be a matter of injustice. If two individuals have the ability to walk, why is it a matter of injustice that one can walk a kilometer in one hour whereas it takes the other 1.5 hours (without experiencing any pain or difficulty)? Regarding inequalities above the sufficiency threshold as a matter of justice is based on the assumption that equality in health has intrinsic value. However, Segall himself is willing to admit that equality has only a “negligible instrumental value” in health (p. 114). Another possible way to claim that the difference in walking capability between the two individuals is unjust is to assume that any quantitative difference always indicates a qualitative difference, or in other words, that descriptive disparity implies normative disparity. As I claimed previously, this is a false assumption. Consequently, the objection does not create any difficulty for SOC, which I shall demonstrate in the discussion of Segall’s position in the case of short-statured children.

Although Segall’s luck-prioritarian equity in health account has several advantages over Daniels’ account, some possible weaknesses in Segall’s position can be demonstrated with the examples used earlier to deconstruct Daniels’ account. These examples will again demonstrate why capabilities, rather

than opportunities, are more accurate currency of justice.

In the growth hormone example, Segall would recommend providing synthesized growth hormone to both groups of short children. In the case of short children with a health deficit (low secretion of growth hormone), we are providing *treatment*, while in the case of short children who are the offspring of short parents, we are providing *enhancement*. According to luck-prioritarian equity in health, both cases are the outcome of bad brute luck, and there is no difference between the duty to provide treatment and the duty to provide enhancement as a matter of justice. In this case, this seems to be a good solution. Nevertheless, Segall's position regarding the *currency* of justice in health as treatment and enhancement, and more specifically his view that the treatment/enhancement distinction is morally irrelevant, may, in my opinion, create difficulties in other cases.

As Segall makes clear, the same medical intervention can be a treatment for one person and an enhancement for another, depending on the individual in question (Note 28). For example, consider the possible uses of Ritalin: For Andy, it could be used as a treatment; for Ben, it could be an intervention that enhances his cognitive capabilities. If there is no moral distinction between treatment and enhancement (as a currency of justice), and we have given Ritalin to Andy in order to compensate for his bad brute luck and to allow him equality of opportunity, but we have also given it to Ben in order to enhance his cognitive capacities, then by doing so we have neutralized the advantage we were intending to provide Andy with. That seems counter-intuitive according to luck-prioritarian equity in health. To make the case even clearer, assume that providing Andy with Ritalin will enable him to get the minimal score required to pass a test and that providing Ben with Ritalin would not enhance his cognitive capacities beyond normal human function but would simply help him to get ten extra points on the test. If that state of affairs is considered to be just according to Segall, then his account will allow and even promote inequalities above what we would define as a threshold level of cognitive abilities for writing tests (that is, the level of cognitive abilities that is sufficient to pass the test). That possible outcome weakens his potential criticism of SOC discussed above.

Luck-prioritarian equity in health is not vulnerable to the Stradivarius objection, and here we encounter another advantage of Segall's account over Daniels'. Segall could in theory provide two responses to the Stradivarius objection: The first has to do with the sufficientarian sentiment of meeting basic needs. Segall avoids the criticism against Daniels on this issue by using the more appropriate terminology of "basic needs" rather than "opportunities". Not surprisingly, this bears some resemblance to the SOC reply I presented in the previous section. Our duty is to meet medical needs (lack of capabilities), which does not include providing indirect compensation, such as cash or goods. The second and more important explanation demonstrates how the luck-prioritarian concern in Segall's account avoids the objection. Segall would be able to offer the following satisfactory reply: The luck-prioritarian concern is to neutralize the effect of bad brute luck on ill health by providing medical treatment that reverses or compensates for a health deficit (Note 29), rather than just guaranteeing the "normal opportunity

range”.

We are left with the third and final case: would luck-prioritarian equity in health support public funding of both reconstructive breast surgery and cosmetic breast enhancement? Losing a breast due to illness (or susceptibility to illness) and having the “wrong” breast size are matters of bad brute luck and thus, according to Segall’s account, should be compensated for. In other words, both types of surgery ought to be publicly funded. Segall argues, however, that we should give priority to reconstructive breast surgery over cosmetic breast enhancement for two practical reasons: (1) there are fewer women who need reconstructive breast surgery, and (2) the risk of moral hazard (Note 30).

I want to point out that Segall’s reasons for not funding cosmetic breast enhancement are justified on grounds other than luck-prioritarian equity in health, that is, other than justice. Segall himself makes a similar criticism of Daniels when he rightfully claims that Daniels’ FEO principle would leave people over the age of seventy-five with no medical attention whatsoever. He writes, “[E]ven the provision of aspirin to individuals who can be said to have completed their life plans must, if we hold Daniels to his theory, *be justified on grounds other than opportunity to pursue life plans, and therefore other than justice*. That seems problematic” (p. 33, emphasis added). Consequently, I find Segall’s reply to be problematic in the third hypothetical case.

It is possible to come up with a different example of cosmetic enhancement that avoids Segall’s two objections to the funding of cosmetic breast enhancement. Assume that a few men wish to have their penis size changed through safe and relatively cheap surgery. Having the “wrong” penis size is a matter of bad brute luck. Even the social significance of penis size is a matter of luck if we can show that its effect on men’s self-esteem varies from one period to another or between cultures. In that case, luck-prioritarian equity in health would seem to have no objection to public funding of this kind of surgery in order to address the inequality faced by men with the “wrong” penis size. Segall might reply that “[S]ometimes the best way to level brute luck inequalities is to alter certain aspects of the social structure so that the condition no longer represents a disadvantage”, such as eliminating the stigma (p. 123). I would certainly advocate that kind of social reform. However, suppose that it is easier and cheaper to perform plastic surgery on the few men who desire it than trying to educate the public that penis size should not affect someone’s opportunities in life. It would appear that proponents of luck-prioritarian equity in health would have no choice but to advocate the public funding of these operations or any other medical intervention that would compensate individuals for properties that are the result of brute luck, such as hirsuteness, shyness, oddly shaped noses, etc.

The problem with this outcome is not only that it seems counter-intuitive but also that it requires us to treat our physical properties much as addicts treat their addiction. Ronald Dworkin (2000) presents this powerful criticism against Cohen’s welfarist account, claiming that it is morally troubling to treat characteristics such as talents, tastes, preferences, physical properties, mental tendencies, etc., as something that happens to us, and not as something we have the ability to modify or resist. My

criticism here is twofold: First, preferences with regard to breast size, penis size, a straight nose, etc., are not a matter of justice. Rather, just distribution of healthcare is about guaranteeing a sufficiency of basic human functional capabilities that are required for the positive freedom to advance one's life goals. Using the notion of luck-prioritarianism instead of SOC leads to a broader and vaguer notion of healthcare injustice. Second, although a theory of justice ought to be concerned with positive freedom, it should also ascribe to people the responsibility to adjust their preferences, ambitions, and tastes to what they can reasonably expect society to provide.

5. Conclusion

Two different accounts of equal opportunity for healthcare were presented and compared to a third account called SOC (Note 31). Several advantages of SOC over egalitarian and luck-prioritarian distributions were demonstrated. First, I claimed that healthcare equality has no intrinsic moral value and that legitimate claims of injustice can be presented only by those who are (or might possibly fall) beneath the sufficiency threshold of basic human functional capabilities. I have shown that this intuition is so strong that even Segall, who starts his inquiry with luck-egalitarian concerns, finds it necessary to present a sufficientarian distribution of healthcare interventions as a fundamental requirement for justice in healthcare. Second, I have shown that the proper currency of justice in healthcare is capabilities rather than opportunities. Focusing on capabilities can guide us in determining what *kinds* of functional disadvantages should be considered as locating individuals beneath the sufficiency threshold, in addition to what *forms* of compensation individuals can reasonably expect to receive. More specifically, in the three hypothetical cases discussed, focusing on SOC helps us explain why we find public funding of synthesized growth hormone and reconstructive breast surgery to be required by justice in healthcare, and why, on the other hand, we should not fund expensive tastes, as in the case of the Stradivarius and cosmetic breast enhancement.

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Notes

Note 1. In section 2, the difference between the terms “health” and “healthcare” will be elaborated. Section 1 deals mainly with the concept of health.

Note 2. According to the leveling-down objection, if our objective is to achieve equality (and specifically outcome equality), then the easiest and cheapest way to do so would be to level down the better-offs by simply not providing them with any treatment.

Note 3. The bottomless pit objection states that if we strive to achieve outcome equality in health, it will consume all of our resources because some people’s conditions are so grave that improving their level of health would be extremely expensive, leaving us with little or no resources for other goods.

Note 4. Ronald Dworkin (2000) provides us with the following distinction between option luck and brute luck: “Option luck is a matter of how deliberate and calculated gambles turn out—whether someone gains or loses through accepting an isolated risk he or she should have anticipated and might have declined” (p. 73). On the other hand, “brute luck is a matter of how risks fall out that are not in that sense deliberate gambles” (p. 73). Winning a sum of money in a lottery is a matter of good option luck, whereas becoming ill due to genetic disposition is a matter of bad brute luck.

Note 5. Consider Segall’s jogger/smoker example (2010, p. 98). For simplicity, assume that the sole reason for the good health of the jogger versus the bad health of the smoker lies in their different lifestyles and is not affected by their genetic disposition or by social factors. According to the luck-prioritarian account, the different levels of health of the two subjects is not a matter of injustice if it is the outcome of option luck.

Note 6. SOC was presented in detail in Efrat Ram-Tiktin (2012, 2016 in press)

Note 7. See, for example, Amartya Sen (1985, 1990, 1993, 2009). See also Martha Nussbaum (1988, 1992, 2000, 2006).

Note 8. See Sen (2009, p. 233). Elsewhere he presents the difference between “means to freedom” and “extent of freedom” (1988, 1990).

Note 9. The distinction between the two opportunity aspects of freedom is connected to another distinction made by Sen, that between culmination outcome and comprehensive outcome. The first relates to the narrow opportunity aspect of freedom, which “regard(s) the existence of options and the freedom of choice to be somehow unimportant” (Sen, 2009, p. 230). The latter is connected to the

broader notion of the opportunity aspect of freedom and focuses on the importance of the individual's role in achieving her desired goals. These observations are part of Sen's critique against welfarist accounts. Theories that focus on individuals' welfare are consistent with the narrow opportunity aspect of freedom, while the capability account stresses the importance of the broader opportunity aspect of freedom.

Note 10. See for example Michael Marmot and Richard G. Wilkinson (1999).

Note 11. There is an ongoing debate on the definitions of health and illness that I am not going to discuss here. The two levels of health and illness and the definitions that I provide in this paragraph are based on my synthesis of two dominant accounts in the literature on health and illness. For Christopher Boorse's bio-statistical view, see Boorse, C. (1975, 1977, 1997). For Lennart Nordenfelt's holistic view see (1993a, 1993b, 1993c, 1995, 2001).

Note 12. A full description of each system and the mutual relations between them is presented in Ram-Tiktin (2016 in press).

Note 13. It is worth noting that Sen and Nussbaum also mention that a scheme of just distribution is not committed to equality. See Sen (2009, p. 295) and Nussbaum (1992, 2000, 2006) and specifically the latter's discussion of "good enough human life threshold". She states as follows: "[our commitment] is to bring each and every person across the threshold into capability for good functioning. This means devoting resources to getting everyone across before any more is given to those who are already capable of functioning at some basic level" (1992, pp. 231-232). The differences and similarities between my account and Nussbaum's of sufficiency thresholds is discussed in Ram-Tiktin (2016 in press).

Note 14. That concern is part of what Sen stresses in the broader opportunity aspect of freedom.

Note 15. Consider the following example as an illustration: If I wish to become an opera singer but have a terrible singing voice, I cannot *reasonably* expect society to compensate me. Society expects people to choose their goals according to their abilities or to fund their singing lessons privately. I will come back to this expectation later.

Note 16. Daniels and Segall write on justice in health in general, but I will be referring to their discussions of just distribution of healthcare.

Note 17. See Daniels (2008, pp. 58-59).

Note 18. Daniels himself points to the similarity between his account and Sen's capability approach, stating that the opportunity range, used by him and Rawls, is equivalent to Sen's capability space (2008, p. 66).

Note 19. Short stature in men has been found to correlate with negative connotations and with fewer opportunities of finding a date (Pawlowski & Jasienska, 2005; Kurzban & Weeden, 2005), as well as with lower income (Perisco, Poslewaite, & Silverman, 2003).

Note 20. Here, I follow Dworkin's example as part of his criticism of welfarist theories (2000, pp. 61-62).

Note 21. Daniels' explanation here is not entirely correct, as I will explain later.

Note 22. I am grateful to David Heyd for his comments on this matter.

Note 23. Segall (2010, pp. 19-20).

Note 24. Those considerations were manifested in the smoker/jogger example in Note 5.

Note 25. See Segall (2010, pp. 103-104).

Note 26. These four challenges were discussed in Ram-Tiktin, 2012.

Note 27. See Paula Casal (2007). Segall criticism of sufficientarian distribution is discussed as part of his reservations regarding Elizabeth Anderson's (1999) democratic equality account, which I think can be regarded as a "close cousin" of the capabilities accounts of Sen and Nussbaum.

Note 28. See Segall (2010, p. 123).

Note 29. Segall (p. 85).

Note 30. The risk of moral hazard exists because if cosmetic breast enhancements were publicly funded, more women would opt for it than if they had to pay for the procedure themselves.

Note 31. The need for precision is important here. Thus, although both accounts address the broader issue of justice in health (and not *healthcare*), the discussion was limited to examples of healthcare provision that were presented by the two authors themselves.