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Healthy enough? A capability approach to sufficiency and equality

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Abstract: 'Sufficiency' approaches to social and global justice stress that everyone must have enough. According to some advocates of this approach, only sufficiency is important, not equality. Martha Nussbaum, who is often classified as a sufficiency advocate, has defied this stricture against egalitarianism by contending that, in several domains, nothing is adequate short of equality. She cites political freedoms as her most persuasive example and suggests that the same may be true of the capability for health care. However, she does not explore this idea in depth: the idea that, in the domain of health, nothing short of equal capabilities is adequate. I explore this by clarifying the main concepts, such as adequacy and capability, in the domain of health. By these means I address three further questions. First, which is primary and which is derivative: capability for health care or capability for health? Second, does duration matter? If we can understand adequate health at a moment, in terms of ranges of physiological and psychological functioning, does adequacy not also imply durability? If so, then, third, is it possible to specify the length of an adequately healthy life, at least as a reasonable expectation? I argue that, due to human diversity and the imperfect state of medical knowledge, we cannot form a reasonable expectation of the length of an adequately healthy life for each person. Nevertheless, duration still matters. Therefore, we must recognize inadequately healthy lives in the only way that we can, by recognizing social disparities in health outcomes. In this sense, nothing short of equality is adequate.

Keywords: capability, equality, health, priority, sufficiency

Scanning the political horizon among the various actors, certain divisions and distinctions stand out. At least for people like me, who self-identify as justice-seeking, the main division is between the justice-seeking, the indifferent or unpredictable, and those who are predictably hostile to change in the direction of greater justice. Nevertheless, among the justice-seekers there is disagreement as well as agreement. One point of agreement is that poverty reduction is a priority. One point of disagreement is whether reducing inequality is a salient priority. Among justice-seekers, then, one group prioritizes poverty reduction, or ensuring that everyone has enough. Another group also holds this as a priority, but not the only priority; rather it is one step towards reducing inequality. In politics, the first tendency might be contrasted as 'liberal' against the second which might be called 'egalitarian' or even 'radical'. In philosophy, the first group is called 'sufficientarians' and the second group 'egalitarians'.

So far, the capability approach has not committed exclusively or decisively to one tendency or the other. However, philosophical sufficientarians are challenging us to make such a choice. Thirty years ago, the sufficientarianism that Harry Frankfurt introduced was explicitly hostile to egalitarianism. In Paula Casal's influential 2007 review of sufficientarian literature, a positive thesis prioritizing enough for all is distinguished from the additional *negative thesis* which denies any intrinsic moral importance to equality (Casal 2007, 297ff). This raises two questions. Is it coherent to advocate sufficientarianism without the negative thesis? Lasse Nielsen has recently included the negative thesis as essential to the 'generic sufficiency view' (Nielsen 2019, 22–23). Martha Nussbaum, on the other hand, abstains in some places from the negative thesis, and, as I will show

later in this paper, in other places she rejects it. The second question is whether it is coherent to advocate sufficiency (enough for all) without egalitarianism. This is the question on which I will focus in this paper. Nussbaum has argued that in some domains, in particular the domain of political freedoms, the answer to this question must be negative, and it is incoherent to advocate sufficiency without equality. Simply put, when it comes to political freedom, nothing is adequate short of equality. My goal in this paper is to explore whether this also holds in the domain of health.

Until recently, policy discussion of adequate health and the goal of achieving 'enough for all' in relation to health has been quarantined from some of the philosophical discussion of sufficiency and the doctrine that has come be known as 'sufficientarianism'. The meaning of 'enough for all', of an 'adequate' or 'sufficient' level of living, and the importance of these for a normatively justifiable society has received extensive discussion for more than thirty years, largely innocent of the facts and problems of insufficient health and health care. Finally, these two words of discourse have collided together, particularly in the 2016 collection of essays, *What is Enough? Sufficiency, Justice, and Health*, co-edited by Carina Fourie and Annette Rid (Fourie and Rid 2016) In this article I want to further impact this collision by considering a thesis that very many sufficiency theorist and advocates ('sufficientarians') hold in common, namely the 'negative thesis' that what is morally important is only (or primarily) that everyone has enough, or, as Harry Frankfurt put it, "If everyone had enough, it would be of no moral consequence whether some had more than others" (Frankfurt 1987, 21). Is this true in relation to health?

1. Nussbaum on sufficiency and equality

All sufficientarians do not accept Frankfurt's negative thesis without qualification, but they do tend to be dismissive of equality and interpersonal comparisons. Some are averse to the kinds of interpersonal comparisons on which egalitarians focus, concerned that these comparisons are alienating, or even envious. Others are concerned that sufficientarianism will not be given due respect if the negative thesis (opposing egalitarianism) is given up, for then its remaining claim, that it is important for all to have enough, will seem obvious if not banal. Without the negative thesis, sufficientarianism would not be much of an 'ism'.

Martha Nussbaum has never shown either of these tendencies, though she is frequently classified as 'sufficientarian'. Those who classify her in this way may be unaware of her view that sufficiency and equality are not incompatible priorities, or else they oppose the view of many sufficientarians that they are incompatible. From the start, when she called for "a minimum threshold of capability for truly human functioning" in *Women and Human Development,* it was clear that her position is much friendlier to egalitarianism than Frankfurt's: "a threshold level of capability," she wrote, "may not suffice for justice, as I shall elaborate later, discussing the relationship between the social minimum and our interest in equality" (Nussbaum 2000, 75). An interest in equality is in three ways quite substantial. First, raising everyone to a capability threshold adequate for 'truly human functioning' would have the effect of reducing inequalities considerably. Second, the capability of association–central to Nussbaum's list of central capabilities–favours relationships of mutual respect, rather than asymmetrical disrespect and discrimination. Hence sufficiency implies elimination of discriminatory inequalities. Third, advocating enough for all at this threshold is

entirely compatible with advocating other conceptions of equality: "Complete egalitarianism, a Rawlsian difference principle, and a weaker focus on a (rather ample) social minimum all would be compatible with the proposal as so far advanced" (Nussbaum 2000, 86). Nussbaum's presentation of the sufficiency threshold, then, is quite incompatible with the negative thesis that is commonly held essential to sufficientarianism, whether in Frankfurt's stronger formulations (which denies any intrinsic moral importance to equality) or, in his more nuanced formulation, that once sufficiency has been achieved, equality becomes unimportant (Frankfurt 1987, 21; Casal 2007, 299).

Nussbaum's second point can be developed as a fatal objection to the negative thesis: people do not associate adequately unless they associate as equals. That is to say, in social relations, nothing short of equality is adequate. According to the negative thesis, if adequacy is achieved, equality is unimportant. According to Nussbaum, in the domain of association there is adequacy if and only if there is equality. The biconditional is supported by beliefs that are as widespread as they are strongly held about political equality and inequality, and Nussbaum pointedly draws attention to these in *Frontiers of Justice.* "To give some groups of people unequal voting rights, or unequal religious liberty, is to set them up in a position of subordination and indignity vis-à-vis others … it is to fail to recognize their equal human dignity." Consequently, "all the political, religious and civil liberties can be *adequately* secured only if they are *equally* secured" (Nussbaum 2006, 293).

This clearly contradicts the negative thesis–the generalization that, once people have enough (of anything), equality never matters. Nevertheless, ambiguities emerge if we attempt to formulate it as an affirmative thesis.

Egalitarian sufficiency: generic

Anyone lacking equal X lacks adequate X

Nussbaum says that this is just difficult to think about (294-95), and that seems correct, considering that some instantiations do seem much more difficult to justify than others. Following Nussbaum's discussion in *Frontiers of Justice*, we might focus particularly on that contrast between these cases:

Egalitarian sufficiency: civil rights

Anyone lacking equal civil rights lacks adequate civil rights.

Egalitarian sufficiency: housing

Anyone lacking equal housing lacks adequate housing.

Focusing on sufficiency and equality in the capability space, Nussbaum does not bother mentioning applications to income and wealth, which would require extraordinary justification:

Egalitarian sufficiency: income

Anyone lacking equal income lacks adequate income.

Egalitarian sufficiency: wealth

Anyone lacking equal wealth lacks adequate wealth.

She does, however, suggest that the following may be less difficult to justify:

Egalitarian sufficiency: education

Anyone with far from equal educational resources lacks adequate educational resources.

Egalitarian sufficiency: health

Anyone lacking equal basic health care lacks adequate basic health care.

What can we conclude from all this? Nussbaum may have been too generous to Frankfurt's negative thesis when she claims that "all statements ought to be tentative" (Nussbaum 2006, 295). We need not be tentative about Frankfurt's negative thesis that "If everyone had enough, it would be of no moral consequence whether some had more than others" (Frankfurt 1987, 21). While in his first article on the topic Frankfurt limited the scope of this generalization to income and wealth, in later publications he lifted this restriction. The result is simply a false generalization, contradicted by the counterexample of civil and political rights.

On the other hand, concerning the generic principle of egalitarian sufficiency and its range of applications, Nussbaum's caution is warranted: "The matter is difficult to think about" (Nussbaum 2006, 295). Nevertheless, in what follows I attempt to think it through at least somewhat more clearly in the domain of health.

2. Health

First, consider the claim that everyone should have adequate basic health care. From a capability perspective, this is a derivative claim. To explain why it is so, I need to introduce some basic capability claims and concepts.[1] The central normative insight of the capability approach is that there

[1] Readers who wish to know more about the capability approach should start with two contributions by

Ingrid Robeyns: her article, "The Capability Approach"

are specific domains such that everyone ought to be equally free with respect to those domains. Generically these domains contain kinds of 'functioning' (or ways of being or doing) that people have reason to value as elements of living well. The capability approach does not claim that everyone should function the same way; rather it claims that everyone should be equally *free* to function in these ways that are elements of living well. Health *care* is a resource or a means for living well, not a constituent of living well that everyone has reason to value as such.

Consider the claim that everyone should be capable of accessing an adequate set of basic health care services. Here the capability space is doing little normative work: what is valued primarily, in this formulation, is actually obtaining adequate basic health services, and from this the idea that everyone should be capable of obtaining those services can be derived. According to this thinking, what makes the capability valuable is the actual use of health services. A robust capability perspective would go a step deeper, placing primary value on our *capability to be healthy*. Then health services would be valued in a derivative way: what makes health care valuable is that it enhances our capability for health.

One reason for making health capability fundamental is that, otherwise, there are no good reasons for selecting any particular set of health care services as adequate or basic. This is evident in three ways. First, it seems plausible that health care services have no intrinsic value; their only value is instrumental, enabling potentially unhealthy beings to achieve and retain good health. If God and angels have no use for health services, then I presume that, as far as their own good is concerned, they would find that health services have no value at all. For beings that are not potentially unhealthy, health care services have no value because their only role is instrumental, enabling potentially unhealthy beings to achieve and retain good health. Second, the fact that others are accessing a treatment is not by itself a good reason for wanting that treatment: wanting something just because others have it not only ignores one's own needs but also smacks of envy. A better reason for wanting access to a treatment should one need it is that this facilitates achieving or retaining good health. So too this is a better reason for *allocating* access to a treatment. Third, 'basic' may be less arbitrary when applied to health functioning and capabilities than it is when applied to health services. The reason for limiting the sufficiency claim to *basic* health services is presumably that providing non-basic services is somehow less important. Yet using 'basic' to modify 'services', would seem to focus on services that are simpler, less difficult, and possibly less expensive. In all of these senses, hydration is more basic than surgery. But simpler is not always more important; we do not develop complex and difficult treatments as a sport, we do so because those treatments are important for patients' health. 'Basic' health care can also be defined in contrast with *enhancement*. Here too there is little correspondence between the spectrum from basic to enhancement and the spectrum of complexity/difficulty/expense. Physical exercise can achieve some enhancement, yet it may not be comparatively complex or expensive. Therefore, in the sufficiency claim that everyone should have

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https://plato.standford.edu/archives/win2016/entries/capability-approach/ and her book, *Wellbeing,*

Freedom and Social Justice; The Capability Approach Re-Examined (Cambridge: Open Book Publishers, 2017).

enough basic health care, 'basic' should be understood to modify 'health'. In other words, the claim is not that there is a set of basic services of which everyone should have enough, but rather that everyone should have enough services to achieve and maintain functioning that is basic to health. From a capability perspective, 'basic' would refer to a particularly important set of health functioning, and the sufficiency claim holds that everyone should be capable of functioning in these ways.

Other approaches to health equity focus more broadly on a statistically normal range of physiological and psychological functioning. In the domain of health, these approaches take this normal range of functioning to be the currency of justice. Capability approaches typically focus more on ranges of functioning that are favourable to other valuable capabilities.

For example, Allen Alvarez proposes to focus on kinds and ranges of physiological and psychological functioning that are necessary for carrying out vital tasks, such as making a living (Rid 2016, 37). This has the consequence of setting the threshold for sufficiency quite low, perhaps lower than the 'ample minimum' that Nussbaum had in mind, as fitting for a life of human dignity. Nevertheless, setting the threshold as low as Alvarez does has one merit, namely that the importance of raising everyone to at least that level will be more readily justifiable and accepted. One reason for keeping people's physiological and psychological functioning sufficient for performing vital tasks is Nussbaum's reason, that this is a necessary condition for achieving a life of human dignity. Also, there are other reasons that converge on recognizing this importance, since whatever is held to be valuable and important in life can only be achieved by people capable of performing vital tasks.

Efram Ram-Tiktin takes a different approach, framing health functioning within a wider life-context that encompasses but goes beyond vital tasks. The distinction between sufficiency and insufficiency, he observes, is not the same as a distinction between malady and intactness. A malady occurs when one's physiological or psychological functioning falls outside normal ranges. Sufficiency and insufficiency presuppose other standards. Abnormal functioning is not insufficient *per se*; it is insufficient if and only if it interferes with a range of life-plans. Conversely, physiological and psychological functioning is sufficient if and only if it is favourable to a range of life-plans. Sufficiency and insufficiency are not reducible to normality or abnormality of functioning, nor are they entirely independent of these ranges; rather, they are supervenient properties relating these naturalistic properties to the wider context of living a life. "A condition of insufficiency is one in which deviation from normal values narrows individuals' ability to pursue their life plans and live a good human life" (Ram-Tiktin 2016, 157). Thus, specific ranges of physiological and psychological functioning, which naturalistic or medical approaches frame only as normal/abnormal, need to be re-framed as favourable/unfavourable to living a life, in the sense of pursuing a life plan, or striving to live well.[1]

Accordingly, Ram-Tiktin identifies nine systems or domains of functioning that have greatest influence on the breadth of life-plans that a person can achieve: thinking and emotions, senses, circulation, respiration, digestion and metabolism, movement and balance, immunity and excretion, fertility, and hormonal control. In the functioning of each system, there are numerous variables each of which has its normal ranges, and Ram-Tiktin offers the following as an example:

> 1. Normal levels of thyroxin are 64–154 nanomoles/liter (nmol/l). Low levels of thyroxin (<64 nmol/l) lead to hypothyroidism, the symptoms of which include low pulse rate, constipation, depression, and dementia. High levels of thyroxin (>154 nmol/l) lead to

> hyperthyroidism, causing (among others) an elevated pulse rate, high blood pressure, diarrhea, and weakness (Ram-Tiktin 2016, 157).

The capability for health, then, is the capability to function in these many ways. This is a very sophisticated conception of health functioning and capability, and yet one key variable is missing for assessing adequacy of health, and that is duration – how long one manages to function within these otherwise sufficient ranges.

3. Duration matters

Is this variable, duration, essential? To know whether people have been sufficiently healthy, is it essential to ask how long they have been healthy? To know whether someone will be sufficiently healthy, after recovering from an illness, do we not want to know how long that person will function within normal ranges? My intuition is that how long one is healthy is not separable from how healthy one is, and indeed this seems so obvious that it is difficult to consider arguments for and against it. Nevertheless, it should be instructive to try.

I begin by observing how common it is to use differences in longevity to show differences in health. This opening paragraph of a 2006 article is not at all unusual:

> Global health inequalities are wide and growing: a child born today in Afghanistan is 75 times as likely to die by age 5 years as a child born in Singapore. A girl born in Sierra Leone can expect to live 50 fewer years, on average, than her Japanese counterpart. The number of African children at risk of dying is 35% higher today than it was 10 years ago (Ruger 2006, 998).

Still, while common practice is instructive, it should not be decisive. Consider the capability for health more closely, then.

The capabilities that populate any evaluative space do not have merely momentary functioning. There is no inconsistency in defining a capability to function in a particular way at a particular moment, for instance the capability to celebrate Canada Day in Ottawa in 2020, but time-fragmented capabilities are of little use in assessing people's advantage or disadvantage over time or in comparison with other people. Basketball players with the capability to make all of the shots they take on February 1 are impressive on February 1, but to assess their advantage over other players we need to know how they are capable of playing for the rest of the season. So too for health: having one fine day in a sickly life does not tell much about a person's capability for health.

In addition, we compare capabilities by their durability. If I was often ill last year but only rarely ill this year, then my capability for health has improved. This is not merely an artefact of capability concepts, but it also rings true of health *per se*, in the sense that one is not entirely healthy unless one can stay healthy. This stands out in a model of health endorsed by Ruger, especially the second and third elements:

> 1. The state of the organism when it functions optimally without evidence of disease or abnormality.
> 2. A state of dynamic balance in which an individual's or a group's capacity to cope with all the circumstances of living is at an optimum level.
> 3. A state characterized by anatomic, physiologic, and psychologic integrity, ability to perform personally valued family, work, and community roles, ability to deal with physical, biologic, psychological, and social stress; a feeling of well-being, and freedom from the risk of disease and untimely death (Stedman 2000, 789–90; cited by Ruger 2009, 85–86).

The second the third elements are clearly dynamic properties bearing on capability for continued functioning over time. The second, 'dynamic balance', could also be described as resilience, a capability to maintain or restore health functioning within the normal ranges in a wide range of life-circumstances. The third, 'integrity', puts this resilience in a social context. In this domain health (a) functioning and resilience (elements 1 and 2) are favourable to functioning in social roles and relationships; (b) one feels that one's life is going well; and (c) all of this is robustly capable of continuing, secure against health and mortality risks.

Finally, Ram-Tiktin proposes that the normal ranges of physiological/psychological functioning that specify the capability of health should be those ranges of functioning that are favourable to a wide set of life-plans, functioning outside those ranges being unfavourable. Since life-plans are executed not instantly but over considerable time, fragmentary, momentary capabilities are less relevant than more durable capabilities. Earning a degree and making a living both require being healthy for more than a day.

So, it seems that we cannot know what constitutes adequate health just by specifying a healthy state. We must also specify how long one achieves that state. Now, there is no inconsistency in giving a mid-range answer, for example: to be adequately healthy means functioning within normal ranges for at least a month. But this answer courts the same objections: (i) people will still cite greater life expectancy as evidence of better health; (ii) it would be more advantageous to string healthy months together; (iii) if I was healthy only a few months last year but every month this year, then my capability for health has improved; and (iv) life-plans typically take more than a month to achieve. Indeed, they can take a lifetime. It seems like we are on a slippery slope, therefore: once durability is accepted as essential to the capability of health, the magnitude of that capability must be expressed in terms of how long one remains healthy. What, then, is adequately long for an adequately healthy life?

4. How (not) to think about what is enough

What I want to consider is how this question of an adequately long life might be answered in a knowledgeable and justifiable way. Sufficiency theorists have proposed several different ways in which sufficiency thresholds might be specified and justified, and here I will consider three such proposals that remain prominent in the literature.

When Harry Frankfurt argued for sufficiency as an alternative to equality, he argued doggedly that our thinking about what is enough for a person should not rest on any comparisons with what

other people have or do. Rather, what is enough for a person should depend entirely on what that person has, does, and aspires to. It should be remembered that the article in which he launched sufficientarianism was intended primarily as a critique of egalitarianism. At the core of this critique was the idea that by requiring too much comparison between ourselves and others, egalitarianism makes us think too little about our own needs in the context of our own lives.

Egalitarianism, he wrote, "tends to divert a person's attention away from endeavoring to discover – within his experience of himself and of his life – what he himself really cares about and what will actually satisfy him…. Exaggerating the moral importance of economic equality is harmful, in other words, because it is alienating" (Frankfurt 1987, 23). In later work, he took pains to argue that comparative thought should have no place even in our understanding of discrimination, which is wrong, not because it arbitrarily denies to some what is granted to others, nor is it even that it fails to treat like cases alike. Rather, Frankfurt considered discrimination to be wrong for the non-comparative reason that it fails to recognize people for who and what they are (Frankfurt 2015, 84–87).

From this perspective, the length of a healthy enough life should not depend in any essential way on how long others live in good health. Considering others' lives may be suggestive, as "the circumstances of others may reveal interesting possibilities and provide data for useful judgments concerning what is normal or typical, and "someone who is attempting to reach a confident and realistic appreciation of what to seek for himself may well find this helpful" (Frankfurt 1987, 23). Considering others' lives, nevertheless, should not play any more important role in determining what is a long enough lifespan for oneself.

There is one way of comparing oneself to others that is neither envious nor alienating, however. Consider the following thought:

> Is my life not as important as theirs? Why should I not be capable of living as long or as well as they do?

I would not describe this thought as envious; I would regard it rather as an expression of self-respect and a demand for equal consideration. I have deliberately inserted a reference to capability, so that the comparison is not to how long or well others do live, but only to how long and well they are capable of living. The thought is not that I must live as long as others – which could perhaps be alienating – but only that this should be my choice, *i.e.* that my *freedom* to live that long and well is as important as theirs. This thought, however, would be blocked by Frankfurt's ban on comparative thinking in determining what is enough. From this I draw two lessons. First, Frankfurt's ban on comparative thinking is seriously flawed. Second, this particular kind of comparison, this *self-respecting call for equal consideration*, may play a central role in thinking reasonably about where to set sufficiency thresholds.

This kind of thought can also be mirrored by an observer who hears the claim and responds affirmatively to it. This affirmative response consists in respecting the person and treating that one with equal consideration, *i.e.,* equal to the consideration given to other people. Roger Crisp finds something like this mirror-image response modelled in Adam Smith's 'impartial spectator'.

Smith famously advised us that since our intuitive answers to questions about right actions and social arrangements may be influenced unduly by our social positions, we should ask ourselves how an impartial spectator would answer them. Crisp adds that asking this question may help to solve a problem concerning the priority principle (that it is generally more important to benefit those who are worse off). The problem is where to stop: is it really more important to benefit millionaires than billionaires? Crisp reasons as follows: what we are looking for in an impartial spectator is an ideally virtuous judge of these matters, and the virtue that seems most relevant to matters of priority for the worst off is compassion. Once people become sufficiently well-off, the ideal spectator's compassion will diminish or, rather, the level of sufficient well-being *is* the point at which the ideal spectator's compassion diminishes. For people above that level, benefitting those who are comparatively worse off no longer has any importance (Crisp 2003, 756–58).

From this it would follow that a healthy lifetime is sufficiently long if and only if an ideal spectator would not respond with compassion to any desires to live longer. For ideal theory this is a very tidy solution, but for actual justice it is not very helpful. You and I are non-ideally situated participants rather than ideally impartial spectators, and so it is not obvious, without adducing further reasons, whose actual judgments are closest to those of an ideally compassionate impartial spectator. Moreover, by making compassion the criterion, we overlook those further reasons, including reasons why one group in one situation may deserve compassion that is not deserved by another. Consequently, attempts to articulate what an ideally compassionate impartial observer would find sufficient can seem hopelessly arbitrary. Unfortunately, that is how Crisp's conjecture appears: "How much is enough? … It is hard to know how to answer such questions, but, on reflection, my own intuition is that, say, eighty years of high-quality life on this planet is enough, and plausibly more than enough, for any being" (Crisp 2003, 262). Not eighty-one? Not seventy-nine years and three months? Or, if that puts too fine an edge on it, why not something closer to seventy-five, or ninety? The difficulty is that a focus on the ideal spectator's compassion draws attention away from the reasons that we might expect an impartial spectator to have.

5. Reasonable expectations of self-respecting people

I observed in response to Frankfurt that self-respecting people demand to be no less free to live well than anyone else and that this demand should not be construed as envy. In that case the impartial spectator's role involves ensuring three things: (1) that robust capability demands of one group are not privileged over comparable demands by others; (2) that people whose aspirations have been suppressed by adversity are not discounted by accepting their adaptive preferences uncritically, and (3) that the society[2] actually has the productive capacity to meet these demands. The result would be to determine what are everyone's reasonable expectations. In my view, this is what we need to know about health and longevity: what are our *reasonable expectations?*

Before developing this idea, however, an alternative should be considered, namely the criterion of *probable contentment*, as advocated by Robert Huseby. He proposes two thresholds. One is minimal sufficiency, below which one does not have enough. The other is a maximal threshold, and we might call this level fully sufficient, meaning that nothing more is required. He sets the threshold for minimal sufficiency at subsistence needs, without specifying for how long. Perhaps he means that

anyone who lacks subsistence needs at any moment falls below the minimum threshold for sufficiency. He adds that "strong priority should be given to those below the minimal sufficiency threshold" (Huseby 2010, 184). Applied to longevity, this would be inconsistent with the idea of a maximal threshold, because the latter idea would imply that there is an age at which the importance of supplying subsistence needs drops off, or, as Huseby puts it more generally, 'individuals below the maximal sufficiency threshold should have *absolute* priority over individuals above this threshold.' (Huseby 2010, 184) Consider Crisp's eighty years of high quality life as a potential threshold. According to Huseby's minimal threshold, high priority should go to an 81-year-old lacking the means of subsistence; but according to the maximal threshold, absolute priority should go to everyone younger. So, there is an inconsistency between the two thresholds.

Let us ignore this inconsistency by considering the maximal threshold on its own. Huseby is critical of Crisp's attempt to set this at a point where the impartial spectator's compassion runs out, on grounds that this would disrespectfully ignore people's own feelings about the matter (including the feelings of the 81-year-olds in my previous example). Instead of this, he proposes overall life satisfaction as the criterion by which thresholds can be set: "the maximal sufficiency threshold equals a level of welfare with which a person is content," where contentment "means not the absence of any desire to further improve one's lot, but rather satisfaction with the overall quality of one's life" (Huseby 2010, 181). This ignores the problem of adaptive preference: under extremely adverse circumstances, people sometimes do reduce their expectations. Hence a contentment criterion would commit us to agreeing that people who would accept a lower than average life expectancy still live long enough. Indeed, under the influence of the 'opiate of the people', some people may believe that God's will alone determines what is a long enough life for them and piously adjust their expectations fatalistically to however long they happen to live. To be charitable, though, possibly this problem can be addressed by Huseby's solution to the opposite problem, expensive tastes, that "some people will require unusually large resources in order to reach a welfare level at which they are content" (Huseby 2010, 181).

To address this, Huseby shifts his criterion from actual contentment to *'a reasonable chance of being content'*. This is understood probabilistically as the level at which at least a majority feel content. Thus, if a great majority would feel satisfied with lives that reach eighty, the cryogenics enthusiasts who want to live forever would have no grounds for complaint as long as they lived to eighty. One serious misgiving about this criterion is that in principle it can endorse the results of oppression. If a small minority enslaved a great majority and worked them to early deaths, some of the slaves might give up hope for living anywhere near as long as the slave-owning elite, and this would skew downward the average age with which the population is content. In that case Huseby's criterion for full sufficiency could be used as an ideological prop for slavery.

Instead of this, what can we say about reasonable expectations for a fully sufficient life, in terms of health and longevity? Unfortunately, what we can know about reasonable expectations about *each person's* health and longevity is *not much*. This results from two general but hard facts about health: one is human diversity, and the other is the limited nature of medical knowledge.

The relevant fact about human diversity is that no two people have the same maladies (and, let us add, the same exposure to accidents) at every time in their lives. One consequence is simply

that people die from accident and illness at different ages. This would not be a consequence if human knowledge and practice of medicine were perfect. In science fiction medicine, any malady and any accident can be successfully treated at any age, so mortality would not necessarily occur within each age group. But our actual medical knowledge and arts are more limited. Given this state of affairs, what could the impartial spectator say when asked what is the maximum threshold, fully sufficient, for a healthy lifespan for each person? The third remit of the impartial spectator (listed at the beginning of this section) is to arbitrate claims on the basis of social productive capacity. Any set of claims that cannot be met jointly within the productive capacity of the society must be scaled back–equitably. We simply lack the knowledge and technology to support *any* minimum *or* maximum threshold of a healthy lifespan for each person, however, since mortality is ubiquitous, beginning *in utero* and continuing after birth, at every age. Thus, the impartial spectator would have to inform us that there are no reasonable expectations to be had, about what is long enough to be healthy enough – sufficiency in health – for each person.

6. What the impartial spectator *can* say

Nevertheless, there are many instances of insufficient health that an impartial spectator might readily point out. It may seem quite odd, if not contradictory, to say that we can recognize health inadequacies without knowing what would constitute adequate health, but others have made just this observation. Madison Powers and Ruth Faden concede that it may not be "plausible to attempt to specify in the abstract precisely what constitutes a sufficiency of health." Nonetheless, they observe that 'in the world we inhabit, there are many clear instances in which populations or population subgroups fall below a level of sufficiency in health" (Powers and Faden 2006, 61; see also Rid 2016, 35). In other words, inequality can be evidence of insufficiency. How can that be? As Powers and Faden explain it as follows:

> [W]e are interested in the well-being, flourishing, and rights of individuals, but in the real, historically situated world, how individuals fare is generally a function of the status, standing, and position within densely woven patterns of systematic disadvantage of the groups of which they are a part… [consequently,] the concept of sufficiency in health has its greatest theoretical value when it is used for comparisons between populations or population subgroups (Powers and Faden 2006, 61).

Social disparities in health outcomes are well documented and widely studied. It is beyond the scope of this article even to present an overview of health disparities at the present time, much less the surrounding research. Health policy institutions typically conceive of health equity in opposition to health disparities. For example, the World Health Organization has recently characterized health equity as "the absence of avoidable, unfair, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically or by other means of stratification."

The WHO adds, "This implies that ideally everyone should have a fair opportunity to attain their full health potential and that no one should be disadvantaged from achieving this potential"

(World Health Organization 2019a). I will set aside the matter of attaining full potential, because it raises a dilemma for health sufficiency as well as for health equity. Some people are born with health-limiting and life-limiting genetic conditions. What, then, do we consider as their potential? If we define their potential within those genetic limitations, we implicitly lower the standards for sufficiency and equity alike for these people. If we do not discount their potential for their genetic limitations, then equity and sufficiency might require outcomes for these people that cannot be achieved, given the current state of medical knowledge and practice. Since I cannot discuss this dilemma fully here, I will not consider 'achieving full potential' as a conception of health equity or health sufficiency.

While health disparities are quite vivid on a global scale (illustrated by the Ruger quote earlier in this article), there are also striking health disparities not only within countries but within cities. As the WHO has recently remarked, "In London, when travelling east from Westminster, each tube stop represents nearly one year of life expectancy lost according to the findings of the London Health Observatory" (World Health Organization 2019b).

This raises an interesting prospect for sufficiency theory. Could we simply take the life expectancy surrounding the Westminster tube station as a threshold for full sufficiency? The impartial spectator would want to know that this is not utopian, *i.e.*, that it is not beyond the productive capacity of British society to raise life expectancy in the outlying regions to the same level. If supporting Westminster life expectancy in all regions is indeed feasible rather than utopian, then not only will other self-respecting Londoners demand it for their boroughs and tube stops as well, but the impartial spectator would have to concur (at least *pro tanto*).

What this illustrates is that choosing a reference group, against which to measure the health disparities suffered by other groups, can *stand in for* choosing a threshold for full sufficiency. The reason for allowing a reference group to stand in for an outcome threshold is that we cannot set a threshold of fully sufficient health outcomes that each person should be able to achieve. Every group of self-respecting people will insist that they should not bear an unequally heavy burden of disease and that the health outcomes of their group should be optimal, *i.e.*, no less that the outcomes for any other group. This should be sustained by an impartial observer but with one qualification: what are chosen as optimal outcomes must not be achievable only at the expense of other groups. The reference group, in other words, should not be an elite whose high health outcomes could not be maintained were it not for ruthless exploitation leading to inferior health outcomes for the exploited. Take a colourful example: suppose that vampires ruled the world and maintained a life expectancy of 100, twice as high as their victims, who included everyone else on Earth. It would not be acceptable to choose the vampires as the reference group for a fully sufficient life expectancy in that world. If it so happened in that world that a group freed from the vampires thereby raised their average life expectancy to 100, then the threshold could still be 100, based on a different reference group, not the vampires but rather on the freed-from-vampires group.

Once an appropriate reference group is found, its health outcomes can stand in as reasonable expectations for other groups. One criterion for appropriateness, I have suggested, is a kind of efficiency: the reference group's outcomes must be optimal, but they must not come about through processes that reduce the outcomes of other groups, given available productive capacity. Extending

the same idea to future generations would make sustainability another criterion: the reference group's optimality must not be based on environmental impacts that will reduce the health outcomes of future generations. Thus, vampires would be disqualified as a reference group even if they did not reduce the life expectancy of their current victims, *if* their vampirism affected their victims genetically, introducing genetic disorders to future generations. A less extravagant example would be the following: a miracle cure is discovered that enables 50% of the population to defer death indefinitely. As this group ages, the productive burden on the society increases until it becomes impossible to maintain the whole population's capability for health and longevity at this level. Therefore, this group should not be chosen as the reference group for sufficiency in health.

So, we can see what reasonable expectations might look like for the capability of health. We cannot know what is healthy enough, for long enough, for each individual. For individual health outcomes, there are still no reasonable expectations of full sufficiency to be had. What we can have instead are reasonable expectations of fully sufficient health outcomes for groups in which case, for groups, we can know what is and is not healthy enough, for long enough.

7. Conclusions

Reasonable expectations for health should focus on the highest health outcomes for which we can find a reference group, within limitations of social productive capacity, non-exploitation, and sustainability. No group's health capabilities are adequate unless they are equal to those of such a reference group. As with political freedoms, though for different reasons, nothing is adequate short of equality.

What are the implications for public policy? In particular, what ought to be done for and with people below this threshold?

Roger Crisp's answer is appealing, though complex. What is most appealing is that it plausibly applies the prioritarian principle that it is important to benefit those who are worst off. Recall that the threshold he proposed was one at which an ideally compassionate impartial spectator's compassion would run out: benefitting people living that well or better has no importance. Below the threshold, our priorities were more complex: "benefiting people matters more the worse off those people are, the more of those people there are, and the larger the benefits in question," with the caveat that "the number of beneficiaries matters less the better off they are" (Crisp 2003, 754).

This solution will not work for health. The reason is that there is no threshold of adequate health for all individuals. Crisp's weighted prioritarianism is meant to guide us in allocating between individuals, and it would not have the same plausibility applied to groups. Groups overlap, and so benefitting all members of a more disadvantaged group may result in benefitting people at the upper fringe of that group who are better off than people at the lower margins of a less disadvantaged group.

However, there is an approach to groups that may still appeal to the broader spirit of prioritarianism. This is proportionate reduction of shortfalls. Once a reference group is identified, we can consider priorities for reducing the shortfalls below it. Suppose, for example, that a reference group has an average life expectancy of eighty, while two other groups have life expectancies of forty

and sixty. The lowest group has a shortfall of forty years, and the other has a shortfall of twenty. If the latter group's life expectancy increases by ten years to seventy, it thereby reduces its shortfall by half. A proportionate reduction for the lower group would involve raising its life expectancy from forty to sixty, an increase of twenty years. In this way, proportionate reduction of shortfalls does give priority to benefitting the worst off, in the context of groups rather than individuals.

Proportionate reduction of shortfalls also answers a question rarely addressed by theories of justice. Ideal theories in particular aim to specify necessary and sufficient conditions for a fully just society (or world, in the case of global justice). One question that disadvantaged people reasonably ask about reaching justice is about how long it will take. Can a process of change moving towards ideal justice move so slowly that the process itself is unjust? A public servant taking a class from me once drew my attention to the fact that progress towards equal opportunity of employment in the Canadian federal public service was proceeding much more slowly for visible minorities than for women. Intuitively, this seems to compound the injustice of unequal opportunity. How long must remediation of a social injustice take, before the slowness of change itself becomes unjust? Apartheid began to be dismantled in 1994, and yet South Africa currently has the highest degree of income inequality of any country on Earth. And so it is a commonplace of South African politics that the process of undoing the injustice of apartheid has been going too slowly. Can political philosophy offer any guidance or clarification? We cannot expect any from ideal theory, but it may also be unclear what guidance comparative theory has to offer. If a comparative approach to justice offers simply to show what are the dimensions of change in which progress constitutes greater justice, this by itself seems to remain silent on the pace of change. By itself, indicating the direction of change has no implications for the proper pace of change. The idea of shortfall equality may offer some helpful guidance. If we recognize proportionate reduction of shortfalls as a principle of justice, then it is clear why slower progress towards equal opportunity for visible minorities than for women is itself unjust. Similarly, it makes clear why it is unjust when disadvantage is reduced so much more quickly for a black South African middle class than for other worse off groups who were also victims of apartheid. Indeed, proportionate reduction of shortfall would seem to pose a bracing challenge to all justice-seeking movements, across the entire spectrum from liberal reform to social liberation.

Notes

[1] 'Striving to live well' refers to the purposive, teleological aspect of human lives, without endorsing the particular goods that individuals seek. The capability approach abstracts from these particulars to identify kinds of functioning that everyone has reason to value as elements of a good life. Striving to live well models what equal concern (as demanded by public reason) is concerned about. In other words, it should be what matters to us, about each other, as a constraint on public reason; it should be what matters to an impartial spectator.

[2] 'Society' could mean either global society or a particular society governed by a nation-state. It is an important question whether sufficiency thresholds should be set country by country or globally, but

that question deserves separate treatment. Either way, the impartial spectator is charged with arbitrating claims so that they are compatible with productive capacity, either local or global.

References

Casal, Paula. 2007. "Why Sufficiency Is Not Enough." *Ethics* 117 (2): 296–326.

Crisp, Roger. 2003. "Equality, Priority, and Compassion." *Ethics* 113 (4): 745–63. https://doi.org/10.1086/373954

Fourie, Carina, and Annette Rid. 2016. *What Is Enough?: Sufficiency, Justice, and Health*. Oxford: Oxford University Press.

Frankfurt, Harry. 1987. "Equality as a Moral Ideal." *Ethics* 98 (1): 21–43.

Frankfurt, Harry G. 2015. *On Inequality*. Princeton, NJ: Princeton University Press. http://catalogue.library.carleton.ca/search/?searchtype=t&SORT=D&searcharg=On+Inequality&searchscope=9&submit=Submit

Huseby, Robert. 2010. "Sufficiency: Restated and Defended." *Journal of Political Philosophy* 18 (2): 178–97. https://doi.org/10.1111/j.1467-9760.2009.00338.x

Nielsen, Lasse. 2019. "What Is Wrong with Sufficiency?" *Res Publica* 25 (1): 21–38. https://doi.org/10.1007/s11158-017-9377-y

Nussbaum, Martha C. 2000. *Women and Human Development: The Capabilities Approach*. Cambridge: Cambridge University Press.

———. 2006. *Frontiers of Justice: Disability, Nationality, Species Membership*. Cambridge MA: Harvard University Press.

Powers, Madison, and Ruth R. Faden. 2006. *Social Justice: The Moral Foundations of Public Health and Health Policy*. Oxford University Press.

Ram-Tiktin, Efrat. 2016. "Basic Human Functional Capabilities as the Currency of Sufficientarian Distribution in Health Care." In *What Is Enough? Sufficiency, Justice, and Health*, Chapter 8, 144-163. Oxford: Oxford University Press.

Rid, Annette. 2016. "Sufficiency, Health, and Health Care Justice." In *What Is Enough?: Sufficiency, Justice, and Health*, 30–47. Oxford: Oxford University Press.

Robeyns, Ingrid. 2016. "The Capability Approach", *The Stanford Encyclopedia of Philosophy* (Winter 2016 Edition), ed. Edward N. Zalta. URL = <https://plato.stanford.edu/archives/win2016/entries/capability-approach/>

Robeyns, Ingrid. 2017. *Wellbeing, Freedom and Social Justice; The Capability Approach Re-Examined*. Cambridge, UK: Open Book Publishers.

Ruger, J. P. 2006. "Ethics and Governance of Global Health Inequalities." *Journal of Epidemiology & Community Health* 60 (11): 998–1002. https://doi.org/10.1136/jech.2005.041947

Ruger, Jennifer Prah. 2009. *Health and Social Justice*. Oxford University Press. http://www.oxfordscholarship.com/view/10.1093/acprof:oso/9780199559978.001.0001/acprof-9780199559978

Stedman, Thomas Lathrop. 2000. *Stedman's Medical Dictionary*. 27th ed. Philadelphia: Lippincott Williams & Wilkins.

World Health Organization. 2019a. "Health Equity." World Health Organization. 2019. http://www.who.int/topics/health_equity/en/

———. 2019b. "Health Inequities and Their Causes." World Health Organization. 2019. https://www.who.int/news-room/facts-in-pictures/detail/health-inequities-and-their-causes